Occupational health: a starting point for European social dialogue

Since 2006, representatives of the staff and management of private and public hospitals have met regularly as members of the European Sectoral Social Dialogue Committee for the Hospital Sector, a body recognised by the European Commission. Occupational health issues quickly made it onto the agenda, and tangible results were soon achieved, with an agreement on sharps injuries being transposed into a directive. Could this initial success pave the way for further improvements in working conditions in the sector?

Interview by
Denis Grégoire
ETUI

In 2010 an agreement between social partners resulted in a Directive on prevention from sharp injuries in the healthcare sector.
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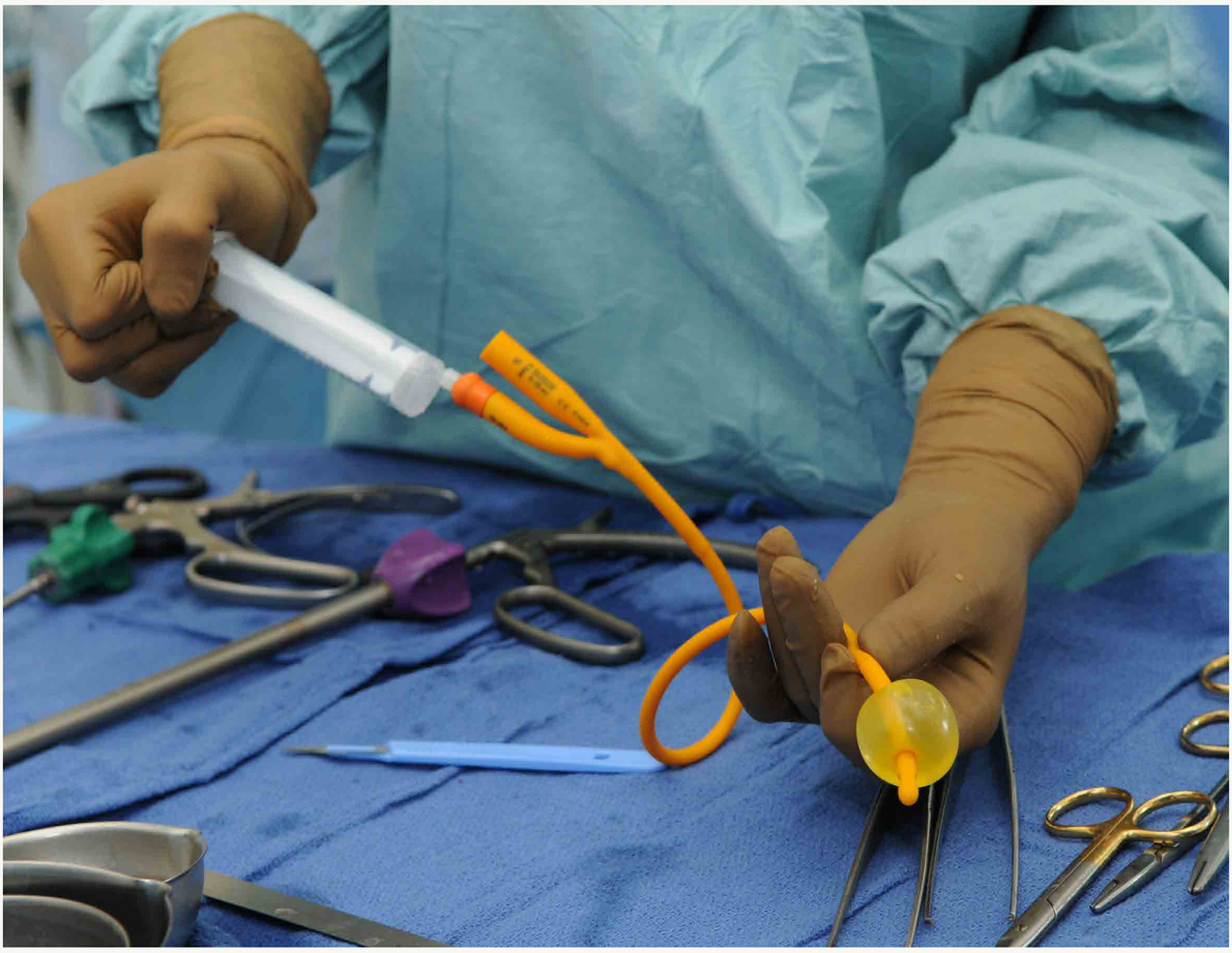

Mathias Maucher

Mathias Maucher is responsible for the 'Health and Social Services' sector at the European Federation of Public Service Unions (EPSU). EPSU affiliates about 8 million public service workers from over 260 trade unions in more than 45 countries, about 3.5 million of them from the health and social services sector.

