# REGIONAL REPORT FOR EASTERN EUROPE:

## Bulgaria, Hungary, Poland and Romania

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# Abbreviations

| | |
|---|---|
| BG | Bulgaria |
| CSRs | Country-Specific Recommendations within the European Semester framework |
| EESC | European Economic and Social Committee |
| EO | Employers' organisation |
| EPSU | European Federation of Public Service Union |
| ES | European Semester |
| EU | European Union |
| EUR/I | EUR per inhabitant |
| GDP | Gross Domestic Product |
| HOSPEEM | The European Hospital and Healthcare Employers' Association |
| HU | Hungary |
| MS | Member States |
| PA | Professional association |
| PL | Poland |
| PPS/I | Purchasing power standard per inhabitant |
| RO | Romania |
| SD | Social dialogue |
| SSD | Sectoral social dialogue |
| TU | Trade unions |

# Introduction

The hospital and healthcare sector is of growing socio-economic significance in the context of an ageing population in Europe. The sector experiences an increasing demand in services and simultaneously a shortage of workforce.[1] **Adequate representation in the European Social Dialogue** (SD) and the involvement of the sectoral social partners in the implementation of the labour issue- and labour market-related reforms is key to a successful continuation of health service delivery for all across the EU.

**To strengthen the role of the social partners at the EU level**, the European Hospital and Healthcare Employers Association (HOSPEEM) and the European Federation of Public Service Unions (ESPU) commissioned a joint project with following aims: (a) identify and address capacity-building needs of the sectoral social partners; (b) obtain quantitative and qualitative data on the current involvement in the European Semester and strengthen their role in this regard. Specifically, the project surveys the priorities of the social partners and how these priorities could be better articulated in the future activities of HOSPEEM and EPSU. The report provides relevant and comparable data and country-specific information from four targeted countries in Eastern Europe: Bulgaria (BG), Hungary (HU), Poland (PL) and Romania (RO).

The findings in this report are the **results of the combined methodology** which includes:
- A tailored online survey dedicated to social dialogue in the hospital and healthcare sector conducted from April to June 2019;
- Desk research conducted from April to July 2019,
- Outcomes of the discussion with national social partner organisations and relevant organisations of the four targeted countries held at the First Regional Workshop in Bucharest on 14 June 2019.

The report is structured as follows:

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

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

## 1. Facts and figures of the hospital and healthcare sector

To strengthen the social dialogue and increase its capacity, the broader context in which the social partners in the hospital and healthcare sector are operating needs to be highlighted. For compiling this report, statistical indicators on healthcare expenditure and financing of the four countries have been provided. Standardised indicators from Eurostat have been used for this analysis

Statistics on healthcare expenditure and financing directly relates to the problems that social partners face and try to address at national and EU level social dialogue. **The limited financing of the sector and an unbalanced distribution of the finances compared to other sectors lead to insufficient public investment, low wages, work overload, impacting the health and safety of employees and that of patients and causing migration of workforce**.[2]

The overall expenditure in the Eastern European Member States ranges from 731 EUR/inhabitant (I) in PL to 431 EUR/I in RO. The average PPS per inhabitant in these countries is 1 296 EUR and the percentage of health expenditure as part of the Gross Domestic Product (GDP) 6,77. Putting these measures in context to other countries, the average expenditure in EUR per inhabitant is approx. 6,5 times lower, the PPS per inhabitant 6 times and the percentage of GDP is 1,5 times lesser than for example in Germany.

[1] Employment and industrial relations in the health care sector, https://ec.europa.eu/social/BlobServlet?langId=en&docId=9423&
[2] Based on the discussion at the Regional workshop in Budapest, June 2019.

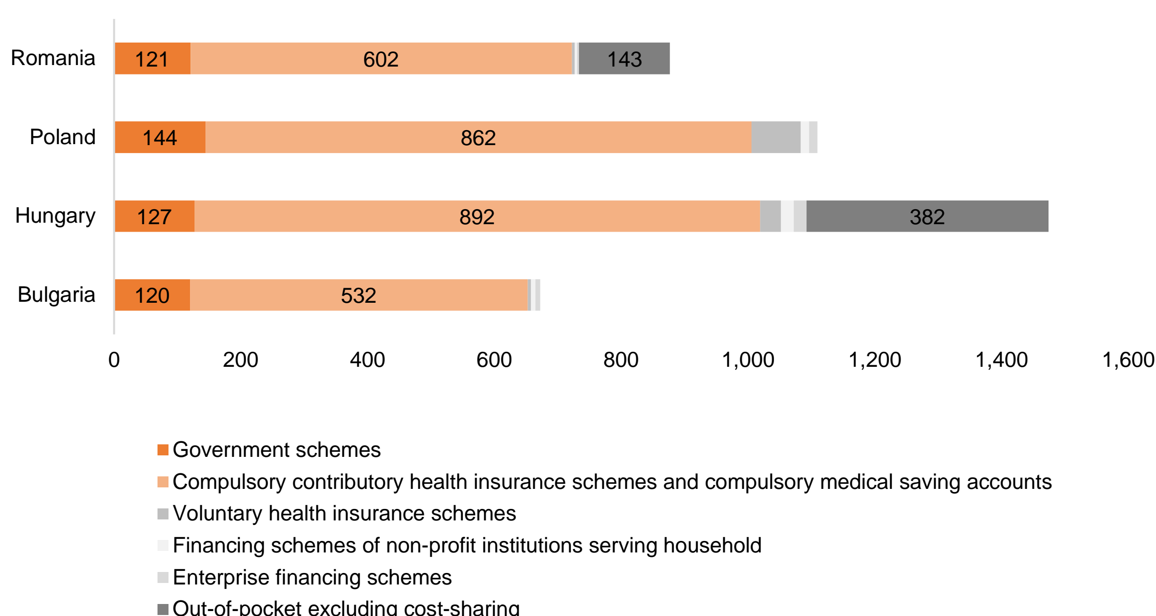
**Table 1**: Healthcare expenditure (all financial schemes, 2016)

