FINAL PROJECT REPORT

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Authored by

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Abbreviations

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
EU	European Union
GDP	Gross Domestic Product
HOSPEEM	European Hospital and Healthcare Employers' Association
MS	Member State
SD	Social dialogue
SSD	Sectoral social dialogue
TU	Trade unions

Countries' abbreviations

BG	Bulgaria	HU	Hungary
CZ	Czech Republic	MT	Malta
EL	Greece	PL	Poland
ES	Spain	PT	Portugal
HR	Croatia	RO	Romania
IT	Italy	SI	Slovenia
CY	Cyprus	SK	Slovakia

1. Introduction

The **hospital and healthcare systems' effectiveness, accessibility, good quality of care and resilience became even more significant** during the recent health crisis. Despite recognising the substantial importance of the sector, **the hospital and healthcare sector is facing long-term challenges** that have been exacerbated since the pandemic outbreak. The crisis has made clear how weaknesses in health systems can have profound effects on public health and economic development across the EU Member States.

The pandemic also showed the increased need for coordinated and inclusive actions at national and European levels to deal with the challenges effectively. Therefore, the social partners' **representation in the European Sectoral Social Dialogue (SD) and their involvement in the European Semester and the national recovery and resilience plans became strategically relevant** to ensure working conditions and the market–related reforms are implemented tackled at the EU level.

However, the representativeness of the European social partner organisations in the health sector and sectoral social dialogue is hampered by the healthcare providers' high segmentation, scaling public sector bodies at different administrative levels to non-profit and private institutions[1]. The providers' fragmentation also influences the social partners' structure; workers and employers organise themselves according to their occupational sector, subsectors, and private/public sectors.

To strengthen the social partners' role at the EU level, the European Hospital and Healthcare Employers Association (HOSPEEM) and the European Federation of Public Service Unions (EPSU) commissioned a joint project. The project aims to (a) identify and address the **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 surveyed the social partners' priorities and how these priorities could be better articulated in the future activities of HOSPEEM and EPSU. The final report provides comparable data and country-specific information from fourteen targeted countries: Bulgaria, Hungary, Poland, Romania, Cyprus, Greece, Italy, Malta, Portugal, Spain, Croatia, Czech Republic, Slovakia, and Slovenia. The final report is a compilation of the three regional reports for Eastern European countries (BG, HU, PL, and RO), Southern European countries (ES, EL, CY, MT, PT, IT) and Central European countries (SK, SI, CZ, and HR).[2]

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 2019 to August 2020 (in three waves devoted to particular groups of the countries);
- Desk research conducted from April 2019 to August 2020;
- Outcomes of the discussion with national social partner organisations and relevant organisations of the 14 targeted countries held at three Regional Webinars (June 2019 in Bucharest, November 2019 in Rome, online workshop in April 2021)

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 14 countries;
- Chapter two lists the **identified social partners** – trade unions and employers' organisations, or other organisations in the 14 targeted countries;
- 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 five discloses the priorities and topics that the social partners wish to communicate to the EU level sectoral social dialogue, their satisfaction with the opportunities to address their problems at the EU level and expectations from the EU.

The report is supplemented with methodological and further information on the Country-Specific Recommendations (CSRs) 2020 issued for the fourteen targeted countries in the European Semester process.

[1] Eurofound (2020), Representativeness of the European social partner organisations: Human health sector, Sectoral social dialogue series, Dublin.
[2] The groups of the countries are created only for the purpose of this project only and might not equal to other European territorial classifications

2. Facts and figures of the hospital and healthcare sector

For compiling this report, statistical indicators on healthcare expenditure and the employment in hospitals of the countries have been provided. In addition, standardised indicators based on the most recent and available data from Eurostat have been used. The comparative data are set in the context of the social partners' testimony of working and compared with real-life conditions.[3]

The healthcare expenditures vary in the targeted countries. The percentage of the gross domestic products ranges from 5,56% in Romania to 9,45% in Portugal. The countries can be structured in countries with EUR per inhabitant under EUR 1 000 (BG, HR, HU, and PL), between EUR 1 000 – 2 000 (CZ, EL, CY, PT, SI and SK) and above EUR 2 000 (IT and MT). Putting these measures in context to other countries, the average expenditure in EUR per inhabitant in Romania is approx. 6,5 times lower, the PPS per inhabitant six times and the percentage of GDP is 1,5 times lesser than, for example, in Germany. All the covered countries have in common that their healthcare expenditure in PPS per inhabitant is under the EU-28 average (EUR 3 067, 80/2018) and the EU-28 average of gross domestic products (9,89%/2018).[4]

Statistics on healthcare expenditure and financing relate to social partners' challenges and address national and EU level social dialogue. However, the limited investment in the sector and the distribution of the finances lead to unfavourable working conditions in some countries, especially Romania, Bulgaria, Poland, and Hungary.[5] Furthermore, due to the underinvestment and expenditure cuts in the public health sector, the sector is not meeting the demand resulting in long waiting lists for necessary procedures.

During the COVID-19 pandemic, the cost of healthcare services increased in all countries due to the necessity to establish new COVID-19 units or re-profile the old ones. Therefore, social partners, pointing to the crucial role of the healthcare sector during the pandemic, call for more investments assured by the higher share of finances from the Recovery and Resilience plan.[6]

Table 1: Healthcare expenditure (all financial schemes, 2018)

Country	Million EUR	EUR per inhabitant	PPS per inhabitant	% of GDP
BG	4 120,53	586,55	1 268,51	7,35
CZ	15 871,89	1 493,13	2 278,56	7,65
EL	14 251,47	1 327,83	1 628,35	7,72
ES	108 109,70	2 310,15	2 464,77	8,99
HR	3 524,46	861,54	1 347,75	6,83
IT	153 085,00	2 533,61	2 504,41	8,67
CY	1 430,98	1 644,67	1 843,76	6,77
HU	8 963,50	916,93	1 544,86	6,70
MT	1 109,70	2 289,79	2 754,27	8,95
PL	31 501,68	829,54	1 518,98	6,33
PT	19 303,39	1 877,06	2 225,83	9,45
RO	11 371,07	583,95	1 211,69	5,56
SI	3 797,15	1 830,93	2 186,27	8,30
SK	5 991,41	1 099,99	1 539,37	6,69

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

Further relevant factors influencing health systems' capacity to deliver health services and meet the increasing and changing demand of care are workforce, availability, and skills. In the European Union, the following external and internal forces are shaping and challenging the resilience of the healthcare workforce: migration patterns,

[3] Based on the discussions at the three Regional Workshops
[4] Eurostat, Healthcare expenditure by financing scheme [online code: hlth_sha11_hf]
[5] Based on the discussion at the Regional Workshop on 14 June 2019
[6] Based on the discussion at the Regional Workshop on 20 April 2021

technological innovation, changing care demands (external) and workforce ageing, recruitment and retention, poor geographic distribution, and skill mismatches (internal).[7]

Based on the health personnel employed in hospitals in 2018, the number of medical doctors per 100 000 inhabitants is the highest in Portugal (261) and the lowest in Cyprus (96)[8]. On the other hand, the number of nursing professionals and midwives per 100 000 inhabitants varies tremendously, from 531 in the Czech Republic to 131 in Croatia.[9]

The migration of healthcare professionals from the targeted countries, mainly to Western and Northern countries, is an economic 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 covered countries' workload while also raising concerns about patient and workforce safety issues.

