Social dialogue in the hospital sector at EU level

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Summary
The increasing presence of the private sector in public health care systems has made social partners question the effectiveness of existing national social dialogue arrangements. The emergence of issues such as patient mobility, workers' mobility and cross-border healthcare, which all required action at European level, led social partners at European level to build an informal process of social dialogue. This article examines the process of developing an informal sectoral social dialogue committee for the hospital sector at EU level, from 2000 until 2006, drawing on an analysis of documents, key informant interviews and participant-observer reflections. The findings show that developing the content of social dialogue is as important as the process itself and adequate representation is central to success. The most outstanding achievement of the informal process of social dialogue was that partners became more articulate about developing shared positions and gradually gained access to European institutions.

Résumé

Zusamenfassung

Keywords
Employers, European Union, social dialogue, trade unions, industrial relations

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Social dialogue has been presented as a new form of industrial relations (Goetschy, 2006) but it is still unclear to what extent it is part of a new system of collective bargaining or a more refined consultation process between management and labour. To understand the implications of social dialogue, it is helpful to revisit three basic models of industrial relations, which seek to highlight the extent to which labour and management have a) similar goals operating within a shared whole, b) both shared and diverse interests, or c) fundamentally different interests (Salaman, 2000). These three models illustrate the potential for different levels of partnership or conflict (Huzzard et al., 2004). Much of the practice of partnership between labour and management has been at a local, regional or national level (HOPE, 1997; ILO, 2002). The development of social dialogue at European Union (EU) level has provided another arena in which to explore the reality of social dialogue.

Social dialogue at the EU level operates at cross-industry level and at sectoral level. In 1985, the three main social partners at European level, the European Trade Union Confederation (ETUC), the Union of Industries of the European Community (UNICE since renamed BusinessEurope) and the European Centre of Public Enterprises (CEEP) agreed on the need for social dialogue at European level. This cross-industry agreement was followed by a series of European Commission policies which promoted more formal sectoral dialogue structures, building on the informal arrangements that had developed during the 1980s and 1990s. This culminated in the 1998 Communication on sectoral social dialogue, which abolished existing structures and created new ones (European Commission, 1998; Keller, 2003).

Since 1998, there has been an expansion of EU-level sectoral social dialogue, with 40 European sectoral dialogue committees, covering 145 million workers (European Commission, 2010). The committees work on a range of issues such as health and safety, vocational training, equal opportunities and worker mobility. Although there were four Communications from the European Commission on sectoral social dialogue between 1998 and 2004, the Commission does not use legislative pressure because it views social dialogue as part of the ‘open method of coordination’ with social partners becoming responsible for the outcomes of their negotiations (Dufresne et al., 2006). An analysis of the process of sectoral social dialogue from 1978 to 2006 shows that the joint activities and texts produced by sectoral committees contribute to a ‘common position’ of a sector in relation to European

institutions and that the different types of texts – binding agreements, rules of procedures, declarations – are also addressed to European institutions. With this evidence, the process of sectoral social dialogue can be seen as a way of entering the EU policy process but not necessarily as a new form of industrial relations. Dufresne et al. (2006) define social dialogue as a set of functions and 'institutional frameworks which provide players with strategic resources in terms of power, influence and finance'.

Social dialogue is also seen as an essential part of the 'European social model'. The concept of the 'European social model' is used widely by different interest groups. For trade unions, it is a Europe characterized by employment protection, welfare regimes and comprehensive collective bargaining (Hyman, 2005). For employers, it is a way of recognizing that economic success and the social quality of Europe are interrelated. Both definitions link economic and social development, supported by European institutions that can facilitate the negotiations between labour and management needed to ensure that both economic and social interests are valued equally. It is a broad term that is useful for both trade unions and employers to suggest that they have shared interests.

