



15 000 hospitals
more than **5 million** employees
24 hours a day at the disposal of
370 million European citizens

**Social Dialogue in the hospital sector in
the EU Member States**

**STANDING COMMITTEE OF THE HOSPITALS
OF THE EUROPEAN UNION**

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Introduction

The Standing Committee of the Hospitals of the European Union (HOPE) is a non- governmental European association, which was created in 1966, and since 1995, is an international social profit association. It includes national hospital associations or representatives from the national health systems of the 15 member states of the European Union, plus Switzerland, as an observer. Cyprus and Malta will become observer members in 1997.

The constitution of 1995 states that it is the Standing Committee's mission, as an NGO, to promote improvements in the health of citizens throughout the countries of the European Union and a uniformly high standard of hospital care throughout the EU, and to foster efficiency, effectiveness and humanity in the organisation and operation of hospital services.

Since 1989, the Committee has been planning some very dynamic action for future years, promoted under the name HOPE, Hospitals for Europe. The HOPE agenda continues to include: improving existing relations within the European Union, collecting statistical and documentary data concerning E.U. regulations and European health care including the role of hospitals and alternatives to hospital care; enlarging the exchange programme which was established in 1981; achieving collaboration between Western, Central and Eastern European hospitals through Hospital twinning in collaboration with WHO Europe and the European Union (PHARE/TACIS); and finally, co-operating with the other health (care) organisations by organising European Health AGORA's (1991, 1993 1995, 1997) and HOPE seminars. For the future, special attention will be paid to quality in health care in its broadest sense.

Since 1992 HOPE has been discussing its role in the Social Dialogue for hospitals (private and public) in Europe, which seemed to be a rather difficult matter. Having established preliminary and exploratory contacts with the European trade unions for the health sector and having discussed the differences between and the barriers in its national delegations, HOPE decided not to enter into a European sectorial social dialogue because according to its constitution the Standing Committee of the Hospitals of the EU is not or should not present itself as a (European) employer's association or a representative of hospital employers. HOPE will of course follow the development in the European social dialogue promoted by the EU and continue its exploratory contacts with the European trade unions.

In order to obtain a better understanding of the evolution of a social Europe it seemed appropriate to publish a brief overview of the different situations in social bargaining in the hospital sector in the Member States preceded by a short description of the European mandate in social bargaining. A questionnaire was developed in order to secure a certain uniformity in the areas covered in the different countries. Sometimes this seemed to be artificial because of the great (structural) differences in some countries and because of lack of information. Therefore it should be clear that the presentation of the material in this leaflet is more a compilation of information rather than a comparison.

EUROPEAN COMPETENCE IN THE SOCIAL DIALOGUE

In the Member States of the EU the social partners play an important role in the organisation of labour relationships between employers and employees. All Member States have structures through which representatives of the social partners can give their views and issue opinions. Most Member States have a solid tradition of social consultation related to labour law and social security, by means of which the public authorities discuss their plans with representatives of workers and employers alike. In all Member States, free collective bargaining governs many aspects of the employment relationship. When the European Community was established (1957) there was a clear wish to create a harmonious society, based on dialogue and participation by the social partners.

HISTORY OF THE SOCIAL DIALOGUE IN GENERAL

***1958-1984: minimum level of social dialogue:** bodies with 'consultative power'

- Economic and social committee (art. 193 of the Treaty of Rome , 1957)
- European social fund (art. 123 of the Treaty of Rome, 1960)
- Standing Committee on Employment, consisting of Ministers of Labour, representatives of the European Commission and representatives of employers and employees, the social partners (1970)
- consultative committees and 'First programme of Social Action (1974)

***1985 (Val Duchess) and 1986 (Single Act)**

The 'social dialogue' was relaunched by President Delors in 1985 at Val Duchess, where the principal European Social Partners met with representatives of the Commission and where the dialogue was given a legal basis in art. 118 B of the Treaty of Rome, introduced by the Single Act (1986): 'the Commission shall endeavour to develop the dialogue between management and labour at European level which could, if the two sides consider it desirable, lead to relations based on agreement'.

The Social Partners at the European level are

- *UNICE: Union of Industrial and Employers' Confederations of Europe (private sector)
- *CEEP: European Centre of Enterprises with public Participation (public sector)
- *ETUC: European Trade Union Confederation: °1973 (public and private sector)

This article however did not give an explicit mandate to the European social partners to conclude collective agreements.

Progress was very slow and limited although the Single Act enlarged in art. 118A, the possibilities of the Council of Ministers to vote on the internal market (free movement of workers, their safety and health at work) with a qualified majority instead of unanimity. For most social matters the unanimity rule however remained valid.

***1989, 9 December, Strasbourg: 'Community Charter of Fundamental Social Rights'**

This Charter (restricted to workers, although drafted for all the citizens), was accepted by the Heads of Government of all the Member States, save that of the UK, in December 1989. The Charter is a political declaration and not an international treaty and has no binding force. It identifies twelve fundamental social rights as the objectives of the signatories. The Commission drew up a programme of action containing specific proposals for directives and other instruments for implementing the Charter in the period 1990-1992. Of these about half had been adopted by the end of 1992: e.g. proof of the employment relationship, measures to encourage improvements in the safety and health at work of workers. Overall, the progress towards the goals of the Community was slow because of the unanimity rule for social topics and although the European Social Partners could avoid directives, imposed by the European Commission (see above), by concluding European collective agreements, this was not done.

1991, 31 October

The European social partners signed an Agreement, expressing formally their willingness to bargain and defining the functions of the social dialogue in terms of consultation, concertation and negotiation.

1991, 9-10 December: the ‘Maastricht Social Chapter’

During this summit the (at that time) 12 Member States, including the UK, agreed first to confirm the ‘acquis communautaire’ (EC Treaty as amended by the Single Act), reached in the social field. Secondly, in a Protocol on Social Policy, the 11 Member States (excluding the UK) noted that “eleven Member States wish to continue along the path laid down in the 1989 Social Charter”. The Maastricht Protocol on Social Policy and the subsequent Agreement on Social Policy include an extension of the social competence of the 11 Member States as well as an enlargement of the possibilities for decision-making by means of a qualified majority and the possibility for the social partners to conclude collective labour agreements at Community level with binding effect after the approval of the Ministers of Social Affairs.