Table 2: Health personnel employed in hospitals (2018)

Country	Hospital employment (headcount)	Nursing professionals and midwives (headcount)	Nursing professionals and midwives/100 000 inhabitants	Medical doctors (headcount)	Medical doctors /100 000 inhabitants	Hospital beds/100 000 inhabitants
BG	70 241	22 419	319,13	16 960	241,42	756,91
CZ	157 775	56 914	535,41	26 521	249,49	661,82
EL	100 662	23 789	221,65	23 354	217,59	419,77
ES	589 236	166 352	355,47	111 795	238,89	297,15
HR	47 834	5 368	131,22	8 714	213,01	561,25
IT	632 546	265 588	439,56	134 389	222,42	314,05
CY	:	4 217	484,68	842[10]	96,77	330,09[11]
HU	106 238	29 834	305,19	20 180	206,43	701,29
MT	10 059	3 185	657,20	1 255	258,96	430,84
PL	:	133 453	351,42	40 387	106,35	653,69
PT	137 486	43 166	419,75	26 879	261,37	344,51
RO	177 002	11 281	57,93	29 687	152,46	696,83
SI	26 143	3 798	183,13	3 878	186,99	442,79
SK	42 287,43	21 352,19	392,02	9 309,16	170,91	569,62

Note: Data from Poland from 2017, Slovakia - full-time equivalent (FTE) measures available only
Source: Eurostat 2018, Health personnel employed in hospital [online code: hlth_rs_prshp1]

Similar problems occur in all targeted countries with mutually reinforcing country-specific challenges. For example, in Greece, the long-term trends in healthcare are influenced by the ageing population, immigration and the public health sector's attractiveness. Inadequate number of workforce and pension insecurity relate to the ageing of healthcare professionals. For example, 65-74 aged physicians comprise 14% in Hungary and 13% in Bulgaria. 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.

[7] European Commission, Healthcare workforce, Overview; Available at https://ec.europa.eu/health/workforce/overview_en
[8] This figure is calculated based on the number of doctors offering their services in public hospitals, excluding private hospitals which constitute a considerable part of the Cypriot healthcare system. The actual ratio of doctors to population is higher, yet cannot be accurately calculated due to incomplete data.
[9] Based on the Eurostat data, the lowest number of nurses per 100 000 inhabitants should be that in Romania (57 nurses and midwives per 1000 000 inhabitants). The healthcare employment data, however, varies by the definitions (as is the case for Romanian indicator on nurses and midwives) and, for some countries, the data are not available
[10] The data on physicians employed in hospitals only cover the hospital manpower in the public sector only. Private sector consists a considerable part of the Cypriot healthcare system
[11] data refers to hospitals of the public sector as well as the total number of beds of the private sector

The low rate of nursing staff for one patient is leading to endangering the safety of the people. Trade unions are calling for an increase in the number of personnel for adequate, needs-based staffing levels and to improve their working conditions The lack of workforce gives rise to the precarious labour characterised by long working hours and many nights' shifts and the calling back of retired staff. In addition, the low wages force the employees to search for additional income sources which leads to difficulties with reconciling work and family.

Despite the overall lack of healthcare professionals that became even more urgent during the COVID-19 pandemic, the health crises also brought positive developments in some countries. The interest in becoming a healthcare professional increased in some countries in 2021 (e.g., CZ). This development is partly due to governmental extra payments and benefits to healthcare workers during the pandemic, negotiated and pushed forward by national social partners. In Croatia, additional payments for healthcare professionals during the crisis have been issued. Still, due to the overall and long-term unfavourable economic situation of the healthcare workforce, it did not bring financial satisfaction to nursing professionals. In some countries, the number of medical doctors is relatively sufficient but hampered by regional disparities (CZ, SK, HR).

3. Social partners in the hospital and healthcare sector

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

The fragmentation and multiple social partners' diversion along the lines of occupations and private/public health sectors are the common characteristics in most covered countries. As the Ministries of Health employers in the public health sector and relevant actors in the national social dialogue and tripartism, these state bodies are listed as employers' organisations in the following tables. In some countries, the professional associations, such as nurses chambers, became relevant and often substituted or complement a trade unions' role (for example, HU, PL, and SK). However, these chambers are usually not an official member of the bipartism or tripartism social dialogue and thus have no rights to participate in negotiations and are therefore not included in the list.

Trade unions tend to focus on particular subsectors and occupations such as doctors, nurses, and specialisations (e.g., radiologists). Some of the employer's organisations are cross-sectoral, while others cover specific domains within the hospital and healthcare sector, as is the case of trade unions. Most of the identified social partners are involved in social dialogue and bargaining at least at one level (national, sectoral, or level of organisation).

	Bulgaria	Hungary	Poland	Romania
Trade Unions				
	Federation of Trade Unions - Healthcare Services (CITUB)[12]	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)[12]	Semmelweis Alliance[13]	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 Union of Private Hospitals (NUPH)	Hungarian Association of Economic Managers in Healthcare	Employers of Poland[14]	National Business Association of Family Doctors[15]
	Bulgarian Association of Employers in Healthcare[16]	Hungarian Association of Hospitals	Business Centre Club (BCC)[17]	National Union of Romanian Employers
	Association of Municipal Hospitals in Bulgaria	National Healthcare Service Center	Polish Confederation of Private Employers 'Lewiatan'	Romanian National Federation of Health and Pharma Employers
			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[18]		Ministry of Health
		Hungarian Medical Chamber[18]		Ministry of Labour and Social Justice

	Czech Republic	Croatia	Slovenia	Slovakia
Trade Unions				
	Trade Union of Health Service and Social Care in Czechia (OSZSP ČR)	Croatian Trade Union of Nurses and Medical Technicians (HSSMS-MT)	Trade Union of Doctors and Dentists of Slovenia (FIDES)	Slovak Trade Union of Health and Social Services (SOZZASS)

[12] Represent public sector employees only
[13] Aims to protect the interests of employees
[14] Represents 7 000 employers in all sectors, including 113 employers active in the health sector, mostly non-public
[15] Does not participate in the collective bargaining or national social dialogue
[16] Branch of the Bulgarian Chamber of commerce
[17] Covers 26 companies in the non-public sector.
[18]Compulsory membership

	Czech Doctors' Trade Union (LOK-SČL)	Trade Union of Health of Croatia (SZH)	Trade Union of Health and Social Services of Slovenia (SINDIKAT-ZSVS)	Labour Union of Physicians (LOZ)
		Autonomous Trade Union in Health Service and Social Protection Service (SSZSSH)	Healthcare and Social Care Union of Slovenia (SZSSS)	Trade Union of Nurses and Midwives (OZSaPA)
		Croatian Medical Union (HLS)	Union of Healthcare Workers of Slovenia (SDZNS)	
			Confederation of Trade Unions in Health – PERGAM (SZS PERGAM)	
			Slovenian Dental Trade Union (DENS)	
Employers' organisation				
	Association of Czech and Moravian Hospitals (ACMN)	Croatian Health Employers' Association (UPUZ-HR)	Ministry of Health and Ministry of Labour, Family and Social Affairs	Association of Hospitals of Slovakia (ASN)
	The Confederation of Industry Czech Republic (SP)	Croatian Employers' Association-Branch Association of Polyclinics, Hospitals, Medical and Health Care Facilities (CEA)	Slovenian Association of Private Doctors and Dentists (ZZZZS) – no participation in social dialogue	Association of State Hospitals of Slovak Republic (AŠN)
				Association of Private Physicians of Slovak Republic (ASL SR)
Professional organisations / other				
			Medical Chamber of Slovenia (ZSS)	Slovakian Chamber of Nurses and Midwives (SKSaPA)

