

Health Risk Outlooks by Social Partners – HEROS

A multi-level analysis of health and safety policy interventions by social partners to identify effective ways to ensure better protection of employees at work.

FINAL PROJECT REPORT (2021 – 2023)

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EXECUTIVE SUMMARY

Health Risk Outlooks by Social Partners – HEROS

The role of national and European social partners for health and safety (H&S) in the hospital and social care sectors in Germany, Italy, Lithuania, Poland, Sweden, United Kingdom (2021 – 2023)

Focus of the research:

The provision and governance of health and safety (H&S) in the workplace involve multiple actors at multiple levels. At the EU level, the Framework Directive on Safety and Health at Work (Directive 89/391 EEC) guarantees minimum health and safety requirements for employees in Europe while member states are allowed to maintain or establish more stringent measures.

With this project, we wanted to understand how social partners (trade unions and employer organisations) at national and European levels contribute to H&S in the hospital¹ and social services sectors² (focusing on care services for older people). These sectors are characterised by similar health risks for their workers, as emerged during the pandemic, but also by markedly different organisations and providers, in terms of size, public, private, for/not for profit, religious nature, as well as different industrial relations systems and structures of employee representation for H&S. We share the view that patients and care service users are safe when workers are safe.

We, therefore, explored the effectiveness and coordination, if any, of policy H&S interventions between European, national, and organisational levels in the two sectors and the role of social partners in different national systems of collective bargaining and workplace mechanisms of H&S. Effective interventions will ensure better quality ('fit for purpose') and wider coverage (type of care workers and employment status) of good H&S protection for health and care workers.

Research methods:

Given the multi-level nature of H&S policies (from European, to national to organisational level), we employed a comparative multi-level analysis of H&S policies and social partners involvement in six countries characterised by different systems of industrial relations and different structures of workplace H&S representation – Germany, Italy, Lithuania, Poland, Sweden, United Kingdom – in the two sectors that were most affected by the Covid pandemic in terms of workers' H&S – the hospital and elderly care sectors.

We conducted 64 interviews with representatives of social partner organisations and H&S experts at the national and European level. This includes 49 interviews with national, sector level representatives of trade unions and employers in the six countries of which 30 are affiliated with EPSU, HOSPEEM, or the Federation of European Social Employers (i.e. organisations that have some form of (potential) involvement and engagement with the

¹ NACE 86 - Human health activities.

² NACE 87- Residential care activities and NACE 88 - Social work activities without accommodation, except child day care activities and other social care activities without accommodation.

European level of sectoral social dialogue) as well as representatives of the European level of social dialogue for the hospital sector and social services sector (EPSU, HOSPEEM and Social Employers).

Key findings:

- **H&S risks** for nurses and care workers are **similar across countries** and include, importantly, **both physical** (heavy weightlifting, back pain, exposure to harmful toxic drugs, sharp injuries, violence by patients and service users) **and psychological** risks (prominently professional burnout and fatigue);
- H&S risks are exacerbated in countries where staff shortages, turnover, and lack of adequate competence are acute, e.g. in countries of health and care staff emigration/drain;
- **National legislation on H&S is the main source of regulation** for workplace H&S conditions in all countries, but variations depend on, for example, whether both physical *and* psychological risks are covered; or on the involvement of social partners at the sector and organisational level;
- **Collective bargaining (CB)** at the sector level in individual countries is **of complementary importance** to the law. Focusing primarily on pay and working time, CB contributes to workload and staff retention, which have been found to be of key value for a good quality and safe working environment;
- Technological solutions to workplace risks (e.g. heavy weight lifting aids) are sometimes available but not used because of lack of time during the busy, long hours of health and care workers;
- The extent to which **social partners are involved in the definition of H&S** policies and measures is **key in facilitating information on H&S** problems and solutions, **both top-down and, crucially, bottom-up**, i.e. the nature of the workplace structure of worker representation in the area of H&S can facilitate feedback to the employers and intervention to reduce risks;
- Compliance with nationally established H&S standards is variable across member states and largely depends on **enforcement mechanisms and institutions**. H&S is regarded as costly, and sanctions are sometimes found more economically efficient; enforcement needs to be combined with knowledge, skills, and sufficient human and financial resources;
- Workplace level structures of representation of H&S can have a positive impact on enforcement. This is particularly so in case studies where there are mixed – union and non-union – systems of worker representation for H&S;
- **H&S conditions are workplace-specific**, esp. in the care sector due to the broad variety of care providers across and within countries; a one-size-fit-all H&S policy might therefore not be suitable;
- The **European level** is an important source of regulation, but social dialogue in the relevant sectors **could do more to coordinate activities** at the cross-border level, between countries, and between the EU and national levels.

Disclaimer: Responsibility for the information, opinions, findings, and conclusions or recommendations expressed in this document lies entirely with the authors.

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INTRODUCTION

Barbara Bechter Durham University

The COVID-19 pandemic highlighted the importance of national and European policy coordination to protect and promote healthy, safe, and well-adapted work environments. Health and safety (H&S) at work represent an important European Union policy area since different standards can directly affect EU citizens' health outcomes and may create market distortions between states. Article 153 of the Treaty on the Functioning of the European Union (TFEU) gives the European Union the authority to adopt legislation in the field of H&S at work. The European Framework Directive on Occupational Safety and Health (OSH) at Work (Directive 89/391 EEC) guarantees minimum H&S requirements throughout Europe while member states are allowed to maintain or establish more stringent measures. This project investigates how social partners (trade unions and employer organisations) at national and European levels protect and promote H&S in the hospital and social services sectors¹. Regarding the social services sector, we focus on the adult social care sector providing care services for older people.

The aim of this study is to analyse:

- The functioning of H&S policy interventions by trade unions and employers in two sectors and six countries.
- The functioning of H&S policy interventions by European sectoral social partner organisations and their national member organisations in two sectors.
- The effectiveness of policy intervention practices at multiple levels – national sectoral and European sectoral levels. Effective interventions ensure better quality ('fit for purpose') and wider coverage (type of care workers and employment status) of H&S protection for health care and care workers².

The provision and governance of H&S policy interventions involve multiple actors at multiple levels. At the company level, H&S representatives together with management are responsible for H&S at work. Fulton (2018) identified different models of H&S representation in different countries in Europe. Trade unions help and provide services to their local union representatives in unionised workplaces. Generally, trade unions and employer organisations provide their

¹ NACE 87- Residential care activities and NACE 88 - Social work activities without accommodation, except child day care activities and other social care activities without accommodation.

² Regarding the workforce covered in the two sectors, we interviewed representatives of trade unions organising health care workers working in hospitals or elderly care homes, mobile care workers, and care workers working in day centres for elderly people.

members with legal advice, training, and information on H&S at work. Through their presence at the company level and the support they provide through training and information, trade unions positively affect the effectiveness of H&S representatives (Walters, 1996). Furthermore, industrial relations systems affect the provision and governance of H&S protection. Health policy interventions may include even measures in collective agreements to maintain economic activity while ensuring a safe working environment (e.g., paid leave, workload, shift work). At the European sectoral level, policy interventions can range from legally binding directives to soft tools providing guidance and examples of good practices (Weber, 2010).

We use a comparative case study design to analyse H&S policy practices used by social partners at the national, sectoral, workplace, and European sectoral levels. To account for differences in sectoral characteristics and their effect on H&S practices and interventions, we investigate two sectors. Although care workers in the hospital and social care sectors are exposed to similar occupational H&S risks, the sectors differ markedly regarding ownership and industrial relations systems. To analyse institutional differences, such as differences in industrial relations and workplace H&S representation, we investigate six countries, Germany, Italy, Lithuania, Poland, Sweden, and the UK. The case studies are based on interviews conducted in 2022 and 2023 with trade unions and employer representatives responsible for H&S at national, sectoral, workplace, and/or EU levels and on supplementary interviews with other actors where relevant (see Table 1 in the Appendix). The interview data were complemented by secondary data, collected in desk research (e.g., literature and research review, union and employer organisation's online sources, social dialogue protocols, and outputs).

The analytical framework draws on the actor-centered institutional perspective, that considers institutional structures and policy intervention processes (Kaufman, 2004). This approach enables us to establish links between (i) industrial relations systems and health and safety representations and (ii) health policy intervention practices by different actors limiting or enabling effective ways of H&S protection. In the following, we analyse industrial relations systems in six countries and two sectors characterised by different institutional and contextual settings but similar H&S risks. The analysis covers policy interventions at the national sectoral and European sectoral levels and coordination efforts between these levels.

Health Risk Outlooks by Social Partners – HEROS. A multi-level analysis of health and safety policy interventions by social partners to identify effective ways to ensure better protection of employees at work

Literature review

July 2023

Jan Czarzasty¹, Maciej Pańków²

Introduction

This report is devoted to a literature review on the functioning of the health and safety sphere in two sectors: health care and social assistance. The review was developed as part of the introductory phase of a study within the project 'HEROS: Health risks outlooks', carried out in an international partnership. It covers six countries: Germany, Italy, Lithuania, Poland, Sweden and the UK.

Health care and social assistance are undoubtedly key sectors, both in terms of their importance to the functioning of society, the health and well-being of the population, and in terms of their share of employment in national economies (on average, workers in these sectors accounted for 11% of total employment in EU countries in 2020) (EU-OSHA 2022: 11). At the same time, these are sectors with their own specificities regarding health and safety practices. On the one hand, they are characterised by a relatively high awareness of OSH issues, while on the other hand, their employees are exposed to specific risks, both ergonomic and psychosocial in nature (EU-OSHA 2022: 8). The first group of risks includes musculoskeletal disorders and back pain resulting from repetitive hand and arm movements, lifting or moving people and prolonged sitting. The second group arises from contact with difficult patients, time pressure and harassment and violence in the workplace (EU-OSHA 2022).

This report consists of four parts. The first will characterise the basic parameters of employment in the sectors studied in the countries surveyed, taking into account the broader context of national industrial relations and OSH protection systems. The second part will discuss OSH issues in the sectors under study present in the literature and the main conclusions of the research conducted so far. In the third, the issue of the impact of

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privatisation and marketisation of national health and welfare state systems will be analysed. Finally, the last topic studied is the impact of the COVID-19 pandemic on the situation of workers in both sectors.

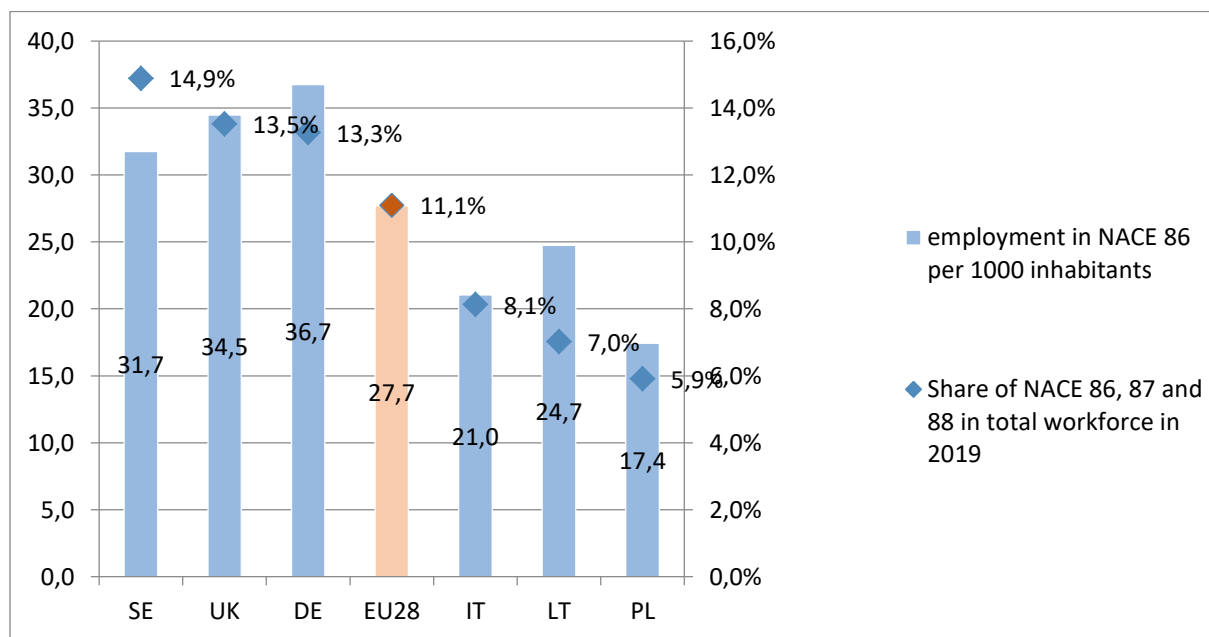
Key data on both sectors under scrutiny

Employment in both sectors

The analysis of the data for the countries covered by the project reveals significant differences in the size of employment in the analysed sectors as a share of employment in the national economy as a whole. The value of this indicator can be considered an important factor influencing the perception of the importance of working conditions in the sector from the point of view of public authorities, as well as the ability of the trade unions to mobilise employees. Thus, it can be considered as the most general characteristic that determines the framework conditions for effective intervention of employee representatives in the field of occupational health and safety. With an average for the EU-28 of 11.9% in 2019, over 13% of the total workforce in Germany, Sweden and the United Kingdom was employed in the analysed sectors (NACE 86, 87, 88). On the other hand, in Italy, and especially Lithuania and Poland, this indicator was clearly lower. The share of employees in the analysed sectors in the total number of employees in Poland is 60% lower than in Sweden.

The ratio of the number of employees to the total population should also be considered an important measure determining the context of employment conditions and social dialogue. As the scope of services under NACE 87 and 88 may differ significantly between countries, this parameter will only be applied to the sphere of health protection. Here, the differentiation between the analysed countries is smaller, but still significant: it ranges from 17.4 employees per 1,000 inhabitants in Poland to 36.7 employees per 1,000 inhabitants in Germany. Detailed data for the analysed indicators are presented in Figure 1.

Figure 1. Chosen employment indicators for NACE 86, 87 and 88 in 2019

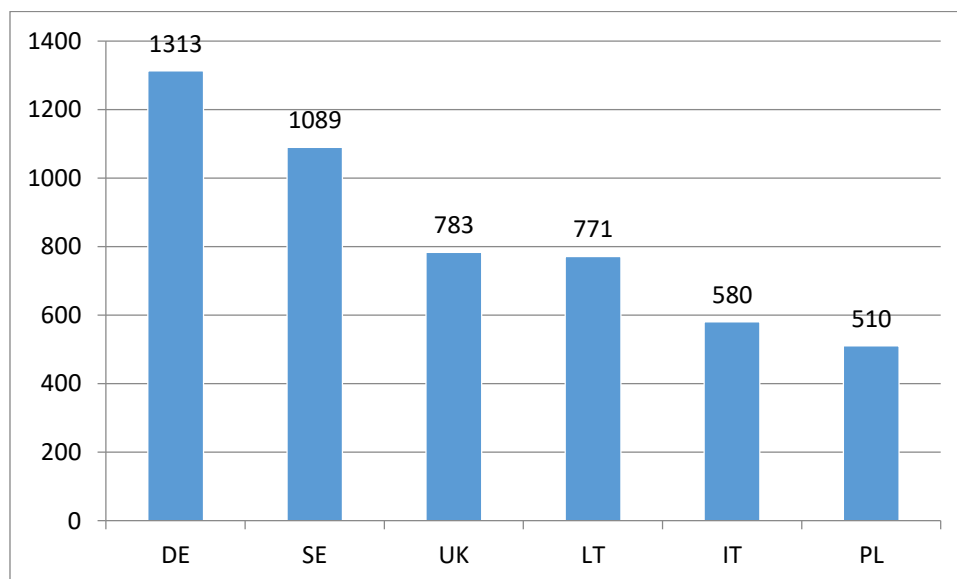


Source: Labour Force Survey, Eurostat.

A more detailed look also reveals very large differences with regard to the number of practicing nurses per 100,000 inhabitants. The value of this indicator was highest in 2017 for Germany and Sweden. The United Kingdom and Lithuania recorded average values, while significantly fewer nurses worked in Italy and Poland. The aging of this professional group should be mentioned as a separate problem. For example, in Poland in 2021 the average age of a nurse was 53 years (NIPiP 2021: 4). At the end of 2019, people over 55 constituted 44.9% of all nurses licensed to practice (CEZ 2020: 32), whereas by the end of 2021, this group already accounted for 50.2% (CEZ 2022: 32).

Aging is also an issue for the long-term care sector. As indicated by Eurofound (2020: 10), 37.9% of workers in this area were over the age of 50, compared to 33.2% on average across all sectors. In addition, a faster increase in the share of this age group has been observed - in 2009 it accounted for 28.1%. At the same time, the share of the youngest workers (aged 15-24) was almost identical to that in the economy as a whole and higher than that in the health care area, which gives grounds for optimism. However, the report's authors point out that young people are more likely to leave their jobs in the sector.

Figure 2. Practicing nurses per 100 thousand inhabitants in 2017



Source: Eurostat.

The detailed statistics concerning employment are provided below. For all countries they are broken down by sex and by age.

Table 1. Employment by sex in NACE 86, 87, 88

	Germany	Italy	Lithuania	Poland	Sweden	UK (2019)
Employment total (thous.)						
NACE 86	3 134,9	1 302,2	84,6	845,8	380,2	2 365,6
NACE 87	1 024,0	313,4	12,4	115,0	192,3	1 015,3
NACE 88	1 611,6	263,6	12,1	171,6	184,5	1 004,2
Female employment (thous.)						
NACE 86	2 406,7	862,0	73,2	672,8	292,8	1 810,0
NACE 87	806,6	248,1	10,9	100,3	140,6	822,9
NACE 88	1 196,8	226,1	11,0	158,0	136,3	783,8
Male employment (thous.)						
NACE 86	728,1	440,2	11,5	173,0	87,4	555,6
NACE 87	217,4	65,2	1,6	14,7	51,7	192,4
NACE 88	414,8	37,5	1,2	13,5	48,2	220,4
Female share in employment (%)						
NACE 86	76.8	66.2	86.5	79.6	77.1	76.6
NACE 87	78.8	79.2	87.9	87.2	73.1	81.0
NACE 88	74.3	85.8	90.1	92.1	73.9	78.1

Notes: aged 15-74, data as of 2022, in the UK as of 2019 (latest available)

Source: calculations based on LFS data [LFSA_EGAN22D]

In health-care (NACE 86) the workforce is most feminised in Lithuania, while in Italy the share of women in employment is the lowest (over 20 percentage points below the level in Lithuania), yet even there male workers still constitute only 1/3 of the labour force in that NACE section. In all the remaining countries in the sample the female share in employment oscillates in the range of 76% to 80%. As far as care services (NACE 87 and 88) are concerned, the two countries from the CEE (Lithuania and Poland) display noticeably higher levels of feminisation in the sectoral employment structures than the Western counterparts, with the gap of over 15 percentage points separating Lithuania from Sweden in NACE 87 and more than 18 percentage points between Poland and Sweden in NACE 88.

Table 2. Employment by age groups in NACE 86, 87, 88

Employment by age group (2022)	Germany		Italy		Lithuania		Poland		Sweden		UK (2019)	
	Thous.	(%)	Thous.	(%)	Thous.	(%)	Thous	(%)	Thous	(%)	Thous.	(%)
NACE 86												
15-24	345,9	11.0	36,0	2.7	3,9	4.6	21,4	2.5	17,9	4.6	150,2	6.3
25-49	1 644,8	52.2	704,0	53.9	37,5	44.1	466,9	54.9	228,6	59.8	1 394,9	58.5
50-64	1 028,2	32.6	498,3	38.2	35,8	42.1	312,5	36.8	113,8	29.8	751,2	31.6
65+	131,7	4.2	67,1	5,2	7,9	9.2	49,1	5.8	22,5	5.8	78,0	3.3
Total	3150,6	100	1305,4	100	85,1	100	849,9	100	382,8	100	2 374,3	100
NACE 87												
15-24	94,8	9.3	10,3	3.3	-	-	-	-	29,8	15.5	102,0	10.0
25-49	515,5	50.3	179,3	57.1	5,0	-	70,8	-	86,0	44.4	523,6	51.5
50-64	390,2	38.0	117,8	37.6	6,3	-	39,2	-	70,7	36.8	354,5	34.8
65+	25,4	2.4	6,2	2.0	-	-	-	-	6,5	3.3	37,1	3,7
Total	1025,9	100	313,6	100	-	-	-	-	193	100	1017,2	100
NACE 88												
15-24	138,5	8.5	11,3	4.3	-	-	-	-	24,2	13.0	85,0	8.4
25-49	874,5	54.2	171,9	65.3	5,7	-	111,3	-	99,6	53.4	569,6	56.4
50-64	541,6	33.5	77,2	29.2	5,0	-	49,2	-	52,4	28.1	313,3	31.0
65+	61,9	3.8	3,2	1.2	-	-	-	-	10,3	5.5	41,6	4.2
Total	1616,5	100	263,6	100	-	-	-	-	186,5	100	1009,5	100

Notes: all (74+ included), data as of 2022, in the UK as of 2019 (latest available), in NACE 87 and 88 data for Lithuania and Poland not available for 15-24 and 65+ brackets

Source: calculations based on LFS data [LFSA_EGAN22D]

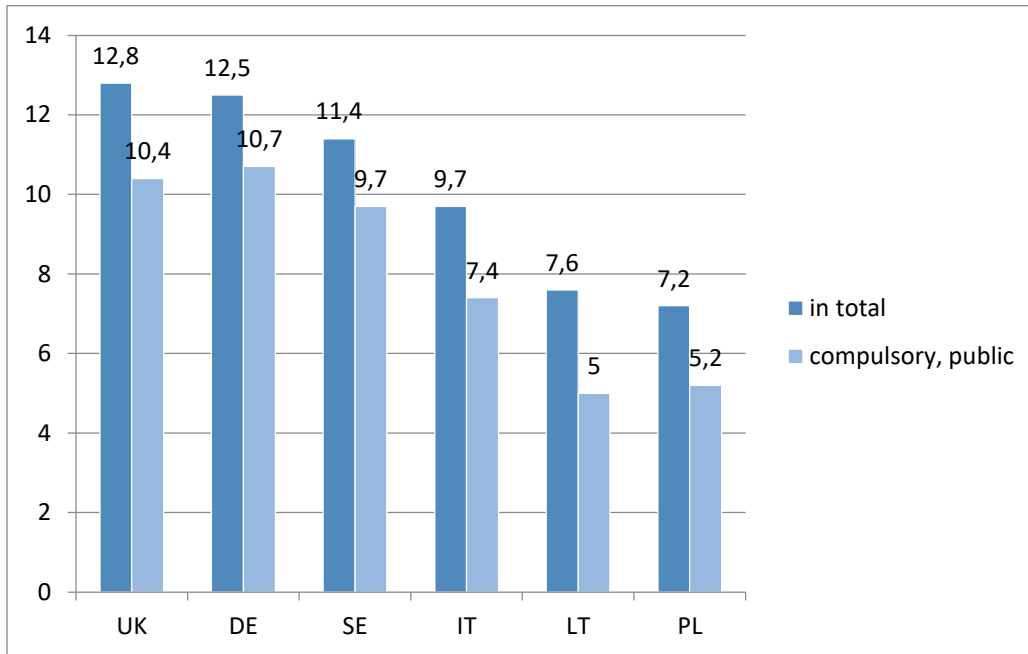
In terms of age structure of the workforce in health-care (NACE 86), Lithuania appears to be in a relatively worse position than the other countries in focus with the lowest level of employees aged 25-49, combined with the highest share of workers between 50 and 64 years as well as those aged over 65, that is already eligible for retirement. In Germany the

significantly higher share of the youngest workers (below 25) is likely due to specificity of the national model of school-to-work transition determined by the dual-education system. Internal proportions of the employment structure by age seem to be the most favourable – regarding sustainability of the human capital in that particular NACE section – in Sweden and the UK, as in each of the two countries employees aged 25-49 constitute around 60% of all, whereas those aged 50-64 form roughly 30% of all. Comparative analysis is complicated for care services (NACE 87 and 88) due to incomplete data for Lithuania and Poland. However, referring to the aggregate data for each section, the estimates could be provided. In NACE 87 in Poland, the share of workers aged 25-49 amounts to roughly 60%, while those aged 50-64 make up for approximately 35%. In Lithuania, the figures could be assessed at 40% and 50%, respectively. As of NACE 88, in Poland the shares for the two age brackets could be estimated at: 65% and 28%, whereas in Lithuania the figures could be assessed at 47% and 41%. For all the remaining countries, the data is complete, so the shares could be calculated precisely. In NACE 87, fractions of workers aged between 50 and 64 are very similar (range between 34.8% to 38%), while the variations seen between the number of employees aged 25 to 49 could be largely explained by difference in the size of the youngest age bracket (15-24). Combining two bottom age classes reveals that in Germany, Italy, Sweden and the UK they constitute around 60% of all the employees. The picture is very much alike in NACE 88, as the size of the 50-64 bracket varies slightly (range between 28.1% and 33.5%), so do the sums of the two youngest age bracket (15-24 and 25-49), which altogether in each of the four countries represent 67.2% (Germany), 69.6% (Italy), 66.4% (Sweden) and 62.8% (UK) of the total labour force in the section.

Healthcare spending

Important information on the situation in the analysed sectors in individual countries is provided by the list of expenditure on them, especially a public part of them. Data on health care expenditure in relation to GDP will be analysed here. Again, significant differences can be observed between the analysed countries. In the UK, Germany and Sweden, public expenditure on this sector is approximately twice as high as in the countries of Central and Eastern Europe, while Italy is situated between these two groups.

Figure 3. Health expenditure as a percentage of GDP in 2020



Source: OECD Database.

Trade union density and collective bargaining coverage

An important factor that may influence the involvement of social partners in interventions in the area of occupational health and safety is the general situation of social dialogue in the analysed sectors. The traditionally shaped systems of collective bargaining and other manifestations of the activity of employee representatives in the area of influencing broadly understood working conditions set the framework for activities in the analysed area, determining the potential of employees' mobilisation and the negotiating power of their representatives. Trade union density and collective bargaining coverage should be considered the main indicators of the situation of social dialogue. Regarding the former, complete data is not available to compare the situation in different countries. Eurofound reports (2022a, 2022b) show significant gaps in data on membership of key unions present in both sectors. A rough picture of the potential of trade unions to act on behalf of workers can be obtained from a comparison of the overall union membership in the economy as a whole. For dependent workers, it ranges from around 10% in Lithuania, through 15% in Poland, 18% in Germany, 26% in the United Kingdom, 35% in Italy, to 70% in Sweden (case).

More comprehensive, even if imprecise, data concern collective bargaining coverage in the analysed sectors and countries. In the case of both sectors, the lowest value of this indicator occurs in Poland, being less than 1% for NACE 87 and 88 and 2% for NACE 86 (Eurofound 2022a). Values for other countries are much higher, reaching even 90 or 100%, especially in the public sector. Table 3 presents the data.

Table 3. Collective bargaining coverage in NACE 86, 87 and 88 in the studied countries

Country	NACE 86	NACE 87, 88
DE	47% (Sectoral CB), 13% (company CB)	more than 90%
IT	100% (public sector), 70-80% (private sector)	between 50 and 89%
LT	60-70%	more than 90%
PL	2%	less than 1%
SE	94%	more than 90%
UK	100% (public sector), 40% (private sector)	more than 90%

Source: Eurofound 2022a, 2022b.

National systems of health and safety employee representation

The way in which the national systems of employee representation in the area of occupational health and safety are organized and how the provisions of Directive 89/391/ EEC have been transposed should have a particularly significant impact on the analysed area.

In **Germany**, the works council (*Betriebsrat*; staff council in the public sector - *Personalrat*) has a crucial role in representing employees on health and safety issues (ETUI). It appoints representatives of the joint health and safety committee and its agreement is required in some areas, such as the appointment of the occupational physician (works doctor). There are also safety specialists (*Fachkraft für Arbeitssicherheit*), who are appointed by the employer. The works council can be established in all workplaces with five or more employees. Additionally, in workplaces with more than 20 employees a health and safety committee (*Arbeitsschutzausschuss*) should be established. This is a joint employer/employee body, which includes two members of the works council/staff council. Finally in workplaces with more than 20 employees there are also safety delegates (*Sicherheitsbeauftragte*), who are appointed by the employer. They are also members of the health and safety committee.

In **Italy**, health and safety representatives are chosen directly by the employees in smaller organisations, and by the existing trade union structures in those with more than 15 employees (ETUI). There is no structure of joint employer/employee safety bodies, other than a meeting with the employer and health and safety staff once a year or when there are major changes. However, Italy does have a structure of local safety representatives who cover smaller companies without their own safety representatives.

In **Lithuania**, companies with at least 50 employees, in accordance with the law, must have elected bipartite joint employee/employer health and safety committee (ETUI) with health and safety responsibilities. Many of the details of how they work – such as the precise number to be elected or their time-off rights – are left to be agreed between employees and employer in the company or should be negotiated as a part of a collective agreement.

In **Poland**, employers are obliged consult with employee representatives, chosen by the union if there is one, on health and safety (ETUI). In companies with more than 250 employees a joint health and safety committee should be set up, and where a union is present, so-called social labour inspectors (*Spoleczny Inspektor Pracy, SIP*) can be elected with some significant entitlements. Legislation does not specify the number of members of the health and safety committee. It should, however, contain an equal number of representatives of the employer and the employees. At the employer's side, employer's occupational health service should be included along with, if there is one, the doctor providing preventative health services to the employees. The employees' representatives should include the SIP.

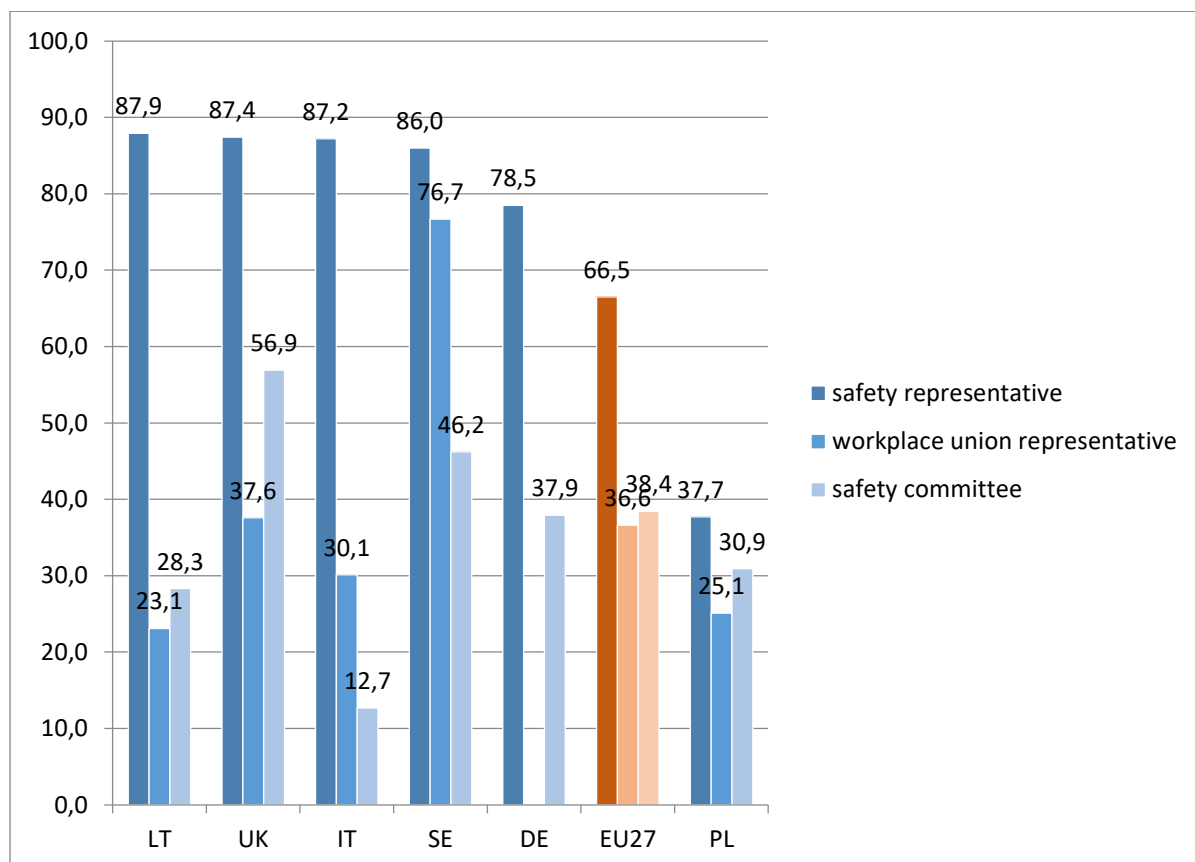
In **Sweden**, the threshold for obligatory establishing a health and safety employee representations is five employees (ETUI). Usually they should be appointed by a trade union. These are the so-called working environment representatives (*arbetsmiljöombud*), although in companies employing at least 50 employees or at the request of the staff a safety committee (*skyddskommitté*) is created. Trade unions have also right to appoint a regional safety representative (*regionalt skyddsombud*) to cover smaller workplaces without a safety committee, where they have members.

In the **UK**, the obligation to establish employee representation is not absolute: if the company does not have a recognized trade union (one with which the employer is negotiating), it is up to the employer to decide whether to appoint workers' representatives for health and safety (ETUI). It may decide that consultations in this area will be conducted directly with employees. Trade union-appointed workers' representatives have more power than non-union-appointed workers: they can conduct inspections and request establishing a safety committee.

The situation of employee representation in the area of occupational health and safety in the research results

According to the results of the last ESENER study (EU-OSHA 2019), the analysed countries differed significantly in terms both of the involvement of employee representation in the field of occupational health and safety and its effectiveness. With regard to the specific form of representation, the presence of workers' representatives for occupational health and safety in the plant is quite common both among the analysed countries and on average in the EU. It is clearly less common only in Poland. Bodies such as safety committees are less widespread - only in the UK, more than half of the respondents declared their presence in the workplace. There are also many of them in Swedish workplaces. In turn, Sweden is the leader in terms of trade union representation, with over 3/4 of the respondents indicating this solution. Apart from that, only in the UK this indicator exceeds 1/3. This solution is not present in Germany, due to the lack of company-level union structures in that country.

Figure 4. Presence of various forms of H&S employee representation in human health and social work activities 2019



Source: European Agency for Safety and Health at Work, ESENER Study 2019 (EU-OSHA 2019).

When asked how often health and safety issues were discussed with the crew or during team meetings, the answer "regularly" was chosen by over 80% of respondents in the studied sectors in the UK and Sweden, approx. 50% in Germany and Italy, 44% in Lithuania and only 36 % in Poland (EU-OSHA 2019). When asked whether the occupational health and safety representatives were provided with training, 98% of respondents in Sweden, 94% in the UK, 88% in Germany, 86% in Italy, 79% in Lithuania and 68% in Poland answered positively. Among units where health and safety issues were discussed with employees, controversy was not very common. They were most often mentioned by respondents from the UK (10%) and Italy (8%), and least often from Poland and Lithuania (no indications in both countries) (EU-OSHA 2019).

Working conditions, health and safety at work

According to the European Industrial Relations Dictionary (2011), “[w]orking conditions refers to the working environment and aspects of an employee’s terms and conditions of employment. This covers such matters as: the organisation of work and work activities; training, skills and employability; health, safety and well-being; and working time and work-life balance”. ILO, in its approach stresses that “generally speaking, working conditions cover a broad range of topics and issues, from working time (hours of work, rest periods, and work schedules) to remuneration, as well as the physical conditions and mental demands that exist in the workplace” (International Labour Organization). While our perspective is not concerned with all the fields mentioned above, it still pertains to such aspects as health and safety, well-being, working time and work-life balance.

Screening of the literature reveals that one of the key correlates to working conditions is job quality. Job quality is a multifaceted concept, which has been tackled from various theoretical perspectives (see: Muñoz de Bustillo et al. 2011)

In the context of our project, it is important to stress out that there is a correlation between low-quality work and health problems workers experience. For example, as Barnay (2016) mentions job strain is associated with a higher propensity to cardiovascular disease, as well as in mental health problems, while high effort–low reward leads to increased cardiovascular risk and psychiatric disorders. Conversely, good jobs and good workplaces have potential to enhance not only workers’ individual health and well-being but also generate positive impact on their social environment beyond work (e.g. at home) (Burgard, Lin 2013).

There is a bulk of literature available on working conditions in health-care. Manyisa and van Aswegen (2017) provide a comprehensive literature review on working conditions in public hospitals, identifying publications concerning **workload** (Cho et al. 2006, Chikanda 2006, Connell et al. 2007, Dielaman et al. 2008, Shirom et al. 2008, Mbindyo et al. 2010, Tomic and Tomic 2008, Holden et al. 2011, Bemelmans et al. 2011), **shiftwork** (Suzuki et al. 2004, Barker et al. 2011, Caruso et al. 2006, Geiger-Brown et al. 2011, Ogińska-Bulik 2006, George and Rhodes 2012, Tomic and Tomic 2008, Lockley et al. 2006, Geiger-Brown et al. 2012, Melchior et al. 2007, Walsh et al. 2010, Mokoka et al. 2011, Rouleau et al. 2012, Thomas and Valli 2006, Lagarde and Blaaw 2011), **long working hours** (Kotzee and Couper 2006, Coovadia et al. 2009, Lockley et al. 2007, Li et al. 2010, Mokoka et al. 2011, Peñaloza et al. 2011), **physical infrastructure** (Schrecker and Labote 2004, Adkoli 2006), **inadequate resources** (Hall 2004, Kuehn 2006, Uebel et al. 2007, Breier et al. 2009) and **shortage of staff in public hospitals** (Schrecker and Laboe 2004, Lagarde and Blaaw 2011, Oosthuizen and Ehlers 2007, Munga et al. 2012, Al-Momani 2008, Rouleau et al. 2012, Lehmann, Dieleman, Martineau 2008). Exposure to contagious diseases is also mentioned, even though it is limited to HIV/AIDS hazards in Africa (Breier et al. 2009, Shisana et al. 2004, Mbindyo et al. 2010, Suzuki et al. 2004, Li et al. 2010, Dielaman et al., 2007, Hansen 2001, Caruso et al. 2006, Barker et al. 2011, Chikanda 2006, Bemelmans et al. 2011, Uebel et al. 2007, Thomas and Valli 2006, Pillay 2009, Taegtmeier et al. 2008, Delobelle et al. 2009, Mbindyo et al. 2009, Barger et al. 2009, Stone et al. 2009). Still it may serve as a valuable point of reference in the context of COVID-19. Similarly earlier outbreaks of the supposed COVID-19 predecessors (SARS and MERS) also attracted some, albeit relatively modest, attention with regard to impact of working conditions in healthcare (e.g. Xiao et al. 2020). There is also a number of publications dealing with job quality in health-care, yet it predominantly concentrates on two key occupational groups, that is physicians and nurses (e.g. Van Ham et al. 2006, Lu et al. 2019).

Resources focused on working conditions in social services seem to be more scattered, supposedly due to greater heterogeneity of the field concerned. However, there is a pool of literature exploring the challenges of emotional work – as Hochschild (1979) defines it – involved in that type of professional activities, which stresses out i.a. high levels of stress and risk of burnout (Lloyd et al. 2002), while, on the other hand, it points out to high potential for job satisfaction that may be derived from such work (Collins 2008). Social workers face high degree risk of violence at work, in large part client-inflicted (Munobwa et al. 2021) but also

related to other features of working environment (Winstanley, Hales 2015). Well-being is stressed as one of the key expectations of social workers delivering services for the elderly as far as working conditions and quality of work are concerned in Lithuania (Naujanienė et al., 2016)

Longitudinal, retrospective study on a giant sample (aggregated sick leave data of 195,100 social workers from four health insurance funds and 3,037 accident claims of social workers from an accident insurance institution were analysed) of social workers in Germany revealed that caregivers in sheltered workshops (besides teachers in residential institutions) were at an increased risk of accidents at the workplace. Accidents were mostly caused by slipping (30%) and by violence (22%) (Wirth et al 2019).

As for home-care workers, there is evidence (collected in Sweden in the early 21st century) that risk factors related to the work system (such as poor ergonomic/lifting conditions, time pressure and lack of professional caring technique) are, alone, strongly related to permanent work disability among home-care worker (Dellve et al. 2003).

There is also evidence indicating that working conditions and labour market characteristics for care workers are influenced by degrees of institutionalisation and regulation of provision of these services which differ across the segments of the labour market: early childhood services are more institutionalised and regulated than in the care services for the elderly. That is reflected i.a. by higher percentage of foreign workers and informal work in the care sector for the elderly (Arlotti et al. 2020).

Impact of privatization and interrelated processes on working conditions

Since the late 1970s, following the paradigmatic political shift towards neo-liberalism, transformation of public sector began (Bognetti, Obermann 2008), marked by ongoing privatization, de-regulation and liberalization thereof. Those processes, despite being interlocked, differ. “While liberalisation refers to the introduction of competition, i.e. the admission of more than one provider for the same service, allowing customers to choose between different suppliers, privatisation involves the transfer of assets from public to private ownership” (Hermann 2010: 128). Deregulation on the other hand refers to reduced role of law and the state (Aalbers 2016).

Those processes would soon be complemented by the rise of New Public Management (NPM), academic theory making remarkable impact on the political practice (and the other way around), leading to ongoing marketization of public services and public sector in general. “New public management is a topical phrase to describe how management techniques from the private sector are now being applied to public services” (Lane 2002: *i*). In Europe, NPM was first implemented in Nordic countries before extending to southern EU countries (Green-Pedersen, 2000), and in the 2000s started advancing further to CEE countries as they were closing the process of EU accession. Paths of NPM implementation varied, mirroring the institutional differentiation of European economies, very much in line with the Varieties of Capitalism (VoC) approach. This was manifested i.a. in “[r]ising insurer competition in Germany, the separation of care delivery and financing in the UK, health care networks in France, and regional delegation in Italy” (Simonet 2011: 823). Yet the common denominator for all was “signal a will to manage health care expenditure more efficiently” (Simonet 2011: 823).

Beyond the USA, it was the UK when the effects of this shift on public services unfolded first. Already in the 1980s, health-care and social services underwent profound market-oriented reforms (Grimmeisen, Frisina 2010). In the 1990s the wave of liberal reforms – promoted not only by the right – but also left-wing parties, swept the European mainland. Health-care was not affected as much as other services of general interest, such as network industries, yet the change was noticeable (Maarse 2006). Marketization of healthcare may take variety of forms, including changes in healthcare financing (private health insurance) and changes in healthcare provision (PPPs, privatization through sales of public hospitals and other facilities, as well as through greenfield investments). “The most radical form of privatisation in healthcare provision is the sale of public hospitals to private investors” (Hermann 2010: 132). In Italy ‘freezing’ of collective bargaining led to decrease in personnel, precarisation of the workforce and under-payment of health workers. Worsening working conditions are attributed also to the 2003 EU working times directive for which a “derogation” was introduced in 2008. This was paired with massive use of short term/agency workers and “socially useful work” (schemes to gain work experience, low cost for the employers). It is estimated that 6.7% of the workforce in the public healthcare sector is employed with non-standard contracts (2009 – 2018) (Vicarelli 2020). Impact of marketization on social services appears to be particularly interesting in case of Sweden, due to a sharp tension the process has caused while being implemented in the country long seen as

epitome of social-democratic welfare state. The process is often described as bringing overtly negative effects to the system (e.g. Andersson, Kvist, 2015). Nevertheless, neo-liberal-oriented public policies, as well as effects of the post-2008 crises also left mark on working life of social workers (Lombardero Posada et al. 2022). Privatisation, is also reported to have derogatory effects not only on workers in social services but, indirectly, also on the recipients of services (see: Marthinsen et al. 2019). There is interesting variety in social acceptance (thus political legitimation) and resistance to privatisation of social care. For instance, Dorigatti et al. (2019) indicate strong opposition of citizens, personnel and trade unions to pure market solutions in the provision of such services, noting, however, less approval (hence more of political reluctance to do so) for privatisation of kindergartens, while services for the elderly were more frequently and less contentiously privatised. Indirectly, privatisation is likely to bring negative effects on occupational work and safety, due to the fact that in case of placing any type of service-providing work in the market context, the recipients tend to position themselves in the role of customers and as such show little willingness to pay for occupational safety and health as it would translate into a higher price in general. Instead, there are expectations that it is the role of the government to bear the costs (Li et al. 2018). On the other hand, there is more responsibility for workplace safety assigned to workers (Grey 2019, Barken et al. 2020), in line with the logic of individualisation of risk.

Health and safety of the groups under scrutiny in the specific working environments

For the sake of clarity, we are interested in specific groups of workers employed in certain types of workplace, as presented in the Table 4.

Table 4. Worker groups and types or workplaces in focus

	Workplaces we are interested in			
Health care workers	Hospitals	Elderly homes	Mobile care workers	Day care centers
Nurses	X	X		X
Ass. Nurses	X	X	X	X
Assistants	X	X		
Temporary staff	X	X		X

Agency staff	X	X	X	
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There are multiple forces posing health risks to workers in the types or workplaces we are looking at. There are embedded in various backgrounds, so we can differentiate among physical, organizational, psychosocial and psychological factors that impact the employee groups under scrutiny.

Nurses (and midwives who are sometimes included in the same category, as well as nursing aides) receive the most extensive coverage in the literature. There is certainly a challenge in locating research publications covering other categories of workers that we are focused on. As for physical challenges of their work, the ones most frequently mentioned are those that concern musculoskeletal disorders (MSDs), which are prevalent among nurses working in hospitals and other all access facilities (Ellapen, Narsigan 2014; Soylar, Ozer 2018), as well as those focused on home care (Carneiro et al 2017). According to the results of the third edition of the 2019 ESENER survey, two-thirds of healthcare workers indicated they had to perform repetitive arm and hand movements in their work, nearly three-fifths had to lift people or heavy loads in their work, and nearly two-fifths worked in tiring or painful positions. The aforementioned problems are considered major factors causing MSDs (EU-OSHA 2020: 3). All three were more prevalent than average in other sectors, with the difference for the first one being negligible, while the other two were at or above 5 percentage points for the healthcare sector. MSDs are, however, attributed to various factors, not only physical workload and unfavourable ergonomics at the workplace (e.g. Serranheira et al 2012) but also less obvious variables such as work-schedules/shift-work (Bazazan et al 2020, Rosa et. al 2019) and psychosocial factors which arguably leave mark on physical health (Bernal et al 2015). The authors of the EU-OSHA (2020) report also note that certain psychosocial factors also indirectly affect the incidence of MSDs. Of these, problems with difficult customers are significantly more frequent than in other sectors - they were declared by more than 4/5 of the respondents, while in the whole less than 3/5. Time pressure is also a frequent factor, hindering the work of almost 3/5 of health care workers and less than 1/2 of representatives of all sectors (EU-OSHA 2020: 3). Therefore, focusing merely on ergonomic risk factors in devising preventive strategies at the workplace may not be sufficient without actions aiming at improving psychosocial work environment (Bernal et al 2015). What cannot be ignored is that lack of proper working conditions for health-care personnel (e.g. not enough sleep) is not only an issue negatively impacting them directly but also hazardous to people in

care (Min et al. 2020, Stimpfel Witkoski et al 2020). Nurses also tend to complain about emotional exhaustion, which is reflected in the statistics on sick-leave (Petersen et al 2023).

Time pressure among employees is also one of the main reasons why it is sometimes difficult for employers to address health and safety issues. This was declared by 41% of respondents in health care against 33% in other sectors (EU-OSHA 2020: 5). The effect of the factors described is the high frequency of complaints about back pain, with 47% of respondents in health care and social assistance indicating this, while higher values were recorded in only three sectors (agriculture, forestry and fishing, water supply and construction) (EU-OSHA 2020: 4).

As home health care (HHC) has been rapidly growing in recent years, working conditions and work-related risks faced by nurses and other home health care providers are now among the major concerns as far as occupational health and safety is considered (Markkanen et al 2017). Among psychological factors, workplace violence experienced both on the hand of fellow workers and patients/service-recipients occupies a significant position in the hierarchy of forces shaping working conditions. Aggression and bullying make definitely a serious issue (Demir, Rodwell 2012; Simons, Sauer 2013, Schablon et al. 2018). Ageing is also a factor of crucial importance as far as well-being of nursing staff is concerned (Utriainen, Kyngäs 2011). Professional burnout of medical staff is a serious issue (e.g. Diehl et al 2020, Diehl et al 2021), yet well-planned preventative actions may help reduce the risk (Pisanti et al 2016). This is also seen among social workers (Frieiro Padín, et al. 2021). Psychosocial risk factors may also contribute to mental health problems among nurses (Freimann, Merisalu 2015), also long-term ones (Roelen et al 2018). All negative experiences may (and do) lead to mental-health related absenteeism (Lamont et al 2017). Social workers working with persons suffering from mental health issues are reported to have been experiencing psychological distress (study conducted in Greece in the post-austerity period) (Karpētis 2015). Social workers suffer from stress which affects not only their work performance but also their well-being (Beer et al. 2021, Gur et al. 2022).

Economic context (budgetary cuts, primarily) is also shown to make impact on social workers in terms of their deteriorating, work-related well-being (Mänttari-van der Kuip 2014). Inadequate working conditions, especially pay, are also highlighted as an important factor affecting social workers (Pentaraki, Dionysopoulou 2019).

COVID-19 and its impact on the groups under scrutiny in the areas of concern

From the onset of the pandemics health-care and social work have been on the fore-front of the battle with the crisis of public health. Thus, work performed in those specific fields has been unanimously regarded as ‘essential’. Due to its social, political and economic significance essential work must be delivered against all odds, which in the age of pandemics bares all discontinuities and contradictions of public services provided under long-time pressure of marketization. It is hardly surprising that working conditions in the two sectors in focus have suffered as a result (Kackin et al 2021). In case of health care the research carried since early 2020 has revealed anxiety of being infected, increased level of stress and lowered sense of workplace security (Gasparro et al 2020; Labrague, de Los Santos 2021). Front-line workers, such as nurses working in respiratory clinical areas have been under unusually high pressure, often unable to effectively cope, thus going through anxiety and depression (Saricam 2020; Roberts et al 2021). Given the fact that the elderly were arguably the age cohort most seriously affected by the pandemics, especially at its early stage, and bearing in mind they are less self-dependent than younger citizens (hence more often under care, either family-provided or institutional), it is hardly surprising that, in particular, in the latter case care-workers were subjected to enormous levels of unbearable physical and psychosocial challenges, and could not cope with some of which in any adequate way (Carter Anand et al. 2022). Addressing those issues, it is recommended in Sweden that “the employers must improve employment security and staff continuity in elderly care and sharply reduce the proportion of staff on zero-hours contracts” (Summary of SOU 2020:80:5).

Growing level of professional burnout is registered, which had been seen already during SARS and MERS pandemics (Magnavita et al. 2021). As a consequence, the numbers of health-care professionals declaring they are pondering quitting their job/occupation has been on the rise (Labrague, de Los Santos 2021). In Germany a large survey study (N= 3678) revealed that “a high percentage of health-care workers demonstrates psychosocial distress” (Morawa et al. 2021). The state of mental health, affecting also physical health of medical workers engaged in battling the effects of the pandemics has also become a serious concern (Zaka et al. 2020, Greenberg et al. 2021). Sleep and Motion Disorders are reported

(Diomidous 2020, Wang et al 2020). As a consequence, the need for mental health care for medical staff and affiliated healthcare workers has been highlighted (Walton et al 2020).

In social services and care work the short-term effects have been examined only so far but their impact appears to be largely negative in physical, psychological as well as economic (losing income) aspects (Atfield et al 2021; Vermeerbergen et al. 2021). In Poland, it has been revealed that long-term care facility (LTCF) staff has been under enormous pressure regarding access to personal protection equipment (PPE) such as facemasks (Senczyszyn et al. 2020). In nursing homes high levels of dissatisfaction and anxiety among nursing home personnel, including financial, psychological, and work-related stressors are reported (Giri et al 2021; Grabowski, Mor 2020). Precarization of work, visible even before the outbreak of COVID, has amplified worries and stress related to inadequate and unstable sources of income (Ladhani et al 2020). COVID-19 pandemics has also barred another – previously often deliberately ignored - aspect of the situation in care work, especially elderly care: significance of migrant workers, often operating in the shadow economy. Lockdowns and restrictions on the freedom of movement affected such workers, not only those coming from outside of the EU (e.g. Ukrainians in Poland) but also engaged in cross-border commuting (like those travelling from Slovakia to Austria, e.g. Leiblfinger et al. 2021) which in effect stroke the service-recipients. It is of utmost importance to remember that care workers, while being unanimously considered ‘essential’ or ‘critical’ workers have not been receiving adequate coverage not only in terms of income and social security protection but also on the level of physical security. While both occupational groups have suffered from depression, anxiety and stress levels, it is health sector employees that have been affected more profoundly than community services employees (Kabasakal et al 2021).

References

- Aalbers, M. B. (2016). Regulated deregulation. In Springer, S., Birch, K., MacLeavy, J., Handbook of neoliberalism, Routledge: 563-573.
- Adkoli, B. V. (2006). Migration of health workers: Perspectives from Bangladesh, India, Nepal, Pakistan and Sri Lanka. *Regional Health Forum*, 10(1), 49–58.
- Al-Momani, M. (2008). Improving nurse retention in Jordanian public hospitals. *Advanced Practice Nursing E-Journal*, 8(4).
- Andersson, K., Kvist, E. (2015). The neoliberal turn and the marketization of care: The transformation of eldercare in Sweden. *European Journal of Women's Studies*, 22(3), 274-287.

- Arlotti, M., Parma, A., Ranci, C., Sabatinelli, S. (2020). Lavoro di Cura. Una nuova frontiera della disuguaglianza sociale, *La Rivista delle Politiche Sociali*, 3, 97-127.
- Atfield, G., Baldauf, B., Kispeter, E. (2021). Mitigating the impacts of COVID-19 Rapid evidence review–Education, childcare and social work and related social care workforce. Warwick Institute for Employment Research. Available from: https://warwick.ac.uk/fac/soc/ier/research/mitigatingimpactsofcovid19/mitigating_the_impact_of_covid_on_the_workforce_ier.pdf [accessed 19 July 2023]
- Barger, L. K., Lockley, S. W., Rajaratnam, S. M. Landrigan, C. P. (2009). Neurobehavioral, health, and safety consequences associated with shift work in safety-sensitive professions. *Current Neurology and Neuroscience Reports*, 9(2), 155–164.
- Barken, R., Denton, M., Brookman, C., Davies, S., Zeytingoglu, IU (2020). Community-based personal support workers’ responses to health and safety risks: tensions between individual and collective responsibility, *International Journal of Care and Caring*, 4(4), 459-478
- Barker, L. M., Nussbaum, M. A. (2011). Fatigue, performance and the work environment: A survey of registered nurses. *Journal of Advanced Nursing*, 67(5).
- Barnay, T. (2016). Health, work and working conditions: a review of the European economic literature. *The European Journal of Health Economics*, 17(6), 693-709.
- Bazazan, A., Dianat, I., Bahrapour, S., Talebian, A., Zandi, H., Sharafkhaneh, A., Maleki-Ghahfarokhi, A. (2020). Association of musculoskeletal disorders and workload with work schedule and job satisfaction among emergency nurses. *International Emergency Nursing*, 44, 8-13.
- Beer, O.W.J., Phillips, R., Quinn, C.R. (2021) Exploring stress, coping, and health outcomes among social workers, *European Journal of Social Work*, 24:2, 317-330.
- Bemelmans, M., van den Akker, T., Pasulani, O., Tayub, N. S., Hermann, K., Mwangomba, B., (2011). Keeping health staff healthy: Evaluation of a workplace initiative to reduce morbidity and mortality from HIV/AIDS in Malawi. *Journal of the International AIDS Society*, 14(1), 1.
- Bernal, D., Campos-Serna, J., Tobias, A., Vargas-Prada, S., Benavides, F. G., Serra, C. (2015). Work-related psychosocial risk factors and musculoskeletal disorders in hospital nurses and nursing aides: a systematic review and meta-analysis. *International journal of nursing studies*, 52(2), 635-648.
- Bognetti, G., Obermann, G. (2008). Liberalization and privatization of public utilities: origins of the debate, current issues and challenges for the future. *Annals of Public and Cooperative Economics*, 79(3-4), 461-485.

Breier, M., Wildschut, A., Mqgolozana, T. (2009). Nursing in a new era: The profession and education of nurses in South Africa. *New England Journal of Medicine*, 351(1), 81–92.

Burgard, S. A., Lin, K. Y. (2013). Bad jobs, bad health? How work and working conditions contribute to health disparities. *American Behavioral Scientist*, 57(8), 1105-1127.

Carneiro, P., Braga, A. C., Barroso, M. (2017). Work-related musculoskeletal disorders in home care nurses: Study of the main risk factors. *International Journal of Industrial Ergonomics*, 61, 22-28.

Carter Anand, J., Donnelly, S., Milne, A. Nelson-Becker, H., Vingare, E., Deusdad, B., Cellini, G., Kinni, R-L, Pregno, C. (2022). The covid-19 pandemic and care homes for older people in Europe - deaths, damage and violations of human rights, *European Journal of Social Work*, 25:5, 804-815.

Caruso, C. C., Bushnell, T., Eggerth, D., Heitmann, A., Kojola, B., Newman, K., (2006). Long working hours, safety, and health: Toward a national research agenda. *American Journal of Industrial Medicine*, 49(11), 930–942.

Centrum e-Zdrowia (CEZ) (2020). *Statistical Bulletin of the Minister Of Health 2020*. Warsaw.

Centrum e-Zdrowia (CEZ) (2022). *Statistical Bulletin of the Minister Of Health 2022*. Warsaw.

Chikanda, A. (2006). Skilled health professionals’ migration and its impact on health delivery in Zimbabwe. *Journal of Ethnic and Migration Studies*, 32(04), 667–680.

Cho, J., Laschinger, H. S., Wong, C. (2006). Workplace empowerment, work engagement and organizational commitment of new graduate nurses. *Nursing Leadership-Academy of Canadian Executive Nurses*, 19(3), 43.

Clark, A., Oswald, A., Warr, P. (1996). Is job satisfaction U-shaped in age?. *Journal of Occupational and Organizational Psychology*, 69(1), 57-81.

Collins, S. (2008). Statutory social workers: Stress, job satisfaction, coping, social support and individual differences. *British Journal of Social Work*, 38(6), 1173-1193.

Connell, J., Zurn, P., Stilwell, B., Awases, M., Braichet, J. (2007). Sub-Saharan Africa: Beyond the health worker migration crisis? *Social Science & Medicine*, 64(9), 1876–1891.

Coovadia, H., Jewkes, R., Barron, P., Sanders, D., McIntyre, D. (2009). The health and health system of South Africa: Historical roots of current public health challenges. *The Lancet*, 374(9692), 817–834.

- Dellve, L., Lagerström, M. Hagberg, M. (2003). Work-system risk factors for permanent work disability among home-care workers: a case-control study. *International Archives of Occupational and Environmental Health*, 76, 216-224.
- Delobelle, P., Rawlinson, J. L., Ntuli, S., Malatsi, I., Decock, R., Depoorter, A. M. (2009). HIV/AIDS knowledge, attitudes, practices and perceptions of rural nurses in South Africa. *Journal of Advanced Nursing*, 65(5), 1061–1073.
- Demir, D., Rodwell, J. (2012). Psychosocial antecedents and consequences of workplace aggression for hospital nurses. *Journal of Nursing Scholarship*, 44(4), 376-384.
- Dieleman, M., Biemba, G., Mphuka, S., Sichinga-Sichali, K., Sissolak, D., van der Kwaak, A., van der Wilt, G. J. (2007). We are also dying like any other people, we are also people: perceptions of the impact of HIV/AIDS on health workers in two districts in Zambia. *Health Policy and Planning*, 22(3), 139–148.
- Diehl, E., Rieger, S., Letzel, S., Schablon, A., Nienhaus, A., Escobar Pinzon, L. C., Dietz, P. (2021). Burdens, resources, health and wellbeing of nurses working in general and specialised palliative care in Germany—results of a nationwide cross-sectional survey study. *BMC Nursing*, 20(1), 1-16.
- Diehl, E., Rieger, S., Letzel, S., Schablon, A., Nienhaus, A., Escobar Pinzon, L. C., Dietz, P. (2020). Health and intention to leave the profession of nursing-which individual, social and organisational resources buffer the impact of quantitative demands? A cross-sectional study. *BMC Palliative Care*, 19, 1-13.
- Dieleman, M., Biemba, G., Mphuka, S., Sichinga-Sichali, K., Sissolak, D., van der Kwaak, A., van der Wilt, G. J. (2007). We are also dying like any other people, we are also people: perceptions of the impact of HIV/AIDS on health workers in two districts in Zambia. *Health Policy and Planning*, 22(3), 139–148.
- Diomidous, M. (2020). Sleep and Motion Disorders of Physicians and Nurses Working in Hospitals Facing the Pandemic of COVID 19. *Medical Archives*, 74(3), 210.
- Dorigatti, L., Mori, A., and Neri, S. (2019) Public, Private or Hybrid? Providing care services under austerity: the case of Italy, *International Journal of Sociology and Social Policy*, 40(11): 1279-1300.
- Ellapen, T. J., Narsigan, S. (2014). Work related musculoskeletal disorders among nurses: systematic review. *Journal of Ergonomics*, 4, 1-6.
- European Industrial Relations Dictionary (2011), Working conditions. Available from: <https://www.eurofound.europa.eu/observatories/eurwork/industrial-relations-dictionary/working-conditions> [accessed 19 July 2023]

ETUI (undated). National Industrial Relations Country profiles. Available from: www.worker-participation.eu/National-Industrial-Relations/Countries [accessed 19 July 2023].

Eurofound (2020), *Long-term care workforce: Employment and working conditions*. Publications Office of the European Union. Luxembourg.

Eurofound (2022a), *Representativeness of the European social partner organisations: Human health sector*, Sectoral social dialogue series, Dublin.

Eurofound (2022b), *Representativeness of the European social partner organisations: Local and regional government sector and social services*, Sectoral social dialogue series, Dublin.

EU-OSHA (2019). ESENER Study results. Available from: <https://visualisation.osha.europa.eu/esener/en/survey/overview/2019> [accessed 19 July 2023]

EU-OSHA (2020). *Musculoskeletal disorders in the healthcare sector. Discussion Paper*. Available from: https://osha.europa.eu/sites/default/files/Discussion_paper_MSDs_in_health_care_sector.pdf [accessed 19 July 2023]

EU-OSHA (2022). *Human health and social work activities – evidence from the European Survey of Enterprises on New and Emerging Risks (ESENER). Report*, Luxembourg.

Freimann, T., Merisalu, E. (2015). Work-related psychosocial risk factors and mental health problems amongst nurses at a university hospital in Estonia: a cross-sectional study. *Scandinavian journal of public health*, 43(5), 447-452.

Frieiro Padín, P., Verde-Diego, C., Fernández Arias, T., González-Rodríguez, R. (2021). Burnout in Health Social Work: an international systematic review (2000–2020), *European Journal of Social Work*, 24:6, 1051-1065.

Gasparro, R., Scandurra, C., Maldonato, N.M., Dolce, P., Bochicchio, V., Valletta, A. (2020) Perceived job insecurity and depressive symptoms among Italian dentists: The moderating role of fear of COVID-19. *International journal of environmental research and public health*, 17(15), 1-12.

Geiger-Brown, J., Rogers, V.E., Trinkoff, A. M., Kane, R. L., Bausell, R. B., Scharf, S.M. (2012). Sleep, sleepiness, fatigue, and performance of 12-hour-shift nurses. *Chronobiology International*, 29(2), 211–219.

Geiger-Brown, J., Trinkoff, A., Rogers, V. E. (2011). The impact of work schedules, home, and work demands on self-reported sleep in registered nurses. *Journal of Occupational and Environmental Medicine*, 53(3), 303–307.

George, G., Rhodes, B. (2012). Is there really a pot of gold at the end of the rainbow? Has the occupational specific dispensation, as a mechanism to attract and retain health workers in South Africa, leveled the playing field? *BMC Public Health*, 12(1), 613.

Giri, S., Chenn, L. M., Romero-Ortuno, R. (2021). Nursing homes during the COVID-19 pandemic: a scoping review of challenges and responses. *European Geriatric Medicine*, 12(6), 1127-1136.

Green-Pedersen, C. (2002). New public management reforms of the Danish and Swedish welfare states: The role of different social democratic responses. *Governance*, 15(2), 271-294.

Greenberg, N., Weston, D., Hall, C., Caulfield, T., Williamson, V., Fong, K. (2021). Mental health of staff working in intensive care during COVID-19. *Occupational Medicine*, 71(2), 62-67.

Grey, G. (2019) The responsabilisation strategy of health and safety: Neo-liberalism and the reconfiguration of responsibility for risk, *The British Journal of Criminology*, 49(3) 326-342.

Grimmeisen, S., Frisina, L. (2010). The Role of the State in the British Healthcare System—Between Marketization and Statism. *The State and Healthcare*, 75-118.

Grabowski, D. C., Mor, V. (2020). Nursing home care in crisis in the wake of COVID-19. *Jama*, 324(1), 23-24.

Gur, A., Shenaar-Golan, V, Cohen, A. (2022) Stress, sense of meaningful work, and well-being among social workers during Covid-19, *European Journal of Social Work*, 25:5, 840-854.

Hall, E. J. (2004). The challenges HIV/AIDS poses to nurses in their work environment. Centre for health policy. *HIV/AIDS in the workplace. Symposium proceedings* (pp. 109–122). Johannesburg: University of the Witwatersrand.

Hansen, J. (2001). Increased breast cancer risk among women who work predominantly at night. *Epidemiology*, 12(1), 74–77.

Hermann, C. (2010). The marketisation of health care in Europe. *Socialist Register*, 46.

Hochschild, A. R. (1979). Emotion work, feeling rules, and social structure. *American Journal of Sociology*, 85(3), 551-575.

Holden, R. J., Scablon, M. C., Patel, N. R., Kaushal, R., Escoto, K. H., Brown, R. L., et al. (2011). A human factors framework and study of the effect of nursing workload on patient safety and employee quality of working life. *BMJ Quality & Safety*, 20 (1), 15–24.

International Labour Organization (undated). Working conditions. Available from: <https://www.ilo.org/global/topics/working-conditions/lang--en/index.htm> [accessed 19 July 2023]

- Kabasakal, E., Özpulat, F., Akca, A., Özcebe, L. H. (2021). Mental health status of health sector and community services employees during the COVID-19 pandemic. *International Archives of Occupational and Environmental Health*, 94, 1249-1262.
- Kackin, O., Ciydem, E., Aci, O. S., Kutlu, F. Y. (2021). Experiences and psychosocial problems of nurses caring for patients diagnosed with COVID-19 in Turkey: A qualitative study. *International Journal of Social Psychiatry*, 67(2), 158-167.
- Kalleberg, A.L., Reskin B.F., Hudson, K. (2000). Bad jobs in America: Standard and nonstandard employment relations and job quality in the United States. *American Sociological Review*, 256-278.
- Karpetis, G. (2015). Psychological distress among mental health social workers, *European Journal of Social Work*, 18:5, 745-755.
- Kotzee, T., Couper, I. (2006). What interventions do South African qualified doctors think will retain them in rural hospitals of the Limpopo Province of South Africa? *Rural and Remote Health*, 6(3), 581.
- Labrague, L. J., de Los Santos, J. A. A. (2021). Fear of Covid-19, psychological distress, work satisfaction and turnover intention among frontline nurses. *Journal of Nursing Management*, 29(3), 395-403.
- Ladhani, S. N., Chow, J. Y., Janarthanan, R., Fok, J., Crawley-Boevey, E., Vusirikala, A. (2020). Increased risk of SARS-CoV-2 infection in staff working across different care homes: enhanced CoVID-19 outbreak investigations in London care Homes. *Journal of Infection*, 81(4), 621-624.
- Lagarde, M., Blaauw, D. (2009). A review of the application and contribution of discrete choice experiments to inform human resources policy interventions. *Human Resources for Health*, 7(1), 62.
- Lamont, S., Brunero, S., Perry, L., Duffield, C., Sibbritt, D., Gallagher, R., Nicholls, R. (2017). 'Mental health day' sickness absence amongst nurses and midwives: workplace, workforce, psychosocial and health characteristics. *Journal of Advanced Nursing*, 73(5), 1172-1181.
- Lane, J. E. (2002). *New public management*. Routledge.
- Lehmann, U., Dieleman, M., & Martineau, T. (2008). Staffing remote rural areas in middle- and low-income countries: A literature review of attraction and retention. *BMC Health Services Research*, 8(1), 19.
- Leiblfinger, M., Prieler, V., Rogoz, M., Sekulová, M. (2021). Confronted with COVID-19: Migrant live-in care during the pandemic. *Global Social Policy*, 21(3), 490-507.

- Li, J., Fu, H., Hu, Y., Shang, L., Wu, Y., Kristensen, T.S. (2010). Psychosocial work environment and intention to leave the nursing profession: Results from the longitudinal Chinese NEXT study. *Scandinavian Journal of Public Health*, 38(3), 69–80.
- Li, S., Chen, H., Huang, X., Long, R. (2018). Who Has Higher Willingness to Pay for Occupational Safety and Health?—Views from Groups with Different Public Identities and Differences in Attention, *International Journal of Environmental Research and Public Health*, 15, 1667
- Lloyd, C., King, R., Chenoweth, L. (2002). Social work, stress and burnout: A review. *Journal of Mental Health*, 11(3), 255-265.
- Lockley, S.W., Evans, E. E., Scheer, F. A., Brainard, G.C., Czeisler, C.A., Aeschbach, D. (2006). Short-wavelength sensitivity for the direct effects of light on alertness, vigilance, and the waking electroencephalogram in humans. *Sleep*, 29(2), 161-168.
- Lombardero Posada, X.M., Aguiar Fernández F.X., Murcia Álvarez. E., Méndez Fernández, A.B., González Fernández, A. (2022). Effects of crises and neoliberalism on Spanish social workers: coping with meaningfulness, dissatisfaction, and withdrawal, *European Journal of Social Work*, 25:5, 894-908.
- Lu, H., Zhao, Y., While, A. (2019). Job satisfaction among hospital nurses: A literature review. *International Journal of Nursing Studies*, 94, 21-31.
- Maarse, H. (2006). The privatization of health care in Europe: an eight-country analysis. *Journal of Health Politics, Policy and Law*, 31(5), 981-1014.
- Mache, S., Vitzthum, K., Nienhaus, A., Klapp, B.F., Groneberg, D.A. (2009). Physicians' working conditions and job satisfaction: Does hospital ownership in Germany make a difference? *BMC Health Services Research*, 9(1), 1-9.
- Manyisa, Z. M., van Aswegen, E. J. (2017). Factors affecting working conditions in public hospitals: A literature review. *International Journal of Africa Nursing Sciences*, 6, 28-38.
- Marchal, B., Brouwere, V.D., Kegels, G. (2005). Viewpoint: HIV/AIDS and the health workforce crisis: What are the next steps? *Tropical Medicine & International Health*, 10(4), 300–304.
- Markkanen, P., Galligan, C., Quinn, M. (2017). Safety risks among home infusion nurses and other home health care providers. *Journal of Infusion Nursing*, 40(4), 215.

- Marthinsen, E, Juberg, A., Skjefstad, N.S., Garrett, P.M. (2019). Social work and neoliberalism: the Trondheim papers, *European Journal of Social Work*, 22:2, 183-187.
- Mänttari-van der Kuip, M. (2014) The deteriorating work-related well-being among statutory social workers in a rigorous economic context, *European Journal of Social Work*, 17:5, 672-688.
- Mbindyo, P., Gilson, L., Blaauw, D., English, M. (2009). Contextual influences on health worker motivation in district hospitals in Kenya. *Implementation Science*, 4(1), 43.
- Melchior, M., Caspi, A., Milne, B. J., Danese, A., Poulton, R., Moffitt, T.E. (2007). Work stress precipitates depression and anxiety in young, working women and men. *Psychological Medicine*, 37(8), 1119–1129.
- Min, A., Yoon, Y. S., Hong, H. C., Kim, Y. M. (2020). Association between nurses' breaks, missed nursing care and patient safety in Korean hospitals. *Journal of Nursing Management*, 28(8), 2266-2274.
- Mokoka, K.E., Ehlers, V.J., Oosthuizen, M. J. (2011). Factors influencing the retention of registered nurses in the Gauteng Province of South Africa: Original research. *Curationis*, 34(1), 1–9.
- Morawa, E., Schug, C., Geiser, F., Beschoner, P., Jerg-Bretzke, L., Albus, C., Erim, Y. (2021). Psychosocial burden and working conditions during the COVID-19 pandemic in Germany: The VOICE survey among 3678 health care workers in hospitals. *Journal of Psychosomatic Research*, 144, 1-10.
- Munga, M. A., Kilima, S. P., Mutalemwa, P. P., Kisoka, W. J., Malecela, M. N. (2012). Experiences, opportunities and challenges of implementing task shifting in underserved remote settings: The case of Kongwa district, central Tanzania.
- Muñoz de Bustillo, R., Fernández-Macías, E., Esteve, F., Antón, J. I. (2011). E pluribus unum? A critical survey of job quality indicators. *Socio-Economic Review*, 9(3), 447-475.
- Mwagomba, B., Bemelmans, M., Van Den Akker, T., Pasulani, O., Tayub, S.N., Hermann, K., Philips, M. (2011). Keeping health staff healthy: evaluation of a workplace initiative to reduce morbidity and mortality from HIV/AIDS in Malawi. *Journal of the International AIDS Society*, 14(1), 1-7.
- Naujaniėnė, R., Motieėienė, R., Mažeikienė, N., Varžinskienė L., Ruškus J. (2016). Socialinių institucijų vadyba. Organizacijos kultūra, tikslai ir vertybės: socialines paslaugas senyvo amžiaus žmonėms teikiančių įstaigų personalo perspektyva, *Socialinė Teorija, Empirija, Politika Ir Praktika*, 12, 90-105.

- Ogińska-Bulik, N. (2006). Occupational stress and its consequences in healthcare professionals: the role of type D personality. *International Journal of Occupational Medicine and Environmental Health*, 19(2), 113–122.
- Oosthuizen, M., Ehlers, V. (2007). Factors that may influence South African nurses' decisions to emigrate. *Health SA Gesondheid*, 12(2), 14–26.
- Oulton, J.A. (2006). The global nursing shortage: an overview of issues and actions. *Policy, Politics & Nursing Practice*, 7(3), 34S–39S.
- Peñaloza, B., Pantoja, T., Bastías, G., Herrera, C., Rada, G. (2011). Interventions for controlling emigration of health professionals from low and middle-income countries September 2011. *Cochrane Database Systematic Review*, 9.
- Pentarakis, M., Dionysopoulou, K. (2019) Social workers: a new precariat? Precarity conditions of mental health social workers working in the non-profit sector in Greece, *European Journal of Social Work*, 22:2, 301-313.
- Petersen, J., Wendsche, J., Melzer, M. (2023). Nurses' emotional exhaustion: Prevalence, psychosocial risk factors and association to sick leave depending on care setting—A quantitative secondary analysis. *Journal of Advanced Nursing*, 79(1), 182-193.
- Pillay, R. (2009). Work satisfaction of professional nurses in South Africa: A comparative analysis of the public and private sectors. *Human Resources for Health*, 7(1), 5.
- Pisanti, R., van der Doef, M., Maes, S., Meier, L.L., Lazzari, D., Violani, C. (2016). How changes in psychosocial job characteristics impact burnout in nurses: a longitudinal analysis. *Frontiers in Psychology*, 7, 1082.
- Roelen, C. A., van Hoffen, M. F., Waage, S., Schaufeli, W. B., Twisk, J. W., Bjorvatn, B. Pallesen, S. (2018). Psychosocial work environment and mental health-related long-term sickness absence among nurses. *International archives of occupational and environmental health*, 91(2), 195-203.
- Rosa, D, Terzoni, S, Dellafiore, F, Destrebecq, A (2019). Systematic review of shift work and nurses' health. *Occupational Medicine*, 69(4).
- Rouleau, D., Fournier, P., Philibert, A., Mbengue, B., Dumont, A. (2012). The effects of midwives' job satisfaction on burnout, intention to quit and turnover: A longitudinal study in Senegal. *Human Resource Health*, 10(1), 9.
- Saricam, M. (2020). COVID-19-Related anxiety in nurses working on front lines in Turkey. *Nursing and Midwifery Studies*, 9(3), 178-178.
- Schablon, A., Wendeler, D., Kozak, A., Nienhaus, A., Steinke, S. (2018). Prevalence and consequences of aggression and violence towards nursing and care staff in Germany—A

survey. *International journal of environmental research and public health*, 15(6), 1274.

Schrecker, T., Labonte, R. (2004). Taming the brain drain: a challenge for public health systems in Southern Africa. *International Journal of Occupational and Environmental Health*, 10(4), 409–415.

Senczyszyn, A., Lion, K. M., Szcześniak, D., Trypka, E., Mazurek, J., Ciulkowicz, M. Rymaszewska, J. (2020). Mental health impact of SARS-COV-2 pandemic on long-term care facility personnel in Poland. *Journal of the American Medical Directors Association*, 21(11), 1576-1577.

Serranheira, F., Cotrim, T., Rodrigues, V., Nunes, C., Sousa-Uva, A. (2012). Nurses' working tasks and MSDs back symptoms: results from a national survey. *Work*, 41(1), 2449-2451.

Shirom, A., Nirel, N., Vinokur, A. D. (2010). Work hours and caseload as predictors of physician burnout: The mediating effects by perceived workload and by autonomy. *Applied Psychology: An International Review*, 59(4), 539–565.

Shisana, O., Stoker, D., Simbayi, L. C., Orkin, M., Bezuidenhout, F., Jooste, S. E., Van Zyl, J. (2004). South African national household survey of HIV/AIDS prevalence, behavioural risks and mass media impact-detailed methodology and response rate results. *South African Medical Journal*, 94(4), 283-288.