The role of the social partners thus has been much enhanced on the occasion of the Maastricht summit: from representation in the ‘Economic and Social Committee’ (where they are still represented but only have a consultative seat) to real consultation with the European Community to the implementation of Community directives, finally to collective bargaining at European level and the possibility to conclude European Collective Agreements at different levels (enterprise, sector, multi-industry or the Community as a whole).

So this means that there is a ‘two-track social Europe’: one for the whole Union (now 15) (within the framework of the EC Treaty, which in regard to social policies, remained largely unchanged after Maastricht) and one for the Union minus the UK (under the Protocol added to the Treaty of Maastricht). This means that if a proposal is vetoed by the UK, under the EU Treaty procedures, the 14 might take it up again under the umbrella of the Protocol on Social Policy and their Agreement.

In July 1992 the European Social Partners decided to create a ‘Committee for Social Dialogue’ to facilitate the implementation of the new rules and community procedures on dialogue, consultation and negotiation (within the framework of their Agreement of 31 October 1991).

1992, 3 July

Creation of the Social Dialogue Committee, which itself created, three months later, two working parties, one on macroeconomics and the other on education and training.

1993, 28 September

Consultation of the social partners on the Commission’s White Paper.

1995, 12 April

Adoption of the medium-term social action programme 1995-1997 (Commission Communication to the Council and the European Parliament, and to the Economic and Social Committee and the Committee of the Regions ; Com (95) 134).

CONCRETE RESULTS OF EUROPEAN SOCIAL DIALOGUE

So far there are two concrete steps taken in the field of the European social dialogue: one via a European directive which enables and encourages the social partners to conclude a CAO (e.g. the establishment of 'European Works Councils', which doesn't affect the hospital sector and via real European collective agreements by the social partners (e.g. the 'European Collective Agreement on Parental leave', which covers the hospital sector as well).

1. Directive on European Works Councils

Taking into account the two possible procedures in the process of social dialogue, the Council of Ministers of the 11 Member States (without the UK) unanimously signed a directive on 22 September 1994 (94/45/EEG), on the basis of the Protocol on Social Policy, on the establishment of European Works Councils. This directive of course also covers the new Member States. The objective of the directive is to: "improve the information and consultation of employees in Community-scale enterprises and groups of undertakings". This directive, however, will only be implemented from 22 September 1996 on, and the Commission encourages Community-scale companies (= more than 1.000 employees in Europe) to make their own arrangements on information and consultation procedures with their employees before that date. In that case the directive will not be applied to those particular companies. If not the companies will have to establish a European Works Council on information and consultation precisely according to the rules of the directive.

2. Parental leave

On 14 December 1995 the European Social Partners (UNICE, CEEP and ETUC) signed, in the presence of Commissioner Flynn (DGV), the first 'European Collective Agreement' (ECA) on parental leave. This ECA concerns only 14 EU Member States since the agreement was concluded under the Protocol on Social Policy in the Maastricht Treaty. The UK employer's representatives, which took part in the negotiations, did not sign the agreement, but there is a possibility of signing a replica of this agreement nationally, if the UK social partners decide to do so. On 3 June 1996 the EU Council of Ministers adopted the Directive (O.J. L 145 of 19/6/96) on the framework agreement on parental leave, which makes the agreement legally binding as a European legislative text. The EU Member States shall comply with the Directive by 3 June 1998 at the latest. The agreement gives all male and female workers the unconditional right to three-months unpaid parental leave during which social security coverage continues uninterrupted. Overall this means social progress for Ireland, Luxembourg and Belgium. For the other countries the directive contains a non-regression clause.

This ECA proves the willingness of the European Social Partners to negotiate and decide instead of waiting for EU regulations, and this directive proves at the same time the viability of the Social Protocol.

The European Commission published a 'Social Action Programme for 1995-1997 and a paper on 'The Future of Social Protection: a framework for a European debate, which again will focus on greater participation and impact by the social partners.

Art. N. 2 of the Treaty of Maastricht lays down that the Treaty will be reviewed by the heads of state of the member countries. This Intergovernmental Conference started on 29 March 1996 in Italy (Turin). The main objectives are: to extend the power of the European Parliament; to prepare for enlargement of EU Membership (e.g. with Central and Eastern European countries) and finally to involve the European citizen more actively in the social construction of Europe via improved participation by the social partners, although citizens' participation is more than only the participation of the social partners.

EUROPEAN SOCIAL DIALOGUE IN THE HEALTH AND HOSPITAL SECTOR

On the European level hospital employees are represented by the 'European Federation of Public Service Unions' (EPSU), member of ETUC, as well as by the European Federation of Employees in Public Services (EUROFEDOP). Both of them represent as well the personnel of the private hospitals in Europe.

Private hospital employers are not specifically represented at EU level, but are included in the general remit of UNICE. Only one Member State, the Netherlands, has formal representation for the hospital sector in UNICE. The public hospital employers are not represented at EU level either, but are included in the general remit of CEEP.

The Standing Committee of the Hospitals of the EU (HOPE) takes an active interest in the progress of the Social Dialogue in Europe and engages in dialogue in a variety of fora. The Standing Committee of the Hospitals of the EU does not, however, act in a representative capacity, on behalf of the the hospitals as employers.

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A - AUSTRIA

GENERAL REMARKS

Social partnership is voluntary, since there is no legal basis for entering into collective agreements. There is no collective bargaining autonomy and Parliament is the final authority. So far Parliament has always adopted the decisions of the social partners as legislation. The public sector covers 45% of all hospitals, but 81% of all hospital employees. 7% of employees work in the private non profit sector, 12% in the private profit sector (1994). As regards the trade union affiliation rate there are no reliable figures available.

ACTORS: THE SOCIAL PARTNERS AND THE GOVERNMENT

As regards the employees, there is a sub-organization of the Austrian Trade Union Congress (Österreichischer Gewerkschaftsbund), the Association for Health Professions (Fachgruppenvereinigung für Gesundheitsberufe), which comprises all employees in health professions (excluding physicians) in the public sector as well as in the private sector. The members come from five trade unions, depending on the type of hospital they work in. The association promotes the actions of the trade unions to gain favourable working and wage conditions, but does not negotiate by itself.

