

## HOSPITALS

Workers' representatives	European Federation of Public Service Unions (EPSU) (1974) <a href="http://www.epsu.org">http://www.epsu.org</a>
Employers' representatives	European Hospital and Healthcare Employers Association (HOSPEEM) (2005) <a href="http://www.hospeem.eu">http://www.hospeem.eu</a>

Representativity study: Traxler, F. (2009), *Representativeness of the European social partner organisations: Hospitals*, EIRO, Dublin, May 2009  
<http://www.eurofound.europa.eu/eiro/studies/tn0802017s/tn0802017s.htm>

### Sectoral Social Dialogue Committee (SSDC)

Informal working group:	2000
SSDC:	20 September 2006 (33 <sup>rd</sup> committee)
Rules of procedure:	20 September 2006 (draft)
Work programme:	2006-2007; 2008-2010
Website:	<a href="http://www.eurocarenet.org">www.eurocarenet.org</a> (no longer active)

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## GENERAL OVERVIEW OF SECTOR

**Although the hospital sector in Europe is highly diverse (from small local units to major regional or national hospitals), it faces a number of similar trends and issues: a reduction in bed numbers and the search for alternatives to full hospitalisation, funding problems, health challenges, etc.**

According to the World Health Organisation (WHO), there are almost 15,000 hospitals in the European Union, with some 2.8 million beds. The vast majority of these are public-sector hospitals, with the private sector providing less than 20% of all hospital beds in 2004.

European hospitals are organised in many different ways, ranging from cottage hospitals and small local units to regional- or national-scale healthcare institutions, not forgetting secondary care establishments and general hospitals. The public sector is predominant in most Member States; in others the private sector, whether profit-making or not, prevails.

As far as financing is concerned, there are also major differences in sources of funding: taxation, social security contributions, patient contributions, private insurance funds, etc.

Regardless of this diversity, European hospitals are affected by some broad across-the-board trends:

1. funding is public in the main, but over the past thirty years or so there has been a trend towards greater private-sector provision;
2. alternatives to full hospitalisation have recently become increasingly widespread (more outpatient treatment). This has led to a reduction in the number of hospital beds and, consequently, in the hospital sector's share of health expenditure (which is rising overall).

Another obvious common trend is that all hospitals are facing similar health challenges. For example, according to a European Commission [report](#), there are expected to be almost 50 million people over the age of 80 in 2050 (compared with 18 million in 2004), while the number of dependants is likely to double by 2050.

It is difficult to obtain a precise picture of employment in the sector. As with many other service activities, the staff play a crucial role. But various discrepancies in the way in which hospital staff are counted makes comparisons between Member States awkward, if not impossible. Some countries use the number of individuals employed while others record "full-time equivalents", without even considering the outsourcing of ancillary services such as maintenance, catering, laundering of work clothing, etc. Public-private partnerships are in fact becoming increasingly widespread, especially for maintenance services.

The [European Commission](#) gives a figure of 3 million workers. EPSU says that it organises 3.5 million members. According to a comparative study on the role of hospitals in Europe ("*Les hôpitaux dans les 27 pays de l'Union européenne*", Dexia

Editions, July 2008, ISBN: 978-2-911065-68-2), hospitals employ more than half of all health workers in many cases, and there are almost 1.5 million staff in the United Kingdom alone, and over a million in France and likewise in Germany.

Hospital staff are highly skilled and, generally speaking, largely feminised. They are also ageing. Contracts in the sector are for the most part permanent, either full-time or part-time. Recently there has been an increase in staff mobility across Member States, but also increasing migration and a brain drain to the benefit of third countries such as the United States, Australia and New Zealand (Green Paper on the European Workforce for Health [COM \(2008\)725](#) final of 10/12/2008).

## PARTICIPANTS AND CHALLENGES

European social dialogue in the hospital sector is still very new: the Sectoral Social Dialogue Committee (SSDC) was not established until 2006. It involves the European Federation of Public Service Unions (EPSU) for the workers, and the European Hospital and Healthcare Employers Association (HOSPEEM) for the employers. The main topics of discussion for the time being are staff recruitment, workforce profiling and new skills. A code of conduct on ethical cross-border recruitment and retention in the hospital sector was adopted in 2008: it is regarded as one of the major achievements of this social dialogue.

For the record, the issue of healthcare was first addressed by the EU in the form of [Regulation 1408/71](#) of 1971 on the coordination of social security schemes (making it possible to finance healthcare abroad). Public health and healthcare issues then rose up the European agenda from the 1990s onwards, when a legal basis was incorporated first into the Maastricht Treaty of 1992 and then, crucially, into the Amsterdam Treaty of 1997.

The Commission launched some Community action programmes based on these provisions, and legislation gradually came into being – on [blood products](#) in 2002, on [human tissue and cells](#) in 2004, and so on. A [European Centre for Disease Prevention and Control](#) was founded in 2005. Finally, the Lisbon Strategy for 2000-2010 introduced an open method of coordination in the fields of social protection and social inclusion.

