Strengthening social dialogue in the hospital sector in the new Member States and candidate countries

A project for EPSU and HOSPEEM

Overview report

May 2008

Introduction

This overview aims to draw together the key findings from the research which accompanied the HOSPEEM/EPSU project on "strengthening social dialogue in the hospital sector in the new Member States and candidate countries". This research looked at the following issues for the EU-27 countries:

- The structure of the European hospital sector and trends in health care reform
- Employment in the health and social care sector
- Key features of the framework of industrial relations
- Collective bargaining and social dialogue structures in the hospital sector
- Key issues affecting the hospital sector labour market and the role of social dialogue

The overview is not intended to be exhaustive and should be read in conjunction with the full study report. As well as providing a comparative summary of the findings, it also includes tables highlighting key information and indicators for each country. It is intended that this overview can be amended and supplemented following discussions at the closing conference of the project in April 2008.

Definitions

For the purposes of this study, the following definitions have been applied in respect of the terminology used to describe different types of collective interest intermediation and information, consultation and negotiating mechanisms:

Social dialogue – the term social dialogue is used to cover a wide range of bi-partite and tripartite information, consultation and negotiating arrangements. Collective bargaining (see below) is one specific form of social dialogue. Here the term "social dialogue" is used to deliberately distinguish between negotiations on wages and terms and conditions of employment (referred to as collective bargaining) and other information and consultation arrangements between social partners on issues affecting their sector (referred to as social dialogue).

Collective bargaining – this term is used to refer to the negotiation of wages and terms and conditions of employment. Collective bargaining can take place at the *national*, *regional or local/enterprise level*. It can be *cross-sectoral, sectoral* or cover a single organisation and can be *bipartite* (involving only representatives of labour and management) or *tripartite* (involving government representatives). In circumstances where employees in the hospital sector are civil servants, such negotiations involving representatives of State authorities are characterised as bi-partite rather than tripartite bargaining, as the State fulfils a dual function in such cases.

Tripartite concertation – this term is used to refer to institutionalised arrangements, usually at the national level, which allow social partner representatives to be informed and consulted on a wide range of policy issues.

Trends affecting health care policy and the hospital sector labour market

The European health care sector plays a critical role in the achievement of the Lisbon goals of making Europe the most dynamic, knowledge based economy in the world by contributing to the overall health and wellbeing of the workforce and society as a whole. In addition, the health and social care sector is also an important employer, whose significance is likely to grow in the context of demographic change. As a result, health care employers are not only affected by trends towards an ageing population in terms of the rising demands this places on service delivery, but also in the context of emerging labour market shortages resulting from declining birth

rates. This study has explored in some detail the extent to which recruitment and retention are defined as issues of concern by the hospital sector social partners in different Member States and the way in which this has been addressed through social dialogue (see below).

Expenditure on health care is also increasing as a result of ongoing advancements in medical science, making it possible to successfully treat and improve the prognoses for many conditions, which would previously have been unthinkable. Such developments have not only opened the door to more advanced (but often also expensive) treatments, but in prolonging healthy life spans are also contributing to the number of individuals living to very old age. This increases the potential to develop more complex ailments and raises the demand for long term care services.

These developments are taking place at a time, when health care funding systems are already coming under pressure from increasingly tight budgets, both for the public purse and for household expenditure. Government finances in many countries are influenced by restrictions on public borrowing imposed by the criteria of the Stability and Growth Pact, as well as by the desire among politicians to maintain or reduce tax burdens for households feelings the impact of rising costs on everyday expenditure such as housing, food, oil, gas, electricity and petrol.

The research was able to provide an overview of the measures which have been taken in different Member States to meet these challenges and to seek to improve health care services while at the same time dealing with the need for cost containment. It was also able to chart the impact of such policy measures on the hospital sector labour market and the ways this has been addressed by the social partners.

The European dimension

It is not only as a result of these trends that the European hospital sector faces many common challenges. In addition to such “global” economic and labour market trends, there has also been an increasing involvement of the European Union in the sector, which could not have been imagined only 10 years ago. Today, the EU is discussing issues such as the cross-border provision of health services, as well as the impact of demographic challenges on health and social care provision. Initially, it was clear that the funding and organisation of health care was an entirely national prerogative in which the European Union only has complimentary powers (the principle of subsidiarity).

However, from the early days of the European Communities, legislation on social security provisions to ensure freedom of movement had some implications, for example on health insurance services and access to treatment while in another EU Member State. With the increasing movement of workers across the EU, European policy makers have become more involved in regulating the transferability and mutual recognition of qualifications and there are obviously EU level regulations setting labour and health and safety standards. Staff mobility has also raised the question of the ethics and practicalities of recruitment from different countries which may also face staff shortages. Staff mobility and migration, as well as the need to provide appropriate facilities to integrate workers from other countries successfully into the labour market have emerged as important concerns for many sectoral social partner organisations at national level throughout this research, and the report contains some examples of how such issues have been addressed through social dialogue. The importance of this issue has already been reflected at European level in the adoption of a joint Code of Conduct in Transnational Recruitment by EPSU and HOSPEEM in December 2007.

In addition, in recent years, the internal market logic has also moved increasingly closer to the health services, with such services being viewed more and more as economic services which can be traded across state boundaries. Various European court cases have solidified the right of patients to seek treatment abroad if they face unreasonably long waits at home and to charge their own health authority for such treatment. Following the decision to exclude health and social

care services from the 2005 Services Directive, the Commission has been working on proposals aiming to allow patients to access health services across borders. A Directive on Patients' Rights had been expected to be issued towards the end of 2008 but are currently stalled in the Commission, as a result of an almost unprecedented tide of concerns regarding the practicality and impact of such proposals from all sides.

The role of the social partners

In light of the significant role of the health care sector, not only as an employer, but also as a provider of critical services and as a result of the many common challenges facing heath care providers and the increasing encroachment of EU policy in this field, the involvement of social partners in relevant decision making processes is crucial. This is true at the national level as well as at the European level.

The "Europeanisation" of health care policy has meant that the social partner had to become increasingly active at this level in order to influence policy making. In September 2006, the European social dialogue committee for the hospital sector was therefore established involving the members of EPSU and HOSPEEM. As well as providing the scope for the bipartite and tripartite exchange of views and information and the formulation of common opinions and policy responses, recognition as sectoral social partners also confers the right to be consulted of relevant European Commission legislative and policy initiatives and to negotiate autonomously on matters of common interest (on the basis of Articles 138 and 139 of the European Treaty).

European social dialogue plays a key role in the structure of EU governance as it provides the partners most closely involved in the delivery or supply of goods and services in the European economy with the opportunity to discuss and negotiate policies affecting the labour market in their sector.

In order for this process to work effectively and to be relevant, it is necessary for the appropriate structures to be in place to feed information and concerns from the bottom up and to implement top down initiatives on the ground in the Member States and at workplace level. Without good bottom up interaction, it is difficult to determine priorities and design relevant responses at EU level. Similarly, without existing, representative and well-functioning national social dialogue structures it is impossible to implement European agreements at national, regional and local level. It was therefore important for this study to explore the "maturity" of social dialogue arrangements on the ground within each Member State. This includes an assessment of the extent to which representative employer and trade union organisations are present in the sector and are currently involved in the European dialogue through the European sectoral organisations EPSU and HOSPEEM.

The structure of the European hospital sector and trends in health care reform

Organisation and management of the hospital sector

In order to understand the structure of collective bargaining and the prevalence of different employer side organisations in different countries, it is important to be aware of the structure of delivery of health care services which predominates in each Member State.

In the EU this is largely achieved through a mixture of public/private and not for profit provision. The balance of these providers varies between countries, but public sector delivery remains prevalent with private activity focused in particular areas (such as dentistry) but growing in importance.

Public sector delivery predominates in Austria, Bulgaria, the Czech Republic, Denmark, Estonia, Finland, Ireland, Italy, Latvia, Luxembourg, Malta, Portugal, Slovak Republic, Sweden and the

UK. However, in many of these countries, the share of private provision has increased in recent years. Greece is one of the few countries with a predominant public sector where the provision of private health care has declined in recent years. The municipalities and regions are most commonly in charge of the delivery of public health care services. In countries with a National Health Service, such as the UK and Portugal, administration, planning and management is done through specific strategic health authorities, separate from the political regional or local administrations. The regions, or indeed the state, are often responsible for the management of larger or teaching hospitals.

In France, there is a split of approximately 25% public, 33% private not for profit and 40% private for profit provision. In Germany, health care provision is just under 50% public and 50% private, with 5% of service being run by churches or other NGOs. In Latvia, 50% of health care provision is public. The largest share of private provision can be found in dentistry and specialists health services. Slovenia also has a mix of private and public provision.

In Belgium, hospital and other health care services are mainly provided by private, not-for-profit organisations run by religious and other charitable bodies. In Cyprus, the private sector is the main provider of health care.

In a number of countries, GPs are set up as private entrepreneurs and in some others (e.g. Malta, UK) they are allowed to mix public with private practice.

Centralised management of health care is increasingly rare and Ireland is the only country to have centralized its management function in recent years. In most countries, overall health care policy is determined at national government level by the Ministry of Health, while the planning of provision is often carried out at regional or municipality level.

Private provision of hospital services is either through chains of clinics of individual private hospitals. While some chains engage in collective bargaining for all their locations, private provision usually implies local level negotiation with individual providers (see also below).

Structure of health care finance

When looking at the funding of health care it is important to remember a number of factors:

- Demand for health care is potentially open ended, particularly with advances in the development of medicines and medical technology. Therefore, a system of rationing has always been in place, be it through a “gatekeeper” system, financial restrictions, decision about the approval of drugs for widespread funding or indeed DNR (do not resuscitate) decisions at operational level.
- Not only as a result of, but exacerbated by medical advances and demographic change, even where there have been significant increases in investment in the health care sector in recent years, it is not easy for such investment to keep pace with the rise in demand.