	Cyprus[19]	Greece	Italy	Malta	Portugal	Spain
Trade Unions						
	Pancyprian Public Servants Trade Union (PASYDY)	Pan-Hellenic Federation of Public Hospital Workers (POEDIN)	Public Service Union (FP-CGIL)	Voices of the Workers (UHM)	Union of Portuguese Nurses (SEP)	Federation of Health Sectors and Socio-Sanitary Sectors of the Trade Union Federation of Workers´ Commission and Sectoral Health Sectors (FSSS – COO)
	Pancyprian Union of Government Nurses (PASYNO)	Confederation of Civil Servants (ADEDY)	Local Authorities Federation (FPL UIL)	General Workers Union (GWU)	Union of Nurses of the Autonomous Region of Madeira (SERAM)	General Union of Workers (UGT)
	Pancyprian Union of Government Doctors (PASIKI)		Federation of Public Workers and Services (FPS-CISL)	Malta Union for Midwives and Nurses (MUMN)	Union of Nurses (SE)	Federation of Public Services of the General Workers Union (FSP – UGT)

[19] The order of the trade unions stands for the number of active members in the sector (based on the Eurofound (2020) Representativeness of the European social partner organisations in hospitals and health care)

	Cyprus Trade Union of Workers-Employees in Governmental. Military and Social Institutions (PASYEK – PEO)		Federation of Autonomous Health Workers (FIALS)	General Workers Union - Government and Public Entities Section	Independent Union of Nursing Professionals (SIPE)	Spanish Trade Unions of Nursing Professionals (SATSE)
	Cyprus Federation of Private Employees (OIYK-SEK)		Federation of Independent Unions - Health Care (FSI)		Independent Union of Doctors (SIM)	Spanish Central Independent and Public Employees´ Trade Unions (CSIF)
			Association of medical and executive staff of the NHS (ANAAD ASSOMED)		Union of Portuguese Nurses (SEP)	
Employers' organisations						
	Cyprus Employers & Industrialists Federation (OEB) – Private sector (cross-sectoral)	Ministry of Health: Public sector	Agency for the contractual representation of the Public Administration (ARAN)	Malta Employers' Association (MEA)	Portuguese Association of Private Hospitals (APHP)	Spanish Private Health Alliance (ASPE)
	Ministry of Health: Main employer for public healthcare	Panhellenic Union of Private Hospitals (PEIK)	Italian Federation of Hospitals and Health Agencies (FIASO)	Ministry of Health: Public sector	Employers Confederation of Commerce and Services (CCP)	Ministry of Health: Public sector
	State health services organisation: Public sector				National Confederation of Institutions of Solidarity (CNIS)	

4. Social partners' involvement in the EU social dialogue structures

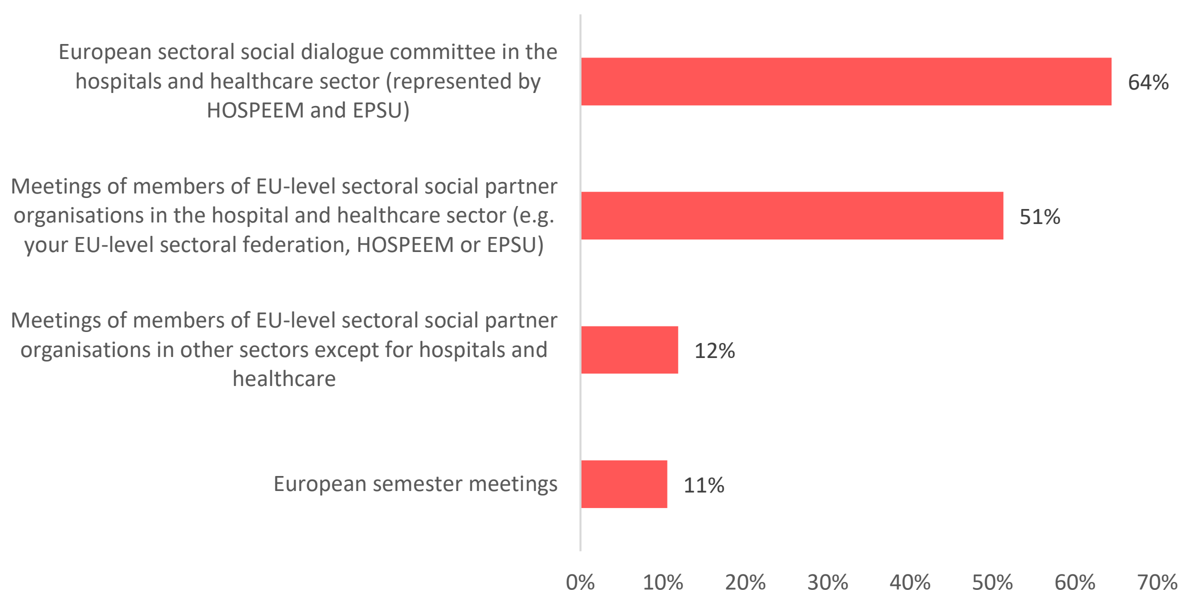
The importance of the European social dialogue is anchored in the Treaty on the Functioning of the European Union (TFEU) by several articles[20]. There are plenty of instances where the **social partners played an active role in the EU-wide agreements**.

> **I am a firm believer in the value of social dialogue between employers and unions, the people who know their sector and their region the best.**
> *Ursula von der Leyen, European Commission President*

The findings related to the involvement of the social partners in the EU social dialogue presented below are based on the online survey circulated to relevant social partners/organisations in the fourteen targeted countries between April 2019 and August 2020. Most of the social partners involved in the survey participate directly at meetings within the EU social dialogue structures. It has to be noted that the majority of respondents are trade union representatives[21].

Out of those involved, **most of the organisations of the targeted countries participated in the EU level SD structures either represented by EPSU and HOSPEEM or cross-sectoral European organisation**. Out of those involved, 64 % participate directly in the EU Sectoral Social Dialogue Committee in the Hospital and Healthcare Sector (SSDC HS) via EPSU or HOSPEEM, and 51% in meetings of members of the two EU level SSD partner organisations over the past four years. Twelve per cent, usually employers' associations, took part in meeting EU-level sectoral social partner organisations in other sectors. Only 11% of respondents participated in the European Semester meetings.

Graph 1: Direct participation at the committee meetings of EU level social dialogue structures since 2015 (%, N = 76)



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

The most frequent reason for non-participation in any EU level social dialogue structures is the lack of financial capacities (30%). The lack of personal capacities, lack of time to participate in meetings, and entry barriers (not meeting representativeness criteria) are the reasons for non-participation at EU level social dialogue for 26% and 23% respondents, respectively. In addition, some do not see added value and progress in improving the social and economic status after long-term membership in one EU organisation (18%). The non-involvement of the social partners from the targeted countries might also be **hampered by their fragmentation at the national level and/or the currently limited independent employers' organisations**.

[20] Art. 152: The European Union recognises and promotes the role of social partners at Union level respecting their autonomy; Art. 154: Consultation of EU level social partners by the Commission; Art. 155: Agreements concluded by social partners.
[21] See the Methodology annex.