Public: public sector employers are representatives from the Länder and the municipalities. The employees are represented by the trade union for civil servants (Gewerkschaft Öffentlicher Dienst) for hospitals of the Länder, and by the union for municipal employees (Gewerkschaft der Gemeindebediensteten) for municipal hospitals.

Private: in the social bargaining process, some of the private employees are represented on the one hand by authorized agents of the hospitals of religious orders and communities, and, on the other hand by the association of private hospitals (Verband der Privatkrankenanstalten). The other employers bargain mostly individually. For employees, there are three trade unions involved: the union for private employees (Gewerkschaft der Privatangestellten), the union for commerce, transport and traffic (Gewerkschaft Handel, Transport, Verkehr) and the union for hotels, restaurants and personnel services (Gewerkschaft Hotel, Gastgewerbe, Persönlicher Dienst).

LEVELS OF SOCIAL BARGAINING

For the **public** sector negotiations take place at all three territorial levels (Federal, Länder and Local level). Settlements from negotiations with the social partners have to be implemented in the competent legislative bodies. Pay bargaining is dealt with centrally. Questions of principle with regard to employment and remuneration are negotiated centrally and then implemented by the Länder, or negotiated separately at Land level or local level. In principle all three territorial levels accept Federal regulations, but it is possible to negotiate more beneficial arrangements at lower levels.

For the **private** church run sector in some Länder negotiations take place at the Länder level, in other Länder on lower or individual levels. The association of private hospitals negotiates for their members (which comprises only a certain percentage of private hospitals).

NEGOTIATED NORMS

Once the settlements from the collective agreements are given a legal basis, they become binding.

LABOUR CONFLICTS

There is no statutory right to strike in Austria. But, the Austrian legal system does not forbid strikes.

GENERAL REMARKS

The hospital sector consists of a public (app. 40% of the hospitals), a private non profit (app. 60% of the hospitals) sector and a very small private profit sector (mainly homes for the elderly). Social bargaining is regulated in the public sector by the Law of 19 December 1974 on the Trade Union Status of civil servants, which came into force by Royal Decree of 1994 and in the private non profit sector by the Law of 5 December 1968. The trade union affiliation rate is low (there are no exact figures available) but has been increasing since 1991, due to a national strike of nurses in the private sector.

ACTORS: THE SOCIAL PARTNERS AND THE GOVERNMENT

Public: as for the employer's organisations they consist of representatives of public (political) authorities at different levels (federal, community, regional and local), which are entitled to negotiate and to conclude 'protocols'. There are no specific trade unions for the hospital sector. Hospital employees are represented by the 3 federal 'representative' trade unions for public services, which are entitled to negotiate and to conclude collective agreements for the whole public sector. The influence of the government in social bargaining in the public sector is very high because it is one of the partners (the employer).

Private non profit: there are 7 different 'representative employer's organisations covering the hospital sector, which are entitled to negotiate and to conclude collective agreements. There are no specific trade unions representing hospital employees. The same 3 federal trade unions as for the public sector also represent the private non profit sector. The influence of the government is indirectly very great because on the one hand the government is not a partner in social bargaining in the non-profit-sector but on the other hand the government is responsible for fixing personnel and quality standards and financial and budgetary rules for the whole hospital sector.

LEVELS OF SOCIAL BARGAINING

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

level A: Committee A: representatives of the federal government, the community and regional governments negotiate with the 3 trade unions protocols for all public sector workers in Belgium. Committee A is responsible for fixing the social intersectoral programming in public services.

level B: Committee B: the bargaining partners involved here are the Minister for the Federal Civil Service, the ministers for the departments concerned, the officials in charge of the public bodies concerned and the trade unions. At this level the bargaining is done in 15 different bargaining committees, known as Sectoral Committees, but there is no specific committee for the hospital sector. Negotiation concerns the implementation of provisions agreed at level A.

level C: Committee C: representatives of political authorities at the provincial and local level negotiate with trade unions and conclude protocols which are applicable to workers in the public sector but only for provincial and local public services (thus public hospitals included). However there is no specific bargaining for public hospitals.

Private non profit: At national intersectoral level the 'National Labour Council' (NAR) negotiates all social affairs concerning the private sector with the trade unions. The employers of the private non profit making (=social profit) sector (including the hospital employer's organisations) are nationally organised in the Confederation of Social Profit Institutions, which is not yet a full member of the NAR and is only entitled to give advice. The NAR concludes national intersectoral collective agreements on social matters for the whole private (profit and non profit) sector.

At national sectoral level there is one specific committee (consisting of the hospital employer's organisations and representatives of the 3 trade unions) for social bargaining concerning private non profit making hospitals. As already mentioned, government is not a direct partner nor represented in this committee, which leads to growing informal contacts between trade unions and the government because the latter indirectly sets the financial limits for social bargaining by fixing the annual budget).

In hospitals themselves there are: a Works Council (minimum 100 employees), which is established by Law and which is only entitled to be informed, to negotiate but not to conclude agreements; a Health and Safety Committee (minimum 50 employees), which is an advisory body to management and finally a Trade Union Delegate (minimum 50), established by collective agreement, for which the right to negotiate collective agreements depends on the agreement with the employer concerned.

NEGOTIATED NORMS

In both the public and the private non profit hospital sector negotiated agreements concern pay and working conditions. In the public sector negotiations also concern pensions and the status of personnel. However an agreement in the public sector (called a 'protocol') is not legally binding on the political authorities, who only have the obligation to negotiate but not to implement the agreement reached. Collective agreements reached in the private sector are legally binding for the signing parties and the members they represent (unionised or not). Agreements can also be made compulsory for the whole private sector by Royal Decree, thus binding for the whole sector. Lately general bargaining in the public sector has in principle been held every two years within Committee A. Since the implementation of these agreements necessitates further bargaining, this may entail the conclusion of implementing agreements at the other bargaining levels. In the private sector the duration of the agreement and the initiative to negotiate depend on the content of the agreement to be reached.

LABOUR CONFLICTS

The right to strike is neither guaranteed in the Constitution nor by Law, but is considered to be a legitimate act in industrial Case Law and is also provided for through the adoption of the European Social Manifest ('90). In both the public and the private sector there is an obligation to provide a minimum service during strikes.

D - GERMANY

GENERAL REMARKS

In Germany social bargaining is regulated by the Constitution and by making law. The public sector covers 44% of hospitals, the private non profit 40% and the private profit 16%. 65% of all employees in hospitals work in public hospitals. There are no reliable figures available on the trade union affiliation rate. The same goes for information on the negotiations in the sector of private profit making hospitals.