| Country | Bulgaria | Hungary | Poland | Romania |
|---|---|---|---|---|
| Million EUR | 3 960,50 | 8 376,04 | 27 756,39 | 8 509,07 |
| EUR per inhabitant | 555,64 | 853,48 | 731,01 | 431,88 |
| PPS per inhabitant | 1 285,28 | 1 538,63 | 1 440,24 | 922,29 |
| % of GDP | 8,23 | 7,36 | 6,52 | 4,99 |

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

Analysing the expenditure by financial schemes, in all Eastern European countries **the compulsory contributory health insurance and compulsory medical savings accounts dominate** over other schemes ranging from 532 PPS/I in Bulgaria to 896 PPS/I in Hungary. The government schemes contribution is much lower and falls in the interval from 120 (in BG and RO) to 144 PPS/I in Poland. The out-of-pocket scheme is estimated to be high in Hungary, running up to 382 PPS/I. For the other two countries of our sample, Bulgaria and Poland, this type of expenditure are not available.

**Graph 1**: Healthcare expenditure by financial schemes (PPS per inhabitant, 2016)




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

The healthcare employment data varies by the definitions and, for some countries, the data are not available. Based on the health personnel employed in hospitals in 2016, the number of medical doctors per 100 000 inhabitants is the highest in Bulgaria (235) and the lowest in Poland (110). **The migration of healthcare professionals, mostly to Western countries, is an economical and societal problem**. For example, in Romania, 35 000 nurses and 15 000 doctors left the country between 2007 and 2017. The migration of healthcare professionals to Western countries is causing a consequent increase in the workload in the Eastern countries, while also raising concerns about patient and workforce's safety issues.

**Table 2**: Health personnel employed in hospitals (2016)

| Country | Bulgaria | Hungary | Poland | Romania |
|---|---|---|---|---|
| Hospital employment (headcount) | 70 449 | 104 188 | N/A | 167 071 |
| Nursing professionals and midwives (headcount) | 22 752 | 28 367 | 134 480 | 10 184* |
| Nursing professionals and midwives/100 000 inhabitants | 319 | 289 | 354 | 52 |
| Medical doctors (headcount) | 16 732 | 19 496 | 41 935 | 27 981 |
| Medical doctors/100 000 inhabitants | 235 | 199 | 110 | 142 |
| Hospital beds/100 000 inhabitants | 727 | 700 | 664 | 684 |

*Source: Eurostat 2016, Health personnel employed in hospital [ online code: hlth_rs_prshp1]*
** In Romania the number of nursing professional relates only to nurses with ISCED 5 graduation[3]; according to other indicators the number of nurses and midwives is 200 000 – 300 000 (see the Annex B).*

The lack of workforce and pensions security relate to the ageing of healthcare professionals. For example, the share of 65-74 aged physicians comprise 14% in Hungary and 13% in Bulgaria (Eurostat, 2016). Due to low wages and lack of personnel, many doctors and nurses are partaking in second employment. Further, between 70% and 80% of the health personnel are female, often sole wage earner.

## 2. Social partners in the hospital and healthcare sector

Based on the desk research and on a shared database between HOSPEEM, EPSU and CELSI, the following social partners representing employees and employers in the hospital and healthcare sector in the Eastern EU countries were identified. When relevant to the national and EU social dialogue, other types of organisations were also included.

[3] See the metadata https://ec.europa.eu/eurostat/cache/metadata/Annexes/hlth_res_esms_an6.pdf