Simonet, D. (2011). The new public management theory and the reform of European health care systems: An international comparative perspective. *International Journal of Public Administration*, 34(12), 815-826.

Simons, S., Sauer, P. (2013). An exploration of the workplace bullying experience: Coping strategies used by nurses. *Journal for nurses in professional development*, 29(5), 228-232.

Songstad, N. G., Rekdal, O. B., Massay, D. A. Blystad, A. (2011). Perceived unfairness in working conditions: The case of public health services in Tanzania. *BMC Health Services Research*, 11(34), 1–15.

Soylar, P., Ozer, A. (2018). Evaluation of the prevalence of musculoskeletal disorders in nurses: a systematic review. *Med Sci*, 7(3), 479-85.

Stimpfel, A.W., Fatehi, F., Kovner, C. (2020). Nurses' sleep, work hours, and patient care quality, and safety. *Sleep Health*, 6(3), 314-320.

Stone, P.W., Mooney-Kane, C., Larson, E.L., Horan, T., Glance, L.G., Zwanziger, J., (2007). Nurse working conditions and patient safety outcomes. *Medical Care*, 45(6), 571–578.

Summary of SOU (2020), Elderly care during the pandemic, 80. Available from: <https://www.government.se/legal-documents/2020/12/summary-of-sou-202080-elderly-care-during-the-pandemic/> [accessed 19 July 2023]

Supreme Chamber of Nurses and Midwives (NIPiP) (2021). Staffing disaster of nurses and midwives. report of the Supreme Chamber of Nurses and Midwives. Warsaw: NIPiP. Available from: https://nipip.pl/wp-content/uploads/2021/09/2021-09-06_Raport_NIPiP_KRAJ.pdf.

Suzuki, K., Ohida, T., Kaneita, Y., Yokoyama, E., Miyake, T., Harano, S., (2004). Mental health status, shift work, and occupational accidents among hospital nurses in Japan. *Journal of Occupational Health*, 46(6), 448–454.

Sverke, M., Hellgren, J., Näswall, K. (2006). Job insecurity: A literature review. Stockholm: Arbetslivsinstitutet.

Taegtmeier, M., Suckling, R., Nguku, P., Meredith, C., Kibaru, J., Chakaya, J. M., (2008). Working with risk: Occupational safety issues among healthcare workers in Kenya. *AIDS Care*, 20(3), 304–310.

Thomas, L. S., Valli, A. (2006). Levels of occupational stress in doctors working in a South African public-sector hospital. *South African Medical Journal Forum*, 96 (11), 1162–1168.

Tomic, W., Tomic, E. (2008). Existential fulfillment and burnout among principals and teachers. *Journal of Beliefs & Values*, 29(1), 11–27.

Uebel, K. E., Nash, J., Avalos, A. (2007). Caring for the caregivers: Models of HIV/AIDS care and treatment provision for health care workers in Southern Africa. *The Journal of Infectious Diseases*, 196(3), 500–504.

Utriainen, K., Kyngäs, H. (2011). Ageing hospital nurses' well-being at work: psychometric testing of the Dignity and Respect in Ageing Nurses' Work Scale. *Scandinavian Journal of Caring Sciences*, 25(3), 617-624.

van der Colff, J., Rothmann, S. (2009). Occupational stress, sense of coherence, coping, burnout and work engagement of registered nurses in South Africa. *SA Journal of Industrial Psychology*, 35(1), 1–10.

Van der Hulst, M. (2003). Long workhours and health. *Scandinavian Journal of Work, Environment & Health*, 171-188.

Van Ham, I., Verhoeven, A.A., Groenier, KH., Groothoff, J.W., & De Haan, J. (2006). Job satisfaction among general practitioners: a systematic literature review. *The European Journal of General Practice*, 12(4), 174-180.

Vermeerbergen, L., Pulignano, V., Domecka, M., Jansens, M. (2021). Working hard for the ones you love and care for under COVID-19 physical distancing. *Work, Employment and Society*, 35(6), 1144-1154.

- Vicarelli, G. (2020). La valorizzazione delle risorse umane nel Sistema sanitario nazionale: un principio disatteso. *La Rivista delle Politiche Sociali*, 3, 75-96.
- Walsh, A., Ndubani, P., Simbaya, J., Dicker, P., Brugha, R. (2010). Task sharing in Zambia: HIV service scale-up compounds the human resources crisis. *BMC Health Services Research* (10), 22.
- Walton, M., Murray, ELF., Christian, M.D. (2020). Mental health care for medical staff and affiliated healthcare workers during the COVID-19 pandemic. *European Heart Journal: Acute Cardiovascular Care*, 9(3), 241-247.
- Wang, W., Song, W., Xia, Z., He, Y., Tang, L., Hou, J., Lei, S. (2020). Sleep disturbance and psychological profiles of medical staff and non-medical staff during the early outbreak of COVID-19 in Hubei Province, China. *Frontiers in psychiatry*, 11, 733.
- Winstanley, S., Hales, L. (2015). A preliminary study of burnout in residential social workers experiencing workplace aggression: Might it be cyclical?. *British Journal of Social Work*, 45(1), 24-33.
- Wirth, T., Wendeler, D., Dulon, M., Nienhaus, A. (2019). Sick leave and work-related accidents of social workers in Germany: An analysis of routine data. *International Archives of Occupational and Environmental Health*, 92, 175-184.
- Xiao, J., Fang, M., Chen, Q., He, B. (2020). SARS, MERS and COVID-19 among healthcare workers: A narrative review. *Journal of Infection and Public Health*, 13(6), 843-848.
- Zaka, A., Shamloo, S.E., Fiorente, P., Tafuri, A. (2020). COVID-19 pandemic as a watershed moment: A call for systematic psychological health care for frontline medical staff. *Journal of Health Psychology*, 25(7), 883-887.

CASE STUDIES – NATIONAL LEVEL

Germany (DE), Italy (IT), Lithuania (LT), Poland (PL), Sweden (SE), the UK

CASE STUDY GERMANY HOSPITAL SECTOR

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Introduction

The information provided in this report is based on qualitative primary data (cf. Appendix), supplemented by desk research where necessary.

Sources for health and safety (H&S) regulations

EU legislation comprises the OSH Framework Directive (89/391/EEC) on the introduction of measures to encourage improvements in the safety and health of workers at work and various related directives, such as Directive 2000/54/EC on Biological Agents at Work.

It is important to note that Germany has a federal structure consisting of 16 ‘regional’ federal states known as “Laender”. The field of health and safety in the workplace operates within a dual system, involving both the state (at federal and Laender levels) and the occupational accident insurance funds. While the state provides acts and ordinances, the insurance entities complement these with detailed regulations e.g. on accident prevention. In a joint policy strategy, the Joint German Health and Safety Strategy (GDA – *Gemeinsame Deutsche Arbeitsschutzstrategie*), the federal government, the 16 Laender governments, and the accident insurance funds collaborate on improving and developing the H&S system.

Employees are insured against occupational accidents and diseases through a statutory accident insurance fund, i.e. one of the sectoral occupational accident insurance funds (*Berufsgenossenschaften* for the private sector, *Unfallkassen* for the public sector), whose members are employers. The insurance entities are self-governing bodies, where social partners are equally represented. The system of labour inspections is made up of technical inspectorates by the occupational accident insurance funds and the occupational safety and health inspectorates in the federal states (Laender).

There are various acts, ordinances and rules which are relevant for H&S (non-exhaustive):

- Occupational Safety and Health Act (*Arbeitsschutzgesetz*)
 - basic obligations, e.g. risk assessment, also sets out the organisation of the dual H&S system in Germany
- Occupational Safety Act (*Arbeitssicherheitsgesetz*)

- requires employers to appoint occupational physicians and occupational safety and health professionals
- supplemented by German Social Accident Insurance (DGUV) Regulation 2, the Accident Prevention Regulation on Occupational Physicians and OSH Professionals
- Working Time Act (*Arbeitszeitgesetz*)
- Act on the Protection of Young People at Work (*Jugendarbeitsschutzgesetz*)
- Maternity Protection Act (*Mutterschutzgesetz*)
- Disabled Persons Act (*Schwerbehindertengesetz*), part of Book 9 of the Social Code (*SGB IX*)
- Ordinance on Preventive Occupational Health Care (*Verordnung zur arbeitsmedizinischen Vorsorge*)
- Ordinance on the Use of Personal Protective Equipment (*PSA-Benutzungsverordnung*)
- Handling of Loads Ordinance (*Lastenhandhabungsverordnung*)
- Operational Safety Ordinance (*Betriebssicherheitsverordnung*)
- Workplace Ordinance (*Arbeitsstättenverordnung*)
- Hazardous Substances Ordinance (*Gefahrstoffverordnung*)
- Biological Agents Ordinance (*Biostoffverordnung*)
- Book VII of the Social Code (*SGB VII*)
 - sets out the legal basis for statutory accident insurance

More specific legislation that applies to the sector is Directive 2010/32/EU - prevention from sharp injuries in the hospital and healthcare sector. National regulation impacting the sector include e.g.

- Ordinance on minimum staffing levels in care (*Pflegepersonaluntergrenzenverordnung*)
 - staffing levels in certain “sensitive” areas in hospitals, e.g. cardiology
- Law on relief for care in hospitals (*Krankenhauspflegeentlastungsgesetz*)
 - pilot phase on staffing levels by ward in representatively chosen hospitals

Throughout the duration of the interviews, few specific references to regulations had been made. Most notable among these were the European Framework Directive (89/391/EEC), the above mentioned so called Needlestick Directive (2010/32/EU), and regulations concerning working time, as well as staffing levels.

Role of collective agreements for H&S regulations and workplace H&S representation

The industrial relations system implies a dual structure of employee representation through trade unions and works councils (referred to as staff councils in the public sector). The main level for

collective bargaining is the sectoral level. Collective bargaining on wages and general working conditions takes place between trade unions and employer organisations, or between trade unions and single employers, while multi-employer sectoral bargaining dominates. While health and safety issues are rarely directly addressed in collective agreements, they are indirectly influenced through the establishment of working conditions. In the hospital sector, a public sector agreement exists at the local level (TVöD-K) which has been signed between the public services trade union ver.di and the employer organisation VKA. A new round of negotiations had commenced in February 2023; a collective agreement could be only reached after a process of mediation. ver.di also has collective agreements with individual hospitals and private company groups. In a broader context, interviewees referred to the general public services agreement (TvöD) as the ‘gold standard’ for collective agreements in the sector.

In recent years, the public services trade union ver.di has concluded several agreements with hospitals dealing with overwork/understaffing referred to as “relief” (*Entlastung*). As of March 2023, ver.di has negotiated 24 such collective agreements with larger hospitals to address workload relief (more staff and regulations for additional days off in case of high work load caused by staff shortages) and had been striving for such an agreement to be the first in a private (for profit) university hospital (ver.di, 2023a). In April 2023, the overall 25th and first such agreement in a private (for profit) university hospital could be reached (ver.di, 2023b).

In general, collective agreements only cover H&S-related concerns in a wider sense, such as working time, while core issues of H&S are regulated by law. In that sense, H&S is much more seen as a “legal” and workplace level topic. Sectoral employer organisation, therefore, do not regard H&S as a topic for themselves, but highlight the role of the statutory sectoral occupational insurance (*Berufsgenossenschaft*). This sentiment is also echoed by trade union interviewees. The occupational insurance also provides guidelines e.g. on the safe handling of needles, or how to conduct risk assessments. Trade unions and employers are represented in the occupational insurance structure. All interviewees identified the works council and the local employer to be the relevant actors for deciding and bargaining H&S matters.

In the area of health and safety, works councils hold the right to information, consultation and codetermination rights (e.g. appointment of the occupational physician). They monitor the employer’s compliance with OSH regulations. The rights and duties of works councils are regulated by a separate law (Works Constitution Act – *Betriebsverfassungsgesetz*), which determines a minimum number of five employees to establish a works council. In workplaces with more than 20 employees a joint employer/employee health and safety committee (*Arbeitsschutzausschuss*) should be established, which includes two works council members. Furthermore, there are safety specialists (*Fachkraft für*

Arbeitssicherheit) and, in workplaces with more than 20 employees, also safety delegates (*Sicherheitsbeauftragte*), who are appointed by the employer. These delegates are members of the joint health and safety committee as well.

Works councils may conclude agreements (*Betriebsvereinbarungen*) on H&S-related matters at the company/organisation level. The interviewed persons from both trade union and employer side lack data on such agreements or on the work of health and safety committees. Data from the 2019 ESENER survey indicates that employee representation at the workplace varies for all sectors in Germany. In 73% of establishments, health and safety representatives are present (EU 27 average: 56%), 24% have a health and safety committee (EU 27 average: 22%), and 18% have a works council (EU 27 average: 24%) (EU-OSHA, 2022a). For the human health sector, the data for all EU countries indicates that the density of health and safety representatives is higher compared to all sectors, and that issues of OSH are more often discussed at company level between employee representatives and management. The frequency of discussions in the sector differs between countries, with Germany nearly reaching the EU average (EU-OSHA, 2022b).

National, sectoral industrial relations system

Overall, the number of employees in the health sector increased during the pandemic. However, this increase is below average and has decelerated notably for care staff within hospitals. In 2019, there was an increase in employees of 4.2%, followed by 3.2% in 2020, and a further moderation to 1.4% in 2021 (in terms of full-time equivalents the increase was 3.7 % / 2.7 % / 0,5 %). At the end of 2021, 510,000 care professionals were employed in German hospitals (Destatis, 2023). Over the recent decades, public provision of health care provided by hospitals has increasingly been supplemented by the private sector in Germany (Eurofound, 2021). In 2021, there were 1,887 hospitals with 483,606 beds in Germany. Almost 39% of hospitals are private (for profit), 32% not-for-profit (charity/church), and 29% public. In terms of beds, the public hospitals account for 48%, not-for-profit for 32%, and private (for profit) for 20% (Destatis, 2022). Trade union membership is rather low, partly stemming from a non-union culture in the sector, which is evident not only in the general context but particularly within the church subsector. However, trade union membership in the hospital sector exceeds that in the elderly care sector (Interview 1).

The threefold structure of the sector – private, charity/church, public – introduces a variety of actors, agreement types and regulations, e.g. due to ecclesiastical labour law. This diversity has implications for industrial relations, resulting in a fragmented employers' side. For collective bargaining, the main actors are ver.di on the trade union side (both public, private, charity and church) and on the employers' side, VKA for the public hospital sector. Some of the private hospitals have company

level agreements with ver.di. For instance, as of November 2021, ver.di listed 23 ‘areas of collective bargaining’ in the health and social services sectors, including the public sector, church/charity providers, but also substantial private employers within the hospital sector and rehabilitation facilities (ver.di, 2021). As described in section Role of collective agreements for H&S regulations and workplace H&S representation, H&S is regarded a topic for the local actors at the workplace. However, recent developments include more than 20 collective agreements on “relief” between the trade union ver.di and hospitals. This development (and the public sector collective agreement for early education (TvöD-SuE) which introduced two additional “relief days” off) is observed by the sectoral public employer organisation, but does not interfere with their assessment that such topics should be best solved at the local level in the sector due to the varying circumstances of hospitals. According to Interviewee 2, the administrative burden of such agreements seems to be high.

Interaction between the national/sectoral level and the local level in the field of H&S appears to be limited. On the trade union side, there is an exchange with works councillors, but as mentioned before, neither on the trade union side nor on the employer organisation side, data on works council agreements etc. are collected. Interviewee 5 noted that exchange of works councils’ agreements may lead to lower demands during the initiation of negotiations for such agreements. This could stem from works councils using agreements reached in other hospitals as a foundational reference point. The occupational insurance provides seminars on H&S-related topics, which are also accessible to works councillors. Overall, there is not much systematic information about practices and workplace representation in the field of H&S in the sector.

Quality assessment by the social partners

Sectoral social partners regard H&S as a more “legal” topic than as a topic for industrial relations, and identify local actors (local management, works councils where existing) as the main actors. At the same time, the role of the occupational insurance in providing guidelines, advice, and inspections, is highlighted (cf. section Role of collective agreements for H&S regulations and workplace H&S representation). As one interviewee articulated, there is no regulatory deficit, but rather an implementation deficit (Interview 1). Furthermore, the pandemic’s repercussions included the neglect of non-Covid-19 H&S matters and risk assessments in other areas (Interview 3). Moreover, the pandemic, with a need for quick decisions, led to many unilateral decisions made by management, which continues to affect works councils (Interview 5). Besides that, the main point for improving health and safety is seen in reducing staff shortages. Staff shortages are regarded as the lever to reduce risks, both physical and psychosocial ones, and to improve working conditions impacting H&S. A sufficient financing of the healthcare system is regarded an important framework condition. Whereas the public debate focuses on care professionals, trade unions also point to the situation of other

occupational groups (e.g. service areas). Here, outsourcing of services is seen as a deterioration and as a problem to reach out to employees (Interview 5). Furthermore, agency workers are assessed to be an expensive measure to counter staff shortages, and their integration into existing teams is noted to increase stress levels for the regular staff members (Interview 5).

Quality assessment by the researcher

It is important to note the federal structure of Germany with 16 German Laender. The Laender organize the labour inspections (together with the different occupational accident insurances), resulting in a fragmented and divers monitoring and enforcement system for H&S. Recent data for Germany shows that the number of workplace visits decreased over the years, with a relatively sharp decrease in 2020, attributed to the pandemic (Best & Biniok, 2022). The problem of monitoring and enforcement has also been highlighted by interviewee 7, who noted that there are employers who refuse to fulfil their obligations in H&S matters. Due to the fact that “traditional” H&S is not regarded as a matter for sectoral industrial relations, it is difficult to receive information from sectoral social partners, and cross-level interactions are challenging to detect from that perspective. However, the interlinkage of working conditions (often regulated in collective agreements) and H&S (as a matter for the workplace level beyond ‘ticking the box’ to fulfil legal obligations) seems to gain in importance. Nonetheless, the trends of outsourcing and the expansion of ambulatory healthcare will pose problems for trade unions in terms of reaching out to these smaller workplaces and organizing within the hospital sector.

H&S challenges and how to tackle them

Overall, staff shortages and working conditions have been on the agenda in Germany for years. There have been improvements in pay in the last years (Carstensen, Seibert & Wiethölter, 2022) due to collective agreements and legal regulations, however, working conditions and workload are reported to be bad (DGB-Index Gute Arbeit, 2018). There are staff shortages, and many employees leave the profession after some years. The pandemic has again highlighted these problems. The employment of agency workers has been criticized as expensive and stressful for existing teams. More in general, the sector is characterised by two developments, outsourcing of services and more ambulant services. Both imply smaller workplaces and more fragmentation, which means a challenge for trade unions to organize. Moreover, smaller establishments are less likely to have works councils. Interviewees pointed to the financing system of the hospital sector. While there has been some improvement (e.g. for re-financing staff costs), the financial framework conditions are regarded as difficult.

A recent analysis by the sectoral occupational insurance and the federal pension fund found that the health situation of care workers in hospitals and elderly care has suffered from the pandemic, leading

to reduced job satisfaction. Recommendations include the development of new concepts to increase workers' influence on their working time (BGW & DRV Bund, 2022). In terms of H&S, surveyed care workers in hospital and elderly care, who left the sector or work part time, criticise risk assessments (only on paper, no measures or evaluation) and point to the need to adapt care work to older and ageing staff. Furthermore, respondents express a desire for greater technical support to manage physical demands and increased prevention efforts to address psychological demands (Auffenberg et al., 2022).

Financing of the healthcare system and tackling staff shortages, i.e. recruiting and retaining professional care staff, are regarded crucial framework conditions influencing H&S by the interviewees, especially on the trade union side. Furthermore, not only regarding general physical and psychosocial risks, but also regarding ageing staff, a 'culture of prevention' should be developed in the establishments (Interview 7). Such a culture, e.g. using technical aids, has gained in importance also in apprenticeships. However, as apprentices are the weakest team member it is difficult for them to break up existing routines (Interview 7). Also, an existing culture of presenteeism has been mentioned, which, while providing short term support to colleagues, stabilizes a system with staff shortages and has negative implications for H&S (Interview 3).

EU-level H&S dialogue and regulations

Affiliations with European sectoral social partners are held by ver.di (EPSU) and VKA (HOSPEEM). VKA is a member of the cross-sectoral social partner organisation SGI Europe. An example of EU law mentioned that led to effective protection was the so called Needlestick Directive (cf. section Sources for health and safety (H&S) regulations), which is based on a social partner agreement in the SSDC hospital. Thus, this outcome of SSDC has been highlighted as a good and important one of that SSDC. However, H&S topics in a narrower sense are not so much in the focus of interviewees, but rather topics connected to staff shortages (Interviews 1, 2). On the trade union side, ver.di is engaged both in EPSU and in the sectoral social dialogue committee (SSDC) for the hospital sector and was also involved in the negotiation of the latest joint outcome (May 2022), the updated framework of actions on recruitment and retention.

The interviewee on the employer side noted that the topics at EU level and within the SSDC are all interesting and of importance but are different from the core activity of their association. Therefore, the organisation is more an 'observer' at that level, and there are not many resources in the organisation to deal with the EU level. However, it is highlighted that the exchange, 'to know of each other', is relevant, although national systems are quite different (Interview 2).

Trade union interviewees noted that they would like to see their employer counterpart more often and active at EU level (Interviews 1, 3). Interviewees (1, 2, 3) pointed to more recent changes of staff (policy officers and elected positions) at the EU level social partner organisations, and trade union interviewees viewed the changes on the employer side to potentially hamper the further development of the SSDC hospital. The question of impact of SSDC at national level was regarded important by trade union interviewees. Monitoring is said to be difficult due to organisations' resources and the Commission should be much more supportive here, e.g. in terms of the so-called Needlestick Directive (Interviews 1, 3). The impact of EU regulation in Germany is regarded rather modest 'because we already implement H&S' (Interview 1).

Multilevel coordination

At the national level, social partners are involved e.g. in several committees of the federal ministry of labour and social affairs, as well as in technical committees within the federal institute for occupational safety and health (*baua*). Both trade unions and employers are represented in the occupational insurance framework (see above). Social partner organisations also exchange with other actors and associations in the sector. Furthermore, on the trade union side, officials responsible for hospital and for elderly care exchange regularly. As touched upon earlier, it is difficult to detect coordination of various levels in the field of H&S. Indirectly, H&S might gain in importance for the sectoral level of industrial relations by linking working conditions to H&S (see the newer collective agreements with hospitals on 'relief').

As described in section EU-level H&S dialogue and regulations, there are affiliations to the sectoral EU level social partner organisations, with the trade union side being much more active than the employer side. Beyond the sectoral level, a trade union interviewee also pointed to the need for more transparency and coordination e.g. in EU4Health. Interviewee 3 reflected on the role of EU-OSHA: ideally, there should be more cooperation on the topic of H&S, for instance in the SSDC. The employer interviewee noted that it is important to be aware of developments at EU level that might impact collective bargaining, e.g. new developments around working time. Interviewee 5 assessed the European level to be very far away from works councils. Interviewee 1 noted that it would be good to show practical evidence for workers, e.g. safe needles, to raise positive awareness for the EU level. However, it was also noted that work realities in the sector during the pandemic boosted coordination and visibility of the sector on a European scale (Interview 1).

Appendix

Table of interviews conducted:

#	Organisation	Sector	EU affiliation
1	Trade union	Social services + Hospital sectors	EPSU
2	Employer organisation	Hospital sector	Hospeem
3	Trade union	Hospital sector	EPSU
5	Trade union	Hospital sector	EPSU
7	Occupational accident insurance	Social services + Hospital sectors	-

Interviews were conducted online between April and September 2022 and lasted between 65 and 100 minutes.

References

Auffenberg, J., Becka, D., Evans, M., Kokott, N., Schleicher, S. & Braun, E. (2022) „*Ich pflege wieder, wenn...*“ – Potenzialanalyse zur Berufsrückkehr und Arbeitszeitaufstockung von Pflegefachkräften. Bremen, Arbeitnehmerkammer Bremen.

Best, U. & Biniok, P. (2022) *Aufsicht vor Ort während der Corona-Pandemie: Veränderungen der Besichtigungstätigkeit seit 2010*. Dortmund, baua.

BGW & DRV Bund (2022) *BeGX – Berufsgesundheits-Index Alten- und Krankenpflege. Branchenmonitoring der BGW und DRV Bund – 2022*. Hamburg, BGW.

Carstensen, J., Seibert, H. & Wiethölter, D. (2022) *Entgelt von Pflegekräften. Aktuelle Daten und Indikatoren*. Nürnberg, IAB. Available from: https://doku.iab.de/arbeitsmarktdaten/Entgelte_von_Pflegekraeften_2021.pdf [13th March 2023].

Destatis (2022) Krankenhäuser 2021 nach Trägern und Bundesländern. Stand 26. Oktober 2022. Available from: <https://www.destatis.de/DE/Themen/Gesellschaft-Umwelt/Gesundheit/Krankenhaeuser/Tabellen/eckzahlen-krankenhaeuser.html> [15th March 2023].

Destatis (2023) 2,9 % mehr Beschäftigte im Gesundheitswesen im Jahr 2021. Press release No. 033 of 26th January 2023. Wiesbaden. Available from: https://www.destatis.de/DE/Presse/Pressemitteilungen/2023/01/PD23_033_23526.html [15th March 2023].

DGB-Index Gute Arbeit (2018) *Arbeitsbedingungen in der Alten- und Krankenpflege*. Berlin, DGB/ver.di.

EU-OSHA (2022a) *Third European Survey of Enterprises on New and Emerging Risks (ESENER 2019): overview report*. Luxembourg, Publications Office of the European Union.

EU-OSHA (2022b) *Human health and social work activities – evidence from the European Survey of Enterprises on New and Emerging Risks (ESENER)*. Luxembourg, Publications Office of the European Union.

Eurofound (2021) *Industrial relations landscape in Europe: central government administration, education, human health, local and regional government, and social services sector*. Dublin, Eurofound.

ver.di (2021) Konzerne und Tarifbereiche. Available from: <https://gesundheit-soziales.verdi.de/tarifbereiche> [4th November 2021].

ver.di (2023a) Klinikpersonal entlasten. Verhandlungsbereit – streikbereit. Available from: <https://gesundheit-soziales-bildung.verdi.de/themen/entlastung/++co++d9e735d6-bda8-11ed-907c-001a4a160111> [14th March 2023].

ver.di (2023b) UKGM: Entlastung erreicht. Available from: <https://gesundheit-soziales-bildung.verdi.de/themen/entlastung/++co++854cb8b8-daca-11ed-9aed-001a4a16012a> [14th August 2023].

CASE STUDY GERMANY SOCIAL CARE SECTOR

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Introduction

The information provided in this sector case study is based on qualitative primary data (cf. Appendix), supplemented by desk research where necessary. The focal point of this sector study on the social care sector is elderly care.

Sources for health and safety (H&S) regulations

EU legislation comprises the OSH Framework Directive (89/391/EEC) on the introduction of measures to encourage improvements in the safety and health of workers at work and various related directives, such as Directive 2000/54/EC on biological agents at work.

It is important to note that Germany has a federal structure consisting of 16 “regional” federal states known as “Laender”. The field of health and safety in the workplace operates within a dual system, involving both the state (at federal and Laender levels) and the occupational accident insurance funds. While the state provides acts and ordinances, the insurance entities complement these with detailed regulations e.g. on accident prevention. In a joint policy strategy, the Joint German Health and Safety Strategy (GDA – *Gemeinsame Deutsche Arbeitsschutzstrategie*), the federal government, the 16 Laender governments, and the accident insurance funds collaborate on improving and developing the H&S system.

Employees are insured against occupational accidents and diseases through a statutory accident insurance fund, i.e. one of the sectoral occupational accident insurance funds (*Berufsgenossenschaften* for the private sector, *Unfallkassen* for the public sector), whose members are employers. The insurance entities are self-governing bodies, where social partners are equally represented. The system of labour inspections is made up of technical inspectorates by the occupational accident insurance funds and the occupational safety and health inspectorates in the federal states (Laender).

There are various acts, ordinances and rules which are relevant for H&S (non-exhaustive):

- Occupational Safety and Health Act (*Arbeitsschutzgesetz*)
 - basic obligations, e.g. risk assessment, also sets out the organisation of the dual H&S system in Germany

- Occupational Safety Act (*Arbeitssicherheitsgesetz*)
 - requires employers to appoint occupational physicians and occupational safety and health professionals
 - supplemented by German Social Accident Insurance (DGUV) Regulation 2, the Accident Prevention Regulation on Occupational Physicians and OSH Professionals
- Working Time Act (*Arbeitszeitgesetz*)
- Act on the Protection of Young People at Work (*Jugendarbeitsschutzgesetz*)
- Maternity Protection Act (*Mutterschutzgesetz*)
- Disabled Persons Act (*Schwerbehindertengesetz*), part of Book 9 of the Social Code (*SGB IX*)
- Ordinance on Preventive Occupational Health Care (*Verordnung zur arbeitsmedizinischen Vorsorge*)
- Ordinance on the Use of Personal Protective Equipment (*PSA-Benutzungsverordnung*)
- Handling of Loads Ordinance (*Lastenhandhabungsverordnung*)
- Operational Safety Ordinance (*Betriebssicherheitsverordnung*)
- Workplace Ordinance (*Arbeitsstättenverordnung*)
- Hazardous Substances Ordinance (*Gefahrstoffverordnung*)
- Biological Agents Ordinance (*Biostoffverordnung*)
- Book VII of the Social Code (*SGB VII*)
 - sets out the legal basis for statutory accident insurance

Finally, more specific legislation that applies to the sector is Directive 2010/32/EU - prevention from sharp injuries in the hospital and healthcare sector. National regulation impacting the sector include:

- Ordinance on working conditions in elderly care (*Pflegearbeitsbedingungenverordnung*)
 - including minimum wages in elderly care (developed by the Care Commission)
- Law on the further development of healthcare provision (*Gesundheitsversorgungsweiterentwicklungsgesetz*)
 - From 1 September 2022, ambulant and residential care providers must pay employees in care according to a collective agreement, church pay guideline, or regional level of pay (“tariff compliance”)

Throughout the duration of the interviews, few specific references to regulations had been made. Most notable among these were the European Framework Directive (89/391/EEC), the above

mentioned so called Needlestick Directive (2010/32/EU), and regulations concerning working time, as well as the new regulation on tariff compliance.

Role of collective agreements for H&S regulations and workplace H&S representation

The industrial relations system implies a dual structure of employee representation through trade unions and works councils (referred to as staff councils in the public sector). Collective bargaining on wages and general working conditions takes place between trade unions and employer organisations, or between trade unions and single employers, while multi-employer sectoral bargaining dominates. While health and safety issues are rarely directly addressed in collective agreements, they are indirectly influenced through the establishment of working conditions. Attempts to reach (via extension) a Germany-wide sector collective agreement for elderly care between *ver.di* and *BVAP* failed in 2021 due to the veto of a church employer. There is a public sector agreement for the local level (TVöD-B), however, the public share of the elderly care sector is very small. Since September 2022, a new regulation obliges employers to pay care professionals according to a collective agreement, an ecclesiastical pay guideline or ‘regional pay tariffs’, since they are otherwise not entitled to refunding with the care insurance.

In general, collective agreements only cover H&S-related concerns in a wider sense, such as working time, while core issues of H&S are regulated by law. In that sense, H&S is much more seen as a “legal” and workplace level topic. Sectoral employer organisations, therefore, do not regard H&S as a topic for themselves, but highlight the role of the statutory sectoral occupational insurance (*Berufsgenossenschaft*). This sentiment is also echoed by trade union interviewees. The occupational insurance also provides guidelines e.g. on the safe handling of needles, or how to conduct risk assessments. Trade unions and employers are represented in the occupational insurance structure. All interviewees identified the works council and the local employer to be the relevant actors for deciding and bargaining H&S matters. Interviewee 4 noted that collective agreements on “relief”, which have been concluded with larger hospitals (more staff and regulations for additional days off in case of high work load caused by staff shortages) would be relevant in the elderly care sector, though enforceability would depend on trade union coverage. However, a regional collective agreement with a private employer in the North of Germany regulates additional days off for shift work and night shifts, which is relevant for H&S. Furthermore, another local collective agreement could reach a reduction in working time, indirectly benefiting H&S conditions (Interview 4).

In the area of health and safety, works councils hold the right to information, consultation and codetermination rights (e.g. appointment of the occupational physician). They monitor the employer’s compliance with OSH regulations. The rights and duties of works councils are regulated by a separate

law (Works Constitution Act – *Betriebsverfassungsgesetz*), which determines a minimum number of five employees to establish a works council. In workplaces with more than 20 employees a joint employer/employee health and safety committee (*Arbeitsschutzausschuss*) should be established, which includes two works council members. Furthermore, there are safety specialists (*Fachkraft für Arbeitssicherheit*) and, in workplaces with more than 20 employees, also safety delegates (*Sicherheitsbeauftragte*), who are appointed by the employer. These delegates are members of the joint health and safety committee as well.

Works councils may conclude agreements (*Betriebsvereinbarungen*) on H&S-related matters at the company/organisation level. The interviewed persons from both trade union and employer side lack data on such agreements or on the work of health and safety committees. Data from the 2019 ESENER survey indicates that employee representation at the workplace varies for all sectors in Germany. In 73% of establishments, health and safety representatives are present (EU 27 average: 56%), 24% have a health and safety committee (EU 27 average: 22%), and 18% have a works council (EU 27 average: 24%) (EU-OSHA, 2022a). For the human health sector, the data indicates that the density of health and safety representatives is higher compared to all sectors, and that issues of OSH are more often discussed at company level between employee representatives and management. The frequency of discussions in the sector differs between countries, with Germany nearly reaching the EU average (EU-OSHA, 2022b).

It is important to note, partly due to the structure of the elderly care sector and cultural reasons, that the number of works councils is estimated to be very low (Schroeder, 2018; cf. also section Quality assessment by the social partners). In elderly care, most establishments are rather small. Establishment size has been found to be a predictor for e.g. the frequency of discussing H&S topics in team meetings (EU-OSHA, 2022b) or the existence of (even legally required) measures (Siegel et al., 2021), with better provision in larger establishments. Therefore, the overall situation within the sector can be assumed to be less favourable than in the hospital sector. This sentiment is shared by interviewees based on their experiences.

National, sectoral industrial relations systems

Overall, the number of employees in the health sector increased during the pandemic. However, this growth did not extend to care professionals in the elderly care subsector. In ambulant care there was a decrease of 0.5% from 2019 to 2021, while residential care saw no change in numbers. At the end of 2021, there were 185,000 professionals working in ambulant care, while (partly) residential care employed 244,000 (Destatis, 2023).

In the social services sector/elderly care sector, there are mainly private, charity and church providers. The public share is very small. This diversity has implications for industrial relations, resulting in a fragmented employers' side. The threefold structure of the sector – private, charity/church, public – introduces a variety of actors, agreement types and regulations, e.g. due to ecclesiastical labour law. For collective bargaining, the main actors are the public services trade union *ver.di* and on the employers' side, the employer organisation for charity elderly care (*AGV AWO*) and *BVAP* (see section Role of collective agreements for H&S regulations and workplace H&S representation). The private employers, including organisations like the *bpa Arbeitgeberverband*, are not interested in collective bargaining and social dialogue, as all interviewees agreed (see also Schroeder, Kiepe & Inkinen, 2022).

Trade union membership in elderly care is low and has been estimated at 11%. Historic and cultural reasons, but also the structure of the sector with a big church subsector, are seen as reasons for low trade union membership (Interview 1). Interviewee 1 claims that in the field of both health and social care, *ver.di* is the biggest trade union with almost 400,000 members. The employer organisation interviewed represents charity providers in different sectors (e.g. also care for disabled individuals, early education), with the elderly care subsector playing a substantial role. However, no concrete numbers are available (Interview 6). The organisation has more than 250 members, most of them full members with collective agreement coverage, and there is a trend to full membership (Interview 6). Less than half (433,000) of the overall 1.2 million employees in elderly care are covered by collective agreements (Schroeder, Kiepe & Inkinen, 2022). There is no sectoral collective agreement for the whole elderly care sector, which comprises 30,000 establishments (Interview 4). The share of public establishments/services, which are covered by the public sector agreement, is estimated at 5%. Because church establishments/services normally adhere to the (pay) regulations in the public agreement, the (pay) coverage of establishments/services in that regard is estimated at 30 to 35% (Interview 4). According to interviewee 4, only 1 to 2% of private establishments/providers in the elderly care sector are covered by collective agreements.

Quality assessment by the social partners

Sectoral social partners regard H&S as a more “legal” topic than as a topic for industrial relations, and identify local actors (local management, works councils where existing) as the main actors. However, according to interviewee 4, more than 70 to 80% of establishments do not have a works council and fluctuation among managers is high. This means that ‘sometimes establishments are without director for weeks, and nobody is there to monitor H&S’ (Interview 4). Furthermore, the (sectoral) occupational insurance plays a significant role in the German H&S system, providing

guidelines, advice and inspections (cf. section Role of collective agreements for H&S regulations and workplace H&S representation).

Staff shortages and staffing levels are regarded as central for improving H&S. Interviewee 6 noted that almost all work in the social services sector implies some kind of stress and asked if “relief days” might lead to new stress in the current situation. Therefore, attracting and retaining staff would be most important. A major attraction factor is seen in good working conditions that can be reached through collective agreements – ‘we need a race to the top concerning working conditions’ (Interview 6). The employment of agency workers has been assessed as an expensive measure to deal with staff shortages, accompanied by disruptive team changes (Interview 4). Although staff shortage is discussed most prominently for care workers in elderly care, there are also shortages in the assistant and service areas, which lead to work intensification (Interview 4). All interviewees pointed to the difficult financing framework for the sector. Re-financing collective agreements is difficult, and the process varies across the 16 Laender (Interview 6). Interviewee 4 called for the regulation of binding staff ratios for all occupational groups within the sector.

Interviewees 1, 4 and 6 noted that there is no interest in collective bargaining and social dialogue by the private employer organisations within the sector. From a trade union perspective, there are problems to organize the sector due to care workers’ limited orientation towards trade unions and non-cooperative (private) employers (Interviews 1, 4). According to interviewee 4, social partner autonomy is ineffective in the elderly care sector, and state support is needed. The preferred approach for the trade union side would be the extension of collective agreements instead of ‘tariff compliance’ (cf. section Sources for health and safety (H&S) regulations), which allows the application of other pay tariffs.

Quality assessment by the researcher

It is important to note the federal structure of Germany with 16 German Laender. The Laender organize the labour inspections (together with the different occupational accident insurances), resulting in a fragmented and diverse monitoring and enforcement system for H&S. Recent data for Germany shows that the number of workplace visits decreased over the years, with a relatively sharp decrease in 2020, attributed to the pandemic (Best & Biniok, 2022). The problem of monitoring and enforcement has also been highlighted by interviewee 7, who noted that there are employers who refuse to fulfil their obligations in H&S matters. Due to the fact that “traditional” H&S is not regarded as a matter for sectoral industrial relations, it is difficult to receive information from sectoral social partners, and cross-level interactions are challenging to detect from that perspective. Nonetheless, the interlinkage of working conditions (often regulated in collective agreements) and H&S (as a matter

for the workplace level beyond ‘ticking the box’ to fulfil legal obligations) seems to gain more attention. Yet, both coverage of works councils and collective agreements are weak in the sector. The elderly care sector contend with mounting pressures on working conditions and H&S due to the rise of “financialisation”, with big care companies, often multinational companies, entering the sector and seeking for profit. Moreover, the re-financing framework for the sector leads to a situation where higher pay rates and therefore staffing costs lead to higher fees for patients (as care costs are only partly financed by the insurance).

H&S challenges and how to tackle them

According to the Federal Statistical Office (Destatis, 2021), 65% of workers in elderly care work part time (68 % of females and 44 % of males), which is above the average of all workers (29%). 85% of workers in elderly care are female. Since 2009, the number of workers in the sector rose by 40%. However, the workforce in elderly care is ageing, with 50-59 year old persons being the biggest group (28%). 60 years and above are 11%, while only 2% of the workforce are younger than 20 years old (data for 2019).

Overall, staff shortages, working conditions and work intensification in elderly care have been on the agenda in Germany for years. There have been improvements in pay in the last years (Carstensen, Seibert & Wiethölter, 2022) due to collective agreements and legal regulations, however, working conditions and workload are reported to be bad (DGB-Index Gute Arbeit, 2018). There are staff shortages, a high fluctuation, and many employees leave the profession after some years. The pandemic has again highlighted these problems. This situation is alarming, as Eurostat projections say the number of elderly persons (aged 65 years or more) in the EU will increase by 37 % between 2022 and 2050, which means the share of the elderly in the total population will increase from 21.2 % in 2022 to 29.5 % by 2050 (Eurostat, 2022). A reform of the vocational education aimed at increasing the number of apprentices. However, one of the trade union interviewees feared that the more generalist education might disadvantage the elderly care profession.

A recent analysis by the sectoral occupational insurance and the federal pension fund found that the health situation of care workers in hospital and elderly care has suffered from the pandemic, leading to reduced job satisfaction. Recommendations include the development of new concepts to increase workers’ influence on their working time (BGW & DRV Bund, 2022). In terms of H&S, surveyed care workers in hospital and elderly care, who left the sector or work part time, criticise risk assessments (only on paper, no measures or evaluation) and point to the need to adapt care work to older and ageing staff. Furthermore, respondents express a desire for greater technical support to

manage physical demands and increased prevention efforts to address psychological demands (Auffenberg et al., 2022).

EU-level H&S dialogue and regulations

Affiliations with European sectoral social partners are held by ver.di (EPSU) and AGV AWO (Social Employers). Both organisations are active within the informal social dialogue between EPSU and Social Employers within the social services sector. While ver.di is also active in the “neighbour” EU social dialogue in the hospital sector, AGV AWO is one of the founding members of Social Employers and has been active there from the beginning (Interview 6). Both trade union and employer interviewees expressed their hopes to finally succeed to set up an officially recognised sectoral social dialogue committee (SSDC). For the employer organisation, this could also contribute to attract new members due to the new channels of influence at EU level (Interview 6). The trade union side expected to develop a (pro-)active SSDC with employer side social partners willing to collaborate (Interview 1). On the employer side, emphasis is placed on the existing fruitful joint work with the trade unions within the informal social dialogue (Interview 6). Both trade union and employer interviewees do not expect private employers to enter an officially recognised SSDC due to their missing interest in national-level social dialogue.

An example of EU law that led to effective protection was the so called Needlestick Directive (cf. section Sources for health and safety (H&S) regulations), which is based on a social partner agreement in the hospital SSDC. Thus, this outcome of SSDC has been highlighted as a good or the ‘best’ (Interview 6) outcome of that SSDC, with impacts for elderly care as well. Interviewee 4 explained that in the care profession, there are a lot of regulations to comply with at the establishment level, with various originating from EU directives and regulations – however, ‘no one is aware of where it comes from originally’ (Interview 4). In the yet informal social dialogue at EU level, social partners have worked together in various joint projects, with the main goal being capacity building (Interview 6). Moreover, the social partners have agreed on various joint texts, several of which address H&S-related issues (cf. Appendix). The impact of (forthcoming) EU social dialogue outcomes is expected to be higher in countries where (even) less structures exist than in Germany (Interview 6), or where H&S is not yet implemented (Interview 1).

Multilevel coordination

At the national level, social partners are involved e.g. in several committees of the federal ministry of labour and social affairs, as well as in technical committees within the federal institute for occupational safety and health (*baua*). Both trade unions and employers are represented in the

occupational insurance framework (see above). Social partner organisations also exchange with other actors and associations in the sector. Furthermore, on the trade union side, officials responsible for hospital and for elderly care exchange regularly. As touched upon earlier, it is difficult to detect coordination of various levels in the field of H&S. Indirectly, H&S might gain in importance for the sectoral level of industrial relations by raising awareness to the interlinkage of working conditions and H&S. However, both coverage of works councils at the workplace level and collective agreements at the regional or company level is expected to remain rather weak in the sector (Interview 4).

As described in section EU-level H&S dialogue and regulations, there are affiliations to the sectoral EU level social partner organisations, and both the trade union and the employer side are hoping for the set-up of an official SSDC for the social services sector. Interviewee 4 noted that the European level is gaining practical relevance for the elderly care sector in recent years, mainly due to transnational employers operating within the sector and the emergence of European Works Councils.

Appendix

Table of interviews conducted

#	Organisation	Sector	EU affiliation
1	Trade union	Social services + Hospital sectors	EPSU
4	Trade union	Social services sector	EPSU
6	Employer organisation	Social services sector	Social Employers
7	Occupational accident insurance	Social services + Hospital sectors	-

Interviews were conducted online between April and September 2022 and lasted between 70 and 105 minutes.

Table of joint texts of the informal social dialogue in social services, 2019–2022

2022
The Social Employers and EPSU joint statement on the situation in Ukraine
Joint press release: A big step towards a European sectoral social dialogue committee for social services
Joint Declaration of the Social Services Social Partners. European Care Strategy: strong social dialogue in social services needed
2021
Joint Position Paper on the forthcoming European Care Strategy
Joint statement: The importance of developing social dialogue in the Social Economy
2020
Joint position paper preparing the social services sector for the COVID-19 resurgence and increasing resilience
Joint position paper on recruitment and retention in European social services
Joint letter to Commissioner Schmit calling for action to tackle the lack of protective equipment for some of the most exposed workers: the 11 million social services workers all across Europe
Joint statement on COVID-19 outbreak – The impact on social services and needed support measures
2019
Joint letter to Ms Thyssen on social dialogue – Building social dialogue for the social services sector: Time to move to the next level!
Joint position paper on digitalisation in social services: Assessment of opportunities and challenges

Joint texts in bold address (also) H & S. Own compilation based on social partners' websites.

References

- Auffenberg, J., Becka, D., Evans, M., Kokott, N., Schleicher, S. & Braun, E. (2022) „*Ich pflege wieder, wenn ...*“ – Potenzialanalyse zur Berufsrückkehr und Arbeitszeitaufstockung von Pflegefachkräften. Bremen, Arbeitnehmerkammer Bremen.
- Best, U. & Biniok, P. (2022) *Aufsicht vor Ort während der Corona-Pandemie: Veränderungen der Besichtigungstätigkeit seit 2010*. Dortmund, baua.
- BGW & DRV Bund (2022) *BeGX – Berufsgesundheits-Index Alten- und Krankenpflege. Branchenmonitoring der BGW und DRV Bund – 2022*. Hamburg, BGW.
- Carstensen, J., Seibert, H. & Wiethölter, D. (2022) *Entgelt von Pflegekräften. Aktuelle Daten und Indikatoren*. Nürnberg, IAB. Available from: https://doku.iab.de/arbeitsmarktdaten/Entgelte_von_Pflegekraeften_2021.pdf [13th March 2023].
- Destatis (2021) *Altenpflegekräfte arbeiten sehr häufig in Teilzeit*. Press release No. N068 of 8th December 2021. Wiesbaden. Available from: https://www.destatis.de/DE/Presse/Pressemitteilungen/2021/12/PD21_N068_2313.html [15th March 2023].
- Destatis (2023) *2,9 % mehr Beschäftigte im Gesundheitswesen im Jahr 2021*. Press release No. 033 of 26th January 2023. Wiesbaden. Available from: https://www.destatis.de/DE/Presse/Pressemitteilungen/2023/01/PD23_033_23526.html [15th March 2023].
- DGB-Index Gute Arbeit (2018) *Arbeitsbedingungen in der Alten- und Krankenpflege*. Berlin, DGB/ver.di.
- EU-OSHA (2022a) *Third European Survey of Enterprises on New and Emerging Risks (ESENER 2019): overview report*. Luxembourg, Publications Office of the European Union.
- EU-OSHA (2022b) *Human health and social work activities – evidence from the European Survey of Enterprises on New and Emerging Risks (ESENER)*. Luxembourg, Publications Office of the European Union.
- Eurostat (2022) *Healthcare personnel statistics - nursing and caring professionals*. Data extracted in July 2022. Available from: https://ec.europa.eu/eurostat/statistics-explained/index.php?title=Healthcare_personnel_statistics_-_nursing_and_caring_professionals [16th March 2023].

Schroeder, W. (2018) *Interessenvertretung in der Altenpflege. Zwischen Staatszentrierung und Selbstorganisation*. Wiesbaden, Springer VS.

Schroeder, W., Kiepe, L. & Inkinen, S. (2022) Die Grenzen selbstorganisierten Handelns: attraktive Pflegeberufe durch Tarifautonomie? *WSI-Mitteilungen* 75 (5), 355–362.

Siegel, A., Hoge, A. C., Ehmann, A. T., Martus, P., Rieger, M. A. (2021) Attitudes of company executives toward a comprehensive workplace health management – results of an exploratory cross-sectional study in Germany. *International Journal of Environmental Research and Public Health* 18, 11475. Available from: <https://doi.org/10.3390/ijerph182111475>.

CASE STUDY ITALY HOSPITAL SECTOR

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Main national health and safety (H&S) regulations

The main source of regulation of health and safety in the workplace in Italy is the law.

Starting from the Italian Constitution (1948), articles 32 and 41 include the “right to health understood as an individual and collective interest” and the “freedom to establish economic activity ... with respect to health, environment, safety, freedom and human dignity”.

The Civil Code (1942)’s article 2087 refers to the employer/entrepreneur’s obligation to ensure physical and moral integrity of the workers

The Criminal Code includes various articles (437, 451, 589, 590) which identify criminal responsibilities connected with the employer’s duty to provide and guarantee a healthy workplace.

The Italian reference law for **H&S at work is the Legislative Decree 81/2008** (*Testo Unico sulla Sicurezza sul Lavoro*). This is a “unified text” which systematises existing rules, procedures and prevention practices aimed at safer workplaces. It also broadened the scope of application and strengthened the implementation of the existing Italian H&S law nr. 626 of 1994, which had been the main reference until 2008.

Amongst other things, the law decree 81/2008 has the merit to identify key formal roles within the organisations that are responsible for H&S:

- the responsible for prevention and protection (**RSPP**, *Responsabile Servizio Prevenzione e Protezione*); the person for this role has to be nominated, can be the employer, or an external person, as long as they have the relevant competences and necessary education degrees; training is provided, and certificates of training need to be obtained/updated every five years. The RSPP has to contribute to the planning on H&S in the workplace and is responsible, amongst other things, for the communication to workers about the H&S practices and procedures;
- the workers’ representative (**RLS**, *Rappresentante dei Lavoratori per la Sicurezza*) who can be elected or appointed, also by formally recognised TUs, their name has to

go to Inail and there are 32 hours of training required for the RLS; for smaller workplaces, there is the possibility to ‘share’ a local/area representative for H&S (*RLS territoriale*);

- The occupational health doctor (*medico competente*).

This law establishes the centrality of the “document of the risk evaluation”, which the parties need to draft and share; the duties, responsibilities and sanctions of all parties involved; the centrality of compulsory training for H&S. This law is referred to by all sectoral collective agreements.

All workers are therefore covered by the law 81/2008 on health and safety at work; contracting companies and their workers are included in the specifications of the law; similarly, self-employed are covered.

Other relevant laws for the healthcare sector include:

- Law Decree 230/95 (radio-protection);
- Law Decree 151/01 (protection of working mothers);
- Law Decree 66/02 (night work and shifts work);
- Law Decrees 325/99 and 262/00 (protection of under-age workers);
- Law decree 66/2003 on working time (implementing EU Directive 93/104 CE and 2000/CE).

During the pandemic, particularly at the beginning of it in 2020, there have been several ‘[joint protocols](#)’ to legally regulate the use of equipment, social distancing, access to the premises (e.g. via the so-called “dirty” and “cleaned paths” for hospitals), enhancing of the Intensive Care Unit activity, inter-regional collaboration, management of data regarding vaccinations and test of staff in the healthcare organisations, hospitals, care homes.

The national level institutions and public bodies in charge of the implementation and follow up on all regulations on H&S at work are the **Ministry of Labour**, the **National Labour Inspectorate**, **INAIL** (*Istituto Nazionale Assicurazione contro Infortuni sul Lavoro*) which is the national insurance public body for work-related incidents and disease; and **Spisal** (*Servizio Prevenzione Igiene e Sicurezza negli ambienti di lavoro*) which is part of the local health authorities (ASL) and, like other healthcare-related functions, they are organised at the regional level. They employ technical and specialist staff (engineers, occupational therapists, experts in

toxic risks, etc) who monitor the health and safety environment of existing and new workplaces. The law 81/2008 makes them formally in charge of specific monitoring duties (e.g. they can request documents and inspections to ensure that local workplaces are healthy and compliant with the law).

Although public healthcare provision is organised at the regional level, with different combinations of private, public and religious providers, coordination is ensured via the so-called State-Regions Conference, which sets and monitors minimum standards of care provision and accessibility (Galetto 2016).

H&S and social partner involvement

Looking at the various potential modes of social partners involvement, we can see that social partners play an important role, particularly (potentially) at the organisation level, via the RLS and RSPP.

Most prominent in the past three years has been the consultation between national level social partners (representative union organisations) and the Ministry of Health. During the pandemic H&S “shared protocols” in the healthcare and social and care services (public services, services provided by cooperatives and private providers) were drafted in response to the emergency and as the situation evolved. Social partners have therefore been actively involved in the definition of guidelines in the health sector, which are a formal responsibility of the Ministry of Health.

Collective bargaining is seen as becoming increasingly but indirectly relevant to H&S because it regulates work organisation, working time, team-work, allowances for unsocial hours or activities. These have an impact on the protocols that define the relationship with patients and service users in a way that is safe.

Before the pandemic, there was a discussion about making H&S discussion at the organisational level as matter of dialogue only, whereas in the latest CA renewal (article 8), H&S is back to being matter of organisational CB. This explicitly recognises the role and importance of subjects like working time and stress as directly linked to health and safety and matter of discussion at the organisational level.

The implementation of the law 81/2008 and the control functions are legally attributed to INAIL, the Labour Inspectorate and Spisal. However, in all forms of monitoring, inspectors

will liaise directly with the representatives for H&S in the workplace, which are sometimes workers elected by workers and/or nominated by the trade unions officially present in the organisations.

In some sectors, social partners can contribute to the establishment of national level observatories on health and safety in their sector. This is what happened for example in March 2022 with the ‘Observatory of H&S for healthcare professionals’ in Italy, a tripartite body that includes representatives from the employers, the Ministry of Labour and workers (in the form of both representatives from unions and from relevant professional bodies). The observatory will focus in particular on violence against medical professionals in the workplace (an alarmingly growing phenomenon in emergency rooms in particular).

Another joint body was mentioned in the interviews as being under discussion. This would involve the Ministry of Health, the AGENAS (a scientific and technical body of the Ministry of Health and representing the regional health authorities), the trade unions, the employers' organisations (Aran), the conference State-Regions. Amongst other, one of the objective is a methodology to establish the costs of personnel and personnel needs for every healthcare activity. This will be providing a uniform assessment of human resources needs to all organisations providing healthcare.

Role of collective agreements for H&S regulations and workplace H&S representation

The law is primarily responsible for the definition of rules, procedures and national level institutional roles in charge of the H&S at work. Workplaces in Italy are regulated by a multi-employer system of industrial relations, articulated in two main levels and corresponding collective agreements (CAs): national sectoral level and organisational level. The two levels have distinct roles and areas of competence (demarcation) but the sector level can also ‘delegate’ to the company level competence to regulate on specific subjects (Paolucci and Galetto 2020). The latest public healthcare sector collective agreement was renewed in 2022 for nurses and healthcare allied professions. Although this is a delayed renewal – it covers the years 2019-2021 – it is an important agreement that comes after years of collective bargaining and hiring freeze, and was therefore welcome by all parties involved. The 2022 CA renewal was signed by ARAN (National Bargaining Agency for the public sector) for the employer side and the representative union organisations FP Cgil, CISL FP, UIL FPL, FIALS, NURSIND and NURSING UP.

Traditionally, CAs do not directly intervene in regulating H&S and instead refer to the law 81/2008. CAs also confirm that the organisational level is responsible for implementing the guidelines of H&S at work. The latest CA renewal in 2022 relaunched the “Bipartite body for innovation” (art. 8, point 2), which was established in a sector CA signed before the pandemic, but which had limited follow up. This body, the CA establishes, should be set up in every organisation (hospital/local health authority) with the aim to promote ‘organisational wellbeing’, by discussing, studying and making recommendations to be implemented via local collective bargaining around the prevention of burnout, occupational diseases, better organisation of work in particular for older workers, training needs, etc.

CAs allow organisational level representatives for H&S to request adjustments if specific needs/risks arise. Social partners can, therefore, play an important role both at national and local level.

National, sectoral industrial relations systems

Industrial relations in the public healthcare sector follow the IR framework of the broader public sector. A key difference with the private sector is that only unions that reach a threshold of representativeness (5% as the average between membership and votes at the local elections) can negotiate at the national level with Aran, the bargaining agency of the state-as-employer.

The national sector collective agreement for the public healthcare and hospital staff (excluding doctors) was renewed in 2022 by ARAN and workers’ unions FP Cgil, CISL FP, UIL FPL, FIALS, NURSIND and NURSING UP. Of these organisations, only FP Cgil and Cisl FP are affiliated to EPSU; ARAN is a longstanding member of HOSPEEM and these three were interviewed as part of the HEROS project. Additionally, an interview was carried out with a labour inspector based in Lombardy.

There are two other collective agreements that cover private healthcare and religious healthcare providers. In terms of number of employees covered, the main one is the public healthcare CA, which covers about 600,000 healthcare staff (nurses and healthcare allied professions).

Quality assessment by the social partners

As mentioned, CAs allow organisational level representatives for H&S to request adjustments if specific needs/risks arise. Social partners can, therefore, play a role both at national and local

level. However, as it emerged in the interviews, this is not always easy. All parties interviewed agree that the existing law on H&S is solid, very detailed and wide-reaching (“In the law, you find everything you need”), but there was general agreement also on the fact that there are limits to the effective implementation of such law. The main limits consistently identified by social partners can be summarised in *resources* and *culture*.

In terms of **resources**, it was raised that very rarely, if at all, one would be able to find an organisation (a hospital) where there are enough financial resources to comply with all the regulations, particularly the architectural and building regulations (“It would require millions of euros”). With regards to this, we have to bear in mind the wide regional financial differences. Several Italian regions struggle financially and face sometime incredibly hard choices in whether to prioritise staffing, paid overtime, new machineries, etc. (Galetto 2016). The case of the pandemic highlighted the need to be able to adapt hospitals to potential emergency situations, but this would require well-functioning infrastructures in the first place. Much of the success in overcoming the challenges of the pandemic relied on the collaboration and networking between healthcare organisations *beyond* the regional boundaries, sharing resources and information, as well as best practices.

The second element that emerged consistently was what some referred to as the lack of **culture** of risk. This refers to a broad range of factors. One is that it is difficult to define and identify ‘the risk’. This was partly attributed to the lack of training. Although the law does refer to training as a key element of H&S, this is not consistently implemented, often relying on external providers and on a minimal, ‘box-ticking’ approach, in line with what found also by the European Agency for Safety and Health at Work (Broughton et al. 2022). All interviewees, and particularly those more closely involved in H&S matters, flagged this is an extremely complex topic. In order to engage with it properly, it would require substantial knowledge and commitment from both sides. Employers and workers representatives, instead, were said to have traditionally prioritised other, equally pressing issues – e.g. pay or working time – and treated H&S as a ‘residual’ subject. The employer (the manager of the hospital) is legally responsible - under criminal law and administration/civil law - for any accident that might happened in their workplace, but the reporting of accidents itself is sporadic, and problems remain unaddressed. The interviewees highlighted that apart from the deaths (which increased during the pandemic, but that are not as frequent as in other sectors, e.g. constructions and agriculture), hospitals are ‘high human labour-intensive places’, where staff are subject to injuries which are, ultimately, down to lack of adequate staffing levels, lack of use of the

supporting tools, pressure to work faster, and tiredness due to stressful working schedules. This leads to injuries, sometimes irreparable, and injured workers, it was noted, become themselves a cost, in terms of absences from work and in terms of care (e.g. physiotherapy) they will require.

Interestingly, the ‘culture’ of H&S at work in the healthcare sector was often framed in the national context of lack of H&S in general. Hospitals had no PPE (or rather minimal stock), but other sectors too (e.g. chemical industries or wood working) were found dramatically unequipped with masks. This has certainly been a learning lesson.

Quality assessment by the researchers

What emerges from the secondary research and the interviews with social partners is a prominent gap between the wide-reaching and detailed legal and regulatory dimension of H&S and the actual implementation of such rules at the workplace level.

To merge the two elements mentioned above (resources and culture) there seems to be a short-sighted cost-benefit approach to H&S and reactive behaviour to risks, admittedly from both sides. We know that, however, due to the unbalanced power relations that characterise employment workplace relations, workers are likely to find it difficult to report H&S problems and/or sue the employer. This is linked also to the potential lack of information derived from a poorly implemented obligation to training around H&S.

While at first sight industrial relations in the sector seem relatively detached and secluded from H&S, where the primary role is played by the law, IR can actively contribute to the extent to which such H&S laws can be effective. However, hiring freeze over a prolonged time (2009 – 2019), low pay, understaffing, difficulties of recruitment and retention, the fragmentation of the workforce with increasing presence of private sector providers or agency workers, contributed on one hand to IR prioritising other issues in their bargaining agendas, both at national and organisational levels (pay, staffing, working time), and on the other to an overall weakening of workers’ voice given the fragmentation and increased precarisation of the workforce (Vicarelli 2020; Mori and Neri 2020), therefore more exposed to income insecurity and work-related stress.

The Italian case of H&S at work seems also characterised by a ‘crowded’ institutional landscape when it comes to H&S, which includes labour inspectorate, local SPISAL staff, the organisation level RSPPs, RLS, INPS (the national institute for pensions) etc. Although they

all have different roles and specific areas of competence, the ultimate responsibility is fragmented. For example, the labour inspectorate is organised at the territorial level (province) and monitors H&S as well as application of correct employment contracts; the INAIL (insurance on accidents) monitors the company risks to ensure they pay the correct social insurance level; INPS (pensions) checks that the right amount of social contributions and pay are applied to staff; SPISAL focuses on prevention of workplace accidents and work-related diseases.

During the pandemic, there has been an initial attempt at creating working groups between all the mentioned roles in view of a more effective coordination, but once the emergency was over, the working groups were discontinued, and the sector was back to business as usual.

H&S challenges and how to tackle them

There are recurrent themes in relation to H&S challenges in the healthcare sector that emerged from all interviews. The main one is staffing levels. The tensions and risks evoked by the questions on H&S at work were consistently referred back to the stressful working conditions that characterise chronically understaffed hospitals. This has knock on effects on working time, with compromised rest being associated to attention at work and health risks.

Whether resources should be implemented to improve staffing levels or to make buildings and the work environment safer, H&S is always seen as a **cost**. This aspect was also often recalled when discussing potential **solutions**, i.e. H&S should be seen as an investment for all, from the employers, to the workers to, crucially, patients. It was widely recognised that a **change of rhetoric around H&S as a cost to a positive, long term investment** is the necessary and only way forward. This could help organisations tackling the problems of recruitment and retention. In order to achieve this in the Italian context, some flagged the need to have a nationally-financed strategy to improve H&S at work, therefore relieving the regions subject to budget pressures.

H&S is recognised as a complex matter that often calls for **local solutions**. The involvement of local representatives would therefore be beneficial to identify tailored, adequate solutions.

Finally, as an interviewee said, “there is no implementation without sanctions”, pointing at the need to make compliance with H&S, again, cost effective in the long term. This would call for the intensification of labour inspections and monitoring functions. It was noted how labour inspectorate staff are increasingly used for admin roles instead of inspection tasks. It is

therefore a challenge that requires the involvement of all actors involved, not only social partners.

EU-level H&S dialogue and regulations

References to the EU level were of course consistent in relation to the origins of the central Italian law 81/2008 on H&S. As mentioned, this unified text replaced existing H&S laws (in particular the Law 626 of 1994) and implemented the 1989 European Directive. A key shift from the existing Italian legislation was said to be towards a more ‘preventive’ approach to H&S at work.

As for the contemporary role of the EU-level social dialogue, what emerged from the fieldwork is that this is perceived as ‘detached’ from the emergency problems of under-staffing and investment in more stringent compliance with the legislation.

While the employer side of the public healthcare sector has regularly engaged with this level of social dialogue – and the current general secretary of HOSPEEM is in fact a former ARAN official -, unions have a more discontinuous participation. There are several unions involved in the collective bargaining of the public healthcare sector, but only two are members of EPSU.

Table 1. Number of organisations and respondents covered in the interviews

	# organisations	# respondents
Trade unions	2	3
Employer organisations	1	1
Other organisations	1 (Labour Inspectorate)	1
TOTAL	4	5

References

Albi, P. (2021) Sicurezza sul lavoro e Pandemia, Lavoro Diritti Europa, *Rivista nuova di Diritto del Lavoro*.

Amnesty International (2021) *Messi a tacere e inascoltati in piena pandemia*, [report](#) on H&S for care workers during the pandemic in Italy.

Broughton, A., Pankowska, P., Battaglini, M and Vicentini, L. (2022) *Human health and social work activities – Report by the European Agency for Safety and Health at Work – EU-OSHA* (<https://op.europa.eu/en/publication-detail/-/publication/8f61cf26-12d1-11ed-8fa0-01aa75ed71a1/language-en>)

Eurofound (2021) *Industrial relations landscape in Europe: Central government administration, education, human health, local and regional government, and social services sectors*. Dublin: Eurofound.

Fulton, L. (2018) *Health and safety representation in Europe*. Labour Research Department and ETUI. Online publication: <http://www.worker-participation.eu/National-Industrial-Relations>

Galetto, M. (2016) *Organised decentralisation, uneven outcomes: employment relations in the Italian public health sector*, *Industrial Relations Journal*, 48(3): 196-217

Leocata G (2021) *Morire di lavoro. II parte*, in *Salute Internazionale* (<https://www.saluteinternazionale.info/2021/10/morire-di-lavoro-seconda-parte/>)

Mori A. and Neri S. (2020) *Relazioni industriali e servizi di cura: frammentazione degli attori e della contrattazione tra pubblico e privato*, *La Rivista delle Politiche Sociali*, 3/2020: 129-152.

Paolucci, V. and Galetto, M. (2020) *The collective bargaining of flexicurity: a case for sector level analysis? The Italian chemical and metalworking sectors compared*, *Human Resource Management Journal*, 30, 2, 165-179

Vicarelli G (2020) *La valorizzazione delle risorse umane nel Sistema Sanitario Nazionale: un principio disatteso*, *La Rivista delle Politiche Sociali*, 3/2020: 75-97.

CASE STUDY ITALY SOCIAL CARE SECTOR

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Main national health and safety (H&S) regulations

The main source of regulation of health and safety in the workplace in Italy is the law.

Starting from the Italian Constitution (1948), articles 32 and 41 include the “right to health understood as an individual and collective interest” and the “freedom to establish economic activity ... with respect to health, environment, safety, freedom and human dignity”.

The Civil Code (1942)’s article 2087 refers to the employer/entrepreneur’s obligation to ensure physical and moral integrity of the workers

The Criminal Code includes various articles (437, 451, 589, 590) which identify criminal responsibilities connected with the employer’s duty to provide and guarantee a healthy workplace.

The Italian reference law for **H&S at work is the Legislative Decree 81/2008** (*Testo Unico sulla Sicurezza sul Lavoro*). This is a “unified text” which systematises existing rules, procedures and prevention practices aimed at safer workplaces. It also broadened the scope of application and strengthened the implementation of the existing Italian H&S law nr. 626 of 1994, which had been the main reference until 2008.

Amongst other things, the law decree 81/2008 has the merit to identify key formal roles within the organisations that are responsible for H&S:

- the responsible for prevention and protection (**RSPP**, *Responsabile Servizio Prevenzione e Protezione*); the person for this role has to be nominated, can be the employer, or an external person, as long as they have the relevant competences and necessary education degrees; training is provided, and certificates of training need to be obtained/updated every five years. The RSPP has to contribute to the planning on

H&S in the workplace and is responsible, amongst other things, for the communication to workers about the H&S practices and procedures;

- the workers' representative (**RLS**, *Rappresentante dei Lavoratori per la Sicurezza*) who can be elected or appointed, also by formally recognised TUs, their name has to go to Inail and there are 32 hours of training required for the RLS; for smaller workplaces, there is the possibility to 'share' a local/area representative for H&S (*RLS territoriale*);
- The occupational health doctor (*medico competente*).

This law establishes the centrality of the "document of the risk evaluation", which the parties need to draft and share; the duties, responsibilities and sanctions of all parties involved; the centrality of compulsory training for H&S. This law is referred to by all sectoral collective agreements.

All workers are therefore covered by the law 81/2008 on health and safety at work; contracting companies and their workers are included in the specifications of the law; similarly, self-employed are covered.

In the social care sector, there is a greater concentration of irregular workers compared to the healthcare sector¹. Although a breach of H&S regulation in any workplace is punishable, informal and irregular workers are likely to have limited awareness of such regulation. Some of the interviews with social partners in the care sector reported that often newly hired staff by (generally small) service providers, e.g. those providing care delivered at home, have little training about H&S. This training is also more difficult to design and deliver due to the complexities and variations in risk assessments with home-delivered care support. Such training is therefore often reduced to minimal, off-the-shelf training provided by private, external companies.

Other relevant laws for the social care sector include:

- Law Decree 151/01 (protection of working mothers);
- Law Decree 66/02 (night work and shifts work);

¹ According to Eurofound (2020: 25) in 32,367 inspections carried out by the Labour Inspectorate in Italy in the 'human health and social work activities' sector, there were 568 instances of undeclared work. The 1,7% rate was found to be similar to that of other sectors. According to the same report, greater than the average (2%) was the rate of bogus self-employment found in the long term care sector (18%).

- Law Decrees 325/99 and 262/00 (protection of under-age workers);
- Law decree 66/2003 on working time (implementing EU Directive 93/104 CE and 2000/CE).

During the pandemic, particularly at the beginning of 2020, there have been several [‘joint protocols’](#) to regulate the use of equipment, social distancing, access to the premises (e.g. via the so-called “dirty” and “cleaned paths” for hospitals), management of data regarding vaccinations and covid-testing of staff working in care homes. Unions and employers association of the ‘third sector’ and in particular the social cooperatives sector were actively involved in the dialogue.

The national level institutions and public bodies in charge of the implementation and follow up on all regulations on H&S at work are the **Ministry of Labour**, the **National Labour Inspectorate**, **INAIL** (*Istituto Nazionale Assicurazione contro Infortuni sul Lavoro*) which is the national insurance public body for work-related incidents and disease; and **Spisal** (*Servizio Prevenzione Igiene e Sicurezza negli ambienti di lavoro*) which is part of the local health authorities (ASL) and, like other healthcare-related functions, they are organised at the regional level. They employ technical and specialist staff (engineers, occupational therapists, experts in toxic risks, etc) who monitor the health and safety environment of existing and new workplaces. The law 81/2008 makes them formally in charge of specific monitoring duties (e.g. they can request documents and inspections to ensure that local workplaces are healthy and compliant with the law).

H&S and social partner involvement

Looking at the various potential modes of social partners involvement, we can see that social partners play an important role, both at national level (as in the case of the pandemic emergency joint protocols) and at the organisational levels, via the RLS and RSPP.

Most prominent in the past three years has been the consultation between national level social partners (representative union organisations) and the Ministry of Health. During the pandemic H&S “shared protocols” in the healthcare and social and care services (public services, services provided by cooperatives and private providers) were drafted in response to the emergency and as the situation evolved. Social partners have therefore been actively

involved in the definition of guidelines in the health sector, which are a formal responsibility of the Ministry of Health.

Collective bargaining is seen as becoming increasingly but indirectly relevant to H&S because it regulates work organisation, working time, team-work, allowances for unsocial hours or activities. These have an impact on the protocols that define the relationship with patients and service users in a way that is safe. IN Italy, national sector collective agreements are binding in principle, but there is no law that makes it compulsory, even for the companies that are part of the signatory organisations. The interviews with the social partners highlighted the need to ensure a more stringent application of the sector agreements, as it makes a difference in the quality of workplace level relations and wellbeing.

The implementation of the law 81/2008 and the control functions are legally attributed to INAIL, the Labour Inspectorate and Spisal. However, in all forms of monitoring, inspectors will liaise directly with the representatives for H&S in the workplace, which are sometimes workers elected by workers and/or nominated by the trade unions officially present in the organisations.

In some sectors, social partners can contribute to the establishment of national level observatories on health and safety in their sector. There is one of the social cooperatives too, although this was hardly mentioned in the interviews as being effective in relation to better H&S.

Role of collective agreements for H&S regulations and workplace H&S representation

The law is primarily responsible for the definition of rules, procedures and national level institutional roles in charge of the H&S at work. Workplaces in Italy are regulated by a multi-employer system of industrial relations, articulated in two main levels and corresponding collective agreements (CAs): national sectoral level and organisational level. The two levels have distinct roles and areas of competence (demarcation) but the sector level can also 'delegate' to the company level competence to regulate on specific subjects (Paolucci and Galetto 2020).

Providers of the social care sector and care homes can be public or private organisations. The latter provide their service to the municipalities via a tender/call for provision, and can be covered by different collective agreements depending on the nature of the organisations. There is a widespread presence of cooperatives amongst the providers, for which there is a specific Collective Agreement of Social Cooperatives, signed by AGCI Solidarietà, Confcooperative Federsolidarietà e Lega Coop Sociali for the employers; and by FP Cgil, FPS Cisl, Fisascat Cisl, Uil FPL and Uiltucs for the union organisations. The latest renewal was signed in December 2019 and covers the years 2017-2019.

During the interviews with social employers and unions, it was noted that in the social cooperatives sector, often ‘owners’ and workers of the cooperatives coincide, due to the cooperative nature and structure of the organisations. This has been said to reduce the power imbalance of employment relations, at least in theory.

The CA of the social sector cooperatives include the provisions for a bilateral body both at national and regional level (Comitato Misto Paritetico Nazionale e Regionale) which monitors, amongst other things, also the correct implementation of H&S legislation in the workplace.

Several social care services, including those dedicated to elderly care, since the end of the 1990s, beginning of the 2000s have been outsourced from the public sector (municipalities were often in charge of these) to private providers, according to the principle of subsidiarity. The finances of individual municipalities will heavily impact the capacity of cooperatives and other provider organisations to function, given that in some cases there are backlog of payments to the organisations which hamper the ability to implement pay rates established by national level sector CAs (Arlotti et al 2020; Dorigatti et al 2020).

National, sectoral industrial relations systems in the social services and elderly care sector

Industrial relations in the social care follows the IR framework of the broader public sector in the case of public organisations, such as for example local authorities and municipalities directly employing social care workers, or the private sector in the case of private providers or cooperatives. In all cases, the IR systems is articulated between national sector level and organisational level. Private providers and their industrial relations were outside the scope of our study, as they were unlikely to be members of national associations affiliated at the

European level². Unions are sometimes present in religious private provider organisations, but to a less extent than in the public and cooperative organisations³.

The social partners of social cooperatives were interviewed in the context of this research. Amongst the several signatories of the Social Cooperatives CA, the following organisations are also members of European level organisations: Confcooperative Federsolidarietà and Lega Coop Sociali are members of the European level Social Employers; while, for the union side, FP Cgil and FPS Cisl are members of EPSU.

There are several collective agreements that these trade unions participate in, depending on who the organisations are. UNEBA for example is a national level association of organisations and initiatives of the social care and social assistance sector, which has its own CA signed with major trade unions. There are also religious organisations that are providers of social care services. None of these are affiliated to the European level organisations of this study.

According to Eurofound (2020) report on long-term care workforce, 10% of social services are public; 46% private non-profit (includes cooperatives) and 44% private-for-profit. While coverage of public national collective agreements is 100%, it is estimated to be around 75%/80% for non-public organisations.

Quality assessment by the social partners

Interesting elements emerged from the interviews with social partners of the social healthcare sector. A key element is that there is a wide-range of activities included in this sector, from residential care homes, to home-delivered care - either for short times per day, or continuously night and day -, day care centres for the elderly and for other groups that need more or less constant support, there are tailored services for elderly with dementia or other conditions. In

² The religious association of healthcare and care providers are members of ARIS (Associazione Religiosa Istituti Sanitari) and private providers of AIOP (Associazione Italiana Ospitalità Privata).

³ Private providers were sometimes referred to by interviewees and said to have a tendency to avoid complying with national collective agreements. Interestingly, this seemed to be attributed to the size of private providers: if very small, they are usually players at very local level and get away with informal relations at workplace level; if large, powerful and often foreign they seem to bring a preferred practice of individual negotiations and deliberate avoidance of national collective agreements. This, however, was not further verified and is based on conversations with interviewees.

terms of H&S at work, this variety means that there cannot be a ‘one size fits all’ approach, as one interviewee said. This was particularly self-evident during the pandemic, when regulations were issued centrally and protocols had to be adapted in all these different circumstances. A pivotal characteristic in the ‘labour process’, let’s call it, of care work, is the ‘**relationship with the person**’, which is both a physical but also emotional relationship between the carer and the person (the service user). This has implications on the ‘risk’ in relation to which H&S will be designed.

The pandemic has highlighted also the key importance of **prevention** and of the **relationship with the commissioning bodies** (whether the local, municipal, regional institutions). At national level, the social partners of the cooperatives have put forward a proposal for commissioning public bodies to be under the obligation to apply the national collective agreements and their pay levels. The low pay in the sector and the often poor working conditions (overtime, unscheduled shifts, etc) was said to be down to the competition strategy providers bidding. The low cost of work proposed has implications on H&S.