ACTORS: THE SOCIAL PARTNERS AND THE GOVERNMENT

Public: at the federal level public employers are represented by the Ministry of Internal Affairs (BMI), on Länder level by the Tarifgemeinschaft Deutscher Länder (TdL), and on municipality level by the 'Vereinigung Kommunalen Arbeitgeberverbände (VKA). As for the public hospitals neither the 'Deutsche Krankenhausgesellschaft (DKG) nor its hospital associations on Länder level are employer's associations (or parties to wage agreements). As for the trade unions there is one organisation for 'public services', transport and traffic (ÖTV), which sometimes also conducts negotiations on behalf of organisations outside the public sector such as the private health sector, the German Union for Employees (DAG) (for white collar workers) and the German Civil Servants Association (DBB), all three at the federal level.

There is a clear distinction between the blue- and white collar workers, on the one hand, and civil servants, on the other hand, in the public sector. For blue- and white collar workers pay and employment conditions are determined through collective bargaining under the German Collective Agreements Act of 1949. For civil servants pay and employment conditions are regulated by parliamentary decisions after a prior hearing with the civil servants' organisations.

Private non profit (charitable): for the charitable hospitals there is a Commission on the federal level (Arbeitsrechtliche Kommission), which is completely independent of the Federal State and regulates the working and pay conditions of the church-run sector. Trade Unions do not have the right to bargain in charitable hospitals. Wage decisions by the Arbeitsrechtliche Kommission are mostly based on wage agreements for the public sector. The government has no authority over on this sector.

LEVELS OF SOCIAL BARGAINING

On the Federal interprofessional level DAG and ÖTV negotiate with representatives of the Federal State, Länder and municipalities (BMI, TdL and VKA) for all the public services to which the public hospitals belong. For the charitable sector the Commission on a Federal level takes decisions on wage and general working conditions for the whole sector. The charitable sector is legally free to draw up its own wage conditions and labour regulations. Very often agreements made for the public sector are taken over by the charitable sector.

In hospitals (public and charitable) themselves there is a works council, with a balance between employers and employees. The main subjects for works councils are health and safety and personnel measures.

NEGOTIATED NORMS

Collective agreements, negotiated on a general basis, both in the public and charitable (following its own regulation system) on pay and working conditions most often have amendments and special regulations for staff in public hospitals. The agreements are binding on the signatories. In the case of framework agreements covering conditions of employment such as working hours etc. the duration is variable.

LABOUR CONFLICTS

The right of employees to strike is derived from the Constitution of the Federal Republic of Germany. Unlike lock-outs, it has constitutional protection. The Constitution however, does not provide for a statutory right to strike, nor does it provide a right to forbid a strike. Jurisprudence has developed general rules for the admissibility of strikes. When a strike is called, there is an obligation to provide a minimum service.

E - SPAIN

GENERAL REMARKS

In Spain social bargaining is regulated by the Constitution (1978) and by Law. 69% of hospital beds are public and 31% private (14.4% non profit making and 16.7% profit making). The trade union affiliation rate is 40% for nurses. INSALUD covers 40% of public hospitals. 60% of public hospitals are run by the autonomous regions (7). In the public sector there are three categories of workers: workers subject to the private law employment relationship, civil servants subject to the special provisions of public law and workers in the health sector which comes under the social administration. There is a distinction between public and private law with regard to bargaining systems. Civil servants in the central administration, social insurance and health sector fall within the public law bargaining system, while private law workers fall within the private law bargaining system.

ACTORS: THE SOCIAL PARTNERS AND THE GOVERNMENT

Public: the bargaining system can be characterised as a semi-centralised system, where the centre of gravity remains with the national government, but where the public employers (central, regional and municipality) are also to a certain extent autonomous. For some public services such as health care the corresponding specialised minister act as bargaining partner to the unions. There are two general trade unions on the national level and some specific health care trade unions which are more professional organisations representing their workers interests. These organisations are entitled to negotiate, to conclude collective agreements and are in fact very powerful.

Private: the private profit making hospital sector is rather small and plays a complementary role to that of the National Health Service. Hospital employers are organised in the 'National Federation of Private Clinics', which is however not entitled to conclude collective agreements.

LEVELS OF SOCIAL BARGAINING

Bargaining in the public sector is conducted centrally for public health. Bargaining in municipalities and regional administrations is linked to central negotiations, but is not directly dependent on them. There is a General Negotiating Round Table, which concludes general collective agreements (recently a Committee on Pay and Employment has been established as well) and several sectoral Round Tables to adapt general agreements to the specificity of the sector. There is one 'Health Sectoral Round Table for hospitals belonging to INSALUD and one for the 7 autonomous regions. In public hospitals there are: a works council for personnel under labour contract and a personnel board for statutory personnel; a trade union representative, an occupational health committee and a board for the selection of temporary personnel. None of these bodies is entitled to conclude agreements with the employer. They can only promote a dialogue.

In the private sector (profit making and non profit making) bargaining is carried out on a provincial level directly with the employer. As a result no agreements are reached on the national level. The yearly pay increases are negotiated directly with the employers at a provincial level.

NEGOTIATED NORMS

In the public sector there are 'pacts' and 'agreements': pacts cover the scope of the competence of the managerial body and agreements cover the scope of the competence of administration. Pacts and agreements are concluded for personnel under statutory employment (not for personnel with a labour contract) and concern pay and working conditions. The duration of agreements is between one to three years depending on the subject but agreements on wage and salaries must be negotiated on an annual basis.

In the private sector pay increases are negotiated on a provincial level and directly with employers. These increases can vary substantially among themselves and from those in the public sector. These 'Provincial collective agreements' focus on a specific year and are binding for all private hospitals at this level.

LABOUR CONFLICTS

The right to strike is guaranteed under the Constitution of 1978, but no further legal provisions exist so far. Employees have the obligation to provide certain minimum services. The right to strike does not in principle vary between the public and private sector.

F - FRANCE

GENERAL REMARKS

In the public health sector social bargaining is regulated by the 'Code de la Santé et de la Sécurité Sociale (Public Law) and in the private (non profit/profit) health sector by the 'Code du Travail' (Common Law). In France 65% of hospitals are public, 20% are private non profit making and 15% private profit making. 72% of all hospital employees work in public hospitals and 28% in private hospitals. The trade union affiliation rate is very low in both the public and private sector (respectively 10% and 7%).