| | Bulgaria[4] | Hungary | Poland | Romania |
|---|---|---|---|---|
| **Trade Unions** | | | | |
| | Federation of Trade Unions - Healthcare Services (CITUB)[5] | Healthcare Trade Union in Hungary | Federation of Trade Unions of the Health Care and Social Assistance Employees | Romanian Trade Union Federation SANITAS |
| | Medical Federation Podkrepa (MF Pokrepa)[5] | Semmelweis Alliance[6] | National Trade Union of Nurses and Midwives in Poland (NTUNMP) | HIPOCRAT |
| | : | Forum for the Cooperation of Trade Unions | Health Protection Secretariat of NSZZ Solidarność | Health Solidarity Trade Union (FSSR) |
| | : | : | : | Central National Trade Union of Health and Social Care |
| **Employers' organisation** | | | | |
| | National Association of Healthcare Employers (NAHE)[7] | Hungarian Association of Economic Managers in Healthcare | Employers of Poland[8] | National Business Association of Family Doctors[9] |
| | National Union of Private Hospitals (NUPH) | Hungarian Association of Hospitals | Business Centre Club (BCC)[10] | National Union of Romanian Employers |
| | Bulgarian Association of Employers in Healthcare[11] | National Healthcare Service Center | Polish Confederation of Private Employers 'Lewiatan' | Romanian National Federation of Health and Pharma Employers |
| | Association of Municipal Hospitals in Bulgaria | : | Nationwide Union of Private Healthcare Employers | PALMED |
| | : | : | Polish Association of Private Hospitals | Employers of Private Medical Service Providers |
| **Professional organisations / other** | | | | |
| | : | Chamber of Hungarian Health Care Professionals[12] | : | Ministry of Health |
| | : | Hungarian Medical Chamber[12] | : | Ministry of Labour and Social Justice |

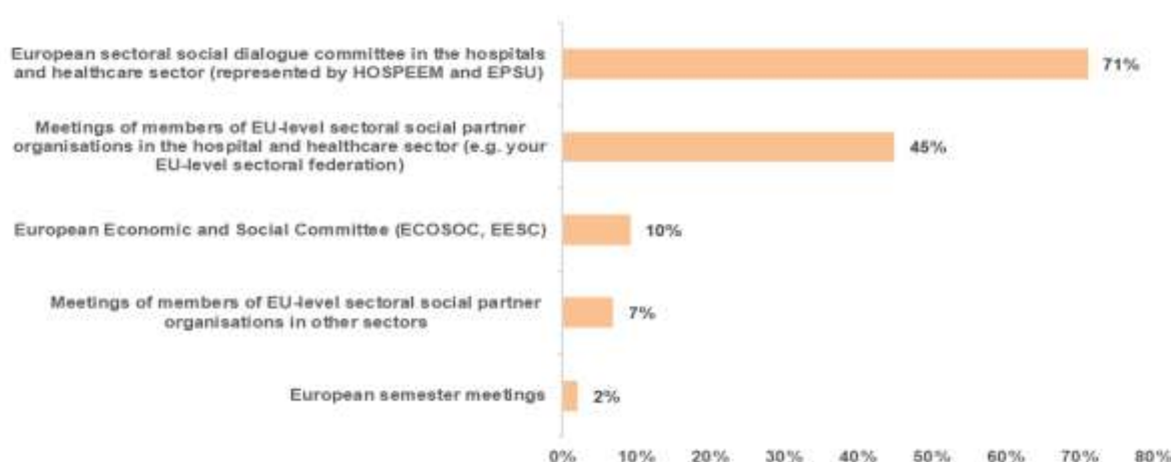
[4] The trade unions and employers' organisations in Bulgaria created a joint informal body - the Public Health Council
[5] Represent public sector employees only
[6] Aims to protect the interests of employees
[7] Represents about 17 of the largest state hospitals and seven emergency aid centres
[8] Represents 7 000 employers in all sectors, including 113 employers active in the health sector, mostly non-public
[9] Does not participate in the collective bargaining or national social dialogue
[10] Covers 26 companies in the non-public sector.
[11] Branch of the Bulgarian Chamber of commerce
[12] Compulsory membership

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

The findings presented below are based on the online survey circulated to relevant social partners/organisations in the four targeted countries between April and June 2019. It has to be noted that the data relate predominantly to trade unions in general, but in particular in the case of Romania (cf. Annexes: A. Methodology) – due to lower participation of employers' organisations in the survey.[13]

**Half of the organisations of the four Eastern EU countries are involved in EU level SD structures. The other half is not involved for multiple reasons.** Out of those involved, 71% participate directly in the EU sectoral social Dialogue Committee in the Hospital and Healthcare Sector (SSDC HS) via EPSU or HOSPEEM, 45% in meetings of members of the two EU-level SSD partner organisations and 10% in European Economic and Social Committee (EESC) in the past three years.

**Graph 2**: Direct participation at the committee meetings of EU level social dialogue structures since 2015 (%, N = 42)




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

The most frequent reasons for non-participation in the EU level social dialogue structures are the lack of personal capacities (28%), not meeting the representativeness criteria (23%) and lack of financial resources for travel cost or for membership fees in the EU social partners organisations (23%). However, 26% of the organisations reached out via the survey do not participate directly but are represented by their super-ordinate union organisation or confederation.[14]

**Table 3**: Reasons of non-participation in EU level social dialogue structures (%, N= 42)

| Reasons for non-participation | Per cent |
|---|---|
| Lack of personal capacities, lack of time to participate in meetings | 28% |
| Other | 26% |
| Barriers of the entry (not meeting representativeness criteria) | 23% |
| Lack of financial resources (high travel costs, high membership fees) | 23% |
| Low importance of EU level social dialogue to the activities of our organisation | 16% |
| Difficulties in understanding the role and functioning of EU level social dialogue | 12% |
| Language barrier | 9% |
| Barriers of the entry (another organisation from our country is a member and is not supporting our participation) | 5% |

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

[13] For more details on the methodology see Annex A.
[14] This was the case mainly for the Romanian respondents as the survey was distributed also to regional levels of trade unions.