Similarly to the healthcare sector, interviewees highlighted a limited ‘**culture**’ of risk and perception of danger. This was attributed partly to:

- less public awareness of care work, compared for example to work-related risks in constructions and agriculture;
- to the employer’s limited proactive role in instructing employees;
- and the off-the-shelf, often very minimal, training provided, if at all, to care workers.

This was linked to the under-reporting of work-related accidents in the care sector.

Another point to emerge in relation to the industrial relations role in H&S was that at national levels there are relatively good institutional infrastructures in place. Collaboration projects, voice and dialogue between different social actors across the care sector were tested during the pandemic and led to an overall positive assessment from all partners involved, confirmed in the interviews. An effort should be made, it was pointed out, to keep this dialogue up in the post-emergency era.

Industrial relations at the organisational level are more variable. Where they are ‘good’, there is also likely to be effective cooperation between the employer and the local RLS and RSPP.

This is fundamental to create a safe and healthy work environment and is ‘in everyone’s interest’. However, due to the often competitive and cost-focused nature of the tenders to provide care services, labour costs are often compressed, with consequences on poorer H&S practices and relations with the local RLS and RSPP.

Quality assessment by the researchers

One of the ‘procedural’ issues in the relation between industrial relation and H&S in the care sector, is the non-binding nature of national level sector agreements. Given the public-private combination of care service provisions, this creates disparities in the working conditions of care workers employed by organisations of different nature.

Private providers have a more stringent relation to profit and efficiency. This can be both positive and negative. It might lead to “cut corners” and make the most of workers while they have them, but could also mean a more genuine interest in creating a safe working environment, which can be seen as a long term investment.

Cooperatives, on the other hand, work on very tight cost margins (1%) which means that any increase in the costs of their operations can break the difference between viability or bankrupt of the business.

The Italian case of H&S at work seems also characterised by a ‘crowded’ institutional landscape when it comes to H&S, which includes labour inspectorate, local SPISAL staff, the organisation level RSPPs, RLS, INPS (the national institute for pensions) etc. Although they all have different roles and specific areas of competence, the ultimate responsibility is fragmented. For example, the labour inspectorate is organised at the territorial level (province) and monitors H&S as well as application of correct employment contracts; the INAIL (insurance on accidents) monitors the company risks to ensure they pay the correct social insurance level; INPS (pensions) checks that the right amount of social contributions and pay are applied to staff; SPISAL focuses on prevention of workplace accidents and work-related diseases.

H&S challenges and how to tackle them

In an attempt to systematise the challenges and proposed solutions, we could distinguish between procedural and substantial observations.

From the procedural point of view, the law and rules in place are fine. There is a need to make them work, though. As one interviewee said, a new relationship with the monitoring bodies and a new collaboration amongst the various roles mentioned above (Inail, SPISAL, Labour Inspectorate, organisations' RLS and RSPP) would be beneficial. Ideally, as many mentioned, this should be accompanied by an intensification of control and inspections.

Given the ageing population and the likely increase in demand for care workers, conditions of work should be protected by national collective agreements, to avoid further fragmentation and race to the bottom. The non-binding nature of sector collective agreements in Italy has been pointed at as a factor that intensifies competition on labour costs. This is particularly true for private providers. The national level is unanimously recognised as strategic in establishing minimum levels of safety and of compliance.

From more substantial points of view, the solutions offered by interviewees have to do with the organisation of work and the shift of the narrative of H&S as a cost into a positive, long term investment for everyone's benefit. This would help tackling the challenge of staff shortages. A healthier and safer workplace can aid recruitment and retention. Care work, it was mentioned, should be included in the list of 'wearing jobs' (lavori usuranti). This should then be part of conversations of re-skilling after a certain age and retention within the organisation. There were references at the past practices of keeping less demanding jobs in the organisation (office, part time jobs) for older/former care workers.

EU-level H&S dialogue and regulations

References to the EU level were of course consistent in relation to the origins of the central Italian law 81/2008 on H&S. As mentioned, this unified text replaced existing H&S laws (in particular the Law 626 of 1994) and implemented the 1989 European Directive. A key shift from the existing Italian legislation was said to be towards a more 'preventive' approach to H&S at work.

As for the contemporary role of the EU-level social dialogue, what emerged from the fieldwork is that this is perceived as ‘detached’ from the emergency problems of under-staffing and investment in more stringent compliance with the legislation. This is often perceived as a ‘faraway’ dimension, that has little visibility on daily work activities.

Some representatives of the employers organisations of the cooperative sector are involved in international talks on guidelines for care work, e.g. with the ILO, but not fully yet with the EU level. There are several unions involved in the collective bargaining of the care sector, but only two are members of EPSU and these have reported discontinuous engagement.

Table 1. Number of organisations and respondents covered in the interviews*

	# organisations	# respondents
Trade unions	2	5
Employer organisations	2	3
Other organisations	1 (Labour Inspectorate)	1
TOTAL	5	9

References

Arlotti M, Parma A, Ranci C, Sabatinelli S (2020) Lavoro di Cura. Una nuova frontiera della disuguaglianza sociale, *La Rivista delle Politiche Sociali*, 3/2020: 97-127.

Burns D J, Hyde P J and Killett A M (2016) How financial cutbacks affect the quality of jobs and care for the elderly, *ILR Review* 69(4): 991-1016

Dorigatti L, Mori A and Neri S (2019) Public, Private or Hybrid? Providing care services under austerity: the case of Italy, *International Journal of Sociology and Social Policy*, 40(11): 1279-1300

Eurofound (2020) Long-term care workforce: employment and working conditions. Dublin: Eurofound.

Garnero, A. and Lucifora, C. (2022) Sui contratti pirata chiudere un occhio non paga, La Voce (<https://lavoce.info/archives/94305/contratti-pirata-chiudere-un-occhio-non-paga/>)

Mori A. and Neri S. (2020) Relazioni industriali e servizi di cura: frammentazione degli attori e della contrattazione tra pubblico e privato, *La Rivista delle Politiche Sociali*, 3/2020: 129-152.

Paolucci, V. and Galetto, M. (2020) The collective bargaining of flexicurity: a case for sector level analysis? The Italian chemical and metalworking sectors compared, *Human Resource Management Journal*, 30, 2, 165-179

CASE STUDY LITHUANIA HOSPITAL SECTOR

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I. GENERAL PART

1. Sources for health and safety (H&S) regulations

Main legal acts, regulating H&S at the national level in Lithuania are:

- Labour Code of the Republic of Lithuania (LC)¹
- Law on Health and Safety of Employees (LHSE) No IX-1672²
- Order of the Minister for Social Security and Labour and the Minister of Health No. A1-457/V-961 On the approval of the General provisions of occupational risk assessment³
- Order of the Minister for Social Security and Labour and the Minister of Health No. A1-251/V-693 On the approval of the Occupational safety and health action plan⁴
- Order No 80/353 of collegial bodies On the approval of the Regulations on the protection of workers against exposure to biological occupational risk agents at work (21 06 2001)⁵
- Order No V-592/A1-210 of collegial bodies On the approval of the Methodological instructions for the investigation of ergonomic risk factors (15 07 2005)⁶

There are also several legal acts, specifically regulating H&S issues in the hospitals and healthcare sector:

- Order of the Minister of Health Protection No V-400 regarding the approval of the procedure for determining the workload of nurses⁷.
- Order of the Minister of Health Protection No A1-157/V-210/V-501 on the approval of provisions for the prevention of injuries with sharp instruments in healthcare institutions⁸.
- Order of the Minister of Health Protection No V-946 on the renewed Hygiene Norm No 47 “Health care institutions. Infection control requirements”⁹.
- Order of the Minister of Social Security and Labour and the Minister of Health of the Republic of Lithuania no. 97/406 on the approval of the regulations for the protection of workers against

¹ TAR, 2016-09-19, Nr. 23709

² Valstybės žinios, 2003-07-16, Nr. 70-3170

³ Valstybės žinios, 2012, Nr. 126-6350

⁴ TAR, 2022-04-05, Nr. 2022-07040

⁵ Valstybės žinios, 2001, Nr. 56-1999; TAR, 2020-11-20, Nr. 2020-24638

⁶ Valstybės žinios, 2005, Nr. 95-3536; TAR, 2021-08-25, Nr. 2021-17898

⁷ Valstybės žinios, 2012-05-12, Nr. 55-2751

⁸ Valstybės žinios, 2012-03-22, Nr. 34-1679

⁹ Valstybės žinios, 2012-10-25, Nr. 124-6241

chemical agents at work and the regulations for the protection of workers against exposure to carcinogens and mutagens¹⁰.

- State Labour Inspectorate (SLI) Recommendations on the protection of medical workers against the Covid-19 virus. Minimum safety and health requirements, Safety and health assurance guarantees¹¹
- SLI Recommendations “Lighten the load. Preventing lower back disorders in the healthcare sector”¹².
- During the interviews, TU identified the following pieces of legislation as important for those working in the sector:
 - Council Directive 2010/32/EU - prevention from sharp injuries in the hospital and healthcare sector of 10 May 2010 implementing the Framework Agreement on prevention from sharp injuries in the hospital and healthcare sector concluded by HOSPEEM and EPSU (Text with EEA relevance)¹³
 - Amendments to Law No VIII-397 on Days of Remembrance¹⁴, which recognises the 12th of March as the European Day to Fight Violence against Doctors and Health Professionals¹⁵.

2. Role of collective agreements for H&S regulations and workplace H&S representation

Though there is a sectoral collective agreement signed (15 11 2021) in the healthcare sector in Lithuania, there are little provisions regulating H&S issues in the CA and its amendments.

Sectoral CA is applied for members of signatory trade unions (list of institutions is annexed to the CA) and is valid in the public sector institutions only. The CA inter alia contains a commitment, echoing the Government’s action plan, to “develop a methodology for determining the workload of health professionals based on the real time costs of performing their job functions”. This partly demonstrates the will of the parties to continue to address the major problems in the healthcare sector in the future through centralised regulation rather than TU/SP solutions.

Issues of particular importance to the healthcare system, such as wages, are dealt with in the CA by means of provisions that are already required by law and the Constitution. For example, the aforementioned CA stipulates that in the event of an increase in the MMW, the GRL undertakes to allocate to healthcare institutions an additional amount of funds to cover the increase in the MMW for employees of the institutions.

¹⁰ Valstybės žinios, 2001-07-27, Nr. 65-2396

¹¹ https://www.vdi.lt/AtmUploads/REKOMENDACIJAS_COVID19_3.pdf

¹² <https://www.vdi.lt/AtmUploads/KroviniuKelimasSveikatosSektoriuje.pdf>.

¹³ L 134/66 Official Journal of the European Union 1.6.2010

¹⁴ Official Gazette, 1997, No. 67-1672.

¹⁵ Law No XIV-1110 came into force on 28 May, TAR, 2022, No. 2022-1133.

A similar situation in the healthcare sector occurs at company-level: company-level CAs usually contain provisions that mirror those of the law or higher-level CAs.

Thus, the most important source regulating H&S issues in the hospitals and healthcare sector remains the aforementioned LHSE, which provides for all main principles of H&S administration and SP cooperation, the duties and rights of employers, the establishment and operation of OHS services in undertakings, the participation of employees in the H&S implementation measures at the workplace, the training of employees, compulsory health checks, the assessment of occupational risks, and other issues related to the H&S implementation.

The LHSE lays down, inter alia, all the conditions under which occupational Health and Safety Committees (HSCs) are to be established in undertakings, as well as the participation of workers' representatives in H&S issues at the workplace level in terms of their roles, rights and obligations.

II. 2 – SECTORS – hospitals

3. National, sectoral industrial relations systems

Hospitals and healthcare sector in Lithuania belongs to the one of rare sectors with sectoral collective agreement in place. It should be noted, that healthcare sectoral CA covers actually only public sector and is signed by the Ministry of Health (MH) on the side of employer and one national trade union, one TU, representing pharmaceutical employees and seven healthcare unions, including Lithuanian Nurses' Organization (LSSO) and Lithuanian Trade Union of Healthcare Employees (member of EPSU), both interviewed during this project. Currently valid sectoral healthcare CA came into force on 1st January, 2022 and is valid for 3 years.

In fact, the sectoral system of **workplace** H&S representation in the hospitals and healthcare sector does not differ from any other sector. As a rule, and in accordance with the LHSE, undertakings with more than 50 employees have HSC – a bipartite institution set up at the workplace level; there are also H&S professional(s) appointed and H&S representative(s) elected at the workplace level. In cases of accidents a Commission for Accidents at Work might be created as well. Interviews with social partners showed that in undertakings with active TUs, representation of employees' interests at the workplace HSC is quite solid. TUs also inform employees about their H&S rights and obligations, working time and rest regime, take care of other H&S issues in terms of ergonomic conditions, hygienic standards and other relevant issues.

At the national level a tripartite Occupational Health and Safety Commission (OHSC) is functioning. The Commission is composed of an equal number of representatives of the parties (public authorities and bodies, employers' and workers' organisations) (5 representatives from each party). The purpose of the Commission is to coordinate the interests of the State, employers and workers in the field of

occupational safety and health, on the basis of tripartite cooperation between the social partners (parties).

Though, as mentioned above, sectoral hospitals and healthcare employees in Lithuania are covered by sectoral and – in some cases – by company-level CAs, these CAs cover only minor issues related to H&S. In the sectoral CA the following issues directly or indirectly related to H&S (and not foreseen in the national legislation) are covered:

More favourable conditions for the remuneration for work. CAs provide for the payment of a substitution bonus (which is at least 30% of the replaced worker's average monthly wage) and of a bonus for work in workplaces exposed to harmful (20%) or dangerous (15%) factors.

Additional rest time and length of breaks. The sectoral CA provides for a longer minimum annual leave for employees who provide direct services to patients and extra leave for uninterrupted service in the same workplace. Other provisions of the CA in the field of H&S echo the legal norms laid down in the LC, LHSE, Government decrees or approved by ministers, such as the employer's obligation to provide safe working conditions, to carry out occupational risk assessments in the workplace, to create a working environment that ensures psychological well-being, to adopt a policy on the prevention of violence and harassment, and so on. The CA also reiterates the provisions of the legislation relating to remuneration for work and working and resting time, etc.

Although there are some minor provisions establishing more favourable conditions for employees in currently valid company level CAs signed in the healthcare (e.g., shorter working hours for those working in greater mental, emotional stress environment, working with blood, organs or their production, packaging, use or decontamination (up to 36 hours working week), or for those working with sources of ionizing radiation (up to 30 hours working week), in majority of cases they actually repeat either national legislation, or provisions of sectoral collective agreement.

In summarising the above information, it should be noted, that the LHSE regulates in great detail the procedures for workers' participation in the implementation of H&S measures, the establishment of HSCs, the rights and obligations of workers' health and safety representatives and the obligations of employers. Meanwhile, other legislation in force in the country regulates in great detail working and rest periods, hygiene standards, occupational risk assessment procedures and a number of other H&S-related issues. For these reasons, the CAs do not address the above mentioned key H&S issues or if address them – often repeating those already provided in legislation.

Since TUs are rather active in the sector, they are involved in solving H&S issues (when dealing with specific issues or updating H&S descriptions/documentation) at the workplaces and contributing to dialogue with employers regarding very practical solutions. However, according to interviewed TUs, there is a problem in those workplaces where work councils implement the role of employees' representatives as they perform their duties formally only, even though if they are elected by

employees – they approve everything that suits well for the employer and needs to be formally approved: work schedules, working time sheets, everything the employer needs, and do not really represent the rights and interests of employees¹⁶.

As regards the multi-level focus, we may conclude that there is actually no interaction in Lithuania among different level actors on H&S issues in CAs. Healthcare sectoral CA does not provide that H&S issues are to be specified and coordinated with the local-level TUs.

It is of note that such a situation may be due to the peculiarities of employer representation in the hospitals and healthcare sector in Lithuania, where sectoral CA is signed by the MH on the employer's side. At the same time, the MH is also the co-founder of a number of institutions in the sector; even when the municipality is the founder of the institutions, their budgets are *de facto* dependent on the decisions of the Government or Parliament of the Republic of Lithuania. The MH together with the Ministry of Social Security and Labour (MSSL) also has the right to initiate legislation, it is the drafter of governmental resolutions relevant to H&S and, lastly, it is the MH together with MSSL that issues the orders regulating some H&S issues (see section 1). In principle, all the substantive H&S guarantees are regulated by the national centralised legal framework. As the MH plays a special role in the hospitals and healthcare sector in Lithuania, it should also be mentioned that, by assuming the function of an employer in the sector and, in principle, by shaping all policies (including H&S issues) together with MSSL (including healthcare reform and healthcare sector management), it tries to involve all stakeholders in the decision-making process. For this purpose MH is using the existing structures: Committee of Health in the National Parliament; consultations with social partners are carried out at the MH and at the Tripartite Council of the Republic of Lithuania; representatives of SPs are involved in the various working groups established by the MH, Government and Parliamentary Committee.

4. Quality assessment by the social partners

In general, TUs poorly rate the level and quality of social dialogue in the sector. According to them: SD contributes to solving H&S issues, but TUs should be more active in submitting proposals, monitoring challenges in workplaces and proposing necessary solutions. During the initial phase of the Covid-19 pandemic, there was really insufficient use of protective measures, extreme savings by bypassing safety instructions, and there were no control mechanisms in place.

The Government itself authorized MH to negotiate sectoral CA, but when agreement with TUs has been reached, it was recommended by the same Government to the MH not sign it as “the budget for the coming year is uncertain”. TUs claim to be often reminded: “there is a war going on and we don't

¹⁶ According to SLI data (in 2020), work councils were active only in 44% of workplaces where they should be unless a TU is in place.

know how we will live tomorrow”. Therefore, for a while TUs did not demand raising employees' salaries for entire system. However, since minimum wage was raised from 1st of January, 2023, the most likely institutions without additional allocation will increase wages by transferring from the variable part of the wage to the constant one. More funds should be allocated, but there are no substantive changes in wage policy.

Another problem, typical specifically for the healthcare sector, is application by employers provisions of CAs to all employees (also to non-TU members) by transferring provisions agreed in the CAs to local documents (internal labour regulations of a workplace). According to TUs these *‘unfair practices worsen the situation of TUs, undermine their rights and reduce membership. <...> Employees also avoid joining TUs because of managers’ negative attitudes towards TU members <...> People are afraid to speak up, there is also a general understanding that H&S issues are to be resolved by the administrator, and should not be raised by the employees themselves <...> It also takes courage to say things that are unpopular or that will cost the institution additional finances (e.g. purchase of equipment, etc.)’*.

During interviews TUs often mentioned irresponsible attitudes of employers (sometimes – including MH) towards occupational health and safety of employees. According to TUs, *‘During negotiations on branch CA we needed to convince MH that in order to reduce the risk of contagious diseases, the employer must vaccinate employees against vaccine-controlled diseases. According to the current legislation, the employer must finance this vaccination, but in practice often employees pay themselves <...> MH drafts hundreds of pages of documents, but if there is a circumvention of every legal act, then nothing will change <...>’*.

In the healthcare sector, some ‘unfair treatment’ of nurses was also mentioned: *‘<...> Especially in the process of CA implementation in workplaces the nursing profession is the one forgotten and pushed to the margins. Doctors are treated with more respect, as a wrong attitude that only doctors earn money for the healthcare institution prevails’ <...> If the salaries are increased, it is done by the same percentage for everyone, which is not very honest as salaries of nursing personnel are low. Even confrontations are created between employees over salaries in workplaces <...>’*.

Some additional tension in the healthcare sector is caused by the ongoing long-lasting reform of the sector: *‘<...> Health reform is causing confusion because people don't know what to expect for. The reform is written in incomprehensible terms, it is not explained in an understandable language for all employees <...>’*.

As regards the participation of employees in the resolution of H&S problems at the workplace level, according to TUs, it is common in Lithuania for an undertaking/institution to have a formally established and functioning HSC, but in practice all decisions are taken by the employer (or a person representing the employer). This situation arises because, according to the LHSE, the chairperson of

the HSC is appointed by the person representing the employer or a person authorised by the employer. In the absence of TUs in the undertaking/institution, the participation of an employee representative in the HSC is often more formal, and although *de jure* employees are deemed to participate in H&S management structures, in reality all matters relating to the H&S of employees are unilaterally decided and regulated by the employer. Another reason for this lack of involvement on the part of employees is their heavy workloads - respondents identified the problem of burnout, i.e. at the end of a shift, employees simply don't want to do additional activities due to fatigue. According to respondents, *'HSCs established at the workplaces are often more of 'paper' than of real nature'*.

5. Quality assessment

In general recent 20 years is a period of continuous progress in the area of H&S in the healthcare sector. Equipment for lifting and turning patients has already been purchased approx. five years ago. However, there is a general understanding that using equipment makes work performance slower, so sometimes nurses don't use lifting equipment (ski sheets, belts, lifts to the bathrooms) because of enormous workloads and professional habits.

While assessing the quality of the H&S regulations, we may conclude from the desk research and conducted interviews that overall quality in practice is rather poor, although rather strict and detailed national legislation as well as institutions ensuring the implementation of H&S regulations exist.

Formally, there is a full set of channels for ensuring H&S at the workplace (also mainly determined by the national regulation) – H&S professionals, H&S committees (often rather formal, but in case of active TUs might be a rather efficient tool); H&S representatives; commissions for accidents at work; TUs (in the absence of TUs – work councils, but very weak in the area of H&S); mandatory occupational risk assessment schemes (followed by the plan for risk prevention; also often rather formal in practice); as well as a number of institutions ensuring H&S supervision and enforcement: State Labour Inspectorate, labour dispute resolution commissions, co-founders of institutions (ministry and/or municipalities, universities), State Health Care Accreditation Agency under the MH, Ombudspersons of the Parliament.

However, the formally existing comprehensive system does not ensure efficient implementation of the national legislation in practice and enforcement thereof. Such a situation is due to a number of reasons, including weak TU's, inactive employees, and ineffective social dialogue (many of the CAs in place in the sector are of a declarative nature; they are lacking concrete measures and agreements aimed at improving workers' H&S and capable of actually improving the workers' H&S in the sector), and the specific "management structure" of supervising institutions.

One of the key H&S problems in the sector is a very high workload (the number of patients per employee triples and there is no solution, especially for nurses visiting patients at home), which

became particularly evident in the last few years and which leads to a burnout and other health problems of healthcare employees. Workload is addressed by the MH – a special order in the form of recommendations is approved by the Minister of Health, however the established norms are not binding. Thus, the present situation might be described as lacking strict legal framework. MH takes a high level of responsibility, but political decisions and resources are insufficient. At the same time the influence of TUs and/or CAs is weak as not all of the major H&S problems identified by the SPs are given consistent and strategic attention. According to interviewed TU representatives, *‘nurses’ workloads in Lithuania might not be even understood in the other countries. We cannot even talk about any quality here’*. Secondary jobs are typical to the sector as well. Nurses work less often (to compare with doctor) in a second workplace, but often work more than one full-time job at the same workplace. *‘It is rare for a nurse to work only full-time, and many choose to work longer working time in the same workplace because of the higher salary and because there is a lack of employees’*. Summarising the H&S situation in the healthcare sector, it might be noted that there are quite marked differences between large cities and regions: tertiary level hospitals (usually located in large cities) still attract specialists, but in regions (secondary level hospitals) lack of specialists is a huge problem. In addition, the salaries of nurses in primary health centres are significantly higher (300 euros) than in hospitals where working conditions are more difficult.

Despite the fact, that educational system prepares a large number of health professionals, due to low salaries and unfavourable working conditions young specialists often start to work, but after several month they decide to quit (and often go abroad). However due to the fact that there is a comparatively large number of young healthcare graduates, healthcare employees (especially nurses) do not feel secure about their workplace. All this additionally contributes to the overall very low psycho-emotional state of sectoral employees.

The psychosocial risk action plan¹⁷ was approved by MH providing measures for psychological well-being of employees in the personal healthcare system until 2024. TUs however claim that there are a lot of nice words that do not convince as it is almost impossible to introduce provisions of the plan into the practice. On the other hand, TUs also admit that this plan includes important measures such as training.

The current situation cannot be changed by TUs, which are quite active in some institutions, and which acknowledge that, although legal instruments are already in place to address the problems of psychosocial risks and staff motivation, the knowledge and resources of TUs are very scarce and the State does not give strategic attention to the fundamental problem of staff workloads in the sector.

¹⁷ Order of the Minister of Social Security and Labour and the Minister of Health No. A1-251/V-693 on the approval of the occupational safety and health action plan (TAR, 2022-04-05, Nr. 2022-07040)

6. H&S challenges and how to tackle them

Despite the fact, that in Lithuanian hospitals and healthcare sector rather detailed and centralized legal regulation, covering all the employees is prevailing, its implementation in practice remains insufficient. Such a situation reveals itself in poor working conditions and numerous H&S challenges. One of the most pressing problems is the culture of trust together with poor psycho-emotional relations with colleagues and administration; mobbing and risk of burnout results in high psycho-emotional risk level in institutions. Other problems to deal with are: heavy workloads (related to the lack of personnel), working time recoding problem, work in several workplaces or in one workplace, but for more than a full-time equivalent, and non-competitive wages. Mobbing is also related to disrespect from managers, patients and their families and also from doctors towards nurses. Despite labour shortages in the sector, employees' fear of losing their jobs keeps employees 'quiet'. There is no trust in confidentiality of psycho-social risks evaluation process as there is a strong belief that employers organize it through acquaintance, so employees' answers do not correspond reality. Among the recent developments in the area of H&S regulation, the most important is regulation of psychological violence (amendments of Art. 30 of the LC¹⁸) and establishment of a specialized "mobbing division" at the SLI.

7. EU-level H&S dialogue and regulations

As there actually are no employer organisations in the hospitals and healthcare sector and trade unions' capacities (including human resources) are rather limited, engagement of national sectoral actors in EU-level H&S activities is modest. The main actor implementing EU-level H&S regulations at the national level is Government (represented by the MH). The main law, regulating H&S in Lithuania – the LHSE as well as other related legislation are transposing all main EU directives in the area of H&S. So, despite rather weak capacities of national level social partners, all mandatory provisions are transposed in the national legislation by the Government. Therefore, social partners in Lithuania, especially trade unions, traditionally emphasize the importance of imperative European regulation as in countries with weak social dialogue this ensures implementation of the European standards in the country. During interviews importance of Council Directive 2010/32/EU – prevention from sharp injuries in the hospital and healthcare sector of 10 May 2010 implementing the Framework Agreement on prevention from sharp injuries in the hospital and healthcare sector concluded by HOSPEEM and EPSU was emphasised as the one that encouraged the Government to take action and implement it.

¹⁸ 2022 06 28 Law (amending Labour Code) No XIV-1187 (valid from 2022 11 01) (TAR, 2022, Nr. 2022-15174)

Here we may mention, that Art 198 of the LC foresees possibility of extension of the scope of application of national and/or sectoral collective agreement, which formally might be used as a legal instrument for transposition of EU directives however it have been never happened in practice.

On the other hand, there are a lot of limitations of this provision¹⁹ and if situation in the area of social dialogue and industrial relations and regulation thereof will not change, the Government will remain the only actor in the area of transposition of EU-level H&S regulations. In the hospitals and healthcare sector this situation is even more determined by the fact, that in this sector the MH actually plays a twofold role – represents the Government in collective bargaining as it is actually the main employer in the sector and is responsible (together with MSSL) for legislation initiatives, including transposition of EU legal requirements into national law.

8. Multilevel coordination

As mentioned above, in Lithuania, the most important role in H&S regulation in the hospitals and healthcare sector is played by the MSSL and MH, and this area is quite strictly regulated. Taking into account the role of the state in this area and the fact that SP organisations are generally rather weak and, as a rule, do not have sufficient human resources to deal specifically with H&S issues, it can be said that SP involvement in developments on H&S is rather low in general. On the other hand, as mentioned above, there are certain institutions and mechanisms through which SPs are involved in decision-making process, including in the area of H&S, such as the Tripartite Council of the Republic of Lithuania, Occupational Health and Safety Commission, various working groups and task forces, created by the MH, Health Committee in the National Parliament, and other.

The same applies to awareness of and involvement of social partners in EU-level developments/SSDCs. Although, in general, TU organisations are represented in the SSDCs, their capacities in the area of H&S are insufficient to participate effectively in the EU-level developments. Given the current situation, i.e. the important role of public institutions and generally rather weak TU organisations and SD, the social partners to some extent put up with the current situation and "make way" for the MSSL and MH to play a leading role in the development of H&S policy and implementation of EU-level initiatives in the area of H&S.

¹⁹ Davulis, T. (2004) Darbo teisė: Europos Sąjunga ir Lietuva. 153-154 p.; Krasauskas, R. (2007) Darbo santykių reguliavimas kolektyvinėmis sutartimis. PhD Thesis. MRU, 157-159 p.; Krasauskas, R. et al. (2013) Kolektyvinė darbo teisė. Vadovėlis. MRU, 409-411 p.

Appendix

1) Table interviews conducted

#	Date (Month)	Duration	TU or EMP	Sector	EU affiliation	IP's role/function, focus (e. g. H&S policy, H&S workplace rep, employment relations, collective bargaining, other)
1.	2022-05-23	1 hour 18 min.	TU	HOSP	European Nursing Forum at the WHO, a member of the Federation of European Nursing Associations (ESAF) within the European Union and also a member of the International Council of Nurses (ICN)	H&S policy, collective bargaining
2.	2022-05-26	49 min.	TU	HOSP		H&S workplace rep, employment relations
3.	2022-06-07	43 min.	TU	HOSP	EPSU	H&S policy, collective bargaining
4.	2022-06-16	54 min.	TU	HOSP		employment relations, collective bargaining

2) Legal framework

HEALTH & SAFETY LEGAL REGULATION IN HOSPITAL AND SOCIAL CARE SECTORS: LITHUANIA

I PART. "HEALTH AND SAFETY" LEGAL STANDARDS INCLUDE:

- 1. General standards on "health and safety"** ("Framework Directive" (89/391/EEC) on the introduction of measures to encourage improvements in the safety and health of workers at work and related directives, international standards (ILO, etc.) and national legal regulation).
- 2. Working and rest time** (Working Time Directive (2003/88/EC), corresponding ILO and national legal regulation).
- 3. Guarantees** (including wage, extra wage for over-time, higher job intensity, pensions, sick leave, professional development, etc.)
- 4. Risks and psychosocial risks assessment, prevention** (including workloads, harassment).
- 5. Other issues indicated by social partners** as important and related to "health and safety" of those working in hospitals and social care sectors.

II PART. LEGAL REGULATION ON HEALTH & SAFETY CONSIST OF 4 LEVELS:

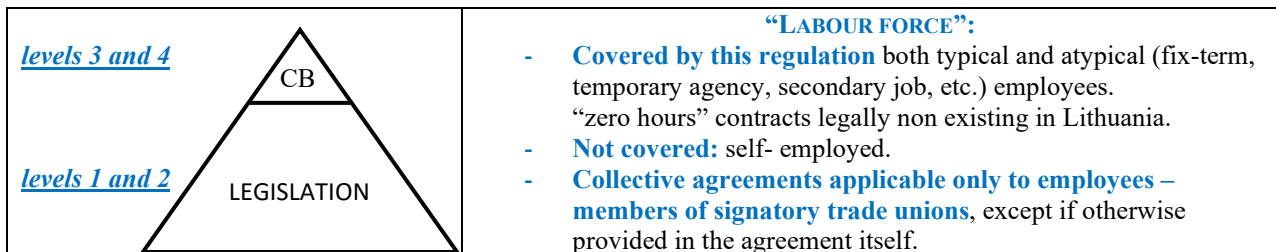
- 1. Law level** legal provisions established in the Labour Code, Law on Safety and Health at Work. Law provisions are of the most general nature and are applicable in all sectors of economy;
- 2. More detailed provisions in by-law level:** i. e. "Description of Short-term Working Standards and Payment Procedures" approved by the Governmental Resolution No 496, June 21th, 2017; „General Provisions on Occupational Risk Assessment" approved by Order No A1-457/V-961 of Minister of Social Security and Labour and Minister of Health; etc.
- 3. Sectoral collective agreements;**
- 4. "Local level" provisions** – established in company level collective agreements and company level documents.

III PART. ROLE OF SOCIAL PARTNERS IN HEALTH & SAFETY LEGAL SYSTEM DESCRIBED BY

3 MAIN FUNCTIONS:

- 1. Consultation** with legislator seeking to adopt the required legal norms (levels 1 and 2, see II PART of this document).
- 2. Collective bargaining or other regulation** – negotiating and approving legal norms via sectoral collective labour agreements and “local level” (levels 3 and 4, see II PART of this document).
- 3. Implementation and control function** – being aware how all 4 legal regulation levels are actually functioning in practice (if not functioning – right to collective actions or consultations for new legal regulation).

CONCLUSIONS: collective bargaining and “local level” provisions (levels 3 and 4) constitute only insignificant part of “health and safety” legal regulation in Lithuania (see triangle below). The dominant levels are 1 and 2.



CASE STUDY LITHUANIA SOCIAL CARE SECTOR

Ramune Guobaite and Inga Blaziene

I. GENERAL PART

1. Sources for health and safety (H&S) regulations

Main legal acts, regulating H&S at the national level in Lithuania are:

- Labour Code of the Republic of Lithuania (LC)²⁰
- Law on Health and Safety of Employees (LHSE) No IX-1672²¹
- Order of the Minister for Social Security and Labour and the Minister of Health No. A1-457/V-961 On the approval of the General provisions of occupational risk assessment²²
- Order of the Minister for Social Security and Labour and the Minister of Health No. A1-251/V-693 On the approval of the Occupational safety and health action plan²³
- Order No 80/353 of collegial bodies On the approval of the Regulations on the protection of workers against exposure to biological occupational risk agents at work (21 06 2001)²⁴
- Order No V-592/A1-210 of collegial bodies On the approval of the Methodological instructions for the investigation of ergonomic risk factors (15 07 2005)²⁵
- Order No A1-448 On the approval of the Guidelines for the organisation and provision of home help services (24 08 2017)²⁶

There are also several legal acts, specifically regulating H&S issues in the social care sector:

- Law on Social Services (LSS) No X-493²⁷
- Order of the Minister for Social Security and Labour and the Minister of Health of the Republic of Lithuania No A1-317 On the approval of Norms for labour time costs of employees providing social care (30 11 2006)²⁸
- Recommendations of the State Labour Inspectorate (SLI) on how to provide services more safely in social care institutions and performing visiting supervision of service recipients during quarantine²⁹

²⁰ TAR, 2016-09-19, Nr. 23709

²¹ Valstybės žinios, 2003-07-16, Nr. 70-3170

²² Valstybės žinios, 2012, Nr. 126-6350

²³ TAR, 2022-04-05, Nr. 2022-07040

²⁴ Valstybės žinios, 2001, Nr. 56-1999; TAR, 2020-11-20, Nr. 2020-24638

²⁵ Valstybės žinios, 2005, Nr. 95-3536; TAR, 2021-08-25, Nr. 2021-17898

²⁶ TAR, 2017-08-24, Nr. 2017-13616

²⁷ Valstybės žinios, 2006-02-11, Nr. 17-589

²⁸ Valstybės žinios, 2006-12-05, Nr. 132-5011

²⁹ https://www.vdi.lt/AtmUploads/Rekomendacijos_socialine.pdf

2. Role of collective agreements for H&S regulations and workplace H&S representation

Though there is a national-level collective agreement (CA), sectoral-level CA as well as a number of company-level CAs signed in the social care sector in Lithuania, there are little provisions regulating H&S issues in these CAs:

- the national-level CA³⁰ establishes a basic salary level impacting on wages in the public sector, additional rest times, and sets out the parties' obligations in the areas of prevention of psychological violence at work, H&S and motivation of workers (for more details see the next section);
- more favourable conditions of remuneration for work to employees, additional rest/holiday days and a shorter working week; the obligation for institutions to set up bipartite councils as well as some other rights for trade unions and employees are foreseen (for more details see the next section);
- company-level CAs usually contain provisions that mirror those of the law or higher-level CAs; some CAs provide for shorter overtime rates than allowed by the LC.

Thus, the most important source regulating H&S issues in the social care sector remains the aforementioned LHSE, which provides for all the main principles of H&S administration and SP cooperation, the duties and rights of employers, the establishment and operation of OHS services in undertakings, the participation of employees in the H&S implementation measures at the workplace, the training of employees, compulsory health checks, the assessment of occupational risks, and other issues related to the H&S implementation.

The LHSE lays down, inter alia, all the conditions under which occupational Health and Safety Committees (HSCs) are to be established in undertakings, as well as the participation of workers' representatives in H&S issues at the workplace level in terms of their roles, rights and obligations.

II. SECTORS – social/elderly care

3. National, sectoral industrial relations systems

Social care sector in Lithuania belongs to the one of rare sectors with sectoral collective agreement in place. It should be noted, that this collective agreement covers actually only public sector and is signed by the Ministry of Social Security and Labour (interviewed in this project) on the side of employer and five trade union (TU) organisations, including General Trade Union of the Republic of Lithuania (interviewed during this project). There is also one employer organisation, belonging to the (The Federation of European) Social Employers – Association "Rūpestinga Globa" (interviewed during this project), but its affiliation to the Social Employers is more formal.

³⁰ National CA (10 10 2022)

Sectoral level collective agreement, signed in the social care sector was valid during 2018-2022 and was at the end of 2022 a new collective agreement, valid for 4 years (2023-2026) was signed.

In fact, the sectoral system of **workplace** H&S representation in the social care sector does not differ from any other sector. As a rule, and in accordance with the LHSE, undertakings with more than 50 employees have HSC – a bipartite institution set up at the workplace level; there are also H&S professional(s) appointed and H&S representative(s) elected at the workplace level. In cases of accidents a Commission for Accidents at Work might be created as well. Interviews with social partners showed that in undertakings with active TUs, representation of employees' interests at the workplace HSC is quite solid. TUs also inform employees about their H&S rights and obligations, working time and rest regime, take care of other H&S issues in terms of ergonomic conditions, hygienic standards and other relevant issues.

At the national level a tripartite Occupational Health and Safety Commission (OHSC) is functioning. The Commission is composed of an equal number of representatives of the parties (public authorities and bodies, employers' and workers' organisations) (5 representatives from each party). The purpose of the Commission is to coordinate the interests of the State, employers and workers in the field of occupational safety and health, on the basis of tripartite cooperation between the social partners (parties).

Though, as mentioned above, sectoral social care employees in Lithuania are covered by national, sectoral and – rather often – by company-level CAs, these CAs cover only the following issues related to H&S:

Additional rest time. The national CA for members of signatory trade unions provides for two extra working days of paid annual leave (for self-study and volunteering) and up to 20 working days of fully or partially paid study leave, as well as five working days for health improvement (when the employee is unwell or for a scheduled visit to a medical facility).

In addition, the sectoral CA provides for member employees with four extra days off (paid holidays) per year in total: two days for employees who uninterruptedly worked at the institution for more than five years and two more extra days for employees who uninterruptedly worked at the institution for more than 10 years.

Moreover, the sectoral CA foresees a shorter weekly working time rate allowing an employee – TU member – to freely choose the working day on which he/she will work shorter while the wage is paid as if he/she worked full day (if there is no possibility to reduce the working time, an employee is paid for this time as for overtime). For parents raising at least one minor up to the age of 12, the CA foresees 12 paid extra days off per year. The CA also stipulates that in order to reduce stress at work and improve psychological health, a one-hour shorter work rate per week is applied, and the length

of the working day is shortened by an additional one hour on public holidays. Short-time work is paid as full-time.

Measures to improve emotional health. The national CA provides for commitments by the parties to take appropriate measures and allocate sufficient funding for the prevention of psychological violence at work; it is agreed that psychological violence, harassment and discrimination are unacceptable and must not be tolerated; and it stipulates that “upon receipt of information, the workplace-level TU shall have the right to propose to the person recruiting the employee <...>, on a parity basis, to set up a commission to investigate the information received about psychological violence, harassment or discrimination experienced by the employee”, and it provides for the basic principles for the operation of this commission.

More favourable conditions for the remuneration for work. The sectoral CA, valid in the social care sector until the end of 2022, provided for an increased salary for signatory trade union members; an obligation to coordinate wage setting issues with the TU or the institution’s bipartite council; and a bonus for substitution. Amendments to the sectoral CA, which have been in force since 1 January 2023, also provide for higher salaries for TU members who are social workers qualified as chief social workers, an increase in official salary, and a higher minimum monthly salary and a higher basic salary.

Establishment of bipartite councils. As regards the social care sector, one particular institution should be singled out, which the SP managed to agree on during sectoral CB: the establishment of bipartite councils at the workplace level, which are also important for addressing H&S issues. The example was presented during one interview when decision, violating CA, was issued by the municipal council with no single consultation with TU and without at least informing employees and explaining the reasons. The decision imposed the obligation on employees to work longer than it is provided in the CA and to substitute each other during one’s rest periods. The CA contained a legal provision stipulating that an employee must be paid at least 30% extra of his/her wage for the period of replacement. But employers found a way to circumvent the obligation imposing unfavourable “replacement-specific formula” to avoid extra payments. In accordance with the procedures provided in the sectoral CA, the TU requested meetings through the bipartite council to find out the impact of the decision on the rights of employees. It was namely the bipartite council that helped to reach an agreement with the employer and municipal council members to comply with the CA.

TUs commitments in the area of H&S. In the national CA, TUs have committed to carry out at least one information campaign through their social media on workers’ rights, for example on psychological violence at work; to inform the SLI about ongoing or potential violations of legislation; to contribute to the containment of the Covid-19 pandemic, and to advise their members on protective measures against the coronavirus infection; to conduct surveys of its members to find out what work-

related stress-reduction measures would be most acceptable and effective in the workplace, and to share the results of these surveys with the Ministry of Social Security and Labour (MSSL); to make suggestions to the employer on the practical improvement of work processes in the workplace; and some other obligations.

To summarise the above material, the LHSE regulates in great detail the procedures for workers' participation in the implementation of H&S measures, the establishment of HSCs, the rights and obligations of workers' health and safety representatives and the obligations of employers. Meanwhile, other legislation in force in the country regulates in great detail working and rest periods, hygiene standards, occupational risk assessment procedures and a number of other H&S-related issues. For these reasons, the CAs do not address the above mentioned key H&S issues. As a rule, issues that are usually less important or provide additional benefits for TU members, such as additional rest days or more favourable pay conditions for TU members, are left to the social partners' agreements. At the same time, it should be noted that quite a lot of attention, even unprecedented, is currently being paid in the national CA to the prevention of psychological violence at work and to the TUs' empowerment to propose preventive measures, to their responsibility in reporting cases and to their participation in the investigation of such reports.

Since TUs are rather active in the sector, they are involved in solving H&S issues (when dealing with specific issues or updating H&S descriptions/documentation) at the workplaces and contributing to dialogue with employers regarding very practical solutions. However, according to interviewed TUs, there is a problem in those workplaces where work councils implement the role of employees representatives as they perform their duties formally only, even though if they are elected by employees – they approve everything that suits well for the employer and needs to be formally approved: work schedules, working time sheets, everything the employer needs, and do not really represent the rights and interests of employees³¹.

As regards the multi-level focus, we may conclude that there is actually no interaction in Lithuania among different level actors on H&S issues in CAs. Although the national CA provides that “the parties shall endeavour to conclude a single sectoral collective agreement”, neither the national nor the sectoral CAs actually contain any other provisions enabling agreement on H&S issues in lower-level CAs, or any provisions elaborating on guarantees. It is true that the sectoral CA provides that H&S issues are to be specified and coordinated with the local-level TUs and set out in the institution's system of remuneration for work.

It is of note that such a situation may be due to the peculiarities of employer representation in the social care sector in Lithuania, where both national and sectoral CAs are signed by the MSSL on the

³¹ According to SLI data (in 2020), work councils were active only in 44% of workplaces where they should be unless a TU is in place.

employer's side. At the same time, the MSSL is also the founder or indirect employer of a large number of institutions in the sector: even when the municipality is the founder of the institutions, their budgets are de facto dependent on the decisions of the Government or Parliament of the Republic of Lithuania. The MSSL also has the right to initiate legislation, it is the drafter of governmental resolutions relevant to H&S and, lastly, it is the MSSL that issues the orders regulating some H&S issues (see section 1). In principle, all the substantive H&S guarantees are regulated by the national centralised legal framework. As the MSSL plays a special role in the social care sector in Lithuania, it should also be mentioned that, by assuming both the function of employer in the sector and, in principle, by shaping all social policies, including H&S issues, it tries to involve all stakeholders in the decision-making process, using the existing structures for this purpose: consultation of the social partners is carried out at the Tripartite Council of the Republic of Lithuania and representatives of the SPs are involved in the various working groups, through the Social Work Council, etc.

4. Quality assessment by the social partners

In general, SPs, especially TUs, poorly rate the level and quality of social dialogue in the sector. According to the SPs: *“SD seems not to be a priority in the country, the Government, ministries do not put efforts to encourage it [...] Lack of managerial awareness together with mentality of "fear of the authorities" hinder SD mostly [...] The general culture of dialogue is low – social dialogue is rather formal: employees are invited formally to speak up, but they do not dare speaking as they are scared to lose their jobs [...] Organisational culture where employers are seen and see themselves mainly as unilateral decision-makers and seek to preserve their "power" is prevailing [...] The reason why employees avoid joining the TU is the persecution carried out by employers after one becomes a TU member, especially TU leader (who becomes exposed to exaggerated performance inspections of his/her job tasks, mobbing and harassment, etc). All those persecutions are carried out by the employer and management; sometimes even psychologists in the institution are used to persecute TU members. Many employees changed their workplace only because of mobbing. The fight against mobbing in institutions is demonstrative only; investigations, answering the question whether there was a mobbing or not, do not correspond to the reality’*. On the other hand, SPs agree that TUs themselves are often rather rigid – they do not support innovations coming from the Government or EU, ignore opinions of young people; SPs agree that in order to survive and be efficient, TUs also have to renew and adopt to a new reality.

As regards the participation of employees in the resolution of H&S problems at the workplace level, according to TUs, it is common in Lithuania for an undertaking/institution to have a formally established and functioning HSC, but in practice all decisions are taken by the employer (or a person representing the employer). This situation arises because, according to the LHSE, the chairperson of

the HSC is appointed by the person representing the employer or a person authorised by the employer. In the absence of TUs in the undertaking/institution, the participation of an employee representative in the HSC is often more formal, and although de jure employees are deemed to participate in H&S management structures, in reality all matters relating to the H&S of employees are unilaterally decided and regulated by the employer. Another reason for this lack of involvement on the part of employees is their heavy workloads - respondents identified the problem of burnout, i.e. at the end of a shift, employees simply don't want to do additional activities due to fatigue.

5. Quality assessment

While assessing the quality of the H&S regulations, we may conclude from the desk research and conducted interviews that overall quality is rather poor, although there is rather strict and detailed national legislation and institutions ensuring the implementation of H&S regulations in practice.

Formally, there is a full set of channels for ensuring H&S at the workplace (also mainly determined by the national regulation) – H&S professionals, H&S committees (often rather formal, but in case of active TUs might be a rather efficient tool); H&S representatives; commissions for accidents at work; TUs (in the absence of TUs – work councils, but very weak in the area of H&S); mandatory occupational risk assessment schemes (followed by the plan for risk prevention; also often rather formal in practice); bipartite councils (in the social care sector) – as well as a number of institutions ensuring H&S supervision and enforcement: State Labour Inspectorate, labour dispute resolution commissions, founders of social care institutions (MSSL and/or municipalities), Ombudspersons of the Parliament.

However, the formally existing comprehensive system does not ensure efficient implementation of the national legislation in practice and enforcement thereof. Such a situation is due to a number of reasons, including weak trade unions, inactive employees, and ineffective social dialogue (many of the CAs in place in the sector are of a declarative nature; they are lacking concrete measures and agreements aimed at improving workers' H&S and capable of actually improving the workers' H&S in the sector), and the specific “management structure” of supervising institutions.

One of the key H&S problems in the sector is the high workload (the number of customers per employee), which leads to burnout and other health problems of employees, is addressed in the MSSL Order in the form of recommendations rather than by binding legal norms and in CAs - by the shortening of working and rest periods. This further complicates the situation, especially in institutions with more TU members. Thus, the lack of a legal framework with a high level of responsibility for the MSSL, the insufficiency of political decisions and resources, and the weak influence of TUs and CAs lead to a situation where not all of the major H&S problems identified by the SPs are given consistent and strategic attention.

Hygiene standards, premises and other “physical” issues dominate the legal framework and the requirements of the controlling authorities, while the human being, the employee, receives insufficient attention. However, it is often the case that even clearly and strictly regulated legal norms are not respected in practice. For example, an example was given during the interview where employees were working in extremely hot and unventilated rooms.

The Department of Supervision of Social Services under the MSSL is involved in the control of social care institutions by controlling the standards of care, not the H&S requirements, and by issuing licences to these institutions, whereas the SLI is responsible for H&S only. The status of the SLI itself, as it is a body subordinate to the MSSL, is also likely to have a bearing on the monitoring of working conditions. The sector has a large number of social service institutions, founded by the MSSL as well. It is therefore difficult to realise that the SLI would in practice impose sanctions on the employer, who is actually the founder of the SLI itself. It is also rare for the SLI to impose sanctions on social service institutions whose founder is a municipality, but the budgets of which are de facto dependent on the Parliament or the Government, and the setting of the requirements themselves (such as recommended workloads, etc.) is the responsibility of the MSSL. This situation suggests that, even with a rather strict and detailed legal framework, compliance with the H&S requirements is best ensured in practice where there are active TUs or a “good” manager.

In summarising the H&S situation in the social care sector, it can be noted that there are quite marked differences between large cities and regions: better working conditions are in regions as there is lower demand for long-term care institutions and institutions are smaller, with less customers, whereas the situation is opposite in large cities – elderly homes are overloaded and workloads and psychological abuse for social care employees are therefore higher. The current situation cannot be changed by TUs, which are quite active in some institutions, and which acknowledge that, although legal instruments are already in place to address the problems of psychosocial risks and staff motivation, the knowledge and resources of TUs are very scarce and the State does not give strategic attention to the fundamental problem of staff workloads in the sector.

6. H&S challenges and how to tackle them

Despite the fact, that in Lithuanian social care sector rather detailed and centralized legal regulation, covering all the employees is prevailing, its implementation in practice remains insufficient. Such a situation reveals itself in poor working conditions and numerous H&S challenges.

One of the most pressing problems is the culture of trust together with poor psycho-emotional relations with colleagues and administration, mobbing and risk of burnout results in high psycho-emotional risk level in long term care institutions, especially in the regions. Other problems to deal with are: heavy workloads (related to the lack of personnel), working time recoding problem, non-

competitive wages and quality of services. Mobbing is also related to lack of confidence in the work performed by employees, constant ingratitude, disrespect which is rather experienced from managers than from customers. Despite labour shortages in the sector, employees' fear of losing their jobs keeps employees "quiet". There is no trust in confidentiality of psycho-social risks evaluation process as there is a strong belief that employers organize it through acquaintance, so employees' answers do not correspond reality.

The existing challenges might be solved by the effective social dialogue, however despite formally rather high trade union density and collective bargaining coverage in the sector, often in practice it is not effective. It was called by the interviewees as rather 'synthetic' or artificial, not fulfilling the role of real dialogue. It might be noted here as well, that in practice active trade unions rather often succeed in defending employees' rights in cases of inappropriate workloads or lifting weight limits, however it is more often done through representing employees' interests in individual labour disputes, but not through collective bargaining or collective agreements. According to interviewees trade unions also not succeeded to incorporate another sore problem into the sectoral collective agreement – additional health insurance and accident insurance; despite all efforts of sectoral trade unions the issue was left for the local level and in practice is not always solved appropriately.

Among the recent developments in the area of H&S regulation and social dialogue, the most often was mentioned new regulation of psychological violence (amendments of Art. 30 of the LC³²) and establishment of a specialized "mobbing division" at the SLI. According to the interviewees despite rather strict and detailed regulation and special attention to the challenge, in practice situation is changing very slowly and trade unions admit existing lack of knowledge and skills to deal with the issue.

Another recent development – shortening of working hours for employees-members of signatory trade unions of sectoral collective agreement – also had a twofold effect. An aim to ensure better working conditions for employees in reality even worsened situation, as challenge of insufficient human resources was even deepened (it became difficult to organize work, especially in institutions with a large share of union members).

Among positive recent developments the amendment of the Law on Social Services providing mandatory supervisions might be mentioned. It is expected that supervision led by a professional supervisor will reduce psychological stress and improve the emotional state of employee, reduce the risk of burnout and improve the human resources situation in social care institutions.

While speaking about the future developments, social partners agree, that among the most urgent tasks are significant reduction of excessive bureaucracy and more efficient use of new technologies

³² 2022 06 28 Law (amending Labour Code) No XIV-1187 (valid from 2022 11 01) (TAR, 2022, Nr. 2022-15174)

(including IT, data exchange via e-health system, etc.); further improvement of some specific legislation related to the clearer description of functions and tasks of social care employees; drafting and implementation of national quality standard (NQS), applicable to all social services providers, which has to ensure not only adequate quality of services provided, but also a quality of working conditions, including their H&S.

7. EU-level H&S dialogue and regulations

As there actually are no employer organisations in the social care sector and trade unions' capacities (including human resources) are rather limited, engagement of national sectoral actors in EU-level H&S activities is modest. The main actor implementing EU-level H&S regulations at the national level is Government (represented by the MSSL). The main law, regulating H&S in Lithuania – the LHSE as well as other related legislation are transposing all main EU directives in the area of H&S. So, despite rather weak capacities of national level social partners, all mandatory provisions are transposed in the national legislation by the Government. Therefore social partners in Lithuania, especially trade unions, traditionally emphasize the importance of imperative European regulation as in countries with weak social dialogue this ensures implementation of the European standards in the country.

Here we may mention, that Art 198 of the LC foresees possibility of extension of the scope of application of national and/or sectoral collective agreement, which formally might be used as a legal instrument for transposition of EU directives however it have been never happened in practice.

On the other hand, there are a lot of limitations of this provision³³ and if situation in the area of social dialogue and industrial relations and regulation thereof will not change, the Government will remain the only actor in the area of transposition of EU-level H&S regulations. In the social care sector this situation is even more determined by the fact, that in this sector the MSSL actually plays a twofold role – represents the Government in collective bargaining as it is actually the main employer in the sector and is responsible for legislation initiatives, including transposition of EU legal requirements into national law.

8. Multilevel coordination

As mentioned above, in Lithuania, the most important role in H&S regulation in the social care sector is played by the MSSL, and this area is quite strictly regulated. Taking into account the role of the state in this area and the fact that SP organisations are generally rather weak and, as a rule, do not have sufficient human resources to deal specifically with H&S issues, it can be said that SP

³³ Davulis, T. (2004) Darbo teisė: Europos Sąjunga ir Lietuva. 153-154 p.; Krasauskas, R. (2007) Darbo santykių reguliavimas kolektyvinėmis sutartimis. PhD Thesis. MRU, 157-159 p.; Krasauskas, R. et al. (2013) Kolektyvinė darbo teisė. Vadovėlis. MRU, 409-411 p.

involvement in developments on H&S is rather low in general. On the other hand, as mentioned above, there are certain institutions and mechanisms through which SPs are involved in decision-making, including in the area of H&S, such as the Tripartite Council of the Republic of Lithuania, Occupational Health and Safety Commission, various working groups and task forces, Social Work Council, other.

The same applies to awareness of and involvement in EU-level developments/SSDCs. Although, in general, TU organisations are represented in the SSDCs, their capacities in the area of H&S are insufficient to participate effectively in the EU-level developments. Given the current situation, i.e. the important role of public institutions and generally rather weak TU organisations and SD, the social partners to some extent put up with the current situation and "make way" for the MSSL to play a leading role in the development of H&S policy and implementation of EU-level initiatives in the area of H&S. Unfortunately, it should also be mentioned that during interviews with MSSL representatives responsible for social services policy in the country, they admitted not being able to comment on EU directives or other EU legal requirements in the field of H&S, as well as on the specific features of H&S in the field of social services, as they do not have the relevant knowledge and competences in the field of H&S.

Appendix:

1) Table interviews conducted

#	Date (Month)	Duration	TU or EMP	Sector	EU affiliation	IP's role/ function, focus (e.g. H&S policy, H&S workplace rep, employment relations, collective bargaining, other)
1.	26 04 2022 and 29 04 2022	1 hour 35 min. and 1 hour	EMP	Social services	Federation of European Social Employers; European Ageing Network	H&S policy, employment relations, other (training for employers)
2.	26 04 2022 and 24 05 2022	1 hour 23 min. and 42 min.	TU	Social services	European Confederation of Independent Trade Unions (CESI)	Employment relations, collective bargaining
3.	29 06 2022	49 min.	EMP/ GOV	Social services	-	Collective bargaining, social services policy
4.	02 08 2022	1 hour	TU	Social services	European Confederation of Independent Trade Unions (CESI)	Collective bargaining, employment relations, TU member representation in individual disputes', EU level representation

2) Legal framework

HEALTH & SAFETY LEGAL REGULATION IN HOSPITAL AND SOCIAL CARE SECTORS: LITHUANIA

I PART. "HEALTH AND SAFETY" LEGAL STANDARDS INCLUDE:

1. General standards on "health and safety" ("Framework Directive" (89/391/EEC) on the introduction of measures to encourage improvements in the safety and health of workers at work and related directives, international standards (ILO, etc.) and national legal regulation).

2. Working and rest time (Working Time Directive (2003/88/EC), corresponding ILO and national legal regulation).

3. Guarantees (including wage, extra wage for over-time, higher job intensity, pensions, sick leave, professional development, etc.)

4. Risks and psychosocial risks assessment, prevention (including workloads, harassment).

5. Other issues indicated by social partners as important and related to “health and safety” of those working in hospitals and social care sectors.

II PART. LEGAL REGULATION ON HEALTH & SAFETY CONSIST OF 4 LEVELS:

1. Law level legal provisions established in the LC, LHSE. Law provisions are of the most general nature and are applicable in all sectors of economy;

2. More detailed provisions in by-law level: i. e. “Description of Short-term Working Standards and Payment Procedures” approved by the Governmental Resolution No 496, June 21th, 2017; „General Provisions on Occupational Risk Assessment” approved by Order No A1-457/V-961 of Minister of Social Security and Labour and Minister of Health; etc.

3. National and Sectoral collective agreements;

4. “Local level” provisions – established in company level collective agreements and company level documents.

III PART. ROLE OF SOCIAL PARTNERS IN HEALTH & SAFETY LEGAL SYSTEM DESCRIBED BY

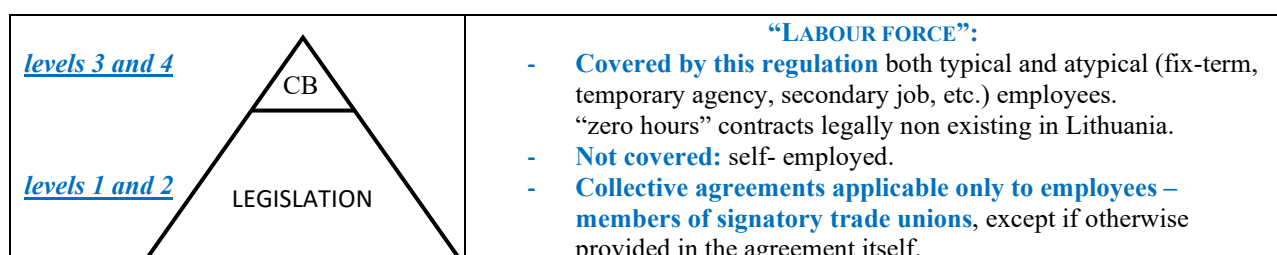
3 MAIN FUNCTIONS:

I. Consultation with legislator seeking to adopt the required legal norms (levels 1 and 2, see II PART of this document).

II. Collective bargaining or other regulation – negotiating and approving legal norms via sectoral collective labour agreements and “local level” (levels 3 and 4, see II PART of this document).

III. Implementation and control function – being aware how all 4 legal regulation levels are actually functioning in practice (if not functioning – right to collective actions or consultations for new legal regulation).

CONCLUSIONS: collective bargaining and “local level” provisions (levels 3 and 4) constitute only insignificant part of “health and safety” legal regulation in Lithuania (see triangle below). The dominant levels are 1 and 2.



HEROS: HEALTH RISK OUTLOOKS BY SOCIAL PARTNERS

Maciej Pańków, Institute of Public Affairs

Country report – Poland

Hospitals and healthcare sector

INTRODUCTION

This report is based on analysis conducted as part of the research project 'HEROS: Health Risk Outlooks by Social Partners'. The main objective of the study is an in-depth description of the functioning of the national health and safety (H&S) system at its different levels in relation to two sectors: healthcare and care services. The study specifically addresses the role of the social partners (trade unions, professional associations, employer organisations) in the regulation and functioning of this sphere. It utilises a desk research analysis and the conclusions of the ten individual in-depth interviews conducted with representatives of the social partners associated with the healthcare and/or social assistance sectors, or involved in the H&S sphere. The interviews were conducted between May and December 2022. Reaching the relevant informants posed serious problems, which may be due to the relatively low level of interest in H&S issues and the general work overload that affects workers in both sectors, which are characterised by significant employment deficits. As evidence of the first reason mentioned, the words of one respondent, representing the national structures of a trade union, can be quoted, who admitted that the representatives of social assistance institutions she interviewed consider the low level of wages to be the main problem of their sector. This is undoubtedly an issue to which they attach more importance than to the problems analysed in this report, and it is on this issue that their activities are focused. A way of dealing with the high level of reluctance of the relevant sectoral actors was to interview representatives of the cross-sectoral structures relevant to the H&S issue. However, it was not possible to conduct any interviews with representatives of employer organisations. This report, after discussing the general characteristics of the Polish H&S and collective labour relations systems, focuses on the healthcare sector, while a separate document analyses the functioning of the H&S sphere and the social dialogue concerning it in the social services sector.

I. GENERAL PART

1. Sources for health and safety (H&S) regulations

In Poland, universally binding acts of general law are the almost exclusive source of regulation of the sphere of occupational health and safety. The protection of employees is guaranteed by the Constitution, which states in Article 24 that "work is under the protection of the Republic of

Poland" and that "the state exercises supervision over the conditions of work". At the same time, Article 66 states that "everyone has the right to safe and hygienic working conditions", adding that the manner in which this right is exercised, as well as the employer's obligations, is determined by law, which is the Labour Code.

a. EU legislation

EU legal acts seem to be little known, at least to those interviewees who do not deal with social dialogue at the EU level or the process of implementing EU acts in the national legal order. However, some interviewees were able to refer to them, albeit usually to a limited extent – for example, the Directive on the prevention of sharps injuries (2010/32/EU) is important in the view of the representative of the nursing community (IP3). In another interview (IP8), reference was made to discussions currently taking place within the European Union Health and Safety Committee on the issue of exposure to substances contained in medical products.

b. National legislation

As indicated above, the basic legal act regulating the sphere of H&S is the Act of 26 June 1974 Labour Code. The H&S issues are regulated in Section X of it. In addition, relevant for the analysed area are some other acts, including those establishing supervision and control over working conditions (the Act of 13 April 2007 on the State Labour Inspectorate) and regulating some specific issues, e.g. the Construction Law. The aforementioned national legal acts are in line with the requirements arising from the acts of European Union law. For example, the Labour Code lists a number of directives that have been implemented in Poland, many of which relate to the field of H&S (e.g. Directive 89/391/EEC of 12 June 1989 on the introduction of measures to encourage improvements in the safety and health of workers at work).

In general, the interviewees rarely referred to specific provisions of the general law in the interviews, which, however, should not be explained by their unfamiliarity, at least with regard to national acts, but rather by the construction of the questions and the logic of the interview scenario.

c. More specific legislation that applies to the 2 sectors

At a lower legislative level, there are specific regulations, i.e. regulations set by individual ministers, which further specify various aspects of H&S, such as the Regulation of the Minister of Health of 2 February 2011 on tests and measurements of factors harmful to health in the working environment. Among these, there are sector-specific regulations. In particular, there is a large number of them for the healthcare sector (according to the IP8 interviewee, there are about twenty), where issues such as harmful biological agents, exposure to sharp injuries or ionising radiation are

regulated. In contrast, according to the same interviewee, there are no specific regulations concerning the H&S sphere in social services sector, which seems to be the case. There are, for example, national standards for the maximum weight of objects to be lifted, but not for people (e.g. patients of nursing homes).

2. Role of collective agreements for H&S regulations and workplace H&S representation

a. substantive issues

The field of H&S, as already noted above, is generally not regulated through collective agreements, which is partly to be explained by the general scarcity of collective bargaining – see point b below. None of the respondents were able to comment on the content of collective bargaining in relation to H&S in the healthcare sector.

b. procedural issues

In general, Poland is characterised by low coverage of collective agreements and almost no, except for a few examples in some industrial sectors, multi-employer agreements. There is also no practice of extending collective agreements to the whole sector. For the sectors surveyed, based on Eurofound's analysis, collective agreement coverage is extremely low even compared to Poland, at 2% for the healthcare sector (Eurofound 2022). There are therefore single collective agreements in force in a small number of establishments. This has been confirmed by the information provided by interviewees, for whom collective bargaining is clearly not a familiar practice. They were only able to comment on this area of union activity from a certain distance, emphasising that a very small proportion of both healthcare and social care institutions are covered by collective agreements. In the case of the first of the sectors analysed, only the representative of the nurses trade union (IP3), with in-depth knowledge of the situation in the region where she holds her position, was able – without giving details – to indicate two hospitals where, to her knowledge, agreements are in force. Another interviewee (IP8) stressed that the negotiations mainly focus on the issue of wages.

II. H&S in the healthcare sector

3. National, sectoral industrial relations systems

a. Levels

In Poland, the dominant level of collective labour relations is the company level. It is at the company level that there are few cases of collective bargaining, where industrial disputes are initiated and where consultation and information of employees is carried out. The primary actor representing employees at the company level is the company-level trade union organisation. Other

bodies, such as works councils, have only an additional, consultative and informative role and are not popular in Poland. In practice, works councils, which, on the basis of national legislation implementing Directive 2002/14/EC of the European Parliament and of the Council, can be established at the request of the workers' side in companies employing at least 50 persons, were not mentioned at all by the interviewees. On the other hand, company-level trade union organisations, set up at the request of at least ten employees, can be both independent entities, as well as join sectoral federations or be part of inter-company organisations present in more than one workplace. They can also form organisational units within large, nationwide unitary unions. In turn, these large organisations can form national sectoral structures representing workers in specific sectors, especially for the purposes of national tripartite dialogue (Social Dialogue Council, RDS) or regional tripartite dialogue (Voivodeship Social Dialogue Councils, WRDS).

b. Actors

A significant number of different trade unions are present in the sectors studied, while the number of relevant employer organisations should be considered limited. On the trade union side, the most key organisations are:

- Both sectors:

- Independent Self-Governing Trade Union "Solidarność" (the largest unitary trade union, nationally representative), with a sectoral structure, coordinating the activities of the company organisations – National Secretariat of Healthcare (affiliated to EPSU), composed of: National Healthcare Section and National Welfare Section;

- Federation of Trade Unions of Health Care and Social Welfare Workers (FZZPOZiPS) - affiliated to EPSU and to the All-Poland Alliance of Trade Unions (OPZZ) (the largest trade union confederation representative at national level);

- All-Poland Trade Union "Workers' Initiative" of Medical and Skilled Carers (OZZ IP OMIK)

- Healthcare sector:

- The Polish National Trade Union of Nurses and Midwives (OZZPiP), affiliated to the Trade Union Forum (FZZ) (the second largest trade union federation representative at the national level);

On the side of employers there are the following organisations:

- Healthcare sector:

- Employers of Private Medicine

- National Association of Poviast Hospital Employers

c. Membership

Trade unions are divided into organisations associating representatives of any professions and jobs present in a given sector, such as NSZZ "Solidarity" or unions that are part of FZZPOZiPS, and into trade unions associating employees of specific professions. OZZPiP should be considered the most important of the latter.

Trade unions do not always disclose the number of their members. However, membership in the two largest unions present in the healthcare sector is known. Based on Eurofound estimates (2022: 114), OZZPiP covers about 12% of employees in this sector. According to the data available on its website, the union associates more than 80,000 nurses and midwives, i.e. nearly 1/3 of all active representatives of these professional groups (according to the data of the Central Register of Nurses and Midwives), within over 650 company organisations. Compared to other sectors and occupational groups in Poland, we are dealing here with a high union density rate. On the other hand, according to Eurofound's estimates (ibid), NSZZ "Solidarność" associates approx. 5% of employees in the healthcare sector.

d. Sectoral system of workplace H&S representation

In Poland, institutions related to the functioning of the H&S field are present mainly at the workplace level. At the same time, it should be noted that the most effective of them, the Social Labour Inspectorate (SIP), is closely linked to the company trade union organisation – if trade unions are absent in a given workplace, this institution will not be there. Social labour inspectors have extensive powers to inspect the broadly defined employment and working conditions for their compliance with the applicable law. Among other things, they can monitor the condition of buildings and equipment, the degree of compliance with collective agreements and take part in examining the circumstances and causes of accidents at work. Interviewees representing unions attach great importance to this institution. Among other things, interviewee IP8, who is active in the national structures of her trade union, participates in the training of social labour inspectors. Another interviewee, IP3, being the president of a multi-company trade union organisation in a number of hospitals, acts as a social labour inspector. In order to perform this function as effectively as possible, she completed postgraduate studies in occupational health and safety management. At the same time, the IP8 interviewee assessed that some employers make the work of SIPs difficult or discriminate against inspectors. Sometimes they restrict their ability to investigate the causes of accidents at work and in some cases even dismiss them, despite the fact that they are employees protected from dismissal under the applicable legislation. This is also where, in the interviewee's

opinion, a too cautious attitude of some inspectors comes from. As a way of dealing with problematic employers, in view of the lengthiness of the labour courts, the cooperation of unions with the State Labour Inspectorate – the main public institution responsible for controlling compliance with labour law – was mentioned. However, its enforcement capacity is also limited, if only because of the small amount of financial penalties it can impose on unreliable employers.

In workplaces with at least 250 employees – so, for example, larger district (local) hospitals, provincial (regional) hospitals or specialised hospitals – the employer is obliged to set up health and safety committees. The committee is an advisory and consultative body composed in equal numbers of representatives of the employer, including the H&S staff and the doctor providing preventive health care to the employees, and representatives of the employees, including the social labour inspector (if there is one in the workplace). The existence of H&S committees in hospitals was mentioned by a representative of the nurses' union (IP3), who is vice-chair of such a body.

e. National, sectoral, and regional, local dialogue on H&S issues

Social dialogue on H&S to a limited extent (as already indicated in the sections on collective bargaining) takes place at the company level. This includes the rare practice of collective bargaining, including a potential practice (and not found in the survey) of negotiating H&S provisions in a shape that goes beyond the common law. Additionally, a possible situation at the company level is the initiation of an industrial dispute by a trade union party. However, no example of such a dispute involving H&S issues was cited during the interviews. In larger entities (with at least 250 employees), the already mentioned H&S committees also play a role, but they are not typical social dialogue bodies but more like working groups. Trade unions also play a role of a consultative nature. This concerns, among other things, the content of employment regulations. The IP3 interviewee suggested that as long as the trade union side agrees on a common position, they can quite effectively block unfavourable proposals for changes to this document. Again, however, she acknowledged that H&S is not an issue that is often discussed, and that the unions' efforts most often revolve around wage issues.

Based on the interviews, it is fair to say that H&S is not a topic that is present at the multi-employer level – there is a lack of both relevant collective agreements and social dialogue bodies. Potentially (which the interviews did not show, however), H&S could be discussed within the framework of the Voivodeship Social Dialogue Councils (WRDS), which are tripartite dialogue bodies at regional level.

At the national level, the tripartite body where H&S issues can be discussed is the Social Dialogue Council (RDS). It should be noted, however, that this body is consultative in nature – the results of

its discussions are not binding on the government side. It is, however, an important forum in which key public policies are consulted. In parallel, the social partners may submit opinions on draft legislation to the relevant ministries – again, their consideration by the government is not obligatory. In addition, there are a number of RDS problem teams dedicated to specific areas of public policies and sectoral tripartite bodies at selected ministries. Therefore, it is possible to speak of as many as two bodies relevant for the healthcare sector – these are:

- Ad hoc Healthcare Team - created for the COVID-19 pandemic, and still in place at the time of the report, a body that replaced the former Healthcare Sub-team within the RDS Tripartite Team for Public Services.
- The Tripartite Team for Healthcare at the Ministry of Health – a social dialogue body separate from the RDS structure, in existence since 2005. In the opinion of the IP5 interviewee, this team has relatively less influence than the one described above, which is due to the lack of opportunities for direct interaction with the RDS (such as, for instance, referring certain issues for discussion in the Council plenary)¹.

As can be seen, the national-level tripartite dialogue concerning the area of healthcare is relatively highly institutionalised. At the same time, it should be borne in mind that with regard to the analysed sector, as well as many other areas of public policies and sectors of the economy in Poland, the dominant model of interaction between the governmental side and the social partners is based on the latter's written opinion on draft legislation.

f. Description of H&S regulation process and practice in the healthcare sector

Generally, regulation in the healthcare sector takes place through legislation, so it is strongly state-driven, and the typical role of the social partners is reactive. Usually, it is the state that initiates the legislative process, with the social partners providing written feedback on draft legislation. More relevant or problematic issues become the subject of consultation within the bodies mentioned in 3e. The interviewees were not able to give many examples of dialogue on specific issues, although it should be assumed that a significant amount of legislation, including specific ministerial regulations on various aspects of H&S, was subject to consultation. Two interviewees were able to refer to dialogue related to the challenges arising from the COVID-19 pandemic. According to information from an interviewee dealing with social policy, health care and occupational safety, representing a nationwide confederation of trade unions, (IP5), the Ad hoc Healthcare Team of the RDS has been dealing quite intensively with the issue of risks to workers in the healthcare area, as

¹ At the same time, however, an interview with another trade union representative from the health sector, who was interviewed by an IPA researcher in another project, shows that this team also plays an important role in the area of consultation and opinion and has been the most active social dialogue body in the sector for years.

well as to workers in nursing homes (DPS), in the context of the pandemic. It set up a working group that developed recommendations for the Ministry of Health on standards for the use of protective clothing to prevent contagion (masks, overalls), including standards for the length of time spent in it. In the course of the work, there was cooperation with expert institutions such as the Institute of Occupational Medicine and the Central Institute for Labour Protection (CIOP). This work resulted in a document addressed to the Ministry containing these recommendations.

g. Multi-level focus – if and how do actors at different level interact

Interaction between the different levels of the H&S system is relatively limited, although it does occur. For example, the IP8 interviewee, working for the national structures of her trade union, on the one hand liaises with the secretaries and presidents of the sectoral structures, obtaining from them knowledge of the needs and expectations of the respective sectors regarding the trade union's position in the area of H&S (in more complex cases, the representatives of the sectors are directly involved in the dialogue at the national level, including within the RDS). On the other hand, she actively supports social labour inspectors, including by organising training for them. However, it is worth noting that – in the opinion of the IP3 interviewee – if the employer hinders the activities of the SIP, trade unionists from the company level most often turn to the State Labour Inspectorate (PIP) for support. In general, however, trade union sectoral structures and trade union federations support company organisations and mediate between them and the government side in articulating their needs and expectations as to the shape of legal regulations, as indicated by the IP3 interviewee.

An additional level of social dialogue can also be distinguished, concerning the implementation of EU law into national legislation. Here, trade unions are involved not only in relevant sectoral bodies, but also in the Problem Team of the RDS for International Affairs, dealing with the implementation of key EU legislation into national law. It examines, among other things, the extent to which national law has been amended to comply with the requirements of directives or other EU legislation. However, a member of the team (IP4) was not able to give examples of policies relating to the sectors under study that had been discussed in this body.

4. Quality assessment by the social partners

a. Concerning effectiveness and coverage of H&S in the sectors

Interviewees were able to refer to some general characteristics of H&S functioning in the sectors studied to a limited extent, providing rather qualitative arguments, which are discussed below in section 4c. Undoubtedly, what emerges from the interviews is a picture of the healthcare sector as better regulated than the social services area. A number of specific regulations by the Minister of Health detail the rules in the area of H&S applicable to hospitals. The coverage of the sector by

collective agreements is, as already indicated above, negligible, which, however, interviewees generally see as a normal situation. More important for them seems to be the possibility to intervene in case of H&S violations, which is mainly possible where trade union organisations are present, thanks to the SIPs led by them. For more on this, see section 4b.

b. Concerning variations between occupational groups, workplaces

The interviews reveal a difference in H&S field mainly between the two sectors - as mentioned above, the social services area has far fewer detailed regulations that health workers enjoy (even if the actual application of these by employers and the possibilities of enforcement may be questionable in some cases - see point c). This difference, given the overwhelming dominance of the common law in regulating working conditions, must have a fundamental impact on the effectiveness of the H&S area in both sectors. In favour of the healthcare sector as providing its employees with better respect for the analysed area is also the presence of stronger trade unions in the sector, with the most important one being the OZZPiP, which ensures the possibility of functioning of the SIP in a relatively large proportion of hospitals and a more audible voice of a consultative nature for employee representatives at the workplace.

c. Overall assessment

The interviewees' assessment of the overall quality of the H&S system in Poland should be considered rather negative. Admittedly, the interviews indicated the presence of specific regulations for the healthcare sector (this situation does not apply to the social services sector) and pointed to the important role played by the Social Labour Inspectorate. On the other hand, when asked directly about the effectiveness of protection, interviewees were critical. A representative of the nurses' union (IP3) assessed that there are cases of H&S being downplayed and not taken into account. There are even cases when employers, in her opinion "pointlessly", appeal against PIP decisions. She gave the example of a very neglected hospital ward that had not been renovated for many years, despite admonitions from the SIP and PIP. She assessed that PIP sanctions are inadequate for H&S negligence – we are talking about fines of a few thousand zlotys at the most (1 zloty = 0.22 euro), which hospital directors earning significant amounts of money, according to the interviewee, are not afraid of. The interviewee's statement regarding the SIP, that it is a necessary institution with a potentially significant role in ensuring safe working conditions, should be considered important; however, the role of inspectors by trade unionists requires knowledge and determination that they do not always have, especially in the face of reluctance on the part of the employer.