Hospital sector

Health systems in Europe are facing several challenges as a result of an ageing population accompanied by a growing demand for health and social care services, a decreasing, skilled workforce expected to retire in the next decade, and increased expenditure through the use of high-technology health care. In many European countries, public-private partnerships (PPPs) are redefining public and private sector relationships. This covers contracting the private sector to supply goods or services through to arrangements where a private company may finance a new hospital in return for a long-term concession to provide services (Pollock, 2004**)**. The process of contracting out of services has an impact on how hospitals are structured and managed (Leys, 2003). Separate collective bargaining systems have often evolved in the public and private sectors. Countries with strong regional administrations have stronger sub-national social dialogue systems. Many organizations, rather than one single body, may represent workers and employers. Government is often represented at several different levels (HOPE, 1997).

According to the principle of subsidiarity, agreed under the Maastricht Treaty, national governments have responsibility for health and social policies, although

there is growing evidence that internal market competition legislation is having an impact on the hospital sector (Mossialos et al., 2001). In the late 1990s, social partners in the hospital sector at EU level began to consider how this sector could benefit from developing social dialogue. Several of these partners had experience of social dialogue at national level. By 2000, both trade unions and employers were becoming aware that there were three major issues facing the hospital sector across Europe – patient mobility, workers' mobility and cross-border issues – which all required European-level action (HOSPEEM, 2007).

Representativeness

One of the criteria for recognition by the European Commission of a sectoral social dialogue is the extent of representativeness of the social partners. This was a central issue in the development of the hospital sectoral committee. A survey of representative organizations in the health care sector in 2009 found that there was extensive national and local trade union representation in the health care sector and hospital sector, with some overlap between hospitals and other health care services, in all EU countries, as well as one trade union federation at European level. In contrast to this high level of trade union organization, seven out of 27 EU countries did not have a social partner organization for hospital or health care employers (European Foundation for the Improvement of Living and Working Conditions, 2009). This indicates the extent of organizational imbalance between trade unions and employers in the hospital sector.

In 2000, when the social dialogue process started, there was one European-wide trade union body, the European Federation of Public Service Unions (EPSU), but three employers' federations, which immediately affected the dynamics of social dialogue (Table 1). EPSU had previous experience of working to set up European-wide sectoral social dialogue committees in gas, electricity and civil service sectors. Its experience of setting up a civil service committee was particularly relevant for the hospital sector because representativeness was unclear and was only resolved after the European Commission reported on representativeness in the sector in 2004 (Dufresne et al., 2006).

EPSU was supported by a core group of national trade unions played supporting roles to EPSU in the Joint Representative Taskforce. Trade unions from Denmark, the Netherlands and the UK, with national experience of social dialogue, played a strong supporting role in the informal development process at European level.

Table 1. Scope of European hospital social partners in 2000

Social partner	**Scope**
European Federation of Public Service Unions (EPSU)	Represents 8 million public service workers including 3.5 million workers in the health and social services sector, through 213 affiliated trade unions. Largest federation of the ETUC.
European Centre of Enterprises & Employers providing Public services (CEEP)	Gathers public and private organizations, at national, regional and local level, which are public employers or providers of services of general interest. One of the three European cross-sectoral social partners.
Council of European Municipalities and Regions (CEMR)	CEMR members are over 50 national associations of towns, municipalities and regions from 37 countries, representing 100 000 local and regional authorities. Largest organization of local and regional government in Europe.
Standing Committee of the Hospitals of the European Union (HOPE)	Represents national public and private hospital associations and hospital owners, either federations of local/regional authorities or national health services. Made up of 32 organizations from 26 Member States of the European Union, plus Switzerland.

Sources: www.epsu.org; www.ceep.eu; www.cemr.eu; www.hope.be

For the employers, the European Centre of Public Enterprises (CEEP) and the Council of European Municipalities and Regions Employers' Platform (CEMR-EP) played an important role in the first part of the informal process. The Standing Committee of the Hospitals of the European Union (HOPE) played a role in promoting social dialogue among its members but because it was not a representative organization it did not feel that it could take an active part in negotiations between social partners. It did not play a central role in the informal social dialogue.

This article explores to what extent the six-year process of establishing an informal sectoral dialogue committee in the hospital sector at EU level, the precursor of a formal, sectoral social dialogue committee, is a new form of industrial relations, or an expansion of EU lobbying opportunities for the social partners.