Table 3: Reasons for non-participation in EU level social dialogue structures (%, N= 57)

Reasons for non-participation	Per cent
Lack of financial resources (high travel costs, high membership fees)	30%
Lack of personal capacities, lack of time to participate in meetings	26%
Barriers of entry (not meeting representativeness criteria)	23%
Low importance of EU-level social dialogue to the activities of our organisation	18%
Difficulties in understanding the role and functioning of EU-level social dialogue	12%
Language barrier	11%

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

EPSU represents most of the trade unions at the European level and is the only recognised social partner in the hospital sector. While other European hospital associations exist, HOSPEEM is the only recognised European sectoral social partner representing national hospital employers' organisation's interest. **The employers' participation in EU level social dialogue structures is currently limited.** Representatives from national trade unions appealed to national employers' organisations to become a member of HOSPEEM to establish effective EU-level social dialogue as many trade unions in the targeted countries within the region do not have their counterparts represented to discuss and agree on EU-level instruments[6].

In some countries (e.g., CZ), the national social dialogue has slowed down during the COVID-19 pandemic, and in other countries, the communication and negotiations between the social partners has been minimised. This was also due to the relatively frequent personnel changes within the responsible governmental bodies. However, in Croatia and Slovenia, the social dialogue with the Ministry was sustained of relatively high quality[6].

5. Social partners' participation in the European Semester

The European Semester (ES) is an annual governance cycle to monitor and enforce compliance with stringent budgetary and structural reforms. **The focus on social aspects in the ES recently intensified by linking it to the European Pillar of Social Rights**. Particularly, principles eight and 16 states that "*the social partners shall be consulted on the design and implementation of economic, employment and social policies according to national practices*" and that "*support for increased capacity of social partners to promote social dialogue shall be encouraged*," as well as "*Everyone has the right to timely access to affordable, preventive and curative healthcare of good quality.*"

The European Semester's Country-Specific Recommendations (CSRs) reflects the relevance of the healthcare sector and social dialogue for fiscal consolidation, social cohesion, addressing (in-work) poverty, and increasing the resilience and functioning of the health system. **As a result, the number of EU Member States (MS) receiving CSRs related to healthcare increases**: 10 MS in 2017, 15 MS in 2019[22]. Since the pandemic outbreak, March 2020, the European Semester mechanisms adjusted to the crisis and set up a recovery and resilience facility to guide the Member States to cope with the health crises. The Member States were encouraged to submit their recovery and resilience plans. The current procedure of the assessment with the countries specific recommendations will be replaced with the assessment procedure of the recovery and resilience plans in 2021[23].

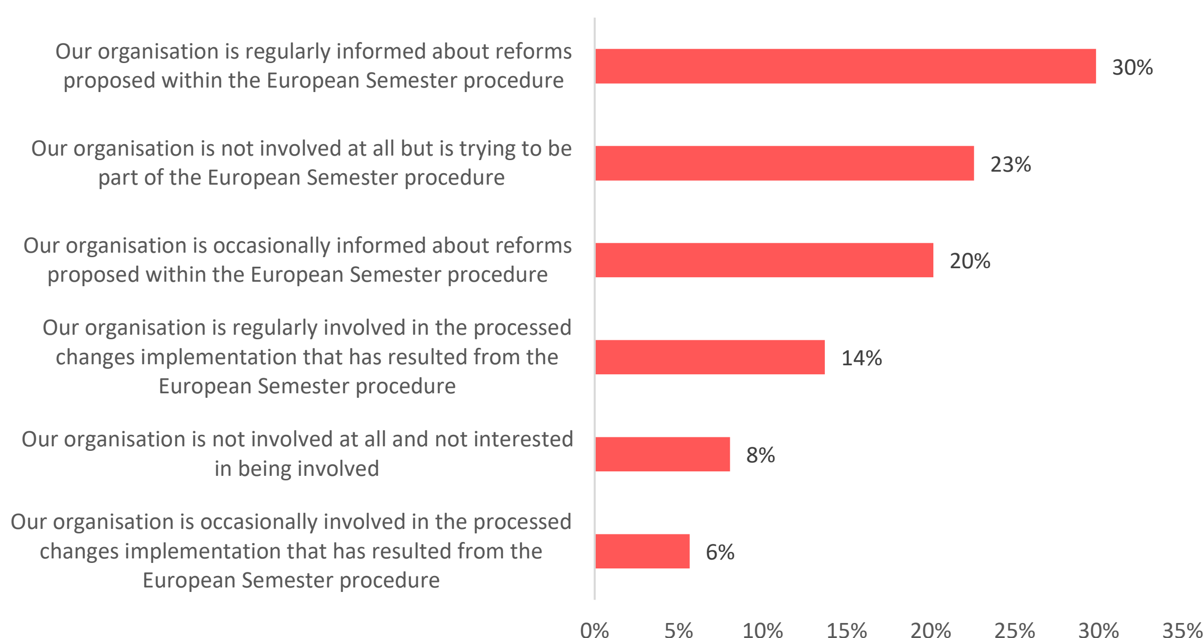
The crisis heightened the need to commit to strengthening the Social Europe and the European Pillar of Social Rights by developing social dialogue. The role of social dialogue is fully recognised as a fundamental element within the EU at various levels by involving EU and national social partners in dialogue. The support for promoting EU social dialogue is also reflected in the European Pillar of Social Rights Action Plan by concrete initiatives, such as a new supporting frame for social partner agreements at the EU level and a new award for innovative social dialogue practices and the new Strategic Framework for Occupational Safety and Health. The European Commission proposed new tools better to measure barriers and gaps in access to healthcare and present an EU report on access to essential services, while encouraging the Member States to invest in the health workforce, improving working conditions and access to training.[24]

[22] For the particular CSRs see annexe B.
[23] Egbert Holthuis, European Commission, The European Semester process: actions to develop and foster the involvement of national sectoral social partners; contribution at the Regional Webinar 20 April 2021.
[24] Presentation of Jan Behrens (DG EMPL A2 Social Dialogue): Social dialogue at EU level, at regional webinar 20 April 2021.

The high commitment of the European Commission and transposed principles of the European Pillar of Social rights into multiple initiatives provide the national social partners new opportunities and inspiration to utilise the sources to developed strategies and strengthen the social dialogue in the Member States, such as to transforms the Plans' initiatives into their daily work and to articulate interests upwards, challenges regarding working conditions, health and safety issues in hospitals, migration of healthcare professionals, and difficulties with collective bargaining to the EU level, to be addressed and integrated into further plans and strengthening the EU level SD in the hospital sector[25].

The European Semester mechanisms is a platform where the weaknesses based on facts can be revealed and communicated further to the relevant EU level committees to search for solutions. The engagement of the social partners is key in this process. The financial assistance by the European Commission will support the efforts of social partners in their commitments to articulate their priorities at the EU level[26]. Even though **the social partners' current involvement in the European Semester procedure is limited**, 30% of organisations are regularly informed about the recommended reforms. The other 23% are interested or trying to be involved either in the European Semester process. 20% of social partners are occasionally informed, and only 14% regularly and 6% are sometimes involved in the process. These findings can be supported by the recurring research conducted by Eurofound on the involvement of national social partners in policymaking[27]

Graph 2: The ways the social partners are involved in the European Semester procedure (%, N= 124)



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

The Regional Webinar discussions revealed that the primary responsibility for good involvement at the national level remains with the Member State. However, in some countries, social partners have only a limited possibility of intervening in the European Semester process and complain about finding themselves out from the process[6]. HOSPEEM and EPSU provide a space for good practice sharing and strengthening; thus, the national and EU level social dialogue. In this regard, the Slovenian social partners call for more intensive support of EPSU to national partners to get include in the EU Semester process.