Also, the representative of the trade union of medical carers (IP2) is not satisfied with the degree to which H&S regulations are enforced, although she pointed out that particularly standards for lifting patients are missing, while – for example – personal protective equipment is mostly provided. It is

worth indicating at this point that medical carers are a specific occupational group, which has just in recent years been recognised and integrated into the healthcare and social services system (although it is still not mandatory for hospitals to employ their representatives), and is also extremely little unionised. A representative of the association that until recently was the only representative of medical carers (IP1) stressed that, lacking trade union status, it had very little power to influence working conditions. Therefore, until it was decided to set up a separate trade union which took over the typical tasks of such an organisation while the association focused on educating workers about their rights. As an example of a poorly working solution, an interviewee indicated the obligation for an employee reporting irregularities to the PIP to provide their personal data. Although this institution is obliged to keep this data confidential, according to the interviewee, some employees are afraid to give it to the employer – the problem would be solved by complete anonymity when reporting a problem.

5. Quality assessment

a. Assessing the quality of H&S regulations

In general, it should be considered that the common law regulates exhaustively the sphere of H&S in the healthcare sector (although it should be agreed with the interviewees that there are some gaps, such as with regard to lifting standards or the duration of time spent in protective clothing). This is due to the alignment of national law with the requirements arising from EU directives and other legislation. It should also be assumed that the regulations are, as a rule, implemented in workplaces, although undoubtedly the problems faced by the analysed sector – shortage of workers, underfunding (see point 6) – induce such compliance with the regulations, which in many cases may not fully effectively protect the health or even life of workers. It is a matter of such implementation, which can be described as minimal, sometimes even superficial (e.g. poor quality and hurriedly conducted H&S training, just to meet the requirement to conduct it), and in extreme cases even – as suggested in the interviews – accepting (of course, informally) by the management of medical facilities to cover the costs resulting from PIP fines for certain violations of H&S regulations, when the cost of e.g. renovation eliminating these violations would be much higher.

The institutions enforcing the implementation of the H&S rules, while potentially having broad powers to execute labour law – this includes both the union-managed SIP and the state PIP (the former can even order the suspension of work until violations are remedied, and the employer side must then appeal to the latter if it raises an objection) – in practice, however, they experience many of the limitations already indicated above. In the case of the former, determination and firmness towards the employer is needed, which in many cases is not easy. With regard to the PIP, the

problem is mainly the already mentioned disproportionate penalties, which do not deter employers from committing H&S negligence.

b. Effectiveness of H&S regulations in protecting different members in the 2 sectors

The effectiveness of the H&S regulations – which are themselves constructed in principle correctly and in accordance with EU law – is limited by the deficits in their enforcement mentioned in section 5a. It should again be particularly emphasised that it is difficult to have effective enforcement in workplaces where trade unions are not present. In this respect, healthcare workers are in a better position than those employed in the second sector under scrutiny, as there are relatively strong trade unions in this sector, and a large proportion of hospitals have at least the presence of the OZZPiP. When there is no trade union, employers are the only party responsible for implementing the regulation, which may raise concerns about its diligence and transparency in the event of an accident or irregularity. The voice of workers in such establishments, even if they have more than 250 employees (obligation to set up an H&S committee), is at best marginal and dependent on the will of the employer side.

One has to agree with the interviewees that effective implementation of H&S regulations can only be hoped for if they have the character of legal acts with assured enforcement, backed by specific and sufficiently severe sanctions, whereas 'soft' guidelines offer no prospect of proper implementation. Interviewee IP5 expressed her disappointment that, at the time of her interview, the recommendations on the use of protective clothing in relation to the COVID-19 pandemic (see point 3f) had still not seen implementation in the form of a legal act binding on employers. The same opinion was expressed by interviewee IP8, who added that, based on observations made by her trade union representatives, these recommendations were not followed by hospital directors.

6. H&S challenges and how to tackle them

a. H&S challenges

In the course of the interviews, virtually all types of challenges in the H&S area shown in the literature were mentioned. Before discussing them, a few comments of a general nature should be made. According to the IP8 interviewee, the accident rate in the two sectors analysed during the HEROS project is not higher than the average in other sectors of the economy, while the presence of some specific occupational hazards and diseases stands out. The general context in which the two sectors operate is also important, namely their underfunding and serious labour shortages, caused by the low attractiveness of jobs (especially through low wages). The shortage of workers is accompanied by a very high average age (a large proportion of nurses are of retirement age, the average age being as high as 53 in 2021; for midwives, the average was 51 [NIPiP 2021]). This

implies specific problems related to fatigue, professional burnout and poor health for many employees.

The H&S challenges mentioned in the interviews can be divided into the following categories:

- Physical hazards – associated with working in awkward positions, carrying patients (including some with significant obesity) in the absence of appropriate support equipment, leading to spinal and musculoskeletal disorders. Exposure to biological agents, including in relation to the risk of cuts from sharp medical instruments and exposure to patients' body fluids. Exposure to ionising radiation or harmful substances, including carcinogens. Exposure to the effects of lack of diligence in carrying out various activities under time pressure and staff shortages. Challenges mostly relevant for the healthcare sector but also, in some cases, for the second sector studied.
- Physical hazards specifically related to the COVID-19 pandemic – exposure to biological agents (coronavirus infection), risks associated with improper/overlong use of protective clothing and masks (including even heat stroke). Relevant for the both sectors under scrutiny.
- Psychosocial risks – working under time pressure, excessive working hours, outside typical working hours, under stress. Negative emotions related to the adverse situation of patients/clients, hiding emotions in difficult situations or in the face of human dramas. Verbal or even physical aggression from patients / guests (including substance abusers), mobbing. Problems more acute in the second sector under scrutiny, but also present in the healthcare sector.
- Psychosocial risks associated with COVID-19 pandemic - isolation (especially during lockdowns in nursing homes), working radically extended hours. Relevant for the both sectors under scrutiny although particularly acute, due to limited resources and delayed response of public policies, in the second sector analysed.

In addition, some problems can be mentioned as a result of negligence in the implementation of the H&S legislation: low-quality mandatory training for workers, poor condition of premises in some workplaces favouring accidents at work and lowering the ergonomics, negligent assessment of occupational risks for individual jobs.

b. Current action

A rather static picture emerges from the interviews with regard to trade union action in response to the challenges of H&S, which can be linked to the already long-standing existence of most of the legislation and its general, even if with some exceptions, coverage of the challenges faced by

workers. Undoubtedly, to some extent, this situation has been dynamised by the COVID-19 pandemic, which has revealed or amplified some of the problems of the healthcare sector, as well as the second one under scrutiny. On the other hand, it seems that this was not the case for long, and already at the time of the survey the challenges of the pandemic were not high on the social dialogue agenda. This was suggested by an IP3 interviewee representing the nursing profession, who ironically referred to the “official end of the pandemic” by the government, and thus explained the reluctance to implement the above-mentioned recommendations on protective clothing working hours in the form of legislation. In addition to the work on these regulations, the interviews also indicated an attempt to draw the attention of public policy makers to the issue of psychosocial risks, in the opinion of interviewee IP5 largely neglected in Poland so far. Provisions concerning them were included in the action programme for the coming years of the national trade union confederation she represented. In addition, the social partners have recently submitted to the Ministry of Labour a proposal containing three recommendations for changes to the legislation (relating to all sectors of the economy). One of them concerns supplementing the H&S training programme with psychosocial issues. Apart from that, reference was made rather to past activities, related to the implementation of the directive on needlestick injuries, the framework agreement on combating stress at work, or the issue of recognition of qualifications of nurses from Poland in other European Union countries.

Additionally, it is possible to point to some activities of an intervention nature, undertaken by trade unions on an ad hoc basis in order to increase the safety of employees in the light of the legislation already in force (an example will be given here, as it should be assumed that a significant part of trade union activities at the workplace level is of this nature). According to the IP3 interviewee, the union side in one hospital had a long dispute with management over the very neglected state of the premises of the pathomorphology department. Its condition literally endangered the health of the workers, as it did not provide sufficient ventilation of the premises, exposing them to harmful fumes. For many years, the authorities appealed against the recommendations of the SIP, which was not even helped by inspections by the PIP conducted at the union's request. However, after many years, the union finally forced the renovation of the entire hospital, including the rebuilding of the ventilation system.

c. Framework conditions for action

Essentially, the framework for action by employee representatives has already been outlined in earlier sections of the report. These are, on the one hand, the constraints on funding public services, the low attractiveness of employment and the resulting deficits of workers and their ageing. On the other hand, we observe the relative weakness of trade unions (although the situation in this respect

in the healthcare sector is relatively better than in many other sectors of Polish economy, including the second of those surveyed in the HEROS project), the regulation of working conditions only by common law and the lack of collective bargaining practice. All this clearly limits the capacity of unions to act. The positive elements of the national framework for union action are the presence of a relatively strong trade union organisation representing nurses in the healthcare sector and a relatively well-constructed institution of social labour inspection (although facing some obstacles to its functioning, as indicated above).

d. Future development

The current situation regarding the H&S system in Poland, despite some expansion of the range of issues of interest to public policy makers and social partners triggered by the COVID-19 pandemic, seems stable and there is no prospect of significant changes in this respect. Rather, such changes could bring more fundamental modifications to the structure of social dialogue institutions, which in itself would have to be significantly strengthened, and this in turn would require political will and the support of many actors. It can be assessed that gradually the functioning of certain aspects of H&S should improve as more future EU legislation is implemented. On the other hand, as suggested by the interviewees, only strengthening of the powers of the PIP and an increase in the severity of the penalties for unreliable employers imposed by this institution would bring a significant improvement in the enforcement of the existing legislation. Some actions of a more bottom-up nature are also important (although they could be strengthened by support from trade unions from the national or sectoral level), especially to improve the competences of social labour inspectors, including their awareness of what this institution offers in terms of protecting workers' health and lives. However, the effectiveness of this institution also depends on the attitudes of the employers, which means that, here too, legislation strengthening the position of the SIPs vis-à-vis them would be useful, including, in particular, effectively protecting inspectors from harassment and discrimination².

7. EU-level H&S dialogue and regulations:

a. National sectoral actors engaged in EU-level H&S activities

There are organisations affiliated to European federations present in the healthcare sector. These organisations are as follows:

² It should be noted that there is protection for the employment relationship while the position is held for a certain period of time after its termination, but this does not guarantee security against other retaliatory actions and, in extreme cases, even against dismissal, due to the lengthiness of cases before the labour courts and the employer's expectation that the dismissed employee will abandon legal action.

- National Secretariat for Healthcare of the Independent Self-Governing Trade Union "Solidarność" (NSZZ "Solidarność") - affiliated to EPSU. NSZZ "Solidarność" is the largest unitary trade union in Poland, covering all sectors of the national economy. It covers about 5% of employees in the healthcare sector, no data for the social services sector. It is composed of several subordinate organisational units, including the two relevant to the study: National Healthcare Section and National Social Assistance Section.
- Federation of Trade Unions of Healthcare and Social Workers (FZZPOZiPS) - affiliated to EPSU and to the largest national trade union confederation, the All-Poland Trade Union Alliance (OPZZ). The number of affiliated employees is not known, but the union is recognised as representative.

In addition, the following actors should be mentioned:

- The National Commission of NSZZ "Solidarność" (the national overarching structure of the NSZZ "Solidarność" union), the H&S representative of which participates in the following European bodies related to the area under analysis: H&S Committee of the European Union, European Agency for Health and Safety at Work and H&S Committee of the European Trade Union Confederation (ETUC).
- All-Poland Trade Union Alliance (OPZZ) - also has representatives on the European Union H&S Committee and the ETUC's H&S Committee.

b. Topics

In the course of the interviews, it was possible to obtain very limited knowledge on H&S issues currently or in recent years on the agenda of the European Social Dialogue. This is due, among other things, to the reluctance of certain key representatives of the sectoral social partners to grant interviews (despite intensive efforts to encourage them to talk). Those who were able to be interviewed pointed to issues they had encountered while participating in the European dialogue, such as:

- The European Framework Agreement on Workplace Stress. This is a document that has been developed for a long time (almost twenty years ago, according to the interviewee's declaration), then implemented in Poland in the form of a ministerial regulation. In addition, the issue of harassment and violence in the workplace was mentioned - here, at the national level, these regulations have only seen "soft" anti-mobbing policies developed by the trade union side.
- Council Directive 2010/32/EU of 10 May 2010 implementing the Framework Agreement on prevention from sharp injuries in the hospital and healthcare sector concluded by

HOSPEEM and EPSU - also a legal act introduced a long time ago, implemented in Polish law in the form of a ministerial regulation.

- Exposure of workers to harmful medical products, including those with carcinogenic effects - the only example of ongoing discussions that came up in the interviews.

Although few examples of issues were given in the interviews, it has to be assumed that the actors mentioned under point 7a are involved in most of the issues currently discussed within the European Social Dialogue, as they are present (according to their declarations) in the relevant bodies and various working groups.

c. Outcomes

When referring to the subject of European Social Dialogue, the interviewees mainly just referred to its already finished outcomes, i.e. to concrete directives or other EU normative acts. Thus, from their perspective, it is the outcomes of the work going on within the European social partners' bodies that are most important. They expect concrete legal acts, containing as precise regulations as possible for specific areas of H&S and – ideally – providing for particular sanctions to enforce these regulations.

d. Implementation of EU level H&S outcomes

The results of European social dialogue are promulgated in the form of EU legal acts, which are then transposed into Polish law in the form of acts, ministerial regulations or amendments of both these types of legal acts in case they were already present in the Polish legal order. However, there is no possibility for the European social partners' framework agreements to be transposed in the form of analogous, sectoral agreements concluded between social partners in the country. This is because there is no practice of collective bargaining for entire sectors or extending multi-employer collective agreements.

e. Example of EU law that led to effective protection

The interviews show that EU legislation is an important factor influencing the quality of national H&S regulations. This was particularly emphasised by the H&S representative of the national trade union (IP8), even suggesting that directives and other legislation have a decisive impact on improving working conditions in Poland. As an important example to illustrate this thesis, one should point to the Council Directive 2010/32/EU on the prevention of sharps injuries, mentioned in the interview with IP3, in Poland implemented in the form of a Regulation of the Minister of Health of 6 June 2013 on occupational health and safety in the performance of work involving exposure to injury by sharp instruments used in the provision of health services. According to the interviewee,

this is a piece of legislation that has made a significant contribution to improving the safety of nurses' work.

Undoubtedly, the European dialogue on H&S also stimulates dialogue and interaction between national social partners, if only by triggering discussion on certain aspects of working conditions as well as works on the transposition of EU legislation into Polish law within the social dialogue bodies mentioned in 3e. However, no detailed examples of such discussions were mentioned in the interviews.

8. Multilevel coordination

a. within country: Awareness of and involvement in developments on H&S

The coordination of social partners' activities at different levels of H&S law-making or enforcement (including both national and European level) is the least recognised issue by interviewees. This can probably be linked to the already described strong “centralisation” of labour law-making, which is reduced to the state level – the source of law is exclusively legislation, i.e. common law, which is generally not complemented by collective agreements (including, in particular, a complete lack of sector-wide agreements). Coordination must thus be limited to transferring the expectations and needs of trade union organisations from a lower level, to a higher level – or, more precisely, to the level of the sectoral bodies involved in giving opinions on draft legislation. Here, in the area of H&S, the coordinating role can be played by specific persons delegated by the union (e.g. representatives for H&S, labour law or social policy issues, etc.), working together with the authorities of the respective sectoral structures.

b. within country: Existing/missing Coordination

With regard to the issue of coordination at the national level, interviewees were unable to provide specific examples of such activities. However, a general pattern emerges from the interviews, which is that national-level trade unions and trade union confederations support sectoral structures or organisations in their efforts to change the law or to consult on draft legislation. Sectoral structures also listen to the needs and expectations of the organisations at the company level when they formulate opinions vis-à-vis the government side.

c. EU-National: Awareness of and involvement in EU-level developments/SSDCs

With regard to national-EU coordination, interviewees were particularly uninformed. An IP8 interviewee, active within such international H&S bodies as the European Union H&S Committee, OSHA and the H&S Committee of the European Trade Union Confederation, was able to address this issue partially and indirectly. Interviewees not representing national trade union structures, on

the other hand, were unable to address the issue of coordination or, more broadly, European social dialogue. At most, they were aware of the fact that certain pieces of EU legislation have a positive impact on national legislation, helping to improve workers' safety (as in the case of the repeatedly mentioned Injuries Directive).

d. EU-National: Existing/missing Coordination

The interviewee, who is involved in dialogue at EU level, albeit not directly in the healthcare and social services sectors (IP8), confirmed the fact of coordination by European federations in the social partners' push for new, more protective legislation for workers. However, she did not provide specific examples (apart from the already mentioned discussions on exposure standards for medicinal substances, in which she is not personally involved). Instead, she indicated that Polish trade union organisations try to develop a common position, which is then presented at the European forum, and is usually in line with the position of the majority of trade union organisations from other countries. She described it as going as far as possible in the direction of improving working conditions, progressive, while at the same time trying to take reasonable account of employers' capabilities. She assessed that most trade unionists in Europe approached H&S issues in a similar way.

References

Eurofound (2022), *Representativeness of the European social partner organisations: Human health sector*, Sectoral social dialogue series, Dublin, available from:

www.eurofound.europa.eu/publications/report/2020/representativeness-of-the-european-social-partner-organisations-human-health-sector

Supreme Chamber of Nurses and Midwives (NIPiP) (2021). *Staffing disaster of nurses and midwives. report of the Supreme Chamber of Nurses and Midwives*. Warsaw: NIPiP. Available from: https://nipip.pl/wp-content/uploads/2021/09/2021-09-06_Raport_NIPiP_KRAJ.pdf

Legal acts

Act of 26 June 1974 Labour Code (Journal of Laws 1974 no. 24 item 141)

Act of 24 June 1983 on social labour inspection (Journal of Laws 1983, No. 35, item 163)

Act of 13 April 2007 on the State Labour Inspectorate (Journal of Laws 2007 No. 89, item 589)

Directive 89/391/EEC of 12 June 1989 on the introduction of measures to encourage improvements in the safety and health of workers at work (Official Journal of the EU 183, 29.6.1989, p. 1–8)

Directive 2002/14/EC of the European Parliament and of the Council of 11 March 2002 establishing a general framework for informing and consulting employees in the European Community - Joint declaration of the European Parliament, the Council and the Commission on employee representation (Official Journal of the EU 80, 23.3.2002, p. 29–34)

Council Directive 2010/32/EU of 10 May 2010 implementing the Framework Agreement on prevention from sharp injuries in the hospital and healthcare sector concluded by HOSPEEM and EPSU (Official Journal of the EU 134, 1.06.2010, p. 66)

Regulation of the Minister of Health of 2 February 2011 on tests and measurements of factors harmful to health in the working environment (Journal of Laws 2011 No. 33 item 166)

Regulation of the Minister of Health of 6 June 2013 on occupational health and safety when conducting work involving exposure to sharp injuries used in the provision of health services (Journal of Laws 2013 item 696)

Social services sector

INTRODUCTION

This report is based on analysis conducted as part of the research project 'HEROS: Health Risk Outlooks by Social Partners'. The main objective of the study is an in-depth description of the functioning of the national health and safety (H&S) system at its different levels in relation to two sectors: healthcare and care services. The study specifically addresses the role of the social partners (trade unions, professional associations, employer organisations) in the regulation and functioning of this sphere. It utilises a desk research analysis and the conclusions of the ten individual in-depth interviews conducted with representatives of the social partners associated with the healthcare and/or social assistance sectors, or involved in the H&S sphere. The interviews were conducted between May and December 2022. Reaching the relevant informants posed serious problems, which may be due to the relatively low level of interest in H&S issues and the general work overload that affects workers in both sectors, which are characterised by significant employment deficits. As evidence of the first reason mentioned, the words of one respondent, representing the national structures of a trade union, can be quoted, who admitted that the representatives of social assistance institutions she interviewed consider the low level of wages to be the main problem of their sector. This is undoubtedly an issue to which they attach more importance than to the problems analysed in this report, and it is on this issue that their activities are focused. A way of dealing with the high level of reluctance of the relevant sectoral actors was to interview representatives of the cross-sectoral structures relevant to the H&S issue. However, it was not possible to conduct a satisfactory number of interviews with representatives of employer organisations. The only interview was conducted with a representative of an umbrella NGO organisation in the area of social assistance services. Information on the employers' side therefore had to be obtained from secondary sources. This report, after discussing the general characteristics of the Polish H&S and collective labour relations systems, focuses on the social services understood as care services in the area of social welfare (mainly the activity of nursing care homes – i.e. institutions providing living, caring, supporting and educational services to persons requiring round-the-clock care due to age, illness or disability – and institutions similar to them). A separate document analyses the functioning of the H&S sphere and the social dialogue concerning it in the healthcare sector.

III. GENERAL PART

9. Sources for health and safety (H&S) regulations

In Poland, universally binding acts of general law are the almost exclusive source of regulation of the sphere of occupational health and safety. The protection of employees is guaranteed by the

Constitution, which states in Article 24 that "work is under the protection of the Republic of Poland" and that "the state exercises supervision over the conditions of work". At the same time, Article 66 states that "everyone has the right to safe and hygienic working conditions", adding that the manner in which this right is exercised, as well as the employer's obligations, is determined by law, which is the Labour Code.

d. EU legislation

EU legal acts seem to be little known, at least to those interviewees who do not deal with social dialogue at the EU level or the process of implementing EU acts in the national legal order. However, some interviewees were able to refer to them, albeit usually to a limited extent – for example, the Directive on the prevention of sharps injuries (2010/32/EU) is important in the view of the representative of the nursing community (IP3). In another interview (IP8), reference was made to discussions currently taking place within the European Union Health and Safety Committee on the issue of exposure to substances contained in medical products.

e. National legislation

As indicated above, the basic legal act regulating the sphere of H&S is the Act of 26 June 1974 Labour Code. The H&S issues are regulated in Section X of it. In addition, relevant for the analysed area are some other acts, including those establishing supervision and control over working conditions (the Act of 13 April 2007 on the State Labour Inspectorate) and regulating some specific issues, e.g. the Construction Law. The aforementioned national legal acts are in line with the requirements arising from the acts of European Union law. For example, the Labour Code lists a number of directives that have been implemented in Poland, many of which relate to the field of H&S (e.g. Directive 89/391/EEC of 12 June 1989 on the introduction of measures to encourage improvements in the safety and health of workers at work).

In general, the interviewees rarely referred to specific provisions of the general law in the interviews, which, however, should not be explained by their unfamiliarity, at least with regard to national acts, but rather by the construction of the questions and the logic of the interview scenario.

f. More specific legislation that applies to the 2 sectors

At a lower legislative level, there are specific regulations, i.e. regulations set by individual ministers, which further specify various aspects of H&S, such as the Regulation of the Minister of Health of 2 February 2011 on tests and measurements of factors harmful to health in the working environment. Among these, there are sector-specific regulations. Unlike the extensively regulated healthcare sector, the social services sector analysed here does not have detailed and exhaustive

H&S regulation, as pointed out by the IP8 interviewee. Only regulations that are more general in their content are in force, such as the Regulation of the Minister of Family and Social Policy on social welfare homes, which does not contain provisions dedicated to the protection of workers' health and safety. Additionally, there are, for example, national standards for the maximum weight of objects to be lifted, but not for people (e.g. patients of nursing homes).

10. Role of collective agreements for H&S regulations and workplace H&S representation

a. substantive issues

The field of H&S, as already noted above, is generally not regulated through collective agreements, which is partly to be explained by the general scarcity of collective bargaining – see point b below. An analysis of the content of the company's collective agreement reached in the course of the survey (none of the respondents were able to comment in detail on the content of collective bargaining in relation to H&S) reveals a very modest range of regulations and their vague nature. The provisions repeat almost exactly the common law regulations (Labour Code as well as some regulations). It is indicated that the employer "shall ensure conditions for safe and hygienic work and health protection" and lists its very basic and universally applicable obligations, such as providing employees with medical examinations, carrying out periodic inspections of buildings and workplaces with regard to working conditions and fire safety, as well as providing employees with social conditions and rooms for storing variable clothing, work tools and eating. The employer must also provide preventive healthcare to employees working in positions with screen monitors, reimburse such employees for the cost of purchasing corrective glasses, and provide employees with personal protective equipment, work clothes and work shoes free of charge³. Additionally, provisions of a multi-employer collective agreement (covering the institution for which the single-employer agreement just analysed is relevant, as well as several other local social welfare institutions) include an additional three days of annual leave for employees providing care for people with mental disorders and disabilities. This is undoubtedly a minor modification of the employment conditions in favour of employees; however – in view of the widespread work overload and exhaustion resulting in many cases in stress, job burnout and other negative psychological effects – it should be assessed as possibly having some relevance for those performing care tasks.

b. procedural issues

³ The reasons why collective agreements in Poland often repeat the provisions of the general law in relation to many areas of employment conditions may not be entirely clear. It is assumed, as pointed out by trade unionists in various interviews and debates, that in this way an attempt is made to perpetuate certain favourable provisions in the face of a general trend towards liberalisation of labour law. Another probable reason is that the actual subject of the negotiations are only selected basic issues mainly related to wages, while issues such as H&S only complement the content of the agreements.

In general, Poland is characterised by low coverage of collective agreements and almost no, except for a few examples in some industrial sectors, multi-employer agreements. There is also no practice of extending collective agreements to the whole sector. For the sectors surveyed, based on Eurofound's analysis, collective agreement coverage is extremely low even compared to Poland, at 1% for the social services sector (Eurofound 2022). There are therefore single collective agreements in force in a small number of establishments. This has been confirmed by the information provided by interviewees, for whom collective bargaining is clearly not a familiar practice. They were only able to comment on this area of union activity from a certain distance, emphasising that a very small proportion of social care institutions are covered by collective agreements. A representative of the national structure of an all-Poland trade union, who is not affiliated with any of the sectors surveyed (IP8), gave a figure of 72 agreements in force nationwide in the social assistance sector, but this figure includes – in addition to nursing homes and care facilities – educational institutions (kindergartens, schools). She also stressed that the negotiations mainly focus on the issue of wages.

Analysis of sources available online indicates the presence of single-employer collective agreements – as well as a local multi-employer agreement – in a number of social welfare institutions in the town of Częstochowa⁴. Such a document is in force in the local nursing home (*dom pomocy społecznej*, DPS) (the provisions of both single- and multi-employer agreement were discussed in point a), as well as in non-residential institutions such as a local Municipal Social Welfare Centre (*Miejski Ośrodek Pomocy Społecznej*, MOPS) (mainly responsible for the distribution of benefits, community care and counselling). Overall, however, the town is highly exceptional compared to the country in terms of coverage of social welfare institutions by collective agreements.

IV. H&S in the social services sector

11. National, sectoral industrial relations systems

a. Levels

In Poland, the dominant level of collective labour relations is the company level. It is at the company level that there are few cases of collective bargaining, where industrial disputes are initiated and where consultation and information of employees is carried out. The primary actor representing employees at the company level is the company-level trade union organisation. Other bodies, such as works councils, have only an additional, consultative and informative role and are not popular in Poland. In practice, works councils, which, on the basis of national legislation implementing Directive 2002/14/EC of the European Parliament and of the Council, can be

⁴ A medium-sized town in the southern part of the country.

established at the request of the workers' side in companies employing at least 50 persons, were not mentioned at all by the interviewees. On the other hand, company-level trade union organisations, set up at the request of at least ten employees, can be both independent entities, as well as join sectoral federations or be part of inter-company organisations present in more than one workplace. They can also form organisational units within large, nationwide unitary unions. In turn, these large organisations can form national sectoral structures representing workers in specific sectors, especially for the purposes of national tripartite dialogue (Social Dialogue Council, RDS) or regional tripartite dialogue (Voivodeship Social Dialogue Councils, WRDS).

b. Actors

A significant number of different trade unions are present in the sectors studied, while the number of relevant employer organisations should be considered limited. On the trade union side, the most key organisations are:

- Both sectors:

- Independent Self-Governing Trade Union "Solidarność" (the largest unitary trade union, nationally representative), with a sectoral structure, coordinating the activities of the company organisations – National Secretariat of Healthcare (affiliated to EPSU), composed of: National Healthcare Section and National Welfare Section;

- Federation of Trade Unions of Health Care and Social Welfare Workers (FZZPOZiPS) - affiliated to EPSU and to the All-Poland Alliance of Trade Unions (OPZZ) (the largest trade union confederation representative at national level);

- All-Poland Trade Union "Workers' Initiative" of Medical and Skilled Carers (OZZ IP OMIK)

- Social services sector:

- Polish Trade Union Federation of Social and Social Welfare Workers (PFZPSiPS)

On the side of employers there is only one organisation relevant for the social services sector:

- Working Community of Associations of Social Organisations (WRZOS) – an association (formally not an employer organisation), which is an umbrella organisation for various non-governmental social organisations, including those running nursing homes, shelters and other non-public social welfare institutions; affiliated to the European Federation of Social Employers.

c. Membership

Trade unions are divided into organisations associating representatives of any professions and jobs present in a given sector, such as NSZZ "Solidarity" or unions that are part of FZZPOZiPS, and into trade unions associating employees of specific professions. OZZ IP OMIK is an example of the latter.

Trade unions do not always disclose the number of their members. In the course of the study, it was not possible to obtain data on membership in the largest trade unions present in the social services sector, among others due to the refusal to grant an interview by representatives of FZZPOZiPS and PFZPSiPS. As for OZZ IP OMIK, associating medical carers in both sectors, this young and just forming trade union had only about 120 people at the time of the interview in late spring 2022.

d. Sectoral system of workplace H&S representation

In Poland, institutions related to the functioning of the H&S field are present mainly at the workplace level. At the same time, it should be noted that the most effective of them, the Social Labour Inspectorate (SIP), is closely linked to the company trade union organisation – if trade unions are absent in a given workplace, this institution will not be there. Social labour inspectors have extensive powers to inspect the broadly defined employment and working conditions for their compliance with the applicable law. Among other things, they can monitor the condition of buildings and equipment, the degree of compliance with collective agreements and take part in examining the circumstances and causes of accidents at work. Interviewees representing unions attach great importance to this institution. Among other things, interviewee IP8, who is active in the national structures of her trade union, participates in the training of social labour inspectors. At the same time, the same interviewee assessed that some employers make the work of SIPs difficult or discriminate against inspectors. Sometimes they restrict their ability to investigate the causes of accidents at work and in some cases even dismiss them, despite the fact that they are employees protected from dismissal under the applicable legislation. This is also where, in the interviewee's opinion, a too cautious attitude of some inspectors comes from. As a way of dealing with problematic employers, in view of the lengthiness of the labour courts, the cooperation of unions with the State Labour Inspectorate – the main public institution responsible for controlling compliance with labour law – was mentioned. However, its enforcement capacity is also limited, if only because of the small amount of financial penalties it can impose on unreliable employers.

In workplaces with at least 250 employees the employer is obliged to set up health and safety committees with representatives of both employer and employees. The committee is an advisory and consultative body. However, interviewees representing the social services sector had no knowledge or experiences regarding this institution. This is undoubtedly due to the fact that the vast

majority, if not all typical care institutions such as nursing homes, employ far fewer staff than the indicated threshold.

e. National, sectoral, and regional, local dialogue on H&S issues

Social dialogue on H&S to a limited extent (as already indicated in the sections on collective bargaining) takes place at the company level. This includes the rare practice of collective bargaining, including a potential practice (and not found in the survey) of negotiating H&S provisions in a shape that goes beyond the common law. Additionally, a possible situation at the company level is the initiation of an industrial dispute by a trade union party. However, no example of such a dispute involving H&S issues was cited during the interviews. In larger entities (with at least 250 employees), the already mentioned H&S committees also play a role, but they are not typical social dialogue bodies but more like working groups. Trade unions also play a role of a consultative nature. This concerns, among other things, the content of employment regulations.

Based on the interviews, it is fair to say that H&S is not a topic that is present at the multi-employer level – there is a lack of both relevant collective agreements and social dialogue bodies. Potentially (which the interviews did not show, however), H&S could be discussed within the framework of the Voivodeship Social Dialogue Councils (WRDS), which are tripartite dialogue bodies at the regional level.

At the national level, the tripartite body where H&S issues can be discussed is the Social Dialogue Council (RDS). It should be noted, however, that this body is consultative in nature – the results of its discussions are not binding on the government side. It is, however, an important forum in which key public policies are consulted. In parallel, the social partners may submit opinions on draft legislation to the relevant ministries – again, their consideration by the government is not obligatory. In addition, there are a number of RDS problem teams dedicated to specific areas of public policies and sectoral tripartite bodies at selected ministries. The most relevant RDS problem team for the social services sector is the Problem Team for Public Services. However, due to the nature of the tasks of entities such as nursing homes, a large proportion of whose residents experience serious health issues, problem teams related to the healthcare sphere can also address specific issues. This was the case during the pandemic, when, according to the IP5 interviewee, nursing homes were one of the key interests of the Ad-Hoc Team for Healthcare (temporarily replacing the Health Sub-team of the Problem Team for Public Services during the pandemic). This forum discussed, among other things, the issue of allowances for staff conducting their duties in pandemic conditions, as well as the standards of working hours in protective clothing, equally relevant from the perspective of hospital staff and nursing homes' employees. At the same time, it

should be borne in mind that, as in case of many other areas of public policies and sectors of the economy in Poland, the dominant model of interaction between the governmental side and the social partners is based on the latter's written opinion on draft legislation.

f. Description of H&S regulation process and practice in the sector

Generally, regulation in the social services sector, as in other sectors of the Polish economy, takes place through legislation, so it is strongly state-driven, and the typical role of the social partners is reactive. Usually, it is the state that initiates the legislative process, with the social partners providing written feedback on draft legislation. More relevant or problematic issues become the subject of consultation within the bodies mentioned in 3e. The interviewees were not able to give many examples of dialogue on specific issues, although it should be assumed that a significant amount of legislation, including specific ministerial regulations on various aspects of H&S, was subject to consultation. Two interviewees were able to refer to dialogue related to the challenges arising from the COVID-19 pandemic. According to information from an interviewee dealing with social policy, health care and occupational safety, representing a nationwide confederation of trade unions, (IP5), the ad hoc Health Care Team of the RDS has been dealing quite intensively with the issue of risks to workers in the healthcare area, but also to workers in nursing homes (DPS), in the context of the pandemic. It set up a working group that developed recommendations for the Ministry of Health on standards for the use of protective clothing to prevent contagion (masks, overalls), including standards for the length of time spent in it. In the course of the work, there was cooperation with expert institutions such as the Institute of Occupational Medicine and the Central Institute for Labour Protection (CIOP). This work resulted in a document addressed to the Ministry containing these recommendations.

g. Multi-level focus – if and how do actors at different level interact

Interaction between the different levels of the H&S system is relatively limited, although it does occur. For example, the IP8 interviewee, working for the national structures of her trade union, on the one hand liaises with the secretaries and chairs of the sectoral structures, obtaining from them knowledge of the needs and expectations of the respective sectors regarding the trade union's position in the area of H&S (in more complex cases, the representatives of the sectors are directly involved in the dialogue at the national level, including within the RDS). At the same time, she actively supports social labour inspectors, including by organising training for them. However, it is worth noting that – in the opinion of the IP3 interviewee – if the employer hinders the activities of the SIP, trade unionists from the company level most often turn to the State Labour Inspectorate (PIP) for support. In general, however, trade union sectoral structures and trade union federations

support company organisations and mediate between them and the government side in articulating their needs and expectations as to the shape of legal regulations, as indicated by the IP3 interviewee.

An additional level of social dialogue can also be distinguished, concerning the implementation of EU law into national legislation. Here, trade unions are involved not only in relevant sectoral bodies, but also in the Problem Team of the RDS for International Affairs, dealing with the implementation of key EU legislation into national law. It examines, among other things, the extent to which national law has been amended to comply with the requirements of directives or other EU legislation. However, a member of the team (IP4) was not able to give examples of policies relating to the sectors under study that had been discussed in this body.

12. Quality assessment by the social partners

a. Concerning effectiveness and coverage of H&S in the sectors

Interviewees were able to refer to some general characteristics of H&S functioning in the sectors studied to a limited extent, providing rather qualitative arguments, which are discussed below in section 4c. Undoubtedly, what emerges from the interviews is a picture of the healthcare sector as better regulated than the social services area. A number of specific regulations by the Minister of Health detail the rules in the area of H&S applicable to hospitals. The coverage of both sectors by collective agreements is, as already indicated above, negligible, which, however, interviewees generally see as a normal situation. More important for them seems to be the possibility to intervene in case of H&S violations, which is mainly possible where trade union organisations are present, thanks to the SIPs led by them. For more on this, see section 4b.

b. Concerning variations between occupational groups, workplaces

The interviews reveal a difference in H&S field mainly between the two sectors - as mentioned above, the social services area has far fewer detailed regulations that health workers enjoy (even if the actual application of these by employers and the possibilities of enforcement may be questionable in some cases - see point c). This difference, given the overwhelming dominance of the common law in regulating working conditions, must have a fundamental impact on the effectiveness of the H&S area in both sectors. The social services sector is also disadvantaged by the lack of a strong trade union that would cover a significant proportion of workers in the sector (as is the case in the healthcare sector). This makes it possible for a SIP to function in a relatively small number of entities, and even where unions exist, their relatively low strength may make this institution ineffective.

c. Overall assessment

The interviewees' assessment of the overall quality of the H&S system in Poland should be considered rather negative. Admittedly, the interviews were pointing to the important and positive role played by the Social Labour Inspectorate. On the other hand, when asked directly about the effectiveness of protection, interviewees were critical. As mentioned above, the IP8 interviewee indicated that it was not uncommon for social labour inspectors to lack determination in their inspection activities due to fear of retaliation by the employer. Cases of strong and sometimes even senseless resistance by the employer to implement the recommendations of the SIP were mentioned by a representative of the nurses' trade union (see: report on healthcare).

Also, the representative of the trade union of medical carers (IP2) was not satisfied with the degree to which H&S regulations are enforced, although she pointed out that particularly standards for lifting patients are missing, while – for example – personal protective equipment is mostly provided. It is worth indicating at this point that medical carers are a specific occupational group, which has just in recent years been recognised and integrated into the social services system (although it is still not mandatory for nursing homes or other facilities to employ their representatives), and is also extremely little unionised. A representative of the association that until recently was the only representative of carers (IP1) stressed that, lacking trade union status, it had very little power to influence working conditions. Therefore, it was decided to set up a separate trade union which took over the typical tasks of such an organisation while the association focused on educating workers about their rights. As an example of a poorly working solution, an interviewee indicated the obligation for an employee reporting irregularities to the PIP to provide their personal data. Although this institution is obliged to keep this data confidential, according to the interviewee, some employees are afraid to give it to the employer – the problem would be solved by complete anonymity when reporting a problem.

13. Quality assessment

a. Assessing the quality of H&S regulations

In general, it should be considered that the common law regulates exhaustively the sphere of H&S in the social services sector (although it should be agreed with the interviewees that there are some gaps, such as with regard to lifting standards or the duration of time spent in protective clothing). This is due to the alignment of national law with the requirements arising from EU directives and other legislation. It should also be assumed that the regulations are, as a rule, implemented in workplaces, although undoubtedly the problems faced by the analysed sector – shortage of workers, underfunding (see point 6) – induce such compliance with the regulations, which in many cases may not fully effectively protect the health or even life of workers. It is a matter of such implementation, which can be described as minimal, and sometimes even superficial (e.g. poor

quality and hurriedly conducted H&S training, just to meet the requirement to conduct it). In the opinion of one interviewee, representing a professional group present in both analysed sectors (IP1), the social services sector is characterised by an even greater deficit of diligence with regard to the H&S sphere than the other sector under scrutiny. This generally refers to compliance with the law regulating this area, including, among other things, the provision of appropriate equipment to facilitate the lifting of patients.

The institutions enforcing the implementation of the H&S rules, while potentially having broad powers to execute labour law – this includes both the union-managed SIP and the state PIP (the former can even order the suspension of work until violations are remedied, and the employer side must then appeal to the latter if it raises an objection) – in practice, however, they experience many of the limitations already indicated above. In the case of the former, determination and firmness towards the employer is needed, which in many cases is not easy. With regard to the PIP, the problem is mainly the already mentioned disproportionate penalties, which do not deter employers from committing H&S negligence.

b. Effectiveness of H&S regulations in protecting different members in the 2 sectors

The effectiveness of the H&S regulations – which are themselves constructed in principle correctly and in accordance with EU law – is limited by the deficits in their enforcement mentioned in section 5a. It should again be particularly emphasised that it is difficult to have effective enforcement in workplaces where trade unions are not present. Especially in the social services sector there are many such workplaces. Employers in such a case are the only party responsible for implementing the regulation, which may raise concerns about its diligence and transparency in the event of an accident or irregularity. The voice of workers in such establishments, even if they have more than 250 employees (obligation to set up an H&S committee) – which, by the way, is extremely unlikely in social assistance institutions – is at best marginal and dependent on the will of the employer side.

One has to agree with the interlocutors that effective implementation of H&S regulations can only be hoped for if they have the character of legal acts with assured enforcement, backed by specific and sufficiently severe sanctions, whereas “soft” guidelines offer no prospect of proper implementation. Interviewee IP5 expressed her disappointment that, at the time of her interview, the recommendations on the use of protective clothing in relation to the COVID pandemic¹⁹ (see point 3f) had still not seen implementation in the form of a legal act binding on employers.

14. H&S challenges and how to tackle them

a. H&S challenges

In the course of the interviews, virtually all types of challenges in the H&S area shown in the literature were mentioned. Before discussing them, a few comments of a general nature should be made. According to the IP8 interviewee, the accident rate in the two sectors analysed in the HEROS project is not higher than the average in other sectors of the economy, while the presence of some specific occupational hazards and diseases stands out. The general context in which the two sectors operate is also important, namely their underfunding and serious labour shortages, caused by the low attractiveness of jobs (especially through low wages). The shortage of workers is accompanied by a very high average age. This implies specific problems related to fatigue, professional burnout and poor health for many employees.

The H&S challenges mentioned in the interviews can be divided into the following categories:

- Physical hazards – associated with working in awkward positions, carrying patients (including some with significant obesity) in the absence of appropriate support equipment, leading to spinal and musculoskeletal disorders. Exposure to biological agents, including in relation to the risk of cuts from sharp medical instruments and exposure to patients' body fluids. Exposure to the effects of lack of diligence in conducting various activities under time pressure and staff shortages. Problems more acute in the second sector under scrutiny, but also present in social services institutions such as nursing homes whose residents require care due to serious illness, old age, disability or addiction..
- Physical hazards specifically related to the COVID-19 pandemic – exposure to biological agents (coronavirus infection), risks associated with improper/overlong use of protective clothing and masks (including even heat stroke). Relevant for the both sectors analysed in the HEROS project.
- Psychosocial risks – working under time pressure, excessive working hours, outside typical working hours, under stress. Negative emotions related to the adverse situation of patients/clients, hiding emotions in difficult situations or in the face of human dramas. Verbal or even physical aggression from patients / guests (including substance abusers), mobbing. Problems more acute in the social services sector, but also in the second of the surveyed sectors.
- Psychosocial risks associated with COVID-19 pandemic - isolation (especially during lockdowns in nursing homes), working radically extended hours. Relevant for the both sectors under scrutiny although particularly acute, due to limited resources and delayed response of public policies, in the social services sector.

In addition, some problems can be mentioned as a result of negligence in the implementation of the H&S legislation: low-quality mandatory training for workers, poor condition of premises in some workplaces favouring accidents at work and lowering the ergonomics, negligent assessment of occupational risks for individual jobs. As the IP1 interviewee indicated, sometimes, even if staff have the right equipment to help lift patients, they do not use it anyway due to the rush and stress resulting from staff shortages.

b. Current action

A rather static picture emerges from the interviews with regard to trade union action in response to the challenges of H&S, which can be linked to the already long-standing existence of most of the legislation and its general, even if with some exceptions, coverage of the challenges faced by workers. Undoubtedly, to some extent, this situation has been dynamised by the COVID-19 pandemic, which has revealed or amplified some of the problems of both sectors studied in the HEROS project. On the other hand, it seems that this was not the case for long, and already at the time of the survey the challenges of the pandemic were not high on the social dialogue agenda – an example illustrating the decrease in pressure for change following the easing of a pandemic situation is provided in the report on the healthcare sector. In addition to the work on some regulations, the interviews also indicated an attempt to draw the attention of public policy makers to the issue of psychosocial risks, in the opinion of interviewee IP5 largely neglected in Poland so far. Provisions concerning them were included in the action programme for the coming years of the national trade union confederation she represented. In addition, the social partners have recently submitted to the Ministry of Labour a proposal containing three recommendations for changes to the legislation (relating to all sectors of the economy). One of them concerns supplementing the H&S training programme with psychosocial issues. Apart from that, reference was made rather to past activities, related to the implementation of the directive on cuts, the framework agreement on combating stress at work, or the issue of recognition of qualifications of nurses from Poland in other European Union countries.

Additionally, it is possible to point to some activities of an intervention nature, undertaken by trade unions on an ad hoc basis in order to increase the safety of employees in the light of the legislation already in force (an example will be given here, as it should be assumed that a significant part of trade union activities at the workplace level is of this nature). A representative of a workplace trade union organisation from a nursing home (IP9) pointed out that, thanks to her union's efforts, the purchase of a special trolley for transporting patients was planned soon. At the same time, she pointed out the limitations in terms of improving ergonomics at work, resulting from the nature of the premises of the nursing home represented by hers – it is located in a historic palace, with an

unfavourable layout of rooms (e.g. narrow corridors), which cannot be changed due to regulations protecting this type of building.

c. Framework conditions for action

Essentially, the framework for action by employee representatives has already been outlined in earlier sections of the report. These are, on the one hand, the constraints on funding public services, the low attractiveness of employment and the resulting deficits of workers and their ageing. Especially with regard to the social services sector, we observe the relative weakness of trade unions, the regulation of working conditions by common, not specifically sector related law and the lack of collective bargaining practice. All this clearly limits the capacity of unions to act. The positive element of the national framework for union action is a relatively well-constructed institution of social labour inspection (although facing some obstacles to its functioning, as indicated above).

d. Future development

The current situation regarding the H&S system in Poland, despite some expansion of the range of issues of interest to public policy makers and social partners triggered by the COVID-19 pandemic, seems stable and there is no prospect of significant changes in this respect. Rather, such changes could bring more fundamental modifications to the structure of social dialogue institutions, which in itself would have to be significantly strengthened, and this in turn would require political will and the support of many actors. It can be assessed that gradually the functioning of certain aspects of H&S should improve as more future EU legislation is implemented. On the other hand, as suggested by the interviewees, only a strengthening of the powers of the PIP and an increase in the severity of the penalties for unreliable employers imposed by this institution would bring a significant improvement in the enforcement of the existing legislation. Some actions of a more bottom-up nature are also important (although they could be strengthened by support from trade unions from the national or sectoral level), especially to improve the competences of social labour inspectors, including their awareness of what this institution offers in terms of protecting workers' health and lives. However, the effectiveness of this institution also depends on the attitudes of the employers, which means that, here too, legislation strengthening the position of the SIPs vis-à-vis them would be useful, including, in particular, effectively protecting inspectors from harassment and discrimination⁵.

⁵ It should be noted that there is protection for the employment relationship while the position is held for a certain period of time after its termination, but this does not guarantee security against other retaliatory actions and, in extreme cases, even against dismissal, due to the lengthiness of cases before the labour courts and the employer's expectation that the dismissed employee will abandon legal action.

15. EU-level H&S dialogue and regulations:

a. National sectoral actors engaged in EU-level H&S activities

There are organisations affiliated to European federations present in the social services sector. These organisations are as follows:

- National Secretariat for Healthcare of the Independent Self-Governing Trade Union "Solidarność" (NSZZ "Solidarność") - affiliated to EPSU. NSZZ "Solidarność" is the largest unitary trade union in Poland, covering all sectors of the national economy. There is no data available for the employees' coverage in the social services sector. It is composed of several subordinate organisational units, including the one relevant to the sector which is National Social Assistance Section.
- Federation of Trade Unions of Healthcare and Social Workers (FZZPOZiPS) - affiliated to EPSU and to the largest national trade union confederation, the All-Poland Trade Union Alliance (OPZZ). The number of affiliated employees is not known, but the union is recognised as representative.
- Working Community of Associations of Social Organisations (WRZOS) - affiliated to the Federation of European Social Employers. Umbrella organisation for several social organisations, including those providing care services (e.g. non-public nursing homes, social shelters); formally not an employer organisation.

In addition, the following actors should be mentioned:

- The National Commission of NSZZ "Solidarność" (the national overarching structure of the NSZZ "Solidarność" union), the H&S representative of which participates in the following European bodies related to the area under analysis: H&S Committee of the European Union, European Agency for Health and Safety at Work and H&S Committee of the European Trade Union Confederation (ETUC).
- All-Poland Trade Union Alliance (OPZZ) - also has representatives on the European Union H&S Committee and the ETUC's H&S Committee.

b. Topics

In the course of the interviews, it was possible to obtain very limited knowledge on H&S issues currently or in recent years on the agenda of the European Social Dialogue. This is due, among other things, to the reluctance of certain key representatives of the sectoral social partners to grant interviews (despite intensive efforts to encourage them to talk). Those who were able to be interviewed pointed to issues they had encountered while participating in the European dialogue, such as:

- The European Framework Agreement on Workplace Stress. This is a document that has been developed for a long time (almost twenty years ago, according to the interviewee's declaration), then implemented in Poland in the form of a ministerial regulation. In addition, the issue of harassment and violence in the workplace was mentioned - here, at the national level, these regulations have only seen "soft" anti-mobbing policies developed by the trade union side.
- Council Directive 2010/32/EU of 10 May 2010 implementing the Framework Agreement on prevention from sharp injuries in the hospital and healthcare sector concluded by HOSPEEM and EPSU – also a legal act introduced a long time ago, implemented in Polish law in the form of a ministerial regulation (Regulation of the Minister of Health of 6 June 2013 on occupational health and safety when conducting work involving exposure to sharp injuries used in the provision of health services). It should be noted that this piece of legislation also applies to the social services sector, wherever the care of dependents is accompanied by the provision of medical services in connection with their health condition.
- Exposure of workers to harmful medical products, including those with carcinogenic effects – the only example of ongoing discussions that came up in the interviews.

Although only few examples of issues were given in the interviews, it has to be assumed that the actors mentioned under point 7a are involved in most of the issues currently discussed within the European Social Dialogue, as they are present (according to their declarations) in the relevant bodies and various working groups.

c. Outcomes

When referring to the subject of European Social Dialogue, the interviewees mainly just referred to its already finished outcomes, i.e. to particular directives or other EU normative acts. Thus, from their perspective, it is the outcomes of the work going on within the European social partners' bodies that are most important. They expect concrete legal acts, containing as precise regulations as possible for specific areas of H&S and – ideally – providing for certain sanctions to enforce these regulations.

d. Implementation of EU level H&S outcomes

The results of European social dialogue are promulgated in the form of EU legal acts, which are then transposed into Polish law in the form of acts, ministerial regulations or amendments of both these types of legal acts. However, there is no possibility for the European social partners' framework agreements to be transposed in the form of analogous, sectoral agreements concluded

between social partners in the country – there is no practice of collective bargaining for entire sectors or extending multi-employer collective agreements.

e. Example of EU law that led to effective protection

The interviews show that EU legislation is an important factor influencing the quality of national H&S regulations. This was particularly emphasised by the H&S representative of the national trade union (IP8), even suggesting that directives and other legislation have a decisive impact on improving working conditions in Poland.

Undoubtedly, the European dialogue on H&S also stimulates dialogue and interaction between national social partners, if only by triggering discussion on certain aspects of working conditions as well as works on the transposition of EU legislation into Polish law within the social dialogue bodies mentioned in 3e. However, no detailed examples of such discussions were mentioned in the interviews.

16. Multilevel coordination

e. within country: Awareness of and involvement in developments on H&S

The coordination of social partners' activities at different levels of H&S law-making or enforcement (including both national and European level) is the least recognised issue by interviewees. This can probably be linked to the already described strong 'centralisation' of labour law-making, which is reduced to the state level – the source of law is exclusively legislation, i.e. common law, which is generally not complemented by collective agreements (including, in particular, a complete lack of sector-wide agreements). Coordination can therefore basically be reduced to transferring the expectations and needs of trade union organisations from a lower level, to a higher level – or, more precisely, to the level of the sectoral bodies involved in giving opinions on draft legislation. Here, in the area of H&S, the coordinating role can be played by specific persons delegated by the union (e.g. representatives for H&S, labour law or social policy issues, etc.), working together with the authorities of the respective sectoral structures.

f. within country: Existing/missing Coordination

With regard to the issue of coordination at the national level, interviewees were unable to provide specific examples of such activities. However, a general pattern emerges from the interviews, which is that national-level trade union organisations and federations support sectoral structures or member organisations in their efforts to change the law or to consult on draft legislation. Sectoral structures also listen to the needs and expectations of the organisations at company level when they formulate opinions vis-à-vis the government side.

g. EU-National: Awareness of and involvement in EU-level developments/SSDCs

With regard to national-EU coordination, interviewees were particularly uninformed. An IP8 interviewee, active within such international H&S bodies as the European Union H&S Committee, OSHA and the H&S Committee of the European Trade Union Confederation, was able to address this issue partially and indirectly. Interviewees not representing national trade union structures, on the other hand, were unable to address the issue of coordination or, more broadly, European social dialogue. At most, they were aware of the fact that certain pieces of EU legislation have a positive impact on national legislation, helping to improve workers' safety (as in the case of the repeatedly mentioned Needlestick Directive).

h. EU-National: Existing/missing Coordination

The interviewee, who is involved in dialogue at EU level, albeit not directly in the social services sectors (IP8), confirmed the fact of coordination by European federations in the social partners' push for new, more protective legislation for workers. However, she did not provide specific examples (apart from the already mentioned discussions on exposure standards for medicinal substances, in which she is not personally involved). Instead, she indicated that Polish trade union organisations try to develop a common position, which is then presented at the European forum, and is usually in line with the position of the majority of trade union organisations from other countries. She described it as going as far as possible in the direction of improving working conditions, progressive, while at the same time trying to take reasonable account of employers' capabilities. She assessed that most trade unionists in Europe approached H&S issues in a similar way.

References

Eurofound (2022), *Representativeness of the European social partner organisations: Local and regional government sector and social services*, Sectoral social dialogue series, Dublin, available from: www.eurofound.europa.eu/pl/publications/report/2020/representativeness-of-the-european-social-partner-organisations-local-and-regional-government-sector

Legal acts

Act of 26 June 1974 Labour Code (Journal of Laws 1974 no. 24 item 141)

Act of 24 June 1983 on social labour inspection (Journal of Laws 1983, No. 35, item 163)

Act of 13 April 2007 on the State Labour Inspectorate (Journal of Laws 2007 No. 89, item 589)

Directive 89/391/EEC of 12 June 1989 on the introduction of measures to encourage improvements in the safety and health of workers at work (Official Journal of the EU 183, 29.6.1989, p. 1–8)

Directive 2002/14/EC of the European Parliament and of the Council of 11 March 2002 establishing a general framework for informing and consulting employees in the European Community - Joint declaration of the European Parliament, the Council and the Commission on employee representation (Official Journal of the EU 80, 23.3.2002, p. 29–34)

Council Directive 2010/32/EU of 10 May 2010 implementing the Framework Agreement on prevention from sharp injuries in the hospital and healthcare sector concluded by HOSPEEM and EPSU (Official Journal of the EU 134, 1.06.2010, p. 66)

Regulation of the Minister of Health of 2 February 2011 on tests and measurements of factors harmful to health in the working environment (Journal of Laws 2011 No. 33 item 166)

Regulation of the Minister of Labour and Social Policy of 23 August 2012 on social welfare homes (Journal of Laws 2012 item 964)

Regulation of the Minister of Health of 6 June 2013 on occupational health and safety when conducting work involving exposure to sharp injuries used in the provision of health services (Journal of Laws 2013 item 696)

Appendix:

1) Table interviews conducted

Id	Organisation	Sector	Affiliation
IP1	association	hosp, socserv	-
IP2	TU	hosp, socserv	-
IP4	TU	intersectoral	ETUC
IP5	TU	intersectoral	ETUC
IP6	TU	socserv	EPSU
IP7	TU	intersectoral	-
IP8	TU	intersectoral	ETUC
IP9	TU	socserv	EPSU
IP10	EO	socserv	Social Employers

CASE STUDY SE HOSPITAL SECTOR

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Main national health and safety (H&S) regulations

The main regulatory framework for health and safety and working environment in Sweden is the Work Environment Act (SFS 1977:1160), which is a general frame law setting rules on obligations for employers and safety officers to prevent illness and accidents and ensure a good work environment in all sectors of the economy. This law is supplemented by the Work Environment Ordinance (SFS 1977:1166), which is meant to facilitate the interpretation of the Work Environment Act by giving more detailed provisions for how work environment representatives and committees should be set up and function. In a broader sense, the working environment is also regulated by the Working Hours Act (SFS 1982:673), which regulates daily, weekly, and yearly working time, as well as rights to breaks and rest, and the Discrimination Act (SFS 2008:576), which aims to counteract discrimination and otherwise promote equal rights and opportunities regardless of gender, transgender identity or expression, ethnic affiliation, religion, belief, disability, sexual orientation or age.

The above laws are supplemented by more specific regulations in the Swedish Work Environment Authority's Statute Book (Arbetsmiljöföreskrifter), which includes around 80 statutory regulations and recommendations. These details ways to meet the general legal requirements on health and safety at work for different areas and sectors. Not all statutes are applicable in the hospital/healthcare and social/elderly care sectors, but some of most important ones during the last decade are that affect these sectors are: AFS 2012:2 Strain/musculoskeletal ergonomics; AFS 2018:4 Risk of infection; AFS 2020:2 Special provisions on personal protective equipment due to the threat from covid-19 disease; AFS 2020:3 Amendment to the Swedish Work Environment Authority's regulations; AFS 2018:4 General advice on infection risks; AFS 2020: 9 General advice with special provisions on personal protective equipment due to covid-19. In addition, AFS 2015:4 Organizational and social work environment is of special importance in both these and other sectors as this statute specifies the systematic work environment management that all employers must carry out.

The main national body regulating and supervising health and safety at work in Sweden is the Swedish Work Environment Authority (Arbetsmiljöverket), which has several objectives: to disseminate information about and to produce provisions clarifying the Work Environment Act; to secure that the

working environment law and statutes are observed – that is, ensuring that employers together with their employees carry out active work environment work so that no one is injured or becomes ill because of conditions at work. This supervision is done through local work environment inspections, accident investigations and information efforts. In addition, the Work Environment Authority has the objective to produce statistics about the work environment, work-related accidents, and occupational illnesses, as well as to promote cooperation between employers and employees in the work environment area.

Health and safety and social partner involvement

Sweden is an example of the Nordic regime of organised corporatism in industrial relations, characterised by strong social partners negotiating bipartite collective agreements through collective bargaining with wide coverage and with a high degree of autonomy from the state (Jansson et al. 2019; Visser et al. 2009; Van Rie et al. 2016). Collective bargaining is mainly performed at sectoral level, though peak level agreements concerning relating to insurances, pensions, and restructuring exist, as well as local level bargaining adjusting or supplementing sectoral agreements (Baccaro & Howell 2017; Larsson and Ulfsson Eriksson 2019). In addition, the social partners at peak and sectoral level have a relatively strong influence on government policy and regulation through corporatist consultation processes.

The legal regulation the area of health and safety is strong, and not possible to set aside through collective bargaining. The regular collective agreements are thus not mainly oriented on issues of health and safety, other than in the more general sense that details regarding working time, staffing and work contracts regulated in them may affect or be related to working environment. Besides the regular agreements there are, however, other collective agreements and joint organisations and committees of central importance for health and safety work. At the peak level there are three main joint social partner organisations active in the area of working environment and health and safety. *Suntarbetsliv* (Healthy Working Life), is an organisation created in 2012 jointly by the public employer organisations SALAR and SOBONA together with nine trade unions in the public sector. The mission is to gather knowledge about preventive, health-promoting and rehabilitative initiatives in the work environment area and to make this knowledge accessible and useful in the workplaces within municipalities, regions and municipal companies.

The corresponding organisation for the private sector is Prevent, which was established in 2000 from the older Occupational Safety and Health Board (Arbetskyddsämnden) established already in 1942. Prevent is owned and governed by the Confederation of Swedish Enterprise (Svenskt Näringsliv) together with the main blue collar confederation LO, and PTK (the council for negotiation and cooperation), a joint organization of 25 member unions, representing 950 000 white-collar employees. Prevent's aim is to make it easier for companies and workplaces to create a good work environment by informing, educating and developing useful instruments for work environment work. The partners that own prevent also own the insurance company Afa Försäkring (Afa Insurance), which administers collectively negotiated insurances providing financial support in the event of incapacity due to sickness, work injury, shortage of work, death and parental leave, supplementing the statutory insurances in the Swedish social insurance system. Afa Insurance also invest large sums in research, development and knowledge dispersal in the area of working environment and health.

In the public part of the sector there also exist a social partner arena called the Welfare Work Environment Council (Välfärdens arbetsmiljöråd, AMR), which aims to support preventive work environment processes at the local level through collaboration between the central parties. The AMR consists of members from SALAR and unions in the municipal area of operations.

Swedish work environment legislation prescribes that the employer is responsible for the work environment and for collaborating with its employees to achieve a good work environment. Local employee health and safety representation is provided through safety representatives (skyddsombud/arbetsmiljöombud). These are often trade union members, but also other staff can be elected by the employees. In larger companies (50 or more employees) or where the employees request this, there is also a safety committee (skyddskommitté). In addition, trade unions can appoint a regional safety representative (regionalt skyddsombud) to cover smaller workplaces without a safety committee. The safety committees are to participate in the planning and monitor the implementation of health and safety measures at the workplace, and the safety representative monitors that the employees have a satisfactory working environment, that safeguards against ill-health and accidents exist, and that the employer compliance with health and safety laws. In situations where the safety representative finds an immediate and serious threat to health, they have the right to halt work. In cases where employees and the employer in the safety committee cannot agree, the issue can be referred to the health and safety authority, to see whether this is an issue on which the authority can make a decision. The Swedish Work Environment Authority may perform an inspection on the basis of such notifications, or by their own initiative focusing on specific sectors or health and safety risks (cf. Fulton 2018).

Role of collective agreements for H&S regulations and workplace H&S representation

The general collective agreements in the public sector covering the sectors in focus is the Main agreement (Huvudöverenskommelse) between SALAR and the nine main unions organising employees within the municipal and regional areas. Beside some specifications in relation to the legal regulations of employment, wages, and leave, the main agreement includes working time conditions that are of relevance to health and safety. In addition, there are requirements that the employer provides health examinations of employees for employees with tasks for which health deficiencies risk risks for others life, personal safety, or health. There are also appendixes to the main agreements with principles concerning on call duty and staff pools, and a specific crisis agreement was negotiated during Covid-19 to solve short time staffing and working time issues. For the private part of the sector there exists separate, if similar, agreements between the trade unions and the various private employer associations in the sectors; often specified for different branches such as care and treatment, and elderly care and home care, which cover similar issues at the public agreements.

There also exist specific collective agreements and joint statements relating to health and safety of relevance for the two sectors. The so-called Cooperation agreement (Samverkansavtalet) signed in 2017 by the social partners in the municipal and regional areas of operation, details forms and levels for cooperation on working environment between employees and representatives locally. The co-signed Letter of intent for healthy workplaces (Avsiktsförklaring för friska arbetsplatser) for the municipal sector is another important document signed by the social partners in the public sector aimed at finding constructive and effective solutions for the future in the working environment area, by joining forces in a knowledge increasing initiative focusing on “long-term-healthy work-places”. The initiative includes research funded by AFA Försäkring, digitalized support from Suntarbetsliv, and digital and regional educational and knowledge conferences on “health factors” organised by AFA Försäkring, Suntarbetsliv and AMR.

The Cooperation agreement is not meant to sidestep legal regulations or existing local collective agreements regarding working environment routines but is rather an overarching supplement to these. The agreement aims to achieve a good working environment by securing that employees have good opportunities to contribute to the organisations development and working environment work, and that this is done in a trustful and dialogic way – mainly by organising so that employees may be informed and have a collective dialogue at workplace meetings, and directly with the line manager, as well as through joint cooperation groups between employer, trade union and safety representatives. It is also worth noticing that the definition of working environment is rather wide in this agreement, as it refers

to “health promotion, prevention and rehabilitative measures where risk and health factors are identified”.

National, sectoral industrial relations systems

There is no clear division between the sectors of hospital/healthcare and social/elderly care in terms of what employer associations and trade unions that organise employers and employees. The main employer organisation on the public side is the Swedish Association of Local Authorities and Regions, SALAR (Sveriges Kommuner och Regioner, SKR), organizing all regions and municipalities in Sweden and employing around 1,2 million persons, a large portion in hospital/healthcare and social/elderly care. There is also an employer organisation for the municipal corporations, SOBONA, employing around 100 000 employees, of which some are in the two sectors. SOBONA cooperates closely with SALAR, and they try to shape a joint view on employer issues. The third large employer organisation of relevance for the sectors is the Association of Private Care Providers (Vårdföretagarna), who organises around 2000 companies employing around 100 000 employees. Beside these three, there are also employer associations organising competence agencies and non-profit employers, who also employ some in these sectors.

The main unions organising nurses, assistant nurses and nursing assistants. The Swedish Association of Health Professionals (Vårdförbundet), has 114 000 members, including nurses, midwives, biomedical scientists, and radiographers. The other is the main union for all municipal employees, the Municipal Union (Kommunal), which organises assistant nurses, healthcare assistants, medical technicians among their 500 000 members. In addition, also the cross-sectoral trade union Vision, which organizes dental nurses, assistants, administrators and social secretaries has some employees in the occupations and workplaces in focus in the two sectors studied. There are also several other trade unions organizing in the hospitals/healthcare and social/elderly care, but as these are more specialized, they are outside of the scope of this report (cf. Eurofound 2021).

When interviewed, the representatives for these social partners agree that there is a well-developed and functioning formal structure for health and safety in the hospital/health care and social/elderly care sectors in Sweden. The legal requirements cover all employees equally. There is a national and sectoral level social dialogue concerning problems and a strong cooperation regarding solutions. The joint organisations Prevent and Suntarbetsliv make relevant knowledge investments, develop concrete tools and there is also dialogue at levels. On the other hand, those responsible at national level have less knowledge about the actual practices and situations locally, as it is mainly when

working environment problems arise locally that information is conveyed upwards. That is, in cases concerning incidents where local workplaces need external support and help to resolve an emerging situation. Since the work environment is primarily handled through collaboration and dialogue at the local level, it may also take time before problems reach actors at regional or national level.

The interviews indicate an agreement among all respondents with the main principle that the ensuring of a good working environment should be built from below with the local workplace as a starting point. They believe this should be done through collaboration, which in turn requires that there is a dialogue between employers, managers, employees, trade union representatives and safety representatives. The employer and the safety representatives are said to have a particularly important role in this strategic work environment management. The employer must also arrange regular workplace meetings that include all employees where the work environment is discussed, and any work environment risks are identified. The main work environment management – to ensure health and safety – thus takes place locally at the workplaces. However, this also means that everyone thereby implicitly shares the responsibility for their work environment, and that both employers and employees actively shall contribute to a dialogue about how risks can be managed at the workplace level.

The respondents also highlight the importance of dialogue and cooperation between the social partners at sectoral and national levels, such as evidenced by the new joint “Letter of Intent for healthier workplaces” (ref) which, based on the challenges identified above, aims to improve work environment management and manage work environment risks at the local level through increased knowledge and support structures. As stated above, this initiative involves educational and knowledge increasing initiatives, and there is an agreement among the respondents that the important thing at national level is to create such knowledge initiatives, support materials and advice to be used at the local level workplaces. Some employer organization representatives actually express that they want to see a greater use of support materials and advice that Prevent and Suntarbetsliv provide their workplaces with.

Even though the employer and trade union representatives agree on the main challenges in health and safety, and that the work should be done locally, there are some slight differences in opinions. Employers want to see slightly fewer rules and regulations and stress more that the solutions must take place in the workplace where the skills exist, whereas trade union representatives want better rules and regulations as well as increased opportunities for sanctions to promote a good working environment for their members. Despite this disagreement, the dialogue between the parties is

generally very constructive and works well at the higher levels, while it may vary more at local levels. There was, however, a slightly more critical view on the union's influence and cooperation in matters related to the work environment and work environment risks among the private employee representatives as compared to the public employers.

Quality assessment by the social partners

At the national level, strategic work is being done to ensure that systematic work environment management includes everyone. However, the interview respondents agree that the welfare mission contain several challenges. Rules for working hours and daily rest cannot always be followed or guaranteed because of the shortcomings in personnel and skills in the hospital/healthcare, and social/elderly care sectors. Recovery may suffer, as employees must work more shifts than planned and can have difficulty in getting their statutory vacation. In addition, staff who work shifts often find it difficult to participate in the systematic work environment management, not least the workplace meetings (Arbetsplatsträff, APT) where the dialogue concerning work environment is to be discussed. Substitutes and fixed-term employees who perform the work during these meetings, are at risk of not being fully involved in the systematic work environment management, despite that everyone must be included and covered by this work according to the regulations. As managers in the hospital/healthcare and social/elderly care sectors often have too many employees, it is difficult to ensure a good working environment. When managers are struggling with finding competent staff and keeping the daily operation running, work environment risks and strategic work environment management may be de-prioritized. Consequently, some trade unions think there should be a regulation concerning the number of staff that line managers have.

Even though good regulations and structures exist at a general level, the respondents thus agree that the quality of the systematic work environment management at local level may vary. There is a challenge in that some local managers do not prioritize work environment issues, either because they do not have the resources or do not understand the importance of investing in employee dialogue and collaboration. Occasionally, there are also difficulties in recruiting safety representatives at the local level, and those who take on the assignment do not always have the adequate knowledge and skills. As mentioned above, a regional safety representative may step in when no local exist, but this also may create difficulties, as they do not always have full insight into the local work environment. This is particularly emphasized by private employer organizations, who find that there are situations in which some local and some regional safety representatives abuse their power to declare a protective halt, thereby shutting down work while waiting for the work environment authority's inspectors.

There are also some problems relating to the fact that the Swedish health care system is decentralized. The regions and municipalities have much freedom in how healthcare should be organized and financed. According to some respondents, the variation created may create uncertainty in different areas, also in relation to working environment issues. This became particularly evident during the pandemic, where regional recommendations could vary. The pandemic also made it evident that the dialogue between different institutions at the national level is not always fully functioning. An example given is that the recommendations from the Public Health Agency of Sweden (Folkhälsomyndigheten) and the National Board of Health and Welfare (Socialstyrelsen) did not fully consider the employer perspective, which meant that they could go against regulations and recommendations from the Swedish Work Environment Authority (Arbetsmiljöverket). The local employer was then faced with a situation where recommendations and rules could not be followed, and uncertainty arose about what really applied.

Looking more specifically at the occupational groups focused on in this project, we find some slight differences worth noticing, relating to their occupations and the two sectors. Nurses, who have a protected professional title and have more responsibility than assistant nurses and nursing assistants, generally have a very tough workload in both hospitals and in elderly care. In addition, they often have a managerial position, particularly those employed in elderly care. When the nurses' situation is discussed in the interviews, the problems highlighted are thus often based on their role as managers, rather than only on their occupational function. One recurrent challenge is that nurses in managerial roles often have many employees, which makes it difficult to work strategically with the working environment, as they have to find employees and fill gaps.

Assistant nurses and nursing assistants are difficult to recruit to the extent needed, and the turnover is greater than for nurses, which increases their occupational health and safety risks as many of the staff have less local workplace knowledge and less formal education and skills. Many employees in elderly care lack adequate training and sufficient knowledge concerning issues such as symptom control, hygiene routines, and the use of protective equipment. Another problem related to the lack of staff is that many employees in elderly care have inadequate language skills, which adds to these health and safety challenges. As the work in elderly care often takes place in smaller teams and workplaces, and as the elderly often have complex care needs, the high demand this place on the healthcare competence of the staff is particularly problematic as employees leave employees may be left at the mercy of making their own decisions in daily work. As also have been highlighted in public reports, our respondents stated that this lack of knowledge became particularly evident during the pandemic when employees went to work despite symptoms and/or did not want to be vaccinated.

Consequently, employers and unions formed agreements according to which staff could be sent home without union negotiations during the pandemic. All in all, then, the respondents agree that the work situation and working environment issues in elderly care are more difficult and pressured compared to the situation in hospital care.

Quality assessment by the researchers

From the above analyses it is obvious that there is an extensive legal regulation that cover most aspects of health and safety for employers and employees regardless of sector in Sweden. There is also a strong ambition to work actively with the implementation of the rules from both trade unions and employer associations. In fact, the joint social partner organisations created to improve knowledge and distribute information, guidelines and recommendations to be used at local levels, are very well developed at the national level, and also the local cooperative structures regulated by law and supplemented by legislation are formally very ambitious and make up a very strong safety net that works both reactive and preventive – when functioning well. Unfortunately, some employers lack the resources and/or commitment to implement them as intended or circumvent them due to staff and skills shortages.

As the needs of the care recipients must be met despite low staffing, employees are from time to time working more than regulated, and their daily rest and vacations cannot always be guaranteed. Patient safety often takes precedence over the safety of staff, which creates work environment risk for employees. In addition, too many employees, not least in elderly care, lack adequate knowledge and training, increasing the health and safety risks of both staff and care takers. Institutions such as the Swedish Work Environment Authority and the Swedish Health and Social Care Inspectorate (Inspektionen för Vård och Omsorg, IVO) have the task of inspecting compliance with regulations and regulations through supervision, but the resources in these institutions are limited. In addition, there exist testimonies that the larger hospitals in some instances choose or are forced to pay fines rather than take the measures needed to follow all requirements.

Types of health and safety challenges and how to tackle them

From the interviews with social partner representatives, it seems that they agree on that the health and safety challenges mainly relate to the lack of staff and skills supply in the healthcare and elderly care sectors. Deficiencies in staffing and competence are a work environment risk for employees but can also affect patient and user safety. When the workload is high, the risk of sick leave also increases,

which is something all respondents also identifies as a problem in a Swedish context. These challenges are well known at national, regional, and local level.

In the hospital sector, the respondents highlight that heavy workload is a great challenge. Employees work in overcrowded wards and have long and many shifts, which means regulated working hours, recovery and statutory holidays cannot always be guaranteed. However, everyone agrees that hospitals are better equipped in the sense that they have greater capacity and more resources, as compared to smaller care units. Employees can then be moved around more easily when the care needs in units vary. This may, however, also create new risks, as redeployed staff may not have the adequate skills. Still, the fact that work takes place in teams, promotes decision-making and patient safety regardless of whether you are a nurse, assistant nurse or nursing assistant.

A main challenge to maintain health and safety at work in hospitals/healthcare is the long-term sustainable staffing. If there is a lack of staff, the workload becomes high, and as a consequence sick leave increase. The lack of staffing can also affect the quality of care and patient safety. Related to these long-term staffing issues, the short-term challenges are the high workloads and an overcrowding in the wards. There is thus a need for greater margins in both staffing a hospital beds. Staff shortage in hospitals is mainly linked to licensed staff, such as nurses, which poses a challenge, and the need for recruitment will be great in the coming years. A recurring suggestion among respondents is thus the need to make work more attractive through an improved working environment, and other initiatives to retain and develop staff. This would supplement measures already taken at national level, such as the increased usage of staffing companies, a delegation of nurses' duties to assistant nurses, and an offer from municipalities for nurses to get their specialist training during paid working hours (SOU 2020: 89). Another measure taken is that hospitals can set themselves in a so-called "state of readiness" when the capacity to deal with urgent care needs are at risk of becoming insufficient; thereby increasing the possibility to move staff around (Socialstyrelsen 2018). Though, this is not seen as a long-term sustainable solution, and more resources and greater margins are needed to overcome the underlying structural problems.

EU-level health and safety dialogue and regulations

The main employer organisations and trade unions in the sectors of hospital/healthcare and social/elderly care are involved in European level organisations and there directly or indirectly also in crosssectoral and sectoral social dialogue. On the employer side, SALAR Is a Member of HOSPEEM, CEMR and SGI Europe (prev. CEEP), to which Swedish section also SOBONA belongs.

SALAR takes part in various social dialogues, among which are the ESSDC in hospitals and healthcare and the informal SSDC in Social services. The Association of Private Care Providers (Vårdföretagarna), is a member of the Confederation of Swedish Enterprise (Svenskt Näringsliv), and thereby indirectly connected to the crosssectoral social dialogue. Also on the union side, all three organisations in the sector, the Swedish Association of Health Professionals, Kommunal and Vision, are members of their European federation, EPSU, and the former two unions take active part in the two sectoral dialogues (cf. Eurofound 2021).

As for the actual relation and activities in the sectoral social dialogues, there is a somewhat disjointed relation among the representatives for trade unions and employer associations to the European level activities. On the one hand, quite little is known about it from representatives, and employer organisations, not directly involved in the European level dialogue: both in terms of its activities and its effects and relevance in Sweden. This might have to do with that when outcomes are implemented or discussions are relevant, these get so integrated in the regular Swedish regulations and agreements that you don't notice their relation to the European level. The most noticeable exception being the "Needlestick" directive, which is remembered as an important achievement.