ACTORS: THE SOCIAL PARTNERS AND THE GOVERNMENT

Public: bargaining in the public sector is still conducted centrally. The relationship between employers and employees is basically governed by the Civil Service Statute. Employees in public hospitals are represented by 5 national federations (specifically for hospitals), which are entitled to negotiate and conclude collective agreements. Especially for nurses a new kind of representation is growing: 'les coordinations infirmières', which are powerful as a lobby but which are not entitled to conclude collective agreements. The government acts on several levels as employer and is very influential when it comes to negotiations.

Private: hospital employers in private hospitals are represented by 5 national hospital employer's organisations, which are entitled to conclude collective agreements. These employer's organisations are grouped on a national level in the 'Confederation of French employers'. Employees in the private hospital sector are represented by the same trade unions as in the public sector. The government has to approve the collective agreements (between the social partners) on a national level and the agreements at hospital level (in order to restrain the financial consequences of the agreement. This influence thus affects the liberty to negotiate (cfr. Belgium).

LEVELS OF SOCIAL BARGAINING

On a national level negotiations are conducted for the public hospitals by the 5 (already mentioned) trade unions and representatives of the government (+ the 'Conseil Supérieur de la Fonction Publique Hospitalière, which is an advisory body to the Ministry of Health'). For the private non profit making hospital sector negotiations are conducted on a national level by the 5 hospital trade unions and the 5 hospital employer's organisations. The private profit making hospital sector is (at present) regulated by two collective agreements. In the hospitals (public and private) there is a works council, which is entitled to negotiate and conclude agreements with the employer, a trade union representative and a health and safety committee, which are only entitled to promote dialogue with the employer.

NEGOTIATED NORMS

In both the public sector and the private sector the collective agreements (called protocols in the public sector) concern pay and working conditions, as well as conditions on permanent education, which is a very important power of the social partners in France. In the private sector these agreements are legally binding for the signatories on a national basis, but as mentioned already the government has a major influence on the negotiations and thus the content of the agreements in the private sector. In the public sector negotiations give rise to non-binding agreements. The Government can unilaterally set, and even freeze the index for general pay rises, as happened in the 1996 pay round. In view of the absence of proper collective bargaining in the public sector consultative bodies are gaining importance alongside informal negotiating procedures. In the private sector the 'Auroux Laws (1992) provide that agreements on pay conditions last one year and agreements on job classification five years. However the Auroux Law does not apply to the public sector and there are no provisions governing the duration of collective agreements or of unilateral arrangements of the Ministry of the Public Sector concerning the employer/worker relations in the public sector.

LABOUR CONFLICTS

The right to strike was first granted to private sector employees (1884), without however appropriate laws to regulate the strike, and then to employees in the public sector (1946 and 1963). Both laws lay down the obligation to provide a minimum service during a strike.

FRANCE

1. Actors: when speaking about the private hospitals: is this private profit or private non profit
2. Auroux Law (1992): ?

GB - GREAT BRITAIN

GENERAL REMARKS

In Great Britain social relations are characterised as a system of 'free collective bargaining'. Historically Britain has remained free of legislative intervention. Management is under no legal obligation to recognize or enter into dialogue with employee organisations although the government encourages them to recognise each other and work together. 90% of hospitals are public and 10% are private (profit/non profit). Trade union affiliation rate is between 20- 60% and declining (there are no exact figures).

ACTORS: THE SOCIAL PARTNERS AND THE GOVERNMENT

Public: public hospital employers are represented by the 'National Association of Health Authorities (NAHAT) and a number of employers are appointed by the Government to sit on the management side of the National Negotiating Machinery (Whitley). Whitley has a range of Functional Councils dealing with specific groups and a General Council to negotiate common issues such as pensions. This machinery is heavily influenced by Government who must approve the outcome of negotiations. Public hospital employees are represented by 12 different organisations (and professional organisations, which are only entitled to 'fair dealings' with management). Since 1991 NHS employers can offer their staff a choice between the nationally negotiated contract and a local contract. Government policy is to encourage the local alternative. Doctors and nurses have an Independent Review Body who make recommendations each year to the Government although these professions can also opt for 'local contract' if they wish.

Private: private hospital employers negotiate their own terms and conditions. Many shadow the NHS Whitley deals. In the private sector government is not directly involved.

LEVELS OF SOCIAL BARGAINING

For the NHS the National Whitley Council Mechanism (Government, Employers, Trade Unions) negotiates pay and working conditions. Independent Review Bodies make recommendations each year in respect of doctors, nurses and professions such as physiotherapy. The government usually accepts their advice but is not legally bound to do so. Since 1991 the Government has been encouraging local bargaining within a national framework by 190 different NHS Employers.

NEGOTIATED NORMS

For the public hospital sector any Whitley agreement approved by the Secretary of State becomes a statutory binding condition of employment of all officers to which it applies. Agreements concerning pay usually last one year. The same goes for the private sector where the agreement is binding on the signatories.

LABOUR CONFLICTS

The right to strike has its roots in English Common Law. English employment law does not generally make any distinction between the public and the private sector. Where a problem cannot be solved on a local level, then voluntary conciliation, arbitration or mediation is carried out through the Agency of Advisory Conciliation and Arbitration Service (ACAS). Strikes were commonplace in the 1970's but are now very rare.

GR - GREECE

GENERAL REMARKS

In Greece the public hospital sector covers 70% of beds and the private sector 30%. For the public sector labour relations are regulated by the Constitution and the Laws on doctors (NHS, 1983) and all the public servants for the others (1978, 1985 and 1989). State employees do not have bargaining rights. In the private sector collective negotiations are conducted between all employers and employees every year. The trade union affiliation rate is about 90%.

ACTORS: THE SOCIAL PARTNERS AND THE GOVERNMENT

Public: public hospital employers are represented by the Ministry of Health and Welfare. The employee's organisations are the 'National Federation of Hospital Doctors' and the 'Pan-Hellenic Association of Public Hospital Employees (for nurses, paramedicals, administrators, technicians and others). The government is unilaterally responsible for regulating the employment conditions of state employees. The unions are consulted on these matters only an informal basis.