According to the OECD, healthcare expenditure as a share of GDP in the EU15 was 9.3% on average in 2005 and an average of 6.6% in the EU12. The lowest investment in the EU15 was in Luxembourg with 6.2% and, while the lowest in the EU12 can be found in Romania with 3.9%.

The most common method of funding is through a system of compulsory health insurance, usually funded through a system of employer and employee payroll contributions which is often complemented some funding from general taxation. Only Denmark, Finland, Ireland, Malta, Portugal, Spain, Sweden and the UK have systems that are funded largely from general taxation (with some out of pocket payment for particular items and services). In almost all cases, the share of private involvement in the health care sector is increasing, for example through a reduction of services covered by health insurance funds, more out of pocket payments, and an increase in

private insurance and hospital care provision. In Austria (28%), Bulgaria (45.5%), Hungary, Poland, Romania (all over 30%) and Spain (23%) private, out of pocket payments are playing an increasingly important role in health care expenditure.

Key trends in health care reform

The main reforms in the sector revolve around the issue of cost containment. This is done in many different ways:

- Lack of inflation proofing
- New ways of calculating reimbursement for costs (fee for service rather than increment of previous year's expenditure)
- Introduction or enhancement of the role of gate keepers (GPs before specialists)
- Reduction of services covered by general insurance
- Restrictions in approval of medicines funded by insurance or public funding
- Direct medical decisions based on cost
- More out of pocket payments (prescription charges, co-payments etc.)
- Growth in private health insurance and provision
- Improving efficiency through shared services
- The use of public-private partnerships and private finance initiatives, particularly to build new infrastructure
- Introduction of market-type mechanisms to encourage competition

Another focus of reform is the desire to improve management in the hospital sector. This is largely done via the decentralisation of decision making (e.g. from the national to municipal or to the local level). This can result in better planning of services adapted to the local community, but can also simply be a way of "passing the buck" for difficult funding decisions to the local level.

Many countries mention the computerisation of medical records, which eases the process particularly for continuity of patient care, but also involves significant expenditure and potentially enhanced risks for patient confidentiality. Surprisingly few countries, on the other hand, directly mention an increasing focus on prevention as a means for cost containment. This approach is tied up in wider public health policy (anti-smoking campaigns, reduction of traffic accidents, actions on alcohol abuse and obesity). Having said that, mainly health care services have become increasingly focused on primary care which (potentially) has a greater focus on prevention.

Other reforms have led to greater emphasis on patients' rights and involvement in the process of health care planning; greater emphasis on quality control.

In the context of demographic change, many recent health service reforms have emphasized the need for more long-term care planning and greater co-operation between health and social care services.

Employment in the health and social care sector

With the exception of Bulgaria and Estonia, which have witnessed some significant declines in health care staff since their transformation to market economies, EU countries have experienced a medium term trend increase in the number of workers in health and social care. Eurostat data (taken from Employment in Europe 2006) only provides combined data for health and social work.

Country	Employment in health and social work in 2005 (% of total employment 15+ by main employment)
AT	9.2
BE	12.4
CZ	6.9
DK	17.9
DE	10.9
EE	5.5
EL	5.0
ES	5.9
FR	12.2
IE	9.7
IT	6.7
CY	4.4
LV	5.8
LT	7.3
LU	9.7
HU	6.7
MT	7.8
NL	15.9
PL	5.8
PT	6.3
SI	5.4
SK	6.8
FI	15.3
SE	16.4
UK	12.3

Key features of the framework of industrial relations

The nature of collective bargaining and social dialogue in the hospital sector is not insubstantially influenced by the framework of industrial relations prevalent in the respective Member State. The importance accorded to collective bargaining vis-à-vis labour legislation, the strength of tripartite social dialogue structures, the prevalence of national multi-sectoral or sectoral bargaining versus regional or local bargaining, the differences between public and private sector collective bargaining and the strength of bipartite bargaining and social dialogue structures have a critical role to play in determining the level at which collective bargaining in the hospital sector takes place, as well as on the quality and level of sectoral social dialogue. The study therefore sought to clarify these questions before elaborating on the relevant structures in the hospital sector.

The role of legislation and collective agreements

In many of the new Member States, the UK and the Southern European countries, legislation forms the most important basis for the regulation of employment and working conditions. In a number of countries this includes the setting of a statutory minimum wage. Collective agreements are then used to build upon and elaborate these provisions. In the Nordic countries, on the other hand, collective bargaining and autonomous dialogue between the social partners often take precedence over legislation.

Differences in public and private sector collective bargaining structures

In many countries a distinction must be drawn between collective bargaining arrangements in the public and in the private sector. While in the private sector centralised bargaining at national or sectoral level is often non-existent, particularly in the new Member States and in the UK, many countries use centralised bi-partite bargaining arrangements in the public sector (at least to settle framework conditions with further conditions and benefits being negotiated at regional or local level). This certainly applies to civil servants, but in most countries covers all public sector employees (often with separate bargaining for different occupational categories).

The prevalence of tripartite and bipartite social dialogue at different levels

Generally, bi-partite social dialogue structures outside the arena of collective bargaining are more prevalent in the EU-15, but even here are by no means present in all countries. In the EU-12 the existence of such structures aimed at discussing key issues affecting sectoral labour markets or policy developments are much rarer. In these countries, tripartite arrangements for concertation and dialogue are often the only platform for employer and employee representatives to discuss relevant policy measure and initiatives. Even here, often not all relevant organisations are involved and the state tends to predominate proceedings. Tripartite systems of interest intermediation are significantly more well established in some of the EU-15.

Trends in the development of trade union and employers' organisations

In the new Member States, social partner organisations, and employers' organisations in particular, are often weak as they often have but a relatively short history during which many have undergone several permutations through mergers and de-mergers. Many employers' organisations continue to resist taking on a mandate for collective bargaining, which makes sectoral bargaining difficult or impossible. The development of stronger organisational structures is often hampered by the lack of resources facing many of these organisations.

Trade union membership has declined in many of the new Member States, largely as a result of changes in the economic structure of these countries and the demise of industrial sectors where trade union membership has traditionally been high. Membership density is therefore an issue in many countries and collective bargaining coverage is often low, ranging around 20%.

A decline in trade union membership can also be found in many of the EU-15, but often from a much higher base. On the whole, it is important to note that trade union membership in the public sector is significantly higher than in the private sector. Similarly, employers' organisation tend to be fairly well established in the EU-15, although in some countries in the hospital sector there is no specific employers' organisation where the state effectively plays the role of employer.

Collective bargaining and social dialogue structures in the hospital sector

Trade union and employers' organisations in the sector

In the majority of countries there is a situation of multi-trade union and often multi-employer representation in the hospital sector.

Employers' organisations

Employers' organisations are often split according to the nature of provision (i.e. public sector/private non-for-profit sector/private for-profit sector; local, regional or state level). This is variously true for Austria, the Czech Republic, Finland, France, Germany, Italy and the Slovak Republic.

In Belgium, there is a further split between socialist, catholic and protestant employers' organisations. Germany also has separate employers' organisation for catholic and protestant care providers, but these are exempted from collective bargaining.

In a number of countries the state (mostly the Ministry of Health) fulfills the role of employer for public sector providers, while the general employers' organisation for the private sector represents private health care providers (Cyprus, Greece[1]).

Bulgaria, Denmark, Hungary, Latvia, Luxembourg, Romania and the UK only have one employers' organisation in the hospital sector.

In Ireland, HSE represents the majority of (public sector) hospitals, whereas the general private employers' organisation IBEC represents private providers.

In Lithuania, public health care providers are represented by the Ministry of Health, while private providers are represented by the Private Healthcare Providers' Association and the Lithuanian Hospitals' Association. Similarly, in Portugal, the public sector is represented by the Department of Public Administration (the state) while the Portuguese Association of Private Hospitalisation represents private providers.

In the Netherlands there are separate employers' organisations for academic hospitals and general hospitals.

In Spain, the employers' role for the sector is played by the various autonomous regional administrations.

In Sweden, there are separate employers' organisations for the public and private sector, but the public sector agreements generally also cover the private sector.

In a number of the new Member States, employers' organisations in the sector are fairly new and still in a state of flux and development. Changes in these organisations have often been the result of reorganisations of hospital sector structures (e.g. from the regional to the municipal level or vice versa). Some of these bodies are not currently involved in collective bargaining and while some are represented in tripartite structures at national level, others are not.

[1] In Greece, private sector employers are split between specialism and region.

Trade unions

Trade unions are often more numerous and as well as being split along religious or ideological lines are frequently representative for particular occupational groups. Indeed, on the whole the can be divided into general unions, which often have a wider membership also outside the hospital sector and specialist unions mainly representing workers in the hospital sector (such as trade unions for nurses, midwives, occupational therapists etc.). Most countries have specific organisations representing the interests of doctors.

Most trade unions are involved in collective bargaining at different levels and many are represented on tripartite bodies.

The role of collective bargaining at different levels

Bi-partite collective bargaining between employers and trade unions can take place at different levels and with a different focus:

- National cross-sectoral level (where this takes place, it is often focused on key issues of labour market regulation)
- National sectoral level (usually on issues such as framework salary structure, minimum wage, key terms and conditions)
- Regional sectoral level (usually in relation to regional supplements)
- Local sectoral level (usually on local wage structures, work organisation and additional benefits)
- Local individual level (usually on additional benefits)

Negotiations on salaries and terms and conditions tend to be dependent on the status of the employee (civil servant or standard labour code).