What is your assessment of the transposition of the framework agreement on sharps injuries into a directive? Is it possible to assess its impact yet?

Mathias Maucher – The first impact was that there was a clear political will, underpinned with legislation, to look in more detail at major health and safety risks in the sector that would have led not only to sick leave but sometimes to long-term disabilities and, in extreme cases, even the death of healthcare workers.

The second is that the agreement enabled us to achieve a strong focus on risk assessment and a role for trade unions there, but also on workers' participation, because risk assessment can only be effective if you also involve the workers, the workers reps, the works council and the health and safety reps.

The sharps injuries agreement is a good example of how the social partners can get involved in designing and implementing European legislation that meets the needs of workers and reflects the realities in the healthcare facilities. It also helped to strengthen the role of social partners in the field of health and safety in general, especially in countries where they would not otherwise have had a role in codifying the process and in monitoring what is happening and how the legislation is being implemented.

Finally, this involvement in transposing and monitoring the directive on sharps injuries[1] also helped in some countries to expand the coverage of this agreement from the hospital sector into some other sectors where there is a risk of sharps injuries, such as elderly care.

The most important point is that the framework agreement allowed us to set out a range of general principles – on risk assessment, prevention, training, etc. – on which the health and safety initiatives pursued by social partners, together with governments, should focus, and these principles can also be applied to other risks.

Could a similar approach be envisaged to counter problems such as musculoskeletal disorders and psychosocial risks?

Those two points are very important for our current work and we are indeed running a joint project with HOSPEEM to look again into possibilities of social partner-based activities to address these health and safety risks, i.e. to prevent and to reduce them. These initiatives will obviously need to be underpinned by national policies and legislation, by European directives and by a European OSH strategy.

In the case of musculoskeletal disorders, it is easier to start our work because there is already European legislation on manual handling. A legislative initiative was undertaken in around 2009 to broaden the scope of the legislation and the range of risks covered in a directive on 'ergonomics', but eventually that could not be pursued due to political resistance from governments and employers' organisations. In principle, there is a strong interest from EPSU in having a broader scope so that risks related to musculoskeletal disorders are covered, with a stronger focus on risk assessment and also an adaptation of the legislation to changes in working realities and work environments in the sector.

What we have heard from several of our affiliates is that the existing legislative framework seems to work rather well in hospitals. But it is obviously more the case in the Nordic and the Western European countries, where there is more money in the system, a generally functioning social partnership and effective legislation. We have generally observed, however, that outpatient/community-based/home care is not that well covered and that improvements are needed there. There are developments such as '*hôpital à domicile*' – home hospital care – with medical care provided outside the walls of a hospital and a trend towards smaller organisations providing medical and care services.

For psychosocial risks and stress in the workplace, it's more complex. They are obviously a very important challenge for the health sector, due to factors such as increased work load and time pressures, the intensification of work, ethical stress (resulting from the fact that you too often cannot do what you have been trained for and what your own work ethics and the ethics of your profession would demand), a lack of worker involvement in decision making, and violence, harassment and bullying. There is also a need to address much more organisational issues leading to psychosocial stress, in addition to support measures for the individual worker. As yet, there is no specific EU legislation on this risk or certain aspects of it.

It's far too early to say what we will be able to agree upon together with HOSPEEM

1. 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 European legislative framework has helped to prevent attacks on national regulation.'
Mathias Maucher

and what the appropriate instruments, the final scope and the priorities for action might be. But both social partners want to use the opportunities afforded by the Healthy Workplace Campaign 2014-2015, initiated by the European Agency for Safety and Health at Work, and enrich that campaign with input from the health sector.

Many nurses complain about how hard their work is and do not believe they will be able to keep going until the legal retirement age. What can be done to tackle the challenge of premature ageing among healthcare professionals?

One major focus of our approach to this challenge, on which we were able to agree guidance with HOSPEEM in 2013, was to look into policies or strategies that would start earlier than the age of 50 or 55. Many workers might not even be able to work at that age because they are worn-out, have already been affected by occupational diseases or disabilities, and are no longer physically or psychologically capable of doing their job.