Private: private hospital employers are represented by the 'Private Clinics and Hospitals Union. Employees are represented by the 'Pan-Hellenic Medical Association' and the 'National Federation of Private nurses'. The government's involvement is limited to the approval of national general wage rates but is not directly involved with the hospitals.

LEVELS OF SOCIAL BARGAINING

In the public sector wages and labour relations are defined by Law. Bargaining between the employer's organisations and the Ministry of Health is conducted only for extra allowances through informal negotiations. In the private sector bargaining concerning wages and labour relations is carried out every year by the National Federation of Private Hospitals.

In public hospitals themselves there is no authority which is mandated to negotiate with the employer. In private hospitals however, each hospital owner can define (after negotiations with hospital employee's representatives and individuals themselves) better wages and labour relations than the national rates.

NEGOTIATED NORMS

For the public sector, pay and working conditions are negotiated and settled by Law for all public servants and by specific Law for hospital doctors. The government has to adopt the content in the Law. The Law stays in force until the next Law is passed.

In the private sector pay and working conditions are negotiated in collective national agreements which cover the whole private sector. Negotiations are carried out every year.

LABOUR CONFLICTS

Trade unions have the right to strike while collective bargaining is in progress. In both the public and the private sector there is an obligation to provide a minimum service during a strike.

GREECE

1. What is meant by the second sentence: 'For the public sector labour relations are regulated by the Constitution and the Laws for doctors.....'
2. Does the private hospital sector includes as well the non profit institution and the profit ones or do the non profit hospitals follow the same administrative and bargaining procedures as for the public hospital sector.
3. Is the hospital employee's organisation for the public sector (Pan-Hellenic Association of Public Hospital employees) different from the one mentioned for the private sector (Pan-Hellenic Medical Association).
4. For the private sector (profit or non profit?) pay and working conditions are negotiated in collective national agreements only or can those agreements be adapted to a Law.

I - ITALY

GENERAL REMARKS

95.3% of hospitals in Italy are public and 4.7% private. Collective bargaining in the public sector is regulated by Law (29/93) and for the private sector by the Civil Code (L., n. 300/70). The trade union affiliation rate in the public hospital sector is about 55% (72% for doctors and 74% for non medical personnel). For the private sector the trade union affiliation rate is 61%. There is no long tradition of trade union organisation among public employees in Italy, since the trade union movement has grown out of the workers' movement in the private sector. The trade union affiliation rate in the public sector (in general) is nonetheless approximately 70%.

ACTORS: THE SOCIAL PARTNERS AND THE GOVERNMENT

Public: the 1992 Act meant that on the employer side the negotiating parties will no longer be the individual ministries, but a newly created national authority 'Agenzia per la Rappresentazione Negoziabile', which includes the hospital employers as well. The scope for action by this association is, however, limited by strict government stipulations. Hospital employees are represented by 3 national trade unions for the whole public sector, including the hospital sector and a great number of trade unions according to the profession.

Private: the private employers are represented by the 'Associazione religiosa degli istituti socisanzitari', the 'Associazione Italiana Ospedalita privata and the 'Fondazione Pro Juventute Don Carlo Gnocchi'. The trade unions for the employees in private hospitals are the same as for the public sector. The government has to approve collective agreements made for the public sector. For the private sector the government has no authorisation.

LEVELS OF SOCIAL BARGAINING

Collective bargaining in the public sector in Italy is more centralised at national level than is the case for the private sector. One of the reforms of the public sector in Italy is the 1992 ACT (421/92), which is meant to create a more unified framework for collective bargaining. Pay, contracts of employment and working conditions will no longer be legally regulated but will be regulated through collective agreements (pay negotiations still take place at the central level) as in the private sector.

Collective negotiations are conducted at three different levels. First the umbrella organisations negotiate at the central level the standard conditions and rules which apply to everyone in the public sector. The next bargaining level is the national sectoral level, where more specific questions relating to employment are dealt with (the public sector is divided into nine sectors of which health and hospitals is one). The final bargaining level takes place at regional or 'hazienda' level (which covers a certain number of hospitals in a territorial authority) on issues which have been expressly reserved for this level.

NEGOTIATED NORMS

For the public sector pay conditions are conducted every two years on a central level, while framework agreements covering conditions of employment are negotiated every four years.

LABOUR CONFLICTS

The right to strike is guaranteed by the Constitution. A new Act regulating strikes was passed in 1990 (146/90), and stipulates that certain services, which are considered important for citizens, must be guaranteed.

ITALY

1. 4.7% of the hospitals are private (is this profit, non profit or both?). If these 4.7% means private profit, does this mean that the private non profit hospitals are treated administratively in the same way as the public hospitals (e.g. the same bargaining procedures, with the same representation)
2. Collective bargaining for the public sector is regulated by Law (29/93) whereas it is mentioned further that the 1992 Act regulates collective bargaining as well. Which Law is correct (most important) and which Law is specific for the hospital sector.
3. Is the 'Agenzia per la Rappresentazione Negoziata' a general negotiating body for the whole public sector or only for the public hospital sector.
4. The description on the negotiating norms is only for the public sector. How about the private (profit, non profit or both) sector.

IRL - IRELAND

GENERAL REMARKS

In Ireland 86% of hospitals are public, 10% are private non profit making and 4% are private profit making. Industrial relations in Ireland are based on collective bargaining and therefore the role of law is always secondary. For all three types of hospitals the 'Trade Union Law Provisions of the Industrial Relations Act 1990' provides for the adoption of codes of practice for the bargaining process. The trade union affiliation rate is about 90% to 100%.

ACTORS: THE SOCIAL PARTNERS AND THE GOVERNMENT

Public: there are 8 health boards (local level), in Ireland covering the different regions. Public hospital employers are represented by the 'Local Government Staff Negotiations Board (LGSNB), which is the central bargaining agency on behalf of the 8 health boards. The employees in public hospitals are represented by 33 organisations according to profession (their status is provided for by the 'Trade Unions Law Provision of the Industrial Relations Act of 1990'. These organisations are gathered in the 'Irish Congress of Trade Unions'

Private non profit/profit: for the private non profit making sector hospital employers are represented by 'The Irish Business and Employment Confederation' (IBEC), which covers all matters relating to industrial relations, labour and social affairs and which has a special group to handle bargaining for hospitals. Private profit making hospital employers are represented by the 'Independent Hospital Association'. The employees in private profit making and non profit making hospitals are represented by the same 'Irish Congress of Trade Unions' as for the public sector.