Methodology

A case study approach was used as a form of exploratory research to understand the process of informal social dialogue that developed between 2000 and 2006. The case study material was drawn from conference and taskforce documents and key informant interviews during the period 2000–2006. The key informant interviews were gathered at two points in the process. The first group were conducted by email survey in 2002–03 and were designed to gather perceptions of both trade unions and employers' organizations about social dialogue. A second group of interviews were conducted by telephone and email with EPSU trade union affiliates in 2005, to gather views about the success and limitations of the informal social dialogue process. These interviews were conducted at a time when the employers were engaged in a consultation process about setting up a new employers' organization, which was a sensitive issue. As a researcher for the trade union side, I was not involved in this latter process.

Both sets of interviews were undertaken and analysed by the author. The first set of interviews were designed to inform a position paper about social dialogue in the hospital sector. The second set were to inform the development of an academic conference paper on social dialogue in the hospital sector. Documents, including conference agendas, statements and reports, and Joint Representative Taskforce agendas and minutes, were analysed using some basic coding, which subsequently identified a set of themes. The author contributed some participant-observer reflections as she was contracted to undertake research for the European Federation of Public Service Unions (EPSU) to support the social dialogue process from 2002 to 2005.

The six-year process of informal social dialogue, which started in 2000, led to the establishment of a formal social dialogue committee for the hospital sector at European level in 2006. The evolution of informal social dialogue is presented in three phases.

1. Introductory phase: 2000–2002

An initial process of dialogue between social partners drew from experiences of social dialogue at national level.

2. Informal social dialogue phase: 2002– 2004

The creation of the Joint Representative Taskforce in 2002 tested an informal social dialogue structure.

3. Representativity achieved: 2004–2006

Achieving representativity with the creation of a health employers' organization.

Phase 1. Introductory phase 2000–2002

Conferences played an important role in the development of the social dialogue process. Each conference was organized by a committee, consisting of both trade union and employers' organizations. After the creation of a joint representative committee, this played a stronger role in determining the content of conferences, influencing choice of speakers, themes and workshop topics. As well as bringing people together, the conferences facilitated a complex process of exploring topics for possible social dialogue. An essential part of the development process was gaining a more detailed understanding of the issues that would benefit from social dialogue, at EU level. These issues emerged through workshop presentations, discussions and conference statements (Appendix A).

Danish social partners played a key role in setting up the 1st Social Dialogue Conference in 2000. They brought a shared experience of working on social dialogue at national and local levels and this helped to shape their aspirations for social dialogue at EU level. Research into local labour markets, in five European countries, showed that there were significant differences between European countries in relation to trade unions and employers' organizations and in terms of numbers of organizations and type of representation. This was used to support the case for social dialogue. The workshop topics for the 1st Conference were strongly influenced by the trade union partners: workshop topics included 'structures, organization and privatization' and 'quality (including working conditions)' as reflected in the use of language. The outcome of the 1st Conference in 2000 was the identification of a number of common issues facing national hospital sectors across Europe, which fell under some type of 'public sector reform' (Developing the Social Dialogue in the Hospital Sector, 1st Conference, 2000).

The European Commission played a significant role at key points in the process, by providing tangible support such as funding and conference facilities but also less

tangible institutional support for a nascent social dialogue process. The Director-General of the Employment and Social Affairs Directorate-General in the European Commission, Walter Faber, said that the 1st Conference 'demonstrated social dialogue'. He said that although the European Commission would provide support, 'the real engine of social dialogue will be yourselves'. The conference participants concluded by calling for help from the European Commission to 'develop a formal framework for a social dialogue in the sector at the European level'.

By the 2nd Conference in 2002, a more detailed appreciation of some of the issues that social dialogue at EU level could address had been informed by an analysis of the 2001 report of the 'High Level Task Force on Skills and Mobility', which examined labour mobility in western and eastern European countries in terms of occupational and geographical mobility and an integrated labour market information system (High Level Taskforce on Skills and Mobility, 2001).