Bargaining structures and processes in the four targeted countries vary from country to country due to historical and institutional structure of the organisation. They can be organised at a national collective level, decentralised regional level or even at the hospital level.

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

**The employers' participation in EU level social dialogue structures is currently limited**. The Employers of Poland are involved in the European Centre of Employers and Enterprises providing Public Services and Services of General Interest (CEEP) and are participating in meetings of the European Economic and Social Committee (EESC). The Bulgarian National Union of Private Hospitals (NUPH) has briefly affiliated with HOSPEEM in the past. The Polish Health Confederation was as well a HOSPEEM member in the past. Some professional and employers' organisations join the meetings of other EU level organisations, such as of the Standing Committee of European Doctors (CPME) or European Association of Hospital Managers (EAHM).

> *The European level social dialogue cannot function without well-functioning national dialogue.*
> From the discussion at the Regional Workshop in Bucharest.

The trade unions in the hospital and healthcare sector might be active at various levels of national social dialogue. However, a tripartite social negotiation is not in place in some Eastern EU countries. For example, in Romania, the Ministry of Health is the main employer. The healthcare sector is decentralised with providers in the 42 counties. In the private sector, employers negotiate at the hospital level with their respective trade unions.
In Hungary, the professional chambers are playing an important role, however, their initiatives are in-between those of trade unions and employers' organisations, at some stages also replacing their competences. The Bulgarian trade unions represent the public sector only, despite the operation of employers' organisation of private hospitals.

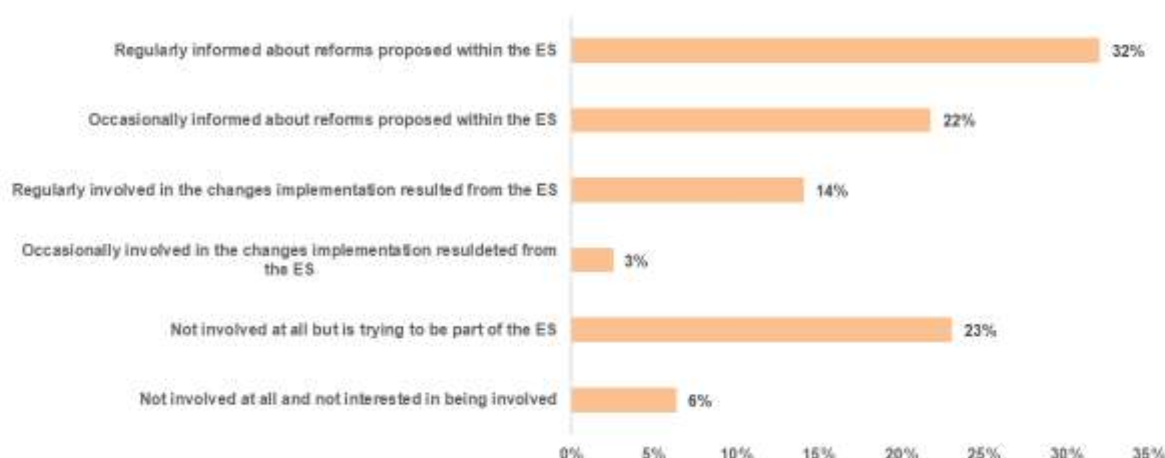
## 4. Social partners' participation in the European Semester

The European Semester (ES) is a mechanism to help the EU Member States to coordinate their economic and social policies and address common challenges. **The focus on social aspects in the ES recently intensified by linking the mechanisms to the European Pillar of Social Rights**, which was proclaimed by the European institutions in 2017. Principles which are directly linked are among other principles 16, which states that "*Everyone has the right to timely access to affordable, preventive and curative healthcare of good quality"*

The relevance of the healthcare sector and social dialogue for fiscal consolidation and social cohesion is reflected in the European Semester's Country-Specific Recommendations (CSRs). **The number of EU Member States (MS) receiving CSRs related to healthcare is increasing**: 10 MS in 2017, 15 MS in 2019. Romania and Bulgaria received CSRs both in 2017 and 2019, Hungary in 2019. Recommendations related to social dialogue and partners have been addressed to 5 MS, including Hungary, Poland and Romania (for CSRs see **annexe C**).

The survey revealed that most of the social partners (54%) are **informed about the reforms proposed within the European Semester** (32% regularly and 22% occasionally). Only 17% of organisations are involved in the implementation of the changes resulted from the procedure. Further 23% are not involved but are trying to be part and only 6% are not interested to be involved at all. Only one organisation participated directly at European Semester meetings in the past three years.