In addition, the structure of collective bargaining in the hospital sector depends on the status of provision (public, private, voluntary). Terms and conditions for civil servants are largely set by government. Public sector bargaining often plays a guiding role, but is restricted by overall public spending plans or the level of social insurance levies. Private providers usually only bargain at the local level, with a number of exceptions (i.e. in the Germany).

The prevalence of tripartite and bipartite social dialogue

With the level of change and reform currently being experienced in the health care sector, social dialogue on these issues is arguably critical. A sectoral report by the ILO (2004) argues that

"*Concern about public health and the increasing cost of health care have made the subject of health one of the most debated political issues in many countries. The vital role of governments, employers and workers' organisations and the importance of social dialogue among them in addressing these issues have only been recognised recently. There is now a wide recognition of the role of social dialogue in advancing and sustaining reform processes in many areas of the health sector…*

In order to ensure a better delivery of health services the institutions and capacities of social dialogue need to be strengthened."

The question is: how are current social dialogue structures organised at national, regional or local level and are they adequate to achieve these goals?

Discussions on the regulation of the labour market (and indeed on health care reform) largely take place at tripartite national level with the responsible government departments (with the

exception, to some extent, of the Nordic countries, where – as indicated above – much of labour market regulation is left up to the social partners). Most countries have structures for such tripartite interest intermediation. In some countries, this form of interaction has a basis in law (e.g. Slovakia) in others, this simply takes place on an informal basis (e.g. Czech Republic). Differences are also apparent in relation to who is involved in these discussions and who has the final say in decision making (this is usually the government). For example, in Poland an employers' organisation for health care workers in GP surgeries was established because of a concern over a lack of consultation regarding health care sector reforms.

National tripartite dialogue between relevant government departments and employers' and trade union organisations exists in Belgium, Bulgaria, Latvia, Luxembourg, Portugal and generally covers wider health care policy issues.

No such dialogue currently exists at national level in Austria, Estonia, France, Hungary, Spain, although some efforts are under way to establish better co-operation.

Tripartite as well as bi-partite dialogue exists in Denmark, Finland, Germany, Ireland, Netherlands, Sweden, UK on questions of health care policy, challenges facing the hospital sector labour market including education and training.

Key issues affecting the hospital sector labour market and the role of social dialogue

There are a surprising number of similarities between countries in relation to the key issues facing the hospital sector labour market, as identified by the social partners themselves. Many of these are also reflected in the priorities for European sectoral social dialogue. This section will focus on the most frequently mentioned challenges as well as some of the solutions implemented through social dialogue in different Member States.

Staff recruitment and retention/skill shortages/migration

The recruitment and retention of hospital sector staff is an important issue in virtually all EU countries, although the reasons why this proves to be a challenge differ. In many of the EU-12, the main concerns include:

Migration to other countries where pay levels are higher (this can involve short-distance migration for example from Slovakia to the Czech Republic, but can also involve migration to countries such as the UK, the Nordic countries or indeed outside the European Union). This is often coupled with inward migration from other countries with lower labour standards and pay. In the EU-12, this often means migration from the countries of the former Soviet Union. However, migration is not only an issue for the EU-12, but also affects other countries such as Germany and the UK.

In the Czech Republic, it was noted by employers that many physicians and also nurses who left the country, did not succeed in finding a job which would be equivalent, in terms of status and responsibilities, to the job they held previously in their home countries. It was suggested that better information of employees, possibly in the form of social dialogue with employees' representatives at regional or local level, on the type of problems encountered by health care stuff leaving the country could contribute to staff retention.

The reasons most frequently given for outward migration in the EU-12 are low levels of pay and a perceived lack of career prospects.

In Latvia, the social partners at the sectoral level have repeatedly demanded the government to raise the remuneration level of the various professional groups in the health care sector and to set the state compensated cost of the services to match the real prices and costs faced by the sector. However, making the state consider and to take in account the results of the social

dialogue in the development of legislation and allocation of financing still remains the central challenges faced by the employer and employee representatives. It is argued that while the socia partners are often able to achieve mutually satisfactory solutions, these are frequently not taken into account by the government.

In all Member States, it is frequently emphasized that a majority of health care staff are women and that it is therefore particularly important to implement measures which assist in the reconciliation of work and family life. This is recognized in a new collective agreement for midwives in Malta. This agreement includes significant opportunities for flexible working including:

- Working mothers can keep working on reduced hours until their children are 12 years old.
- More flexibility to the use of parental leave.
- Additional “career break” leave has been raised from three to five years.
- New avenues for flexitime work, job sharing and teleworking.

In the UK, a comprehensive system of flexible working was introduced as part of the “Improving working lives” initiative. This offers different shift systems, self rostering, term-time working and many other working patterns which making it easier for working parents to reconcile work with bringing up children.

Another factor in the departure of health care workers was considered to be the lack of access to ongoing training and career progression. A number of initiatives therefore focus on creating opportunities and a clearer structure for progression in the various health care professions.

In Belgium, one of the solutions put in place has been the implementation of flexible training systems whereby unqualified hospital staff can benefit from training to raise their level of qualifications (e.g. to qualify to become a nurse for instance). Part time training has been encouraged. These training programmes resulted from the discussions in the last collective agreement and were put forward by the trade unions. In the private sector a project called ‘Project 600’ aims at creating 600 jobs by replacing employees who are attending training. This creates new job for low-qualified employees, while around 1500 employees upgrade their skills. Other measures include better accompanying measures for new recruits and employees who resume their career after an interruption; the creation of a "gateway" between licensed nurse and graduate nurse status; and a continuing training programme to take into account technological developments in the area of healthcare.

In Luxembourg, measures were also taken to reduce the number of workers leaving the sector prematurely. The issue of staff retention was addressed through various collective agreements that resulted in a substantial improvement of work conditions in the sector. Between 1995 and 2005:

- Wages substantially increased (between 32 and 56%) thanks to the careers being re-valued (recognition of qualifications), the introduction of a 13th month and of a holidays ‘bonus’ (*pécule de vacances*).
- Working time was reduced of 5% (38 hours per week) while preserving salaries, working time was reorganised (e.g. 35 days annual leave and maximum working days per year).
- A system of part-time work and early retirement was created.
- Provisions were put in place to facilitate work/life balance such as the introduction of ‘social’ leave (*congé social*) and other forms of unpaid leave.
- Setting up of co-financing for lifelong learning.

In a number of countries, measures have been implemented to attract health care staff of different countries, including outside the EU. In relation to this, the need for ethical recruitment practices from 3rd countries is also often mentioned. In the UK, guidance for ethical requirement has been in place for a number of years with the aim of ensuring that recruitment does not take place from countries which are themselves facing shortage and to ensure that workers can return home with greater skills to offer to their national labour market.

Interestingly, trade unions in France remarked that the introduction of the 35 hour work had increased the pressure on the hospital sector labour market and in staff in the hospitals, thus worsening working conditions.

Another important issue in international recruitment is the integration of such migrant workers into the workplace and wider society, as well as ensuring that they are able to work to the level they are qualified for. Several different pilot projects have been implemented for example in Stockholm, Göteborg and Malmö which bring together different parties to design programmes that allow foreign qualified healthcare professionals to acquire a permission to work in the Swedish healthcare sector. In addition, special language courses have been designed as a way of shortening the route to employment. Furthermore, different programmes have been implemented that have allowed Swedish healthcare professional to evaluate the skills of foreign healthcare workers, and then design short, tailored training courses that allow individuals gain experience in fields in which they do not match the experience required to work in Sweden. These projects, overall, have been successful at creating and shortening routes to employment for foreign healthcare professionals. In the UK, many schemes are under way at regional level to help in the cultural and social integration of migrant workers in the sector.

The issue of retaining older workers is also important and will be treated under the heading of "demographic change/ageing workforce".

Demographic change and ageing workforce

Many countries have implemented measures seeking to retain older workers by creating flexible working patterns and offering the possibility of reduced working time for those over 45 (Belgium) or 50 (Luxembourg). Others have created possibilities to combine the receipt of a partial pension with working (UK, Germany). In addition, Finland introduced schemes to address the training needs of older workers.

It is surprising, that relatively few of the organisations interviewed as part of the research, referred to specific initiatives aimed at dealing with the impact of demographic change. This could be an important consideration in planning the future work of the European social dialogue as it is clearly a priority area for action.

Ongoing skills development

As well as assisting with encouraging staff retention, ongoing skills development is seen to be critical to enable workers to keep their knowledge up to date with the latest clinical advancements. Some employers in particular expressed concern over the cost of training and possibility of highly trained staff subsequently being poached by other hospitals. In the Czech Republic, as a solution to avoid such staff "leakage" some employers started practicing conditional training contracts in which they specify that if the trained nurse or a doctors leaves the hospital during or within a specified period following the training, they have to partially reimburse the costs of training. Such contracts can be an important incentive for staff to stay with the employer as the costs of training to be recovered are high.

Of similar importance is ensuring that education and training provision is relevant to clinical practice at hospital level. In Finland the social partners are therefore engaged in education and training of health care professionals from the national to local level. With regards to the national

level, the social partners from the health sector are represented in tripartite, sector-specific working groups on education and training policies and related laws. These working groups negotiate on matters such as the number of training places and the course content, though the relevant ministries are responsible for making the final decisions.

In relation to the local and regional level, the Finnish social partners are regular members of governing bodies and consultative committees of individual educational institutions. Social partners are also engaged in the competence-based qualification system, which is the framework for vocational education and training in the country. The VET system is based on a tripartite collaboration at national, regional and local levels. The tripartite qualification committees, appointed by the National Board of Education, define the competence based examinations. At local and regional level it is their role together with training providers to supervise the organisation of the tests and confirm approved qualifications. In practice this means that sectoral social partners are engaged in the design and deliver of VET in Finland. This also applies to the health and social sector, though the health sector to a lesser degree as for example doctors are educated in Finnish universities rather than within the VET system. But, for example, further VET qualifications for ambulance service personnel are provided within the VET system.