6. Social partners' priorities to be communicated to the EU level

The social partners listed their priorities to be expressed at the EU level, for example, through their membership in the respective EU level social partner organisation in the hospital and healthcare sector. In the survey, social partners revealed their priorities that they would like to communicate at the EU level social dialogue. The topics range from comprehensive, overall structural problems, such as increased investments in healthcare, safety and health at work and working conditions, workforce retention to work-family reconciliation. However, health workforce shortages, addressing the sectors' attractiveness, and improving the recruitment and retention policies for all health workers are common topics for most social partners from the targeted countries surveyed. For the variability in the answers, we list all the priorities reveals authentically in the following three tables.

[25] Based on the discussion at the Dissemination Workshop 16 June 2021.
[26] Jan Behrens, the Policy Officer, European Commission at the Dissemination Workshop 16 June 2021.
[27] Eurofound (2020), Involvement of national social partners in policymaking – 2019, Publications Office of the European Union, Luxembourg.

Table 4: Priorities to be communicated to the EU level

Country	Priorities	
	Trade unions	**Employers' organisations**
Romania	• Working conditions - wages and bonuses regulations; • Working time, staffing norms; • Unification of medical staff training; • Improvement of the social partners' representatives and collective agreements	No information available
Hungary	• Wages, especially minimum wage at the European level; • Working time legislation in connection to work overload; • Work and family reconciliation	Labour migration and associated workforce shortage*
Poland*	• Increasing the staff of nurses in hospitals concerning guarantee the safety of the patients; • Financial demands regarding wage increase, especially for nurses; • Staff retention in the context of ongoing changes in the organisation of the hospital sector;	• Mitigating disparities in the growth of the wages between doctors and nurses; • Increase in healthcare investment
Bulgaria	• Wages of medical specialist – support of the single minimum wage in the EU; • Problems of health and safety - third-part violence and psychosocial risks; • Workforce retention	• Cross-border access to healthcare services; • More opportunities to be involved at the EU level.
Cyprus	• Lack of nursing staff and resources (especially in private hospitals); • Health sector reform (general health system & autonomy of public hospitals); • The reduced state budget for the health section concerning the EU28; • Professional Development and Life-long learning.	• Lack of nursing staff • Sustainability of the national health system; • Functional and financial autonomy of public hospitals; • Implementation of a common legal and regulatory framework for the public and private health sector.
Greece	• Lack of staff and labour issues; • Interference of primary structures with appropriate equipment; • Specialist doctors for the central; structure-medical technological equipment; • Interconnection with similar systems abroad; • Healthcare in risk occupations.	• Increasing the financing of the health system from 5% to 8% of GDP; • Equal treatment from the state of the private sector with the public; • Minimising bureaucracy • Costing method (DRG'S, ICD 10), financing of investment in existing private hospitals; • Minimum operating standards for providing safe health services.
Italy	• Collective bargaining; • Employment in the healthcare sector; • Dialogue with sectoral trade unions; • Working conditions; • Safety and health at work; • Reconciliation of work and family; • Recruitment and retention policies for all health workers.	• Lifelong learning and continuing professional development; • Work organisation; • The digitalisation of workplace / digital skills; • Vocational education and training; • Recruitment and retention policies for all health workers.
Malta	• Collective bargaining; • Private partnership; • Employee rights in a healthcare setting; • Burn out at work; • Reconciliation of work and family.	• Posting of workers; • The attractiveness of the sector for young workers.
Portugal	• Collective bargaining; • Enhancement of nurses' skills; • Career progression; • Cross-border recognition of professional qualifications.	• EU Convergence; • Safety and health at work; • Working conditions; • Ageing workforce; • Vocational education and training; • Recognition of skills at the national level; • Continuing Professional Development and Life-long learning.

Country	Priorities	
	Trade unions	**Employers' organisations**
Spain	• Working and employment conditions, especially the working day and salaries; • Health and safety at work with a gender perspective; • Ratios of healthcare personal; nurse-to-patient and patient safety ratio; • Digitisation; • Exposure to toxic and biological agents, risk prevention; • Professional development and retention of staff; • Validation of studies and professions.	• Implementing technology; * • Legislation on recognition of some health specialist, such as embryologists; • The long waiting list for screenings.
Croatia	• Recruitment and retention policies for all health workers • Safety and health at work • Salaries in health care and of nurses specifically • Working conditions • Staff training • Material rights of health professionals' • Rights and obligations • Overtime • Collective agreements • Lack of health workers	• All the topics surveyed; • Synergy of private and public healthcare • Occupational safety
Czech Republic	• Remuneration of employees in health and social services • Safety and health protection at work • Staff protection and security • Social dialogue with employers and the creation of agreements and guidelines • Recruitment and retention policies for all health workers • Working conditions	• Directive on Working Conditions; • European minimum wage; • Recruitment and retention policies for all health workers; • The attractiveness of the sector for young workers.
Slovakia	• Woking conditions and • Reconciliation of work and family • Continuing professional development and life-long learning • Recruitment and retention policies for all health workers • Lack of personnel and increasing the value of nurses' work	• To promote the interests of its members in the distribution of EU structural funds (ASN); • Creating decent conditions for employees (ASN); • Increase in payments for state insured persons (ASL SR)[28].
Slovenia	• Recruitment and retention policies for all health workers • Safety and health at work • Working conditions • The attractiveness of the sector for young workers • Ensuring effective public health • Care personnel norms in health care • Remuneration system in health care • Working time	No information available

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

[28] Based on desk-research (as of February 2021)

The respondents had the opportunity to rank the listed topics to be addressed at the EU level SD on a scale from 1 to 5 (five stands for the highest-rated priority). The highest-rated topics are working conditions in general (weighted average 4,7) and safety and health at work (weighted average 4,6). Continuing professional development and life-long learning, recruitment and retention policies for all health workers and reconciliation of work and family got the third-highest rating (weighted average per 4,3). None of the listed priorities scored less than 3 points, indicating the relevance of all the topics.

In some countries, the highest-rated topics by employers differ slightly from those of trade unions. For example, employers need to focus on vocational education and training (weighted average 4,8), continuing professional development and life-long learning (4,6), and the ageing workforce in Southern countries. On the other hand, trade unions want to address working conditions (4,5), safety and health at work (4,5), and reconciliation of work and family (4,3).