**Graph 3**: The ways the social partners are involved in the European Semester procedure (%, N = 78)




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

The survey shows some country specificities regarding the involvement in the ES. The Bulgarian trade unions are informed regularly whereas employers' organisations only occasionally about the reforms. Some Hungarian professional associations are regularly informed about reforms; others are not involved at all and not interested in being involved. The trade unions in Hungary participating in the survey are not involved but are trying to participate. For Poland, there is only limited information in this regards, but some of the trade unions indicated they are only occasionally informed about reforms, and other are not involved at all and not interested in being involved.

> *"The involvement of social partners in the European Semester by an institutional framework is a political priority in Sweden."*
> Sandra Bergendorff, Swedish Association of the Local Authorities and Regions (SALAR)

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

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

The social partners listed their priorities to be communicated at the EU level, for example, through their membership in the respective EU level social partner organisation in the hospital and healthcare sector. Their **priorities relate mostly to working conditions, health and safety issues, but also to better involvement of the social partners in the social dialogue.**

**Table 4**: Priorities to be communicated to the EU level

| Country | Priorities |
|---|---|
| Bulgaria | • Wages of medical specialist – support of the single minimum wage in the EU (TU);<br>• Problems of health and safety - third-part violence and psychosocial risks (TU);<br>• The problem of cross-border access to services (EO). |
| Hungary | • Wages, especially minimum wage at the European level;<br>• Working time legislation in connection to work overload;<br>• Labour migration and associated workforce shortage. |
| Poland* | • Increasing the staff of nurses in hospitals with regard to guarantee the safety of the patients;<br>• Financial demands regarding wage increase, especially for nurses;<br>• Mitigating disparities in the growth of the wages between doctors and nurses. |
| Romania | • Working conditions - wages and bonuses regulations, working time, staffing norms;<br>• Unification of medical staff training;<br>• Improvement of the social partners' representativeness and collective agreements. |

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

For some of the targeted countries, to ascertain common priorities is difficult due to the fragmentation of the social partners. For example, in Poland, except the priorities listed in table 4, the current and future healthcare policies, reforms and service planning are long-term topics of the national social dialogue. The limited healthcare

expenditure is related to cuts of services. Staff retention and ongoing changes in the organisation of the hospital sector are the key topics related to the labour market.[15]

**Not all social partners consider the EU level as the most appropriate to communicate their priorities.** The most appropriate social dialogue committee to address the priorities is, according to the organisations participating in the survey, the national social dialogue committee (32%). The EU level social dialogue committee is on the second place (27%), followed by the sectoral social dialogue committee structures in the countries respectively (25%) and establishment-level collective bargaining with the individual employers (15%).

The social partners from the Eastern EU countries, predominantly trade unions, consider the **safety and health at work and the working conditions as their highest-rated priorities**. Nevertheless, none of the listed priorities scored less than 3 points, indicating the relative relevance of all the topics.

**Table 5**: The organisations' priorities with the highest rating (in %, N = 59)

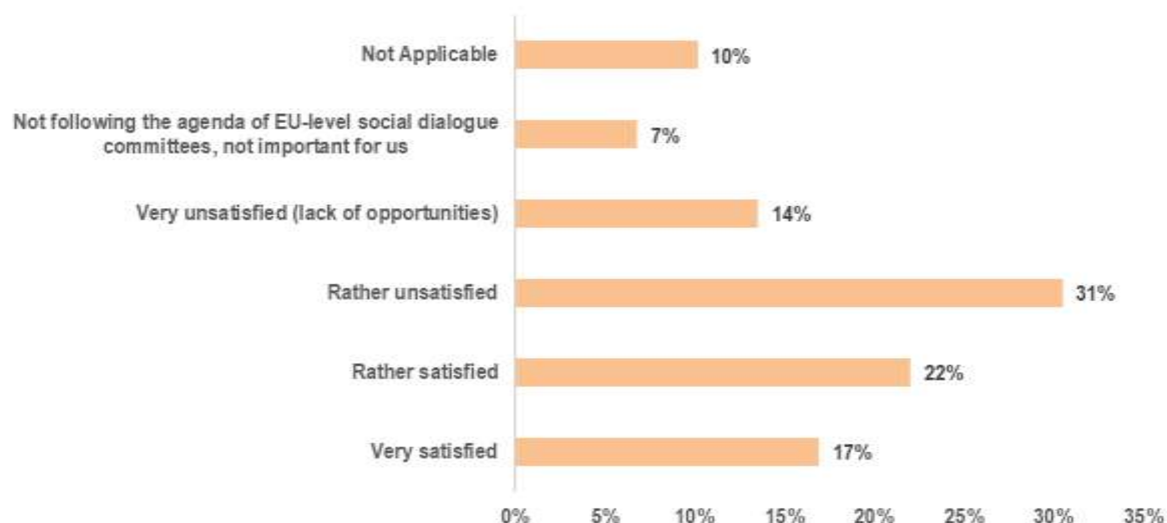
| Priority | Rating at 4 | Rating at 5 | Weighted average |
|---|---|---|---|
| Recruitment and retention policies for all health workers | 14% | 63% | 4,3 |
| Safety and health at work | 10% | **81%** | **4,7** |
| Working conditions | 12% | **83%** | **4,8** |
| Ageing workforce | 17% | 41% | 3,9 |
| The attractiveness of the sector for young workers | 22% | 44% | 3,9 |
| Vocational education and training | 22% | 56% | 4,3 |
| Recognition of skills at the national level | 22% | 56% | 4,2 |
| Continuing Professional Development and Life-long Learning | 24% | 59% | 4,4 |
| Mobility of health professionals in the EU | 27% | 36% | 3,8 |
| Cross-border recognition of professional qualifications | 29% | 49% | 4,2 |
| Digitalisation of workplace / digital skills | 24% | 54% | 4,1 |
| Reconciliation of work and family | 36% | 46% | 4,2 |