One of the most important features of this sector should be highlighted from the outset: although a Community health policy is tending to emerge, the Member States remain responsible for organising their own health systems. The EU is exerting gentle pressure to promote a common attitude towards hospital sector issues; moreover, the enforcement of the single market rules is having a major impact on hospitals (procedures for procurement of medical equipment, collection of blood products, working conditions of health professionals, etc.).

This, then, was the backdrop to the very gradual establishment of European social dialogue in this sector in the early 2000s. An initial conference was organised by the Danish social partners in May 2000 under the European vocational training programme *Leonardo*. A website was created at that time ([www.eurocare.net](http://www.eurocare.net) — the website has since been closed down) as a tool for exchanges of experience between the social partners (CEEP for the employers and EPSU for the workers). This first meeting dealt mainly with labour market issues: recruitment, skills, etc.

A second conference took place in February 2002 to reflect more broadly on developments in the sector, the European challenges it faces, sectoral social dialogue and how to strengthen it in the new Member States. This conference paved the way for the creation of the SSDC, the inaugural meeting of which took place on 20 September 2006. Meanwhile, the “hospital” members of CEEP – which represents all public-sector employers – set up a new organisation, HOSPEEM, so as to comply

with the Commission's criteria on representativeness (HOSPEEM has remained a member of CEEP).

So it was not until 2006 that sectoral social dialogue was put on a formal footing and the new employers' body was recognised by the Commission. The topics included in the first work programme, for 2006-2007, were staff recruitment, workforce profiles and new skills. Two joint texts have been adopted since then: a joint opinion on health services in 2007 (in the light of the draft directive on cross-border healthcare), and in 2008 a code of conduct on ethical cross-border recruitment and retention in the hospital sector.

This code of conduct, which constitutes a reciprocal commitment on cross-border mobility for health professionals, is regarded as a major success story of this (still new) sectoral social dialogue. Referring to the ILO standards, it is aimed at protecting workers' rights, ensuring that highly skilled staff are available to the employers, accessibility and quality in public health services, as well as transparency, justice and equity in the management of human resources.

In July 2009 the social partners in the sector went on to conclude an important Framework Agreement on prevention from sharp injuries in the hospital and healthcare sector. This document assesses the risk of injury to hospital workers caused by medical sharps (including needlesticks), as well as risk prevention, protection and elimination, training and awareness raising, and response and follow-up procedures. The social partners explicitly call upon the EU institutions to make this text legally binding.

## OUTCOMES

**The single market and freedom of movement have caused the social partners in the European hospital sector to fear the onset of social dumping practices. Crucial to social dialogue in this sector, therefore, is the upholding of European social values: solidarity, social justice and social cohesion.**

The main driver of social dialogue in the hospital sector seems to have been the ever more pressing impact of European integration on health policy.