Recently, a training agreement has been signed to safeguard the development of skills and competence of the employees in the health and social sector. Local authorities are legally bound to take care of the further training of their personnel.

In the UK, the social partners in the hospital sector agreed on a new “skills escalator” which was linked to the pay review and allows staff to continuously develop their capacities.

Equal opportunities and diversity

Equality and diversity measures also play an important role in the hospital sector labour market in not least in relation to the retention of female staff, measures to encourage more men into some of the female dominated professions, to ensure equality of opportunity to ethnic minority and migrant workers and to ensure that the workforce reflects the patient population.

In addition to work-life balance measures, the achievement of equal pay is one of the important goals, particularly for trade union representatives. In the UK one of the goals of agenda for change was the address the gender pay gap. A system of job evaluation was negotiated at national level and subsequently implemented at local level.

As well as addressing vertical segregation by seeking to attract more men for example into nursing (such schemes exist, for instance in Sweden), dealing with horizontal segregation is another priority area for action aimed at fully utilizing the potential of the hospital sector workforce. In Austria (Vienna hospitals), an initiative was agreed to increase the number of women in management positions. A decision was made that if two candidates with equal qualifications applied for the same job, the woman should be given preference over the man. The goal is to address the current imbalance which means that while there are 60% female doctors, this percentage is reduced to 37% among more senior, specialised medical doctors and drops further to 14% among chief medical doctors.

Based on the recognition that the Belgian hospital sector is becoming more and more multicultural, both in terms of workforce and in terms of patients treated, diversity policies are being emphasized by the Belgian social partners. This includes recruitment initiatives to ensure a good mix of staff from diverse backgrounds, as well as language teaching for hospital employees to allow them to communicate with patients from increasingly diverse national and cultural backgrounds.

Health and safety

Many initiatives exist in the hospital sector to address the important issue of harassment and violence in the workplace. In recent years there has been an increasing concern regarding third party violence and many hospitals and ambulance trusts have responded by introducing zero tolerance campaigns.

For example, the social partners in the hospital sector in Salzburg reached an agreement on how to deal with violence in hospitals. Similarly, the sectoral social partners in Vienna negotiated an agreement on mobbing in the workplace in 2006.

In the Netherlands, a 'Safe Healthcare' plan was drawn up by the social partners, which has been adopted by a number of hospitals. Examples in relation to the measures that have been put in place include staff using yellow and red cards to punish violent guests and refuse them admittance to the hospital for a period of three to six months. In addition, the participating hospitals seek to stimulate staff to report incidents by allowing them to mention the address of the hospital in the police report, so that perpetrators cannot discover the address of the person filing the report.

Working time and work organisation

Implementing changes resulting from the SIMAP and Jaeger jugements of the ECJ on on-call working time have been an important concern for a number of employers. At the time of writing important negotiations were under way in Austria regarding the implications of the working time directive and the SIMAP and Jaeger ECJ judgements between the medical doctors' association and trade unions. The aim is to follow a holistic approach for all hospital sector staff in relation to working time. Currently, it is possible to modify working hours set down in law, but such variations need the agreement of the relevant trade union.

In Germany a new collective agreement has been signed to enable the use of the opt-out to cope with the impact of ECJ judgements in relation to on-call time. Many other countries also mention difficulties related to the need to accommodate new rulings on on-call time, with difficulties in recruiting sufficient additional staff and the need to change working patterns over time.

Health care reform

Financing and cost containment are important issues and in some countries this has led to hospital closures. In orders the issue of privatization has moved higher on the agenda and several systems have experimented with market type mechanisms. This often has implications for the contracts of hospital sector staff, who might be being transferred to private providers. The question of decentralized management and the question of how to make efficiency savings is being discussed by social partners in a number of countries.

Lack of social dialogue structures

As noted above, the employers' representation in health care is currently very fragmented. This is, for the moment, a key structural challenge for social dialogue in this sector, particularly in many of the EU-12. In an other of countries, including the Czech Republic, efforts are currently under way to seek to address the fragmentation of employers organisations. The ongoing development of better bipartite dialogue appears critical if the challenges facing European health care systems are to be addressed and if social partners are to be able to feed their concerns into the European debate and furthermore to be able to implement European agreements on the ground. The experience of the capacity building part of this project has shown the added value of such activities and the learning which can be achieved by the transnational sharing of experiences. This benefit is by no means limited to the EU-12. Indeed, this research has shown that hospital sector social partners in all Member States share common concerns and have

important experiences to share from existing practices. This mutual learning forms an important part of the European social dialogue process.

Country	National healthcare expenditure as % of GPD	Employment in health/ social care (% of total employment)	Structure of hospital sector	Key recent healthcare reform	Social partner organisations	Key features of sectoral social dialogue	Key issues for hospital sector labour market
Austria	10.2 (2005)	9.2	Funded through statutory health care insurance based on employer and employee contributions. Private resources play and increasing role (28% in 2005). 80-85% of hospitals are operated by the public sector, 5% are for profit and around 15% are operated by the non-for profit sector, mainly churches.	Increasing involvement of private sector; creation of electronic patient's database; new hospital framework law; new legislation on patients' rights; federal law on quality in health care services.	<u>Employers:</u> Austrian Hospital and Health Services Platform of the Austrian Association of Public and Social Economy (Verband der Öffentlichen Wirtschaft und Gemeinwirtschaft Österreichs – VÖWG) represents public sector hospitals. FVPKK (Fachverband der privaten Krankenanstalten und Kurbetriebe) represents private health and social care institutions. VPÖ's (Verband der Privatkrankenanstalten) organises private health care organisations. Association of Interest Representation of Catholic Hospitals and Old People's Homes and Nursing Homes (Verein Interessenvertretung von Ordensspitälern und von konfessionellen Alten- und Pflegeheimen Österreichs, VIO) represents church run hospitals. <u>Trade unions:</u> GdG (Gewerkschaft der Gemeindebediensteten) GÖD (Gewerkschaft der Öffentlicher Dienst) GPA-DJP (Gewerkschaft der Privatangestellten, Druck, Journalismus, Papier) Vida *ÖAK (represents all dependently employed doctors as well as self-employed doctors. ÖAK is not strictly speaking a trade union and has compulsory membership.*	Pay, terms and conditions of most public sector staff are set unilaterally at Land level. Main negotiations take place at regional level. There are separate collective agreements for private hospitals and hospitals in the non-profit sector. Currently no federal social dialogue for hospital sector.	Working Time Demographic change Equal Treatment Violence in the workplace Undeclared work in social care

Country	National healthcare expenditure as % of GPD	Employment in health and social care (% of total employment)	Structure of hospital sector	Key recent healthcare reform	Social partner organisations	Key features of sectoral social dialogue	Key issues for hospital sector labour market
Belgium	9.4 (2004)	12.4	Funded from compulsory health insurance and taxation. Delivery mainly in "private" non-profit hospitals owned by religious charitable orders, sickness funds or universities (70%) or by facilities publicly owned by municipalities or communities.	Hospital finance reform including the introduction of fixed-sum payments per treatment Hospital building programme encouraging hospitals to rationalise and redeploy their supply and to seek complementarity with other facilities in the area. Greater emphasis on primary care and strengthening "gatekeeping" role of GPs	<u>Employers:</u> Confédération des Entreprises Non Marchandes (C.E.N.M) Caritas Cartholica Christian Confederation of Social and Healthcare Institutions Socialist Association of Healthcare Institutions (ASIS) <u>Trade unions:</u> Centrale Générale des Services Publics – Secteur des Administrations Locales et Régionales (CGSP-ALR) Syndicat des Employés, Techniciens et Cadres (SECTA) Landelijke Bediendecentrale Nationaal Verbond voor kaderpersoneel Syndicat Libre de la Fonction Publique (SLFP ACV – Openbare Diensten (ACV) The General Federation (Centrale Générale) The ACLVB Liberal trade union	At tripartite level, there is the National Council for Hospital Facilities, which plays and important role in the formulation of health care policy. Collective bargaining differs for public and private hospitals. For public hospitals, collective bargaining takes place between the state and trade unions. Such national negotiations then have to be translated into regional and local collective agreements. Negotiations in the private sector take the lead from the public sector negotiations but have to be "converted" into collective agreements signed between the respective trade unions and employers.	Revision of pay scales Reduction of workload Staff retention Cost containment Equality and diversity

Country	National healthcare expenditure as % of GPD	Employment in health and social care (% of total employment)	Structure of hospital sector	Key recent healthcare reform	Social partner organisations	Key features of sectoral social dialogue	Key issues for hospital sector labour market
Bulgaria	4.3 (2005)	n/a	Decline in public health care expenditure and an increase in expenditure from private sources from 34.6% in 1999 to 45.5% in 2003.	Increase in private out of pocket payments to obtain treatment or drugs. Increasing standards in health care and encouraging staff retention are priorities.	Employers: National Association of Employers in Health (NAEH) represents mostly large and municipal hospitals and health care estalbishments. Trade unions: Federation of Trade Unions in Health Services (FTU-HS) Medical Federation Podkrepa (MF Podkrepa) Federation of Independent Trade Union of Governmental organisations (FITUGO)	Social dialogue in the health sector takes place at national, sectoral, regional and local level. National and sectoral dialogue is tripartite involving the Ministry of Health. National triparitite dialogue does currently not involve the NAEH directly and covers issues such as general wage policy, them minimum wage, relevant labour legislation and health policy. Sectoral dialogue covers specific labour legislation and sectoral policies, collective bargaining and industrial relations. At regional level, social dialogue and collective bargaining take place on wages, regional health policy and restructuring. At local level, specific working conditions and benefits are set.	Staff recruitment and retention.