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

However, only 39% of respondents are satisfied (very or rather) with the opportunities to address the highest rated priorities in the EU level social dialogue committee in hospital and healthcare. 45% were unsatisfied and 7% are not following the EU level agenda.

[15] The latest committee session of the Tripartite Healthcare Team focused on an Act on the qualification demands of healthcare professionals in non-business providers. The qualifications are expected to be assessed with regards to the new developments in the medicine and transformation of the individual study programs in healthcare education

**Graph 4**: Satisfaction with the opportunities to address the priorities at the EU level social dialogue (in %, N= 59)




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

The reasons for non-satisfaction are lack of financial resources (58%), lack of personnel resources (54%), lack of interaction with the EU level organisation (43%) and the language barrier (8%). 31% of respondents revealed that their priorities differ from the priorities of EU level social partners in the hospital and healthcare sector.

**Table 6**: The organisations' expectations from the EU level social dialogue structures (%, N= 56)

| Expectations | Per cent |
|---|---|
| Support domestic collective bargaining (e.g. wage-related bargaining) | 68% |
| Greater acknowledgement of our organisation's interests and incorporation into the EU level agenda of social dialogue | 55% |
| Support of EU level social partners to our organisation in order to make a stronger impact on the policies in the health sector in our country | 84% |
| To provide space for networking and exchange of experiences | 39% |
| Capacity building – providing specific guidance on how to strengthen social dialogue and collective bargaining in our country's hospitals and healthcare | 50% |
| Other | 4% |

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

The social partners expect the following from the EU level: support in making a stronger impact on the polices (84%), support in domestic collective bargaining (68%), a greater acknowledgement of organisation's interest and involvement in the EU level agenda (55%) and to provide space for networking and exchange of experiences (39%) Even though some of the expectations are out of EU level social partners' competencies (for example, wage negotiating), the revealed aspects might be relevant for future discussion in order to involve the social partners from the Eastern EU countries to EU level more intensively.

## Conclusion

The report shows how the four Eastern EU countries under analysis – Bulgaria, Hungary, Poland, Romania are challenged by their health expenditure and personnel constraints. Despite some improvements in working conditions, for example, wages increase, the migration of healthcare professionals is continually contributing to the multiple problems in the healthcare sector.

The role of social partners is crucial to support improvements in the sector and the labour conditions. However, the fragmentation and lack structures of the social partners in the targeted countries hamper not only the national social dialogue but also their involvement at the EU level as well. In some countries the state is replacing

independent employers' organisations; in other countries, the role of the social partner is unclear e.g. no employers' organisation but in-between a professional association and trade union. Despite the ambiguous structure of an indented social partner, the particular organisations are active at various national levels of collective bargaining or participating in meetings at the EU level.

The European Semester is a mechanism that can contribute, among others, to greater social cohesion. The mechanism gained on its importance by linking it to the European Pillar of Social Rights. The involvement of the social partners is crucial in this regard. The European Semester in the recent years – in case there is meaningful and comprehensive participation in the relevant processes also by national and EU level social partners – has become an additional platform to have a voice and to contribute effectively with the social partners' demands. So far, the social partners from the Eastern EU countries are mostly informed but not involved in the European Semester process, depending on the level of operation. However, the involvement of social partners, for example through an institutional framework as is the case in Sweden, is inevitable and feasible.

The social partners' priorities relate mostly to working conditions, health and safety issues, but also to stronger involvement in the social dialogue. Nevertheless, not all social partners consider EU level as the most appropriate to communicate their priorities. This might be caused by the relatively low satisfaction with the opportunities to address their priorities at the EU level social dialogue hampered by the lack of personal and financial resources and interaction with the EU level organisation.

On the other hand, the national social partner's expectations from the EU level social dialogue partners are multiple and high. They need support in making a stronger impact on the policies and in domestic collective bargaining. Further, they expect to gain a higher acknowledgement of their interests and consequently their incorporation in the EU level agenda.

Despite the multifaceted challenges that the social partners are facing in the area of national social dialogue and indecisive involvement into the EU level structures, it needs to be stressed that only by learning from each other, social dialogue can be enriched with opportunities and mitigate challenges that the hospital and healthcare sector will be facing in the coming years.