On the other hand, those directly involved in the work at the European level are very committed and emphasise its importance. To a great extent, the interviews seem to confirm previous research (e.g., Larsson 2020; Larsson et al 2021; Larsson and Ulfsdotter Eriksson 2019). That is, they believe that the European level dialogue works fine – particularly when it is committed to "the right" issues, which often are the softer ones besides health and safety. They very much appreciate information sharing and mutual support, but are against the regulatory ambitions from certain members and countries, as this goes against the Swedish model of industrial relations with autonomous collective agreements and cooperation between the social partners at lower levels. Even so, there is an appreciation for the regulatory outcomes in the health and safety area, as illustrated by the "needlestick" directive and also the "recognition of professional qualifications" directive. This negative stance towards regulatory ambitions, is particularly strong on the employer side. As for the commitment, there are those who express an ambition to take European level social dialogue even more seriously, as they perceive themselves as still being too passive on the European arena, as they tend to mainly show their commitment in issues important to the Swedish context and model of industrial relations. In connection to this, there also a recognition of the positive effects on national level cooperation that the European level dialogue may have, as a consequence of the prework done jointly between trade unions, and between trade unions and employer organisations, before the meetings at the European level.

References

Baccaro, L., and Howell, C. (2017) *Trajectories of Neoliberal Transformation. European industrial relations since the 1970s*. Cambridge, UK: Cambridge University Press.

Eurofound (2021) *Industrial relations landscape in Europe: Central government administration, education, human health, local and regional government, and social services sectors*. Dublin: Eurofound.

Fulton, L. (2018) Health and safety representation in Europe. Labour Research Department and ETUI. Online publication: <http://www.worker-participation.eu/National-Industrial-Relations>

Huupponen, Mari (2021). *Pandemin i sjukvården*. Stockholm: Kommunal

Jansson, O., Jansson, J. and Ottosson, J. (2019) *Neither sticks nor carrots: Swedish trade union involvement in the European Semester*. Case study Sweden. National trade union involvement in the European Semester (INVOTUNES) project. OSE Working Paper Series, Research Paper No. 42, Brussels: European Social Observatory.

Larsson, B. (2020) "Cultural Obstacles in Transnational Trade Union Cooperation in Europe", *Nordic Journal of Working Life Studies*, 10 (1), 3-18.

Larsson, B. and Ulfsson, Y (2019) *Enhancing the Effectiveness of Social Dialogue Articulation in Europe. Case Study for Sweden (WP3)*. Working Papers – Dept. of Sociology and Work Science, 1, 2019. Gothenburg: University of Gothenburg.

Larsson, B., Galetto, M., Weber, S., Bechter, B., Prosser, T. (2020). What's the point of European Sectoral Social Dialogue? : Effectiveness and polycontextuality in the hospital and metal sectors. *Industrial relations journal*. 51. 410-426.

Socialstyrelsen (2018) *Kapaciteten i sjukvården – att hantera kritiska lägen*. Stockholm

SOU 2020:80. *Sverige under pandemin*. Stockholm. Regeringskansliet.

Van Rie T., Maes R. and Dion D.P. (2016) Social dialogue. In *Employment and Social Developments in Europe 2015*. Brussels: European Commission.

Visser J., Beentjes M., van Gerven M. and Di Stasio V. (2009) The quality of industrial relations and the Lisbon Strategy. In: *Industrial Relations in Europe 2008*. Brussels: European Commission.

SFS 1977:1160 Arbetsmiljölöag (Work Environment Act – including amendments up to SFS 2020:476).

SFS 1977:1166 Arbetsmiljöförordningen (Work Environment Ordinance – including amendments up to SFS 2018:938).

SFS 1982:673 Arbetstidslag (Working Hours Act– including changes up to SFS 2014:660).

SFS 2008:576 Diskrimineringslag (Discrimination Act – including amendments up to SFS 2017:1128).

Swedish Work Environment Authority's Statute Book (Arbetsmiljöföreskrifter)
<https://www.av.se/en/work-environment-work-and-inspections/publications/foreskrifter/>

CASE STUDY SE SOCIAL CARE SECTOR

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Näringsliv) together with the main blue collar confederation LO, and PTK (the council for negotiation and cooperation), a joint organization of 25 member unions, representing 950 000 white-collar employees. Prevent's aim is to make it easier for companies and workplaces to create a good work environment by informing, educating and developing useful instruments for work environment work. The partners that own prevent also own the insurance company Afa Försäkring (Afa Insurance), which administers collectively negotiated insurances providing financial support in the event of incapacity due to sickness, work injury, shortage of work, death and parental leave, supplementing the statutory insurances in the Swedish social insurance system. Afa Insurance also invest large sums in research, development and knowledge dispersal in the area of working environment and health.

In the public part of the sector there also exist a social partner arena called the Welfare Work Environment Council (Välfärdens arbetsmiljöråd, AMR), which aims to support preventive work environment processes at the local level through collaboration between the central parties. The AMR consists of members from SALAR and unions in the municipal area of operations.

Swedish work environment legislation prescribes that the employer is responsible for the work environment and for collaborating with its employees to achieve a good work environment. Local employee health and safety representation is provided through safety representatives (skyddsombud/arbetsmiljöombud). These are often trade union members, but also other staff can be elected by the employees. In larger companies (50 or more employees) or where the employees request this, there is also a safety committee (skyddskommitté). In addition, trade unions can appoint a regional safety representative (regionalt skyddsombud) to cover smaller workplaces without a safety committee. The safety committees are to participate in the planning and monitor the implementation of health and safety measures at the workplace, and the safety representative monitors that the employees have a satisfactory working environment, that safeguards against ill-health and accidents exist, and that the employer compliance with health and safety laws. In situations where the safety representative finds an immediate and serious threat to health, they have the right to halt work. In cases where employees and the employer in the safety committee cannot agree, the issue can be referred to the health and safety authority, to see whether this is an issue on which the authority can make a decision. The Swedish Work Environment Authority may perform an inspection on the basis of such notifications, or by their own initiative focusing on specific sectors or health and safety risks (cf. Fulton 2018).

Role of collective agreements for H&S regulations and workplace H&S representation

The general collective agreements in the public sector covering the sectors in focus is the Main agreement (Huvudöverenskommelse) between SALAR and the nine main unions organising employees within the municipal and regional areas. Beside some specifications in relation to the legal regulations of employment, wages, and leave, the main agreement includes working time conditions that are of relevance to health and safety. In addition, there are requirements that the employer provides health examinations of employees for employees with tasks for which health deficiencies risk risks for others life, personal safety, or health. There are also appendixes to the main agreements with principles concerning on call duty and staff pools, and a specific crisis agreement was negotiated during Covid-19 to solve short time staffing and working time issues. For the private part of the sector there exists separate, if similar, agreements between the trade unions and the various private employer associations in the sectors; often specified for different branches such as care and treatment, and elderly care and home care, which cover similar issues at the public agreements.

There also exist specific collective agreements and joint statements relating to health and safety of relevance for the two sectors. The so-called Cooperation agreement (Samverkansavtalet) signed in 2017 by the social partners in the municipal and regional areas of operation, details forms and levels for cooperation on working environment between employees and representatives locally. The co-signed Letter of intent for healthy workplaces (Avsiktsförklaring för friska arbetsplatser) for the municipal sector is another important document signed by the social partners in the public sector aimed at finding constructive and effective solutions for the future in the working environment area, by joining forces in a knowledge increasing initiative focusing on “long-term-healthy work-places”. The initiative includes research funded by AFA Försäkring, digitalized support from Suntarbetsliv, and digital and regional educational and knowledge conferences on “health factors” organised by AFA Försäkring, Suntarbetsliv and AMR.

The Cooperation agreement is not meant to sidestep legal regulations or existing local collective agreements regarding working environment routines but is rather an overarching supplement to these. The agreement aims to achieve a good working environment by securing that employees have good opportunities to contribute to the organisations development and working environment work, and that this is done in a trustful and dialogic way – mainly by organising so that employees may be informed and have a collective dialogue at workplace meetings, and directly with the line manager, as well as through joint cooperation groups between employer, trade union and safety representatives. It is also worth noticing that the definition of working environment is rather wide in this agreement, as it refers

to “health promotion, prevention and rehabilitative measures where risk and health factors are identified”.

National, sectoral industrial relations systems

There is no clear division between the sectors of hospital/healthcare and social/elderly care in terms of what employer associations and trade unions that organise employers and employees. The main employer organisation on the public side is the Swedish Association of Local Authorities and Regions, SALAR (Sveriges Kommuner och Regioner, SKR), organizing all regions and municipalities in Sweden and employing around 1,2 million persons, a large portion in hospital/healthcare and social/elderly care. There is also an employer organisation for the municipal corporations, SOBONA, employing around 100 000 employees, of which some are in the two sectors. SOBONA cooperates closely with SALAR, and they try to shape a joint view on employer issues. The third large employer organisation of relevance for the sectors is the Association of Private Care Providers (Vårdföretagarna), who organises around 2000 companies employing around 100 000 employees. Beside these three, there are also employer associations organising competence agencies and non-profit employers, who also employ some in these sectors.

The main unions organising nurses, assistant nurses and nursing assistants. The Swedish Association of Health Professionals (Vårdförbundet), has 114 000 members, including nurses, midwives, biomedical scientists, and radiographers. The other is the main union for all municipal employees, the Municipal Union, (Kommunal), which organises assistant nurses, healthcare assistants, medical technicians among their 500 000 members. In addition, also the cross-sectoral trade union Vision, which organizes dental nurses, assistants, administrators and social secretaries has some employees in the occupations and workplaces in focus in the two sectors studied. There are also several other trade unions organizing in the hospitals/healthcare and social/elderly care sectors, but as these are more specialized, they are outside of the scope of this report (cf. Eurofound 2021).

When interviewed, the representatives for these social partners agree that there is a well-developed and functioning formal structure for health and safety in the hospital/health care and social/elderly care sectors in Sweden. The legal requirements cover all employees equally. There is a national and sectoral level social dialogue concerning problems and a strong cooperation regarding solutions. The joint organisations Prevent and Suntarbetsliv make relevant knowledge investments, develop concrete tools and there is also dialogue at levels. On the other hand, those responsible at national level have less knowledge about the actual practices and situations locally, as it is mainly when

working environment problems arise locally that information is conveyed upwards. That is, in cases concerning incidents where local workplaces need external support and help to resolve an emerging situation. Since the work environment is primarily handled through collaboration and dialogue at the local level, it may also take time before problems reach actors at regional or national level.

The interviews indicate an agreement among all respondents with the main principle that the ensuring of a good working environment should be built from below with the local workplace as a starting point. They believe this should be done through collaboration, which in turn requires that there is a dialogue between employers, managers, employees, trade union representatives and safety representatives. The employer and the safety representatives are said to have a particularly important role in this strategic work environment management. The employer must also arrange regular workplace meetings that include all employees where the work environment is discussed, and any work environment risks are identified. The main work environment management – to ensure health and safety – thus takes place locally at the workplaces. However, this also means that everyone thereby implicitly shares the responsibility for their work environment, and that both employers and employees actively shall contribute to a dialogue about how risks can be managed at the workplace level.

The respondents also highlight the importance of dialogue and cooperation between the social partners at sectoral and national levels, such as evidenced by the new joint “Letter of Intent for healthier workplaces” (ref) which, based on the challenges identified above, aims to improve work environment management and manage work environment risks at the local level through increased knowledge and support structures. As stated above, this initiative involves educational and knowledge increasing initiatives, and there is an agreement among the respondents that the important thing at national level is to create such knowledge initiatives, support materials and advice to be used at the local level workplaces. Some employer organization representatives actually express that they want to see a greater use of support materials and advice that Prevent and Suntarbetsliv provide their workplaces with.

Even though the employer and trade union representatives agree on the main challenges in health and safety, and that the work should be done locally, there are some slight differences in opinions. Employers want to see slightly fewer rules and regulations and stress more that the solutions must take place in the workplace where the skills exist, whereas trade union representatives want better rules and regulations as well as increased opportunities for sanctions to promote a good working environment for their members. Despite this disagreement, the dialogue between the parties is

generally very constructive and works well at the higher levels, while it may vary more at local levels. There was, however, a slightly more critical view on the union's influence and cooperation in matters related to the work environment and work environment risks among the private employee representatives as compared to the public employers.

Quality assessment by the social partners

At the national level, strategic work is being done to ensure that systematic work environment management includes everyone. However, the interview respondents agree that the welfare mission contain several challenges. Rules for working hours and daily rest cannot always be followed or guaranteed because of the shortcomings in personnel and skills in the hospital/healthcare, and social/elderly care sectors. Recovery may suffer, as employees must work more shifts than planned and can have difficulty in getting their statutory vacation. In addition, staff who work shifts often find it difficult to participate in the systematic work environment management, not least the workplace meetings (Arbetsplatsträff, APT) where the dialogue concerning work environment is to be discussed. Substitutes and fixed-term employees who perform the work during these meetings, are at risk of not being fully involved in the systematic work environment management, despite that everyone must be included and covered by this work according to the regulations. As managers in the hospital/healthcare and social/elderly care sectors often have too many employees, it is difficult to ensure a good working environment. When managers are struggling with finding competent staff and keeping the daily operation running, work environment risks and strategic work environment management may be de-prioritized. Consequently, some trade unions think there should be a regulation concerning the number of staff that line managers have.

Even though good regulations and structures exist at a general level, the respondents thus agree that the quality of the systematic work environment management at local level may vary. There is a challenge in that some local managers do not prioritize work environment issues, either because they do not have the resources or do not understand the importance of investing in employee dialogue and collaboration. Occasionally, there are also difficulties in recruiting safety representatives at the local level, and those who take on the assignment do not always have the adequate knowledge and skills. As mentioned above, a regional safety representative may step in when no local exist, but this also may create difficulties, as they do not always have full insight into the local work environment. This is particularly emphasized by private employer organizations, who find that there are situations in which some local and some regional safety representatives abuse their power to declare a protective halt, thereby shutting down work while waiting for the work environment authority's inspectors.

There are also some problems relating to the fact that the Swedish health care system is decentralized. The regions and municipalities have much freedom in how healthcare should be organized and financed. According to some respondents, the variation created may create uncertainty in different areas, also in relation to working environment issues. This became particularly evident during the pandemic, where regional recommendations could vary. The pandemic also made it evident that the dialogue between different institutions at the national level is not always fully functioning. An example given is that the recommendations from the the Public Health Agency of Sweden (Folkhälsomyndigheten) and the National Board of Health and Welfare (Socialstyrelsen) did not fully consider the employer perspective, which meant that they could go against regulations and recommendations from the Swedish Work Environment Authority (Arbetsmiljöverket). The local employer was then faced with a situation where recommendations and rules could not be followed, and uncertainty arose about what really applied.

Looking more specifically at the occupational groups focused on in this project, we find some slight differences worth noticing, relating to their occupations and the two sectors. Nurses, who have a protected professional title and have more responsibility than assistant nurses and nursing assistants, generally have a very tough workload in both hospitals and in elderly care. In addition, they often have a managerial position, particularly those employed in elderly care. When the nurses' situation is discussed in the interviews, the problems highlighted are thus often based on their role as managers, rather than only on their occupational function. One recurrent challenge is that nurses in managerial roles often have many employees, which makes it difficult to work strategically with the working environment, as they have to find employees and fill gaps.

Assistant nurses and nursing assistants are difficult to recruit to the extent needed, and the turnover is greater than for nurses, which increases their occupational health and safety risks as many of the staff have less local workplace knowledge and less formal education and skills. Many employees in elderly care lack adequate training and sufficient knowledge concerning issues such as symptom control, hygiene routines, and the use of protective equipment. Another problem related to the lack of staff is that many employees in elderly care have inadequate language skills, which adds to these health and safety challenges. As the work in elderly care often takes place in smaller teams and workplaces, and as the elderly often have complex care needs, the high demand this place on the healthcare competence of the staff is particularly problematic as employees leave employees may be left at the mercy of making their own decisions in daily work. As also have been highlighted in public reports, our respondents stated that this lack of knowledge became particularly evident during the pandemic when employees went to work despite symptoms and/or did not want to be vaccinated.

Consequently, employers and unions formed agreements according to which staff could be sent home without union negotiations during the pandemic. All in all, then, the respondents agree that the work situation and working environment issues in elderly care are more difficult and pressured compared to the situation in hospital care.

Quality assessment by the researchers

From the above analyses it is obvious that there is an extensive legal regulation that cover most aspects of health and safety for employers and employees regardless of sector in Sweden. There is also a strong ambition to work actively with the implementation of the rules from both trade unions and employer associations. In fact, the joint social partner organisations created to improve knowledge and distribute information, guidelines and recommendations to be used at local levels, are very well developed at the national level, and also the local cooperative structures regulated by law and supplemented by legislation are formally very ambitious and make up a very strong safety net that works both reactive and preventive – when functioning well. Unfortunately, some employers lack the resources and/or commitment to implement them as intended or circumvent them due to staff and skills shortages.

As the needs of the care recipients must be met despite low staffing, employees are from time to time working more than regulated, and their daily rest and vacations cannot always be guaranteed. Patient safety often takes precedence over the safety of staff, which creates work environment risk for employees. In addition, too many employees, not least in elderly care, lack adequate knowledge and training, increasing the health and safety risks of both staff and care takers. Institutions such as the Swedish Work Environment Authority and the Swedish Health and Social Care Inspectorate (Inspektionen för Vård och Omsorg, IVO) have the task of inspecting compliance with regulations and regulations through supervision, but the resources in these institutions are limited. In addition, there exist testimonies that the larger hospitals in some instances choose or are forced to pay fines rather than take the measures needed to follow all requirements.

Health and safety challenges and how to tackle them

From the interviews with social partner representatives, it seems that they agree on that the health and safety challenges mainly relate to the lack of staff and skills supply in the healthcare and elderly care sectors. Deficiencies in staffing and competence are a work environment risk for employees but can also affect patient and user safety. When the workload is high, the risk of sick leave also increases,

which is something all respondents also identifies as a problem in a Swedish context. These challenges are well known at national, regional, and local level.

In the social/elderly care organisations, the main challenges are rather connected to skills shortage and the turnover of staff resulting in many substitutes and fixed-term employees. As the care needs of elderly granted care often are great, it requires increased knowledge among the employees, which is then hard to secure through recruitment. As the work to a greater extent done individually or in smaller teams as compared to hospitals, the employees in elderly care are often left at the mercy of their own decisions and in greater uncertainty. Nurses in elderly care often work completely alone and they often have a managerial position. This means that their tasks – in addition to the purely care-related ones – also involve finding competent staff, distributing the work and conducting systematic work environment management with limited resources and a high number of employees. Home care workers also have this problem, in addition to which there is often a lack of materials.

A main future issue in the social/elderly care sector, is to raise the status and attractiveness of the care professions to be able to provide good quality care. The background is that the staff shortage is great in this sector, and that more employees need to be offered permanent jobs. In addition, the medical competence in elderly needs to be strengthened, as the elderly have increased care needs. There have been suggestions to set requirements for minimum training for care professions, and to offer more extra training initiatives – including language training for care staff who currently lack satisfactory language skills (Huupponen 2021). The need for more nursing expertise in elderly care have also been highlighted. One proposal is that such expertise should be available in all retirement homes around the clock to secure the elderly's increased care needs, and to provide the existing staff with support and guidance in their work. In addition, the employers would also need to improve the conditions managers to make good leadership possible in elderly care, by for instance reducing the number of employees for managers are responsible. All in all, there is need for more government efforts and resources, in order to overcome the structural problems of elderly care.

EU-level health and safety dialogue and regulations

The main employer organisations and trade unions in the sectors of hospital/healthcare and social/elderly care are involved in European level organisations and there directly or indirectly also in crosssectoral and sectoral social dialogue. On the employer side, SALAR Is a Member of HOSPEEM, CEMR and SGI Europe (prev. CEEP), to which Swedish section also SOBONA belongs. SALAR takes part in various social dialogues, among which are the ESSDC in hospitals and

healthcare and the informal SSDC in Social services. The Association of Private Care Providers (Vårdföretagarna), is a member of the Confederation of Swedish Enterprise (Svenskt Näringsliv), and thereby indirectly connected to the crosssectoral social dialogue. Also on the union side, all three organisations in the sector, The Swedish Association of Health Professionals, Kommunal and Vision, are members of their European federation, EPSU, and the former two unions take active part in the two sectoral dialogues (cf. Eurofound 2021).

As for the actual relation and activities in the sectoral social dialogues, there is a somewhat disjointed relation among the representatives for trade unions and employer associations to the European level activities. On the one hand, quite little is known about it from representatives, and employer organisations, not directly involved in the European level dialogue: both in terms of its activities and its effects and relevance in Sweden. This might have to do with that when outcomes are implemented or discussions are relevant, these get so integrated in the regular Swedish regulations and agreements that you don't notice their relation to the European level. The most noticeable exception being the "Needlestick" directive, which is remembered as an important achievement.

On the other hand, those directly involved in the work at the European level are very committed and emphasise its importance. To a great extent, the interviews seem to confirm previous research (e.g., Larsson 2020; Larsson et al 2021; Larsson and Ulfsdotter Eriksson 2019). That is, they believe that the European level dialogue works fine – particularly when it is committed to "the right" issues, which often are the softer ones besides health and safety. They very much appreciate information sharing and mutual support but are against the regulatory ambitions from certain members and countries, as this goes against the Swedish model of industrial relations with autonomous collective agreements and cooperation between the social partners at lower levels. Even so, there is an appreciation for the regulatory outcomes in the health and safety area, as illustrated by the "needlestick" directive and also the "recognition of professional qualifications" directive. This negative stance towards regulatory ambitions, is particularly strong on the employer side. As for the commitment, there are those who express an ambition to take European level social dialogue even more seriously, as they perceive themselves as still being too passive on the European arena, as they tend to mainly show their commitment in issues important to the Swedish context and model of industrial relations. In connection to this, there also a recognition of the positive effects on national level cooperation that the European level dialogue may have, as a consequence of the prework done jointly between trade unions, and between trade unions and employer organisations, before the meetings at the European level.

References

Baccaro, L., and Howell, C. (2017) *Trajectories of Neoliberal Transformation. European industrial relations since the 1970s*. Cambridge, UK: Cambridge University Press.

Eurofound (2021) *Industrial relations landscape in Europe: Central government administration, education, human health, local and regional government, and social services sectors*. Dublin: Eurofound.

Fulton, L. (2018) Health and safety representation in Europe. Labour Research Department and ETUI. Online publication: <http://www.worker-participation.eu/National-Industrial-Relations>

Huupponen, Mari (2021). *Pandemin i sjukvården*. Stockholm: Kommunal

Jansson, O., Jansson, J. and Ottosson, J. (2019) *Neither sticks nor carrots: Swedish trade union involvement in the European Semester*. Case study Sweden. National trade union involvement in the European Semester (INVOTUNES) project. OSE Working Paper Series, Research Paper No. 42, Brussels: European Social Observatory.

Larsson, B. (2020) "Cultural Obstacles in Transnational Trade Union Cooperation in Europe", *Nordic Journal of Working Life Studies*, 10 (1), 3-18.

Larsson, B. and Ulfsson, Y (2019) *Enhancing the Effectiveness of Social Dialogue Articulation in Europe. Case Study for Sweden (WP3)*. Working Papers – Dept. of Sociology and Work Science, 1, 2019. Gothenburg: University of Gothenburg.

Larsson, B., Galetto, M., Weber, S., Bechter, B., Prosser, T. (2020). What's the point of European Sectoral Social Dialogue? : Effectiveness and polycontextuality in the hospital and metal sectors. *Industrial relations journal*. 51. 410-426.

Socialstyrelsen (2018) *Kapaciteten i sjukvården – att hantera kritiska lägen*. Stockholm

SOU 2020:80. *Sverige under pandemin*. Stockholm. Regeringskansliet.

Van Rie T., Maes R. and Dion D.P. (2016) Social dialogue. In *Employment and Social Developments in Europe 2015*. Brussels: European Commission.

Visser J., Beentjes M., van Gerven M. and Di Stasio V. (2009) The quality of industrial relations and the Lisbon Strategy. In: *Industrial Relations in Europe 2008*. Brussels: European Commission.

SFS 1977:1160 Arbetsmiljölöag (Work Environment Act – including amendments up to SFS 2020:476).

SFS 1977:1166 Arbetsmiljöförordningen (Work Environment Ordinance – including amendments up to SFS 2018:938).

SFS 1982:673 Arbetstidslag (Working Hours Act– including changes up to SFS 2014:660).

SFS 2008:576 Diskrimineringslag (Discrimination Act – including amendments up to SFS 2017:1128).

Swedish Work Environment Authority's Statute Book (Arbetsmiljöföreskrifter)
<https://www.av.se/en/work-environment-work-and-inspections/publications/foreskrifter/>

CASE STUDY UK HOSPITAL SECTOR

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Main national health and safety (H&S) regulations

Whilst the UK is no longer a member of the European Union, EU legislation as it applied to the UK on 31 December 2020 is now a part of UK domestic legislation. An EU Directive was first transposed into UK health and safety law on 1 January 1993 when a Framework Directive on Health and Safety Management was implemented under the existing UK Health and Safety at Work Act 1974. Individual Directives tailor the principles of the Framework Directive to specific tasks, specific hazards at work, specific workplaces and sectors, and specific groups of workers (e.g., pregnant women, and young workers)¹. Since 1993, several other EU Directives have been introduced into UK law, such as Directive 2010/32/EU prevention from sharp injuries in the hospital and healthcare sector becoming part of the Health and Safety (Sharp Instruments in Healthcare) Regulations in 2013 (HSE, 2013).

At the national level, the key UK health and safety legislation is the Health and Safety at Work, etc Act 1974, and the Management of Health and Safety at Work Regulations 1999². An additional two regulations require employers to consult their workforce about health and safety (HSE, 2013a):

- the Safety Representatives and Safety Committees Regulations 1977 (as amended); and
- the Health and Safety (Consultation with Employees) Regulations 1996 (as amended).

In workplaces where the employer recognises trade unions for collective bargaining purposes, the Safety Representatives and Safety Committees Regulations 1977 (as amended) applies. Health and safety representatives are appointed by a trade union recognised for collective bargaining purposes (ibid). “Reps” have a right to health and safety training and to paid time off to undertake their duties, including the right to investigate potential hazards and dangerous occurrences at the workplace, complaints by an employee relating to health and safety, and to examine causes of workplace accidents. Furthermore, they have the right to inspect the workplace, receive certain information from inspectors and attend health and safety committee meetings. In workplaces where employees are not members of a trade union and/or the employer does not recognise the trade union, health and safety representatives are elected by the workforce under the Health and Safety (Consultation with Employees) Regulations 1996 (as amended). The employer must establish a health and safety

¹ [Health and safety legislation - laws in the workplace \(hse.gov.uk\)](https://www.hse.gov.uk/legislation/)

² [Health and Safety at Work etc Act 1974 – legislation explained \(hse.gov.uk\)](https://www.hse.gov.uk/legislation/1974/)

committee if at least two health and safety representatives request that a safety committee is formed in the workplace (HSE, 2013a).

The Health and Safety Executive (HSE) is the national regulator and main enforcement body in the UK for health and safety inspections, enforcement, and investigations and covers both the hospital and care sectors.

More specific legislation that covers health and safety in the hospital sector is set out in the NHS England Health and Safety Policy (NHS, 2012, 2017), meaning that each NHS employer has a duty to ensure the health safety and welfare of all its employees. There is no specific health and safety legislation applicable to the care sector. Particularly relevant to this sector, at the national level the UK has no specific legislation on psychosocial risks, including workplace stress. Despite union pressure, the HSE has not produced a so-called “Approved Code of Practice” on stress, but only “Management Standards”, a list of the principal causes of work-related stress and how they can be tackled, which are advisory rather than enforceable (Fulton, 2018). Harassment is another key issue in this sector and the UK ratified ILO convention No. 190 treaty tackling violence and harassment at work (GOV.UK, 2021).

Role of collective agreements for H&S regulations and workplace H&S representation

All NHS hospital staff, apart from doctors, dentists, and very senior managers are covered by a collective agreement. This is set out in the NHS Terms and Conditions of Service, commonly known as “Agenda for Change”. The agreement covers the terms and conditions of employment including national pay grades, progression, overtime, sickness, holiday, and maternity rights, etc., and includes several specific references to Health and Safety legislation mentioned above. Pay however is negotiated by independent pay review bodies, who take recommendations from the NHS Staff Councils and recommend pay awards to the national government. There is no collective agreement for private sector care workers.

The NHS Staff Council is a tri-partite body with employer, staff, and Health Department representatives, able to negotiate any changes in core conditions in the Agenda for Change. The conditions of service are set out in the NHS Terms and Conditions of Service Handbook (NHS, 2022). apply in full to all staff directly employed by NHS organisations.

The NHS staff council and the health, safety, and wellbeing partnership group, a special working group within the NHS staff council, develop and update workplace health and safety standards that are used by NHS Trusts to develop their Health and Safety Policy. Consequently, Health and Safety Policies are not identical between NHS Trusts and vary across the UK.

The health and social work sector is the second most unionised sector in the UK after education (GOV.UK, 2022)³ rising from 1.25 million members (1995) to 1.63 million (2021). Trade union interviewees advised membership is concentrated in the NHS hospital sector rather than care. These statistics reflect national UK trends in union membership whereby public sector, degree-educated, female staff working in larger workplaces are more likely to be in a trade union (Dept for Business, Energy, and Industrial Strategy, 2022). In 2021, the average union density, covering all types of employees in the human health and social work activities sector, was 39.2 %. Trade unions are present in 72.1% of workplaces, and the pay of 38.2% of employees is affected by a collective agreement. Collective bargaining coverage of full-time employees in the sector is 41.5%, with 39.0% of permanent workers, 31.0% of part-time workers, and 27.4% of temporary staff in a union (LMS, 2022). Regarding the sectoral density of trade unions, Unison represents the largest share of workers in the health sector (20%), followed by the RCN (19%), Unite (4%), RCM (2%), and GMB (1%) (Eurofound, 2020:95).

On pay, the NHS Pay Review Body provides independent advice on the pay of NHS staff in all parts of the UK: since wages are set by the government based on the recommendations of Pay Review Bodies, there was no involvement by trade unions. A consolidated recommendation of 3% (NHS, 2021). by the Pay review bodies under Agenda for Change was rejected however by the government, with a wage freeze for public sector workers NHS, 2021). Later, the UK government offered a 1% pay increase to NHS health workers that unions attacked as being too low to compensate for real-term pay losses in recent years and the additional workload caused by the pandemic.

Health and safety were the key topics in negotiations between employers and trade unions during the Covid-19 pandemic (Pedersini & Molina, 2022: 15).

Procedural issues are regulated in NHS terms and conditions of service (Agenda for Change), Part 4, Employee Relations Section 25/Health and safety representatives (NHS, 2022)

- 25.19 *'The Safety Representatives and Safety Committee Regulations 1977 provides a legal entitlement for trades, union-appointed safety representatives, to have paid time from their normal work to carry out their functions and undergo training'* (ibid).
- Annex 27: *'Principles and best practice of partnership working (recognised partners of the Agenda for Change). To deliver partnership working successfully it is important to develop good formal and informal working relations that build trust and share responsibility, whilst respecting differences. To facilitate this, all parties commit to adopting the following*

³ The trade union membership 2021 report uses the Labour Force Survey to provide an estimate of the levels and density of trade union membership for all UK workers. It also covers union presence and collective bargaining.

principles in their dealings with each other: e.g., early discussion of emerging issues and maintaining dialogue on policy and priorities, ensuring a “no surprise” culture’ (ibid).

Trade unions recognised by the employer (those with whom the employer negotiates) have the right to appoint workplace health and safety representatives, often known as ‘safety reps’. Recognition depends upon the number of trade union members within the workplace and the employers’ willingness to negotiate. Where there is no recognised trade union, the employer should consult employees either directly or through elected safety representatives. The legislation does not specify the number of safety reps, however, leaving this to negotiation between unions and employers. A safety committee should be set up if an employer receives a written request from at least two safety representatives. The regulations also require the employer to share information with safety representatives and to advise of any official health and safety inspections. The regulations do not specify the functions of the safety committee though HSE guidance suggests tasks should include the analysis of accident and disease trends, the development of safety rules, and advice on safety communication (HSE, 2013a).

Whilst the consultation requirements apply to both the union and elected representatives, (known as Representatives of Employee Safety (ROES)), only union health and safety reps have the crucial right to undertake inspections. Both union-appointed safety representatives and ROES have the right to paid time off to carry out their functions, but the legislation does not specify the length of time, just “as may be reasonable in all the circumstances”. Both safety representatives and ROES have some protection against dismissal and should not suffer any detriment for carrying out their legal functions.

National, sectoral industrial relations systems

At the national level, NHS England is an independent, autonomous public body, operating at arm’s length to the government and publicly funded through taxation by the Department of Health and Social Care. NHS England’s overarching role is to ensure that the NHS delivers continuous improvements in outcomes for patients within the resources available (The King’s Fund, 2017). The Health and Social Care Act (2012) extended market-based approaches to the NHS leading to some outsourcing of health services to private health service providers to increase competition and improve patient choice and access to hospital treatment (ibid).

Cooperation and dialogue exist between social partners (see Appendix Table 1) and policymakers in the National Forum and the regional Social Partnership Forums (SPF). The National Forum was first set up in 1998 in recognition of the positive contribution that partnership working can make towards improving patient care. At a regional level, 12 SPFs bring together the employee side and employers. In the SPFs NHS employers, NHS Trade Unions, NHS England, Health Education England (HEE),

NHS Improvement, and the Department of Health discuss the development of policy and its implications for the workforce. The forums are not expected however to discuss or negotiate issues regulated in working contracts, including pay.

Pay reforms are implemented through ‘quasi-collective bargaining’ through the independent body, the NHS Pay Review Body (PRB). The PRB represents a form of unilateral pay determination. The PRB makes recommendations to the Secretary of State under the Agenda for Change pay system which covers over a million NHS staff (Cope 2017).

On the employer side, the NHS Employers organisation provides services to member employer organisations (e.g., NHS hospitals and NHS hospitals Trusts) across the UK and leads the national collective relationship with the unions. It feeds into the NHS Confederation which brings together all parts of the system across the UK. As of 2021, there were 219 trusts across the UK, including 10 ambulance Trusts, managing all NHS hospitals. Many trusts run more than one hospital, for example, Manchester University NHS Foundation Trust runs nine hospitals (The King’s Fund, 2022).

Sectoral actors include a number of recognized trade unions by NHS Hospital Trusts e.g., 16 by the University Hospital Southampton (2021). First, there are professional membership bodies acting as unions, such as the Royal College of Nursing (RCN) and the Royal College of Midwives (RCM). Second, more general trade unions such as Unison and Unite the Union, together with GMB tend to recruit from other bands of staff e.g., healthcare assistants, support workers, ambulance staff porters, etc. RCM, RCN, Unison, GMB, and Unite the Union are affiliated with the European Public Sector Union (EPSU).

The Royal College of Midwives (RCM) recruits both midwives and maternity support workers. Midwives are registered healthcare professionals with the Nursing and Midwifery Council following a 3 or 4-year graduate training course. In 2021 26,781 Midwives worked for the NHS or Councils Digital NHS UK⁴ with interviewees reporting nearly all staff are members of the RCM and covered by the collective agreement. Another 9000 maternity services support staff include 4,478 healthcare assistants and 1,603 support workers. The Royal College of Nursing (RCN) likewise represents nurses registered through the Nursing and Midwifery Council. Membership has risen from approx. 327,000 members in 1999/2000, to 469,000 in 2019/2020 (Clark, 2022).

Unison, which tends to represent public sector employees, is the largest union in the sector with 1.37 million workers, in 2020 (Clark, 2022). Just behind in terms of members, Unite the Union is the

⁴ NHS Hospital and Community Health Services (HCHS): Nurses & health visitors, Midwives and Support to doctors, nurses & midwives, by staff groups, care setting, level, gender and age band, in NHS Trusts and CCGs in England, as at 31 December 2021, headcount. <https://digital.nhs.uk>

largest union in the UK, which has tended to represent non-specialist and administrative workers. It has mostly grown through mergers of many smaller unions including the Union for the Finance Industry (UNIFI), Graphical Paper & Media Union (GPMU), Manufacturing Science & Finance Union (MSF), Amalgamated Engineering & Electrical Union (AEEU), and Transport & General Workers Union (T&G) who before 2002 acted as separate entities (Clark, 2022). GMB had over 608,000 members in 2019/20 falling from a peak of 704, 000 in 2002/03 (Clark, 2022).

At the workplace level, the local Health and Safety Committee leads on health and safety issues and is a partnership group of elected health and safety representatives and health and safety leads. NHS hospital Trusts have a health and safety committee, and both employers and trade union interviewees advised most NHS hospitals to have elected union representatives upon it.

All unions offer training to members who want to become health and safety reps training, but the number of health and safety reps tends to reflect trade union density and the perceived danger of the workplace e.g., ambulance and paramedic work is considered relatively dangerous and tends to have more health and safety reps than hospitals. COVID highlighted the importance and general perception by members of the role of a health and safety rep with union interviewees advising they may have overlooked the importance of the role in the past. They now actively prioritise the role both to attract new members and to ensure they have up-to-date information. Members previously had not wanted to become reps but now realised its importance: time to exercise their H & S union duties on top of their roles, however, was hampered due to high vacancy rates across the NHS.

On the employer side, managers appreciated that risk assessment is better done with a health and safety rep, they and their members doing the jobs know what the hazards and risks are. Trade unions could communicate new policies at multiple levels and locations assisting implementation. This view varied between Trusts however and only happens when management and reps work in partnership. It was also reported that some employers may bring in their own health and safety champions who tend not to understand the regulations, despite trade union health and safety reps being in place. In consultations where management tends to listen to these people, rather than the trade union health sector reps, this undermines the trade union's role.

The RCN has three types of union representatives, learning and development representatives, safety reps, and stewards. Members employed by the RCN can become officers, and senior regional officers who support the representatives, and operational managers, and that feeds up to regional directors or country leads. The RCN is short of health and safety reps at the workplace level (approx. 1000 safety reps for nearly half a million members). Not all NHS hospital Trusts necessarily have one RCN safety rep. The RCN has members in those organisations, maybe a Stewart but not necessarily a health and

safety rep. Accordingly, the RCN also does not have an accredited union representative sitting on the health and safety committee.

Due to institutional factors, the RCM does not have a health and safety rep in every workplace as there are often 50 - 70 wards across hospital sites, midwifery being just one of them, and therefore many RCM reps do not sit on health and safety committees. As a comparatively small trade union, being short-staffed, getting access to facilities, and protected time for this role is difficult, and frequently larger unions with a presence in many wards have those places. The RCM supports health and safety reps through guidance and advice e.g., on conducting workplace inspections. Campaigns at the workplace level, with heads of Midwifery and their health and safety reps, committed to a Caring for you Charter, addressing members' health and safety issues. Covid-19 prompted the union to establish a health and safety expert role aimed at promoting health and safety in maternity wards and recruiting reps.

Meanwhile, the GMB union tends to represent support staff in NHS hospitals and is more active in the private sector e.g., especially in social care, where health and safety reps, according to interviews, are often non-existent.

A key actor in health and safety working groups is the NHS Staff Council, a tri-partite body that translates health and safety legislation into standards of workplace health and safety in the NHS is the NHS Staff Council and its Health, Safety, and Wellbeing Group (HSWG). These standards are aimed at directors and managers with health and safety responsibilities, health and safety professionals, and trade union safety representatives. This policy applies to all statutory employees of NHS England, contractors, seconded staff, placements, and agency staff (NHS employers⁵).

The health and safety regulation process in this sector typically means that national-level health and safety legislation is translated into applicable standards and processes by social partners in the NHS Staff Council, then shared in the NHS hospital's health and safety policies documents (NHS 2017). Next, these policies are discussed in the Social Partnership Forum which delegates discussion into special working groups, e.g. the workforce issues group, the harassment group etc. to draw on specialist expertise and translate the policies into practical guidelines to be used by NHS hospitals at the workplace level. Each individual NHS hospital Trust will then have its own health and safety policy (e.g. Southampton NHS hospital Trust) but will draw on this advice. At the workplace level, health and safety reps and members of the hospital health and safety committees are then expected to implement these standards and procedures. Although managers at all levels are responsible for implementing and reinforcing health and safety policies, health and safety reps and individual

⁵ <https://www.nhsemployers.org/nhs-staff-council>

employees are accountable for complying with rules and regulations and reporting any problems. The HSE, trade unions, and the NHS employer organisation also provide advice and guidelines for their members and member organisations, on health and safety policy standards and procedures. The example below illustrates the health and safety regulation process at one NHS hospital Trust.

Typical hazards identified in the Southampton NHS Hospital Trust (University Hospital Southampton, 2021) are clinical care, care processes and procedures, slips, trips and falls, manual handling, fire, chemicals, moving parts of machinery, and electricity. Regarding roles and responsibilities, the Southampton NHS Hospital Trust health and safety policy reminds all employees of their duty to take reasonable care of their own health and safety and that of other people (Health and Safety at Work, etc. Act 1974), inform their employer of any danger to health and safety, inform their employer of any shortcomings in the employer's protection, and to co-operate with their employer's health and safety arrangements (The Management of Health and Safety at Work Regulations 1999). The policy therefore leans heavily on legislative standards rather than emerging psychosocial threats.

On the employers' side at the national level, the NHS Chief Executive has overall responsibility for health and safety within NHS England, and the National Director the delegated responsibility for implementation. Directors within the Regions and Centre have delegated responsibility from the Chief Executive to ensure this policy and associated procedures, protocols, guidance, and management systems are fully understood, applied, and resourced within their respective areas of responsibility. This includes suitable and sufficient risk assessments; ensuring that health and safety that may affect staff is always considered; reporting and investigating all accidents/incidents to identify learning or improvements needed to improve safety; monitoring the effectiveness of the health and safety system; ensuring that line managers are accountable for health and safety in areas of their control and compliance is reviewed at the annual appraisal.

Interaction at different levels exists between social partners and policymakers in the National Forum and the regional Social Partnership Forums (SPF). The national forum was initially set up in 1998, recognising the positive contribution of partnership working in improvements to patient care and with the 12 local SPFs, brings together the employee side and employers. In the SPFs, NHS Employers, NHS Trade Unions, NHS England, Health Education England (HEE), NHS Improvement, and the Department of Health discuss the development of policy and its implications for the workforce. Discussion of pay however is explicitly excluded from these forums.

At the EU-level, the trade unions Unison, RCN, RCM, Unite, and GMB are affiliated with the European social partner organisations, the European Federation of Public Service Unions (EPSU).

Quality assessment procedures by the social partners

NHS Hospital Trust's health and safety policy includes information about existing controls and required reviews if the precautions for each hazard still adequately control the risk. Reviews and revisions are required at least annually, because of an accident/near miss, change in process/equipment/personnel, or change in legislation. Monthly reviews (i.e., of the hospital's health and safety reports) are undertaken by the organisation commissioning services to an NHS hospital Trust. Safety representatives are also entitled to receive information from health and safety inspectors regarding their visits to the employer's premises, but only union health and safety reps have the right to undertake inspections – a crucial right for union-appointed safety representatives. On the functions of the health and safety committee, guidance from the HSE recommends that its tasks include analysing accident and disease trends, developing safety rules, and advising on safety communication (HSE, 2013a).

Yet despite the collective agreement, there are variations in health and safety due to occupational groupings and workplaces. Healthcare staff in hospitals differ in their types of training and education. Registered nurses have graduated or successfully passed a nursing program from a recognized nursing school. Healthcare care support workers include a range of healthcare support roles such as e.g., healthcare assistant, nursing assistant, theatre support worker, and maternity support worker. They support the practice nursing team in the delivery of nursing services and have access to training to learn basic nursing skills (e.g. an opportunity to do an apprenticeship). Healthcare support workers work under the supervision of a healthcare professional, supporting them. When employed by an NHS hospital Trust, they are all covered by the collective agreement and all employees employed by the hospital are covered by the same health and safety policies and standards. It is good practice to extend these standards to workers not employed by NHS hospitals (e.g., agency workers). However, no information is available in either interview data or secondary literature on how this recommendation is managed, enforced, and controlled in practice.

Union interviewees reported that health and safety protection also vary depending on where staff work. For example, staff employed by the NHS, or Councils are covered by similar standards, but little is known about the regulation of health and safety in GP surgeries. Registered nurses or general practice nurses in GP surgeries and visiting nurses (registered nurses who visit patients at home) are affected by varying standards, as they work in smaller workplaces or often alone.

Overall, therefore, there are varying standards between NHS hospital Trusts, and management, especially those newly appointed, who lack knowledge and understanding of the importance of health and safety and its practical implementation. Understaffing and work intensification make it difficult

for healthcare staff to safely follow rules and regulations. In a workplace with unionised health and safety reps, health and safety protection and awareness are better than in hospitals with elected representatives (ROES).

Quality assessment by the researcher

There are several policy levels, and responsibilities for implementation delegated to specific managerial levels in NHS hospital Trusts. However, those made accountable for implementation and compliance with the regulations are individual employees at the workplace level. This means there are wide variations in the quality of implementation of health and safety regulations. The SPF and trade union involvement is responding to developing threats to the health and safety of employees including workplace stress and violence at work.

Regarding the effectiveness of health and safety regulations in protecting different members of the sector because there is a collective agreement, all employees, regardless of grade employed by the NHS are covered by the same agreement (NHS terms and conditions of employment) and also by NHS hospital Trust health and safety policies and regulations. However, since every Trust develops its own policy, health and safety standards vary between hospitals and workplaces and there is a lack of consistency at all levels.

Types of health and safety challenges and how to tackle them.

The key challenge reported in interviews and supported by literature is understaffing, leading to high vacancies, high workloads, and poor working conditions; a lack of flexible working arrangements to meet staffing levels, shift work (a mostly female workforce with caring responsibilities), high vacancies causing staff stress and exhaustion, and moral stress since employees are unable to provide a good level of patient care. Patient health and safety standards can only be maintained at the expense of staff health and safety. A lack of union recognition, poor pay, and violence and aggression towards healthcare/NHS staff, means many healthcare workers are leaving the profession.

Key to tackling challenges are improvements in working conditions, focusing on workforce planning, recruitment, retention, pay, training, progression, and flexible working arrangements to retain staff, including an improved focus on the health, safety, and wellbeing of employees particularly to address workplace stress.

EU-level health and safety dialogue and regulations

Since Brexit, UK trade unions no longer participate in European Sectoral Social Dialogue (ESSD). However, UK unions such as Unison, RCN, RCM, GMB, and Unite the Union are still affiliated with

and engaged in European social partner organisations such as the European Public Sector Union (EPSU). Liz Snape from Unison is one of the elected EPSU Vice Presidents for the Congress period 2019-2024. Despite Brexit, the NHS employer organisation is affiliated with the European Hospital and Healthcare Employers' Association (HOSPEEM) and participated in some ESSDC meetings.

Multilevel coordination of health and safety

Interviewees reported good coordination between social partners in the NHS staff Council and special working groups, the SPF, and its working groups. Unions compete to recruit new members and use improvements in health and safety and better guidelines and regulations to attract new members. But there is a general lack of coordination at all levels between management, HR, government, and trade unions. Health and safety appear to be regarded as an issue of legal compliance, with the individual employee bearing ultimate responsibility for implementation.

Since Brexit, there is no involvement by UK social partner organisations in SSDCs. At the national level, trade unions are involved in EPSU but not in SSDC meetings. Trade unions that are affiliated with EPSU mentioned cleaning fluids as a topic of interest with sector-wide regulations needed to protect staff health, especially for non-nursing staff e.g., porters, and health-care assistants.

References:

Care Quality Commission (2022) Inspection Reports. Available from: <https://www.cqc.org.uk/> [Accessed 30 January 2023].

Clark, D. (2022) Union membership in the United Kingdom (UK) 1999-2020. Available from: <https://www.statista.com/statistics/286076/union-membership-in-the-uk/> [Accessed 30 January 2023].

Cope, J. (2017) NHS Pay Review Body Thirtieth Report 2017. Cm 9440.

Department for Business, Energy and Industrial Strategy (2022) Trade Union Membership UK 1995-2021. Statistical Bulletin. Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1077904/Trade_Union_Membership_UK_1995-2021_statistical_bulletin.pdf. [Accessed 24 February 2023]

Department of Health and Social Care (2022) Social care: Independent report by Baroness Cavendish How can we lock in the lessons of the crisis to build a more robust, sustainable, joined-up system of health and social care? Published February 2022. Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1059888/social-care-reform-Baroness-Cavendish-report.pdf [Accessed 30 January 2023].

Digital NHS UK (2023) Data and technology that improves lives. Available from: <https://digital.nhs.uk/> [Accessed 30 January 2023].

Eurofound (2020) Representativeness of the European social partner organisations: Human health sector, Sectoral social dialogue series, Dublin.

GOV.UK (2022) Trade Union Membership Statistics UK, May 2022. Available from: <https://www.gov.uk/government/statistics/trade-union-statistics-2021> [Accessed 30 January 2023].

Hayes, L. (2017) 8 Good Reasons why Adult Social Care Needs Sectoral Collective Bargaining, published by the Institute of Employment Rights 4th Floor, Jack Jones House, 1 Islington, Liverpool, L3 8EG.

HSE (2013) Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 Guidance for employers and employees. Published by the Health and Safety Executive HSI7 03/13. Available from: <https://www.hse.gov.uk/pubns/hsis7.pdf> [Accessed 30 January 2023].

HSE (2013a) Consulting employees on health and safety. A brief guide to the law Published by the Health and Safety Executive 04/13 INDG232(rev2). Available from: <https://www.hse.gov.uk/pubns/indg232.pdf> [Accessed 30 January 2023].

HSE (2014) Health and safety in care homes. HSG220 (2nd edition). Available from: <https://www.hse.gov.uk/pubns/priced/hsg220.pdf> [Accessed 30 January 2023].

Fulton, L. (2018) Health and safety representation in Europe. Labour Research Department and ETUI (online publication). Produced with the assistance of the Workers' Interest Group of the Advisory Committee for Safety and Health at Work (of the EU Commission). Available from: <http://www.worker-participation.eu/National-Industrial-Relations> [Accessed 26 May 2020].

GOV.UK (2023) International treaty ILO Violence and Harassment Convention, 2019 (No.190) [MS No.7/2021]. Available from: <https://www.gov.uk/government/publications/ilo-violence-and-harassment-convention-2019-no190-ms-no72021> [Accessed 31 January 2023].

Legislation.gov.uk (2020) Legislation and UK law. Available from: <https://www.legislation.gov.uk/eu-legislation-and-uk-law> [Accessed 31 January 2023].

LMS (2022) Labour market statistics time series (GOV.UK), EU Economic Activity Classification. Available from: <https://www.gov.uk/government/statistics/labour-market-statistics-time-series> [Accessed 30 January 2023].

NHS (2017) Health and Safety Policy. Document number: POL_1002. Available for download: <https://www.england.nhs.uk/wp-content/uploads/2017/04/pol-1002-health-safety-policy.pdf> [Accessed 30 January 2023]

NHS (2021) NHS Pay Review Body Thirty-Fourth Report 2021. Available from: <https://www.gov.uk/government/publications/nhs-pay-review-body-thirty-fourth-report-2021> [Accessed 30 January 2023].

NHS (2022) NHS Terms and Conditions of Service Handbook. Handbook amendment number 48 Pay Advisory Notice (02/2022). Available from: <https://www.nhsemployers.org/publications/tchandbook#:~:text=The%20NHS%20terms%20and%20conditions%20of%20service%20handbook,sections%20or%20in%20full.%20Amendments%20to%20the%20handbook> [Accessed 30 January 2023].

NHS Employers (2022) NHS Employers. <https://www.nhsemployers.org/> [Accessed 24 February 2023].

Pedersini, R. & Molina, O. (2022) Collective bargaining in seven European countries throughout the pandemic. International Labour Organization, Working papers 74.

Skillsforcare (2022) The state of the adult social care sector and workforce in England, 2022. Published by Skills for Care, West Gate, 6 Grace Street, Leeds LS1 2RP. Available from: <https://www.skillsforcare.org.uk/Adult-Social-Care-Workforce-Data/Workforce-intelligence/documents/State-of-the-adult-social-care-sector/The-state-of-the-adult-social-care-sector-and-workforce-2022.pdf> [Accessed 30 January 2023].

The King's Fund (2017) Is the NHS being privatised? Available from: <https://www.kingsfund.org.uk/publications/articles/big-election-questions-nhs-privatised-2021> [Accessed 15 February 2023].

The King's Fund (2022) Key facts and figures about the NHS. Available from: <https://www.kingsfund.org.uk/audio-video/key-facts-figures-nhs> [Accessed 30 January 2023].

Unison (2021) Supreme Court sleep-in appeal decision is a blow for everyone in social care, says UNISON. Available from: <https://www.unison.org.uk/news/press-release/2021/03/supreme-court-sleep-appeal-decision-blow-%e2%80%8beveryone-social-care-says-unison/> [Accessed 30 January 2023].

University Hospital Southampton (2021) Health and Safety Policy, Version 10.0, Date issued 21/11/18, Date reviewed 21/11/21. Available from: <https://www.uhs.nhs.uk/Media/Controlleddocuments/Governanceandsafety/Health-and-safety-policy.pdf> [Accessed 30 January 2023].

CASE STUDY UK SOCIAL CARE SECTOR

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Main national health and safety (H&S) regulations

Whilst the UK is no longer a member of the European Union, EU legislation as it applied to the UK on 31 December 2020 is now a part of UK domestic legislation. An EU Directive was first transposed into UK health and safety law on 1 January 1993 when a Framework Directive on Health and Safety Management was implemented under the existing UK Health and Safety at Work Act 1974. Individual Directives tailor the principles of the Framework Directive to specific tasks, specific hazards at work, specific workplaces and sectors, and specific groups of workers (e.g., pregnant women, and young workers)⁶. Since 1993, several other EU Directives have been introduced into UK law, such as Directive 2010/32/EU prevention from sharp injuries in the hospital and healthcare sector becoming part of the Health and Safety (Sharp Instruments in Healthcare) Regulations in 2013 (HSE, 2013).

At the national level, the key UK health and safety legislation is the Health and Safety at Work etc Act 1974, and the Management of Health and Safety at Work Regulations 1999⁷. An additional two regulations require employers to consult their workforce about health and safety (HSE, 2013a):

- the Safety Representatives and Safety Committees Regulations 1977 (as amended); and
- the Health and Safety (Consultation with Employees) Regulations 1996 (as amended).

In workplaces where the employer recognises trade unions for collective bargaining purposes, the Safety Representatives and Safety Committees Regulations 1977 (as amended) applies. Health and safety representatives are appointed by a trade union recognised for collective bargaining purposes (ibid). “Reps” have a right to health and safety training and to paid time off to undertake their duties, including the right to investigate potential hazards and dangerous occurrences at the workplace, complaints by an employee relating to health and safety, and to examine causes of workplace accidents. Furthermore, they have the right to inspect the workplace, receive certain information from inspectors, and attend health and safety committee meetings. In workplaces where employees are not members of a trade union and/or the employer does not recognise the trade union, health and safety representatives are elected by the workforce under the Health and Safety (Consultation with Employees) Regulations 1996 (as amended). The employer must establish a health and safety

⁶ [Health and safety legislation - laws in the workplace \(hse.gov.uk\)](https://www.hse.gov.uk/legislation/)

⁷ [Health and Safety at Work etc Act 1974 – legislation explained \(hse.gov.uk\)](https://www.hse.gov.uk/legislation/1974/)

committee if at least two health and safety representatives request that a safety committee be formed in the workplace (HSE, 2013a).

The Health and Safety Executive (HSE) is the national regulator and main enforcement body in the UK for health and safety inspections, enforcement, and investigations and covers both the hospital and care sectors. The Care Quality Commission (CQC) is the independent regulator of health and social care in England and regularly inspects and grades care homes and domiciliary services, providing public ratings on the quality of care. A key part of its inspection procedure or Key Lines of Enquiry (KLOES) concerns ensuring that staff are effectively trained in safety systems, processes, and practices (Care Quality Commission, 2022). The CQC also has a statutory duty to advise if a care provider is financially unviable.

More specific legislation that covers health and safety in the hospital sector is set out in the NHS England Health and Safety Policy (NHS, 2012, 2017), meaning that each NHS employer has a duty to ensure the health safety, and welfare of all its employees. There is no specific health and safety legislation applicable to the care sector. Particularly relevant to this sector, at the national level the UK has no specific legislation on psychosocial risks, including workplace stress. Despite union pressure, the HSE has not produced a so-called “Approved Code of Practice” on stress, but only “Management Standards”, a list of the principal causes of work-related stress and how they can be tackled, which are advisory rather than enforceable (Fulton, 2018). Harassment is another key issue, particularly for lone workers in domiciliary care and the UK has ratified ILO convention No. 190 treaty on tackling violence and harassment at work (GOV.UK, 2021).

Role of collective agreements for H&S regulations and workplace H&S representation

Unlike the publicly funded NHS hospital sector, there is no collective agreement for private sector care workers. Whilst the Health and social work sector is the second most unionised sector in the UK after education (GOV.UK, 2022)⁸ rising from 1.25 million members (1995) to 1.63 million (2021), both employer and trade union interviewees advised that membership is concentrated in the NHS hospital sector rather than the largely privatised care sector. These statistics reflect national UK trends in union membership whereby public sector, degree-educated, female staff working in larger workplaces are more likely to be in a trade union (Dept for Business, Energy and Industrial Strategy, 2022).

No information is available on collective agreements in this sector: any collective agreements made are concluded between an employer and recognised trade unions at the workplace and establishment

⁸ The trade union membership 2021 report uses the Labour Force Survey to provide an estimate of the levels and density of trade union membership for all UK workers. It also covers union presence and collective bargaining.

level. Trade unions estimated that union density at approx. 20% and concentrated in larger private firms and those still employed by local authorities. Employment terms and conditions and health and safety regulations are set out in the employment contract, but employment protection is heavily dependent on individual rights (Heyes, 2017). Almost a quarter of the adult social care workforce (24%), and over half of the domiciliary care workers (54%) (SkillsforCare, 2022) are employed on ZeroHourContracts (ZHCs).

Many care workers are employed on the national minimum wage, (ibid), making them amongst the lowest paid workers in the UK. Terms and conditions are often individually negotiated with wide variations in pay for travel and supplies compared to other sectors. For instance, care workers are not entitled to the national minimum wage for each hour of sleep-in shifts although they are away from home and on call (Unison, 2021). In contrast, NHS pay is nationally decided based on independent NHS Pay Review Bodies. Both employer and trade union interviewees reported that pay rates and recruitment activities in the NHS hospital sector often impact recruitment issues in care, as employees with care experience can earn approx. 20% more in the other sector, although the skills and duties are the same.

Whilst procedural issues are regulated in NHS terms and conditions of service (Agenda for Change), Part 4, Employee Relations Section 25/Health and safety representatives (NHS, 2022), there is no such agreement in care. Trade unions recognised by the employer (those with whom the employer negotiates) have the right to appoint workplace health and safety representatives, often known as 'safety reps'. Recognition depends upon the number of trade union members within the workplace and the employers' willingness to negotiate. Where there is no recognised trade union, the employer should consult employees either directly or through elected safety representatives (Fulton, 2018). The legislation does not specify the number of safety reps, however, leaving this to negotiation between unions and employers. A safety committee should be set up if an employer receives a written request from at least two safety representatives. The regulations also require the employer to share information with safety representatives and to advise of any official health and safety inspections. The regulations do not specify the functions of the safety committee though HSE guidance suggests tasks should include the analysis of accident and disease trends, the development of safety rules, and advice on safety communication (HSE, 2013a).

Whilst the consultation requirements apply to both the union and elected representatives, (known as Representatives of Employee Safety (ROES)), only union health and safety reps have the crucial right to undertake inspections (HSE, 2013a). Both union-appointed safety representatives and ROES have the right to paid time off to carry out their functions, but the legislation does not specify the length of time, just "as may be reasonable in all the circumstances". Both safety representatives and ROES

have some protection against dismissal and should not suffer any detriment for carrying out their legal functions. Trade union interviewees advised that given the poor union density in this sector (approx. 20%) and recruitment issues due to the high turnover of staff and the nature of much care work (care workers working alone, often for small private firms etc), recruitment and retention of staff or health and safety reps was poor.

National, sectoral industrial relations systems.

At the national level, the provision of care in the UK, in contrast to the hospital sector, is funded by the Ministry of Housing, Communities, and local government to local authorities, who commission mostly private care providers, charities, and local authority-governed care services.⁹ (National Audit Office, 2018). Whilst the Department for Health and Social Care (DHSC) is responsible for securing the funding, the Ministry is responsible for most of its distribution to local authorities, through the annual local government finance settlement. The Ministry uses an adult social care relative needs formula, which has not been updated since 2013-14. DHSC acknowledges that many local authorities pay below a sustainable rate for care either at home or in a residential home (DHSC, 2023). Local authorities are required by the Care Act 2014 to provide a range of care services, i.e., to create a market for care in their area, to provide information, and to focus on preventing people's care needs from becoming worse (DHSC, 2016).

Key actors in this fragmented sector, therefore, include the 333 local authorities, who commission care services; the 17,900, mostly private, organisations, across 39,000 locations that provide care services (Skillsforcare, 2022) either in residential homes or increasingly, in people's own homes, domiciliary care; trade unions and employer associations.

Local authorities, and the commissioners of care services are also key actors in this sector. Those care employees directly employed by local authorities are part of the national collective bargaining agreement, the National Joint Council for local government services, the so-called "Green Book" which sets a framework for pay levels, which benchmarks pay and outlines in detail all terms and conditions for local authority employees (LGAA, 2022). On average directly employed care workers are better paid and trained and enjoy better health and safety protection through established

⁹ See appendix 1 for diagrammatic explanation from National Audit Office (2018). The adult social care workforce in England. Report by the Controller and Auditor General. Available from: <https://www.nao.org.uk/wp-content/uploads/2018/02/The-adult-social-care-workforce-in-England.pdf> [accessed 17 February 2023].

communication channels, for example benefitting from the joint backdated pay deal 2022 averaging 7%, working with Unite and GMB (Unison, 2022).

The many private care firms are mostly small, 37% only employ 1-4 employees, and 85% employ less than 50 employees. Approximately 79% of care staff are employed by private sector firms; only 7% are directly employed by local authorities; 7% of staff are directly employed by individuals and 7% by the NHS (SkillsforCare 2022). There are an estimated 39,000 establishments providing care, split equally between residential and domiciliary care. There is some evidence of multi-national ownership of English care firms, e.g., the Spanish-based firm Clece (Clece, 2023). The many small firms and high turnover of staff make it challenging for unions to recruit, retain, and train health and safety representatives.

There are several organisations representing employers, none of which work as a collective employer's body. Care England the employers' organisation appeared to act more as a lobbying business organisation; the Homecare Association acts as an advice and representation body for home care providers. Both employer and trade union interviewees noted that especially small domiciliary care firms are vulnerable to collapse. Trade union interviewees were concerned that some private residential care homes are owned by private equity firms, heavily indebted yet paying significant dividends, and highlighted the significant risk for local authorities, who are obliged to step in when firms fail (BBC, 2021). The National Audit Office also notes the indebtedness of the care sector and its vulnerability to collapse (NAO, 2018). Employer representatives highlighted increased costs due to inflation and higher wages, arguing that a reasonable minimum price for care is £23.20 per hour to cover wages, travel time, and the costs of a business. Most local authorities pay under £20 per hour for care, however, meaning that local authority work is unsustainable (HomeCare Association, 2021). When councils tender for care bids, they may also award the tender to the lowest bidder, to save costs. Employers also noted that as care is paid for either by councils or the individual, rather than being free at the point of need like the NHS, care users must complete both a care needs assessment and satisfy financial eligibility criteria, causing delays in payments. Employers also questioned the accuracy of some care needs assessments noting that more complex needs patients were sometimes not properly assessed.

Key trade unions in this sector include Unison, Unite and GMB. There is low trade union density in this sector with large non-specialist trade unions active. Interviewees estimated membership at approx. 20% of all care workers, and concentrated in local authority and residential care, or larger private employers (Heyes, 2017). Some decades ago, most workers were employed directly by local authorities and covered by the collective agreement but when care is outsourced to private firms, employees lose this protection, significantly affecting their terms and conditions of employment

meaning that on average they are better paid, trained and enjoy better H & S protection through established communication channels (Smith Institute, 2014; TUC, 2015).

The estimated 1.5 million care staff and approx. 1.2 million workers directly providing care (SkillsforCare, 2022) are characterised by several factors. There is little career progression or training available, with approx. 860,000 care workers, and only 79,000 senior care workers, whilst 120,000 workers are directly employed by individuals (ibid). There are an estimated 32,000 nurses, mostly employed in residential care, whilst 51% of the workforce is full-time and 49% works part-time. The workforce is mostly female (82%), whilst 66% of care workers are over 55. An estimated 23% of care workers are BAME (Black and Minority Ethnic) but concentrated around London at 68% of care workers.

Approximately 54% of domiciliary care workers are employed on zero-hour contracts (ZHCs) where employers are not required to provide minimum working hours, but employers are still responsible for their health and safety (Gov.UK). Practically exercising this right however means that workers run the risk of being “zero-ed out” i.e., losing work in the future, a key vulnerability since enforcement of health and safety relies upon individuals knowing and understanding their rights and responsibilities. Approx. 2% of care workers are employed by agencies. The average turnover rate in this sector is 29%; but there was wide variability – with care workers the highest at 36% and in large (<50 staff) independent providers at less than 10%. (ibid). Workers in the local authority sector had the most experience in their roles.

Care staff is required to complete a Care certificate, and an online training module as the minimum qualification for employment which includes a basic health and safety module (SkillsforCare, 2022). On completion of the module, the employee can be signed off as competent by the manager. Unlike Scotland and Wales, carers are not required to do specific qualifications and there is no registration system for staff. The online module should be supplemented by additional training to include e.g. handling of medication and manual handling but there is no registration or online system to track this.

Pay for care workers is amongst the lowest in the economy, with the median hourly rate of £9.50 compared poorly to newly qualified health care assistants in the NHS of £10.50. There was poor evidence of progression for care workers with more males and whites in higher management roles (SkillsforCare, 2022). Both employer and trade union interviewees suggested that Brexit had impacted the sector with EU nationals, particularly in nursing roles, choosing to leave the sector.

There is little evidence of interaction between the national government, employers, and trade unions, although trade unions reported good relationships with local authorities and some large private firms. Given the collective agreement covering local authority-employed care staff (approx. 7% of care

workers, (SkillsforCare, 2022) some trade union interviewees actively seek to influence the commissioning process, which focuses on quantitative and cost measures including care home placements, staff time, and tasks rather than quality outcomes for patients.

Trade union interviewees were mixed on improved communication with the central government during the pandemic as the government sought trade union views on the vaccination of care workers etc.

Quality assessment by the social partners

Several trade union interviewees questioned if there was effective health and safety in the care workforce. Trade union interviewees actively compared the Hospital and Care sectors and noted the lack of workforce structures, data, or consideration for the health, safety, and well-being of care staff. Interviewees questioned how it was possible that the low hourly rates paid for care could possibly cover the costs of effective health and safety and noted how the emphasis on hourly rates in the commissioning process mitigated against the quality of care for patients.

Quality assessment (by researchers)

Given the lack of data, it is difficult to assess the quality of staff health and safety, but the commissioning process, low pay rates, and high turnover of staff suggest that the inevitable costs associated with effective health and safety are not being met. Unlike the NHS Staff survey, there is no equivalent for care staff, again suggesting this staff is poorly valued and overlooked. Of particular concern are the growing personal care market and the use of agencies to supply domiciliary care workers, emphasising how responsibility for staff health and safety is individualised and laid on the employee rather than the employer.

H&S challenges and how to tackle them

Key concerns reported by both employers' organisations and trade union interviewees included the lack of funding in the care sector, high staff turnover, and many vacancies leaving existing staff overworked and stressed. Other issues include low wages and lack of career progression for employees. The large number of many small care firms (employees <4) means that frequently the risk assessment process is undertaken by management only, rather than health and safety reps. This combined with the lack of union members or union health and safety reps also means that communications can be patchy, with wide variations in effective health and safety implementation.

Analysis of employer secondary literature showed an alarming minimal discussion of employee health and safety or wellbeing. Health and safety standards are focused on compliance with legislative standards including the recording and minimisation of trips, slips, and falls as required by HSWA

1974 rather than more modern, incremental threats to health and safety including workplace stress, lone working at night or in people's homes, psycho-social impacts, overwork, violence from patients, racism and sexism at work.

As care is increasingly delivered to patients in their own homes, many female care workers work alone, with minimal supervision, but face increasing violence from patients with complex or undiagnosed needs including Alzheimer, and mental health conditions. They also lack the peer support afforded by national training standards and professional registration, both of which would support tracking of employee numbers and recruitment to trade unions. A renewed move to online health and safety training emphasised by the Covid pandemic meant that many newer employees lacked a practical understanding of health and safety issues. Whilst online training may ensure contract compliance and that employers are seen to have provided training, both trade union and employer interviewees suggested that practical risk assessment of hazards in the home was complex and challenging, relying on overworked managers and care staff. Issues included female staff working alone, traveling at night, lifting without the correct equipment, dealing with patients with complex needs including undiagnosed mental health issues; correct disposal of medical waste, and protection of the employee might be lacking, particularly given the high turnover of employees.

Some trade unions focus on the local authority care commissioning process to address these issues. One interviewee advised that as care contracts came up for renewal, they encouraged local authorities to consider re-insourcing services back into direct local authority control to avoid the risk of small firms collapsing and to reduce administrative costs. Re-insourcing would ensure staff was covered by the existing local authority collective agreement and make recruitment of both union members and health and safety reps easier through recognition, common training facilities, etc. Alternatively, they look to include clauses within the commissioning contract of the right for employees to be in a trade union or a commitment by commissioning local authorities to pay the Foundation living wage (higher than the minimum wage) (Unison, 2022). Some private firms refuse to pass this on to employees however as Another interviewee suggested a change of national government was required to ensure long-term workforce planning; to professionalise the workforce and ensure that more money was paid in staff wages, rather than for private firms' profits.

Trade union interviewees were concerned about the lack of minimum staffing standards and how unrealistic schedules, poor risk assessment, and a lack of the correct equipment for manual handling e.g. lifts, hoists, etc in the home could impact both staff and patients, contributing to health and safety incidents. Trade union interviewees emphasised that given the low respect and attention to the health and safety of care workers, it was necessary to use the health and safety incidents impacting patients

as a proxy for poor health and safety standards applied to staff. It was also politically necessary to frame health and safety employee standards in terms of patient welfare.

Larger trade unions actively challenge the legislative framework to protect the health and safety of employees, e.g., on travel time and payment for night work, but this is an expensive and time-consuming option not available to smaller unions.

EU-level H&S dialogue and regulations

At the EU level, there is very little involvement by employers or trade unions. Whilst trade unions are members of EPSU, they are not involved in ESSD, and employers' organisations are not represented in any EU employer associations. Interviewees predominantly referred to the UK 1974 HSWA though general trade unions showed interest in the "EU sharps" directive. The multi-national aspect of some care delivery could potentially be exploited by UK trade unions working collaboratively with EU partners.

Multilevel coordination

There is little evidence of multi-level coordination within the care sector: whilst stakeholders including large national providers, charities, trade unions, and the National Audit Office note poor coordination and attention to workforce issues from the DHSC. With so many firms in a very cost-driven market, the individualised nature of health and safety employment law in the UK and the lack of any collective agreement leaves many care workers unable to assert their individual rights under HSWA. The administration of care funding through local authorities means there are wide variations in payment rates, the care threshold, and inconsistencies in payments e.g., for Covid funding.

There are two gaps at the national and local level with trade union interviewees advising that whilst they could often negotiate at the national level with large firms and trusts, the lack of members and health and safety reps at the local level meant implementation was compromised and subject to variable local management experience with a lack of data available. The varied settlements to local authorities from central government; local variations in commissioning processes and effective diagnosis of medical conditions also means that the delivery of care and staff health and safety varies across the country (IPPR, 2022). More integration into community care and care in the home could address unmet care needs, high costs, and poor-quality integration of care caused by these variations (ibid).

Effective coordination within the country is blocked by several institutional and structural factors. First, the muddled funding for care in comparison to health means that care is funded through the Department for Communities to local authorities who then commission mostly small private sector

providers. This hinders a coordinated workforce approach and means that care is not standardised on a national basis. The lack of coordination is reflected in the organisation of DHSC which does not prioritise care in the same way as the hospital sector despite their co-relationship, particularly in the way that elderly patients cannot be discharged from the hospital until a care package is in place and effectively “block” NHS hospital beds.

Many small private care providers hinder effective policy messaging and implementation, despite good relations reported by trade unions and large employer representatives. Since cost is the key concern, trade unions must rely on the patient, rather than workforce, health, and safety standards and incidents as a proxy for poor workplace standards. Many vacancies and high turnover rates of staff together with the low rates of pay reflect a lack of respect and concern for this workforce. The move towards domiciliary rather than residential care means that many care workers work alone and lack management support or professional training to support them. The lack of a system of professional training and registration also hampers effective representation. All these factors mean that the workforce and its health and safety are effectively overlooked and ignored, producing a void in data. A sectoral collective agreement is one way to ensure consistency of health and safety standards across the many private firms in this sector, together with standardisation of care standards for patients across the country, regardless of local authority area (Heyes, 2017).

Trade unions have good knowledge and experience of health and safety issues which could be effectively transferred to this workforce, with general trade unions such as Unison, Unite, or GMB perhaps best placed to represent and improve working conditions for staff.

References

- BBC (2021) Care homes: following the money trail Available from: <https://www.bbc.co.uk/news/uk-59504521>. [Accessed 25 February 2023].
- Care Quality Commission (2022) The State of Health Care and Adult Social Care in England 2021/22. Available from: <https://www.cqc.org.uk/publication/state-care-202122>. [Accessed 25 February 2023].
- Care Quality Commission (2022) Key Lines of Enquiry for Social Services. Available from: <https://www.cqc.org.uk/guidance-providers/adult-social-care/key-lines-enquiry-adult-social-care-services>. [Accessed 24 February 2023].
- Clark, D. (2022) Union membership in the United Kingdom (UK) 1999-2020. Available from: <https://www.statista.com/statistics/286076/union-membership-in-the-uk/> [Accessed 30 January 2023].
- Clece. (2023) Clece International – United Kingdom. Available from: <https://www.clece.es/en/international/united-kingdom/>. [Accessed 24 February 2023].
- CPD online college (2023) Care Act 2014 Principles. Available from: <https://cpdonline.co.uk/knowledge-base/care/care-act-2014-principles/>. [Accessed 24 February 2023].
- Department for Business, Energy and Industrial Strategy (BEIS) (2022) Trade Union Membership UK 1995-2021. Statistical Bulletin. Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1077904/Trade_Union_Membership_UK_1995-2021_statistical_bulletin.pdf. [Accessed 24 February 2023].
- Department for Health and Social Care (DHSC) (2016) Care Act 2014 Factsheets. Available from: <https://www.gov.uk/government/publications/care-act-2014-part-1-factsheets/care-act-factsheets>. [Accessed 25 February 2023].
- Department for Health and Social Care (DHSC) (2023) Market Sustainability and fair cost of care fund 2022-2023: Guidance. Available from: <https://www.gov.uk/government/publications/market-sustainability-and-fair-cost-of-care-fund-2022-to-2023-guidance/market-sustainability-and-fair-cost-of-care-fund-2022-to-2023-guidance#introduction>. [Accessed 25 February 2023].
- Eurofound (2020) Representativeness of the European social partner organisations: Human health sector, Sectoral social dialogue series, Dublin.

Fulton, L. (2018) Health and safety representation in Europe. Labour Research Department and ETUI (online publication). Produced with the assistance of the Workers' Interest Group of the Advisory Committee for Safety and Health at Work (of the EU Commission). Available from: <http://www.worker-participation.eu/National-Industrial-Relations> [Accessed 26 May 2020].

GOV.UK (2023) International treaty ILO Violence and Harassment Convention, 2019 (No.190) [MS No.7/2021]. Available from: <https://www.gov.uk/government/publications/ilo-violence-and-harassment-convention-2019-no190-ms-no72021> [Accessed 31 January 2023].

GOV.UK (2022) Trade Union Membership Statistics UK, May 2022. Available from: <https://www.gov.uk/government/statistics/trade-union-statistics-2021> [Accessed 30 January 2023].

GOV.UK (2022) Contract types and employer responsibilities. Available from: <https://www.gov.uk/contract-types-and-employer-responsibilities/zero-hour-contracts> [Accessed 25 February 2023].

Hayes, L. (2017) 8 Good Reasons why Adult Social Care Needs Sectoral Collective Bargaining, published by the Institute of Employment Rights 4th Floor, Jack Jones House, 1 Islington, Liverpool, L3 8EG.

HSE (2013) Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 Guidance for employers and employees. Published by the Health and Safety Executive HSI7 03/13. Available from: <https://www.hse.gov.uk/pubns/hsis7.pdf> [Accessed 30 January 2023].

HSE (2013a) Consulting employees on health and safety. A brief guide to the law Published by the Health and Safety Executive 04/13 INDG232(rev2). Available from: <https://www.hse.gov.uk/pubns/indg232.pdf> [Accessed 30 January 2023].

HSE (2014) Health and safety in care homes. HSG220 (2nd edition). Available from: <https://www.hse.gov.uk/pubns/priced/hsg220.pdf> [Accessed 30 January 2023].

Home Care Organization (2021) Minimum price for care. Available from: <https://www.homecareassociation.org.uk/resource/homecare-association-minimum-price-for-homecare-2022-2023.html>. [Accessed 23 February 2023].

IPPR Institute for Public Policy Research (2022) Community First Social Care. Available at https://www.ippr.org/files/2021-09/1631196359_community-social-care-2021.pdf. [Accessed 23 February 2023].

LMS (2022). Labour market statistics time series (GOV.UK), EU Economic Activity Classification. Available from: <https://www.gov.uk/government/statistics/labour-market-statistics-time-series> [Accessed 30 January 2023].