In both sectors government is involved as a partner in 4 major national programmes on pay norms for the whole country. The current Programme for Competitiveness and Work runs from 1994 to 1997 and is a revision of the other programmes. The agreement encompasses pay bargaining as part of a wider economic and social agenda. The programme provides for fiscal parameters for the coming years which will govern the extent to which bargaining in the hospital sector takes place.

LEVELS OF SOCIAL BARGAINING

Collective bargaining takes place at three levels: national, sectoral and local. Pay bargaining since the late 1980's has taken place centrally within a tripartite system including the employer and employee organisations and Government and resulting in a series of multi-year national agreements covering all employees in the private and public sectors. Since 1987 4 major national programmes have been agreed for the public and private sector. Hospital employees fall under these conditions. On the sectoral level further negotiations are possible to obtain 'extra's. For the public (state) hospitals this is done by the 'Labour Relations Commission (LRC), which is tripartite, consisting of representatives of the 8 health boards, trade unions and independent representatives and by the 'State Conciliation and Arbitration Scheme (1950), which since 1971 is called the 'Local Government Staff Negotiations Board'. This board performs conciliation and arbitration on behalf of the management of health boards and negotiates as well with the trade unions; for the private non profit making and profit making hospitals negotiations are carried out by the 'Labour Relations Commission', which consists of IBEC and the 'Irish Congress of Trade Unions'. This commission is entitled to conclude collective agreements.

At the individual hospital level each hospital (public, private non profit or profit) has a personnel division which meets the trade unions on local issues. Joint consultation arrangements are possible as well.

NEGOTIATED NORMS

For the public and private non profit making hospital sector collective agreements on pay and working conditions are carried out by representatives of government, health boards, IBEC and the Irish Congress of Trade Unions. For the private profit making sector employers' - and employees' organisations have agreed to be bound by the collective agreements set out by the public and voluntary sector. The agreements are binding on all signatories and last for 3 years.

LABOUR CONFLICTS

In general the right to strike is outlined in the Industrial Relations Act of 1990.

For the public sector the Labour Relations Commission provides a conciliation service as a first stage. If a problem is not solved, it is dealt with by the Labour Court. For the private sector the Trade Union Law of the Industrial Relations Act 1990 sets out the position on lawful picketing and sets out provisions for secret ballots before a strike.

LUX - LUXEMBOURG

GENERAL REMARKS

In Luxembourg the public sector covers 50% of hospitals and private non profit making hospitals cover the other 50%. All hospital services are covered in the Law on Public Services in health care. There is only one real state hospital and there is only one private profit making hospital. All services in health care are regulated in the 'Conventionnement Obligatoire'. Collective bargaining is regulated by Law (12 June 1965). The trade union affiliation rate for full residents is 90% and 60% for mixed residents.

ACTORS: THE SOCIAL PARTNERS AND THE GOVERNMENT

For the public as well as for the private (= non profit making) sector the hospital employers are represented by the 'Entente des Hôpitaux Luxembourgeois', which covers all hospitals except the one state hospital. There are no specific trade unions for hospital employees, but instead 3 national general organisations of which 2 for blue collar workers and 1 for white collar workers. The government has an indirect influence on bargaining through its mediation and conciliation role.

LEVELS OF SOCIAL BARGAINING

The 'Entente des Hôpitaux Luxembourgeois' negotiates on a national level with the 3 national trade unions (2 for blue collar workers and 1 for white collar workers). These negotiations cover the whole hospital sector. At the hospital level all hospitals (public and private) have a personnel representative (+ 50 employees): 1 for white collar workers and 1 for blue collar workers. Advice on working conditions given by the personnel representative is not binding. For the state hospital there is a mixed committee, which is an advisory body to the employer. Some kinds of advice are binding.

NEGOTIATED NORMS

For both the public and the private hospital sector collective agreements on a national level are negotiated on pay and working conditions by the 'Entente' and the 3 national trade unions. These frame conditions (agreements) have to be further elaborated and negotiated on a local level between management and the representative of the personnel. Collective agreements negotiated on a national level are legally binding on the signatories and thus cover the whole hospital sector. Agreements negotiated on the hospital level are only binding for the hospital concerned. Negotiations are carried out periodically.

LABOUR CONFLICTS

When labour conflicts arise the 'Office National de Conciliation, which is a joint body of employers' and employees' representatives, tries to find a solution. If no solution is reached the Constitution provides for the right to strike. So far there have not been any strikes in the hospital sector.

NL - THE NETHERLANDS

GENERAL REMARKS

In The Netherlands almost all hospitals are private non profit making and there are 8 university hospitals. Collective bargaining is regulated by the Law of 24 December 1927. The trade union affiliation rate is 27% of all hospital workers.

ACTORS: THE SOCIAL PARTNERS AND THE GOVERNMENT

Public: university hospital employers are represented by the 'Dutch Association of University Hospitals' which acts as an employer on several levels and which is a private association. University hospitals however (still) have public status. Hospital employees are represented by 3 national (general) trade unions and by the 'Dutch Independent Trade Union for the Public and Non Profit Making Sector'.

Private non profit making: hospital employers in private non profit hospitals are represented by the 'Nederlandse Zorgfederatie' (NZF), which covers almost 100% of the hospitals (intramural care). Employees in private non profit making hospitals are represented by the same 3 national (general) trade unions as the public sector. In this sector the government is not a partner in negotiations. The government fixes annually the hospital budget which thus indirectly influences the liberty of the social partners to negotiate.

LEVELS OF SOCIAL BARGAINING

Private non profit making hospitals are represented in intersectoral national negotiations in the 'Stichting van de Arbeid' and the 'Sociaal Economische Raad' which are advisory bodies to the government on all socio-economic questions and agreements. Recently (since 01.01.96) the (private) 'Dutch Association of University Hospitals', is entitled to negotiate primary and secondary working conditions with trade unions on the sectoral level.

Negotiations for the private hospitals are carried out by 'Sociaal Overleg Ziekenhuiswezen', which consists of representatives of the NZF and the 3 trade unions for the private sector. Collective agreements can be broadened to the whole private hospital sector by Royal Decree, by Law and by the Minister of Social Affairs and Labour who can declare a collective agreement binding on all employers.