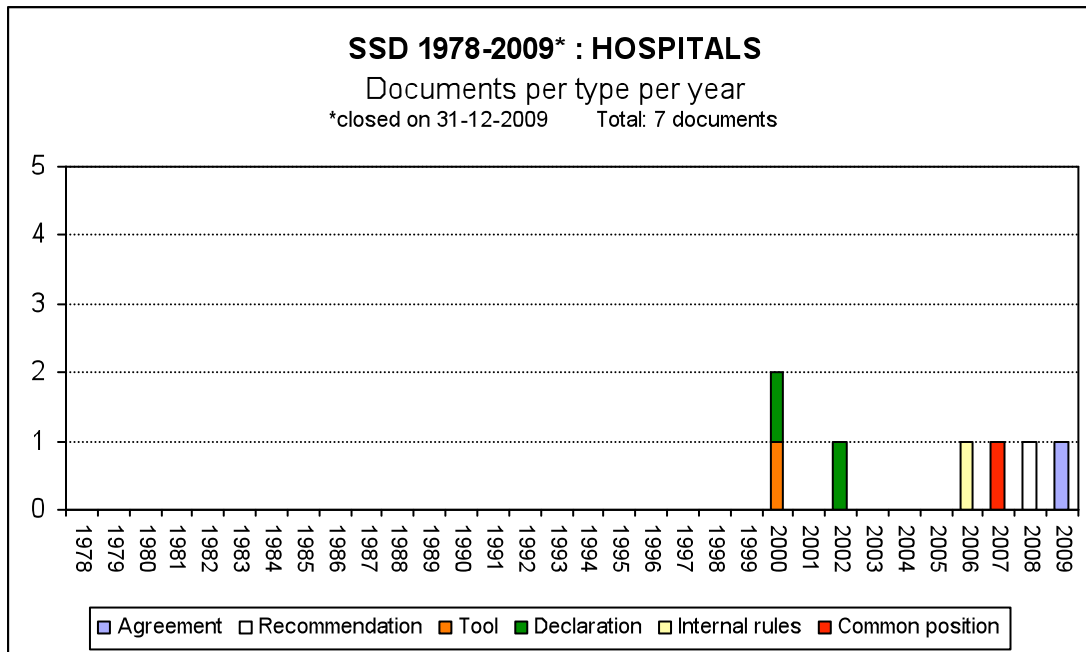
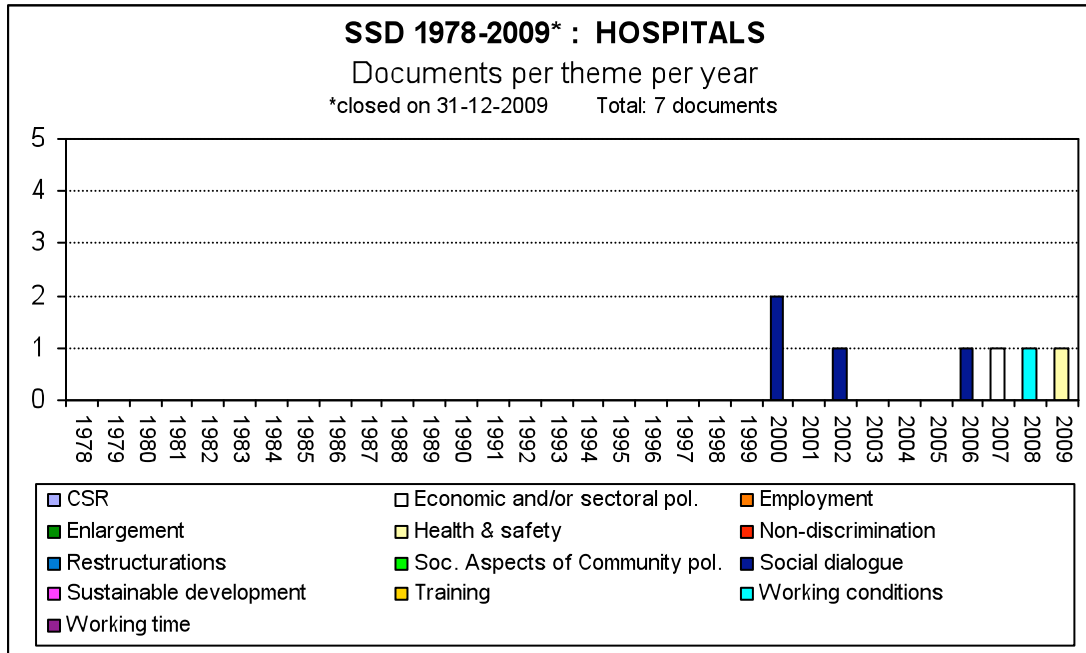
Issues such as the single market, free movement and enlargement have clearly caused the social partners to fear the onset of social dumping practices. They have moreover focused their social dialogue on the organisation of healthcare in Europe, which, in their opinion, must be founded on the basis of European social values: solidarity, social justice and social cohesion.

Reading their 2007 joint text, one detects a degree of suspicion about the role division between the EU and its Member States. The signatories emphatically reassert the principle of subsidiarity and their belief that the EU should not interfere in the funding, organisation and planning of healthcare. They call for a clarification of powers in order to avoid any unwarranted intervention by the European Court of Justice.

Similar suspicion is expressed with regard to any desire on the part of the EU institutions to impose market-based, competitive practices on the sector, which would have the effect of lowering the quality of care and sacrificing the values of solidarity and social justice.

# JOINT TEXTS

The “hospitals” sectoral social dialogue has resulted, since 2000, in the adoption of 7 joint texts.





<b>Date</b>	<b>Title</b>	<b>Theme</b>	<b>Type</b>	<b>Addressee</b>
17/07/2009	Implementing the Framework Agreement on prevention from sharp injuries in the hospital and healthcare sector concluded by HOSPEEM and EPSU	Health and safety	Agreement	European institutions
7/04/2008	EPSU-HOSPEEM code of conduct and follow up on Ethical Cross-Border Recruitment and Retention in the Hospital Sector	Working conditions	Recommendation	National organisations
14/11/2007	Joint declaration on health services	Economic and/or sectoral policies	Joint opinion	European institutions
20/09/2006	European Social Dialogue Committee of the Hospital sector Inaugural meeting	Social dialogue	Rules of procedure	European social partners
05/02/2002	Declaration on the second conference on social dialogue in the hospital sector Brussels, 4 - 5 February 2002	Social dialogue	Declaration	European social partners
13/05/2000	Conference on the social dialogue in the hospital sector in Europe - Brussels 12-13 May 2000 Follow-up and conclusions from workshops	Social dialogue	Declaration	European social partners
01/02/2000	Creation of website <a href="http://www.eurocarenet.org">www.eurocarenet.org</a> (social dialogue)	Social dialogue	Tool	National organisations