All social partners identified the increasing shortage of qualified personnel as a shared issue in the context of the free movement of labour and the role that social dialogue at EU level could play in solving this problem, which would involve recruitment, training and education for all social partners. The conference stressed the importance of recognizing diversity between countries in positive ways as had been explored in a workshop on culture, education, organization and language. It argued that 'the free movement of workers must take place while avoiding social dumping and brain drain' (2nd Conference Declaration, 4–5 February 2002). These issues reflect an understanding of how the sector would be affected by EU enlargement and wider economic and social issues, which was informed by participants from the then accession countries, who presented a central and eastern European model of social dialogue.

During this introductory phase of social dialogue, the European Federation of Public Service Unions (EPSU) played a key role in both facilitating and informally leading the process of social dialogue motivated by the aim of improving pay and working conditions. It had previous experience of social dialogue and was clearly representing millions of health workers across Europe. This was reflected in a statement by the Vice-President of EPSU Standing Committee on Health and Social Services, LB Hansen, who saw:

> 'The challenge for the actors is to identify a system, which allows for dialogue to take place in a way, which is both practical and representative … with a

> view to clarifying and improving social conditions in the sector in the EU.' (Hansen, 2002)

EPSU took a more active approach to EU enlargement and social dialogue. It organized training workshops and took an active role in involving its members from the accession countries.

By contrast, the employers' social partners wanted to focus on the importance of exchanging information and experiences of social dialogue, rather than facilitating its creation. CEMR-EP considered this the first step in the informal social dialogue process and necessary to reach 'the same level of awareness of the "social dialogue" process as … social partners have at national level'. In a wider context, CEEP saw the importance of improving social welfare legislation as a way of contributing to the European integration process. The employers found it more difficult to find employers' organizations that could be potential members in central and eastern Europe and so were unable to offer the training support that EPSU provided to trade union affiliates.

Phase 2 case study. Informal social dialogue structure 2002–2004

One of the most important conference outcomes was the 2nd Conference joint statement, where trade unions and employers' organizations agreed to set up a Joint Representative Taskforce, which acted as an informal social dialogue committee until 2006. The Joint Representative Taskforce provided important learning experiences for both trade unions and employers in organizing the practical process of social dialogue. This covered setting agendas, conducting meetings and agreeing minutes. It also contributed to the planning of conferences and choice of workshop topics. EPSU played an important role in leading this process. The Chair of the Joint Representative Taskforce was a trade union member of EPSU (Minutes of first meeting of Joint Representative Taskforce, 2002). A group of national trade unions from Denmark, the Netherlands and the United Kingdom, all with experience of social dialogue, provided support for EPSU in the Taskforce meetings. The creation of a website, Eurocare.net, provided a shared site for both trade unions and employers to disseminate information.

Although the creation of the Joint Representative Taskforce, which met every three to four months after April 2002, established some form of dialogue, by the following year, there were several challenges to this evolving process of social dialogue. During 2003, CEMR-EP appeared unwilling to take a more active role in developing

social dialogue and then withdrew both from the Joint Representative Taskforce and completely from the social dialogue process in the hospital sector. One interpretation of why this happened was that CEMR-EP was already an active social partner in the sectoral social dialogue committee for municipal services, which was just being formally recognized by the European Commission. Its presence in another sectoral committee, at EU level, could have compromised its influence in the municipal services sectoral social dialogue committee (UK respondent).

Plans for another social dialogue conference were held up because an application to the Commission for funding had been turned down. The explanation given for this refusal was that the funding for social partnership projects had been frozen because of differences in the legal categorization of social partners in different countries. However, there were other reasons, related to the dynamics between different Commission departments, particularly the Health and Consumer Affairs Directorate-General and the Employment and Social Affairs Directorate-General, which illustrate some of the difficulties in dealing with sectoral specific issues at EU level that transcend different Commission Directorates (Personal communication with EPSU Officer, 2003).