Table 5: The organisations' priorities with the highest rating (%, N = 101)

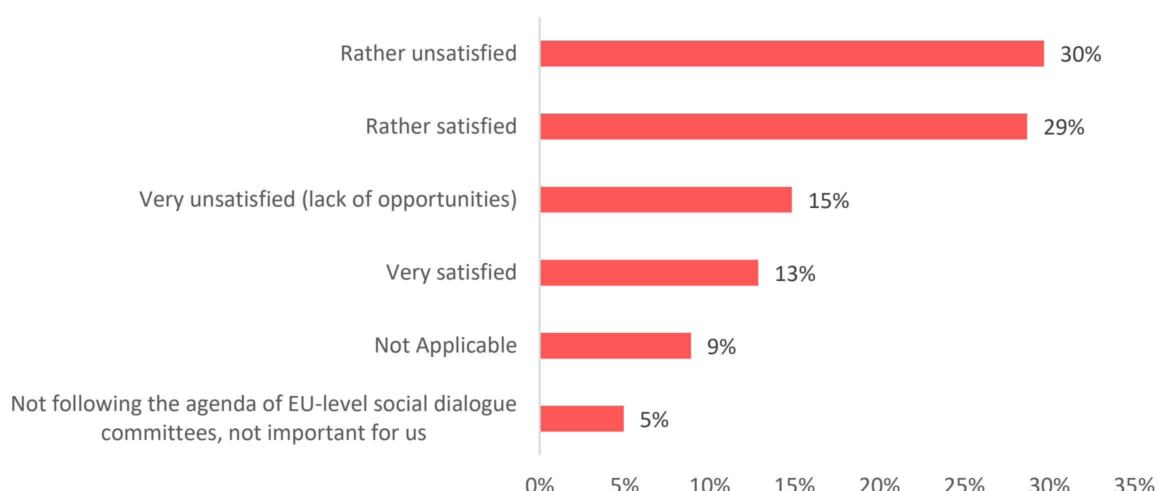
Priority	Rating at 4	Rating at 5	Weighted average
Working conditions	12%	78%	4,7
Safety and health at work	15%	74%	4,6
Continuing Professional Development and Life-long learning	29%	54%	4,3
Recruitment and retention policies for all health workers	22%	57%	4,3
Reconciliation of work and family	31%	51%	4,3
Vocational education and training	29%	49%	4,2
Recognition of skills at the national level	28%	49%	4,1
Digitalisation of workplace / digital skills	29%	47%	4,1
Cross-border recognition of professional qualifications	28%	42%	4,0
The attractiveness of the sector for young workers	26%	43%	4,0
Ageing workforce	24%	38%	3,9
Mobility of health professionals in the EU	31%	29%	3,7

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

Asking for satisfaction with the opportunities to address the EU level social dialogue priorities, the findings show room for improvement regarding national organisations' involvement, creating a more engaging and participatory environment for the national partners at the EU level. One-third of the respondents are rather unsatisfied with the opportunities, and 15% even see a lack of opportunities to communicate their priorities to the EU level. On the other hand, 42% of respondents are rather or very satisfied (29% and 13% respectively).

The reasons for dissatisfaction with the opportunities to communicate the priorities to the EU level social dialogue is the lack of financial resources (58%) and human/staff resources (51%). Forty per cent of respondents respond that they have no interaction with EU-level organisations. However, 18% of respondents think that their priorities differ from the priorities of EU-level social partners in the hospital and healthcare sector.

Graph 3: Satisfaction with the opportunities to address the priorities at the EU level social dialogue (%, N= 101)



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 the previous question in EU level sectoral social dialogue committee in hospitals and healthcare? Select one option."

Based on the survey, the social partners expect the following from the EU level: 1) support to make a stronger impact on the national policies in the health sector (78%) and 2) support in domestic collective bargaining (e.g., wage-related bargaining) (65%). These two most vocal expectations reveal that national social partners need to increase their influence at the national level. EU level social dialogue structures are expected to be supportive in these terms. Fifty-five per cent of respondents expect capacity building – providing specific guidance on strengthening social dialogue and collective bargaining in our country's hospitals and healthcare and 52% greater acknowledgement of our organisation´s interests and incorporation into the EU-level agenda of social dialogue.

Table 5: The organisations' expectations from the EU level social dialogue structures (%, N= 95)

Expectations	Per cent
Support of EU-level social partners to our organisation to make a stronger impact on the policies in the health sector in our country	78%
Support for us in domestic collective bargaining (e.g., wage-related bargaining)	65%
Capacity building – providing specific guidance on how to strengthen social dialogue and collective bargaining in our country's hospitals and healthcare	55%
Greater acknowledgement of our organisation's interests and incorporation into the EU-level agenda of social dialogue	52%
To provide space for networking and exchange of experiences	47%

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 COVID-19 pandemic changed the priorities of the social partners, intensifying even more the urgency of certain problems, already identified before the crisis. The social partners from Croatia, Slovenia, Czechia, and Slovakia that had an opportunity to discuss their priorities during and after the second wave of the pandemic revealed that difficulties that had not been addressed for a long-time were exaggerated during the pandemic. Specifically, the lack of staff became critical. Health and safety issues have acquired additional dimensions in infection prevention and control, and personal protective equipment availability. In Croatia and Slovenia, the importance of mental health intensified during the crisis[6].

The regional workshop discussion with Central European countries uncovered a new topic to be communicated to the EU level. Both social partners call for increased investment from the Recovery and Resilience Plans that was communicated on the national levels (HR, SK). The workshop participants considered their involvement in the consultation process of the recovery plan insufficient. The opportunities to negotiate the fair share in social dialogue at the national level was not utilised. The social partners have often been excluded from the process.

The dissatisfaction with the percentage of investments set at the national level provides the EU-level social partners' space for action.

Representatives of Romanian trade unions revealed that the opportunities to influence the measures during the pandemic and address the precarious working conditions in healthcare minimised with the current government. The trade unions are ignored in calling for an adequate supply of personal protective equipment, access to the vaccine, and salary increase. Nearly all the hospitals transformed into Covid hospitals, jeopardising the health of other patients[24].

Spain also confirmed limited participation in social dialogue and low investment in health care leading to multiple shortcomings. On the other hand, Croatia is satisfied with the social dialogue during the pandemic, leading to a 10% increase in salaries. Also, in Italy, negotiations with social partners are going on despite the pandemic. Collective bargaining did not suffer from the Covid-19. ARAN managed to close different public contracts, such as the National Collective Agreements on "Local Functions" and on "Healthcare", and currently working on the National Collective Agreements "Central Functions"[25].

7. Conclusion

The final report presented the findings on the social partner's involvement in the EU level social dialogue and The final report presented the findings on the social partner's involvement in the EU level social dialogue and priorities to be addressed at the EU level for Bulgaria, Hungary, Poland, Romania, Cyprus, Greece, Italy, Malta, Portugal, Spain, Croatia, Czech Republic, Slovakia, and Slovenia.

The targeted countries' commonalities are that their healthcare expenditure is below the EU-27 average in the long term and staff shortages are causing a consequent increase in the workload and endangering the safety of patients and the staff. In addition, the migration of healthcare professionals, mainly to Western and Northern countries, is an economic and societal challenge for all targeted countries. The workforce shortages give rise to the precarious labour characterised by long working hours and an increase in numbers of night shifts and re-employing retired workforce. The working conditions during the COVID-19 crisis showed the increased need for coordinated and inclusive actions at national and European levels to deal with the challenges effectively. As a result, the social partners' representation in the European Sectoral Social Dialogue and their involvement in the European Semester has become essential.

Social partners at the national level are encouraged to pursue the high commitment of the European Commission for a Social Europe and contribute to finding solutions for the pressing challenges in healthcare. The initiatives at the EU level, on the other side, can be a source of information and inspiration for developing strategies and strengthening social dialogue in the Member States.