At the municipality level there is no bargaining for private hospitals.

In the hospital itself there is a work council (+ 35), which is entitled to negotiate for its own hospital collective agreements, within the sectoral (national) collective framework agreement.

NEGOTIATED NORMS

For the private hospital sector agreements on pay and working conditions are negotiated at the national level. All agreements are binding on the signatory parties and can be broadened by ministerial decree to the whole sector when it comes to private hospitals. Although most collective agreements in the public sector are in force for one year, there has been an increase in the number of collective agreements valid for two years. In the private sector negotiations on pay and working conditions are conducted every year or two years.

LABOUR CONFLICTS

The right to strike in the Netherlands is provided through the ratification of the European Social Manifesto. There is no specific law on the right to strike, but there are special stipulations in jurisprudence on the basis of which rules are settled when strikes take place.

DK - S - SF - THE NORDIC COUNTRIES

GENERAL REMARKS

For the Nordic countries information is based on a general leaflet on the social dialogue, printed jointly by the National Association of Local Authorities in Denmark, the Association of County Councils in Denmark, the Commission for Local Authority Employers Finland, the Norwegian Association of Local Authorities and the Federation of Swedish County Councils. The term County Councils will be used to cover all forms of local and regional government in the Nordic countries. The private sector for hospitals is very small. Almost all hospitals are owned by the local authorities. Collective bargaining is delegated on a legal basis to the local authorities. They have 'local self-government' competence on education, health, medical care, technical operations and social planning. Labour Law Statutes are similar in the different countries. Trade union affiliation rate is about 90%.

ACTORS: THE SOCIAL PARTNERS AND THE GOVERNMENT

Public: hospital employers are represented by 'Federations of County Councils', which act on a national level and cover all local authorities. Employees in public hospitals are represented by 'National Union cartels/organisations. As for the influence of the government it should be clear that all responsibilities rest with the local authorities. The national government only sets out a framework law on financing, planning, programming. Bargaining is done on a local level and differs from one authority to another. Agreements between the local authorities and the trade unions do not have to be approved by government.

LEVELS OF SOCIAL BARGAINING

The Federations of County Councils and the national trade unions negotiate a central agreement on the scope for pay increase and working hours and other working conditions within the framework of the national economy. On the County level negotiations are conducted between the county councils and the local trade unions which cover the whole public sector in one county. Negotiations and agreements are based on the framework established in central negotiations (local agreements however can differ and deviate from these central agreements). The degree of freedom in local negotiations has increased. In hospitals themselves there are trade union representatives for each group of employees, who are entitled to negotiate within the framework laid down in general agreements. Currently up to 1% of total wages are negotiated at this level. Furthermore in each hospital there is an occupational health service, in which the trade union representative monitors the interests of employees in regard to the working environment.

NEGOTIATED NORMS

Collective agreements are negotiated on a national (by the federation of county councils and trade unions) and a local level (county council and trade unions) on pay and working conditions. On the national level agreements are binding on the whole public sector. Agreements at the local level are binding on the signatories. The duration of agreements varies but is normally between one and a couple of years.

LABOUR CONFLICTS

The right to take industrial action is extensive compared to other countries, but parties have the responsibility to avoid conflicts and the obligation to refrain from industrial action. The right to strike exists only during the period in which the collective agreement has expired and negotiations on a new one are in progress. Disputes on the labour market are divided into legal disputes and conflicts of interest. Before a strike starts the parties must try to reach an agreement with the assistance of a public conciliator in the Court of Arbitration, and in most cases an agreement is reached. If a conflict endangers human life the Parliament can intervene and terminate the conflict by law.

FINLAND

1. Does this description of social bargaining apply to the situation in Finland

P - PORTUGAL

GENERAL REMARKS

In Portugal 52% of hospitals are public, 27% private non profit making and 21% private profit making. 83% of hospital beds are public, however, 13% private non profit making and 4% profit making. Collective bargaining is regulated by the Law of 25 May '92, which installed the 'Economic and Social Committee', and by the Law of 3 February '84 for the public sector. There are no reliable figures on the trade union affiliation rate.

ACTORS: THE SOCIAL PARTNERS AND THE GOVERNMENT

Public/private non profit: hospital employers are represented by the 'Department of Public Administration'. Employees are represented by two general national trade unions and by specific health care trade unions by profession (doctors, nurses, technicians, pharmacists,...), which are entitled to negotiate and conclude collective agreements at the national level. The government acts as an employer and negotiates with trade unions through its central departments. It determines the budget and the functioning of hospitals (which only have administrative independence). The government also has the obligation by law to consult and negotiate with the trade unions when defining social legislation.

Private profit: hospital employers are represented by the 'Portuguese Association of Private Hospitalisation', which also is entitled to negotiate and conclude agreements with trade unions, which are the same as for the public sector. For the non member hospitals, each private hospital negotiates directly with the unions. The government is not directly involved except if the parties (employers/employees) do not reach an agreement. Then the government has a conciliatory role. The government does however control, supervise and regulate hospital activities.

LEVELS OF SOCIAL BARGAINING

For both the public and the private non profit making sector there is one annual meeting of the 'Economic and Social Committee' which settles the framework principles of collective negotiations to be followed by employers' and employees' representatives in their negotiations. This Committee is a joint committee, co-ordinated by the government and consists of: 3 confederations of employers' associations and 2 confederations of trade unions. Negotiations in this 'Economic and Social Committee' influence the hospitals indirectly.

For the private profit making sector negotiations are conducted between the 'Portuguese Association of Private Hospitalisation' and the trade unions. At present there are two collective agreements ('92 and '95) which regulate the private profit making hospital sector.

In hospitals (public as well as private) themselves no real negotiations take place but there are bodies to advise management: the health and safety committee, the trade union representative and an ethical committee.

NEGOTIATED NORMS

Protocols (in the public sector) and collective agreements (in the private sector) are concluded on pay and working conditions. As for the public sector the government is obliged to adopt the protocol by law. For the private (non profit/profit) sector a collective agreement is only binding on the signatories. Agreements on pay last one year, agreements on working conditions two years.

LABOUR CONFLICTS

The right to strike is regulated by Law (65/77). Trade unions have the obligation to provide a minimum service during a strike.