In 2003, both the Employment and Social Affairs and the Health and Consumer Affairs Directorate-General were contributing funds to support the development of the social dialogue process. The Employment and Social Affairs DG wanted greater recognition of its contribution. There were fears that these two DGs might merge. The Health and Consumer Affairs DG continued to be supportive to the sectoral social partners and encouraged a further application for funds, which was successful. The funds were used to continue to support the meetings of the Joint Representative Task Force and the organization of a 3rd Conference in February 2004.

During this second phase, that of the creation of informal social dialogue, the trade union side was a determined partner, treading a delicate path, through what, technically, should have been a shared decision-making process initially. The lead EPSU officer and the Chair of the Joint Representative Task Force, an EPSU affiliate, were well aware of the sensitivities involved. The trade union side often offered to draft some key points in order to move specific discussions forward. At an extended meeting of the Joint Representative Task Force, the trade union side was keen to draft the 'Statement of Intent' so that the momentum of working together was not lost (personal observation 2002/03). This was at a time when the application for

further EU funding had been turned down and the future of informal social dialogue seemed uncertain.

Another trade union contribution to the process was seen in its suggestion that both trade unions and employers needed time to meet, to refine their specific points of view, in order to facilitate negotiations (personal observation, 2002). The trade union side had extensive experience of achieving consensus with its members, but the employers often had to be encouraged to develop a consensual position with their members. This difference could be attributed to the clearer systems of representation on the trade union side as compared to the lack of European representativeness for the employers.

Phase 3 case study. Improved representativity for employers 2004–2006

Between 2000 and 2006, the employers' interests were represented by several organizations, although by 2004 CEEP was the only active member. Representivity is one of the criteria that the European Commission uses to assess a formal application to set up a social dialogue committee. Although CEEP is a membership organization, its members cover many parts of the public services, not only health care. This made it difficult for CEEP to speak on behalf of health care employers and, coupled with a lack of appropriate employers' organizations in central and eastern Europe, undermined the credibility of CEEP as a social partner in the hospital sector. The future of the social dialogue process by 2004 depended on whether the main employers' organizations could successfully resolve the problems of representivity.

There was widespread recognition that the structure of CEEP was a major barrier to the development of social dialogue in the hospital sector at EU level. One trade union player saw the process of defining the employers' platform as an integral part of the process of developing social dialogue (Danish respondent). 'There is no single body which has comprehensive representation of employers in the sector' (UK respondent). This was in contrast to EPSU, which had a clear system of representation and played a crucial role in maintaining the momentum of the social dialogue process. It was an issue that was central to the future of social dialogue but one over which the trade union side had no influence.

In the autumn of 2004, at a crucial point in the informal social dialogue process, CEEP launched a process for establishing employers' representation in the hospital sector at EU level. This culminated in an internal meeting of CEEP in March 2005,

which decided that CEEP should set up a new structure to represent hospital employers in Europe. This decision was a key indicator of the commitment of the members of CEEP to developing social dialogue in the hospital sector in Europe, and to the financial implications of a new structure. A decision was taken to set up a separate organization for the employers' organizations of the sector, called the European Hospital and Healthcare Employers Association (HOSPEEM), which would have its own offices, executive and staff. The decision to set up a formal employers' organization, specifically for the sector, was the most significant decision in this informal process of social dialogue and facilitated the setting up of the formal European committee. It was a decision that could only be taken by the employers' side.

The process of developing some form of social dialogue in the hospital sector at EU level was slow. The partners had to explore the process of working together, tentatively. The initial motivation of the social partners appeared to be different, with the trade union side being more committed to setting up a formal social dialogue committee. After the formation of a specific sectoral employers' organization, the enthusiasm of the employers became stronger, a further reflection of the importance of representation for all social partners.

The officers of the two main social partners and their ability to use 'officer' discretion played a crucial role in the development of the social dialogue process. The EPSU officer was fully committed to the development of social dialogue and was willing to take the initiative, taking risks to move the process forwards. He had strong organizational support. Within CEEP, there were signs, as seen through conference contributions, that there were different levels of active commitment to the social dialogue process. The General Secretary of CEEP always presented a very upbeat view of CEEP's commitment to social dialogue, in public speeches. This contrasts with CEEP's officer on the Joint Representative Task Force, who, although supportive, was less willing to take risks in the development of joint work. These two different organizational arrangements show the importance of maintaining intra-organizational support for social dialogue.