Local Government Association. 2022. Strategic Collaborative Planning and Commissioning – a guide. Available from: <https://www.local.gov.uk/publications/strategic-collaborative-planning-and-commissioning-guide>. [Accessed 23 February 2023].

Local Government Association. 2022. Local Government Terms and Conditions (Green Book). Available from: <https://www.local.gov.uk/local-government-terms-and-conditions-green-book>. [Accessed 25 February 2023].

National Audit Office (2018). The adult social care workforce in England. Report by the Controller and Auditor General. Available from: <https://www.nao.org.uk/wp-content/uploads/2018/02/The-adult-social-care-workforce-in-England.pdf> [Accessed 17 February 2023].

Skillsforcare (2022). The state of the adult social care sector and workforce in England, 2022. Published by Skills for Care, West Gate, 6 Grace Street, Leeds LS1 2RP. Available from: <https://www.skillsforcare.org.uk/Adult-Social-Care-Workforce-Data/Workforce-intelligence/documents/State-of-the-adult-social-care-sector/The-state-of-the-adult-social-care-sector-and-workforce-2022.pdf> [Accessed 10 January 2023].

Smith Institute (2014) *Outsourcing the Cuts: Pay and employment effects of contracting out*. Available from: <http://www.smith-institute.org.uk/wp-content/uploads/2015/09/Outsourcing-the-cuts.pdf>. [Accessed 25 February 2023].

TUC (Trade Union Congress) (2015) *Outsourcing Public Services*. London: TUC and the New Economics Foundation.

Unison (2021). Supreme Court sleep-in appeal decision is a blow for everyone in social care, says UNISON. Available from: <https://www.unison.org.uk/news/press-release/2021/03/supreme-court-sleep-appeal-decision-blow-%e2%80%8beveryone-social-care-says-unison/> [Accessed 30 January 2023].

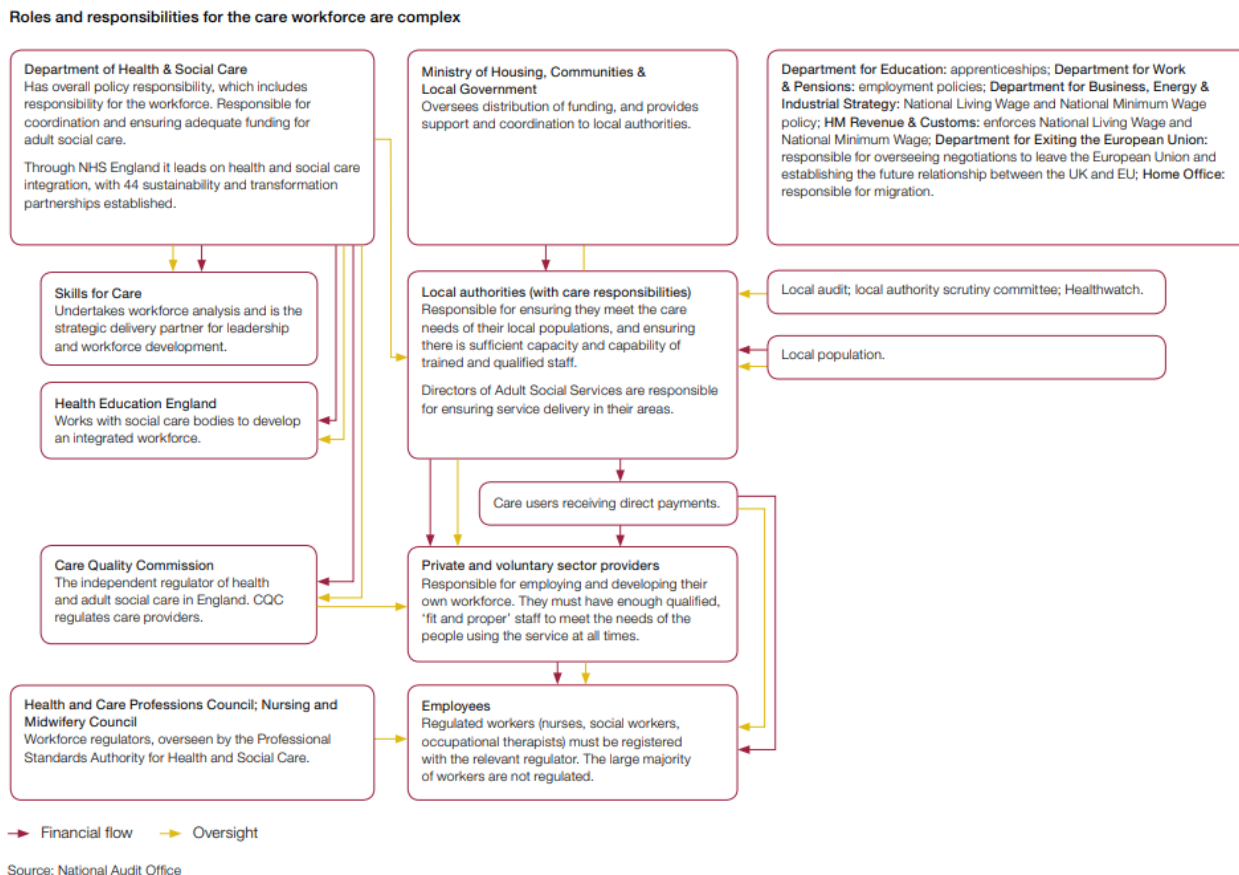
Unison (2022). Council workers accept deal that will give lowest paid 10.5%. Available from: <https://www.unison.org.uk/news/article/2022/11/council-workers-accept-deal-that-will-give-lowest-paid-10-5/>. [Accessed 24 February 2023].

Unison (2022). Greater Manchester care workers win Living Wage award. Available from: <https://www.unison.org.uk/news/article/2022/07/greater-manchester-care-workers-win-living-wage->

[award/#:~:text=The%20UNISON%2Dled%20campaign%2C%20titled,and%20commissioned%20social%20care%20workers.](#) [Accessed 24 February 2023].

Appendix:

Figure: Roles and responsibilities for the care workforce



Source: National Audit Office (2018). The adult social care workforce in England. Report by the Controller and Auditor General. Available from: <https://www.nao.org.uk/wp-content/uploads/2018/02/The-adult-social-care-workforce-in-England.pdf> [Accessed 17 February 2023].

CASE STUDIES – EU LEVEL

Hospitals Sector and Social Care Sector

EU-LEVEL CASE STUDY– HOSPITAL SECTOR

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Introduction

This report elaborates the part of the HEROS study that regards the EU-level analysis concentrating on the Hospital sector, including the role of the actors involved in the European sectoral social dialogue and interactions with other EU and national-level institutions. The objectives of the study were addressed by collection of secondary data based on literature review at the EU and national levels and semi-structures interviews with the relevant EU-level stakeholders. In total six anonymised interviews were conducted with the representatives of EPSU, HOSPEEM, ETUC, European Commission (Social dialogue unit and Health and safety unit at the DG Employment) and EU-OSHA agency in the period May-September 2022 after receiving consent to take part in the study from the respondents. Also representatives of other EU-level institutions were requested to participate in the project, but the invitations were rejected (see the full list of interviewees and attempted interviews in the Appendix 1).

Sources for health and safety (H&S) regulations

Interviewees in the HEROS study – representing sectoral and cross-sectoral social partners, the European Commission and EU-OSHA - referred to a number of legal regulations at the EU level. The point of reference was the Council Directive 89/391/EEC of 12 June 1989 on the introduction of measures to encourage improvements in the safety and health of workers at work called the “Framework Directive” which is the fundamental legislation encompassing the key areas relevant for health and safety. Also the latest legal initiatives undertaken by the Sectoral Social Dialogue committee for the Hospitals and Healthcare Sector were discussed (see the Appendix 2 for the full list). Special attention is put to the “Guidance on the safe management of hazardous medicinal products (HMP) at work” that was a subject of broad public consultations conducted by the European Commission recently (in 2022) – presented in the report as an example of involving social partners and other stakeholders at the EU level and national level. Also other pieces of legislation and guides were mentioned during the interviews as an exemplification of social dialogue mechanisms at the EU level (eg. Directive 2004/37/EC - carcinogens, mutagens or reprotoxic substances at work (and its amendments – Directive 2022/431), Directive 2010/32/EU - prevention from sharp injuries in the hospital and healthcare sector, Directive 2006/42/EC on

machinery, EU-OSH: Guides regarding rehabilitation and return to work for victims of COVID and long COVID for workers and managers).

The full list of the EU level legislation on health and safety has been collected on the EU-OSHA website¹, including the EU directives, EU guidelines, EU standards, OSH strategies, etc.

The interviewees did not refer explicitly to legislation from other levels (national level, beyond the EU).

Role of social partners and collective agreements for H&S regulations and workplace H&S representation

All interviewees in the HEROS project – representing EU-level social partners, European Commission and EU-OSHA – highlighted that health and safety at workplace level is at heart of discussions and regulations conducted in the European social dialogue. For European stakeholders, direct contact and feedback from their national affiliates and local level stakeholders is therefore crucial. The social partners - both trade unions and employers' organisation - see their role as subservient to this most important principle, i.e. improving the quality of working conditions and services in the hospital sector. Thus, they attach great importance to consulting with member organisations on current issues discussed, among others, in the SSDC HOSPITAL and obtaining a mandate for action at EU level. Also the issue of implementation and enforcement of the EU-level policies is constantly monitored through analysis of reporting provided by independent sources or own reports produced by the social partners.

Another important aspect of the context of the role of social partners and collective agreements for Health and safety regulations is that those unions / employers organisations participating in national level negotiations are more likely to be engaged also in the European level social dialogue – mostly due to their larger capacities. While weaker sectoral social dialogue at national level goes together with lesser capacity to be engaged at the EU level. In some countries, e.g. Poland, Italy, there are unions engaged in collective bargaining processes, but not affiliated to the EU-level social partners (mostly due to limited resources) which makes the picture even more complex. In the Eastern and Southern European countries therefore reach out to the EU-level social dialogue from the perspective of the national stakeholders is weaker and relations more distant. While for German or Scandinavian unions and employers EU-level is more incorporated in the national strategies of social partners. The Swedish stakeholders were overall more concerned about the risk of seeing

¹ See the link to the legislation database: <https://osha.europa.eu/en/safety-and-health-legislation>

their home standards – in terms of collectively agreed health and safety regulations and practices – deteriorated by a European level.

The European Commission, on the other hand, puts a lot of effort into ensuring that EU policies are widely consulted and reviewed by the stakeholders well acquainted with the workplace level. European Commission's role is also to facilitate the European social dialogue by providing some resources, which include relevant and updated information, logistics for SSDC HOSPITAL and other consultative bodies, as well as financial and political support in surging social partners' initiatives.

The dynamics of the relationship between the EU and national levels of the social partners and the approach of the European Commission are analysed in detail in the following sections of the report.

Sectoral social dialogue at EU level - Hospital sector

Background

The Sectoral Social Dialogue committee for the Hospitals and Healthcare Sector (SSDC HOSPITAL) has been established in 2006 and covers activities defined by NACE (Rev.2) codes 86 (hospitals and human health)². According to the European Commission, there are over 13 million workers in this sector employed in the European Union. Key areas on which members of the SSDC HOSPITAL have been focusing on in the recent years include the following³:

- Occupational health and safety,
- Recruitment and retention of health care workforce,
- Continuing professional development and life-long learning for all health care staff,
- Strengthening the capacity of hospital and health care social dialogue structures across all EU countries,
- Promoting an exchange of knowledge and experience among the social partners' organisations and their representatives,
- Influencing policies at EU level by monitoring and getting involved in EU consultation and legislative processes.

² Currently, it is one of 44 sectoral social dialogue committees

³ Source: <https://ec.europa.eu/social/main.jsp?catId=480&langId=en&intPageId=1838>

Actors and membership

The Sectoral Social Dialogue committee for the Hospitals and Healthcare Sector is constituted by an equal number of members representing two social partners organisations: European Public Service Union (EPSU) and European Hospital and Healthcare Employers' Association (HOSPEEM). The EPSU is the representative⁴ trade union organisation bringing together affiliated organisations from public sector covering 8 mln workers), including healthcare (both public and private sectors). EPSU is a member of the European Trade Union Confederation (ETUC). The HOSPEEM is a representative at the European level national employers' organisations operating in the hospital and healthcare sector, which spun off in 2005 from SGI Europe (Services of General Interest in Europe, formerly CEEP) who felt that there was a need for a distinct voice on health workforce issues at European level (HOSPEEM is, since its creation, a sectoral member of SGI Europe).

The work of the SSDC HOSPITAL is organised by DG Employment of the European Commission (Social dialogue unit). The SSDC HOSPITAL meetings are attended by invited experts and officials depending on agenda e.g. from various European Commission DGs (DG SANTE, DG GROW), European Commission agencies (e.g.: EU-OSHA, Eurofound), etc.

National sectoral actors engaged in European sectoral social dialogue

Participation of the national sectoral actors was not mentioned by the interviewees explicitly. European social partners (EPSU, HOSPEEM) are granted the power from their affiliates to act on their behalf and represent their interests at the EU level, which includes specifically also the Sectoral Social Dialogue committee for the Hospitals and Healthcare Sector. Particular issues, however, which are subject of the initiatives, are consulted with the affiliates in internal structures that allows for collection of statements and comments, and for formulation of the positions in the EU-level social dialogue.

Differences between countries are also outlined, with Nordic countries seeking to avoid agreements at EU level due to the developed social dialogue at national level, which often provides better conditions for workers. Central and Eastern European countries, on the other hand, tend to be less active, but are more likely to opt for hard measures at the EU level in order to compensate for the fragility of social dialogue in their countries. On the other hand, the great value of the diversity among countries is the possibility to exchange experiences and adopted measures in various

⁴ Criteria for representativeness of the social partners at the EU level are defined in the Commission decision of 20 May 1998 – 98/500/EC. The European Foundation for the Improvement of Living and Working Conditions ([Eurofound](#)) provides regular representativeness studies on social partners in particular sectors.

countries and to transfer some solutions between countries. Also interviewees pointed out the role of the “key players” from both TUs and employers’ sides, which include German and the Scandinavian countries as particularly influential in steering the debate. Actors from these countries sometimes undertake some alliances for the sake of some issues which might take various forms like engaging in separate talks to build ‘coalitions’ against arguments proposed by other countries, or more informal talks / initiatives.

Topics in European sectoral social dialogue in hospital sector

Members of the SSDC HOSPITAL adopt a three-year work programme, which organises activities of the committee. The last HOSPEEM-EPSU Joint Work Programme⁵ was adopted for the years 2020-2022⁶ and encompassed the following themes:

- Occupational Safety and Health
 - Opportunities and challenges related to Occupational Safety and Health
 - Third-party violence and harassment at the workplace
 - Follow-up on the Directive 2010/32/EU on the prevention from sharps injuries in the hospital and healthcare sector
 - Prevention of exposure to hazardous drugs at the workplace
- Recruitment and retention of the health workforce
 - Active and healthy ageing /prolongation of working careers/end of career planning/management of older workers’ replacement
 - New models of care, roles and skills for sustainable future healthcare systems
 - Labour mobility and migration of health workers within the EU
 - Integration of refugees/asylum seekers with a professional background in healthcare into the labour market
 - Management of the diversity of workforce (gender, age, culture, disability, under-represented group and refugees)
 - Long-term and youth unemployment / re-integration of workers
- Continuing Professional Development (CPD) and Life-Long Learning (LLL)
 - Promotion of CPD and LLL for all healthcare staff, also in the context of the digitalisation of the hospital/healthcare sector
- European/ EU-level healthcare policy – hospital and healthcare sector workforce

⁵ Earlier multi-annual joint work programmes covered the following periods: 2006-2007; 2008-2010; 2011-2013; 2014-2016; 2017-2019.

⁶ In November 2021 at the plenary meeting of the Sectoral Social Dialogue Committee, HOSPEEM and EPSU extended the Work Programme until 2023.

- Capacity building of national social partners for better involvement of social partners in the work of the SSDC HOSPITAL and better uptake of the outcome of the SSDC HOSPITAL at the national level
- Role of EU-level sectoral social dialogue (committee) and sectoral social partners with regard to the European Economic Governance (European Semester / Annual Growth Survey)

Outcomes

The tangible outcomes of the SSDC HOSPITAL's work are joint texts (See appendix 2 for full list of joint statements adopted since 2006⁷). In the last period covered by the Joint Work Programme HOSPEEM and EPSU published the following documents:

- HOSPEEM-EPSU position in view of the European Commission study supporting the assessment of different options concerning the protection of workers from exposure to hazardous medicinal products (Joint opinion, 24/09/2020)
- Sectoral Social Dialogue Committee for the Hospital Sector on EU-OSHA Campaign 2020-22 Healthy Workplaces Lighten the Load (Declaration, 12/10/2020)
- HOSPEEM-EPSU Solidarity message with Ukraine employers and trade unions (Joint opinion, 11/03/2022)
- Updated Framework of Action on Recruitment and Retention in the Hospital Sector (Framework of actions, 31/05/2022)

Minutes from the SSDC HOSPITAL meetings are also publicly available in the CIRCABC database, which allows the work of the committee to be followed. At the time of writing the report, only minutes from the meetings before 2021 (including the 2021) were available in the database.

Description of H&S regulation process and practice in European sectoral social dialogue

One of the main tasks of the European social dialogue, and in particular of the SSDCs, is not only to discuss current issues specific to the sector, but also to come up with initiatives for regulation and to give an opinion on initiatives of the European institutions. In the context of the SSDC in the Hospital sector, a number of such processes can be found, and in particular those relating to the OSH occupying a prominent place in the work of the Committee.

The best example of this is the regulation on protection of workers against sharp injuries in the hospital sector. The starting point for the work on establishing regulations to prevent workers'

⁷ Types of documents adopted by the SSDC: agreement Council decision, autonomous agreement, code of conduct, declaration, follow-up report, framework of actions, guidelines, joint opinions, policy orientations, procedural text, tool.

injuries caused by all medical sharps (including needlesticks) was the Framework Agreement on Prevention from Sharp Injuries in the Hospital and Health Care Sector concluded in 2009. The Framework agreement took the form of the “Agreement Council decision” which is a binding-obligation for social partners (EPSU and HOSPEEM), in this case, to set up an integrated approach establishing policies in risk assessment, risk prevention, training, information, awareness raising and monitoring related to protection of workers against sharp injuries in the sector.

This agreement was preceded by some EU-level initiatives focusing on this issue, including the following: the resolution of the European Parliament of 6 July 2006 on protecting European healthcare workers from blood-borne infections due to needlestick injuries (2006/2015(INI)), the first and second stage consultation of the European Commission on protecting European healthcare workers from blood-borne infections due to needlestick injuries, the seminar of the EPSU-HOSPEEM technical seminar on needlestick injuries on 7 February 2008, joint ILO/WHO guidelines on health services and HIV/AIDS and the joint ILO/WHO guidelines on post-exposure prophylaxis to prevent HIV infection.

Based on the EPSU-HOSPEEM Framework Agreement on Prevention from Sharp Injuries in the Hospital and Health Care Sector, the Directive 2010/32/EU - prevention from sharp injuries in the hospital and healthcare sector⁸ (so called the Needlestick Directive) has been adopted. The Directive went through the full legislative path involving the European Parliament, the European Commission and the Council, and was consulted also with the Advisory Committee for Safety and Health at Work, the European Agency for Safety and Health at Work, as well as the relevant consultative bodies of the EPSU and HOSPEEM. After enacting the Directive 2010/32/EU, two follow-up reports were prepared in 2013⁹ and 2019¹⁰ by the SSDC HOSPITAL demonstrating the position of the sectoral social partners.

The example of the regulations on protecting workers against sharp injuries in the hospital sector shows that the joint initiatives of the social partners may find its institutional way to improve working conditions in the sector and what might be the role of the social partners on consecutive phases: advocating, negotiating, consulting, implementing and monitoring the regulations.

⁸ Council Directive 2010/32/EU of 10 May 2010 implementing the Framework Agreement on prevention from sharp injuries in the hospital and healthcare sector concluded by HOSPEEM and EPSU (Text with EEA relevance)

<https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX%3A32010L0032>

⁹ Promotion and Support of Implementation of Directive 2010/32/EU on the prevention of sharps injuries in the hospital and health care sector <https://ec.europa.eu/social/main.jsp?catId=521&langId=en&agreementId=5593>

¹⁰ Final report – follow-up on the Directive 2010/32/EU on the prevention from sharps injuries in the hospital and healthcare sector, <https://ec.europa.eu/social/main.jsp?catId=521&langId=en&agreementId=5591>

EU-level H&S dialogue and regulations' impact

Awareness of and involvement in EU-level developments

Health and safety issues are a subject of work for various consultative bodies at the EU level that involve social partners. European Commission has established Advisory Committee for Safety and Health at Work (ACSH) in 2003 as a tripartite body bringing together national administrations, trade unions and employers' organisations in order to support the Commission in the preparation, implementation and evaluation of activities in the field of occupational safety and health. This includes giving opinion in EU initiatives in the area of OSH (eg. draft proposal for new legislation, EU programmes or strategies), identifying OSH policy priorities, as well as exchange of views and experiences between Member States and stakeholders.

There are also two relevant bodies on the side of trade unions, namely:

- EPSU Standing Committee on Health and Social services¹¹ that covers also OSH matters and
- the ETUC – Health and safety Committee¹² that includes also issued relevant for the hospital sector.

Interviewees on the union side ensured about tight cooperation between the two bodies. Representatives of EPSU are invited to the ETUC Committee are invited to present and discuss current issues to formulate common cross-sectoral positions or action plans on OSH relevant for the hospital and social services, and representatives of ETUC are included in the works of the EPSU Committee, when peak-level organisation's support is needed in resolving some sectoral issues, which includes also OSH issues.

Also the European Agency for Safety and Health at Work (EU-OSHA) tripartite agency has been established in order to provide expertise in the field of health and safety as well as organising campaigns, delivering tools preventing risks and creating partnerships helping in implementation of OSH in national level. The key priority to EU-OSHA is to contribute to implementation of the European Commission's Strategic Framework on Health and Safety at Work 2021-2027 and other relevant EU strategies and programmes.

¹¹ The last meeting of the Committee (58th) took place in Brussels on 23 February 2023
<https://www.epsu.org/event/health-and-social-services-standing-committee-58th-meeting>

¹² See the communications of the Committee under the following link: <https://www.etuc.org/en/committee/health-and-safety-committee>

Implementation of EU level H&S outcomes

The SSDC HOSPITAL has been involved in evaluating the impact of various EU policies relevant for the sector, some of which include also the H&S matters. In the recent years, the following joint documents have been adopted and published by the EPSU and HOSPEEM¹³:

- Sectoral Social Dialogue Committee for the Hospital Sector on EU-OSHA Campaign 2020-22 Healthy Workplaces Lighten the Load (12.10.2020). In this declaration, HOSPEEM and EPSU stressed that they have considered musculoskeletal disorders (MSD) of great importance in the health sector, e.g. by carrying out a project on MSDs and psycho-social risks and stress at work in the past years showing that the cooperation of employers and trade unions is fundamental in successfully managing and preventing MSDs. Social partners declared to 1) update the existing HOSPEEM-EPSU Framework of Actions on Recruitment and Retention (2010)¹⁴; 2.) Continue the discussion among European social partners to exchange good practices and strategies in the field of MSD; 3.) Continue to exchange on the relevance of the current regulatory framework on MSD at European level.
- HOSPEEM-EPSU position in view of the European Commission study supporting the assessment of different options concerning the protection of workers from exposure to hazardous medicinal products (24.09.2020). The social partners expressed a joint opinion calling the European Commission to amend the Directive 2004/37/EC - carcinogens, mutagens or reprotoxic substances at work (CMD) by including hazardous drugs (and cytotoxic drugs) as a category enlisted in Appendix I to be covered by the regulations. The proposals were included on the fourth Directive implementation report and in the amendments adopted by the European Parliament for the revision of the CMD in 2020-2021. The joint opinion was followed by the Stop cancer at work campaign (2020-2021) organised by broad coalition of professional organisations (including EPSU). Finally, the Directive 2022/431 on the protection of workers from the risks related to exposure to carcinogens or mutagens at work has been adopted and included the changes proposed by the EPSU and HOSPEEM in result of their join opinion, the Stop cancer at work campaign and other advocacy initiatives.

¹³ It is worth mentioning that EPSU published also the following document: Position of EPSU Standing Committee on Health and Social Services on lessons learnt so far from the pandemic and resilience of European Health and Social Care Systems (May 2021)

https://www.epsu.org/sites/default/files/article/files/Position%20of%20EPSU%20on%20lessons%20learnt_final-EN.pdf

¹⁴ Which was done in 2022: [Updated Framework of Action on Recruitment and Retention in the Hospital Sector](#)

- Final report – follow-up on the Directive 2010/32/EU on the prevention from sharps injuries in the hospital and healthcare sector (13.02.2019). This follow-up report was the second in a row after the report prepared in result of the partnership project “Promotion and support of the implementation of Directive 2010/32/EU on the prevention of sharps injuries in the hospital and healthcare sector” (2012-2013). Both reports concern the Directive 2010/32/EU which was a direct result of the HOSPEEM-EPSU Framework Agreement on Prevention from Sharp Injuries in the Hospital and Health Care Sector (2009). The second follow-up report (2019) was based on qualitative study in the form of an online survey distributed among EPSU and HOSPEEM affiliates organising workers in health and social services in European Economic Area (EEA) and 14 HOSPEEM members in the countries of the EEA between the December 2017 and March 2018. In total, 29 answers were collected (in English from the HOSPEEM affiliates and in national languages of the EPSU affiliates), including five responses from organisations not affiliated to any of the EU-level social partners. The full-length report includes detailed description of the evaluation study co-authored by representatives of EPSU and HOSPEEM. The report concludes with a list of recommendations addressed to the national and EU-level social partners, national bodies and European institutions. The authors of the report highlighted also that “the adoption and implementation of the Directive were more rapid and the compliance considered has been more effective when they are involved from the very beginning, creating a sense of ownership. Therefore, practising grassroots level implementation in the field of OSH can be seen as a major justification for the success in the formulation and the support of the implementation.”

Example of EU regulation that led to effective protection

In-depth analysis of the process of establishing the Guidance on the safe management of hazardous medicinal products (HMP) at work has been undertaken under the study. The Guidance has been developed by the European Commission DG Employment, Health and Safety at Work Unit in line with the EU OSHA Strategic Framework on Health and Safety at Work 2021-2027 with the aim to improve the situation and prevention of work-related diseases caused by: carcinogenic, mutagenic and reprotoxic substances (CMR). The European Commission was responsible for conducting the public consultation of the Guidance involving various stakeholders representing whole lifecycle chain of production, delivery and end-use of the (HMP). Tripartite approach was adopted in the consultation process involving employers organisations, trade unions and the national authorities as well as other relevant stakeholders. The timeframe dedicated to this process fitted 10 month period between March and December 2022.

The Guidance was a subject of discussions in the Advisory Committee for Safety and Health at Work (project steering committee in the form of an under-group, and a working group on chemicals) and in the Senior Labour Inspectors' Committee (SLIC). Much effort in the consultation process was put also in organising 10 interactive workshops that focused on the structure and specific provisions of the document, that aimed at collecting input from the social partners (both unions and employers), national authorities, academic experts and other stakeholders from various parts of the EU. At the stage of preparing this report, the draft of the Guidance has been sent to the participants of the process for comments, and visit conferences are planned with the EU-level organisations in order to discuss the draft after integrating the comments. The next step was to pilot the Guidance to selected workplaces from all lifecycle stages of the HMP in order to check in practice how the Guidance works. Eventually, the draft document will be presented to the Council, and the European Parliament for final approval.

On the workers side EPSU was involved strongly in the consultation process, backed with ETUC's Health and Safety Committee support (due to the fact that experiences at workplace level was key to construct the Guidance), while on the side of employers' organisation, HOSPEEM was the main party.

According to the interviewee from the European Commission, the public consultation process – especially the workshops – were very successful and greatly contributed to the final content and quality of the Guidance. This includes engagement of social partners in ACSH, the workshops and other stages of the consultation process. The European Commission put much effort in engaging representative stakeholders covering all parts of the lifecycle of the HMP, and adopting true participative and tripartite process. The interviewee declared that similar approach has been adopted (with his participation) while enacting the Directive 2022/431 on the protection of workers from the risks related to exposure to carcinogens or mutagens at work¹⁵.

Quality assessment of European sectoral social dialogue by the social partners

Social partners interviewed under the HEROS project expressed their general positive perception of the dynamics and the outputs of the Sectoral Social Dialogue Committee for the Hospitals and Healthcare Sector. The Committee meets for one plenary session and in parallel two working group meetings are organized per year. The SSDC HOSPITAL adopts approximately two joint posts per year (see Appendix 2), which are of a different nature. However, the scope of work goes well

¹⁵ This directive was a subject of the advocacy campaign “Stop cancer at work” – see details in the chapter on coordination of social partners initiatives

beyond this and is closely linked to the HOSPEEM-EPSU Joint Work Programme. The SSDC HOSPITAL is a forum where all current initiatives of importance to the sector are discussed, including legislative work, research reports, projects involving social partners, social campaigns, etc. In recent years, however, starting from the period of the COVID-19 pandemic, in person meetings were substituted with on-line meetings and they take place less frequently as earlier. Social partners – both unions and employers – expressed their concerns related to limitations in conducting full-scale discussions that may lead to decreasing role of social dialogue and the SSDC HOSPITAL in particular.

Both the trade union side and the employers' side place highlighted the importance of the discussions conducted in SSDC HOSPITAL, and the partnership itself that is based on long-term cooperation and trust. The social partners emphasised in interviews that the issue of health and safety is of utmost importance to ensure quality jobs and stable improvement of working conditions. Social partners perceive operation of SSDC HOSPITAL as very active as compared to other sectoral committees, discussing in a conclusive way the key sector-related issues and coming up with various initiatives autonomously. Social partners invite also representatives of European Commission (various DGs) in order to have updated insight to the latest information about certain initiatives. The involvement of the European Commission and information provided is assessed positively by the social partners.

Members on the trade union side are considered to be the main driving force behind the work of the committee, which naturally follows the unions' agenda of improving working conditions. In terms of health and safety, workers' entitlements or protective procedures are at the same time an obligation on the part of the employer, with the consequent costs of implementing new regulations, guidelines and reorganising work. Consequently, the employer side is more willing to accept 'soft' solutions such as framework of action, recommendations, guidelines, tools, rather than 'hard' measures in the form of EU directives (or laws at the national level) or framework agreements of social partners. This causes some tensions between the unions and employers which naturally exists in the contest of divergent interests.

Both interviewees from trade unions and employers' organisation highlighted that one of the important results of the SSDC HOSPITAL is the exchange of information and positions between the members, sharing of good practices, and mutual learning, which allows for getting more familiar with national industrial relation systems and actors' interests. Moreover, the exchange leads to the learning process about certain topics and solving various problems at national and EU-level. This sharing and learning experiences have been pointed out as a value in itself by both EPSU and

HOSPEEM representatives. Obviously, the European Commission is also a beneficiary of this exchange for the purpose of creating and implemented EU-level policies.

Importantly, the social partners share agreement on what is the idea for SSDC HOSPITAL and what topics can be a subject of the dialogue (and which are not). They also expressed that there is a true space for dialogue and exchange, thanks in particular to the role of the EPSU, HOSPEEM and European Commission's secretariats. Despite limitations described above the setting allows for development of trust amongst participants.

From the perspective of the European Commission, the value of sectoral dialogue as such and building social partnerships are emphasised above all. The Commission sees its role in the SSDC HOSPITAL as the organiser of the dialogue process, which is filled with the content of the social partners' initiatives. The European Commission does not assess or judge the content of discussions nor the written outputs of the sectoral committees and perceives its role as a facilitator of autonomous dialogue between the parties – even if some initiatives are undertaken against some Commissions actions. A key value placed in the foreground is the autonomy of the social partners and the freedom to take initiatives of a sectoral nature. European Commission is also interested in substantial results and relevance of the sectoral dialogue, therefore it supports the social partners – financially and organisation-wise – in order to achieve effective operation of the body. As stated above, the texts of the sectoral committees and minutes from the meetings are publicly available in the CIRCABC system in order to make the dialogue transparent. The SSDC HOSPITAL is also the body which is involved in the public consultation processes of all the European Commission's initiatives which are relevant to the sector.

When it comes to assessment of the European Commission representatives in the European social dialogue, social partners highlight the importance of its coordinator role, but also some criticism has been formulated. In their opinion the representatives of the DG EMPL express their expertise in SSDC but not always the sector knowledge, and on the other hand the officials from other DGs where there is expertise in the sector but no SSDC knowledge. The sectoral social partners reported they are also quite satisfied with high-level contacts they could establish through the European Commission. From the point of view of the EU secretariats, for instance talks with Commissioners about endorsing on of the SSDC's non-binding agreements signals affiliates the importance and recognition of SSDC. The EU secretariats in this context regard themselves as a facilitator for affiliates to access the 'European arena' and European actors, above all the Commission, and to give them a voice. Overall, the Commission is therefore an important target of social partner activities, i. e. joint lobbying. However, social partners notice that their role is challenged by some officials in DG EMPL and widely unknown in other DGs. According to the respondents, this is

highly individual and might be also related to the background of the Commission officials, their (missing) experience with and knowledge of social dialogue in general. Therefore, there is also a feeling of social partners at best serving as fig leaf or being reduced to a legitimizing role.

In political terms the European Commission is perceived in an ambivalent way as an institution surging its own agenda which not always is in line with the results of the autonomous social dialogue. Although the positive role of the European Commission has been pointed out in the case of transforming the Framework Agreement on Prevention from Sharp Injuries in the Hospital and Health Care Sector into a directive in 2010, and in the case of adopting the Directive on the protection of workers from the risks related to exposure to carcinogens or mutagens at work that was preceded by the joint opinion of social partners in 2020.

Quality assessment of European sectoral social dialogue – external perspective

The overall assessment of the SSDC HOSPITAL from the research perspective overlaps to large extend with the opinions of the social partners and is mostly positive in regards to the following dimensions: institutional operation, contents of dialogue and output of the SSDC HOSPITAL.

The SSDC HOSPITAL has been a stable body with well-defined and unchanging actors, acting consequently in line with the adopted joint work programme. Although some changes in personnel has been made in the recent years. Work programmes define clear steps and a time frame for each of the actions envisaged. In addition, there have also been annual or bi-annual overview reports by the social partners summarizing the ‘main activities and outcomes’ of their SSDC HOSPITAL. In 2016, the social partners celebrated 10 years of SSDC and issued an overview of their activities and outcomes from 2006 to 2016. The meetings of the body were regular and predictable – with some exceptions in the period of COVID-19 pandemic period. Operation of the committee has been extensively supported by the Social Dialogue Unit at the DG Employment of the European Commission as well as the Secretariats of EPSU and HOSPEEM.

The topics of the work programme were scrupulously and efficiently selected by the Secretaries of social partners / members of the SSDC HOSPITAL. EU-level social partners were looking for and received input from their affiliates. After identification of SSDC HOSPITAL topics, affiliates were asked to add topics, which in the next step were selected and prioritized on a final list. There seems to be a good level of transparency and involvement into the development of the work programme. This selection and topics relevant for current public debate and social dialogue have been brought to the plenary sessions and working groups after earlier consultation with affiliates of EPSU and HOSPEEM and the consideration of all inputs from national level organisations. It might be

assessed that the topics have been relevant so far, as they were an immediate reflection of the either European Commission's or the affiliates' initiatives or a response to some urgently emerging issues like COVID-19 pandemic or consequences of war in Ukraine. What is also of utmost importance is that both social partners put much effort in finding common ground where possible adopting the principles of open dialogue and building mutual trust and partnership. There have been a shared understanding that the partners focus primarily on quality of care that covers workers, employers and patients (while wages are out of the scope of the discussions). Unions highlight the aspect of better working conditions, while employers' organisation stresses providing good service in proportion to costs (principle: "better working conditions for staff = better provision of care"). This approach is seen also in other fields like applying for extra-funding from the open European Commission's calls. Both HOSPEEM and EPSU have been the partners in a number of projects including those covering the OSH matters (2012-2013 implementation of the needlestick directive 2010/32/EU; 2014-2016 musculoskeletal disorders and psycho-social risks and stress at work). This approach to focus on controversy-free matters allows for building mutual trust and give tangible results (see below). On the other hand is criticised by some national level stakeholders – especially on the unions side – as not enough progressive and not less relevant for their agenda. This, however, does not apply to health and safety issues, as there is a shared understanding that this is of key importance for union, employers and patients.

As regards the outputs, the SSDC HOSPITAL has adopted 19 joint documents since its establishment in 2006 (18 years of operation). Distribution of the documents is uneven: the most frequently the partners were adopting one document per year (in 2007, 2008, 2009, 2010, 2018, 2019), but there were some years with no documents (2006, 2014, 2015, 2017, 2021) or more than one document (2 documents – in 2012, 2013, 2016, 2020, 2022, 3 documents – in 2011). The text are of different sorts from declarations (4) and joint opinions (6) through tools (1), guidelines (2) and follow-up reports (2) to frameworks of actions (2) and agreement council decisions (1). As outlined above, "soft" documents prevail as it is easier to find agreement between the social partners to agree upon non-binding and general statements. The social partners also managed to take joint decisions as in the case of Framework of Actions on Recruitment and Retention (2010 and its update in 2022) and the Framework Agreement on Prevention from Sharp Injuries in the Hospital and Health Care Sector (2009). The latter has been transformed into a directive (2010)¹⁶ which is a binding EU-level regulation. Also recently the Directive 2022/431 on the protection of

¹⁶ Council Directive 2010/32/EU of 10 May 2010 implementing the Framework Agreement on prevention from sharp injuries in the hospital and healthcare sector concluded by HOSPEEM and EPSU <https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX%3A32010L0032>

workers from the risks related to exposure to carcinogens or mutagens at work¹⁷ which was preceded by the joint opinion of HOSPEEM and EPSU concluded in the SSDC HOSPITAL in 2020.

One should not forget about intangible results of the SSDC HOSPITAL operation which is development of mutual trust and partnership between the EU-level trade unions and employers' organisation, which impacts also relevant counterparts at national level.

Multilevel coordination – if and how do actors at different level interact

According to the declarations of the social partners interviewed in the study, EU-level social partners do not have an explicit mandate to coordinate cross-border initiatives that come up from national level, unless they receive the mandate from their affiliates. As stated above initiatives discussed at the EU-level, including in the SSDC HOSPITAL, are consulted with their members directly in order to collect perspectives and statements from the national organisations, that then are presented in various fora, including the SSDC HOSPITAL. Some concerns were expressed by the interviewees on representativeness of the EU-level social partners – especially in the case of HOSPEEM (mostly with regards to the private sector and some countries in the Central Eastern Europe), that might be a barrier for effectiveness of their operation of the effectiveness of the SSDC HOSPITAL.

For the national affiliates the possibility to bring the national point of view to the EU level as of paramount importance for a number of reasons: the EU-level dialogue and regulations are seen as a way to achieve specific goals that cannot be reached at lower levels (national, sectoral, company-levels), strengthening or developing national solutions (regulations, collective agreements, guidelines), necessity to deal with certain matters that are transnational in nature (e.g. recognition of qualifications, migrations), etc. National level social partners highlighted the benefits from interaction with the EU-level social partners and specifically the SSDC HOSPITAL by the direct access to the ongoing discussions and matters proceeded with the European Commission or EPSU and HOSPEEM, and by bringing this information to the national / sectoral level. This allows for updating their strategies and facilitating relevant responses to the policies and contexts. Also the fact of institutional stability of the SSDC HOSPITAL, namely the presence of EU-level representative organisations: EPSU and HOSPEEM, as well as involvement of the same persons over a long period of time, allows for establishing expertise, well-operating communication and relationships, and last but not least mutual trust and sense of partnership. In the last years some

¹⁷ <https://eur-lex.europa.eu/eli/dir/2022/431/oj>

changes in personnel has been made on both EPSU and HOSPEEM side which poses a challenge for the partnership. To date, however, the culture of the organisation that has been developed allows the mechanisms for cooperation and dialogue to be maintained.

Also some barriers for effective multilevel coordination were mentioned by the interviewees. This involves gaps in representativeness (mentioned above), limited resources at both EU and national-level organisations (including human resources), insufficient language skills (mostly on the side of national affiliates), and reduced number of meetings due to the COVID-19 pandemic at all levels. The above barriers might lead to self-selection of national affiliates representatives to be engaged in processes at the EU level (meetings, committees, working groups and other forms of activities). From the perspective of EU-level social partners, they rely to much extend on inputs from their affiliates and the mandates given to the EU secretariats, therefore affiliates with greater capacity bring more into SSDC HOSPITAL (including preparatory work, giving presentations in SSDC meetings, etc.) On the other hand, the challenge is to involve and represent affiliates with lesser institutional capacities (especially from Central and Eastern Europe). This regards also receiving feedback on reception and implementation of the SSDC HOSPITAL outcomes at national level.

Moreover, social partners support their affiliates directly at national level in various forms like advocacy activities, training, research, capacity building, etc. In practical terms, however, the interviewed social partners were not able to point out any country-level initiatives that needed to be coordinated cross-nationally, nor cross-sectoral issues that weren't universal regulations.

Interviewees, however, mentioned their involvement in several EU-wide social campaigns relevant also for the Hospital sector which aimed at reaching out to national stakeholders relevant for the sector. These included the following:

- Stop cancer at work (2020-2021) is an advocacy campaign organised by broad coalition of professional organisations (including EPSU) aimed at the European Commission, European Parliament and Council to act to stop cancer at work by including in the Carcinogens and Mutagens Directive (CMD) 2022/431 carcinogenic cytotoxic drugs which cause cancer, such as leukaemia, in healthcare workers and patients in Appendix I, and reprotoxins, which harm all workers' fertility, in the title of the CMD. The campaign is an example of successful impact of the unions coordinated at the EU-level on the final provisions of the CMD¹⁸.

¹⁸ See more on the results of the campaign here: <https://www.epsu.org/article/stop-cancer-work-campaign-welcomes-progress-made-protecting-workers-cancer-and-reproductive>

- Healthy Workplaces – Lighten the Load (2020-22) is a campaign focusing on the prevention of work-related musculoskeletal disorders (MSDs) organised by the EU-OSHA. It aimed to disseminate high-quality information on the subject, encouraged an integrated approach to managing the MSD problem, and offered practical tools and solutions that can help at workplace level. The European Public Service Unions and Federation of European Social Employers joined the campaign as the official partners¹⁹.
- Zero deaths at Work (2022-23) is a manifesto calling on the European Union, its member state governments, and employers to genuinely commit, and take the actions needed, to achieve zero death at work by 2030. The campaign is coordinated by the European Trade Union Confederation and signed by a number of stakeholders, including national-level unions, ministers of labour, members of the European Parliaments and members of national parliaments, sectoral professional organisations and academic experts.

H&S challenges and how to tackle them

Based on the interviewees' contributions there might be distinguished two sorts of challenges to be addressed in the nearest future in the social dialogue at the EU level or own initiatives undertaken by the social partners in the area of health and safety: cross-sectoral issues and sector-related issues.

Cross-sectoral issues impacting the hospital sector:

- Legal recognition of the COVID-19 disease as occupational disease at the EU-level in all sectors. ETUC and EPSU advocated already to extend this recognition to all sectors – this regards especially the hospital sector which was hit the most during the pandemic. This issue has been a subject of work of the Advisory Committee for Safety and Health at Work that recommended to include COVID-19 as an occupational disease in health and social care and in domiciliary assistance sector²⁰.
- Autonomous initiative of cross-sectoral social partners on telework and the right to disconnect (legally binding agreement), including aspects related to psychosocial risks (eg. stress at workplace), with the aim to transform the agreement into a directive²¹. Social partners are highly motivated to undertake this rare opportunity after a long period of lack of

¹⁹ See the commitment statement here: <https://www.epsu.org/article/social-employers-and-epsu-partners-eu-osha-campaign-healthy-workplaces-lighten-load>

²⁰ See the Opinion under the following link: <https://circabc.europa.eu/ui/group/cb9293be-4563-4f19-89cf-4c4588bd6541/library/e5dcd649-8338-473a-b18c-d008c678e6d3/details> and communication of the decision: https://ec.europa.eu/commission/presscorner/detail/en/IP_22_3117

²¹ See more here: <https://www.etuc.org/en/pressrelease/european-unions-and-employers-sign-historic-deal>

this type of initiatives – like in the case of the Needlestick Directive in 2010. The regulation will be general in nature (not sectoral regulation) therefore it will apply also to the hospital sector.

- Joint social partners initiatives to support dual transition encompassing digitalization and green transition that would cover the issue of skills, job retention, just transition (management of the process), appropriate public funding and investments. This includes identification of new health and safety risks that green transition may bring and how green transition is going to change the world of work.
- A long-standing demand of trade unions (both the ETUC and the EPSU) to adopt a directive on the prevention of psycho-social risks^{22,23}
- Initiatives preventing violence at work mostly in the context of the Proposal for a directive on combating violence against women and domestic violence. See also the Statement by EU sectoral social partners to mark International Day for the Elimination of Violence against Women “Gender-based violence is also a workplace matter: time for EU action” signed by EU-level trade union organizations, including EPSU.
- War in Ukraine and its impact on inflation, energy sector, labour market, etc.

Hospital sector related issues

- Labour shortage and human resources needs that put a threat among others to health and safety (due to understaffing, long working hours, etc.). This includes recognition / nostrification of diplomas, recognition of job tasks in specific occupation in hospital sector in order to enable internal mobility of labour within the EU,
- Development of skills especially in care occupations, including upskilling and reskilling, as well as mentoring programmes (nurses in the last years before retirement train younger workers in order to transfer their skills and knowledge, and conduct less physical work which is a relief in the context of often experienced musculoskeletal disorders in this group).
- Improving working conditions in the hospital sector and care occupations to prevent musculoskeletal disorders. HOSPEEM and EPSU worked together to update the Framework of Actions on Recruitment and Retention (2022) with findings and practices from national social partners in the field of OSH. Social partners contributed also to the EU-OSHA

²² See e.g. An ETUC resolution on actions for combatting stress and eliminating psychosocial risks in the workplace <https://www.etuc.org/en/document/etuc-resolution-actions-combatting-stress-and-eliminating-psychosocial-risks-workplace>

²³ See also recent report of ETUI on "Psychosocial Risks in the Healthcare and Long-Term Care Sectors" <https://www.epsu.org/article/joint-etui-epsu-seminar-preventing-damage-mental-health-health-and-care-workers>

Healthy Workplace Campaign partners focusing on MSD. Currently they continue to exchange on the relevance of the current regulatory framework on MSD at European level. EPSU (together with ETUC) pursue to adopt a directive on MSD. Besides, HOSPEEM and EPSU have facilitated the development of the EU-OSHA discussion paper on MSD in the healthcare sector, which outlines the latest findings on MSD in the sector²⁴.

- Improvement of working conditions of the healthcare assistants. The EPSU has already established the Health Care Assistants Network that aims at registration, staffing and skills development in this group²⁵.
- Issue of development of digital platforms entering the care services which might lead to further precarisation of the workers and serious Health and safety fraudulent practices.

²⁴ See the report here: <https://osha.europa.eu/en/publications/musculoskeletal-disorders-healthcare-sector>

²⁵ See: <https://www.epsu.org/search?f%5B0%5D=networks%3A370>

Appendix:**1) Interviews conducted in the Hospital sector at the EU level**

#	Date (Month)	Organisation	Note
1	05-2022	Policy officer at the sectoral trade union at the EU level	Interview conducted
2	07-2022	Management of the sectoral employers' organisation at the EU level	Interview conducted
3	07-2022	Policy officer at the European Commission, DG Employment, Social dialogue unit	Interview conducted
4	08-2022	Advisor at the peak-level trade union organisation at the EU level responsible for the health and safety issues	Interview conducted
5	09-2022	Policy officer at the European Commission, DG Employment, Health and Safety at Work Unit	Interview conducted
6	09-2022	Project manager at the EU-OSHA dealing with studies in the Hospital sector	Interview conducted
		Representative of the European Commission, DG SANTE	<i>Attempted interview DG SANTE does not follow the H&S at work issues, therefore refused to take part in the study.</i>
		Representative of the European Commission, DG GROW	<i>Attempted interview DG GROW does not follow the H&S at work issues, therefore refused to take part in the study.</i>
		Representative of the peak-level employers' organisation at the EU level	<i>Attempted interview</i>

2) Sectoral Social Dialogue Committee Hospital at EU level - outcomes

English Title	Date	Type of Text
Updated Framework of Action on Recruitment and Retention in the Hospital Sector	31/05/2022	Framework of actions
HOSPEEM-EPSU Solidarity message with Ukraine employers and trade unions	11/03/2022	Joint opinion
Sectoral Social Dialogue Committee for the Hospital Sector on EU-OSHA Campaign 2020-22 Healthy Workplaces Lighten the Load	12/10/2020	Declaration
HOSPEEM-EPSU position in view of the European Commission study supporting the assessment of different options concerning the protection of workers from exposure to hazardous medicinal products	24/09/2020	Joint opinion
Final report – follow-up on the Directive 2010/32/EU on the prevention from sharps injuries in the hospital and healthcare sector	13/02/2019	Follow-up report
10-year anniversary of the EPSU-HOSPEEM Code of Conduct on Ethical Cross Border Recruitment and Retention in the Hospital Sector	09/04/2018	Joint opinion
Joint declaration on Continuing Professional Development (CPD) and life-long learning (LLL) for all Health workers in the EU	08/11/2016	Declaration
Framework of Actions on Recruitment and Retention – Follow-up report	15/02/2016	Follow-up report
Guidelines and examples of good practice to address the challenges of an ageing workforce	04/12/2013	Tool
Promotion and Support of Implementation of Directive 2010/32/EU on the prevention of sharps injuries in the hospital and health care sector	15/11/2013	Follow-up report
Use and implementation of the EPSU-HOSPEEM Code of Conduction Ethical Cross-Border Recruitment and Retention in the Hospital Sector	05/09/2012	Joint opinion
Joint Statement on the Action Plan for the EU Health Workforce	05/09/2012	Guidelines

English Title	Date	Type of Text
EPSU-HOSPEEM response to the European Commission's green paper on reviewing the directive on the recognition of professional qualifications 2005/36/EC	20/09/2011	Joint opinion
“Riga Declaration” on Strengthening Social Dialogue in the Healthcare Sector in the Baltic Countries	26/05/2011	Declaration
EPSU - HOSPEEM contribution to public consultation on the Directive on the Recognition of Professional Qualifications (2005/36/EC)	23/03/2011	Joint opinion
Recruitment and Retention – A Framework of Actions	17/12/2010	Framework of actions
Framework Agreement on Prevention from Sharp Injuries in the Hospital and Health Care Sector	17/07/2009	Agreement Council decision
EPSU- HOSPEEM code of conduct and follow up on Ethical Cross-Border - Recruitment and Retention in the Hospital Sector	07/04/2008	Guidelines
Joint Declaration of HOSPEEM and EPSU on Health Services in the EU	13/12/2007	Declaration

Source: European Commission’s social dialogue texts database, available at <http://ec.europa.eu/social/main.jsp?catId=521&langId=en> [accessed 20 July 2023]

An overview of jointly reached outcomes (until 2016), including also joint projects, can be found at <http://hospeem.org/wordpress/wp-content/uploads/2016/12/10th-Anniversary-SSDC-List-Key-Documents-Outcomes.pdf> or <http://www.epsu.org/sites/default/files/article/files/10th-Anniversary-SSDC-List-Key-Documents-Outcomes.pdf>.

EU-LEVEL CASE STUDY – SOCIAL SERVICES SECTOR

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Introduction

The focus of this report on the social services sector is on social/elderly care. This EU-level case study draws from two main sources: semi-structured interviews conducted at the EU level in 2022 with social partners and other stakeholders (cf. Table 1 in the Appendix), and the six national sector case studies within the HEROS (Health Risk Outlooks by Social Partners) project.

Sources for health and safety (H&S) regulations

Interviewees identified several sources for health and safety (H&S) regulations.

In terms of **EU legislation/regulation**, the Occupational Health and Safety (OSH) Framework Directive (89/391/EEC) is prominent, along with descending directives like the Manual Handling of Loads Directive (90/269/EEC), which interviewees referenced. Overall, OSH has been assessed as an area with strong EU level legislation (e.g. compared to the public health area which lies within the Member States' competence). On OSH legislation at EU level, the existence of a potential gap in terms of psychosocial risks at work has been advanced. OSH legislation, primarily centred on prevention and minimum requirements, could serve as a basis to address a 'more supportive environment ... for example, prevention of violence' (EU4). Other directives mentioned include the Working Time Directive (2003/88/EC), the Directive on Work-Life Balance (2019/1158/EU), and the Directive on Transparent and Predictable Working Conditions (2019/1152/EU). One interviewee emphasized that the existing legislation should be strengthened and *used* specifically for the social services sector (EU6). From the trade union perspective, the Directive on Adequate Minimum Wages (2022/2041/EU) has been mentioned, as it is expected to put pressure on companies within the sector to engage in collective bargaining. One interviewee's overall assessment was that in terms of OSH-relevant EU level regulations, revisions and updates to existing directives are more likely to occur than introducing new regulations, in terms of accommodating shifts in the changing world of work.

National legislation or regulation have been addressed by interviewees in a more general way, acknowledging that countries organise the sector differently and that different regulatory frameworks apply. The Nordic countries, namely Sweden, were mentioned to be forerunners concerning the issue of psychosocial risks at work (EU4). Concrete national legislation or regulations have not been mentioned by EU level interviewees except for cases beyond this study's country scope (e.g.

Luxembourg on procurement, Spain on gender equality). Information on national legislation or regulations relevant for the social services sector can be found in the six national sector case studies (Bechter, 2023; Galetto, 2023; Guobaite & Blaziene, 2023; Hiltunen & Larsson, 2023; Pańków, 2023; Weber, 2023).

Concerning **more specific legislation/regulation that applies to the sector**, the Directive 2010/35/EU on the prevention from sharp injuries in the hospital and healthcare sector (“Needlestick Directive”) is also of relevance in the social services sector. The directive transposed a Framework agreement that had been reached by the social partners in the sectoral social dialogue committee (SSDC) Hospital, i.e. EPSU (European Public Service Union) and Hospeem (European Hospital and Healthcare Employers’ Association). The agreement and its transposition have been referred to as a best practice from the trade union side, claiming that the main aim of SSDCs should be reaching (binding) agreements. Furthermore, interviewees especially on the trade union side highlighted the European Commission’s updated recommendation on occupational diseases (European Commission, 2022a), where the Commission recommends that Member States recognise COVID-19 as an occupational disease in health and social care, following a tripartite agreement reached in May 2022 in the Advisory Committee on Safety and Health at Work.

Also, the inclusion of hazardous medicinal products in the field of carcinogens, mutagens or reprotoxic substances at work has been noted to be relevant for the sector (for an overview EU-OSHA, 2021). Finally, the Commission’s proposal for a directive on combating violence against women and domestic violence has been referred to, as ‘this actually has the element of workplace in it’ (EU6), even more in a female dominated sector like social services (see also Czarzasty & Pańków, 2023).

Another EU level initiative of importance for the sector is the European Care Strategy (European Commission, 2022b), where according to one of the interviewees the joint position paper on the forthcoming European Care Strategy by the trade union and the employer organisation (2021; cf. Table 2 in the Appendix) has been taken well into account (EU6). The European Care Strategy has been assessed as a positive and important impulse from the Commission to ‘wake up’ Member States (EU3).

On a **global** scale, references have been made to WHO (World Health Organization) and ILO (International Labour Organization). From ILO, the concept of ‘decent work’ has been mentioned, and ILO convention 190 on eliminating violence in the world of work. WHO has been underlined as an entity where trade unions will be able and need to develop more cooperation and collaboration (EU4). This can be set in the more general context that due to the Covid-19 pandemic, the until then perceived ‘silos’ of public health and health and safety at the workplace have been questioned and

more exchange arises, as the workplace impacts on health (EU4; EU6). Therefore, OSH actors have been more recognised as key stakeholders in both preventative measures and during pandemic times (EU4). The Covid-19 pandemic has highlighted the fact that the care sector was inadequately connected to the broader health system. Accordingly, the care sector and care workers had been neglected before but have now been recognised by the WHO (EU6). Overall, it has been mentioned that certain aspect related to health and safety in the care sectors have a global dimension (e.g. migration, use of e-health; EU2; EU5).

Role of social partners and collective agreements for H&S regulations and workplace H&S representation

The interviews conducted for this case study focused on sectoral social partners and sectoral social dialogue, therefore the workplace or workplace H&S representation was addressed more in general. Concerning the role of social partners, collective agreements and workplace H&S representation, interviewees mentioned country differences more generally, both in substantial and procedural terms. Interviewees emphasized that the role of social partners and collective agreements is also depending on the political and legal framework in countries, which sometimes is less favourable for social partners, e.g. in Hungary, Poland, or Romania (EU1; EU3). It was also noted that certain issues are more prominent among social partners in some countries compared to their counterparts in other Member States. For instance, psychosocial risks have been mentioned to be on the social partners' agenda in countries such as Spain and Sweden (EU4).

Social partners stressed that the final aim or target of their activities at EU level is to reach out to the workplaces. In this context, problems of multilevel coordination were addressed and the challenge to reach out to the national and local level, especially to small workplaces and workplaces where no affiliation to an employer organisation is given (EU2). Risk assessment has been identified as an area in need of advancement at the workplace. Establishing a framework of actions might be beneficial in providing guidance on the process and frequency of risk assessments, as well as determining the necessary stakeholders to be involved. The aim is to ensure the presence of both trade unions and employers (EU6).

To support national organisations, EU level social partners collaborate on joint projects, for which they apply and receive funding from the European Commission. These projects play an important role in terms of capacity building (EU1; EU3; EU6), and as part of them, trainings are conducted within countries for national social partner organisations, e.g. on how to build sectoral organisations and how to develop a bipartite social dialogue. For instance, good practices on collective agreements are shared (EU3). The goal therefore is to build membership, especially on the employer side, and to

support national organisations to establish industrial relations in the sector. Starting in 2011, a series of projects (PESSIS projects, 2011-2019) aimed at building and establishing a European level employer organisation. In 2017, the Federation of Social Employers (Social Employers) was established.

Overall, it has been acknowledged that the social services sector is characterized by low unionisation and employer organisation membership, and that sectoral organizations are missing in some countries, mainly on the employer side. Thus, in some cases prerequisites for social partners to play a role and to conclude collective agreements are missing. As mentioned above, the trade union side hopes the Directive on Adequate Minimum Wages to be a lever for more collective agreements. Also, the European Care Strategy which stressed the role of collective bargaining could be used by national trade union affiliates to push for stronger collective bargaining and more collective agreements in the sector. The trade union side would have preferred to see also conditionalities on procurement in the European Care Strategy, i.e. an obligation to follow the representative collective agreement for the sector.

Broadly speaking, OSH topics like psychosocial risks are not (yet) a classical topic for collective action at the sectoral level. An example given however was Spain, where trade unions collaborated to use compulsory gender equality plans as a framework to work on the prevention of psychosocial risks for female workers, i.e. to “work around” missing legislation on psychosocial risks. Another example mentioned in that context was work life balance, where even in countries with strong collective bargaining, no collective agreements or good practices could be identified, ‘because what gets through to the collective bargaining level has to do with salaries’ (EU4).

Sectoral social dialogue at EU level – Social services sector

It is important to note that until July 2023, sectoral social dialogue at EU level in the social services sector has been taken place within an *informal* setting, i.e. not within an officially recognised sectoral social dialogue committee (SSDC).

Background

The sectoral social dialogue at EU level in the social services sector has evolved from an informal stage to a more formalized one from around 2011 on. This progression led to the application of the social partners EPSU and Social Employers to the Commission in 2021, with the objective to set up an SSDC for social services. Finally, on 10 July 2023 the Commission officially established the SSDC Social Services, including CEMR (the Council of European Municipalities and Regions) on the

employer side. UNI-Europa and CESI (the European Confederation of Free Trade Unions) will be part of the workers' delegation to plenary meetings. This 44th SSDC will cover around 9 million workers in Europe (European Commission, 2023).

The informal phase of the social dialogue was characterised by joint projects (see above) and the development of joint statements (cf. Table 2 in the Appendix). With the recent set-up of the SSDC in 2023, now the full range of potential social dialogue outcomes applies (cf. Table 3 in the Appendix). The set-up of the SSDC has been awaited by the social partners. Whereas EPSU has been active in other SSDCs such as hospital sector or local and regional government and had therefore already been recognised by the Commission as a representative social partner for years, the Commission decision to set up the SSDC means that Social Employers are now also a recognised social partner. This strengthens their role in terms of social partner hearings or the Liaison Forum (EU1; EU3; EU6). Also, for EU-OSHA it is 'easier' to deal with officially recognised social partners (EU2).

Actors and membership

EPSU and Social Employers can be identified as the main actors for the SSDC Social Services. They have had a fruitful informal relationship and jointly applied for an SSDC in 2021. Social Employers mainly represent not-for-profit providers and are working on extending and deepening their membership. Here, capacity building activities through joint projects play an important role.

To enrich the representativeness of the actors, the inclusion of CEMR on the employer side has been discussed already before the application. CEMR represents public providers and their members play a key role in some countries for the sector, e.g. the Nordic countries, but also France (EU3; EU6). Social Employers lack members for instance in Sweden. EPSU, but also Social Employers therefore were in favour to include CEMR to have both the union side and the employer side represented for certain countries. Within EPSU, there has been a working group on social services which includes members both of the internal Standing Committee Health & Social Services and the Standing Committee on Local and Regional Government. It is expected that with the new SSDC, this working group will become a Standing Committee (EU6). According to the trade union side, the reason for having separate SSDCs for the hospital sector and the social services sector is the different employer structures, whereas the topics and challenges in both sectors are assessed to be very similar (EU1).

According to interviewees, scarce resources and staff changes in CEMR prevented a joint application for the SSDC Social Services in 2021. It remains to be seen how social partners in the newly established SSDC and especially on the employer side will develop their working relationships. There might be reservations among not-for-profit providers in certain countries, as the German case study suggests, regarding local and regional governments to "sit on the other side of the table" in the

national setting. In some countries, an important share of social services is provided by cooperatives, such as in Italy, or by church organisations, such as in Germany. Whereas Social Employers have cooperatives in Italy among their membership, these members are said to be unfortunately not active at EU level (EU3). Church organizations are not among the membership of Social Employers. However, Social Employers cooperate with Social Services Europe (including, among others, Caritas Europa and Eurodiaconia) to work closely together e.g. in the political sphere (EU3). Social Services Europe has also been a project partner in some of the joint projects (Social Employers, 2023).

National sectoral actors engaged in European sectoral social dialogue

According to the trade union interviewees, the Nordic, but also the French, Italian, Spanish, and German members are quite active, which has been also linked to the bigger capacity of those members (EU1; EU6). From Eastern European countries, Romania is active, while there is no participation by Poland. A reason for the latter is seen in language problems because there is no translation to Polish (EU1). A trade union interviewee also pointed to the fact that some big national members work along separated subsectors or ‘branches’ (examples mentioned include Belgium and the UK), which makes it even more important to bring all representatives together in the internal working group for social services (EU1).

On the employer side, where in many countries capacity building is the very focus of sectoral social organisations, there are nonetheless some members that are regularly active and supportive at EU level. Members in some countries are still missing (e.g. Hungary), in other countries, there are small and rather weak members and support is given in terms of joint projects, e.g. in Greece, Romania, and Slovakia. Social Employers regret that the Italian members, representing a big country, are not at all active at EU level, and the French could be more active, according to the interviewee. Some members are however regularly active and supportive at EU level, namely from countries such as Austria or Finland (EU3).

According to observers, countries with more resources are more actively engaged, and it has been observed that it takes some time for national sectoral actors to get used to the work at EU level and to understand the different ‘languages’, i.e. to realize that for instance concepts might differ between countries. Therefore, it is of utmost importance that for instance EU secretariates moderate and clarify before it comes to potential misunderstandings (EU2). It remains to be seen with the new SSDC which national members will take an active role, both on the trade union side and on the employer side, where in the latter case membership is still developing.

Topics in European sectoral social dialogue in the social services sector

The joint texts reached between EPSU and Social Employers (cf. Table 2 in the Appendix) provide an indicative list of topics of joint interest in the social dialogue in the social services sector. Issues of H&S have been addressed in a total of six joint texts. These include the joint position paper on digitalisation (2019), three joint texts in 2020 related to the Covid-19 pandemic, the joint position paper on recruitment and retention (2020) and the joint position paper on the then forthcoming European Care Strategy (2021). EPSU and Social Employers have also been partners in EU-OSHA's campaign 'Lighten the load' on musculoskeletal disorders (MSDs) in the years 2020 to 2022.

With their application for an SSDC in 2021, the social partners had set up a joint work programme for the years 2022 and 2023. According to the trade union side, the joint work programme was inspired by the one in the SSDC Hospital, because of similar sectoral challenges (EU1). The work programme includes the following four main thematic areas (which are further divided into nine subthemes):

- recruitment and retention
- working conditions
- public procurement
- capacity building

After the official set-up of the SSDC, this draft work programme will then have to be finalised (EU3).

Working together to improve the working conditions within the sector has been underlined as the key topic and joint objective among social partners during the interviews. In that regard, interviewees agreed that it is important to stress that work in the social services sector necessarily is 'qualified, skilled and professional' (EU3; EU1; EU6; EU4). Topics that have been identified through the interviews for potential future joint work include MSDs and psychosocial risks as well as issues of recruitment and retention, work life balance, third party violence and issues related to digitalization. Furthermore, it has been stressed in terms of H&S, that in the sector 'practically all kind of risks are present', i.e., chemical, biological, physical, ergonomic, and psychological risks (EU5; EU2).

As mentioned above, joint projects, i.e. where both Social Employers and EPSU are part of the project consortium, play a significant role: they are important for capacity building activities in the countries, but also for developing topics of joint interest. Examples for more recent joint projects include 'Foresee' (More attractive social services through social dialogue; 2021-2023), or FORTE (Social dialogue for skills, training and working conditions; 2022-2024).

Outcomes

Outcomes reached so far include joint texts (cf. Table 2 in the Appendix), but also other joint activities such as previous and current joint projects (Social Employers, 2023). Within the EU-OSHA campaign ‘Lighten the Load’, a joint webinar on preventing MSDs in the social services sector has been organized in September 2021 and a fact sheet on MSD prevention was developed (Social Employers & EPSU, 2021). The social partners’ assessment of the joint activities and texts reached so far is very positive. The aim of the trade union side is to reach joint agreements within the (meanwhile established) SSDC, while joint projects and capacity building are regarded as important activities as well (EU1; EU6).

In two fields of the joint work programme (see above), working conditions and recruitment and retention, negotiations for a joint text are envisaged, and it remains to be seen what kind of outcome the social partners will be able to reach (e.g. guidelines, framework of actions, framework agreement, cf. Table 3 in the Appendix). Regarding recruitment and retention, the integration of migrant workers has been raised, as well as missing career opportunities, which is also seen to be linked to the staff shortages in the sector. Therefore, a joint outcome on lifelong learning, which has been reached in the SSDC Hospital, would be also appreciated for the social services sector (EU1).

Whereas knowledge sharing and sharing of best practices in terms of working conditions and different risks are regarded important to develop guidelines, it is hoped that this could then lead up to an agreement (EU6). From the point of view of the trade union side, Social Employers are expected to be quite open for instance towards binding agreements on MSDs or psychosocial risks (EU1). Finally, references have not only been made to outcomes reached in the SSDC Hospital (EU1; EU6), but also to cross-sectoral social dialogue agreements e.g. on violence and harassment which are identified as important topics for the social services sector as well (EU4).

Description of H&S regulation process and practice in European sectoral social dialogue

In March 2022, the social partners organized a pilot social dialogue meeting, ‘to see what the issues are and how we could work’ (EU1). The meeting was assessed very positively by social partner interviewees, also due to the broad participation of national representatives (EU1; EU6). Both the joint work programme developed in 2021 (see above) and the mock sectoral social dialogue meeting in 2022 were used to show to the European Commission the joint readiness for an SSDC and ‘to put pressure on the Commission’ (EU6; EU3).

The role of the Commission for social dialogue has been addressed as well, and a shift to more project-oriented support is seen more critical from the trade union side than from the employer side (EU3; EU6). The social partners have approached the Commission through meetings, e.g. also with the Commissioner for Social Affairs and Employment, and joint letters and positions. The joint position

on the European Care Strategy has been assessed as a joint lobbying success (EU6). A need for more informational support from the Commission has been raised, which is expected to be reached for both social partner sides with the set-up of an SSDC (EU1). Besides the directorate-general (DG) for employment, social affairs and inclusion (EMPL), also DG SANTE, which deals with health and food safety, will be an important addressee for the social partners in the future (EU6).

The involvement of national actors and members is facilitated through internal bodies, including the utilization of surveys among members to gather feedback and information such as good practices. Additionally, their participation is fostered within the context of joint projects (see above). In the latter case, those involved ‘become more part of a team, contribute to EU work’ (EU3). The joint projects are important for the small secretariat of the European employer organisation to support the employment of staff (EU3). More in general, observers have expressed their concern of scarce personal resources of EU secretariats on both sides, claiming that staff there is very committed and enthusiastic about their respective sectors but suffering from heavy workloads, also preventing them for instance from providing feedback timely (EU2).

The joint work done so far within the informal social dialogue has been very positively evaluated by the social partners and they expect the future work of the SSDC to continue to be progressive (EU1, EU3, EU6). On the trade union side, also their experience with the SSDC Hospital and good practices developed in that sector have been underlined, meaning that an operating SSDC Social Services could also be ‘put on track and deliver quickly’ (EU1).

EU-level H&S dialogue and regulations’ impact

Awareness of and involvement in EU-level developments

Regarding awareness of and involvement at EU level, language problems and scarce resources of members have been pointed out (EU1; EU3). Furthermore, a lack of awareness of the importance of the EU level for the sector by some members, or lack of interest to engage at EU level – although financial and logistic support is provided – has been noted (EU3). National case studies conducted for this study support the finding that the EU level is often regarded as far away and detached from the daily work of social partners (e.g. Galetto, 2023), or that awareness of the EU origin of many regulations in the field of H&S is very low (e.g. Hiltunen & Larsson, 2023).

However, joint projects or dissemination events, as exemplified by initiatives like EU-OSHA’s ‘Lighten the Load’ campaign in 2021, serve as opportunities to raise awareness for the EU level and the work of social partners there. These activities also serve as a means to integrate members and

their ‘expertise from the ground’ into the EU level work, because ‘when you work on EU affairs you are aware it’s always better to refer to concrete cases’ (EU3). Feedback by national members is used to compare policies and to collect examples, e.g. on collective agreements. Members use the compiled information then at the national level, so that ‘there is a return of investment’ (EU3). However, it can be sometimes difficult to get feedback from some smaller members, due to their scarce resources. The good working relationship in social dialogue between EPSU and Social Employers can also impact in the more intangible ‘cultural’ sphere: ‘by doing so, we also show to national members – where the situation is quite often a lot more complicated – that social partnership works well when it is friendly’ (EU3).

Overall, according to interviewees, the Covid-19 pandemic provided more attention for the social services sector. Moreover, at EU level there has been more attention and new efforts to bring together the (public) health sphere and health and safety at work, as well as to take health and safety issues more into account since then (EU2; EU4).

Implementation of EU level H&S outcomes

Joint projects are an occasion where national actors and members are involved, enabling them to take up EU social dialogue activities and profit from others’ experience and guidance. Events like the webinar on MSDs in the context of EU-OSHA’s campaign ‘Lighten the Load’ contribute to the dissemination of EU level information, materials, and the sharing of good practices.

The SSDC has therefore been described as ‘a place where EU legislation and all these good things that are there can be discussed with national affiliates and then can be implemented on a national level’. In terms of the different outcomes and activities though, it is noted that ‘to maximize the impact you would hope for an agreement that then has to be implemented at national level. But even through [the joint projects], you can have a big impact if you go to the countries’ (EU6). For the future work of the SSDC, a trade union respondent also brings up as an important question ‘when we have an agreement... how will you implement this agreement?’ (EU1).

Besides the already abovementioned problems of weak or missing membership on the employer side, another challenge to deal with EU level social dialogue results might be the perceived distance of that level from the point of view of national actors (e.g. Galetto, 2023). Furthermore, in terms of H&S related topics it is feared that the sometimes low awareness of H&S and existing risks in the sector and the missing expertise on H&S-related issues such as MSDs or psychosocial risks in the small premises could have a hindering effect (EU3).

Example of EU regulation that led to effective protection

No concrete examples of EU regulation that led to effective protection have been raised in the interviews. The “Needlestick Directive” (2010/35/EU) which implements an agreement reached between the social partners in the SSDC Hospital has been assessed as relevant for the social services sector as well. This has been validated by the national case studies conducted in the context of this study, where the Needlestick Directive has been mentioned in five of the six cases (Bechter, 2023; Guobaite & Blazenie, 2023; Hiltunen & Larsson, 2023; Páńkóń, 2023; Weber, 2023). Further EU regulations that have been brought up more in general by the EU level interviewees have been described in the first section of this report.

Quality assessment of European sectoral social dialogue by the social partners and by observers

The assessment of the social dialogue in the social services sector is very positive by both sides of industry. The trade union side engages in several SSDCs and claims that the dialogue in the social services sector is ‘one of the best’ and ‘extremely positive’ so far. One of the reasons for joint interests and goals, e.g. to improve working conditions in the sector, is seen in the membership on the employer side (Social Employers), made up of not-for-profit organisations (EU1). In the same vein, on the employer side, the very good personal and working relationship and the trust built through joint activities is highlighted. Of course, ‘we know we are not on the same side’, but social partners have the same goals and to work together in a very cooperative and transparent way (EU3). Also, observers note that there is a good relationship and a common understanding of problems and main goals among the social partners in the sector. Nonetheless it is noted that the heterogeneity of national actors and systems sometimes pose challenges (EU2; EU4).

Quality assessment of European sectoral social dialogue by the researcher

The phase of informal social dialogue in the social services sector has allowed the social partners, EPSU and Social Employers, to build trust and a friendly and stable working relationship, supported by stable personal relationship. The variety of joint activities such as joint texts and projects provides a solid base that can be further build on within the newly established SSDC. A draft joint work programme has been developed already in 2021, and a mock social dialogue meeting has been organised in 2022. Furthermore, the trade union side can build on experiences with several SSDCs, including the one in the hospital and healthcare sector where many similar sectoral issues and challenges are at stake, but also with the SSDC in local and regional government, where CEMR is

involved on the employer side. It remains to be seen if and how the ‘diversification’ on the employer side within the new SSDC, encompassing both Social Employers and CEMR, will add complexity to the joint work of the social partners.

Multilevel coordination – if and how do actors at different level interact

Observers assess health and safety to be still not a priority at EU level, an indicator for that being also the relatively small unit dealing with H&S at work in DG EMPL. However, it is noted that there is recently a shift in attention, due to the experience of the Covid-19 pandemic where it became clear that OSH – and certain sectors – are highly important in economic terms. Some new exchange between the ‘silos’ public health on the one hand and health and safety at work on the other hand has been observed and is welcomed (EU2; EU4).

It has been noted that the social services sector is characterised by decentralisation which makes the dissemination of knowledge, ‘like advice on how to use these legislations’, difficult (EU6). Missing membership in countries as well as missing awareness of the EU level by national members (see above) contribute to problems of multilevel coordination between social partners. In the field of H&S at the workplace, EU-OSHA plays an important role for anticipating risks, involving social partners and supporting the dissemination of knowledge (EU5). The promotion of the OSH Framework Directive is central, to reach out from the ‘a little bit artificial’ EU level to the workplaces, through social partners as intermediaries. However, it has been noted that there are problems to reach out to the national level and the workplaces, although many of the social partners involved are very committed (EU2).

Multilevel coordination can also be achieved through committees such as SLIC (Senior Labour Inspectors Committee). An interviewee noted however that the labour inspectorates in many countries suffer from scarce resources or have to fulfil also other tasks, such as the fight against undeclared work (EU2). Overall, the involvement of countries is said to be unevenly distributed due to resources, with the Nordic countries being most active, be it in the context of SLIC or in dissemination activities of EU-OSHA campaigns and tools, where social partners are asked to approach the ‘national focal points’ to also play a role. One of the supportive factors identified is the existence of a social partnership or a ‘tripartite culture’ in the countries, which EU-OSHA tries to support and to promote but cannot impose (EU2).

H&S challenges and how to tackle them

This case study has already addressed several H&S challenges for the sector that have been raised by the stakeholders and that have to be tackled, involving different actors at various levels: From a supportive political and regulatory European and national framework to social partners at different levels to the workplace. Most notably these challenges include:

- Improving **working conditions** in the sector to increase attractiveness and reduces staff shortages (conducting joint work in the SSDC, using the increased attention for the sector as a political window of opportunity also to lobby for sustainable (public) **financing**);
- considering adverse **employment conditions** (e.g. precarious work, platform work, entitlements for sick pay and leave) in the sector because they may impact H&S negatively;
- further building **capacities** among national social partners especially on the employer side, promoting social partnership and a tripartite culture to address H&S issues;
- addressing and anticipating **risks** such as psychosocial risks and developing regulatory and practical frameworks to deal with, promote a culture of risk prevention, including doing risk assessments properly;
- strengthening and integrating the role of H&S at work at the various levels (further break-up of ‘**silos**’, allocating resources to institutions and actors in the field of OSH, raising awareness at the different levels and among different actors);
- strengthening the implementation of and **compliance** with existing regulations such as EU directives, e.g. also strengthening labour inspectorates’ resources (e.g. increase number of company visits) and possibilities of enforcement (‘stick’).