There is a need to develop a comprehensive approach spanning the entirety of the worker's life and career, based on measures to support effective recruitment and retention. We are very much in favour of developing measures and policies to prolong healthy working careers from the start, but opposed to increases in the retirement age.

We are therefore endeavouring to build up a package of measures that would help reduce the particularly physically and psychologically demanding elements of work, such as night shifts and weekend work, or lifting patients. We are also seeking to improve the organisation of work, to provide for continuous professional development, and to allow for time for tutoring and mentoring. We are talking about a mix of arrangements to enable workers, especially nurses, healthcare assistants and paramedics, but many others too, to keep working for longer, but in the healthiest way possible. Another strong focus of our approach to the ageing workforce was on demonstrating the positive effect of investing in measures to achieve these aims. It is also in employers' interests to promote measures that reduce the costs of sick leave and long-term absences from work due to disability or occupational diseases caused by exhaustion and excessive work-related stress.

Measures to reduce the operating costs of healthcare systems have been imposed in many European countries. Is it possible to gauge the consequences of these measures on the working conditions of nursing staff yet?

First of all, the measures have had an immediate impact, with pay freezes and, in several countries, pay cuts, as well as clear staff shortages. In several countries, the economic crisis has seen many of our colleagues made redundant, as well as an increase in unemployment among qualified health workers. This results in an increased workload for those in employment. In some cases we are also witnessing more precarious employment conditions. When the economic crisis hit, in many countries, there was no systematic investment in equipment or training, and often not enough money for continuous professional development and life-long learning for all health workers.

What we saw with regard to the health and safety provisions is that where there was no strong European legislative framework giving rise, in turn, to national regulations and other supporting actions – ranging from awareness raising to training, risk assessment, education and investment in equipment, etc. – health and safety policies and provisions came under enormous pressure or were no longer respected, to the detriment of the health and safety of workers and patients.

The European policy and legislative framework has helped to prevent attacks on national regulation, as we have seen in Spain where the legislation on the prevention of sharps injuries provided a safeguard against reducing the level of protection. What we hear from our Spanish colleagues, for example, is that when you have this European legislation and these OSH strategies in place, then the national health and safety institutions can better underpin their work, put aside money and keep up a political commitment to preventing and reducing OSH risks.

Where there is a strong European legislative framework that has also been underpinned by social partner-based arrangements, governments, ministries and employers are more inclined, or even obliged, to act. In countries where these pre-conditions are not met, the situation has become more difficult and in some cases disastrous.

EPSU and Hospeem have agreed to a code of conduct on cross-border recruitment in an effort to prevent social dumping in the sector. Is this kind of measure, which is not legally binding, enough to counter such practices, particularly in the elderly care sector, where staffing needs are considerable?

With regard to the use of and compliance of recruitment agencies and the non-discriminatory treatment of migrant workers by employers who are members of HOSPEEM[2], it seems that the code is working well. But we at EPSU are also interested in the broader sector encompassing residential and home-based elderly care. In this sector in particular, there are employers that do not work with properly functioning agencies, will not necessarily comply with European and national legislation and, last but not least, will not sign up to collective agreements that would bind them to provide certain employment conditions.

We are seeing improper behaviour at two levels: first of all, especially in the commercial private hospital and elderly care sectors, some employers use recruitment agencies that do not comply with the principles set out in the code of conduct and then also fall back on contractual arrangements with lower pay, longer working hours, professional qualifications that are not properly recognised, and clauses linked to language courses that bind the workers to the employers for a longer period. We have seen this with Spanish nurses in intensive home care.

The other point is that the professional qualifications of nurses are not properly recognised, particularly when employers have not signed up to collective agreements. If you are a general nurse, you need to be recognised as a general nurse in another EU Member State. Language difficulties cannot be a reason not to recognise a professional qualification and not to comply with the existing legislation and collectively bargained pay and working conditions.