The national sectoral social partners had used the period from 2000 to 2004 to develop bilateral and internal links. This started with the 1st Social Dialogue Conference in 2000, which was organized by the Danish partners. By 2004, the Dutch social partners organized the 4th Social Dialogue Conference in the

Netherlands, which received support from the Dutch social dialogue unit. At that point, the employers had become more influential and had reached a consensus with the trade union side about possible topics for social dialogue.

Post 2006 – key events and agreements

The formal Social Dialogue Committee was launched at a conference on 16–17 March 2006. The workshops formed a series of working groups which drew up a joint programme for 2006–2008, building on work that had been done in previous conferences as well as commissioning research to inform the work programme. The topics covered were international recruitment, new skills needs, and recruitment and retention issues. These represented the culmination of discussions that had taken place in the previous conferences and in the Joint Representative Taskforce.

EU enlargement featured as a central issue in the development of social dialogue in the sector at EU level. An increased awareness of the differences between levels of social dialogue in new and old Member States gradually emerged during the informal social dialogue. This has continued in the more formal Social Dialogue Committee as reflected in a research project into social dialogue in the Czech and Slovak Republics commissioned by the formal Social Dialogue Committee in the Hospital sector in 2007 (GHK, 2008). This was followed in 2010 by a project on social dialogue in the Baltic region, effectively integrating members from across the region, with different experiences of social dialogue (HOSPEEM/EPSU, 2010).

The formal Social Dialogue Committee has created a platform for promoting the perspectives of the hospital sector to the European Commission. There are indications that the social partners in the hospital sector are being recognized in wider health care issues, for example, the Green Paper on the health workforce mentioned the 'Code of Conduct and follow-up on ethical cross-border recruitment and retention' developed by the European Social Dialogue Committee (European Commission, 2008a). This recognition came at a time of the publication of a Draft Directive on cross-border health care in 2008, the first example of specific health care policy at EU level (European Commission, 2008b).

The first major agreement by the European Social Dialogue Committee took place in June 2009 on medical needle sharps, and aims to prevent over a million accidents each year (HOSPEEM/EPSU Hospital Partners, 2009), an important health and safety issue. This has been followed by a proposal for a Council Directive to

implement the Framework Agreement on medical sharps, an indication of the effectiveness of the Social Dialogue Committee in influencing European-level policy.

Conclusion

Although the aim of social dialogue is to bring social partners together to enter into a dialogue, inevitably, some partners are stronger and more forceful than others. In this case, the trade union social partner, EPSU, played a role in leading, encouraging and facilitating and was influenced by a strong vision of what social dialogue could achieve. A large group of trade unions attended the European conferences and there was a stronger commitment to the development of social dialogue by trade unions. However, although there was a process of facilitation, social partners had to be ready to make their own decisions. Frequent conferences and meetings helped to stimulate the interaction of both sets of social partners at national level as well as across Europe. For the employers, consolidation was a slower process, complicated by uncertainty about appropriate systems of representation, which was only resolved after almost five years of informal dialogue.

Not only does the structure of the social dialogue process have to be created, but equal effort has to be invested in developing the content of social dialogue. During the informal social dialogue process, there were significant changes in the language used for workshop topics. The process of discussing possible topics was part of a social dialogue process. Research to provide an overview of topics and experiences played a significant role. Recruitment and retention and the problems of an ageing society became shared concerns by the time the formal Committee was set up in 2006.

The record in the hospital sector of informal social dialogue before 2006, and formal social dialogue since 2006, shows that partners have become more familiar with operating at European level, which they will have to do if they are to influence the three issues identified in 2000: patient mobility, workers' mobility and cross-border issues. This does not necessarily translate into a new form of collective bargaining although what can initially be seen as 'soft' issues may develop into stronger agreements in future. The experience of the hospital sector informal social dialogue committee shows that the players became more widely recognized by the European Commission and more able to articulate shared positions on European-wide health care. The extent to which national-level collective bargaining can be integrated into

European-level institutions is still being explored and may require new players and initiatives.