Social partners' representation reveals to be fragmented, diverse along the lines of occupations and private/public health sectors. These common characteristics in most targeted countries are complemented by the lack of an official counterpart. Most of the organisations of the targeted countries participated in the EU level SD structures either represented by EPSU and HOSPEEM or another cross-sectoral European organisation. The employers' participation in EU level social dialogue structures is currently limited.

Even though the number of EU Member States receiving country-specific recommendations related to healthcare within the European Semesters process, the social partners' involvement is limited. Social partners revealed their priorities that they would like to communicate at the EU level social dialogue. The topics range from comprehensive, overall structural problems, such as higher investments in healthcare in general, safety and health at work and working conditions, workforce retention and work-family reconciliation to discussions on the European Minimum Wage Directive. The highest-rated topics are working conditions and safety and health at work related to the long-term challenges of lack of health force and worsening working conditions.

There is room for improvement regarding national organisations' involvement, creating a more engaging and participatory environment for the national partners at the EU level. Based on the survey, the social partners have clear expectations from the EU level social dialogue. The national social partners need to increase their influence at the national level to make a more substantial impact on the national policies in the health sector. The EU level social dialogue structures are expected to support them.

The following steps of the EU-level social partners will lead to more work on the recruitment and retention initiatives and explore more the capacity building programmes that would help increase the political support for the social dialogue.

Annex

A. Methodology

A combined methodology design was used:

a) Desk research conducted focused on the 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 priorities and expectation from the EU level social dialogue structures.

The survey was translated into national languages and distributed online via the Survey Monkey systems. Approximately different organisations, both trade unions and employers' organisations, have been repeatedly invited to complete the survey. The structure of the respondents participating in the survey was as follows:

Total sample	**Per cent**	**Number**
Total number of respondents	100%	181
Type of organisation		
Employers' organisation	6,6%	12
Trade union	87,9%	159
Other	5,5%	10
Position of the respondent within the organisation		
President	20,7%	35
Vice-President	4,7%	8
General Secretary	4,7%	8
Member of the Presidium	29,0%	49
Member of staff	16,0%	27
Other	25,0%	42
Country		
Bulgaria	1,20%	2
Croatia	5,99%	10
Cyprus	1,80%	3
Czech Republic	2,40%	4
Greece	5,39%	9
Hungary	2,99%	5
Italy	3,59%	6
Malta	2,40%	4
Poland	2,40%	4
Portugal	2,40%	4
Romania	59,88%	100[29]
Slovakia	4,19%	7
Slovenia	2,40%	4
Spain	2,99%	5

[29]The high number of respondents from Romania is caused by the survey's distribution to regional level trade unions

c) Analysis of the discussion at the Regional Workshops: The workshop's discussion was facilitated by structure prepared in advance; notes have been taken and consolidated into summary findings, complementing the survey and desk-research results.

Periods of the research phases for particular country groups

Countries	Desk research	Survey data collection	Analysis of webinar workshop
BG, HU, PL, RO	From April to July 2019	From April to June 2019	Regional Workshop in Bucharest in June 2019
CY, EL, IT, PT, MT, ES	From July to November 2019	From July to November 2019	Regional Workshop in Rome in November 2019
HR, CZ, SK, SI	From February to August 2020	From February to August 2020	Online Regional Workshop in April 2021

B. European Semester Country-Specific Recommendations

The table below outlines the four targeted countries 'CSRs and other in-text recommendations regarding health and social policy areas. It has to be noted that the information below is excerpts of the country's recommendations, adopted in July 2020.

Areas of recommendation	Bulgaria	Hungary	Poland	Romania
Health policy				
Healthcare system and infrastructure	• Characterised by public spending; • Limited access to healthcare caused by an uneven distribution of limited resources and low health insurance coverage; • Out-of-pocket payment is considerable.	• Inadequate screening and primary care; • Public spending is below EU average; • Citizens rely on out-of-pocket payment to access quality services; • System is strongly hospital centred, with weakness in primary care	• Unmet need for medical services declined but remains high in the EU; • Waiting times have increased substantially since 2010; • Developed map of healthcare needs but have not become a tool for supporting decisions; • Healthcare system is too focused on hospital care provision; • 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; • Prevalence of informal payment is high; • Access to healthcare services for those living in rural areas and vulnerable groups is limited;
	CSR: Improve access to health services, including reducing out-of-pocket payments and addressing shortages of health professionals.	**CSR**: Improve health outcomes by supporting preventive health measures and strengthening primary care		**CSR**: Improve access to and cost-efficiency of healthcare, including through the shift of outpatient care
Shortages of health workforce	• Low availability of practitioners is constraining the delivery of primary care; • A significant shortage of nurses with the number per capita among the lowest in the EU.	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; • 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
	Recommendation: Swifter and more effective implementation of the national health strategy would help tackle these weaknesses.			
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 **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[30]

[30] 81% of employers having difficulties filling job vacancies

Areas of recommendation	Czech Republic	Croatia	Slovenia	Slovakia
Health policy				
Healthcare system and infrastructure	The current crisis has shown the need for crisis preparedness plans in the health sector includes improved purchasing strategies, diversified supply chains, and strategic reserves of essential supplies. They are key elements for developing broader crisis preparedness plans. Recommendation: Ensure the resilience of the health system, strengthen the availability of health workers, primary care and the integration of care, and deployment of e-health services.	Enhance the resilience of the health system. Promote balanced geographical distribution of health workers and facilities, closer cooperation between all levels of administration and investments in e-health	Ensure the health and long-term care system's resilience, including providing an adequate supply of critical medical products and addressing the shortage of health workers.	Strengthen the health system's resilience in the health workforce, critical medical products, and infrastructure. Improve primary care provision and coordination between types of care.
Social policy				
Skills	Support the provision of skills, including digital skills and access to digital learning.	Increase access to digital infrastructure and services. Promote the acquisition of skills.	Promote digital capacities of businesses, and strengthen digital skills, e-Commerce, and eHealth.	Strengthen digital skills. Ensure equal access to quality education.
Labour force	Support employment through active labour market policies	Strengthen labour market measures and institutions and improve the adequacy of unemployment benefits and minimum income schemes.	Provide adequate income replacement and social protection. Mitigate the employment impact of the crisis, including enhancing short-time work schemes and flexible working arrangements. Ensure that these measures provide adequate protection for non-standard workers.	Provide adequate income replacement, and ensure access to social protection and essential services for all