We are confronted with often scandalous treatment of thousands of health and social care workers, in particular from the Mediterranean area and from Central and Eastern Europe, and mostly in the elderly care sector. In these countries, not least as a consequence of the crisis, there is a depletion of the workforce. These countries are losing considerable numbers of their highly qualified, motivated, and well-trained workers, in whose general education, professional training and medical studies they have invested. A code of conduct alone cannot help in this context. We would

2. The code stipulates that 'only agencies with demonstrated ethical recruitment practices should be used for cross-border recruitment.'

need other legislative or policy measures to better protect and support workers in the countries with outward migration and more investment in these health systems to provide better pay and working conditions there, too.

Brussels, 13 March 2015

For more information

EPSU devotes part of its website to the European social dialogue in the healthcare sector: www.epsu.org/r/20

Tjitte Alkema

Tjitte Alkema is Secretary General of the European Hospital and Healthcare Employers' Association (HOSPEEM).

HOSPEEM was formed in 2005 to represent the interests of European Hospital and Healthcare Employers on workforce and industrial relations issues. It has members across the European Union both in the state- or regionally-controlled hospital sector and in the private health sector.

In 2009, your organisation signed a framework agreement on sharp injuries with EPSU that has been transposed into an EU directive. What conclusions do you draw from this experience?

Tjitte Alkema – As representatives of an employers' federation, we are not per se looking for additional regulations at the European level because we think there are already quite a lot of directives that are also influencing the national settings. So we select the instruments that we think are appropriate. In the case of the medical sharps agreement, at first the social partners were not so interested in dealing with this issue because it was seen as very technical. It was only after a seminar was organised, where the impact of this problem, supported by facts and figures, was introduced into the discussion, that the social partners became aware that dealing with this problem was about more than finding a technical solution.

In the context of the agreement, we included key principles, especially risk assessment, prevention of worker injuries with the introduction of safe needles when needed, information, awareness raising and training of medical professionals. We had four regional seminars on the implementation of the directive. During one seminar, a medical doctor from one of the participating hospitals told us a story about entering an operating theatre after the safe needles were introduced there. She was looking around in this operating theatre and she saw a load of plastic capsules lying around. She asked one of the operating nurses what these capsules were. The nurse told her: 'well, these are the capsules that we have now on the safe needles and we break them up before we start the procedure, then we can keep on working like we used to'.

This is exactly the point that we wanted to make by reaching this agreement, that it is not just about finding a technical solution, but mostly about awareness raising and also influencing the cultural aspects of workplace safety.

Could the process that led to the transposition of the European social partners' agreement on sharp injuries into a directive be used to address other risks?

Occupational safety and health is an area that is very well regulated both at the European and at the national level. I don't think that additional regulation is particularly necessary. What we do think is that, like what is currently happening in the REFIT programme, all these directives have to be reconsidered in terms of whether they are still fit for purpose. It's always important to evaluate what you have put in place as regulation to see if it is still an appropriate way of reducing the risk that it was intended for.

In the instruments that we are using with EPSU in the social dialogue we also always include a paragraph on monitoring and evaluation, forcing ourselves to follow-up on our agreements to see if they are still having the effects that they were intended to have.

Your sector is deeply affected by musculoskeletal disorders and psychosocial risks. What plans do you have to tackle these problems?

In 2014, HOSPEEM and EPSU agreed on a work programme in which one of the key elements is dealing with these two topics especially. In two weeks' time in Paris, on 25 March (the interview was recorded in early March, Ed.), we are going to have a large conference on the issue of musculoskeletal disorders (MSDs) with many stakeholders, including research institutes. It's important that we start with a conference like this to distinguish between facts and opinions and also to identify effective practices already in place. It's not an issue that requires new regulation. What it does require is a good exchange of information on the most effective approaches for dealing with it.

With regard to psychosocial risks, I have seen from research that the two issues can even be interrelated. Sometimes MSDs lead to psychosocial risks in the workplace. So there is coherence between the two. I think that the approach of the conference in Helsinki[3] will be mostly the same, namely trying to establish an objective platform where we can discuss facts and research outcomes and exchange good practice examples. But of course, the approach will also be different because within the area of MSDs there is a technical aspect that needs to be taken into consideration, whereas for psychosocial risks and stress at work this will be different. It's more linked to industrial relations, relations between management and professionals and work organisation issues.

It's very obvious that there is a prominent reason to tackle these two hazards, for employers too, not just because we want to create the safest possible workplace for staff, but also because there is a very clear economic incentive. The two issues that we are talking about now are the major causes of staff absenteeism.