Country	National healthcare expenditure as % of GPD	Employment in health and social care (% of total employment)	Structure of hospital sector	Key recent healthcare reform	Social partner organisations	Key features of sectoral social dialogue	Key issues for hospital sector labour market
Cyprus	4.1 (2003)	4.4	The private sector plays a more significant role in the delivery of health care than in most other member States. Health care reform is under way and a National Health Service was established by law in 2001. However, change is slow to take effect, which has been criticised by the public and social partners.	Decentralisation of management Introduction of National health Insurance Scheme Strengthening primary health care in rural areas.	<u>Employers:</u> Ministry of Health (public) Employers and Industrialists' Federation (private) <u>Trade unions:</u> Federation of Public Service Employees Cyprus (FPSEC-SEK) Pancyprian Public Employees Trade union (PA.SY.DY) Cyprus Turkish Civil Servant's Trade Union (KTAMS) The Pancyprian Union of Government Doctors (PASYKI) The Pancyprian Union of Government Nurses (PASYNO) The Federation of Private Sector Workers The Cyprus Industrial, Commercial, Press-Printing and General Services Workers' Trade Union (SEVETTYK) The Pancyprian Government and Military Workers' Trade Union (PASYEK)	Wages in the public hospitals are set by national legislation following negotiation with the Ministry of Health. In the private sector, terms and conditions are set at local level.	There are currently no medical schools or primary teaching facilities for health care professionals in Cyprus. Current lifelong learning policy provides access to training on the basis of seniority rather than need. While all nurses in the public sector are registered, only a fifth of nurses in private health care facilities are registered and the Ministry of Health can therefore not ensure overall quality control.

Country	National healthcare expenditure as % of GPD	Employment in health and social care (% of total employment)	Structure of hospital sector	Key recent healthcare reform	Social partner organisations	Key features of sectoral social dialogue	Key issues for hospital sector labour market
Czech Republic	6.7 in 2004	6.9	The system is funded through compulsory health insurance paid for by employer and employee contributions. 95% of primary health care was privatised in 2002. Hospitals are still largely public and managed by regional and municipalities. University hospitals are run directly by the state.	Key issue for the health care sector is the significant cumulated deficit and frequent changes of government and ministerial responsibilities have meant a lack of long term planning. A reform currently being discussed could involve increases in private co-payment; changes in what is covered by compulsory health insurance and the introduction of complementary health insurance.	<u>Employers:</u> Association of Czech and Moravian Hospitals (ACMN) Association of Czech Hospitals (ANCR) Association of University Hospitals (SFN) Association of Specialist Centres Association of Private Hospitals (ASN) <u>Trade Unions:</u> Trade Union of the Health Service and Social Care of the Czech Republic (OSZP CR) The Czech Moravian Trade Union of Civilian Employees of the Army (CMOSA) Trade Union of Doctors in the Czech Republic (LOK-SČL) Professional and Trade Union of Medical Workers of Bohemia, Moravia and Silesia (POUZPČMS)	The fragmentation of employers' organisations poses some difficulties and there are currently efforts to establish one representative national employers' organisation. As a result, there is no national higher level collective bargaining for the hospital sector. Collective bargaining largely takes place at the level of each individual establishment and is linked to minimum wages set by central government and regional adjustment tables. There are salary differences between the public and private sector.	Low remuneration leads to retention difficulties. This is a function of the financial difficulties of the overall health care sector. Migration away from the Czech Republic is an important issue, as is the entry of workers from the Slovak Republic and former USSR into the country who are often prepared for work for lower salaries. There are particular problems with retaining older nurses. Initial and ongoing training systems also need to be addressed.

Country	National healthcare expenditure as % of GPD	Employment in health and social care (% of total employment)	Structure of hospital sector	Key recent healthcare reform	Social partner organisations	Key features of sectoral social dialogue	Key issues for hospital sector labour market
Denmark	6.9	17.9	Health care is funded from general taxation and provision is almost exclusively public. Health care provision is largely the responsibility of the regions.	Local government reform in 2007 reduced the number of regions in Denmark and thus shifted responsibility for health care to fewer, larger, regional authorities.	Employers: Danish Regions Trade unions: FOA – Trade and Labour Trade Union of Local Government Employees (HK/Kommunal) The Danish Nurses' Organisation (DNO) Statsansattes Kartel (StK) Association of Danish State Employees' Organisations State Public Servants Trade Union (CO II) Danish Association of Biomedical Laboratory Scientists (Dbio) Danish Association of Junior Hospitals Doctors, (YL) Danish Association of Medical Specialist, (FAS) The Danish Association of Lawyers and Economists, (DJØF) The Danish Society of Engineers, (IDA) The National Federation of Social Educators in Denmark, (SL) Danish Diet and Nutrition Association,	Negotiations take place between the trade unions and Danish Regions. General agreements cover all staff and are supplemented by specific agreements for particular groups of staff. Danish Regions also participate in a bi-partite information and consultation forum with the Ministry of Health and Ministry of Finance. Social dialogue extends beyond collective bargaining on wages and terms and conditions.	Full implementation of the changes resulting from local government reform. Quality reform. Staff recruitment and retention. Demographic change and retention of older workers.

					Kost & Ernæringsforbundet Association of Danish Physiotherapists, Danske Fysioterapeuter United Federation of Danish workers, Fagligt Fælles Forbund ,3F Danish Association of Pharmaconomists, Farmakonomforeningen The Danish Association of Occupational Therapists, Ergoterapeutforeningen The Danish Association of Midwives, Jordemoderforeningen Danish Association of Professional Technicians, Teknisk Landsforbund		

Country	National healthcare expenditure as % of GPD	Employment in health and social care (% of total employment)	Structure of hospital sector	Key recent healthcare reform	Social partner organisations	Key features of sectoral social dialogue	Key issues for hospital sector labour market
Estonia	4.2 (2004)	5.5	System has transformed from state-controlled and funded, centralised system to a decentralised system based on health insurance contributions paid for through social insurance contributions paid by employers and employees.	Launch of health insurance system Introduction of family practitioner system Ongoing re-organisation of the hospital system	Employers: Estonian Hospitals Association *(Eesti Haiglate Liit, EHL),* which represents 19 major hospitals. The government is represented by the Ministry of Social Affairs. Trade unions: The Estonian Medical Association (*Eesti Arstide Liit, EAL*) represents doctors The Federation of Estonian Healthcare Professionals Unions *(Eesti Tervishoiutöötajate Ametiühingute Liit, ETTAL)* represents a variety of health care personnel. The Estonian Nurses Union *(Eesti Õdede Liit, EÕL)* The Trade Union Association of Health Officers of Estonia *(Eesti Keskastme Tervishoiutöötajate Kutseliit, EKTK)*	Health is one of the few areas with sectoral bargaining, which is a tripartite process between the ministry, EHL and the sectoral trade unions. Negotiations usually focus on minimum wages for different jobs which apply both to the public and private sector. These leave room for local negotiations to improve on pay deals. Tripartite and bi-partite dialogue on other issues is weak.	Staff shortages made worse by migration out of the country. The trade unions consider this to be fuelled by low wages and a lack of career advancement opportunities. Competition between hospitals and the speed of reforms has led to the "irrational" use of resources at times.

Country	National healthcare expenditure as % of GPD	Employment in health and social care (% of total employment)	Structure of hospital sector	Key recent healthcare reform	Social partner organisations	Key features of sectoral social dialogue	Key issues for hospital sector labour market
Finland	6.5 (2004)	15.3	Health care is universal and funded from general taxation. While the government decides on general health care policies, hospital and social care services are managed and run by the municipalities.	To ensure the longer term sustainability of the health system, the government is undertaking an institutional reform aimed at redirecting responsibility for health care to the inter-municipal and sub-regional entities. The aim is to improve efficiency. Restructuring of local authorities to create bigger intermediate entities means a transfer of the healthcare budget and service responsibilities from the municipal to the sub-regional level.	Employers: Commission for Local Authority Employers, represents municipal hospitals. Private Health Services Association (Terveyspalvelualan Liitto ry) represents private hospitals Employers's Association for Service Entreprises represents a small number of providers. Trade unions: The Union of Health and Social Care Services / TEHY *(Terveys- ja sosiaalialan koulutetun henkilöstön ammattijärjestö)* is the largest trade union for trained health care practitioners and social workers in Finland. Trade union for the public and welfare sectors / JHL *(Julkisten ja hyvinvointialojen liitto)* The Federation of Salaried Employees PARDIA represents state personnel. The Finnish Union of Practical Nurses (SuPer) Union of Professional Social Workers (Talentia) Central Union of Special Branches within Akava (AEK) for example represents Occupational Therapists. Bargaining Organisation for Technical and Basic Services (BOTBS) *(Tekniikan ja Peruspalveluiden Neuvottelujärjestö)* represents municipal workers.	In the public health sector, the terms and conditions of workers are negotiated under the sectoral bargaining framework for the local government sector. Five separate agreements are concluded in order to take into consideration the specific nature of different occupations within the sector. Wages of private sector health workers are determined under separate bargaining arrangements. There are three framework agreements for the private health care sector, which all private health care providers have to follow: private health care agreement, private social care agreement and private ambulance services agreement. Social dialogue in the sector is not only restricted to negotiations on wages and other terms and conditions of	Labour shortages and ageing workforce Educational reforms in the health care sector (delaying specialisation) Increase in fixed-term employment Equal pay Health care reform

					The Finnish Medical Association, FMA represents more than 90 per cent of Finnish physicians. The Federation of Special Service and Clerical Employees, ERTO (Erityisalojen Toimihenkilöliitto) is an organisation of employees working in expert positions in the private service sector. The Finnish Association of Occupational Health Nurses_(Suomen Työterveyshoitajien liitto)	employment; regular meetings between the state, employers and employee representatives take place. The health care policy has been to a large extent been based on a tripartite concertation. Bipartite meetings between the Commission for Local Authorities and the trade unions are also regular. Bi-partite co-operation mainly takes place through working groups on topics that are often chosen during bargaining rounds.	