Areas of recommendation	Cyprus	Greece	Italy	Malta	Portugal	Spain
Health policy						
Healthcare system and infrastructure	Progress made on healthcare by adopting legislation to establish the new National Health System: • seeks to improve access; • introduce universal health coverage; • reduce the high level of out-of-pocket payments; • increase the efficiency of care delivery in the public sector; • ensures the financial and operational autonomy of public hospitals. **CSR**: Take measures to ensure that the National Health System becomes operational in 2020, as planned, while preserving its long-term sustainability.	A far-reaching reform of the primary healthcare system initiated in 2017: • relevant to ensure access; • continued investment through the deployment of local healthcare unit required. **CSR**: Focus on investment-related economic policy on sustainable healthcare, considering regional disparities and the need to ensure social inclusion;	Overall good outcome but disparities in healthcare provisions across regions impacting: • access; • equity; • efficiency; Potential for improvement by: • better administration; • monitoring the standard levels of services. **Recommendations:** • More home and community-based and long-term care to people with disabilities and other disadvantaged groups; • Geographical disparities to be considered in health and long-term care availability of services. **CSR:** Improve effectiveness, accessibility, and sustainability of health care	Current situation: • Increase of the age-related public spending in healthcare systems; • Risk of rising debt in the long term; • Ongoing measures to decentralise services from hospitals to primary care; • Tackling long waiting time by expanding the capacity of public-hospital outpatient care; • Increasing demand for long-term care; • Introduction of new types of community-based and home services; • No impact of the measures taken on fiscal sustainability so far. **CSR**: Ensure the fiscal sustainability of the healthcare system, including by • restricting early retirement; • adjusting the statutory retirement age given expected gains in life expectancy.	• Continuous pressure on public finances from the adverse demographic trends; • Promotion of the cost-effectiveness by increased centralised purchasing and use of generics; • Inadequate budgetary planning and accounting control resulting in high hospital arrears; • introducing a new governance model for public hospitals to structurally addressing arrears in 2019. **CSR**: Improve the quality of public finances by prioritising growth-enhancing spending while strengthening overall expenditure control, cost efficiency, and adequate budgeting, focusing on a permanent reduction of arrears in hospitals.	
Social policy						
Skills	Access to quality education and training with life-long perspectives considering future needs. **Recommendations:** • Increase the capacity of vocational education and training; • Increase employers' engagement and learners' participation in	Rising skills shortages and mismatches and a changing world of work. **Recommendations**: • Increase the capacity of vocational education and training • Strengthen and modernise education and training systems.	Consider the future-oriented acquisition of skills, including measures to promote adult learning. **Recommendations**: • Strengthen the attractiveness of the teaching profession; • Upskilling is particularly needed for digital skills.	Additional efforts to improve quality and inclusiveness of education and training systems, with particular attention to disadvantaged groups.	Skills levels remain low for several population groups. Improving employability and social mobility by investing in education, training, and infrastructure. **CSR**: Improve the skills level of the population, in particular, their digital literacy, including by making adult learning more relevant	Skills shortages and mismatches hamper the development and use of advanced technologies, particularly by small and medium-sized firms. Stalled efforts to reform the education system.

	vocational education and training. **CSR**: Improve labour market relevance of their education and training systems.		**CSR:** Improve educational outcomes, also through • adequate and targeted investment; • foster upskilling in digital skills.		to the needs of the labour market.	**CSR**: Reduce early school leaving and increase cooperation between education and businesses to improve labour market-relevant skills and qualifications, particularly for information and communication technologies.
Wage		**Recommendation:** completion of more comprehensive reforms of welfare benefits.	Income inequality and risk of poverty are high, with wide regional and territorial disparities. The gender employment gap remains one of the highest in the Union. A comprehensive strategy to promote women's participation in the labour market is still missing.		Despite decreased income inequality, still significantly higher than the Union average. The adequacy of the minimum income scheme is among the lowest in the Union. **Recommendation:** Improve the coverage, adequacy, or effectiveness of the social safety net, including minimum income schemes	Regional disparities presented in regional minimum income schemes; Limited portability between regions reduces incentives for labour mobility. **Recommendations:** • Integrate territorial development strategies, including actions promoting entrepreneurship, digitalisation, and the social economy. • Address coverage gaps in regional minimum income schemes.
Social dialogue		Effective social dialogue and responsible social partnership can support • the environment for the implementation; • ownership of sustained reforms.	The initially envisaged reform of the collective bargaining framework aimed to bring wages and salaries more in line with economic conditions at the regional and firm level. A framework agreement signed with the three major Italian trade unions to • expand second-level bargaining; • increases legal certainty by setting more precise rules for the representation of social partners at negotiations; • establishment of an improved algorithm for setting wage minima.			While the setting-up of tripartite round tables is a good step towards more significant involvement by the social partners in policy design, there is room for more in-depth and more timely consultations.

Source: Overview compiled by CELSI team based on Country-Specific Recommendations within the European Semester 2020

C. Participant list dissemination workshop

Last name	First name	Organisation	Affiliation	Country
Albuquerque Arenga	Margarida	Portuguese Permanent Representation	Other	Belgium
Avram	Adam	EPSU	EPSU	Belgium
Barecka-Bach	Anna	NSZZ "Solidarność" Fresenius Nephrocare	EPSU	Poland
Bartlet	Céline	HOSPEEM	HOSPEEM	Belgium
Behrens	Jan	European Commission	Other	Belgium
Berislavic	Marija	Croatian Trade Union of nurses and medical technicians	EPSU	Croatia
Bota	Ovidiu	SANITAS Cluj	EPSU	Romania
Branca	Marta	HOSPEEM	HOSPEEM	Italy
Břeňková	Ivana	TUHSS CR/OSZSP ČR	EPSU	Czech Republic
Cojocariu	Victoria	Eurofound	Other	Ireland
Das	Sarada	Standing Committee of European Doctors (CPME)	Other	Belgium
De Bruyn	Myriam	Zorgnet-Icuro	HOSPEEM	Belgium
Dechorgnat	Elisa	FEHAP	HOSPEEM	France
Drug	Roxana	EPSU	EPSU	Belgium
Fasoli	Sara	HOSPEEM	HOSPEEM	Belgium
Gae	Razvan	SANITAS Federation	EPSU	Romania
Gil Alonso	Yolanda	FSS-CC.OO	EPSU	Spain
Goudriaan	Jan-Willem	EPSU	EPSU	Belgium
Hnykova	Jana	OSZSP ČR	EPSU	Czech Republic
Holubová	Barbora	CELSI	Other	Slovakia
Howe	Samantha	EPDU	EPSU	Belgium
Kahancova	Marta	CELSI	Other	Slovakia
Malapitan	Christopher	Graphic artist	Other	Belgium
Michelutti	Paolo	ASL Roma 3	HOSPEEM	Italia
Mohrs	Simone	HOSPEEM	HOSPEEM	Belgium
Negru	Liliana	SANITAS Arad	EPSU	Romania
Oarna	Ana Maria	Patronatul Furnizorilor de Servicii Medicale Private – PALMED	Other	Romania
Papp	Katalin	Chamber of Hungarian Health Care Professionals, University of Debrecen Faculty of Health	Other	Hungary
Paun	Tanja	Croatian Health Employers' Association	Other	Croatia
Pereira	Ana Carla	European Commission	Other	Belgium
Petcu	Claudia	Sanitas	EPSU	Romania
Prasnjak	Anica	Croatian Trade Union of nurses and medical technicians	EPSU	Croatia
Ptak-Bufkens	Katarzyna	European Commission	Other	Belgium
Renouvel	Sylvain	Federation of European Social Employers	Other	Belgium
Rinversi	Silvia	ARAN	HOSPEEM	Italy

Robert	Alexandre	European Federation of Nurses Associations (EFN)	Other	Belgium
Rodríguez Contreras	Ricardo	Eurofound	Other	Ireland
Rogalewski	Adam	EPSU	EPSU	Belgium
Romeao	Sandra	Sanitas	EPSU	Romania
Scarparo	D'Emanuele	UIL FPL	EPSU	Italy
Schriefer	Jan	FNV the Netherlands	EPSU	The Netherlands
Slangen	Sylvie	Zorgnet-Icuro	HOSPEEM	Belgium
Vannini	Michele	FP-CGIL	EPSU	Italy
Zlatanova	Slava	Federation of Trade Unions - Health Services (FTU-HS)	EPSU	Bulgaria