3. Besides the Paris conference on MSDs held in Paris at the end of March, a second conference has been scheduled in Helsinki in November to discuss the issue of psychosocial risks and stress at work.
4. Research shows that investing in training for an employee aged 45-50+ has a much longer-lasting effect for the organisation than investing in training for a staff member aged 30-35.

The average age of nursing staff is on the increase. What practical measures do you intend to take to retain workers who don't feel able to work until the retirement age?

In the Netherlands, the legal retirement age has been lifted from 65 to 67. As a result, the effective retirement age has indeed gone up very rapidly in the hospital sector, but without any increase in absenteeism due to sick leave.

My perspective is that it's also a mental thing. I don't mean that people are not dealing with it properly, but we are coming from a situation where people were used to thinking of early retirement as a part of their career path.

In Member States where the official retirement age has been lifted and age-related vacancy schemes or holiday schemes have adopted a more proactive approach, a mental shift in the workforce has taken place: 'How can I remain fit enough at work to reach my retirement age? What do I need in order to reach my official retirement age in good health?' And it seems to work.

With agreement between trade unions, employers and governments, it is possible to put into practice approaches that enable health professionals to reach the retirement age in a healthy and pleasant way.

A mental shift, combined with good work approaches, makes it possible to continue to work until the retirement age.

Concerning the manual lifting of people, new technical approaches have been put in place in many Member States, where lifting patients manually is not part of the protocol at all anymore.

There are quite a number of initiatives that have reduced the physical burdens on nurses as a professional group. These new approaches are available and cost-effective. This can be done without introducing new regulation or new rules.

These approaches can work very well. On top of that, training and continuous training should be put in place. Beyond the age of 45, and also beyond the age of 50, there is not currently a huge training budget available for professionals in these age groups in the sector. We should rethink this approach to investment in training in health professionals because investment in training should, as far as I am concerned, continue until retirement age[4].

European countries with an ageing population have been trying to respond to the growing medical care demand by recruiting nurses in Eastern Europe or in countries severely affected by the crisis such as Spain. In some cases, they have been hired on less advantageous terms than the national workers. How do you respond to that?

In 2008, EPSU and HOSPEEM adopted a code of conduct on ethical cross-border recruitment and retention that states that if international recruitment is required because there is a temporary shortage of health professionals in the receiving country, then the terms and conditions under which these migrant workers are employed should be the same as the terms and conditions applied to the local workforce.

As a European employers' Federation, I stick very much to the agreement that we have with EPSU, which makes it very clear that the terms and conditions, the availability of training and the relevant ILO conventions should all be maintained.

My Federation has no intention whatsoever of approving a situation where there is social dumping or wage dumping.

I would also like to stress that distinguishing between facts and opinion is very important. The absolute number of nurses working as migrant workers in Western EU countries is really very low. And it is also a result of the fact that due to austerity programmes in many Western European countries, instead of having a shortage of health professionals, we have an abundance of health professionals. In Western European countries, we now have unemployment among well-trained young health professionals who were educated to fill positions that we anticipated would absolutely need filling in the near future.

For a couple of years there has been a trend across Europe of bringing new private-sector-inspired organisation and management methods into care settings. Some professionals consider this as a fundamental transformation of the nature of their job and can no longer see themselves carrying on. Are these new methods inevitable?

Actually, I think that most professionals in the sector should be happy with the fact that new insights in human resource management are being introduced in a sector that has not been influenced that much by outside influences like modern human resources and management theories. I think in many Western European countries, you are already seeing a mix of public health providers and private health providers. I don't think that the quality of human resource management in a private setting is worse than in a public setting. I know from my own experience working in a university environment that investing in the skills and education of public-service employees is often a much-neglected part of human resources policy.

I don't think that many health professionals are leaving the sector because human resource strategies from the private sector are being introduced. I think that it is more of a plus than a risk. What you do see is that, as a result of privatisation, the budgetary system sometimes also changes, putting pressure on health providers to provide more services at lower cost. This creates work-related stress among health professionals that cannot always be dealt with within the hospital setting. And if this is happening, it is nothing to do with introducing private organisation methods: it is a result of budgetary restraints. I think that we should be very clear about one thing: the hospital sector will never be a real private sector. It will always be a sector that provides services of general interest. So we need to align the interests of the health professionals who want to provide these services of general interest and introduce effective human resources strategies to support them. ●

Brussels, 11 March 2015