Overall, the social services sector aims for differentiation and recognition as a sector of its own (e.g. in contrast to the healthcare sector) while suffering from comparatively weak social partner structures and capacities. The increased attention for the sector, due to the Covid-19 pandemic, constitutes a window of opportunity the sectoral social partners at EU level are willing to use. It remains to be seen how the newly established SSDC Social Services will be able to contribute to tackle current and future H&S challenges of the sector.

Appendix:

Table 1. Interviews conducted at EU level.

#	Organisation
EU1	Trade union
EU2	EU-OSHA
EU3	Employer organisation
EU4	Sector expert
EU5	European Commission, DG EMPL
EU6	Trade union

Note: Interviews were conducted online between May and September 2022 and lasted between 45 and 110 minutes. Two further interviews requested (DG EMPL, EU-OSHA) could not be realised.

Source: Own compilation.

Table 2. Joint texts of the informal social dialogue in social services, 2019–2022.

2022
The Social Employers and EPSU joint statement on the situation in Ukraine
Joint press release: A big step towards a European sectoral social dialogue committee for social services
Joint Declaration of the Social Services Social Partners. European Care Strategy: strong social dialogue in social services needed
2021
Joint Position Paper on the forthcoming European Care Strategy
Joint statement: The importance of developing social dialogue in the Social Economy
2020
Joint position paper preparing the social services sector for the COVID-19 resurgence and increasing resilience
Joint position paper on recruitment and retention in European social services
Joint letter to Commissioner Schmit calling for action to tackle the lack of protective equipment for some of the most exposed workers: the 11 million social services workers all across Europe
Joint statement on COVID-19 outbreak – The impact on social services and needed support measures
2019
Joint letter to Ms Thyssen on social dialogue – Building social dialogue for the social services sector: Time to move to the next level!
Joint position paper on digitalisation in social services: Assessment of opportunities and challenges

Note: Joint texts in bold address (also) H&S. Source: Own compilation based on social partners' websites.

Table 3. Range of potential outcomes of the new SSDC Social Services.

Category of texts	Sub-categories	Follow-up measures
Agreements	Implementation by directives Implementation by social partners (Article 155 TFEU)	Implementation reports
Process-oriented texts	Framework of actions; guidelines, codes of conduct, policy orientations	Follow-up reports
Joint opinions and tools	Declarations, guides, handbooks, websites, tools	No follow-up clauses Promotional activities

Source: European Commission 2010: Annex 3.

References:

Bechter, B. (2023) *HEROS Case Study UK Social Care Sector*.

Czarczasty, J. & Pańków, M. (2023) *HEROS Literature Review Hospital & Social Care Sector*.

EU-OSHA (2021) Directive 2004/37/EC - carcinogens, mutagens or reprotoxic substances at work. Available from: <https://osha.europa.eu/en/legislation/directive/directive-200437ec-carcinogens-or-mutagens-work> [Accessed 12th July 2023].

European Commission (2010) *Commission staff working document on the functioning and potential of European sectoral social dialogue. SEC(2010) 964 final*. Brussels.

European Commission (2022a) Commission recommends recognising COVID-19 as occupational disease in certain sectors and during a pandemic. Press release of 28 November 2022. Available from: <https://ec.europa.eu/social/main.jsp?langId=en&catId=89&furtherNews=yes&newsId=10463> [Accessed 12th July 2023].

European Commission (2022b) *Communication from the Commission on the European Care Strategy. COM(2022) 440 final*. Brussels.

European Commission (2023) Commission decision setting up the European social dialogue committee for social services. Press release of 10 July 2023. Available from:

<https://ec.europa.eu/social/main.jsp?langId=en&catId=329&furtherNews=yes&newsId=10630>
[Accessed 10th July 2023].

Galetto, M. (2023) *HEROS Case Study Italy Social Care Sector*.

Guobaite, R. & Blaziene, I. (2023) *HEROS Case Study Lithuania Social Care Sector*.

Hiltunen, L. & Larsson, B. (2023) *HEROS Case Study Sweden Social Care Sector*.

Owczarek, D. (2023) *HEROS Case Study EU-level Hospital Sector*.

Pańków, M. (2023) *HEROS Case Study Poland Social Care Sector*.

Social Employers (2023) Projects. Available from: <https://socialemployers.eu/en/projects/> [Accessed 14th July 2023].

Social Employers & EPSU (2021) Social services: musculoskeletal disorders are preventable and manageable. Available from: <https://socialemployers.eu/files/doc/MSDs%20webinar%20-%20factsheet.pdf> [Accessed 12th July 2023].

Weber, S. (2023) *HEROS Case Study Germany Social Care Sector*.

PROPOSITIONS

The aim of this part of the study is to analyse and compare the functioning of H&S policy interventions by trade unions and employers across six countries, and to compare H&S interventions at the European level between two sectors. The analysis of Propositions 1-7 covers different levels and actors to investigate the H&S protection at different levels and different workforce groups and between sectors.

PROPOSITION 1: Collective agreements represent effective ways to address health and safety risks at the national level. Countries with sectoral bargaining, high union density, and workplace representation are expected to be able to ensure better (sector-wide) protection compared to countries with single company-level bargaining, where protection is possible only for the workforce of this company.

PROPOSITION 2: Countries with union workplace health and safety representation that have close links with trade unions are expected to be able to provide better health and safety protection at work compared to countries with non-union employee health and safety representation only.

PROPOSITION 3: Collective agreements may not be an effective way to protect workers who are embedded in institutional and contextual settings characterised by factors such as low union density, decentralised bargaining, and non-standard employment.

PROPOSITION 4: European sectoral social dialogue agreements are an effective way to provide EU-wide health and safety standards and workforce protection.

PROPOSITION 5: European sectoral social dialogue agreements may not be an effective way to provide health and safety protection because of the different national sectoral industrial relations systems and their capacity to implement and guarantee compliance with European sectoral social dialogue interventions.

PROPOSITION 6: European sectoral social dialogue interventions such as soft texts, guidelines, and tools may be an effective way to protect workers in countries with union health and safety representatives. In countries with non-union health and safety workplace representation, effective protection depends on employer support.

PROPOSITION 7: The current Covid-19 pandemic highlights the importance of greater national and European level policy coordination. Isolated policy interventions at the national and the European sectoral level are less effective ways to protect workers' health and safety compared to coordinated interventions between levels.

PROPOSITIONS 1 and 3

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The right of employees to work in a safe environment and the employers' responsibility to ensure risks to their health are properly controlled to prevent work-related illness are laid down in the National Health and Safety (H&S) Acts. At the European level, the Framework Directive on Safety and Health at Work (Directive 89/391 EEC) sets out rights and liability rules to protect workers from health risks throughout Europe. This Directive also regulates the involvement of H&S representatives in the process of installing adequate health and safety (H&S) procedures in the workplace. Member states are obliged to implement the directive into national law to encourage improvements in the H&S at work.

Despite encompassing H&S legislation, workers with certain employment statuses or in precarious workplaces are often not sufficiently protected from health risks (Gevaert et al., 2021). This became especially clear during the Covid-19 pandemic when many employers failed to protect workers. The report by the World Health Professions Alliance and the World Health Organization reveals the physical and psychological damage done to healthcare professionals during the pandemic because employers failed to protect them (Downey, 2023). Since H&S legislation does not provide sufficient protection, collective agreements may represent an effective way to set standards and manage H&S risks at work (Fischhoff, 1984).

Collective bargaining and collective agreements are instruments to set collective standards and regulate the terms and conditions of employment (Malmberg, 2002). Health and safety at work are important issues and unions often negotiate for better working conditions. A recent article brought together the health benefits of unionisation and working under collective agreements (Muller et al., 2022). However, the inequality of bargaining power which characterises precarious work arrangements deprives workers of the ability to protect themselves from health risks at work (Ollé-Espluga et al., 2014).

PROPOSITION 1: *Collective agreements represent effective ways to address health and safety risks (H&S) at the national level. Countries with sectoral bargaining, high union density, and workplace representation are expected to be able to ensure better (sector-wide) protection compared to countries with single company-level bargaining, where protection is possible only for the workforce of this company.*

PROPOSITION 3: *Collective agreements may not be an effective way to protect workers who are embedded in institutional and contextual settings characterised by factors such as low union density, decentralised bargaining, and non-standard employment.*

In the following, we analyse as outlined in propositions 1 and 3 if collective agreements represent effective ways to address H&S risks in two sectors and six countries. We start with an analysis of the characteristics of employers and employees working in the two sectors. This is followed by the analysis of the recent collective agreements concluded and the workforce covered by the agreements to draw conclusions about the effectiveness of collective agreements to protect workers' H&S in six countries and two sectors.

Collective bargaining systems in the hospital sector¹ - DE, IT, LT, PL, SE, UK (Eurofound, 2022):

1. The countries in our sample characterized by *predominantly public ownership* are **Lithuania, Sweden,** and the **UK**. In **Lithuania** over 80% of hospitals are public institutions, approx. 10% are private and approx. 5% budgetary institutions. In **Sweden**, most hospitals are public institutions only a few private hospitals exist. In the **UK**, more than 90% of hospitals are public institutions, and the size of employment in private hospitals, in 2006, was approx. 4% of the employment in the NHS (Ponds, 2006:20).
2. The countries in our sample characterized by rather *balanced public and private ownership* structures in the hospital sector are **Italy** and **Poland**. In **Italy** approx. 40% of hospitals are public institutions and 60% are private (both for-profit and non-profit) employers (Montagu, 2021). These are typically accredited private hospitals that complement the public provision of hospitals. This looks different when we focus on hospital beds provided in public and private hospitals, here the split is approx. 70% public and 30% private (AIOP, 2022). In **Poland**, 57% of hospitals are public institutions, 1% are non-profit owners, 29% of hospitals are co-owned by local governments and private providers, and 13% are privately owned hospitals.
3. **Germany** is the case characterized by *predominantly private ownership*. In **Germany** 29% of hospitals are public institutions, 32% are owned by non-profit organisations (charity and church-run hospitals) and 39% are for-profit privately owned hospitals.

¹ Hospital sector in the HEROS project covers NACE 86 - Human health activities.

However, in terms of beds, public hospitals account for 48%, not-for-profit for 32%, and private (for profit) for 20% (Destatis, 2022).

Germany: In 2023, the latest Public Services Agreement covering hospitals (TVöD) was negotiated for the federal and municipal sectoral level (16 regional federal states). A CA was concluded by VKA (representing municipal employers) and ver.di for public services employees in hospitals (TVöD-K) and one for doctors by Marburger Bund (MB) and the VKA on the employer side (TV-Aerzte/VKA). A sectoral agreement at the federal state level (including 15 of the 16 federal states) is in force (TV-L), covering most university hospitals. For doctors at university hospitals, there is a separate agreement between MB and TdL (TV-Aerzte (TdL)). Private hospitals are typically covered by single-employer agreements. As mentioned in interviews, company/hospital agreements exist that deal with overwork/understaffing ('Entlastung'/ 'relief'). Based on the ownership structure of the sector, the sectoral agreements for public services cover approx. 29% of hospitals. From an employee perspective, approx. 47% of employees are covered by sectoral agreements, and approx. 13% of employees are covered by company agreements.² (Eurofound, 2022).

Regarding *health and wellbeing* issues covered in CAs, ver.di negotiated 24 CAs with bigger hospitals in the public sector on workload relief, and one CA on workload relief with the only privately owned university hospital. Overall, collective agreements do only cover H&S-related issues in a wider sense, such as working time. Core H&S issues are regulated by law. In that sense, H&S is much more seen as a 'legal' and workplace-level topic than a collective bargaining topic, especially by employers. Working conditions are typically settled by works agreements. According to the Hans Boeckler Foundation's Company Agreement Archive, most works agreements were settled in public hospitals (Kraemer, 2011). In general, the company and works agreements do not show a particular tendency to deal with the challenges of the sector but rather address a broad range of issues. Thus H&S-related topics might be covered by works council agreements (in the public sector they are called staff council agreements) at the company/organisation level. Based on the interviews, no data about such agreements are available as evidence, however, in interviews the existence of such agreements was mentioned.

Italy: In the hospital sector, ARAN is the agency representing the public hospital sector's employer. The latest national sector CA for the public healthcare and hospital staff (excluding doctors) was renewed in 2022 between ARAN and workers' unions FP-CGIL, FP-CISL, UIL

² Figures for the sector "health and education".

FPL, FIALS, NURSIND, and NURSING UP. CGIL FP and FP-CISL are the two major unions in the sector in terms of represented workers and the only two unions also members of EPSU.

There is a national CA for cooperatives in the health and social care sectors, signed by the organisations of cooperatives (AGCI – SOLIDARIETÀ, LEGACOOPOSOCIALI CONFCOOPERATIVE- FEDERSOLIDARIETÀ) – and FP-CGIL and FP-CISL. There are two other collective agreements that cover private healthcare and religious healthcare providers. The CA covers all employees, nurses, and healthcare allied professionals. The coverage of CA for public sector organisations is 100% and between 70% and 80% for hospitals in the private sector.

Regarding *health and wellbeing*, issues covered in the CAs are increasingly, though indirectly, relevant to H&S because they regulate work organisation, working time, teamwork, and allowances for unsocial hours or activities. The latest public healthcare CA renewal in 2022 relaunched the “Bipartite body for innovation” (Article 8, point 2), which was established in a sector CA signed before the pandemic, but which had limited follow up. This body, the CA establishes, should be set up in every organisation (hospital/local health authority) with the aim to promote ‘organisational wellbeing’. It recognises the role and importance of subjects like working time and stress as directly linked to H&S and as matters of discussion at the organisational level.

Lithuania: The public sector healthcare institutions concluded a CA in November 2021. This CA was renewed in October 2022 and covers all public sector hospitals; private hospitals are not covered. The sectoral level CA was signed by the Minister of Health representing employers in the sector and by one national trade union, representing pharmaceutical employees, and by seven healthcare unions, including the Lithuanian Nurses’ Organization (LSSO) and Lithuanian Trade Union of Healthcare Employees (members of EPSU). Approx. 20% of sectoral employees are trade union members (Eurofound, 2020).

About the employees covered by the agreement, the CA covers employees who are members of the trade unions who signed the CA, exemptions are possible when the CA is applicable to non-trade union members. According to Statistics Lithuania, in Q1 of 2023, there were 91,440 employees employed in NACE Q86. More detailed statistics on the structure of employees' union membership are not provided. In Lithuania, more than 80% of hospitals are public institutions, however, the number of employees working in the public sector and their union

membership are not available. As the best estimate, between 60% and 70% of employees are covered by the sectoral CA (Eurofound, 2022).

Regarding *health and wellbeing* issues covered in CAs, bonuses are paid for work in workplaces exposed to harmful (20%) or dangerous (15%) factors. Other provisions of the CA in the field of H&S echo the legal norms, such as the employer's obligation to provide safe working conditions, to carry out occupational risk assessments in the workplace, to create a working environment that ensures psychological wellbeing, to adopt a policy on the prevention of violence and harassment, for example. Generally, CAs do not address key H&S issues, if they address them, they tend to refer to those already provided in legislation.

Poland: The social partners engaged in the healthcare sector are on the union side the Independent Self-Governing Trade Union "Solidarność", with a sectoral structure, coordinating the activities of the National Secretariat of Healthcare unit (i.e. KSOZ NSZZ "Solidarność"), which is affiliated to EPSU, and is composed of a National Healthcare Section and National Welfare Section. Furthermore, the Federation of Trade Unions of Health Care and Social Welfare Workers (FZZPOZiPS) which is also affiliated to EPSU and to the All-Poland Alliance of Trade Unions (OPZZ), and the All-Poland Trade Union "Workers' Initiative" of Medical and Skilled Carers (OZZ IP OMIK).

Unions especially representing the health care sector, are the Polish National Trade Union of Nurses and Midwives (OZZPiP), affiliated to the Trade Union Forum (FZZ) (the second largest trade union federation representative at the national level). Trade unions are divided into organisations associating representatives of any professions and jobs present in a given sector, such as NSZZ "Solidarity" or unions that are part of FZZPOZiPS, and into trade unions associating employees of specific professions. OZZPiP and OZZ IP OMIK are examples of the latter.

On the side of employers, there are the following organisations: The Employers of Private Medicine (OPMP) and the National Association of Poviats Hospital Employers (OZPSP). Although they are formally employer social partner organisations, they are not interested in entering collective bargaining.

In Poland, CAs are typically negotiated between unions and employers at the company level. No collective agreement was identified during this study in the hospital sector. Generally, CAs play a marginal role in Poland. A representative of the nurses' trade union (IP3), with in-depth knowledge of the situation in the region where she holds her position, was able – without giving

details – to indicate one hospital where, to her knowledge, an agreement is in force. A very small number of hospitals and their employees are covered by CAs, the coverage is approx. 2%.

Regarding *health and wellbeing* issues covered in CAs, they are regulated by legislation. There is one exemption, in interviews it was mentioned that in some local hospitals, the union pushed through that self-employed nurses working in roentgen did not have to buy their own protective clothing. Such situations, albeit on a small scale, can occur in various hospitals, but are generally the result of ad hoc, interventionist action by trade unions.

Sweden: Collective agreements are concluded on a sectoral level with local level collective agreements specifying certain details. There are no state or municipal hospitals in Sweden, all public hospitals are run by regions, and there are only a few private hospitals. As for outpatient/primary care, the situation is more diverse. The employer organisation representing public hospitals and other public healthcare organisations is the Swedish Association of Local Authorities and Regions (SALAR), and they sign several CAs. The Huvudöverenskommelse is the main agreement (the most recent one from 2022), consisting of a number of similar agreements signed separately by SALAR with individual trade unions or trade union cartels: Kommunal, which is the municipal workers' unions; OFR-healthcare and OFR (general), which is a negotiation cartel that gathers 16 trade unions in the public sector, who are all members of the Swedish Confederation of Professional Employees (TCO); and trade unions representing professional groups such as the Swedish Medical Association (representing physicians), and Akademikeralliansen (the alliance of academics), which consists of 16 trade unions in the Swedish Confederation of Professional Association (SACO). In addition, the Swedish Employers' Organisation for Municipal Enterprises (SOBONA), which is the employer association for municipal corporations signs around 50 CAs for different areas, and for the private care providers in elderly care and primary/outpatient, Vårdföretagarna the Healthcare Companies, members of Almega, (which is Sweden's largest business and employers' organisation for service companies in the private sector) signs CAs in seven different areas with the trade unions and cartels mentioned above.

With these agreements, all staff in the public sector is covered by CAs, but while we have no information about coverage in the private sector. As all employees are covered when an agreement is signed by the employer, however, we get some indications in that trade union membership for many staff categories is just slightly lower in private sector, as compared to

public sector employees: for nurses the union membership figures are 82% in the public sector and 68% in the private, for assistant nurses 81% in public, and 71% in private, for care assistants 55 % in public, and 44 % in private, and for general care workers membership is in total 63% (72% in public, 51% in private) (Eurofound, 2022).

Besides these regular Cas, there is an Agreement on Cooperation and Working Environment (Samverkansavtalet), from 2017, which is a special type of CA detailing the processes of employer—employee cooperation in the implementation of H&S processes. This is signed by SALAR and Arbetsgivarförbundet Pacta (Now SOBONA), and most of the trade unions/cartels mentioned above.

UK: In May 2023, the latest CA, the NHS Terms and Conditions of Service (Agenda for Change), became effective. The NHS Terms and Conditions of Service handbook sets out the conditions of employment negotiated by the NHS Staff Council at the national sectoral level which has representatives from both employers and trade unions. The agreement was negotiated between NHS employers and ten trade unions, among them Unison, RCN, GMB, RCM, and Unite which are unions affiliated with EPSU at the European level.

Employers covered by the sectoral agreement are 215 NHS trust hospitals, and 10 ambulance trusts (information for England). According to interviewees, there were a few CAs concluded in the private sector, but no information is available about the number of agreements. In the case of single-employer or company bargaining between management and unions recognised by the employer, there is no information available on whether negotiations are conducted by coalitions of unions or individual unions.

About the employees covered by the sectoral CA, all staff directly employed by NHS organisations is covered, except very senior managers and staff in the remit of the doctors and dentists review body. In December 2022, NHS England employed a total of 1,409,447 nurses, 364,871 health visitors, 26,850 midwives, and 328,574 health care support workers/assistants. Regarding trade union membership, membership of registered nurses (RCN) and registered midwives (RCM) is close to 100%. No membership figures are available for general unions including Union, GMB, and Unite, but they are significantly lower than for professional unions. The sectoral trade union membership for the healthcare sector in the UK is as follows: Unison (20%), RCN (19%), Unite (4%), RCM (2%), and GMB (1%) (Trade Union Statistic Gov.UK³).

³ <https://www.gov.uk/government/collections/trade-union-statistics>

According to Eurofound (2022), the coverage of the sectoral agreement is for public/NHS employers 100% and 40% for private hospitals (representing approx. 10% of all hospitals).

Regarding *health and wellbeing* issues in the wider sense covered in CAs, the CA provides that at the local/trust level employers can pay recruitment and retention premia, and subsistence allowances. The agreement states that work should be organised to protect the H&S of the workforce (e.g., including rest times, and breaks) and their work-life balance. Protection against special hazards or heavy physical or mental strain, health assessment for night work. The CA regulates sick leave and sick leave allowances, and e.g., H&S for new and expecting mothers. Furthermore, the agreement specifies issues related to union H&S workplace representation (H&S union reps), the provision of facilities, time off, and activities of accredited trade union representatives.

Conclusion – Hospital Sector

Generally, in countries with a predominance of public sector hospitals collective bargaining is characterised by high coordination and outcomes that are all-encompassing, except in the case of Lithuania, where CAs negotiated between the Ministry of Health on the employer side and sectoral unions only cover union members. In Sweden, collective bargaining is highly coordinated, and CAs are concluded at sectoral, regional, and municipality levels, allowing local adjustments. Because of the high fragmentation of ownership in the hospital sector in Germany and Italy (public, private for-profit, non-profit charities, cooperatives, and church-run hospitals), collective bargaining is fragmented, and different agreements are in place for different types of hospitals (ownership). In the case of Germany, the country with the smallest share in public ownership in our sample, special clauses in CAs for public service agreements and separate agreements for federal states (e.g., Hessen) promote greater derogation from sectoral agreements. Poland is the country in our sample, where there is no social partner organisation representing employers in the sector and negotiating CAs. There is also no evidence available about CAs for private hospitals.

In the case of private sector agreements, CAs tend to be negotiated between a single employer or a group of employers and trade unions depending on the fragmentation of the social partner organisations. In Sweden and Italy, coalitions of unions typically negotiate collective agreements, and there can be individual unions that participate in the negotiations of sector CAs representing specific workforce groups (e.g., professional unions). In the case of the UK, sectoral trade unions negotiate jointly in the public sector. Most collective bargaining

arrangements in the UK are voluntary. In the private sector unions that are recognised by employers engage in collective bargaining, this can be a single union or a group of unions working together (Interview 1 UK/social care). Regarding Germany, with predominant private ownership in the hospital sector, there are sector-wide agreements concluded for public services hospitals at the federal state level, and for municipalities. In the private sector, ver.di conducts CAs for groups of hospitals, hospitals belonging to large private providers, and single organisations. Deviations from CAs are allowed when hospitals face difficult financial circumstances. Another important source of collective bargaining fragmentation and coverage is the diverse workforce represented by different unions (doctors, care workers, and other staff employed by hospitals or outsourced units), leading to greater fragmentation and diversification of working standards.

Regarding *health and wellbeing* issues covered in CA, as indicated by interviewees, in Germany ver.di negotiated CAs in the public sector on workload relief and the first CA for a privately owned university hospital. Generally, health and wellbeing-related issues covered in CAs are aimed at improving overall working conditions and not H&S in the narrow sense as defined by law. In the case of Germany, H&S is much more seen as a ‘legal’ and workplace-level topic than a collective bargaining topic, especially by employers. Accordingly, working conditions are typically settled at the workplace level in work agreements. This applies especially to Poland since no collective agreements exist in the hospital sector. In Lithuania, CAs do not address H&S, if they address health issues, they tend to refer to those already provided in legislation. Similarly in Sweden, the main H&S principles are set by law and not in CAs. In the case of the UK, the NHS Terms and Conditions of Service contain recommendations to protect the H&S of the workforce and their work-life balance. However, these recommendations are of a rather general nature and need to be translated into practice before being implemented.

Collective bargaining systems in the social care sector⁴ in six countries – DE, IT, LT, PL, SE, and UK (Eurofound, 2022a):

1. The countries in our sample characterized by *predominately public ownership* in the social care sector are **Sweden** and **Lithuania**. The main public employer organisation in **Sweden** is Sveriges Kommuner och Regioner (SKR), organising all regions and

⁴ Social care in the HEROS project covers NACE 87 - Residential care activities; NACE 88 - Social work activities without accommodation, except child day care activities and other social care activities without accommodation.

municipalities in Sweden, among them a large portion in hospital/healthcare and care/social assistance. SKR signs the central collective agreements for almost 1.2 million employees in municipalities and regions. There is also an employer organisation for municipal corporations, SOBONA, employing around 100,000 employees, of whom some are working in the hospital and care sector. The third large employer organisation of relevance for the sectors is Vårdföretagarna (the Association of Private Care Providers), which organises around 2,000 companies employing around 100,000 employees. Besides these three organisations, there are also employer associations organizing competence agencies and non-profit employers, who also employ some care workers in these sectors. In **Lithuania**, there were 228 residential care institutions for elderly and disabled people in the first half of 2023. Out of them 32 (14%) are founded by the Ministry of Social Security and Labour, 84 (37%) – by municipalities, 12 (5%) – by private persons, and 100 (44%) – by NGOs. However, this structure does not represent the share of employees, as state (the ministry and municipality-founded) institutions usually are the largest ones.

2. The country in our sample characterized by a rather *balanced public and private ownership* is **Poland**. In **Poland**, nursing homes and other 24-hour care facilities are run by local government units (109 facilities or 3,884 inhabitants), counties (683 facilities or 61,700 inhabitants), regional government (1 facility or 67 inhabitants), and private non-profit owners (1,327 facilities or 53,164 inhabitants).
3. In the social care sector *private for-profit ownership* is predominant in the **UK**. In the **UK** approx. 79% of care staff are employed by private sector firms; 7% by local authorities; 7% by individuals and 7% by the National Health Service (NHS). There are approx. 39,000 establishments providing care, split equally between residential and domiciliary care. Furthermore,
4. *Private non-profit ownership* is the prevalent type of ownership in **Germany** and **Italy**. In **Germany** the minority of care providers are publicly owned, private for-profit is the second most important ownership type, and the great majority of care providers are non-profit organisations. The ownership structure is similar in **Italy**, although the proportion of public-owned care providers is slightly larger (44%), and the private for-profit ownership is smaller (10%). The largest proportion, 46%, are non-profit organisations.

Germany: There are mainly private for-profit and charity and church-run providers, which has implications for industrial relations, with a fragmented employers' side. In terms of care homes, in 2021 non-profit providers accounted for 53% and for-profit providers for 43% of the 16,115 care homes (Destatis, 2023). Regarding care workers employed with Protestant and Catholic charity organisations, they are covered by Ecclesiastical Labour Law. Under this law, employment terms and conditions are set by commissions consisting of representatives from both the employer and worker sides. There is no collective bargaining with the trade unions. However, some regional Protestant organisations deviate from this principle (Kraemer, 2011). These historical, structural factors are possible reasons for the relatively low unionisation of the elderly care sector (11 %).

The main actors in this sector are the public services trade union ver.di, the non-profit employers' organisations AGV AWO (Workers' Welfare Association), and BVAP (employer organisation founded by NGOs). The organisations representing private social service employers, AGVP and bpa-Arbeitgeberverband, do not engage in collective bargaining and social dialogue.

There is no sectoral collective agreement for the elderly care sector, which comprises approx. 30,000 establishments. A German-wide sector collective agreement between ver.di and BVAP for elderly care failed in 2021 due to a church employer's veto. There is a public sector agreement for the municipality level (TVöD-B), however, the public share in elderly care is very small. Approx. 5% of public establishments/services are covered by the public sector agreement. Usually, church establishments/services adhere to the (pay) regulations in the public agreement, therefore it is estimated that between 30% and 35% of establishments/services in the sector are covered. Only 1% to 2% of private establishments/providers in the elderly care sector are estimated to be covered by collective agreements. Overall, approx. one-third of the 1.2 million employees in elderly care are covered by agreements (Schroeder et al., 2022).

Since September 2022, a new regulation has obliged employers to pay care professionals according to a collective agreement, an ecclesiastical pay guideline, or 'regional pay tariffs' (otherwise they are not entitled to a refund with the care insurance).

All interviewees identified the works council and the local employer to be the relevant actors for deciding and bargaining H&S matters. BUT: It is estimated that more than 70 to 80 % of establishments do not have works councils and fluctuation among managers is said to be high.

Italy: Providers of the social care sector and care homes can be public or private organisations. The latter provide their service to the municipalities via a tender/call for provision and can be covered by different collective agreements depending on the nature of the organisations. Some private healthcare CA agreements have been signed at the national level, but these are not signed by those recognised and representative unions (the so-called pirate CAs). There are then individual private providers that will have company-level agreements, although interviewees said that this is not always easy to obtain, especially when these are foreign-owned companies. However, specific data on private company-level CAs is not available.

The non-profit actors on the employer side negotiating CAs are UNEBA (National Union of Institutions and Initiatives of Social Care of Catholic orientation) and Agidae (Association of Management of Church-dependant Institutes) including care homes, where they employ workers. UNEBA signed a national collective agreement with all three major unions for 2017-2019 but still waiting for renewal. However, UNEBA has signed CAs at the regional level in several regions, to update pay levels with FP-CGIL and FP-CISL.

There is a widespread presence of cooperatives amongst the providers, for which there is a special national CA for cooperatives in the health and social care sectors. The CA was signed by AGCI Solidarietà, Confcooperative Federsolidarietà, and Lega Coop Sociali for the employers (the latter two organisations are affiliated with the European Social Employers). On the employee side, FP -CGIL, FPS CISL, Fisascat CISL, Uil FPL, and Uiltucs are the union organisations negotiating CAs. The latest CA renewal was signed in December 2019 and covers the years 2017-2019.

In the social care sector, there is a greater concentration of irregular workers compared to the healthcare sector. Other problems are the ‘procedural’ issues and the non-binding nature of national-level sector agreements. Given the public-private combination of care service provisions, this creates disparities in the working conditions of care workers employed by organisations of different natures.

Regarding *health and wellbeing* issues covered in CAs, collective bargaining is seen as becoming increasingly but indirectly relevant to H&S because it regulates work organisation, working time, teamwork, and allowances for unsocial hours or activities. These have an impact on the protocols that define the relationship between patients and service users in a way that is safe. The interviews with the social partners highlighted the need to ensure a more stringent

application of the sector agreements, as it makes a difference in the quality of workplace-level relations and wellbeing.

The CA of the social sector cooperatives includes the provisions for a bilateral body both at national and regional level (Comitato Misto Paritetico Nazionale e Regionale) which monitors, amongst other things, also the correct implementation of H&S legislation in the workplace.

The national CA provides for commitments by the parties to take appropriate measures and allocate sufficient funding for the prevention of psychological violence at work.

Lithuania: There is a national-level collective agreement (CA), sectoral-level CA as well as a few company-level CAs signed in the social care sector in Lithuania. The agreements cover public sector workers in the social care sector. One institution should be singled out, which the SP managed to agree on during sectoral CB: the establishment of bipartite councils at the workplace level, which is also important for addressing H&S issues. In order to foster social dialogue in companies without CAs in place, social partners at the sectoral CA agreed to establish in member companies, bipartite councils, which consider issues important for workplace-level employees (such councils also might be established in member companies with CA in place, if parties agree thereof).

The social care sector in Lithuania is one of the rare sectors for which sectoral collective agreements are in place. It should be noted that this collective agreement covers actually only the public sector and is signed by the Ministry of Social Security and Labour on employer side five sectoral trade union organisations, and one national level union - the General Trade Union of the Republic of Lithuania. The national-level CA establishes a basic salary level of the wages in the public sector, and additional rest times, and sets out the parties' obligations in the areas of prevention of psychological violence at work, H&S, and motivation of workers. The national CA provides for commitments by the parties to take appropriate measures and allocate sufficient funding for the prevention of psychological violence at work.

There is also one employer organisation, which is a member of the Federation of European Social Employers (until the end of 2022), that signed a salary increase for signatory trade union members.

Furthermore, the social partners managed to agree as part of the sectoral negotiations, the establishment of bipartite councils at the workplace level, which are important institutions for addressing H&S issues.

In the national CA, trade unions have committed to carry out at least one information campaign through their social media on workers' rights, for example on psychological violence at work; to inform the Sectoral Labour Inspectorate about ongoing or potential violations of legislation; to contribute to the containment of the COVID-19 pandemic, and to advise their members on protective measures against the coronavirus infection; and to conduct surveys of its members to find out what work-related stress-reduction measures.

Poland: Unions organising employees in NACE 87 and 88 are the Polish Trade Union Federation of Social and Social Welfare Workers (PFZPSiPS), Federation of Trade Unions of Health Care and Social Welfare Workers (FZZPOZiPS) and All-Poland Trade Union "Workers' Initiative" of Medical and Skilled Carers (OZZ IP OMIK). On the employer side, there is only one organisation relevant to the social services sector, Working Community of Associations of Social Organisations (WRZOS). This is not a social partner organisation engaging in collective bargaining, an association that is an umbrella organisation for various non-governmental social organisations, including those running nursing homes, shelters, and other non-public social welfare institutions. This organisation is affiliated to the European Federation of Social Employers.

In general, Poland is characterised by low coverage of collective agreements and almost no, except for a few examples in some industrial sectors, multi-employer agreements. There is also no practice of extending collective agreements to the whole sector. Generally, collective agreement coverage is extremely low, and only a few single collective agreements are in place in a small number of establishments. This has been confirmed by the information provided by interviewees, for whom collective bargaining is clearly not a familiar practice. They were only able to comment on this area of union activity from a certain distance, emphasising that a very small proportion of social care institutions are covered by collective agreements. A representative of the national structure of an all-Poland trade union, who is not affiliated with any of the sectors surveyed (IP8), gave a figure of 72 agreements in force nationwide in the social assistance sector, but this figure includes – in addition to nursing homes and care facilities – educational institutions (kindergartens, schools). She also stressed that the negotiations mainly focus on the issue of wages.

Furthermore, there are single-employer collective agreements – as well as a local multi-employer agreement – in several social welfare institutions in the town of Częstochowa in place. A collective agreement is in force in a local nursing home (dom pomocy społecznej,

DPS), and in non-residential institutions such as a local Municipal Social Welfare Centre (Miejski Ośrodek Pomocy Społecznej, MOPS). The agreement covers issues such as the distribution of benefits, community care, and counselling). However, the town is highly exceptional compared to the country in terms of coverage of social welfare institutions by collective agreements.

Sweden: The main employer organisation on the public side is Sveriges Kommuner och Regioner, SKR (the Swedish Association of Local Authorities and Regions, SALAR), organizing all regions and municipalities in Sweden and employing around 1,2 million persons, a large portion in hospital/healthcare and care/social assistance. There is also an employer organisation for municipal corporations, SOBONA, employing around 100,000 employees, of which some are in the hospital and social service sectors. SOBONA cooperates closely with the Swedish Association of Local Authorities and Regions (SALAR), and they try to shape a joint view on employer issues. The third large employer organisation of relevance for the sectors is Vårdföretagarna (the Association of Private Care Providers), which organises around 2000 companies employing around 100,000 employees. Besides these three, there are also employer associations organising competence agencies and non-profit employers, who also employ some in these sectors.

Just as for the hospital/healthcare sector, the main agreement (Huvudöverenskommelsen) between SALAR and the trade unions and trade union cartels cover all employees in the public sector. In addition, the Swedish Employers' Organisation for Municipal Enterprises (SOBONA) signs around 50 CAs for different areas, and a large proportion of the staff employed by private care providers in elderly care and primary/outpatient care are covered by Cas between Vårdföretagarna, the Healthcare Companies and the same trade unions and trade union cartels. These agreements are often specified for different branches such as care and treatments, and elderly care and home care, which offer similar issues as the public agreements. To a large extent, these agreements in the private sector are similar in content to the collective agreements in the public sector.

In addition, for public employees in the social/elderly care sector, the Agreement on Cooperation and Working Environment (Samverkansavtalet), from 2017, which is a special type of CA detailing the processes of employer-employee cooperation in the implementation of H&S processes, also applies.

Regarding *health and wellbeing* issues covered in CAs, besides some specifications in relation to the legal regulations of employment, wages, and leave, the main agreement includes working time conditions that are of relevance to H&S. In addition, there are requirements that the employer provides health examinations for employees performing tasks with the potential risk to health deficiencies and causing risks to others life, personal safety, or health more generally.

UK: Although the responsibility for social care resides with local councils, most of the services are outsourced to private providers and outside the control of the councils. Thus, the adult social care sector in the UK is dominated by private for-profit employers, with few very large multinational care providers and many very small care homes. In the UK, approx. 79% of care staff are employed by private sector firms; 7% by local authorities; 7% by individuals and 7% by the NHS. There are approx. 39,000 establishments providing care, split equally between residential and domiciliary care. The social care sector is characterised by high turnover and low union density.

Regarding collective bargaining, CAs are negotiated at the company level between management and trade union representatives, there is no employer organisation representing employers in negotiations. CAs are negotiated at the national-sectoral level or the group level for groups of care homes so that all care homes belonging to a specific group/employer in England, Scotland, and Wales are covered by the agreement. If a union has sole recognition, then this union negotiates with management, in the case of multiple union recognition, unions negotiate jointly with other unions. Given the fragmented structure of the sector, CAs may also be negotiated at the local level for single employers. Generally, CAs are concluded at the company level between management and unions which must be recognised by the employer, which is more likely the case by large care home providers.

In the UK, 37% work in firms with 1-4 employees, and 85% in firms with less than 50 employees (Skills for Care, 2022). Furthermore, the UK adult social care sector is characterised by very low union density and the absence of social partnership organisations on the employer side bargaining CAs. Because of the lack of social dialogue structures, an interviewee mentioned “There need to be broader national standards for the treatment of care workers and working on a partnership body for the social care sector, a similar one to that in the NHS, with national employers and the Local Government Association on behalf of councils” (Interview UK 2/social care).

Aside from establishment size, factors hampering protection via collective agreements are the non-typical forms of employment. Almost a quarter of the adult social care workforce (24%), and over half of the domiciliary care workers (54%) are employed on zero-hours contracts (Skills for Care,

2023). Although unions represent agency workers, as mentioned in interviews “we don’t generally have recognition agreements with agencies” (Interview 1 UK/social care). Usually, to be covered by a collective agreement, employees would need to be on standard contracts and employed by an organisation that recognises unions and concludes CA.

Regarding *health and wellbeing* issues covered in CA, as mentioned in an interview, “H&S is sometimes explicitly included in collective agreements, e.g., may include procedural elements such as making clear that health and safety reps should have time off that they're allowed by law” (Interview 2/UK social care).

Conclusion – Social Care Sector

Generally, the ownership structure of social care providers has an impact on collective bargaining and the availability of CAs. In Sweden and Lithuania, there is still a significant share of public-sector social care employers. In Germany and Italy, although there are private for-profit providers, most private sector providers are non-profit and church-run. While in Poland public and private for-profit social care ownership is rather balanced, the UK is the country in this study with predominately private for-profit social care providers.

Usually, CAs for public sector social care providers are negotiated at the sectoral level for federal state, region, and municipalities, while the interviews highlight that in the private sector, agreements are negotiated for groups of care providers or single employers. In Sweden CAs for public social care owners’ sectoral level, municipality levels. In Sweden, the general CA in the public sector, which covers the entire social services sector is the main agreement (Huvudöverenskommelse) between SALAR and the nine main unions organising employees within the municipal and regional areas. For the private part of the sector, there exist separate agreements between the trade unions and the various private employer associations in the sectors. These agreements are often specified for different branches such as care and treatments, elderly care, and home care, which offer similar issues as the public agreements. To a large extent, these agreements in the private sector are similar in content to the collective agreements in the public sector.

The social care sector in Lithuania is one of the rare sectors for which sectoral collective agreements are in place. There is a national-level CA, sectoral-level CA as well, and a few company-level agreements. However, this CA covers only the public sector and is signed by

the Ministry of Social Security and Labour on the employer side five sectoral trade union organisations, and one national level union for their members.

In Poland, CA coverage is generally extremely low, and only a few single collective agreements are in place in a small number of establishments. CAs such as those concluded for several social welfare institutions in the town of Częstochowa, in a local nursing home, and in non-residential institutions such as a local Municipal Social Welfare Centre.

In Germany, it is estimated that one-third of the employees are covered by CAs. The CA for public social care services at the municipality level covers only a very small part of the sector directly. However, in the case of non-profit employers, church-run establishments normally adhere to the public sector (pay) CA. For-profit employers are rarely covered by CA.

Generally, in the private for-profit sector, CAs are more likely concluded by large care home providers than the typical small private care homeowners. In the UK more than one-third of care workers work in firms with 1-4 employees, and the majority work in firms with less than 50 employees. This is of special interest for collective workplace representation (presence of H&S reps) and company-level bargaining. In small workplaces, unions are very often not present or not recognised by employers, and therefore no CAs exist. In the UK, CAs exist for big care home providers, or groups of care homes, and some individual care homes, however, details about the agreements are not available.

Another important factor influencing the protection of the workforce via CA is the employment status of care workers. For example, in the UK non-typical forms of employment are widespread in adult social care. Almost a quarter of the care workforce and over half of the domiciliary care workers are employed on zero-hours contracts. Because union recognition is voluntary, and low unionisation in the sector, unions are too weak to get hostile employers to recognise them (statutory recognition) and engage in collective bargaining.

Regarding *health and wellbeing* issues covered in CA, like the hospital sector CAs, H&S is an issue first and foremost regulated in legislation.

Conclusion Proposition 1 and 3 - Hospital and Social Care Sector

In the Health and Safety (H&S) legislation the key duties and obligations of employers, such as creating a safe work environment to ensure the safety and health of all their employees, are

set out. As the interviews revealed, the problem with H&S legislation lies less with the regulations themselves and more with the way they are interpreted. Another problem mentioned in interviews is the way H&S regulations are applied and their inconsistent enforcement. Would the involvement of social partners with their expertise and industry knowledge help make sure H&S regulations are adequately interpreted and fit for purpose? In the following, we discuss the factors enabling or hampering effective ways to address H&S in collective bargaining and CAs.

Regarding the questions asked in Proposition 1 “Are CAs effective ways to address H&S risks in the workplace”? CAs are the outcome of collective bargaining at different levels and among different actors. Aside from industrial relations actors, the ownership of hospitals and social care providers is an important factor for collective bargaining. As expected, this is less likely the case for private providers. Regarding factors affecting whether CAs are an effective way to protect workers, contextual factors characterising the two sectors tend to hamper effective collective bargaining and the governance of outcomes. An important factor in the hospital sector is whether collective agreements are concluded for all employees employed in the sector or hospitals and whether they cover the entire workforce, specific occupational groups, or union members only (Proposition 3). Especially in the social care sector, the type of employment contract and employment status can have a significant impact on how well or not employees are protected by CAs and by H&S legislation in case of flexible and precarious forms of work.

References

Destatis (2022) Krankenhäuser 2021 nach Trägern und Bundesländern. Stand 26. Oktober 2022. Available from: <https://www.destatis.de/DE/Themen/Gesellschaft-Umwelt/Gesundheit/Krankenhaeuser/Tabellen/eckzahlen-krankenhaeuser.html> [Accessed 15th March 2023].

Destatis (2023) Pflegestatistik – Ambulante und stationäre Pflegeeinrichtungen: Grunddaten, Personalbestand, Pflegebedürftige, Empfänger und Empfängerinnen von Pflegegeldleistungen. Available from: <https://www.gbe-bund.de> [Accessed 15th August 2023].

Downey E, Fokeladeh HS, Catton H. (2023) What the COVID-19 pandemic has exposed: the findings of five global health workforce professions. Geneva: World Health Organization; Human Resources for Health Observer Series No. 28. Licence: CC BY-NC-SA 3.0 IGO.

Eurofound (2020) Representativeness of the European social partner organisations: Human health sector, Sectoral social dialogue series, Dublin.

Eurofound (2022) Representativeness of the European social partner organisations: Human health sector. Updated version January 2022. Sectoral social dialogue series, Dublin.

Eurofound (2022a) Representativeness of the European social partner organisations: Local and regional government, sector and social services. Updated version January 2022. Sectoral social dialogue series, Dublin.

Fischhoff, B. (1984) Setting Standards: A Systematic Approach to Managing Public Health and Safety Risks. *Management Science*, Vol. 30, No. 7, pp. 823-843.

Gevaert, J., Van Aerden, K., De Moortel, D., & Vanroelen, C. (2021) Employment Quality as a Health Determinant: Empirical Evidence for the Waged and Self-Employed. *Work and Occupations*, 48(2), 146–183.

Kraemer, B. (2011) Germany: Industrial Relations in the Health Care Sector. EuroWORK. European Observatory of Working Life. Available from: <https://www.eurofound.europa.eu/publications/report/2011/germany-industrial-relations-in-the-health-care-sector> [Accessed 29th July 2023].

Malmberg, J. (2002) The collective agreement as an instrument for the regulation of wages and employment conditions. *Scandinavian Studies in Law*, 189–213.

Montagu, D. (2021) The Provision of private healthcare services in European countries: recent data and lessons for universal health coverage in other settings. *Frontiers in Public Health*, Vol.9, 636-750.

Muller, J., Mohamed, F.A., Masciangelo, M.C., Komakech, M., Bryant, T., Rafiq, A., Jafry, A. and Raphael, D. (2022) A bibliometric analysis of Health Promotion International content regarding unions, unionization and collective agreements. *Health Promotion International*, 37(2), p.137.

Ollé-Espluga, L., Menéndez-Fuster, M., Muntaner, C., Benach, J., Vergara-Duarte, M. and Tamin, J. (2021) COVID-19 and vulnerable workers. *Occupational Medicine*, 71(3), 161-161.

Schroeder, W., Kiepe, L. & Inkinen, S. (2022) Die Grenzen selbstorganisierten Handelns: attraktive Pflegeberufe durch Tarifautonomie? *WSI-Mitteilungen* 75 (5), 355–362.

Skills for Care (2022) The state of the adult social care sector and workforce in England, 2022. Published by Skills for Care, Leeds. Available from: <https://www.skillsforcare.org.uk/Adult-Social-Care-Workforce-Data/Workforce-intelligence/documents/State-of-the-adult-social-care-sector/The-state-of-the-adult-social-care-sector-and-workforce-2022.pdf> [Accessed 18th July 2023].

Skills for Care (2023) The workforce employed by adult social services departments in England, 2022. Workers employed by local authorities in the adult social care sector, February 2023. Available from: <https://www.skillsforcare.org.uk/Adult-Social-Care-Workforce-Data/Workforce-intelligence/documents/The-workforce-employed-by-adult-social-services-departments-England-2022-Final.pdf> [Accessed 7th August 2023].

PROPOSITION 2

M Galetto

The OSH Directive makes it compulsory for employers to take appropriate *preventive* measures to make work safer and *enables employee involvement and consultation on H&S at work*. The workplace level is of key importance in the compliance with H&S measures. In our research, we therefore wanted to probe the following proposition (proposition 2 in our proposal):

*Countries with **union** workplace health and safety representation which have close links with trade unions are expected to be able to provide better health and safety protection at work compared to countries with **non-union** employee health and safety representation only.*

We did so by interviewing social partners (union organisations and employers' associations) at the national level for the relevant sector organisations affiliated to EPSU, HOSPEEM and the European Social Employers. Interviewees involved in the sector organisations at national level were able to offer a good overview of what happens inside workplaces (hospitals and care providers) and provided useful examples and data.

Our six country case studies cover four types of H&S workplace level representation (typology based on Fulton 2018):

1. **Sweden**, the **UK** and **Poland** fall under the category of workplaces with composite structures that combine H&S reps (elected or chosen); joint employee-employer committee and H&S professionals;
2. **Lithuania** is an example of joint employee-employer H&S committee;
3. **Italy** has employee-only H&S structures, whose members are either elected by the workplace recognised unions or chosen by the workers. There is no joint committee as such, but the legislation, like in other countries, heavily regulates practices of H&S and, for example, includes that the 'Risk evaluation document' of the company has to be signed by both employer and H&S representatives;
4. In **Germany**, H&S is dealt with at workplace level through the existing representational structure (e.g. works councils, not the trade unions).

There are then differences in relation to the threshold number of employees needed to have H&S reps in the workplace, varying from a non-required minimum (Italy) to Germany's 20 (see Table 1 in the Appendix).

According to our proposition, countries falling under types 1 and 3 would be the ones expected to provide better H&S protection (Sweden, UK, Poland, and Italy) compared to groups 2 and 4 (Lithuania and Germany). Studies showed that “having trade union representation leads to better observance of the rules, lower accident rates and fewer work-related health problems” (Menéndez et al 2009). Although we have not ‘measured’ the quality of H&S protection, the data collected from the interviews show that the presence of unions is indeed an important element to ensure H&S in the workplace is well implemented, but not necessarily an exclusive indicator of better protection for workers, particularly given the increasing fragmentation of workforce and employers in the sectors. There are in fact limits within which unions can act to ensure H&S regulations are followed, which depend on factors often common across countries and that have to do with the characteristics of the healthcare and social care sectors.

Before each individual country's profile, we list below the **similarities** found in our research:

- Often, in the governance of H&S, the responsibility is shifted towards the weakest part in the system, which can be carers themselves, especially employed with precarious employment contracts, but also employers of, for example, non-profit organisations (e.g. cooperatives) which often struggle to contain costs in order to maintain their status as ‘providers’. This means that actors who are key to raise concerns and prevent risk in the workplace are not always in the ideal position to effectively report and address hazards;
- Labour shortages in healthcare and care across virtually all countries, mean that often those workers who are elected or nominated to take on the workplace level H&S representative role are not the best qualified, i.e. do not have adequate knowledge but are simply ‘available’ to do it; when there are qualified professionals willing to take on H&S reps roles, they often do not have enough time to carry out the role as effectively as needed due to their heavy workload;

- For smaller workplaces, the reliance on local/territorial representatives for H&S means that these might not have full understanding of often very different needs and risks of individual organisations;
- The private or public nature of organisations, with the different levels of unionisation and profit VS patients driven principles, can also be found to perceive H&S differently, seen as a cost or as an investment to different degrees.

Key differences are in the individual country profiles, which we now turn to for insights into their workplace level governance structures of H&S.

Sweden

In Sweden we find extensive national level primary legislation, but also joint cooperative bodies focusing on H&S. The interviews showed that employers would welcome *fewer* rules and regulations and emphasised the key role of workplace level, where the skills exist to address risks; trade union representatives, on the other hand, want *better* rules and regulations as well as increased opportunities for sanctions to promote a good working environment for their members. Nevertheless, the dialogue between the parties is generally very constructive and has been found to be effective, particularly at national and sectoral levels, while it may vary more at local level.

Generally, collective agreements are not in charge of H&S, but there are cooperation agreements (social dialogue) in place on H&S which are effective in Sweden and there is an ambition to make these work at the workplace level too.

Possible limitations have been identified in the following factors:

- Diversification of workplace structures due to regionalisation: Employers depend on regional level regulations – during the pandemic this led to confusion, as different regions issued different guidelines;

- Difficulty to recruit H&S reps: those who take on the task, do not always necessarily have adequate knowledge and skills (and time). This is further complicated by staffing levels and nurses managerial roles (with less staff, H&S is likely to be de-prioritised);
- In the care sector, dialogue and cooperative structures are less developed than in the well-established healthcare sector, but some large hospitals were also found to be struggling. They reported sometimes having to “choose” or being “forced to” pay fines rather than complying with all the needed requirements;
- On the other hand, large hospitals were also reported to have the advantage of being able to move staff around if certain units/wards are particularly struggling with staffing levels.

Unions are concerned primarily about staffing levels, as this is what makes H&S become less of a priority – staffing levels affect the capacity for staff to rest and, indirectly, to be alert to potential hazards.

United Kingdom

A key characteristic of the UK case with regards to H&S in the workplace is the room for interpretation of the relevant regulations. For example, there is no legislation on psychosocial risk, nor code of practice, but only “management standards”.

Whilst the consultation requirements apply to both the union and elected representatives (known as Representatives of Employee Safety, ROES), only union health and safety reps have the crucial right to undertake inspections. Both union-appointed safety representatives and ROES have the right to paid time off to carry out their functions, but the legislation does not specify the length of time, just “as may be reasonable in all the circumstances”. Both safety representatives and ROES have some protection against dismissal and should not suffer any detriment for carrying out their legal functions.

Not surprisingly, a key difference was highlighted between the healthcare sector – covered by public sector arrangements, e.g. the Agenda For Change collective agreement, it is more unionised,

although understaffed – and the care sector, characterised by small companies and higher rates of precarious, low paid employees, provision contracts through commissioning local authorities that make H&S perceived as a cost.

Within the healthcare sector, there is variation at the Trust level on the collaboration between managers and staff on H&S – when collaborative, these partnerships can be very effective, it was raised, but it is not always the case. At times, for example, despite H&S reps being in place some employers bring in their own H&S champions, who do not necessarily fully know the regulation and specific workplace hazards. These usually include clinical care, care processes and procedures, slips, trips and falls, manual handling, fire, chemicals, moving parts of machinery, and electricity.

Training and expertise of H&S reps was found to be a crucial difference between the two sectors. Simplifying, registered nurses will be better placed and trained on H&S than support care workers, who will have varying backgrounds and degree of preparation. Furthermore, 54% of domiciliary care workers are employed on zero-hour contracts, have high turnover rates and the training often consist of an online module at the end of which they are signed off as competent to start the work.

Trade unions have been actively pushing in the care sector for H&S to be included in the commissioning processes, arguing also in terms of importance for the quality of patients care. TUs notice that H&S discussion in this sector is alarmingly minimal, despite the wide range of workplace risks reported by care workers (violence from patients, racism and sexism, lone working, etc.).

Poland

More than in other countries, Poland's crucial source of regulation of H&S at work is national legislation. There are also *ad hoc* Ministerial Decrees issued by the Ministry of Health that covers H&S issues in the healthcare sector, less so in the social services. It is mainly at national level that other institutions related to H&S operate, such as the Health Care Team created in the context of Covid, when they also effectively collaborated with the Institute of Occupational Medicine and the Central Institute for Labour Protection.

Compared to the other case studies, there is a weaker - if at all - role of collective bargaining. The dominant level of industrial relations is the company level, where workers can be represented by independent, company or nationally affiliated unions. There are two key institutions at the workplace level for H&S:

- the Social Labour Inspectorate, which can investigate a broad range of H&S-related issues and in which local/organisational level union reps are involved;
- a H&S committee made of reps from both employees and employer must be set up and given advisory and consultative roles in large (250+) workplaces. These are said to be more like working groups than social dialogue structures.

The interviews showed that if trade union reps and labour inspectors at organisation level are prevented from carrying out effective H&S monitoring (at times employers have appealed against claims from the Social Labour Inspectorate), they refer to the State-level labour inspectorate. Given the key importance of union at the workplace level, the healthcare sector seemed better equipped than the social service one (even less unionised and less covered by CAs) in terms of workplace H&S infrastructure. The Polish healthcare and social care sectors experience dramatic staff shortages – with Polish nurses and carers leaving to some of the other countries of the research – which increases the risks at work for those remaining and having to face heavy workloads and increased burnout.

Finally, what emerged from the research is the weak enforcement of national laws at the local level, which can be attributed to the unbalance power relation between workplace actors. Employers, in particular, do not seem deterred by the existing penalties associated to negligence to H&S in the workplace.

Lithuania

Lithuanian undertakings with more than 50 employees have a Health and Safety committee, which is a bipartite institution set up at the workplace level; there are also H&S professional(s) appointed

and H&S representative(s) elected at the workplace level. In cases of accidents, a Commission for Accidents at Work can be created.

Trade unions are involved in the information work about H&S rights and obligations, working time and rest regime, and other H&S issues such as ergonomic and hygienic standards.

At national level, there are comprehensive laws and institutions dedicated to occupational H&S – lately, particular attention focused on the prevention of psychological violence at work. Such laws formally empower TUs to propose preventative measures, give them responsibility to report cases and grant them participation in the investigation of such cases. However, what emerged from the interviews is that in some workplaces there tend to be a managerialist/unilateral approach whereby works council comply without questioning what needs their formal approval, such as shifts and working time sheets.

There are formal and practical reasons for this:

- On one hand, “the chairperson of the HSC is appointed by the person representing the employer or a person authorised by the employer”, which clearly signal their interest priorities;
- On the other, the systematic, heavy workloads of most workers in both healthcare and care sectors lead to burnout and disengagement from additional work related to H&S, particularly for H&S workplace reps.

Trade unions representatives interviewed highlighted how they have someone managed to support individual workers in their disputes on workload, or in establishing limits to heavy weightlifting, but these disputes struggle to be addressed collectively.

Therefore, despite a formally strong system in place, Lithuanian workers in both sectors analysed in our research bear the consequence of a weak enforcement and monitoring system. High workload and harassment at work constitute concrete risks for workers that the law, focusing mainly on physical risks, overlooks. Furthermore, a lack of strategic, state-level attention on the care and healthcare staffing problems was raised in the interviews.

Italy

A key level of regulation of H&S in Italy is the law (specifically, the Law Decree 81/2008). Sector collective agreements can only improve what is already established by the national legislation and in the cases of healthcare and social care, the CAs tend to simply refer to the law. Collective bargaining is seen as becoming increasingly albeit indirectly relevant to H&S because it can intervene and contribute to the regulation of work organisation, working time, team-work, allowances for unsocial hours or activities. These aspects of the work organisation have an impact on the protocols that define the relationship with patients and service users in a safe way.

The law identifies key formal roles within the organisations that are responsible for H&S in the workplace (e.g. the responsible for prevention and protection; the workers' representative(s); the occupational doctor) and establishes the centrality of the "Risk evaluation document"; the duties, responsibilities and sanctions of all parties involved; the centrality of compulsory training for H&S.

What emerges from the secondary research and the interviews with the sector-relevant social partners is however a prominent gap between the wide-reaching and detailed legal and regulatory dimension of H&S and the actual implementation of such rules at the workplace level. Although workplaces do have the relevant H&S reps, two limitations seemed prominent:

1. One is that, for the law to be observed in full, there would be a need of substantial financial investments (e.g. to upgrade old hospital buildings). This brings to the fore the wide diversity of the Italian regionalised healthcare systems. Several Italian regions struggle financially and face sometimes incredibly hard choices about whether to prioritise staffing, paying overtime, buying new machineries, building maintenance (Galetto 2016);
2. More in general, interviewees pointed to a lack of a "culture of risk". This was attributed to a lack of training, as well as to the de-prioritisation of H&S. In the case of public hospitals, this was also attributed to the fact that the public labour inspectorate might be reluctant to carry out in depth investigations on other public sector organisations. In the case of social services, given the commissioning role of local authorities, H&S is often

seen as a cost that, like others, should be contained. Providers such as small cooperatives for social care often have limited scope for ensuring adequate training to carers.

An interesting ongoing development for the sector collective dialogue (not necessarily collective bargaining) is the establishing of a “Joint body for innovation” in the healthcare sector which will have the function at national level to define the so-called resourcing needs. This, it is hoped, will ensure for example the “right” and safer staff-patients ratios, which should then be consistent across regions and organisations.

GERMANY

Key elements of the German case are the occupational insurance systems and the federal structure organised in 16 Laender.

Employees are insured against occupational accidents and diseases with a statutory accident insurance fund, i. e. one of the sectoral occupational accident insurance funds (*Berufsgenossenschaften* for the private sector, *Unfallkassen* for the public sector), whose members are employers. Social partners are represented in the occupational insurance.

Like in other cases, laws on H&S are extensive, but issues emerged with regards to their full implementation. German interviewees from both sectors agree in identifying “the works councils and the local employers to be the relevant actors for deciding and bargaining H&S matters”. However, it is worth noting that less than 50% of German employees work in an establishment (with at least 5 employees) where a works council is in place¹.

H&S is much more seen as a “legal” and workplace level topic. Sectoral employer organisations therefore do not regard H&S as a topic for themselves but highlight the role of the statutory sectoral occupational insurance (*Berufsgenossenschaft*). The role of the occupational insurance was also

¹ The figure for 2021 for the private sub-sector of “health and education” show that 13% of establishments (private, with at least 5 employees) have a works councils, which means a coverage of 47 % of the employees in the sector (Ellguth and Kohout 2022).

important for trade union interviewees, which also provides guidelines and seminars on how to carry out risk assessments and on H&S-related topics where also works councilors can take part.

Two core themes emerged from the interviews about potential levers that can improve workplace H&S:

- The first is that of staffing, which can only be guaranteed with adequate financing of the healthcare system. The outsourcing of services and the increase on ambulant services, as well as on the expensive use of agency workers (which create stress for colleagues when they have to integrate them into their teams) are said to be workplace level characteristics that represent a major challenge for trade unions and workplace level H&S reps;
- Secondly, according to many, a stronger ‘culture of prevention’ should be developed to contain general physical and psychosocial risks and support ageing staff. Such a culture, e. g. using technical aids, has gained in importance also in apprenticeships. However, as apprentices are often the weakest of team members it is difficult for them to break up existing routines. Also, an existing culture of presenteeism has been mentioned, which might be helpful in the short term but normalises staff shortages and has longer term negative implications for H&S.

Conclusions

To conclude and linking back to the starting proposition:

*Countries with **union** workplace health and safety representation which have close links with trade unions are expected to be able to provide better health and safety protection at work compared to countries with **non-union** employee health and safety representation only.*

The research confirmed that indeed a link to established unions is important for the workplace level H&S protection, and this is particularly evident when comparing the healthcare sector – generally well established and more unionised – with the social care sector – less unionised,

characterised by more precarious employment and low costing approaches, even within the same country and common industrial relations systems (e.g. in particular UK, Poland, Italy).

There are other intervening factors:

- **Enforcement** of usually strong, usually national legislation and powers of monitoring bodies, are at odds with:
 - o *Regional difference (Sweden, Germany, Italy);*
 - o *Perceived over-regulation on the employers' side (Sweden, Italy)*
 - o *Light touch regulation (UK)*
- **Financial resources** (whether it is via national spending on healthcare, or local authorities commissioning of social services) can make a difference in whether H&S is approached as a priority and an investment (given the staff shortages experienced by all countries of the study) or as a cost to be minimised;
- **Training** of individual workers on H&S, at times provided in a rather light touch fashion (e.g. brief online certifications), if at all.

Everywhere, and in both sectors, adequate staffing and efficient resourcing are a key to safe workplaces. Workplace level negotiations regarding working time and staffing are increasingly relevant to H&S of the workforce, as hazards are linked to workload and priorities at work.

Appendix 1

Table 1. Typology of workplace structure H&S representation by country

Country	Main form of representation	Mode of nomination/election of reps	Threshold for representative	Threshold for committee
Germany	Works council plus joint health and safety committee and non-elected safety delegates	Works council elected; representatives on health and safety committee chosen by works council; safety delegates chosen by employer with the involvement of the works council	20	5 for works council 20 for specialist health and safety committee

Italy		Elected by employees in small companies; chosen by the union structures in larger ones. Area safety can be chosen for multiple, local small firms	None	
Lithuania	Joint health and safety committed	Elected		50
Poland	Joint health and safety committee plus health and safety representatives in union workplaces	Committee members chosen by union or elected if no union; health and safety representatives elected by workforce	Only if union	250
Sweden	Health and safety representatives and joint committee	chosen by union or elected if no union. Regional H&S for local small (<50) organisations	5	50
United Kingdom	Health and safety representatives and joint committee but if no union, safety representatives have fewer powers and there is no joint committee	Chosen by union; if no union elected, provided the employer wants to have representatives	Not specified by law	Not specified by law – but employer should set up a safety committee if formally requested by at least two H&S reps

Source: www.worker-participation.eu (<https://worker-participation.eu/National-Industrial-Relations/Across-Europe/Health-and-Safety2>)

REFERENCES

Ellguth, Peter; Kohaut, Susanne (2022). Tarifbindung und betriebliche Interessenvertretung: Ergebnisse aus dem IAB-Betriebspanel 2021. *WSI-Mitteilungen* 75 (4), 328-336.

Fulton, L. (2018) Health and safety representation in Europe. Labour Research Department and ETUI (online publication). Produced with the assistance of the Workers' Interest Group of the Advisory Committee for Safety and Health at Work (of the EU Commission). Available at: <http://www.worker-participation.eu/National-Industrial-Relations>.

Galetto, M. (2016) Organised decentralisation, uneven outcomes: employment relations in the Italian public health sector, *Industrial Relations Journal*, 48(3): 196-217.

Menéndez, M. Benach J., Vogel L., (2009) The impact of safety representatives on occupational health. A European Perspective, [Report 107](#), European Trade Union Institute.

PROPOSITION 4

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PROPOSITION 4: European sectoral social dialogue agreements are an effective way to provide EU-wide health and safety standards and workforce protection.

Social partner agreements are one of the most important outcomes of EU social dialogue. As the only one and the main agreement reached among the partners within the both analysed – health care and social care – sectors is a Framework Agreement on Prevention from Sharp Injuries in the Hospital and Health Care Sector, we will check our Proposition basing on this agreement.

The Framework Agreement on Prevention from Sharp Injuries in the Hospital and Health Care Sector was reached by social partners on 17 July, 2009 and implemented via so-called ‘needlestick directive’ – Council Directive 2010/32/EU of 10 May 2010 implementing the Framework Agreement on prevention from sharp injuries in the hospital and healthcare sector concluded by HOSPEEM and EPSU.

The purpose of the Directive is to implement the Framework Agreement so as:

- to prevent workers' injuries caused by all medical sharps (including needlesticks);
- to protect workers at risk;
- to set up an integrated approach establishing policies in risk assessment, risk prevention, training, information, awareness raising and monitoring.

Member States shall bring into force the laws, regulations and administrative provisions necessary to comply with this Directive or shall ensure that the social partners have introduced the necessary measures by agreement by 11 May 2013 at the latest. Moreover, Member States shall determine what penalties are applicable when national provisions enacted pursuant to this Directive are infringed¹.

Actually, all sectoral social partners, interviewed during our project within the hospital sector confirmed the exclusivity of this Agreement among other joint texts of sectoral social partners as well as its importance thereof.

In **Germany** during the interviews, few specific references to regulations were made. Among the most prominent the needlestick directive (2010/32/EU) was mentioned as well. It has to be noted, that this outcome of SSDC has been highlighted as a good and important one of the SSDC not only

¹ OSHA (2021). Directive 2010/32/EU – prevention from sharp injuries in the hospital and healthcare sector. European Agency for Safety and Health at Work, 18 June. Available at: <https://osha.europa.eu/en/legislation/directives/council-directive-2010-32-eu-prevention-from-sharp-injuries-in-the-hospital-and-healthcare-sector>

in the hospitals sector, but also in social care sector: “*The needlestick directive was, honestly speaking, the best and the only example of a concrete output. And it is a good one*” (Interview 6)².

German interviewees noted also the issue of awareness of EU level activities: “there are a lot of regulations to comply with at the establishment level, with various originating from EU directives and regulations – however, ‘*no one is aware of where it comes from originally*’ (Interview 4)”³.

It should be mentioned also, that interviewees in Germany stressed the issue of monitoring – the monitoring is difficult “due to organisations’ resources and the Commission should be much more supportive here, e.g. in terms of the so-called Needlestick Directive (Interviews 1, 3)”⁴.

In **Italy** interviewed social partners did not mention specifically the needlestick agreement/ directive, however in general they were rather sceptical regarding ESSD: they stressed the lack of awareness and overall knowledge on the EU level developments in the area of health and safety: “*there is neither awareness, nor knowledge about what is being done at EU level*” (Interview I6_TU2_SOCSER (TU2 x 2))⁵.

Nevertheless, social partners in Italy agree, that EU level activities are important for the whole Europe in the long-run: “*EU level activities are important in the long term, because they set a path that all members states have to follow [...]; if we look at a EU guideline or recommendation, it is clear that the effects will be visible (diluted) in the long term*” (Interview I7_EO_SOCSERV)⁶. Moreover, they also mention the fact, that “*in Italy, if there is a Directive, then Italy complies if it can't avoid it [...]*” (Interview I3_EO_HOSP)⁷.

In **Sweden** interviewed social partners also recognised the ‘needlestick directive’ as the most noticeable example, “which is remembered as an important achievement”⁸. It might be noted, that Swedish report emphasised an important aspect, to some extent relevant also for other countries: social partners, who are not directly involved in the European level dialogue know about it quite little. However, those, directly involved in the work at the European level, “believe that the European level dialogue works fine – particularly when it is committed to “the right” issues, which often are the softer ones [...]”. Swedish social partners are against “the regulatory ambitions [...] as this goes against the Swedish model of industrial relations [...]”⁹. Swedish social partners expressed also some

² HEROS Case Study Germany Hospital Sector by Sabrina Weber; HEROS Case Study Germany Social Care Sector by Sabrina Weber.

³ HEROS Case Study Germany Social Care Sector by Sabrina Weber.

⁴ HEROS Case Study Germany Hospital Sector by Sabrina Weber.

⁵ HEROS interview summary Excel form – Italy

⁶ *ibid*

⁷ *ibid*

⁸ HEROS Case Study Sweden Hospital Sector by Linda Hiltunen and Bengt Larsson.

⁹ *ibid*

'fears' regarding EU level 'hard texts': "*we are afraid of detailed regulation from the EU. [...] The fear of detailed regulation is quite high on the Nordic side. [...] there is not always a very clear structure for how we are going to bring home what we produce in Europe. If it not becomes a directive, of course*" (Interview 4 – TU)¹⁰.

However even despite such a position "there is an appreciation for the regulatory outcomes in the health and safety area, as illustrated by the "needlestick" directive [...]"¹¹. Incidentally, while welcoming the Directive in general, Swedish interviewees also mentioned that they had no information on the implementation of its provisions into the practice (e.g., Interview 8 – TU¹²).

UK report also mentions Directive 2010/32/EU which became a "part of the Health and Safety (Sharp Instruments in Healthcare) Regulations in 2013"¹³. However, there is no information to ground the Proposition within the UK interviews and the Report, as since Brexit, UK trade unions and employer organisations no longer are supposed to participate in the ESSD. On the other hand, we may consider the UK as a positive example, as even after Brexit, provisions of social partners' agreement are still in place in the UK as they were transposed into the national legislation. However, despite Brexit, the NHS employer organisation is affiliated with the European Hospital and Healthcare Employers' Association (HOSPEEM) and based on information provided in interviews participated in some ESSDC meetings.

Also, in **Poland** the interviews showed, that EU level activities is an important factor influencing national H&S regulations: "*[...] in the context of Poland, it is the European dialogue that is crucial. Any regulations that are developed in the field of H&S, either in the form of directives or regulations, are crucial. [...] this is translated into Polish regulations, and thanks to this we actually have [...] some protection, and this would never have happened if this dialogue had not existed, if these directives had not been created*" (Interview 8 – TU)¹⁴.

According to interviewed trade union representatives, directives and other [EU] legislation have a decisive impact on improving working conditions in Poland. As an important example to illustrate this thesis, the Council Directive 2010/32/EU on the prevention of sharps injuries, was mentioned in the interview. According to the interviewee, a piece of legislation transposing the Directive into the Polish legislation "has made a significant contribution to improving the safety of nurses' work".

¹⁰ HEROS interview summary Excel form – Sweden

¹¹ HEROS Case Study Sweden Hospital Sector by Linda Hiltunen and Bengt Larsson.

¹² HEROS interview summary Excel form – Sweden

¹³ HEROS Case Study UK Hospital Sector by Barbara Bechter.

¹⁴ HEROS interview summary Excel form – Poland

Moreover, the “European dialogue on H&S also stimulates dialogue and interaction between national social partners”¹⁵.

In **Lithuania**¹⁶ engagement of national sectoral actors in EU-level H&S activities is modest. The main actor implementing EU-level H&S regulations at the national level is Government (represented by the Ministry of Health). The main law, regulating H&S in Lithuania – the LHSE as well as other related legislation are transposing all main EU directives in the area of H&S. So, despite rather weak capacities of national level social partners, all mandatory provisions are transposed in the national legislation by the Government. Therefore, social partners in Lithuania, especially trade unions, traditionally emphasize the importance of imperative European regulation as in countries with weak social dialogue this ensures implementation of the European standards in the country.

During interviews importance of the Council Directive 2010/32/EU was emphasised as the one that encouraged the Government to take action and implement EU standards into the national legislation: “*Prevention of injuries with sharp instruments [...] directive and it’s implementation into Lithuanian legislation. The result – unified standards should be followed in all workplaces*” (Interview 3 – TU)¹⁷.

To summarise the information provided, several conclusions can be drawn:

1. There is a clear lack of information on ESSD activities, and its dissemination at the national level. In most of the countries analysed, there were a number of cases where national social partners were either not aware of ESSD activities at all or did not identify/associate national level developments with ESSD activities. In contrast, national social partners, who themselves are involved in various ESSD activities, were very positive about the work of the ESSD as being really important and influencing the whole EU. Closely related to the problem of information on EU level developments is another – the language barrier – issue, which makes it more difficult for national social partners to keep track of developments at EU level (this problem was mentioned by interviewees from Germany, it is also relevant for Lithuania, as well as for some other countries).
2. Actually interviews, conducted in all countries confirm, that *European sectoral social dialogue agreements are an effective way to provide EU-wide health and safety standards and workforce protection*, however only in cases, when European or national level pathways of transposition of the agreement into the national legislation/practice are foreseen/available (as in case of the Directive 2010/32/EU).

¹⁵ HEROS Case Study Poland Hospital and Social Care Sectors by Maciej Pańków.

¹⁶ HEROS Case Study Lithuania Hospital Sector by Ramunė Guobaitė and Inga Blažienė.

¹⁷ HEROS interview summary Excel form – Lithuania

3. Another point to mention, which was particularly emphasised by the social partners in Sweden and partly in some other countries (e.g., Germany), is that, despite the excellent experience with the 'needlestick directive', the national social partners (mainly – employers) are not interested in having the ESSD produce a large number of “hard” texts. Aware of the competences and importance of the EU level, national social partners want to remain both sufficiently autonomous and to negotiate issues of importance to them at the national level (instead of simply reconcile with the EU regulations). On the other hand, in countries with a poorly developed social dialogue, low union density and low collective bargaining coverage, social partners, in particular trade unions, emphasise the need for mandatory EU regulation, otherwise no EU level agreements would be implemented in countries where social partners do not have enough powers to transpose them into the national legislation/practice.
4. The issue of monitoring of implementation of the Directive seems to remain unresolved. Interviewed national social partners either raised the issue of monitoring as a problem at the national level or did not mention it at all, suggesting that the issue at the national level has been resolved (although it is likely that social partners do not have full information on the implementation of the provisions of the Directive), or that monitoring is not taking place at all, although the latter is only an assumption that would need to be verified by further research.

PROPOSITION 5

Sabrina Weber, Pforzheim University

PROPOSITION 5: *European sectoral social dialogue agreements may not be an effective way to provide health and safety protection because of the different national sectoral industrial relations systems and their capacity to implement and guarantee compliance with European sectoral social dialogue interventions.*

European sectoral social dialogue interventions can range from legally binding directives to soft tools providing guidance and examples of good practices. The fora for joint *sectoral* health and safety (H&S) policy interventions by European sectoral social partner organisations and their national member organisations are European sectoral social dialogue committees (SSDCs). In the two sectors studied here, hospital and social care, social partners have worked on various H&S-related interventions at EU level to address H&S risks and to ensure better protection of workers (Owczarek, 2023; Weber, 2023; cf. Tables 1 and 2 in the Appendix). Effective interventions ensure better quality ('fit for purpose', i.e. how well an intervention is able to protect the individual employee) and wider coverage (e.g. different type of employment status) of H&S protection.

In general, to be effective, social partner interventions developed at EU level need to consider different national institutional settings, such as the institutional setting of industrial relations. The countries investigated in this study – Germany, Italy, Lithuania, Poland, Sweden and the UK represent different systems of national industrial relations, which also vary within countries between sectors (Bechter, Brandl & Meardi, 2012; European Commission, 2013).

While Propositions 1 & 3 set out in detail the sectoral collective bargaining systems in the six countries and Proposition 2 takes a closer look at workplace H&S representation, Proposition 4 analyses the only sector-specific social partner agreement implemented through EU law so far: the framework agreement on the prevention from sharp injuries in the hospital and health care sector, which was reached by the social partners HOSPEEM and EPSU in 2009 and which was transposed into a Directive (so-called 'Needlestick Directive'; Directive 2010/32/EU). Proposition 6 focuses on 'softer' European sectoral social dialogue interventions. The aim of Proposition 5 is to complement the aforementioned Propositions. In the following, we will therefore assess country-wise the capacity to implement and guarantee compliance with European sectoral social dialogue interventions, based on the national HEROS Case Studies.

Germany

In the case of Germany, the industrial relations system implies a dual structure of employee representation through trade unions and works councils (staff councils in the public sector). Interviewees identified the works council and the local employer to be the relevant actors for deciding and bargaining H&S matters. However, the individuals interviewed from both the (sectoral) trade union and the employer organisation lack systematic data regarding works council agreements, as such data is not gathered. Both sectors studied here have a threefold structure, consisting of private, non-profit (charity/church), and public providers. This setup leads to a variety of types of regulations, such as those related to ecclesiastical labour law. In terms of industrial relations, it results in a fragmentation of the employer side. During recent decades, public provision of health care provided by hospitals has increasingly been supplemented by the private sector. In the social care sector, there are mainly private and non-profit (charity/church) providers, while the public share in elderly care is very small. The private employer organisations especially in elderly care are not interested in collective bargaining and social dialogue (see also Schroeder, Kiepe & Inkinen, 2022).