Country	National healthcare expenditure as % of GPD	Employment in health and social care (% of total employment)	Structure of hospital sector	Key recent healthcare reform	Social partner organisations	Key features of sectoral social dialogue	Key issues for hospital sector labour market
France	9.5 (2001)	12.2	Health care is largely funded through statutory health care insurance, although in recent years, additional voluntary health insurance coverage has grown rapidly as the level of costs reimbursed through the statutory system has declined. There has been a gradual decentralisation of health care planning and management from the state to the regional level. Nearly 75% of hospitals in France and private (40% for profit and 35% not for profit).	Key focus of present reforms is cost containment, improving management, public safety and equity. Cost are to be reduced by reducing waste and over-consumption (esp. on pharmaceuticals); reduce reimbursement on expensive drugs and continue the move towards gatekeeping.	Employers: Fédération Hospitalière de France (FHF) represents all public hospitals. Fédération de l'Hospitalisation Privée (FHP) represents private hospitals. Fédération des établissements hospitaliers et d'assistance privés **(**FEHAP) covers the private non-profit making sector. Trade unions: Fédération Santé Sociaux – CFDT CGT Santé Fédération des personnels des Services Publics et des Services de santé (FPSPSS-FO) UNSA CFTC Santé-services sociaux CFE-CGC de la santé, de la médecine et de l'action sociale The national health and social service workers' federation (Fédération nationale SUD Santé sociaux SNCH - national union of hospital managers. Medical profession CMH - Coordination médicale hospitalière CHG - Confédération des Hôpitaux Généraux	Workers in public hospitals are civil servants. Therefore, national agreements are negotiated by Department of Health or Social Security. In private hospitals wages and working conditions are determined by collective bargaining between social partners. At the national level, agreements concern mostly salaries and work conditions. Agreements at the workplace level are related to work condition and work organisation (working time), profit-sharing and participation. Branch agreements are often negotiated in the private not-for-profit sector. Agreements on salaries also have to be accredited by the Ministry. In general social dialogue is limited to the collective bargaining process and there is no strong	Staff retention and shortage of qualified staff (35 hour working week has contributed to shortages) Cost containment (new system of funding leading to greater competition between hospitals, some consider at the expense of more "social considerations) New governance system for hospitals towards greater self governance.

					SNAM-HP - Syndicat National des Médecins des Hôpitaux Publics SNAM - Syndicat National des Médecins, Chirurgiens, Spécialistes et Biologistes des Hôpitaux Publics INPH - Intersyndicat National des Praticiens Hospitaliers Intersyndicat de praticiens hospitaliers	dialogue between social partners outside collective bargaining.	

Country	National healthcare expenditure as % of GPD	Employment in health and social care (% of total employment)	Structure of hospital sector	Key recent healthcare reform	Social partner organisations	Key features of sectoral social dialogue	Key issues for hospital sector labour market
Germany	10.9 (2004)	10.9	Health care is funded through health insurance based on employer and employee social insurance contributions. The split between municipal and private provision in the hospital sector is almost 50/50.	Recent reform relate to the system for calculating reimbursements to hospitals for particular procedures. There are growing concerns regarding the perceived under-funding of hospital care.	<u>Employers:</u> The Association of Municipal Employers (VKA – Verband Kommunaler Arbeitgeber) organises most municipal health care providers. Tarifgemeinschaft deutscher Länder (TdL) represents Länder owned health care providers. Bundesverband Deutscher Privatkliniken e.V. is the Federal Association of German private hospitals. The charity organisations of the Catholic Church named CARITAS, as well as the charity organisation of the Protestant church (Diakonie) operate hospitals. However, these organisations are regulated by church law. Therefore, they are not part of collective bargaining. <u>Trade unions:</u> Ver.di represents the majority of hospital sector. bbb Tarifunion represents civil servants working in a limited number of state run hospital sector organisations. Marburger Bund represents hospital doctors. Gewerkschaft Öffentlicher Dienst und Dienstleistungen (GOED) is a Christian Public Service Workers' Union Gewerkschaft für Beschäftigte im Gesundheitswesen (GIB) is a general health sector employees' union.	Collective agreements are signed with the Länder for the hospitals run by them and with the employers association for the municipalities for the majority of hospitals which are run at this level. The only collective agreements negotiated at federal level in the sector are for doctors in the military. Of the 16 provincial employer associations, only 14 take part in the co-ordinated collective bargaining process. Church hospitals cannot be forced into negotiations with trade unions by law. In the private sector, the negotiations usually take place at workplace (or chain) level.	Hospital financing Privatisation Impact of Working Time Directive Ageing workforce Health and safety (including harassment and violence) Training and qualifications Recruitment and retention.

Country	National healthcare expenditure as % of GPD	Employment in health and social care (% of total employment)	Structure of hospital sector	Key recent healthcare reform	Social partner organisations	Key features of sectoral social dialogue	Key issues for hospital sector labour market
Greece	6.7 (2003)	5.0	Health care is funded through a mixture of general taxation and employer and employee social insurance contribution. Public and private provision co-exist, but the number of public facilities has increased while the number of private hospitals has declined. Since 2001 Regional Health Authorities have largely been responsible for planning and managing health care delivery.	The current reform agenda focuses on the unification of numerous social insurance funds; regional expansion of primary health care through the establishment of family practitioners (GPs); implementation of several public health and mental health initiatives; creation of regional directorates; and improving management capacity in hospitals (professional managers).	<u>Employers:</u> In the public sector, the employers' role is performed by the state and there is no specific employers' organisation. In the private sector, employers organisation are split between specialisms (psychiatry, general hospitals etc) and region. <u>Trade unions:</u> The Confederation of Public Servants (ADEDY) represents workers in public sector. Association of Hospital Doctors of Athens and Piraeus (EINAP) Pan Hellenic Federation of Public Hospital Employees (POEDIN) Federation of Hellenic Hospital Physicians' Unions (OENGE). OSNIE is the most important organisation representing workers in the private health care sector.	Social dialogue in the hospital sector is in its infancy in Greece. A legislative settlement recognising the right of trade unions in the public sector to engage in collective bargaining was adopted only in August 1999. The new legislation recognises the right to bargaining, not for pay issues (which are excluded from the collective bargaining process), but for education and training, health and safety, mobility, and trade union rights. Bargaining on other issues remains limited. Bargaining in private hospitals takes place at local level.	Poor match between supply and demand for health care staff

Country	National healthcare expenditure as % of GPD	Employment in health and social care (% of total employment)	Structure of hospital sector	Key recent healthcare reform	Social partner organisations	Key features of sectoral social dialogue	Key issues for hospital sector labour market
Hungary	8.4 (2004)	6.7	Health care is funded through statutory national health care insurance taken from employer and employee contributions. Private expenditure from out of pocket payments is increasing.	Many structural reforms have been implemented. These have included the introduction of a purchaser-provider split in social health insurance structures, the introduction of new prospective and performance-oriented payment methods, as well as a reduction in and geographical reallocation of inpatient capacity.	<u>Employers:</u> The Hungarian Hospital Association (Magyar Kórházszövetség, MKSZ) <u>Trade unions:</u> The Democratic Union of Health Care Employees (Egészségügyi és Szociális Ágazatban Dolgozók Demokratikus Szakszervezete, EDDSZ) is the oldest trade union in the sector. LIGA Health Federation (LIGA Egészségügyi Szövetség) has members in a number of public health institutions. Federation of Hungarian Physicians (Magyar Orvosok Szövetsége, MOSZ) represents physicians with employee status. Trade Union of Defence Employees (Honvédségi Dolgozók Szakszervezete, HODOSZ) and Trade Union of Hungarian Railwaymen (Vasutasok Szakszervezete, VSZ) represent all types of employees in the separate healthcare system of the army and railway. The Medical Universities' Trade Union Federation (Orvosegyetemek Szakszervezeti Szövetsége) represents employees in hospitals belonging to four universities.	For all public employees (including the vast majority of health employees) annual wage agreements are regularly concluded in the Public Service Interest Reconciliation Council (Közszolgálati Érdekegyeztető Tanács, KÉT). The latter is a tripartite body involving employer, government and trade union representation. There is no multi-sector agreement in the private sector; only 95 single employer agreements.	Key issues include staff recruitment and retention and the perceived lack of adequate hospital sector funding.