# Annex

## A. Methodology

A combined methodology design was used:

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

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

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

The survey was translated into the four national languages and distributed online via the Survey Monkey systems from April to June 2019. Approximately 50 organisations, both trade unions and employers' organisations (and chambers) have been repeatedly invited to complete the survey. The structure of the respondents participating in the survey was as follows:

| | Per cent | Number |
|---|---|---|
| Total number of respondents | | 110 |
| **Country** | | |
| Bulgaria | 1,83% | 2 |
| Hungary | 4,59% | 5 |
| Poland | 2,75% | 3 |
| Romania | 90,83% | 100 |
| **Type of organisation** | | |
| Employers' organisation | 0,91% | 1 |
| Trade union | 94,55% | 104 |
| Other | 4,55% | 5 |
| **Position of the respondent within the organisation** | | |
| President | 15,45% | 17 |
| Vice-President | 1,82% | 2 |
| General Secretary | 4,55% | 5 |
| Member of the Presidium | 34,55% | 38 |
| Member of staff | 14,55% | 16 |
| Other | 29,09% | 32 |

c) Analysis of the discussion at the Regional Workshop in Bucharest in June 2019
The discussion at the workshop was facelifted by structure prepared in advance, recorded and transcribed; selected findings of the discussion complemented the survey and desk-research results.

## B. Statistical annexe

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

| Country | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 |
|---|---|---|---|---|---|---|---|
| Bulgaria | 7,14 | 7,59 | 7,87 | 8,50 | 8,20 | 8,23 | 8,10 |
| Hungary | 7,54 | 7,47 | 7,26 | 7,09 | 6,97 | 7,13 | 6,88 |
| Poland | : | : | 6,38 | 6,25 | 6,34 | 6,52 | : |
| Romania | 4,70 | 4,72 | 5,19 | 5,03 | 4,94 | 4,99 | 5,16 |

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

**Table 8**: Number of physicians (all ages)

| Country | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 |
|---|---|---|---|---|---|---|---|
| Bulgaria | : | : | : | : | 28 801 | 29 038 | 29 492 |
| Hungary | 28 686 | 29 500 | 30 641 | 31 748 | 32 791 | 30 486 | 31 515 |
| Poland | 83 201 | 84 221 | 85 025 | 85 246 | 87 687 | 88 437 | 91 730 |
| Romania | 50 778 | 51 153 | 52 362 | 52 828 | 53 720 | 54 807 | 55 975 |

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

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

| Country | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 |
|---|---|---|---|---|---|---|---|
| Bulgaria | : | : | : | : | 35 319 | 34 795 | 34 443 |
| Hungary | 88 322 | 89 488 | 90 513 | 92 078 | 92 413 | 93 011 | 92 033 |
| Poland | : | : | : | : | : | : | : |
| Romania | 179 639 | 178 138 | 179 423 | 183 068 | 186 742 | 193 037 | 200 630 |

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

## C. European Semester Country-Specific Recommendations

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

| Areas of recommendation | Bulgaria | Hungary | Poland | Romania |
|---|---|---|---|---|
| **Health policy** | | | | |
| **Healthcare system and infrastructure** | • Characterised by public spending;<br>• Limited access to healthcare caused by an uneven distribution of limited resources and low health insurance coverage;<br>• Out-of-pocket payment is considerable.<br>**CSR**: Improve access to health services, including by reducing out-of-pocket payments and addressing shortages of health professionals. | • Inadequate screening and primary care;<br>• Public spending is below the EU average;<br>• Citizens rely on out-of-pocket payment to access quality services;<br>• The system is strongly hospital centred, with weakness in primary care.<br>**CSR**: Improve health outcomes by supporting preventive health measures and strengthening primary care. | • Unmet need for medical services declined but still remains high in the EU;<br>• Waiting times have increased substantially since 2010;<br>• Developed map of healthcare needs but have not become a tool for supporting decisions;<br>• Healthcare system is too focused on hospital care provision;<br>• Primary and ambulatory care remain underdeveloped. | • Low funding, inefficient use of public resources and the lack of reform limit the effectiveness of the health system;<br>• Prevalence of informal payment is high;<br>• Access to healthcare services for those living in rural areas and vulnerable groups is limited.<br>**CSR**: Improve access to and cost-efficiency of healthcare including through the shift of outpatient care. |
| **Shortages of the health workforce** | • Low availability of practitioners is constraining the delivery of primary care;<br>• A significant shortage of nurses with the number per capita among the lowest in the EU.<br>**Recommendation:** Swifter and more effective implementation of the national health strategy would help tackle these weaknesses. | A sizeable shortage of healthcare staff, in particular, general practitioners and nurses, thwarts access to care in poorer areas. | • Access to and the effectiveness of the healthcare system is affected by low spending and staff shortages;<br>• The ratio of practising doctors and nurses relative to population size is among the lowest in the EU with ¼ of the medical staff above retirement age. | Shortages of health workforce exist, in particular, due to the emigration of doctors and nurses. |
| **Social policy** | | | | |
| **Skills** | **Recommendation**: Strengthen employability by reinforcing skills, including digital skills. | **Recommendation**: Developing digital skills could help improve employability. | Weaknesses in digital skills, literacy and numeracy<br>**CSR**: Foster quality education and skills relevant to the labour market, especially through adult learning. | Not evolving in line with the needs of expanding economic sectors.[16] |