Trade union membership in the two sectors is rather low, also due to a non-union culture for historic and cultural reasons. Membership in the hospital sector is higher than in elderly care, where it is estimated at 11%. According to figures for the healthcare sector for 2012-2014, trade union membership was 20% (Conrads et al, 2016). However, also in the hospital sector, recent trends of outsourcing and ‘ambulisation’ will pose problems for the trade union to reach out to these smaller workplaces and to organize the sector. In 2018, 56% of employees and 43% of companies in the healthcare plus social services sectors were covered by collective bargaining (Eurofound, 2022). Whereas less than half (433,000) of the overall 1.2 million employees in elderly care are covered by collective agreements (Schroeder, Kiepe & Inkinen, 2022). Works council coverage is also estimated to be higher in the hospital sector than in social care / elderly care, where in the latter case it is estimated that more than 70 to 80 % of establishments do not have works councils, and fluctuation among managers is high, according to the interviewees. In 2013, 8% of establishments and 48% of the workforce in the healthcare plus social service sector were covered (Conrads et al., 2016).

When it comes to the affiliation of social partner organisations to the EU-level organisations, the trade union side (ver.di) is actively engaged in the SSDCs, but in both sectors the employer side is only partly represented. In the hospital sector, only the local public employers’ organisation is a member of HOSPEEM, and in the social care sector, once again, only one

employer organisation, which represents a part of the not-for-profit (charity) subsector, is involved. Therefore in both sectors, private employers and the church subsector are not represented within the SSDCs. Private employers are not expected to enter the European SSDC due to their missing interest in social dialogue at the national level. The question of impact of SSDC at national level was regarded important by trade union interviewees, however, monitoring is said to be difficult due to organisations' resources. Trade union interviewees therefore called for the European Commission to support, e.g. to provide implementation assessments in terms of the 'Needlestick Directive'. Overall, the impact of EU regulation is regarded rather modest, since H&S regulations are said to be already complied with. For both sectors, the 'Needlestick Directive', which is based on a social partner agreement in the SSDC Hospital, has been highlighted as a good and important EU social dialogue intervention. According to interviewees, the impact of (future) interventions from the SSDC Social Services is expected to be higher in countries where (even) less structures exist than in or where H&S is not yet implemented. The EU level has been assessed to be quite 'far away', for instance for works councils.

Thus, there is a rather mixed picture when it comes to the capacity to implement and guarantee compliance with European sectoral social dialogue interventions. On the one hand, the trade union side is quite actively engaged at EU level, on the other hand, on the employer side important shares of the sectors (e.g. private, churches) are not affiliated to the sectoral social partner organisations and are therefore not represented in the EU sectoral social dialogue committees. Furthermore, coverage of trade unions, of works councils and collective bargaining are weak, especially in the social care sector. It is rather unclear how H&S-related policy intervention from the European SSDC could 'trickle down' to works councils and local management to be implemented. The overall situation can be assumed to be less favourable in the social care than in the hospital sector. The non-profit employer organisation affiliated in the social care sector might however play a proactive role for the newly established SSDC Social Services which might positively impact the capacity to implement and guarantee compliance with European sectoral social dialogue interventions.

Italy

Workplaces in Italy are regulated by a multi-employer system of industrial relations, the main levels are the national sectoral level and the organisational level. The sector level can also 'delegate' to the company level competence to regulate on specific subjects. Social partners play an important role, both at national level, and at the organisational levels, via the RLS

(workers' representative) and RSPP (the responsible for prevention and protection). Whereas at national levels there are relatively good institutional infrastructures in place in the field of H&S. Industrial relations at the organisational level, i.e. effective cooperation between the employer and the local RLS and RSPP, are more variable. While the hospital sector is predominantly public, the social care sector is more fragmented, with public (10%), private for profit (44%), or non-profit providers such as cooperatives (46%) (Eurofound, 2020). Since the end of the 1990s, beginning of the 2000s social services such as elderly care have been outsourced from the public sector to private providers. However, also in the healthcare sector there is a development of fragmentation of the workforce with increasing presence of private sector providers or agency workers. Unions are sometimes present in religious private provider organisations, though to a lesser extent than in the public and cooperative organisations.

Collective bargaining is seen as becoming increasingly but indirectly relevant to H&S because it regulates e.g. work organisation or allowances for unsocial hours or activities. Collective agreements do not directly regulate H&S but refer to the law, and allow organisational level representatives for H&S to request adjustments if specific needs/risks arise. In social care, providers can be covered by different collective agreements depending on the nature of the organisation. Besides the national public sector collective agreement, there is a special national collective agreement for cooperatives. There are some private healthcare collective agreements at the national level, and some company-level agreements. Overall, the coverage of collective agreements is 100% for public sector organisations and ranges between 70% and 80% for private organisations in the two sectors. The latest public healthcare collective agreement relaunched a body ('Bipartite body for innovation') which should be set up in every hospital/local health authority with the aim to promote 'organisational wellbeing', i.e. it deals with subjects directly linked to H&S at the organisational level. In social care, there is a special national collective agreement for cooperatives which also includes provisions for a bilateral body both at national and regional level which monitors e.g. implementation of H&S legislation in the workplace.

The EU level of sectoral social dialogue is perceived as 'detached' from the emergency problems at the sectoral national level (e.g. under-staffing, more stringent compliance with the legislation) in both sectors. The EU level of social dialogue has been noted in the interviews as rather 'faraway' dimension that has little visibility on daily work activities. In the hospital sector, the employer side of the public healthcare sector has regularly engaged with EU-level social dialogue and is represented in the governing bodies of the EU-level sectoral employer organisation HOSPEEM. Trade unions have a more discontinuous participation in the sectoral

social dialogue at EU level. There are several unions involved in the collective bargaining of the public healthcare sector in Italy, but only two major of them (CGIL FP and FP-CISL) are affiliated to the European level sectoral trade union EPSU. In the social care sector, the employers' organisations of the cooperative sector are not fully yet involved with the EU-level sectoral social dialogue. The sectoral employers' organisation at the EU level expressed their regret regarding this matter (Weber, 2023). Private providers were outside the scope of our study, as they were unlikely to be members of national associations affiliated at the European level. Also none of the religious organisations that are providers of social care services in Italy are affiliated to the EU-level organisations. There are several unions involved in the collective bargaining of the social care sector, but only two (CGIL FP and FP-CISL) are members of EPSU and have reported only discontinuous engagement.

Thus, when it comes to the capacity to implement and guarantee compliance with European sectoral social dialogue interventions, on the one hand, there are several limitations. First, there seems to be only limited engagement on the trade union side in the two EU-level sectoral social dialogue committees (SSDCs). Second, on the employer side, this seems to be the case also for the Italian affiliates in the social care sector, representing cooperatives. In the hospital sector, the public employers' organisation is said to be much more involved at the EU level. On the other hand, the Italian system of industrial relations provides institutionalized opportunities to let EU-level sectoral social dialogue interventions 'trickle down' from the sectoral social partner level to the local level, which has been identified as the adequate level to develop tailored H&S solutions. However, interviewees mentioned scarce resources (e.g. there are wide regional financial differences), a lack of culture of risk, and a 'cost approach' to H&S as limiting factors. Employers and workers' representatives at the local level were said to often prioritise other issues (e.g. working time) than H&S.

Lithuania

The Lithuanian case is characterised by the important role of law, social partners' dialogue with political institutions and a formally strong, but practically weak framework of industrial relations and social dialogue. The most important source regulating H&S issues in both the hospital and the social care sectors remains the Law on H&S of Employees (LHSE) which provides detailed regulations. As a rule, collective agreements do not address key H&S issues or often repeat those already provided in legislation, except for (1) those provided for in the public sector Branch collective agreement of social care (2021) related to bipartite councils at the workplace level and (2) those in the public sector National collective agreement (2022)

related to trade union empowerment in solving employees' mental health issues preventively and helping victims of psychological violence, harassment and discrimination. Though there is a sectoral collective agreement in the healthcare sector for public institutions, there are little provisions regulating H&S issues in the agreement. In the company-level collective agreements in both sectors there are also little provisions regulating H&S issues or they contain provisions that mirror those of the law or higher-level collective agreements. On the employer side, party to public sector agreements are ministries – in the hospital sector the Ministry of Health, and in the social care sector the Ministry of Social Security and Labour.

In both the hospital and the social care sectors, the regular workplace H&S representation applies. Undertakings with more than 50 employees are obliged to have a bipartite occupational H&S Committee (HSC) set up at the workplace level. According to interviews with social partners, in undertakings with active trade unions, representation of employees' interests at the HSC is quite solid. Trade unions also inform employees about relevant H&S issues. Trade union interviewees noted that there are workplaces where work councils represent the rights and interests of employees and perform it rather formally. According to the State Labour Inspectorate, in 2020 work councils were active in only 44% of the workplaces where they should be unless a trade union is in place. In the social care sector, during sectoral collective bargaining, the parties agreed on the establishment of bipartite councils at the workplace level. These councils are not only important for addressing H&S issues but also ensuring compliance with collective agreements.

It can be concluded that there is no interaction among different level actors on H&S issues in collective agreements. This lack of interaction may be due to the peculiarities of employer representation in the two sectors, where the two ministries or both signatories of the collective agreements and at the same time (co-)fundors or, in the case of social care, indirect employers of a number of institutions in the sector. To sum up, the national legislation is characterised by its stringent and comprehensive nature. On a formal level, there exists a full set of channels dedicated to upholding workplace H&S. However, in reality, the overall quality of the measures is perceived to be rather poor by social partners, particularly trade unions. For instance, according to trade unions, it is common to have a formally established and functioning bipartite HSC at the workplace level, but in practice all decisions are taken unilaterally by the employer side. Another reason for this lack of involvement is heavy workloads of employees which deter them from engagement at the workplace level. Furthermore, union busting can be observed.

Engagement of national sectoral actors in EU-level H&S activities is modest. There are some employer organisations in the hospital sector, but actually with minor interest in collective bargaining and social dialogue, whereas trade unions' capacities (including human resources) for active participation in EU-level H&S activities are quite limited. Although, in general, trade unions are represented in the two SSDCs, their capacities in the area of H&S are insufficient to participate effectively. In social care, there is also one employer organisation – Association 'Rūpeštinga Globa' – affiliated to the EU-level sectoral employer organisation Social Employers. However, they are not active members thereof. In the hospital sector, trade union interviewees identified the Council Directive 2010/32/EU as important for those working within the sector. The Directive implemented the Framework Agreement on the prevention from sharp injuries in the hospital and healthcare sector, which had been reached by the EU-level social partners in the SSDC in the hospital sector, HOSPEEM and EPSU, in 2009. In that context, it is worth noting that the Labour Code envisions the option to extend the scope of application of national and/or sectoral collective agreements. This formal provision could potentially serve as a legal instrument for transposing EU Directives. However, this option has never been used.

The capacity to implement and guarantee compliance with European sectoral social dialogue interventions can therefore be assessed to be relatively limited. Affiliation to and involvement in the social dialogue activities at EU level are missing or weak. Accordingly, awareness of EU-level developments in SSDCs is modest. In the country, the system of industrial relations has been assessed by interviewees to be rather 'artificial', and social dialogue is said to often exist only formally because of weak trade unions and inactive employees, among other reasons. Due to the strong role of the state and the fact that social partner organisations are generally quite weak (i.e. in terms of sufficient human resources to deal specifically with H&S issues), social partner involvement in developments on H&S is rather low. If that situation does not change, the Government will remain the only actor in the area of transposition of EU-level H&S interventions.

Poland

Poland is characterised by low coverage of collective agreements, the dominant level being the company level. There is no practice of extending collective agreements. Negotiations focus mainly on wages and the field of H&S is generally regulated by law. Collective agreement coverage in the two sectors of this study is 2% for the healthcare sector and 1% for the social care sector (Eurofound, 2022). In the two sectors, a significant number of general and

professional trade unions are present, while the number of employer organisations is very limited. For the healthcare sector, it is estimated that two of the trade unions cover 17% of employees (Eurofound, 2022), which is a high number compared to other sectors in the country. For both sectors, the common law regulates exhaustively H&S. However, the social care sector has less detailed and exhaustive H&S regulation. The social care sector is also said to be characterised by an even greater deficit in terms of compliance. One of the factors for effective enforcement in workplaces is the presence of trade unions, which is often not the case in social care. At the company level, the primary actor representing employees is the company-level trade union organisation. It can also form organisational units within large, nationwide unitary unions which can then represent sectors in regional or national tripartite structures. Works councils have an additional consultative and informative role but rarely exist.

Institutions in the field of H&S exist mainly at the workplace level. Trade union interviewees attached great importance to the Social Labour Inspectorate (SIP), which is only in place when there is a company trade union organisation. However, they also noted adverse employer behaviour which (self-)restricts effectiveness of the SIP. In workplaces with at least 250 employees an advisory/consultative H&S committee must be set up. Thus, this body is typically present in larger hospitals but lacks effectiveness within the social care sector, where establishments are considerably smaller. Interaction occurs between the different levels of the H&S system. Trade union structures at the different levels liaise, and trade unions support SIPs e.g. with training. Intervention in case of H&S violations is mainly possible where trade union organisations – and therefore a SIP – are present at the company level. Moreover, in case of H&S violations, trade union interviewees assessed fines and sanctions by the State Labour Inspectorate inadequate and assume underreporting by employees because of non-anonymous reporting channels. The framework conditions of the two sectors, such as public underfunding, staff shortages and an ageing workforce, add to H&S challenges.

There are two trade unions affiliated to the sectoral European trade union federation EPSU, the largest unitary trade union (NSZZ ‘Solidarność’), and a professional union (FZZPOZiPS). On the employer side, WRZOS is relevant for the social care sector and affiliated to the EU-level employer organisation Social Employers. WRZOS is formally not an employer organisation, but an association for social organisations running e.g. non-public nursing homes. Some interviewees were able to refer to the EU level, including not only the two SSDCs, but also various other (often tripartite) consultative bodies and EU agencies. A major emphasis was on EU law, which might be linked to the fact that trade unions are involved in relevant sectoral bodies and tripartite bodies at the national level when implementing EU law. The interviews

showed that EU legislation is an important factor influencing the quality of national H&S regulations. Reference to existing social dialogue interventions have been made to the cross-sectoral Autonomous Framework agreement on workplace-related stress, implemented by ministerial regulation. In addition, the issue of harassment and violence in the workplace was mentioned – here, ‘soft’ anti-mobbing policies have been developed by the trade union. Furthermore, reference has been made to one intervention stemming from the SSDC Hospital: Council Directive 2010/32/EU implementing the Framework agreement on the prevention from sharp injuries (‘Needlestick Agreement’) concluded by HOSPEEM and EPSU, which has also been implemented through a ministerial regulation. The ‘Needlestick Directive’ has been assessed to having made a significant contribution to improving the safety of nurses’ work. It has to be noted that there is no possibility to transpose European social partners’ framework agreements through sectoral social partner agreements, due to the lack of sectoral bargaining or extensions practices.

The capacity to implement and guarantee compliance with European sectoral social dialogue interventions can therefore be assessed to be rather limited. While on the trade unions side, there are affiliations to the European sectoral trade union EPSU for both sectors, the employers’ side only has one affiliate to the European sectoral employer organisation in the SSDC Social Services. At the national level, that affiliate is formally not even an employer organisation. Awareness of social partner of SSDCs and social dialogue interventions was relatively limited. However, the ‘Needlestick Directive’ has been highlighted, albeit more in the general context of EU legislation that helped to improve national legislation. It was stressed that EU legislation has a positive impact on national legislation, helping to improve workers’ safety. For the national context, interviewees noted that effective implementation of H&S regulations can only be ensured by legal acts plus adequate enforcement procedures, whereas ‘soft’ guidelines do not offer prospect for proper implementation. Given the strong role of state actors and law, along with the rather weak situation of social partners particularly at sectoral level in the country, the capacity to implement and guarantee compliance with the European sectoral social dialogue interventions seems to be rather limited to state actors, and to ‘hard’ interventions such as Framework agreements implemented via Council decision.

Sweden

The Swedish industrial relations system is characterised by strong social partners, extensive collective bargaining with wide coverage and a high degree of autonomy from the state. The main bargaining level is the sectoral level. Local collective agreements can adjust or

supplement sectoral agreements. It is important to note that for the two sectors studied here, hospitals and social/elderly care, there is no sectoral division, i.e. the same employer associations and trade unions organise both sectors. In terms of collective agreements, the so-called Main agreement between employer organisation SALAR and nine main unions covers the public part. For the private part, similar agreements are in force. These 'regular' collective agreements are not mainly oriented on issues of H&S, as legal regulation of H&S is strong and cannot be set aside by collective bargaining. However, there are separate agreements, joint organisations and committees important for H&S. The so-called Cooperation agreement details forms and levels for cooperation on H&S issues locally, and supplements legal regulations or existing local collective agreements. The Letter of intent for healthy workplaces for the municipal sector aims at finding constructive and effective solutions for future workplace H&S. In terms of joint social partner organisations, there is one for the public part (Healthy Working Life), and one for the private sector part (Prevent). These organisations strive to render H&S-related knowledge both accessible and useful, by information, training, and the development of tools. In the public part there is also a social partner arena (Welfare Work Environment Council) which aims to support prevention at the local level through collaboration.

The general concept used to address H&S issues in Sweden is the local 'working environment'. There are local elected employee H&S representatives, often trade union members. In larger companies with at least 50 employees or in cases where employees request it, there is also a safety committee. Trade unions can appoint a regional safety representative to cover smaller workplaces. Interviewees shared the view of a well-developed and functioning structure for H&S, and all respondents agreed with the main principle, i.e. the local workplace as a starting point. According to the interviews, the dialogue between social partners is generally very constructive and works well at the higher levels, while it may vary more at local levels. Interviewees also highlighted the importance of their cooperation at sectoral and national levels. The national level is to create knowledge initiatives, materials and advice to be used at the local level workplaces. Interviewees further agreed that in the two sectors H&S challenges mainly relate to the lack of staff and skills, with the situation in social/elderly care sector being more difficult.

Swedish social partners are well affiliated to the EU-level organisations. The public employer organisations and trade unions in the two sectors are directly or indirectly involved in sectoral social dialogue at EU level. SALAR is affiliated to both HOSPEEM, the EU sectoral employer organisation of the SSDC Hospital, and to CEMR, which will be part of the newly established SSDC Social Services. Also SOBONA is a member of CEMR. All three trade unions in the

sectors are members of EPSU, the European sectoral trade union is involved in both SSDCs. The Swedish Association of Health Professionals and Kommunal actively take part in SSDCs. In the private sector, there is more of a distance to EU-level issues, as their connection to European level organisations and dialogue is only indirect, through their peak level umbrella organization. It could be observed that social partner representatives, who are not directly involved in SSDC, have little knowledge about SSDC activities and effects and relevance at national level. This might be due to the fact that implementation or discussions of SSDC outcomes get so integrated into the regular Swedish regulations and agreements that the EU-level origin is not obvious. The most noticeable exception being the ‘Needlestick Directive’, which is remembered as an important achievement. Representatives directly involved in SSDC are very committed and emphasise its importance and well-functioning – particularly when it is committed to ‘the right’ issues, which often are the ‘softer’ ones besides H&S. Social partners appreciate information sharing and mutual support, but are against regulations, particularly the employer side, as this could ‘violate’ the Swedish industrial relations system. Though, there is an appreciation for the regulatory outcomes in H&S, e.g. the ‘Needlestick Directive’. There is also a recognition of positive effects of SSDC on national-level cooperation, as a consequence of the preparatory work done jointly between trade unions, as well as between trade unions and employers.

The capacity to implement and guarantee compliance with European sectoral social dialogue interventions can be assessed to be rather strong in Sweden. Swedish social partners are well affiliated to the EU-level social partner organisations, and some representatives are committedly involved in SSDC work. In connection to that, there is prework between trade unions and between trade unions and employers. This mirrors the strong cooperative approach between employers and trade unions in the country at various levels. In the field of H&S, there is also a strong ambition from both trade unions and employer associations to work actively with the implementation of rules and regulations and there is much agreement about the general approaches to H&S. Joint social partner organisations make relevant knowledge investments and develop concrete tools. Both ‘hard’ (such as the ‘Needlestick Directive’) and ‘softer’ EU-level social dialogue interventions can therefore in principle be implemented and complied with through the country’s well-developed H&S framework.

United Kingdom

In the UK, the hospital sector and the social care sector differ markedly, with the former publicly funded with relatively well established industrial relations structures and the latter

largely privatised with very weak industrial relations structures. Whilst the health and social care sector is the second most unionised sector in the UK, according to interviewees membership is concentrated in the NHS hospital sector rather than the largely privatised care sector. In the UK, trade unions recognised by the employer have the right to appoint workplace H&S representatives. Recognition depends upon the number of trade union members within the workplace and the employers' willingness to negotiate. While NHS employers and trade unions work in partnership, in the private sector and especially in the elderly care sector which is characterised by small employers, union workplace representation is often missing. Where there is no recognised trade union, the employer should consult employees either directly or through elected safety representatives. A safety committee should be set up if an employer receives a written request from at least two safety representatives.

All NHS hospital staff, apart from doctors, dentists, and very senior managers are covered by a collective agreement that covers the terms and conditions of employment and includes several specific references to H&S legislation. However, NHS pay is nationally decided based on independent NHS Pay Review Bodies. On the employer side, the NHS Employers organisation leads the national collective relationship with the unions. Sectoral actors include a number of recognized trade unions by NHS Hospital Trusts, acting professional unions, and more general trade unions such as Unison and Unite the Union. The NHS Staff Council is a tri-partite body able to negotiate any changes in core conditions. This body and a special working group within the NHS Staff Council develop and update workplace H&S standards that are used by the various NHS Trusts to develop their H&S Policy. Consequently, these vary across the UK. NHS hospital Trusts have a H&S committee, and according to both employers and trade union interviewees, most NHS hospitals to have elected union representatives upon it.

Unlike the publicly funded NHS hospital sector, there is no collective agreement for private sector care workers. Employment terms and conditions and H&S regulations are set out in the employment contract. There is a collective agreement covering local authority-employed care staff (approx. 7% of care workers) but no information on further collective agreements in this sector, as any collective agreements made are concluded between an employer and recognised trade unions at the workplace and establishment level. There are several organisations representing employers, none of which work as a collective employer's body. Key trade unions in this sector include Unison, Unite, and GMB. Trade unions estimate union density at approx. 20%, concentrated in larger private firms and those still employed by local authorities. For the social care sector, there is little evidence of interaction between the national government, employers, and trade unions, although trade unions reported good relationships with local

authorities and some large private firms. Several trade union interviewees questioned if there was effective H&S in the care workforce.

Since Brexit, UK trade unions no longer participate in EU-level sectoral social dialogue committees (SSDCs). However, UK unions such as Unison, RCN, RCM, GMB, and Unite the Union are still affiliated with and engaged in EPSU, and one of the elected EPSU Vice Presidents for the current Congress period is from Unison. On the employer side, in the hospital sector, the NHS employer organisation is affiliated with the EU-level sectoral employer organisation of the SSDC in the hospital sector, HOSPEEM. Despite Brexit, the NHS employer organisation also participated in some SSDC meetings and activities. In the social care sector, employers' organisations are not represented in any EU-level employer associations. During the interviews, trade unions that are affiliated with EPSU mentioned cleaning fluids as a topic of interest with sector-wide regulations needed to protect staff health, especially for non-nursing staff e.g. porters, and health-care assistants. In the social care case study, general trade unions showed interest in the 'EU sharps' directive, i.e. Directive 2010/32/EU which implemented the Framework agreement on the prevention from sharp injuries concluded by the social partners HOSPEEM and EPSU within the SSDC in the hospital sector.

Theoretically, the capacity to implement and guarantee compliance with European sectoral social dialogue interventions can be assessed to be stronger for the hospital sector than for the social care sector. In the latter case, there is no affiliation with EU-level organisations on the employer side. Furthermore, structures in the sector and interactions between the different levels are considerably more present and established in the hospital sector than in the social care sector. In practice, since Brexit implementation of and compliance with European sectoral social dialogue interventions is no longer at stake for the UK. However, as trade unions and NHS employers are still involved in the European social partner organisations, issues and discussions on that level may inform activities of UK trade unions and employers in the country. Exchange with EU partner organisations may also be fruitful in terms of multinational aspects e.g. of care delivery.

Conclusion

Based on the analysis of twelve sector case studies in six countries we can assume a mixed capacity to implement and guarantee compliance with European sectoral social dialogue interventions. Speaking generally, to date the capacity can be assessed to be higher for the hospital than the social care sector. This is related to weaker affiliation or engagement of social partners at the sectoral EU level, which mirrors the situation of weaker or non-existent social

partner structures in the social/elderly care sector in many of the countries. Furthermore, the interaction between several levels within the countries is of major importance in the context of implementing and complying with European sectoral social dialogue interventions in the field of H&S. Proposition 7 analyses the coordination between levels in more in detail.

Appendix

Table 1: Joint texts of the SSDC Hospital.

Title	Date	Type of Text
Updated Framework of Action on Recruitment and Retention in the Hospital Sector	31/05/2022	Framework of actions
HOSPEEM-EPSU Solidarity message with Ukraine employers and trade unions	11/03/2022	Joint opinion
Sectoral Social Dialogue Committee for the Hospital Sector on EU-OSHA Campaign 2020-22 Healthy Workplaces Lighten the Load	12/10/2020	Declaration
HOSPEEM-EPSU position in view of the European Commission study supporting the assessment of different options concerning the protection of workers from exposure to hazardous medicinal products	24/09/2020	Joint opinion
Final report – follow-up on the Directive 2010/32/EU on the prevention from sharps injuries in the hospital and healthcare sector	13/02/2019	Follow-up report
10-year anniversary of the EPSU-HOSPEEM Code of Conduct on Ethical Cross Border Recruitment and Retention in the Hospital Sector	09/04/2018	Joint opinion
Joint declaration on Continuing Professional Development (CPD) and life-long learning (LLL) for all Health workers in the EU	08/11/2016	Declaration

Framework of Actions on Recruitment and Retention – Follow-up report	15/02/2016	Follow-up report
Guidelines and examples of good practice to address the challenges of an ageing workforce	04/12/2013	Tool
Promotion and Support of Implementation of Directive 2010/32/EU on the prevention of sharps injuries in the hospital and health care sector	15/11/2013	Follow-up report
Use and implementation of the EPSU-HOSPEEM Code of Conduct on Ethical Cross-Border Recruitment and Retention in the Hospital Sector	05/09/2012	Joint opinion
Joint Statement on the Action Plan for the EU Health Workforce	05/09/2012	Guidelines
EPSU-HOSPEEM response to the European Commission’s green paper on reviewing the directive on the recognition of professional qualifications 2005/36/EC	20/09/2011	Joint opinion
‘Riga Declaration’ on Strengthening Social Dialogue in the Healthcare Sector in the Baltic Countries	26/05/2011	Declaration
EPSU - HOSPEEM contribution to public consultation on the Directive on the Recognition of Professional Qualifications (2005/36/EC)	23/03/2011	Joint opinion
Recruitment and Retention – A Framework of Actions	17/12/2010	Framework of actions
Framework Agreement on Prevention from Sharp Injuries in the Hospital and Health Care Sector	17/07/2009	Agreement Council decision
EPSU- HOSPEEM code of conduct and follow up on Ethical Cross-Border - Recruitment and Retention in the Hospital Sector	07/04/2008	Guidelines

Joint Declaration of HOSPEEM and EPSU on Health Services in the EU	13/12/2007	Declaration
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Joint texts in bold address the field of H&S, according to the European Commission’s database. Source: European Commission’s social dialogue texts database. Available from: <https://ec.europa.eu/social/main.jsp?catId=521&langId=en> [Accessed 15th August 2023].

Table 2: Joint texts of the (informal) EU social dialogue in social services, 2019–2022.

2022
The Social Employers and EPSU joint statement on the situation in Ukraine
Joint press release: A big step towards a European sectoral social dialogue committee for social services
Joint Declaration of the Social Services Social Partners. European Care Strategy: strong social dialogue in social services needed
2021
Joint Position Paper on the forthcoming European Care Strategy
Joint statement: The importance of developing social dialogue in the Social Economy
2020
Joint position paper preparing the social services sector for the COVID-19 resurgence and increasing resilience
Joint position paper on recruitment and retention in European social services
Joint letter to Commissioner Schmit calling for action to tackle the lack of protective equipment for some of the most exposed workers: the 11 million social services workers all across Europe
Joint statement on COVID-19 outbreak – The impact on social services and needed support measures
2019

Joint letter to Ms Thyssen on social dialogue – Building social dialogue for the social services sector: Time to move to the next level!

Joint position paper on digitalisation in social services: Assessment of opportunities and challenges

Joint texts in bold address (also) H&S. Own compilation based on social partners' websites.
Source: Weber, 2023.

References

Bechter, B., Brandl, B. & Meardi, G. (2012) Sectors or countries? Typologies and levels of analysis in comparative industrial relations. *European Journal of Industrial Relations*, 18(3), 185–202.

Conrads, R., Holler, M., Kistler, E., Kühn, D. & Schneider, D. (2016) *Branchenanalyse Gesundheits- und Sozialwesen*. Working Paper Forschungsförderung No 5, January 2016. Hans Boeckler Foundation.

Eurofound (2020) *Long-term care workforce: employment and working conditions*. Dublin, Eurofound.

Eurofound (2022) *Representativeness of the European social partner organisations: human health sector*. Sectoral social dialogue series. Dublin, Eurofound.

European Commission (2013) *Industrial relations in Europe 2012*. Luxembourg, Publications Office of the European Union, 23–66.

Owczarek, D (2023). *HEROS EU-level case study hospital sector*.

Schroeder, W., Kiepe, L. & Inkinen, S. (2022) Die Grenzen selbstorganisierten Handelns: attraktive Pflegeberufe durch Tarifautonomie? *WSI-Mitteilungen* 75 (5), 355–362.

Weber, S. (2023). *HEROS EU-level case study social services sector*.

PROPOSITION 6

M. Pańków

Proposition:

European sectoral social dialogue interventions such as soft texts, guidelines and tools may be an effective way to protect workers in countries with union health and safety representatives. In countries with non-union health and safety workplace representation, effective protection depends on employer support.

The presence of trade unions in the workplace and their active role in working to protect workers' interests is one of the key factors influencing the quality of workplaces, decent employment conditions as well as the health and safety sphere. Different models of trade union presence and involvement in the workplace have taken shape in various countries, and their role in the H&S area varies. The following analysis adopts the positioning of trade union representation in the structure of the institutional framework ensuring respect and enforcement of workers' safety standards as a potentially influential factor in the proper functioning of this sphere, as described in the literature (cf. Proposition 2, where Menéndez et al 2009 is cited). One important aspect should be the effectiveness of the implementation of certain good practices, guidelines and other “soft” texts as a vital complement to “hard legislation”, assuming that trade unionists present in the workplace will be the guarantor of respecting them by employers. This can have a positive impact on the whole sphere of H&S, allowing a more flexible application of safety standards while taking into account the specificities of workplaces in a given sector or even a specific workplace. In this way, the achievements of European social dialogue can be implemented in a simpler, more flexible, less costly and more effective way in specific venues and contexts. The only condition is that the social partners are there, ready to conduct the dialogue and respect its results.

For the countries studied in the HEROS project, there are four different types of H&S workplace representation, as already shown in the description of Proposition 2. In general, for Italy, Poland, Sweden and the UK, there is a type of representation that explicitly takes into account the role of the trade union in H&S mechanisms in the workplace. The situation is different in Lithuania,

where the regulations do not mention directly trade unionists as actors present in joint occupational health and safety committees; However, in practice – as representatives of the employees – they are often part of committees. In Germany, there are no workplace trade union organisations and the role of social dialogue bodies is performed by works councils. From this it could be concluded that in the first four countries "soft" texts should be more effectively implemented and respected in the workplace, while in the other two this mechanism may work less effectively.

However, important caveats need to be made at this point to guard against jumping to conclusions (which will ultimately be based on the views of the interviewed social partners). Various other circumstances and rules governing the social dialogue may affect the functioning of the workplace health and safety representation. For example, the German system includes the presence of works councils in the workplace, but they are strongly supported by sectoral trade unions e.g. with training and advice. Therefore, the employee side has strong support from large, thriving multi-enterprise organisations. On the other hand, the example of Poland shows that even a well-constructed H&S representation may not function properly if the level of unionisation is low, and thus - employees' representatives responsible for the analysed sphere will not be present in many workplaces because there are simply no trade unions there.

Additionally, other, more specific circumstances may affect the potential for implementing "soft" texts at the workplace level. These include, for example, the extent to which the general law leaves the details of the functioning of H&S representation and the bodies dealing with this sphere to the negotiations of the social partners in the workplace. Another possible factor in the effectiveness of the implementation of "soft" guidelines may be the detailed rules for the functioning of H&S representation, e.g. employment thresholds above which it must be appointed or the scale of involvement of trade unions in it (for instance, as a rule, in Italy, in companies with less than 15 employees, union H&S representatives are provided externally; typically there are no H&S committees in Lithuania in companies with less than 50 employees).

Germany

In Germany, trade unions are not directly responsible for workers' representation in the H&S sphere. Works councils or staff councils (in the public sector) are responsible for this area. These are social dialogue bodies that can be created in entities employing at least five people. However, in small entities, a works council is often missing. The number of members of the council is legally linked to the size of employment. It should be remembered, however, that the councils have strong support from sectoral trade unions and a significant number of trade unionists (depending on the sector, they account for 3/5 to 4/5 of the councils' members [ETUI]). In addition, in organisations employing at least 20 people, safety delegates are appointed by the employer and joint H&S committees should be established, consisting of an employer's representative, two representatives of the works council, an occupational physician, a safety specialist and the aforementioned safety delegates. With regard to works councils, they have broad competences in the field of H&S, including among others ensuring safety measures, preventing accidents, conducting inspections or post-accident analysis. According to EU-OSHA research, compared to other countries, the coverage of H&S representation is high – in 2014 it amounted to 72% of workplaces, while 25% of establishments had an H&S joint committee.

Despite this positive data, HEROS interviewees were mostly sceptical of the concept of “soft” texts as a way to implement the ESSD H&S standards. Although there was also an opposing voice, talking about the benefits of soft guidelines (more room for adaptation to the national context), the prevailing belief was that both clear and precise regulations and specific sanctions for non-compliance with H&S standards were needed. Interviewees pointed to a “hard” social dialogue outcome, the so called needlestick agreement which has been transposed into a Directive, as an example that led to effective protection. This outcome of the European social dialogue in the hospital sector has impacts for the social services sector/elderly care as well.

Italy

In Italy, there is also health and safety employee representation linked to trade unions. H&S representatives are elected directly by employees in the smallest entities, however, when employing 15 or more employees, they can also be appointed by the trade union. In addition,

there are area H&S representatives who support employees in small businesses that do not have their own internal H&S representatives. H&S representatives' function is regulated by the law. In general, the H&S representation has extensive powers to implement measures to protect employee safety, prevent risks and accidents, or make recommendations to improve occupational safety. It is also to have access to a range of company information and documentation related to the safety of employees, including e.g. assessment of occupational risks and preventive measures, the use of harmful substances, the equipment used or accidents at work. There are no joint H&S bodies, but annual meetings of the H&S representation with the employing party are held. According to EU-OSHA data, Italy is characterised by the highest degree of workplace coverage by H&S representation, reaching 87% in 2014 (ETUI).

Among the interviewees of the HEROS project, there were voices suggesting a positive attitude towards regulations through collective bargaining, which may be an argument in favour of the thesis on the effectiveness of the implementation of "soft" texts. On the other hand, there was also a voice saying that it is collective bargaining at the national level that gives employees measurable benefits, while guidelines and recommendations from the EU level may have a positive impact on working conditions, at best, in the long term but is then blurred. Very limited or even absent awareness among social partners about what is on the ESSD agenda was also pointed out, or it was stated that the H&S sphere is not discussed at the EU level in relation to the sectors under study. In general, therefore, it should be stated that there is some scepticism about the potential of implementing "soft" outcomes of the ESSD among the Italian social partners.

Lithuania

In Lithuania, there is a legal obligation of employers to establish joint H&S committees in companies with 50 or more employees. There must be at least one employee representative from each shift, although the number of staff representatives may be greater if both parties so agree. Also, a number of other details of the functioning of the committees might be negotiated by the social partners separately for each workplace. In organisations with fewer than 50 employees, a committee may also be established if requested by the employer, employee representation (e.g. trade unions) or at least half of the staff. In addition, unions or, in their absence, works councils –

represent the interests of employees also in relation to the H&S field. However, it should be remembered that Lithuania is a country with a low level of both unionisation and collective bargaining coverage. This is not conducive to the actual implementation of H&S standards, especially as the mechanisms for enforcing the law are also failing.

The functions of employee representatives in committees include, among others: participation in the appointment of employees responsible for first aid or evacuation, equipping employees with protective equipment such as work clothes or accident analysis. They can also recommend specific precautions as needed and participate in occupational risk assessments.

Interviewed representatives of trade unions were sceptical about the possibility of effective implementation and enforcement of "soft" recommendations. In general, as in Poland, the sphere of OSH is regulated almost exclusively by legislation, so that workers' representatives expect above all the results of the European social dialogue to be implemented in it. Trade unions often have limited human resources and even if they participate in various ESD activities, later on as a rule, the information is not explicitly provided or/and soft law, as a result of ESD, is not implemented on their initiative in cooperation with branch level and especially with the company level unions. Another problem is the already mentioned low level of trade union membership and the lack of sufficient capabilities and means to implement recommendations that are not binding legal acts.

Poland

Poland is a country where there is a workplace health and safety representation closely linked to trade unions. This is the Social Labour Inspectorate, which is an employee-led social service that aims to ensure safe and healthy working conditions in the workplace and to protect employees' rights as defined by labour law. It is headed by the company trade union organisations and has broad powers, including:

- inspecting the premises and equipment of the workplace,
- making recommendations to the employer regarding H&S field,

- participating in the post-accident team and determining, together with the occupational H&S officer, the causes and circumstances of the occupational accident

In the event of an imminent threat to the safety of workers, the social labour inspector may order the immediate elimination of the threat and, if this order is not complied with, the suspension of the technical equipment in question or specific works. The employer may appeal against the decision of the social labour inspector to the State Labour Inspectorate. At the same time, persons performing the function of social labour inspector are protected from dismissal during the period of performance of this function and for some time after its discontinuation.

Despite the wide powers and legal protection, the interviewees pointed to a number of problems encountered by social inspectors, including various forms of veiled discrimination in retaliation by the employer. At the same time, due to low union density, social labour inspection does not exist in many workplaces, and compliance with H&S standards is the only responsibility of the employer.

Almost all interviewees in the HEROS project strongly prefer "hard" legislation and do not believe in the effectiveness of "soft" texts. The main problems are the lack of diligence of employers and unreliable mechanisms for enforcing standards (often even those enshrined in legislation), which is associated with deep structural problems of the analysed sectors, such as underfunding, staff shortages, aging staff or a tendency to exceed working time standards.

Sweden

In Sweden, the obligation to appoint staff representatives for H&S already applies to entities with five employees. Importantly, as a rule, these so called "environmental representatives" are appointed by the trade union and have wide-ranging powers, including the ability to stop work if a risk to the health or life of workers is identified. Health and safety representatives are tasked with monitoring workplaces for safety and compliance with statutory standards, in areas including, but not limited to, injury prevention, risk assessment and remediation, or ensuring a safe and healthy working environment. They can be appointed even in entities with fewer than

five employees, if the situation so requires. Joint health and safety committees are established in organisations with 50 or more employees, but they can also be established in smaller entities at the request of employees. EU-OSHA research has shown the high incidence of H&S representation and its significant impact on working conditions compared to other EU countries, despite some gaps in certain areas of the labour market (etui).

Despite widespread and well-functioning trade union representation on H&S, interviewees in the HEROS project remained sceptical about the effectiveness of the implementation of the soft texts produced by European social dialogue. Paradoxically, this is because the level of functioning of the studied sphere in this country is so high that the guidelines prove unnecessary - Swedish workers already enjoy the standards they bring since legislation and nationally produced agreements and texts such as guidelines and tools often set the bar even higher. Additionally, an interviewee suggested that it is not always clear how the European guidelines would be implemented. He prefers 'hard' legislative acts, such as directives, which bring a clearer implementation path. Despite these reservations, the Swedish H&S and industrial relations system seems to be a particularly good environment for the implementation of any non-mandatory regulatory solutions, as indicated by a national expert in the report in the HEROS project about the high involvement of social partners in the implementation of guidelines and recommendations at the local level.

United Kingdom

The UK also has trade union representation for H&S, although where there is no union in the workplace, it is not the employer's responsibility to appoint staff representatives. Instead, staff can be consulted directly. Unions recognised by employers have the right to appoint safety reps. Detailed organisational issues, such as the number of them in the workplace, are not provided for by common law but are left to be agreed between the two parties. There are, however, some recommendations as to how the number of representatives should be determined based on the employment characteristics of the establishment. The tasks of the representatives include, among others: analysing occupational accidents, assessing risks and hazards, investigating workers' complaints in the H&S sphere, carrying out inspections on a quarterly basis and in the event of

more serious safety incidents, participating in meetings of joint H&S committees, which the trade union may request to be established.

According to EU-OSHA data, the UK performs well above the EU average in terms of the extent of employee H&S representation: it was present in 70% of workplaces in 2014, and 27% had H&S committees (ETUI). Research from 2017 suggests that these figures may be even more favourable (ibid).

It should be borne in mind that the UK is no longer a member of the European Union and therefore, in principle, the results of the European Social Dialogue are not implemented in the sectors studied in the country. Admittedly, some room for this remains due to the continued participation of UK social partners in European sectoral social dialogue (without voting rights) and membership in HOSPEEM and EPSU. For example, according to interviews, a representative of the NHS employers (a member of HOSPEEM) still participates in ESSDC meetings, representing the UK employer's perspective of problems which are then discussed. Thus, it is possible to imagine the implementation of precisely “soft” recommendations influenced by the will of the trade unions, while “hard” acts of EU law are the ones that no longer apply. In the researcher's opinion, “soft” texts are not excessively valued by social partners. The health sector is generally considered to be over-regulated, so there is a tendency to implement, at most, the general recommendations of the social partners, while taking care to adapt them to the local context and the needs of specific hospitals. A contributing factor to the effectiveness of the implementation of soft texts is the presence of large employers and the coverage of hospitals by NHS standards. The situation is different in social services, where there is a significant dispersion of employers and zero-hours contracts or self-employment predominate. Workers can therefore only rely on the protection of common law, which in itself also does not guarantee that all H&S standards are respected.

Conclusions

It should be noted that the study conducted in six countries under the HEROS project does not allow to clearly confirm the theoretical proposition according to which ESSD interventions such as soft texts, guidelines and tools may be an effective way to protect workers in countries with

union health and safety representatives while in countries with non-union health and safety workplace representation effective protection depends on employer support. Apart from the limited sample of countries and the lack of significant differences in the influence of trade unions on employee representation in the field of H&S (practically everywhere this influence is present to a certain extent), and finally the only qualitative research techniques used, the findings from the interviews themselves do not give a clear picture. It can probably be pointed out that the mere presence of the trade union representation of H&S is not enough to talk about the effective implementation of "soft" recommendations as a real supplement to "hard" legal acts. Other aspects of the national industrial relations system must also function properly, and there must be a truly developed culture of social dialogue. This is clearly visible on the example of Poland, where there is a potentially well-structured and effective H&S representation in the form of social labor inspection in the opinion of the majority of interviewees. But other pieces of the puzzle are failing, ranging from faulty enforcement mechanisms, to severe structural problems that drive employers to lower H&S standards, to low union density that leaves many workplaces without inspection at all. As a country where the space for the implementation of "soft" texts really exists, Sweden can be considered as having an effective and harmonious system of collective labour relations.

It seems that a circumstance that is particularly conducive to the implementation of guidelines and recommendations of European social partners may be not so much trade union representation for H&S in the workplace, but a common and well-developed system of collective bargaining, under which recommendations from the EU can be transposed in the form of company or sectoral law. However, this is beyond the scope of the current proposal and should be a subject of a separate analysis.

REFERENCES

ETUI (undated). National Industrial Relations Country profiles. Available from: www.worker-participation.eu/National-Industrial-Relations/Countries [accessed 19 July 2023].

Fulton, L. (2018) Health and safety representation in Europe. Labour Research Department and ETUI (online publication). Produced with the assistance of the Workers' Interest Group of the

Advisory Committee for Safety and Health at Work (of the EU Commission). Available at: <http://www.worker-participation.eu/National-Industrial-Relations>
Menéndez, M. Benach J., Vogel L., (2009) The impact of safety representatives on occupational health. A European Perspective, [Report 107](#), European Trade Union Institute

PROPOSITION 7

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In the following, we analyse the importance of policy coordination in relation to isolated policy interventions against the background of the Covid-19 crisis. Before presenting the background and the details from the six country cases, let us first recap the proposition:

PROPOSITION 7: The Covid-19 pandemic highlighted the importance of greater national and European level policy coordination. Isolated policy interventions at the national and the European sectoral level are less effective ways to protect workers' health and safety compared to coordinated interventions between levels.

As discussed in the HEROS literary review, the hospitals and social care sectors were at the front in not only battling, but also in being exposed to the Covid-19 pandemic. The Covid-19 crisis did not only add new health and safety risks – physical as well as psychosocial – in the two sectors. It also highlighted existing and long-term problems, such as understaffing and a lack of equipment as well as insufficient health and safety knowledge and practices locally – the latter particularly being a problem at smaller workplaces and in home care. To some extent, the acute problems related to the pandemic also had some negative consequences, by making other Health and safety issues fall into the background during the crisis.

As regards the long-term problems of understaffing, a lack of equipment and health and safety knowledge, and other organisational and resource related deficiencies, the crisis indicated the need for more policy coordination between levels, both between the national and the European and between the intranational levels hierarchically, as well as horizontally between organisations and workplaces in the countries studied. Besides policy coordination, the crisis highlighted the need for continuous sharing and coordination of knowledge and information as well as recommendations and good practices in all countries studied. As Health and safety issues mainly are regulated by law in all six countries studied, the main problem, however, does not seem to have been in the area of policy coordination, but rather in the level of implementation of policies in local workplaces.

Germany

In Germany, Health and safety issues are by tradition seen more as legal and workplace related issues (that is handled by works councils, or staff councils in the public sphere), than as collective bargaining related. Recently, there are, however, some developments in which health and safety-connected issues are handled in collective agreements, particularly additional leave for regeneration. The situation created by the Covid-19 Pandemic highlighted already discussed long-term problems of working conditions in both the hospital and the social care sectors, related to staff shortages and an increase of parttime work, ambulant services, and outsourcing. In the hospital sector, trade unions came to fear that the pandemic would have lasting consequences the involvement of works councils in the health and safety work. The reason was that the acute situation during the pandemic increased the need for quick decisions, which managements often took unilaterally, without involving works councils. In the social care sector, any such problems added to a situation in which many employees already were without representation in local works councils because of the large proportion of small workplaces.

As regards coordination, Germany has a complex dual multilevel structure, in which the federal state level is supplemented by the regional (Laender) structure, as well as by the occupational insurance associations – where the social partners are represented and work jointly to improve the health and safety system. Employee representation exist both through sectoral trade unions and local work councils, however the existence of a non-union culture, especially in the social services /elderly care sector, can make it difficult for trade unions to organize members. In addition, for both sectors, a lack of a culture of prevention in Health and safety has been observed by our interviewees. There is thus a lot of coordination needed – and going on – in the area of health and safety, and there is a long way from the EU-level initiatives in health and safety to trickle down to local level workplaces. A trade union interviewee noted that it could be helpful to show the very practical evidence of the EU-level at the local level, such as safe needles to raise positive awareness for EU-level initiatives, particularly that the so called Needlestick directive ((2010/32/EU), was based on joint social partner dialogue resulting in a framework agreement. It seems from the interviews that the Covid-19 crisis increased the awareness of the need of further coordination between social partners and levels.

Italy:

In Italy, the Covid-19 pandemic highlighted a lack for resources and health and safety culture in both the hospital and the social care sector. The lack of protective equipment was a prominent

sign of this, but also staffing and overtime issues, as well as deficiencies in the infrastructure to adapt to the emergency situations exacerbated the risks during the pandemic. Health and safety aspects of work are regulated primarily by law in Italy, however, the acute situation during the Pandemic led to the signing of several joint protocols by the social partners. Even though guidelines are primarily the responsibility of the state, the partners thereby cooperated in the developing of such guidelines regarding the use of equipment, social distancing, staff testing, interregional collaboration, etc. These protocols also adapted some centrally developed principles to the different situations in workplaces of various sizes and areas of operation. In addition, the post pandemic collective agreement in the hospitals and healthcare sector from 2022 relaunched bipartite bodies for innovation, to be set up in every organisation with the aim to promote organisational wellbeing and prevent burnout, occupational diseases, training needs etc. The tackling of the pandemic situation also relied on a collaboration and networking in sharing resources, information, and solutions between organisations, beyond the regional boundaries (e.g. staff of hospitals specialised in infectious diseases contributed their expertise at the national level and with other general hospitals heavily affected by Covid).

Coordination between actors and levels nationally was thus important, and even increased, in Italy during the crisis. The European level of social dialogue seemed, however, according to the interviews rather detached from the local situation and work with health and safety. Concerns have also been raised by some unions' interviewees regarding the involvement (or lack thereof) in the use of the Next generation EU's Resilience and Recovery plan funds, of which Italy is a major receiver.

Lithuania

Health and safety issues are principally regulated by law in Lithuania, and there is also a tripartite national Occupational Health and safety Commission. As in the other countries collective agreements play a rather minor role for health and safety arrangements. The Covid-19 pandemic made it obvious that there was a lack of both protective measures and control mechanisms following up on the observance of safety instructions, and the situation of heavy workload, staffing shortage and psychosocial risks were acutely highlighted. As compared to other sectors, trade unions are rather active in both the hospitals and the social care sector, also in helping to find solutions to health and safety issues. However, there is no coordination between levels around health and safety, and trade union are said to be not adequately active in such issues. The weak coordination between levels is also noticeable in relation to European

level social dialogue, because of weak organisation and lacking resources – even though trade unions formally partake.

Poland

Health and safety is mainly regulated by law in Poland, with many specific lower-level provisions for the hospitals sector, but none in the social care sector. Collective agreements are scarce and collective bargaining and works councils play practically no role for health and safety issues – though the Social Labour Inspectorate is closely connected to trade unions, but such workplace representation through which local social dialogue or trade union consultation may take place is only present in trade union organised workplaces. This means that health and safety issues are not coordinated at the sectoral level. Though, at national level there are tripartite bodies in which health and safety issues can be addressed. During the Covid-19 crisis, the national tripartite Social Dialogue Council (RDS) formed an ad-hoc Health Care Team, which set up a working group that developed recommendations regarding protection equipment for staff, in cooperation with national medical expert institutions. Even though some coordination thus exists, and also in the form of social labour inspector training, there is generally a lack of interaction and coordination between levels in health and safety issues. As regards the EU-level, trade unions are involved in the process of implementing EU-directives, but as implementation is to be done at local workplaces the actual effectiveness of such regulation is described as often being minimal or superficial – particularly initiatives of a “soft” character. In addition, the knowledge about European Social Dialogue is rather weak.

Sweden:

Legal regulation in the area of Health and safety is strong in Sweden, prescribing that the employer is not only responsible for the working environment, but also for collaborating with the employees to achieve a good work environment. Health and safety representation is provided through local safety representatives, and in larger organizations also through safety committees. Effective health and safety management at the local level requires employers and employees to have sufficient knowledge, and this is generally thought to be the case in Sweden, but there are exceptions, and the Covid-19 pandemic also revealed some broader problems in this area. As in other countries, the pandemic highlighted problems with understaffing, and a high number of short time, intermittent, and temporary workers – the latter particularly in the social care sector. In both sectors there was also a lack of protective equipment and knowledge about health and safety issues among employees.

As for coordination, besides the regular health and safety work both employer organizations and trade unions produced information and recommendations to support their members, during the covid crisis, as did the joint social partner organisations Prevent and Suntarbetsliv (Healthy Working Life). In addition, the partners negotiated a specific crisis agreement to solve short time staffing and working time issues, which supplemented the existing “Cooperation agreement”, and the “Letter of intent for healthy workplaces”, which both specifies ambitions and routines in relation to law and provisions. However, during the pandemic, employers found it very challenging to comply with health and safety regulations. Still, the partners tried to use and even supplement existing cooperation structures and processes to handle the most acute problems.

United Kingdom

Health and safety is mainly regulated by law in the UK, and inspections are performed by the state authority HSE. Regarding workplace health and safety representation, the unions are the ones appointing local health and safety representatives, who also perform inspections, though their recognition depends on the employers’ willingness to negotiate. In the hospital sector, health and safety issues are discussed by the Staff Council, a tripartite body responsible for pay and terms and conditions of employment in NHS hospitals. The second layer is the Social Partnership Forum (SPF), which has to do with general policies and how they impact upon staff working in the NHS. More specific policies are discussed in partnership with sub-groups. The workforce issues group focuses on e.g., health, wellbeing, staffing, etc., and the violence reduction group on harassment and stress. The national SPF works closely with regional forums and working groups. In the last year that partnership has come under strain because trade unions have been in dispute with the government about pay. “Although that has put some strain, I do think the fundamentals are sound and there is a genuine desire to work together [...] and whilst the government's politics aren't naturally pro-trade union” (Interview 10). Besides this, collective bargaining plays only a marginal role in relation to health and safety issues.

The Covid-19 crisis highlighted problems with understaffing and infrastructural deficiencies, such as bad ventilation in buildings, and in the long run also a Covid fatigue effect was noticed. As an effect of the Covid crisis, health and safety issues were recognized to a higher degree than before the crisis, both by staff and employers, and initiatives were taken both by the government, trade unions, and HR-departments in larger organisations, running information

campaigns and producing guidelines to raise the awareness. Similar structures coordinating terms and conditions of employment as in the hospital sector, including policies on worker health and wellbeing are missing in the social care sector. In this way although the interaction between the social partners and the government increased, there is generally a lack of coordination between actors and levels. Although NHS Employer and NHS Unions are still members of HOSPEEM and EPSU, because of Brexit, no actual coordination of policies between the European level and national social partner organisations has been reported in interviews.

Conclusion

Even though general and overarching policy coordination is to be preferred to isolated interventions, there may be deficiencies related to the former, but also benefits relating to the latter. As the formal legal structures are rather adequate in all countries, policy coordination aimed at hard regulation does not seem to be the major deficiency – though, coordination around regulations in specific areas might be needed from some countries, say for instance psychosocial risks. Many of the health and safety problems accentuated by the Covid-19 crisis in the two sectors related rather to the lack of preparedness and an inadequate implementation of established principles and rules in local practices, as well as a lack of resources and staff. Therefore, there is need for further coordination of information, recommendations, guidelines, and best practices both between countries and levels within countries, to increase implementation of existing rules as well as good practices and a strong health and safety culture. There seems to be less of a lack of instruments such as rules, guidelines and recommendations, than a lack of coordination in the sharing of them, and in how to improve knowledge and usage of them locally. Of course, in the end the usage of such softer instruments has to do with resources and priorities by the management at the local workplace level, but a greater general awareness and access to such health and safety strengthening instruments would make it harder to deprioritize locally. At the most general level, this relates to strengthen a joint European health and safety culture, that supplements the legal regulations.

In addition, from the interviews it seems that the covid-crisis forced the actors to also shape new ad-hoc fora and cooperation structures or improvising in using existing structures in new ways to find solutions between social partners at different levels and solve some of the acute problems. Thus, even though the covid-crisis was a heavy burden in the sectors and increased health and safety risks for employees, there are also a number of our interviewees who say that

they managed to work outside of and improve the existing cooperation structures and processes to handle acute problems. Some of them state that this work in many instances was truly constructive, and that there are lessons to be learned from these processes. As they found such cooperation fruitful, they think it would be unfortunate if such improvised cooperation structures would get lost after crisis committees and the similar are shut down and the health and safety work returns to old established structures and routines.

SUMMARY & CONCLUSION

In the following, we summarise the coordination of H&S issues (e.g., policies, guidelines, good practice) in six countries and two sectors characterised by different institutional and contextual settings but whose workforce is exposed to similar H&S risks. Tables 2 and 3 highlight the links between industrial relations systems, respectively (i) employer fragmentation and H&S workplace representations, and (ii) health policy coordination practices at the national and the European level in Sectoral Social Dialogue Committees (SSDCs). Employers have the duty to ensure the safety of their workforce; therefore, we focus on trade unions and their role in coordinating H&S policies within unions between levels (central, sectoral, and workplace level) and between unions, thereby contributing to healthy and safe workplaces.

Table 2: Comparison of H&S policy actors and intervention structures for the hospital sector in six countries. Focus on trade unions representing healthcare workers.

	Hospital Sector					
	Prevalent type of ownership	Workplace H&S representation	H&S coordination <u>within</u> trade unions between levels, regions	Coordination <u>between</u> trade unions on H&S issues	Unions affiliated with EPSU	Participation in ESSDC
DE	Private	Work council	Weak	No/no evidence	Yes (2)	Regular
IT	Public & private	Union	Weak	Yes	Yes (2)	Irregular
LT	Public	Union	Weak	Yes	Yes (1)	Rarely
PL	Public & private	Union	Weak	No	Yes (2)	Rarely
SE	Public	Union	Strong	Yes	Yes (3)	Regular
UK	Public	Union	Strong	Yes	Yes (6)	No since Brexit

Source: Information collected in interviews and/or provided by country experts. Own compilation.

The coordination of H&S policies and interventions within social partner organisations and between levels varies between countries and within countries between sectors. In the case of the hospital sector (Table 2), coordination within countries is relatively weak in countries characterised by fragmented employer organisations (i.e., representing public and private for-profit and non-profit employers). Coordination is strong in Sweden and the UK, countries characterised by public ownership and union workplace representation (including union H&S

reps). The hospital sector in Lithuania is characterised by predominant public ownership and robust social dialogue. Regarding the coordination of H&S policies between unions in Italy, Sweden, and the UK, trade unions tend to coordinate H&S issues. Still, there is no evidence of the coordination of H&S issues in Germany and Poland. In Lithuania, there seems to be a policy exchange at the national/sectoral level and weak coordination between the sectoral and workplace levels. In all countries studied, unions are affiliated with EPSU. However, participation in SSDCs varies significantly between countries. Union representatives from Germany and Sweden regularly participated, colleagues in Italy irregularly, and Lithuania and Poland rarely. Since Brexit in 2022, unions from the UK no longer participate in SSDC meetings.

Table 3: Comparison of H&S policy actors and H&S intervention structures for the social care sector (elderly care) in six countries. Focus on trade unions representing healthcare workers.

	Social Care Sector					
	Prevalent type of ownership	Workplace H&S representation	H&S coordination <u>within</u> trade unions between levels, regions	Coordination <u>between</u> trade unions on H&S issues	Unions affiliated with EPSU	Participation in ESSDC
DE	Non-profit (almost balanced non-profit and for-profit)	Work council (not present in all eligible establishments)	Weak	No/no evidence	Yes (1)	(Regular ¹)
IT	Balanced public & private	Union	Weak	Yes	Yes (2)	(Irregular)
LT	Public	Union	Weak	Yes	Yes (2)	(rarely)
PL	Balanced public & private	Union	Weak	No	Yes (1)	(rarely)
SE	Public	Union	Strong	Yes	Yes (3)	No
UK	Private for-profit	Union (rarely, recognised)	Weak - absent	No/no evidence	Yes (3)	No

Source: Information collected in interviews and/or provided by country experts. Own compilation.

The social care (particularly elderly care) sector (Table 3) is characterised by even more fragmented employer structures and the greater importance of the private sector. This affects

¹ Goal to participate regularly, but not yet proven since SSDC Social Services was officially established only in July 2023

the coordination of H&S policies and practices within and between trade unions. Countries in which elderly care is still predominately provided by public employers are Lithuania and Sweden. Like the hospital sector, in the case of the prevalence of public employers, the coordination of H&S issues between levels and unions is strong in Sweden and exists in Lithuania between sectoral and workplace levels. Generally, the more important private sector employers are in the elderly care sector, the lower the union presence and the weaker the coordination of H&S issues within and between unions. Regarding European level coordination, the SSDC for Social Services was officially established in July 2023. According to the interviews, Germany is the country in our study that regularly participated in the ‘informal’ SSDC, and representatives from Italy, Lithuania, and Poland have engaged until now to a lesser extent.

To conclude, interviewees confirmed that (and this applies to the six countries and two sectors) there is no lack of H&S policies, guidance, and good practices. What is often missing is an H&S culture, awareness among managers, and the implementation and enforcement of H&S at work. Furthermore, interviewees mentioned that too many H&S-related regulations are in place. This includes H&S legislation, interrelated policies such as wellbeing and mental health programmes, and patient safety legislation. Generally, the development and implementation of these different H&S policies and regulations are not coordinated. Furthermore, different actors are involved, union and non-union actors representing different groups and interests at the workplace level. Despite good intentions, H&S policies and regulations can lead to over-regulation.

The COVID-19 pandemic highlighted the importance of national and European policy coordination to protect and promote H&S in the workplace. However, our study shows that the capacity to coordinate H&S policies - legislation and guidelines and good practice - within and between trade unions varies between sectors and across countries. This project generated new insight into the role of trade unions and the coordination of policies between levels for good H&S outcomes at work. Strong coordination between levels and actors is likely in sectors and countries with trade union presence at national/sectoral and workplace levels. In the absence of union actors and linkages at different levels, H&S matters are in the employers/managers' hands. In addition, this project points out the importance of investigating different staff and patient H&S campaigns to identify synergies and opportunities to coordinate policies to improve H&S protection.

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Appendix

Table 1: Summary of interviews for the HEROS Project in 2022 (majority of interviews) and 2023.

#	Interview	Organisation	Sector(s)
Country level			
1	DE-1	Trade union	Social services + Hospital sectors
2	DE-2	Employer organisation	Hospital sector
3	DE-3	Trade union	Hospital sector
4	DE-4	Trade union	Social services sector
5	DE-5	Trade union	Hospital sector
6	DE-6	Employer organisation	Social services sector
7	DE-7	Occupational accident insurance	Social services + Hospital sectors
8	IT-1	Employer organisation	Social services sector
9	IT-2	Labour inspectorate	Social services + Hospital sectors
10	IT-3	Employer organisation	Hospital sector
11	IT-4	Employer organisation	Social services sector
12	IT-5	Trade union	Hospital sector
13	IT-6	Trade union	Social services sector
14	IT-7	Employer organisation	Social services sector
15	IT-8	Trade union	Hospital sector
16	IT-9	Trade union	Hospital sector
17	LT-1	Employer organisation	Social services sector
18	LT-2	Trade union	Social services sector
19	LT-3	Trade union	Hospital sector
20	LT-4	Trade union	Hospital sector
21	LT-5	Trade union	Hospital sector
22	LT-6	Trade union	Hospital sector
23	LT-7	Ministry (acting employer)	Social services sector

24	LT-8	Trade union	Social services sector
25	PL-1	Professional organisation	Social services + Hospital sectors
26	PL-2	Trade union	Social services + Hospital sectors
27	PL-3	Trade union	Hospital sector
28	PL-4	Trade union (intersectoral)	Social services + Hospital sectors
29	PL-5	Trade union	Social services + Hospital sectors
30	PL-6	Trade union	Social services sector
31	PL-7	Trade union	Social services sector
32	PL-8	Trade union	Social services + Hospital sectors
33	PL-9	Trade union	Social services sector
34	PL-10	Employer organisation	Social services sector
35	SE-1	Employer organisation	Social services + Hospital sectors
36	SE-2	Employer organisation	Social services + Hospital sectors
37	SE-3	Trade union	Social services + Hospital sectors
38	SE-4	Trade union	Social services + Hospital sectors
39	SE-5	Trade union	Social services + Hospital sectors
40	SE-6	Employer organisation	Social services + Hospital sectors
41	SE-7	Trade union	Social services + Hospital sectors
42	SE-8*	Trade union	Social services + Hospital sectors
43	SE-9**	Employer organisation	Social services + Hospital sectors
44	UK-1	Trade union	Social services sector
45	UK-2	Trade union	Social services sector
46	UK-3	Employer association	Social services sector
47	UK-4	Trade union	Hospital sector
48	UK-5	Trade union	Hospital sector
49	UK-6	Trade union	Hospital sector
50	UK-7	Trade union	Social services sector
51	UK-8	Social Partnership Forum (representing employer side)	Hospital sector
52	UK-9	Trade union	Hospital sector

53	UK-10	Employer organisation	Hospital
54	UK-11	Local authority (acting employer)	Social services + Hospital sectors
EU level			
55	EU-1	Trade union	Social services sector
56	EU-2	EU-OSHA	Social services + Hospital sectors
57	EU-3	Employer organisation	Social services sector
58	EU-4	Sector expert	Social services sector
59	EU-5	European Commission (DG EMPL)	Social services + Hospital sectors
60	EU-6	Trade union	Social services sector
61	EU-7	Trade union	Hospital sector
62	EU-8	Employer organisation	Hospital sector
63	EU-9	European Commission (DG EMPL)	Hospital sector
64	EU-10	Trade union (cross-sectoral level)	Social services + Hospital sectors
65	EU-11	European Commission (DG EMPL)	Social services + Hospital sectors
66	EU-12	EU-OSHA	Hospital sector

Source: Own compilation.

* Secondary analysis of an interview conducted in 2017 (organisation not available for an interview in 2022).

** Secondary analysis of an interview conducted in 2019 (organisation not available for an interview in 2022).

Table 4a: Interview guideline (topics and main guiding questions) - national level interviews.

Part A. Introduction

Topic 1. interviewee & organisation - background, role, experience, membership, H&S

- 1.1 Could you please briefly introduce yourself and your role in [the SP organisation]?
- 1.2 Could you please describe [the SP organisation] in terms of: (membership, H&S policy)
- 1.3 What is your definition of “Health & Safety”, which aspects does it include in the sector [HOSP/SOCSERV]? What are key elements to deal with/to manage H&S?

Part B. National level (industrial relations, H&S)

Topic 2. National industrial relations system in the sector (general and H&S)

- 2.1 Could you please describe the general state of the industrial relations/employment relations system in [HOSP/SOCSERV]?
- 2.2 Let’s move to the topic H&S in the sector [HOSP/SOCSERV]. How is H&S addressed and regulated in the sector?
- 2.3 Overall: How do you assess the functioning of the IR/ER system and the regulation of H&S in the sector?

Topic 3. Workplace representation (general in the sector and H&S)

- 3.1 Let’s take a closer look at the level of the workplace. Could you please describe how workplace representation looks like in the sector?
- 3.2 What about H&S implementation (and control) at the workplace? How does it look like in the sector?
- 3.3 Overall: How do you assess the functioning workplace H&S implementation in the sector?

Part C. European level (ESSD, H&S)

Topic 4. European level ESSD: awareness, importance, use/implementation

- 4.1 Let’s now move to the European level in the sector. [SP organisation] is a member of [EU SP organisation], and there is an ESSD (SSDC/informal social dialogue) with [counter EU SP organisation]. Could you describe the role of ESSD for [SP organisation]?
- 4.2 Let’s now take a closer look at concrete activities of the SSDC/informal social dialogue. What is the overall importance of ESSD activities? Which ones would you say are most important? Why?
- 4.3. Overall: What is your assessment of ESSD and its activities and outcomes?

Topic 5. European level regulation of H&S at work

- 5.1 Let’s now take a broader view on European level regulation of H&S at work. In general, there are ‘soft’ regulations, e. g. guidelines, and ‘hard’ regulations, e. g. legally binding regulations, EU directives:
What are preferred forms of regulation for [SP organisation] and why?

What examples of H&S issues could result in a 'hard' or a 'soft' ESSD activity/outcome?
Why?

Which factors do you think promote 'soft' European H&S regulations in the workplace?

Which factors do you think promote 'hard' H&S regulations, such EU law (directives)?

5.2 Overall: What is your assessment of the different types of regulations at EU level, how well are they able to protect employees?

Part D. National and European level(s) and sectors (coordination)

Topic 6. H&S coordination - between national and EU level, and between the two sectors

6.1 Finally, let's talk about H&S coordination between the national and the EU level, and between sectors:

Could you give examples of coordination/exchange that took/take place between the national sector and ESSD?

Could you give examples of coordination that took/take place between the sectors HOSP and SOCSERV?

6.2 What is your general assessment: Which factors hamper, which factors foster greater coordination/exchange?

Part E. Conclusion

Topic 7. Sum up, AOB

7.1 To sum up: What are the most important issues to tackle in the sector/in terms of H&S, and how should they best be tackled?

7.2 Are there any other topics or aspects you would like to add?

Source: Own compilation. Note: The basic interview guideline was used in a flexible manner to adapt to the interviewed person and has been adopted in accordance with the interviewee's background (e. g. social partner representative, other actor).

Table 4b: Interview guideline (topics and main guiding questions) - European level interviews.

Part A. Introduction

Topic 1. interviewee & organisation - background, role, experience, membership, H&S

1.1 Could you please briefly introduce yourself and your role in [the SP organisation]?

1.2 Could you please describe [the SP organisation] in terms of: (membership, H&S policy)

1.3 What is your definition of “Health & Safety”, which aspects does it include in the sector [HOSP/SOCSERV]? What are key elements to deal with/to manage H&S?

Part B. European Sectoral Social Dialogue (industrial relations, H&S, Commission)

Topic 2. European Sectoral Social Dialogue (ESSD) in the sector (general and H&S)

2.1 Could you please describe the general state of ESSD in [HOSP/SOCSERV]?

2.2 Let’s move to the topic H&S in ESSD in the sector [HOSP/SOCSERV]. How is H&S addressed in ESSD in the sector?

2.3 Overall:

How do you assess a) the functioning of the ESSD as a process to develop outcomes?

How do you assess b) the functioning of the outcomes/activities, e. g. of the topic H&S in ESSD in the sector?

Topic 3: Role of the European Commission for ESSD and H&S

Let’s now take a look at the European Commission:

3.1 What is the role of the Commission for ESSD in the sector?

3.2 How does the ESSD in the sector address/approach the Commission?

3.3 How do you assess the Commission’s role for ESSD?

Part C. European level and national members (ESSD, H&S)

Topic 4. EU level ESSD & national members: awareness, importance, use/implementation

4.1 Let’s now move to the members of [EU SP organisation]. Could you describe what role the ESSD has for [EU SP organisation]’s members?

4.2 Let’s now take a closer look at concrete activities of the SSDC/informal social dialogue. What is the overall importance of ESSD activities for members? Which ones would you say are most important for them? Why?

4.3 Let’s take a closer look at the H&S-related ESSD activities. Which ones would you say cover aspects of H&S?

4.4 Overall: What is your assessment of the ‘use’ of ESSD and its activities and outcomes by [EU SP organisation]’s members?

Topic 5. European level regulation of H&S at work

5.1 Let's now take a broader view on European level regulation of H&S at work. In general, there are 'soft' regulations, e. g. guidelines, and 'hard' regulations, e. g. legally binding regulations, EU directives:

What are preferred forms of regulation for [EU SP organisation] and why?

What examples of H&S issues could result in a 'hard' or a 'soft' ESSD activity/outcome? Why?

Which factors do you think promote 'soft' European H&S regulations?

Which factors do you think promote 'hard' H&S regulations, such EU law (directives)?

5.2 Overall: What is your assessment of the different types of regulations at EU level, how well are they able to protect employees?

Part D. National and European level(s) and sectors (coordination)

Topic 6. H&S coordination - between national and EU level, and between the two sectors

6.1 Finally, let's talk about H&S coordination between the national and the EU level, and between sectors:

Could you give examples of coordination/exchange that took/take place between the ESSD and the national sector?

Could you give examples of coordination that took/take place between the sectors HOSP and SOCSERV?

6.2 What is your general assessment: Which factors hamper, which factors foster greater coordination/exchange?

Part E. Conclusion

Topic 7. Sum up, AOB

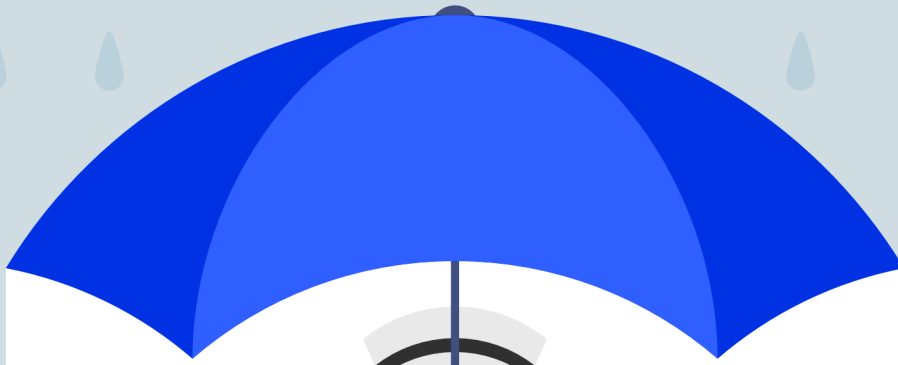
7.1 To sum up: What are the most important issues to tackle in the sector/in terms of H&S, and how should they best be tackled?

7.2 Are there any other topics or aspects you would like to add?

Source: Own compilation. Note: The basic interview guideline was used in a flexible manner to adapt to the interviewed person and has been adopted in accordance with the interviewee's background (e. g. social partner representative, other actor).

Key challenges for care occupations in hospital and social services sector:

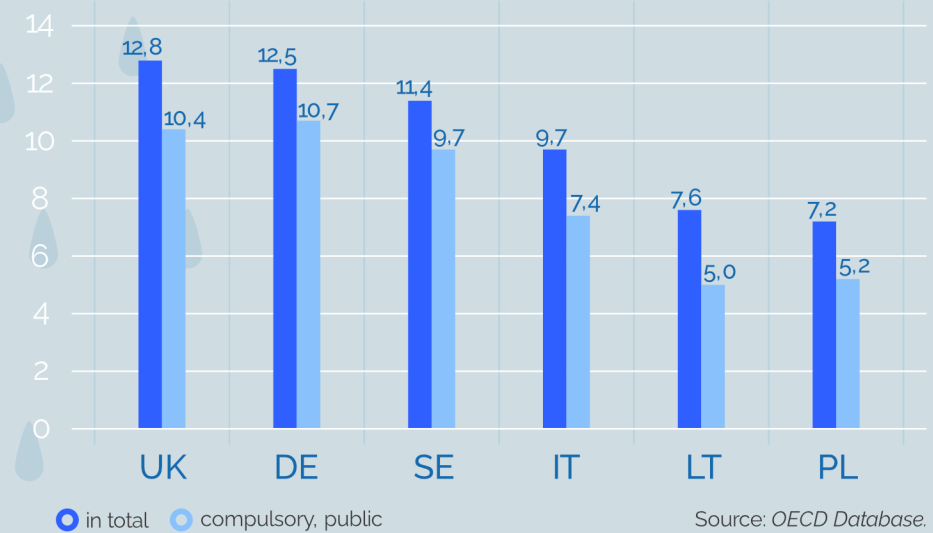
- aging of care workers
- understaffing
- low wages
- long working hours
- multiple jobholding
- underfinancing



NURSE SAFETY IS PATIENT SAFETY



Health expenditure as a percentage of GDP in 2020



Collective bargaining (CB) coverage in hospital sector and social services sector

COUNTRY	HOSPITAL SECTOR	SOCIAL SERVICES SECTOR
DE	47% (Sectoral CB*), 13% (company CB*)	more than 90%
IT	100% (public sector), 70-80% (private sector)	between 50 and 89%
LT	60-70%	more than 90%
PL	2%	less than 1%
SE	94%	more than 90%
UK	100% (public sector), 40% (private sector)	more than 90%

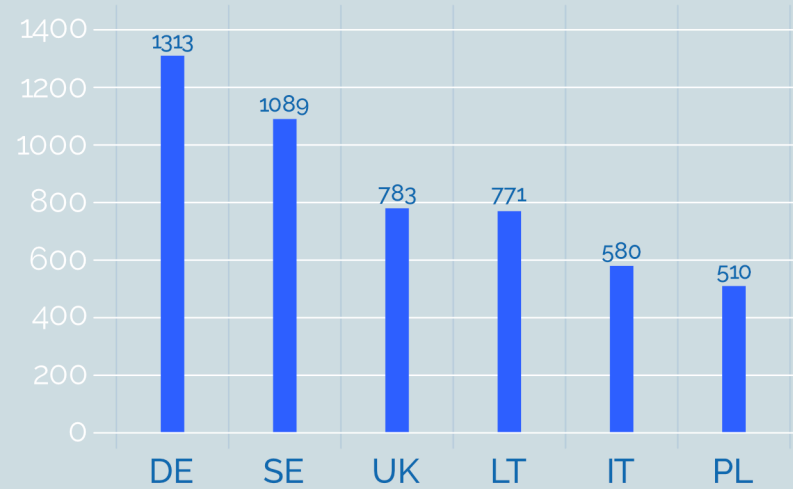
*CB - collective bargaining

Source: Eurofound.

Health and safety risks in care occupations:

- understaffing
- work overload
- stress at workplace
- violence and harassment at work
- professional burnout

Practicing nurses per 100 thousand inhabitants in 2017



Source: Eurostat

Information about the project:

"Health Risk Outlooks by Social Partners – HEROS. A multi-level analysis of health and safety policy interventions by social partners to identify effective ways to ensure better protection of employees at work" (VS/2021/0234) carried out in the years 2021-2023 and co-financed by the DG Employment, Social Affairs and Inclusion, European Commission.

Project partnership encompassed the following institutions:

University of Durham (UK) – the leader, University of Warwick (UK), Hochschule Pforzheim (Germany), Linnaeus University (Sweden), Institute of Public Affairs (Poland)