Country	National healthcare expenditure as % of GPD	Employment in health and social care (% of total employment)	Structure of hospital sector	Key recent healthcare reform	Social partner organisations	Key features of sectoral social dialogue	Key issues for hospital sector labour market
Ireland		9.7	The HSE was in established in January 2005 and is responsible for providing health and personal social services for the Republic of Ireland. Its objectives were introduced in the Health Act 2004. Prior to its formation health care services were delivered through a complex structure of ten regional Health Boards, the Eastern Regional Health Authority and other organisations and agencies.	Centralisation of responsibility for health care planning in HSE.	<u>Employers:</u> HSE (Health Service Employers Agency) represents public sector facilities. Hospitals and health care services in the private sector are represented by the Irish Business Employers' Confederation (IBEC). <u>Trade unions:</u> Social, Industrial, Professional and Technical Union (SIPTU) IMPACT mainly has members in the public sector Irish Nurses Organisation (INO) Psychiatric Nurses' Association (PNE) Irish Medical Organisation (IMO) represents doctors. The Irish Hospital Consultants' Association (ICHA) The blue collar unions UNITE and TEEU (Technical, Engineering and Electrical Union) also represent workers in the sector.	Collective bargaining in the hospital sector takes place at a national level. Negotiations of terms and conditions of staff are generally tripartite, involving the government. In addition to regulating terms and conditions for employees, social dialogue between employers and trade unions takes place on other key issues. The National Joint Council discusses human resource issues, such as flexible working and worklife balance. This has been rolled out in the hospital sector.	Managing work with private sector outsourcing Long term social partner negotiations

Country	National healthcare expenditure as % of GPD	Employment in health and social care (% of total employment)	Structure of hospital sector	Key recent healthcare reform	Social partner organisations	Key features of sectoral social dialogue	Key issues for hospital sector labour market
Italy	8.4	6.7	Italy's health care system is a regionally based national health service that provides universal coverage free of charge at the point of service. Health care provision is financed from a mixture of general taxation and payroll contributions with the latter increasing vis a vis the former.	Devolution of financial responsibility to the regional level.	<u>Employers:</u> ARAN is a cross sectoral employers' organisation covering the public administration. Private non-religious hospital and care facilities are represented by Associazione Italiana Ospedalità Privata, AIOP (Italian Association of Private Hospitalisation, AIOP) The private religious establishments are represented by Associazione Religiosa istituti Sociosanitari, ARIS (Association of Religious Sociomedical Institutions). <u>Trade unions:</u> Federazione Lavoratori Funzione Pubblica Cgil, FP CGIL Federazione dei Lavoratori Funzione Pubblica Cisl, FP CISL (Public Function Cisl) Federazione Cisl Medici (Federation of Medics, Cisl Medici) represents doctors. Uil Federazione Poteri Locali, UIL F.P.L. (Federation of Local institutions, UIL FPL) Federazione Italiana Autonoma Lavoratori Sanità, FIALS (The Italian Autonomous Federation Health Workers, FIALS Federazione Sindacati Indipendenti Sanità, FSI Sanità (Independent Trade Union Health Federation, FSI Sanità) Unione Generale del Lavoro Sanità, UGL Sanità (the General Union of Work – Health Sector, UGL Sanità) Confederazione Italiana Veterinari e Medici della Prevenzione, CIVEMP (Italian Confederation of Veterinary Surgeons and Preventative Medics, CIVEMP) Federazione sindacale medici dirigenti, FESMED (Trade Union	Collective bargaining largely takes place at national and local level, although there is also some regional bargaining.	Change the mentality of the labour force by fostering the managerial skills of the doctors; Enhance the reform process; Tackle the shortage of nurses and the ageing of the labour force; Develop the enrolment of the labour force in training programmes (to acquire new skills for ex IT skills); Develop new flexible forms of work especially for older workers Foster internal mobility

					Federation of Medical Managers, FESMED) Unione medici specialisti dirigenti, UMSPED (Union of Medical Specialist Managers, UMSPED) Coordinamento Italiano dei Medici Ospedalieri – Associazione Sindacale dei Medici Dirigenti, CIMO-ASMD (Italian Coordination of Hospital Medics-Trade Union Association of Medical Managers, CIMO-ASMD) Associazione medici Dirigenti, ANAAO ASSOMED (Association of Medical Managers, ANAAO ASSOMED Associazione Nazionale Primari Ospedalieri, ANPO (The National Association of Head Physicians of Hospitals, ANPO) For the non-medical managers in the public hospital structures, the trade union organisations are: Sindacato Italiano Dirigenti Servizio Sanitario, SIDir.S.S, (Italian Trade Union of Health Service Managers, SIDir.S:S). Associazione Unitaria Psicologi Italiani, AUPI, (United Association of Italian Psychologists, AUPI). Sindacato Nazionale Farmacisti Dirigenti del SSN, Si.Na.F.O, (National Trade Union of Chemist Managers of the SSN, SI.Na.F.O). Sindacato Nazionale Dirigenti Sanitari del Servizio Sanitario Nazionale (SSN) e delle Agenzie Regionali per la Prevenzione Ambientale (ARPA), SDS SNABI (National Trade Union of Health Managers of the National Health Service – SSN - and the Regional Agencies for Environmental Prevention - ARPA, SDS SNABI). Confederazione dei sindacati dei funzionari direttivi, dirigenti e delle elevate professionalità della funzione pubblica - Sanità, CONFEDIR SANITA' (Confederation of the Trade Unions of Directive Officials, Managers and High Professionality in the Public Function – Health, CONFEDIR SANITA'). Confederazione Italiana Medici Ospedalità Privata, CIMOP (Italian Confederation Private Hospital Medics, CIMOP)		

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Latvia	7.6	5.8	Eight regional sickness funds are responsible for distributing national funds for healthcare. Provision is largely public, but privatisation has been a feature of recent reforms.	Shift towards primary health care services and increasing privatisation of certain aspects of health care provision.	<u>Employers:</u> The Lativan Hospitals Assocication <u>Trade unions:</u> Trade Union of Health and Social Care Employees of Latvia (LVSADA) Nursing and Healthcare Personnel Trade Union (LAADA)	Collective bargaining takes place in the National Tripartite Cooperation Council (NTCC) between Latvian Employers' Confederation (LDDK), Free Trade Union Confederation of Latvia (LBAS) and the representatives of the Government of the Republic of Latvia. Specific issues related to the hospital sector are discussed in the relevant Health Care Sector Sub-council. Specific NTCC working groups are focusing on improvement of labour conditions, salaries, tariff policies, compulsory social insurance and social guaranties, healthcare as well as employment, vocational education and lifelong learning.	Financing of health care Lack of qualified staff due to declining status of health care professions.

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Lithuania	7.6 (2003)	7.3	The health care system is largely funded from statutory health insurance contributions. 50% of health care provision is public. The vast majority of private health care is made up of dentistry services.	Increasing share of private health care providers Greater emphasis on primary health care Reducing time spent in hospitals	<u>Employers:</u> The main employer in the sector is the State (Ministry of Health) Private healthcare providers association Lithuanian hospitals association <u>Trade unions:</u> Lithuanian healthcare workers trade union (LSADPS) Lithuanian Trade Union Federation of Public Services (LVPF) Lithuanian hospital managers union Lithuanian doctors union Lithuanian medical workers trade union, Lithuanian healthcare institutions administrators trade union Lithuanian national healthcare institutions managers association Lithuanian nursing managers union Lithuanian nursing specialist union Lithuanian odontologists' association Lithuanian general care doctors association, Lithuanian Work Federation's Medical Workers Federation Lithuanian forensic psychiatrists' association National medical workers association	General terms and conditions of employment for public hospitals are negotiated with the state in the employer function. Further bargaining takes place at the local level.	Lack of sectoral collective bargaining covering all health care providers Lack of social dialogue Lack of healthcare funded Perceived unfair competition between public and private health care providers

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Luxem-bourg	6.2 (2002)	9.7	Funding is based on compulsory health insurance and taxation. provision is largely public.	Curbing expenditure by increasingly restricting treatment to what is "useful and necessary"	Employers: Entente des Hôpitaux Luxembourgeois (EHL) Trade unions : Confederation of Independent Trade Unions OGB-L (Confédération Syndicale indépendante du Luxembourg) Confederation Generale du Travail du Luxembourg, Secteur Public (CGT-L) Confederation of Christian Unions in Luxembourg (LCGB)	Collective bargaining takes place in the *Commission Paritaire*, with equal representation on both sides (trade unions and employers). In addition to the Collective bargaining process described above, a more informal 'social dialogue' is taking place on a more regular basis. Collaborative work platforms are set up to reflect upon specific issues such as career development or on call shifts.	Pay Recruitment Retention of older workers
Malta	4.2	7.8	Funded from taxation and largely publicly provided Some physicians also work in private practive	Decentralisation of responsibility Greater performance management Better provision for long term care	Employers: Ministry of Health Trade unions: General Workers Union (GWU) represents workers in the public sector Union Haddiema Maghqudin (UHM) represents workers in the public and private sectors. Malta Union of Midwives and Nurses (MUMN) Malta Union of Professional Psychologists Medical Association Malta (MAM) represents doctors	There are four types of collective agreements relevant for the hospital sector: The collective agreement applying to all public sector workers; the agreement for civil servants; the agreements for different groups in the health sector and local level agreements with private providers. The former three are negotiated with the government.	Recruitment and retention Managing demographic change