[16] 81% of employers having difficulties filling job vacancies

| | | | | |
|---|---|---|---|---|
| Wage | Scope in place for greater consensus between social partners about an objective and transparent wage-setting mechanism. | Gaps in employment and wages between skills groups and men and women remain wide in comparison with the EU average. | | • One of the fastest rates of wage growth in the EU;<br>• Government policies increasing public and minimum wages, record low unemployment rate and structural labour supply shortages;<br>• No objective mechanism in the minimum wage.<br>**Recommendation**: ensure minimum wage setting based on objective criteria<br><br>**CSR**: Ensure that the minimum wage is set on the basis of objective criteria, consistent with job creation and competitiveness. |
| **Social dialogue** | Despite ratification of ILO Convention concerning minimum wage fixing and of several rounds of negotiations in 2018, social partners still have diverging views on criteria to be applied when setting a minimum wage. | • Social dialogue structures remain underdeveloped and do not allow for meaningful involvement of the social partners in policy design and implementation;<br>• Deficiencies in stakeholder engagement and limited transparent undermine the evidence base for and the quality of policymaking.<br><br>**CSR**: Improve the quality and transparency of the decision-making process through effective social dialogue and engagement with other stakeholders and through regular, appropriate impact assessments. | **Recommendation**: Strengthening the role of consultations of social partners and public consultations – by ensuring a sufficient length of time for consultations, improving the uptake of the stakeholders' opinions gathered in the process, and minimising the number of laws exempted from consultations – would substantially help to minimise the administrative burden resulting from frequent changes in the law, increase investment and promote sustainable economic growth in the long term. | • Low collective agreement coverage, in particular at the sectoral level[17];<br>• The timely and meaningful involvement of social partners on policy issues and reforms is limited;<br>• The social dialogue takes place within the Economic and Social Council and the Social Dialogue Committees;<br>• Stability and the role of the institutions has weakened over the last year;<br>• Involvement of stakeholders in designing and implementing reforms is weak.<br><br>**CSR**: Improve the functioning of social dialogue. |

*Source: Overview compiled by HOSPEEM and EPSU Secretariats based on Country-Specific Recommendations within the European Semester 2019*

[17] Due to the current definition of sectors; the authorities have initiated plans to revise the definitions of economic sectors, but no agreement has been reached.

## D. Participant list of Regional Workshop: Eastern Europe

| Last name | First name | Organisation | Affiliation | Country |
|---|---|---|---|---|
| **Alexandru** | Madalin | Ministry of Labour and Social Justice | Other | Romania |
| **Alkema** | Tjitte | HOSPEEM | HOSPEEM | Belgium |
| **Barlet** | Celine | HOSPEEM | HOSPEEM | Belgium |
| **Bergendorff** | Sandra | SALAR | HOSPEEM | Sweden |
| **Berislavic** | Marija | HSSMS-MT | EPSU | Croatia |
| **Branca** | Marta | ARAN | HOSPEEM | Italy |
| **Cozma** | Carla | Sanitas | EPSU | Romania |
| **Dorobantu** | Andrei | Ministry of Health | Other | Romania |
| **Duch** | Cyrille | CFDT Santé Sociaux | EPSU | France |
| **Fasoli** | Sara | HOSPEEM | HOSPEEM | Belgium |
| **Gae** | Razvan | Sanitas | EPSU | Romania |
| **Gelev** | Georgi | Bulgarian Association of Employers in Healthcare | Other | Bulgaria |
| **Griskonis** | Sigitas | Lithuanian National Association of Health Care Organizations | HOSPEEM | Lithuania |
| **Grudev** | Krasimir | NUPH | Other | Bulgaria |
| **Holubová** | Barbora | CELSI | Other | Experts |
| **Ionascu** | Corina | Hipocrat | EPSU | Romania |
| **Kahancová** | Marta | CELSI | Other | Experts |
| **Karanikova** | Svetlana | Latvian Hospitals Association | HOSPEEM | Latvia |
| **Kitnere** | Alina | Latvian Hospitals Association | HOSPEEM | Latvia |
| **Malapitan** | Christopher | Graphic designer | Other | Belgium |
| **Maucher** | Mathias | EPSU | EPSU | Belgium |
| **Mohrs** | Simone | HOSPEEM | HOSPEEM | Belgium |
| **Papp** | Katalin | Chamber of Hungarian Health Care Professionals | Other | Hungary |
| **Raducan** | Roxana | Sanitas | EPSU | Romania |
| **Stan** | Sabina | Dublin City University and University College Dublin | Other | Ireland |
| **Travaglini** | Michaela | ARAN | HOSPEEM | Italy |
| **Weltner** | János | Hungarian Doctor's Trade Union | EPSU | Hungary |
| **Zlatanova** | Slava | FTU-HS -CITUB | EPSU | Bulgaria |