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Nether-lands	9.1 (2004)	15.9	Funding is through statutory and private insurance schemes. There is a mixture of public and private provision, with public, not for profit providers predominating	Decentralisation to the local level	Employers: The Association of Hospitals (NVZ) The Association of Academic Hospitals (VAZ) Trade unions: ABVAKABO FNV CNV Public Affairs Nieuwe Unie '91 Federation of Associations of Executive Personnel in healthcare and care for the elderly (FHZ) Healthcare and Welfare Union	The wages and conditions for the staff of the hospital sector are determined at national level through bipartite and tripartite negotiations. Apart from regulating terms and conditions for employees, "social dialogue" between employer and trade union organisation in the sector also occurs in relation to other key issues affecting hospitals and the health care sector.	Ageing workforce Health and safety Benefits of centralisation versus decentralisation
Poland	4.2 (2002)	5.8	Mandatory universal health care insurance was introduced in 1999. Private expenditure accounts for nearly 30% of the health care budget.	Decentralisation of responsibility for health care planning Controlling expenditure on pharmaceuticals Planning for long term care	Employers: Health Corporation (Korporacja Zdrowia), an affiliate of the Confederation of Polish Employers (Konfederacja Pracodawców Polskich, KPP) Polish Association of Hospital Directors (Polskie Stowarzyszenie Dyrektorów Szpitali, PSDS) Trade unions: Forum Health Care Unit - FZZ assembles organisations such as the Nationwide Union of Nurses and Midwives (Ogólnopolski Związek Zawodowy Pielęgniarek i Położnych, OZZPiP), the Nationwide Union	Minimum wages and terms and conditions are set centrally Other additional salary awards and benefits are negotiated locally	Staff retention Ongoing changes in the organisation of the hospital sector

					of Administrative and Service Health Care Employees (Ogólnopolski Związek Zawodowy Pracowników Administracji i Obsługi Służby Zdrowia), the Nationwide Union of Operating Bloc, Anaesthesiology, and Intensive Therapy Workers (Ogólnopolski Związek Zawodowy Pracowników Bloku Operacyjnego Anestezjologii i Intensywnej Terapii), and the Nationwide Union of Medical Diagnostics and Physiotherapy Employees (Ogólnopolski Związek Zawodowy Pracowników Diagnostyki Medycznej i Fizjoterapii). Federation of Health Care and Social Aid Employee Unions (Federacja Związków Zawodowych Pracowników Ochrony Zdrowia i Pomocy Społecznej, FZZPOiPS), a member organisation of OPZZ. The FZZPOiPS assembles single-entity, multi-entity, and regional union organisations of health care employees. The Health Care Secretariat (Sekretariat Ochrony Zdrowia) of NSZZ 'Solidarność' has two sections of relevance to the hospital sector, namely the Nationwide Ambulance Service Section (Sekcja Krajowa Pogotowia Ratunkowego) of NSZZ 'Solidarność' and the Nationwide Health Care Section (Sekcja Krajowa Służby Zdrowia) of NSZZ Doctors' Trade Union of Poland (Ogólnopolski Związek Zawodowy Lekarzy, OZZL)		

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Portugal	8.2	6.3	Portugal has a National Health Service Funded from General Taxation. Health care provision is largely public.	Transform-ation of a number of NHS hospitals into public enterprises Increasing use of public private partnerships in the building of hospitals.	Employers: Department for Public Administration (public sector) Portuguese Association of Private Hospitalisation (private) Trade unions: Sindicato Nacional dos Trabalhadores da Administração Local (STAL) Sindicato dos Quadros Técnicos do Estado (STE) Sindicato dos Trabalhadores da Administração Pública (SINTAP)	Separate collective bargaining takes place for the public and private sector, but there are few differences in the level of agreements. Triparatite social dialogue takes place in relation to healthcare policy reforms.	Changes in the organisation of the health care system and possible impact on the status of employees
Romania	3.9	n/a	Health care is largely public. The largest share of private provision is made up of pharmacy services. Health care is funded through a mixture of taxation, health insurance and out of pocket payments (approx. 30%).	Decentrali-sation	Employers: Romanian Hospital Association (Asociația Spitalelor din România) Trade Unions: Romanian Trade Union Federation (SANITAS) Medical-Sanitary and Pharmaceutical Trade Union Federation Hipocrat (Federația Sindicală Medico-Sanitară şi Farmaceutică Hipocrat, Federația Hipocrat) National Free Trade Unions Federation Technic – Economic and Administrative from Healthcare and Balnear Units	Basic terms and conditions for public hospitals are negotiated at national sectoral level.	Low levels of health care funding and gaps in provision.

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Slovak Republic	5.8 (2003)	6.8	Funding is from social insurance based on employer and employee contributions. There has been a transfer of responsibility for the running of some hospitals to the municipal and to the regional level.	There is a need to address the significant debts in the health care systems and to address staff shortages.	Employers: The Associations of Hospitals of Slovakia (Asociácia nemocníc Slovenska - ANS The Association of Private physicians (Asociácia súkromných lekárov Slovenska – ASL SR The Association of University Hospitals (Asociácia fakultných nemocníc - AFN) Trade Unions: Slovak Association of trade unions for health care and social sector (Slovenský Odborový Zväz Zdravotníctva a Sociálnych Služieb, SOZZaSS) Slovak Trade Union of Workers in Services (SOZPS)	Higher level collective agreements are negotiated at national level and cover wages and terms and condition and cover different groups of employees. Further benefits and aspects of work organisation are negotiated at local level.	Lack of funding Privatisation Staff retention Skills and ongoing training
Slovenia	8.5	5.4	Compulsory health insurance funded from employer/employee contributions. There is a mixture and private and public provision.		Employers: Ministry of Health Trade unions: Union of health care workers of Slovenia (Sindikat zdravstva in socialnega varstva Slovenije FIDES – the Slovenian Union of Physicians and Dentists Slovenian Health Service and Social Welfare Union (SZSS) Healthcare Trade Union (SDZNS); Association of Trade Unions in Health (SZS)	Collective bargaining takes place between trade unions and the government. There is also a tripartite dialogue on health care policy.	Privatisation Staff shortages Working hours

Country	National healthcare expenditure as % of GPD	Employment in health and social care (% of total employment)	Structure of hospital sector	Key recent healthcare reform	Social partner organisations	Key features of sectoral social dialogue	Key issues for hospital sector labour market
Spain	7.4 (2003)	5.9	The health care system is largely funded from taxation and is administered at the regional level. Private out-of pocket expenditure has been increasing and was 23% in 2003.	Cost containment Decentralised management Planning for long term care	Employers: Regional Government Administrations Trade unions: Health Federation of CC.OO (Federación de Sanidad y Sectores Sociosanitarios de Comisiones Obreras is a member of EPSU. Public Services Federation of the General Workers' Confederation (Federación de Servicios Públicos de la Unión General de Trabajadores) is a member of EPSU. Nurse Trade Union (SATSE Sindicato de Enfermería) Independent Trade Union Confederation (Confederación Sindical Independiente-CSI) Independent Trade Union Confederation Of Public Servants (Confederación Sindical Independiente de Funcionarios-CSIF)(CSI-CSIF) Cesmsatse is an organisation which was formed by two union confederarions: National Confederarion of Doctors Trade Unions (CESM Confederación Estatal de Sindicatos Médicos) and Nurse Trade Union (SATSE Sindicato de Enfermería) which have traditionally represented doctors and nurses.	The sector is largely governed by public sector collective bargaining. Responsibility for this was transferred from the central to the regional level. Collective agreements reached at regional level affect the whole region and the rate of collective bargaining coverage is high. In addition, there are national framework working conditions which have to be integrated into collective bargaining at lower level. There are currently no tripartite or bipartite bodies dealing with sector-specific issues outside of wage bargaining.	

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Sweden	8.5 (2003)	16.4	Health care is funded from general taxation and provided by the counties, with limited involvement from the private sector.	Improve access to primary care Decentrali-sation to county and municipality level Cost containment	Employers: Swedish Association of Local Authorities and Regions (SALAR) The Association of Private Care Providers (Vårdföretagarna) Trade unions: The Swedish Medical Council SLF is represents doctors and other health care professionals. The Swedish Municipal Workers Union *(Kommunal)* The Swedish Union of Local Government Officers Akademikerförbundet SSR Vårdförbundet, the Swedish Association of Health Professionals The Swedish Association of Health Professionals SAHP Sveriges Psykologförbund: Swedish Psychological Association Förbundet Sveriges Arbetsterapeuter (FSA): The Swedish Association of Occupational Therapists Legitimerade Sjukgymnasters Riksförbund: The Swedish Association of Registered Physiotherapists Sveriges Farmacevtförbund: The Swedish Pharmaceutical Associations Akademikerförbundet SSR: Association of Graduates in Public administration and Ledarna: the Swedish Organisation for Managers	Collective bargaining in the health (hospital) sector takes place both at sectoral and local levels, but local (workplace) level bargaining is increasingly predominant. Sectoral agreements are usually concluded between trade unions and SALAR for different occupational groups within the health sector. Separate agreements are normally concluded for doctors on one side and for nurses, midwives and other healthcare professional on the other. These agreements cover both public and private providers. Social dialogue between employers and the unions on other issues than the terms and conditions of employment is widespread. The unions and SALAR have several different working groups on matters concerning, for example, employment in the sector and patient safety. Both parties also collaborate closely with the National Board of Health and Welfare.	Shortage of specialist nurses Recruitment challenges Integrating foreign healthcare professionals

Country	National healthcare expenditure as % of GPD	Employment in health and social care (% of total employment)	Structure of hospital sector	Key recent healthcare reform	Social partner organisations	Key features of sectoral social dialogue	Key issues for hospital sector labour market
UK	7.7 (2002)	12.3	The National Health Service is funded from general taxation and provision is largely public. Doctors and dentists are allowed to combine NHS and private practice and a number of private hospital providers exist. Public-private partnership, particularly for hospital building has been an increasing trend	The NHS Plan was introduced in 2000. This 10 year plan included a number of proposals to change the delivery of health care services in England. Critical to its implementation were increases in service personnel, modernisation of delivery and administration and a greater number of training places for those wishing to enter the health service	Employers: NHS Employers Trade Unions: UNISON Royal College of Nursing (RCN) UNITE Royal College of Midwives Society of Radiographers Hospital Consultants and Specialists Association	The NHS staff council provides the framework for the negotiation of wages, pensions and terms and conditions. National agreements are reached which are ratified by the Secretary of State for Health. Partnership structures exist at the national and local level. A partnership agreement has been signed between the Department of Health, NHS Employers and the NHS trade unions. There is wideranging social dialogue on issues outside the scope of collective bargaining.	Recruitment and retention Demographic change Ensuring ongoing skills development