Recommendations

- A realistic period of time should be allowed to develop trusting relationships between social partners.
- Representivity should be addressed at the beginning of the negotiations by all social partners.
- The use of research to provide evidence of the effectiveness of social dialogue as well as exploring possible topics is essential.
- Adequate resources are needed both to start and to maintain the process of informal social dialogue.
- The European Commission should play an important role in providing resources and encouragement.
- A flexible approach to dealing with the tensions between national and European agendas as well as sub-regional differences in Europe is needed.
- Continual institutional support for officers involved in negotiations helps to maintain a momentum.

Acknowledgements

I would like to thank and acknowledge the support of Brian Synnott, Health and Social Services Officer, EPSU (2001–06). I would like to thank the two *Transfer* journal referees for their helpful comments.

Funding

This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

References

De Boer, R Benedictus H and van der Meer M (2005) Broadening without Intensification: the Added Value of the European Social and sectoral Dialogue. *European Journal of Industrial Relations* 11(1): 51–70.

Developing the Social Dialogue within the Hospital Sector (1st Conference) (2000) Programmes, declarations, lists of participants, 12–13 May 2000, Brussels, Belgium.

Developing the Social Dialogue in the European Hospital Sector (2nd Conference) (2002) Programmes, declarations, lists of participants, 4–5 February 2002, Brussels, Belgium.

Developing the Social Dialogue in the European Hospital Sector (3rd Conference) (2004a) Programmes, declarations, lists of participants, 2–4 February 2004.

Developing the Social Dialogue in the European Hospital Sector (4th Conference) (2004b) Programmes, declarations, lists of participants, 2–3 December 2004.

Dufresne A, Degryse C and Pochet P (eds) (2006) *The European Sectoral Social Dialogue Actors. Developments and Challenges* Brussels: P.I.E.-Peter Lang.

European Commission (1998) *Adapting and promoting the social dialogue at Community level.* Communication from the Commission. COM(1998) 322 final, 20 May 1998, Brussels.

European Commission (2008a) Proposal for a Directive of the European Parliament and of the Council on the application of patients' rights in cross border health care. SEC(2008) 2163/2164/2183, COM(2008) 414 final, 2008/0142 (COD), 2 July 2008, Brussels.

European Commission (2008b) *On the European Workforce for Health*. Green Paper, COM(2008) 725 final, 10 December 2008, Brussels.

European Commission (2010*)* Commission Staff Working Document on the functioning and potential of European sectoral social dialogue. SEC(2010) 964 final, 22 July 2010, Brussels.

European Federation of Public Service Unions (EPSU) (2005) Detailed work programme for the project *Formalising the European Sectoral Social Dialogue in the hospital sector.* Application for Budget heading 04.03.03.01 Industrial Relations and social dialogue – support for European social dialogue European Commission.

European Foundation for the Improvement of Living and Working Conditions (2009) *Representativeness of the European social partner organisations: Hospitals*. Available at: www.eurofound.europa.eu

European Social Dialogue Committee (2006) Work programme of the European Social Dialogue Committee in the hospital sector in the European Union 2006–7. Available at: http://www.epha.org/a/2465

GHK (2008) Strengthening social dialogue in the hospital sector in the new Member States and candidate countries. Commissioned by EPSU and HOSPEEM. Available at: http://www.epsu.org/a/3812

Goetschy J (2006) Taking stock of social Europe: is there such a thing as a Community social model? In: Pascual AS and Jepsen M (eds) (2006) *Unwrapping the European Social Model.* Bristol: Policy Press.

Hansen LB (2002) Developing Social Dialogue in the Hospital Sector at EU level. Paper presented at an EPSU Workshop, 25 September 2002, Brussels, Belgium.

High Level Task Force on Skills and Mobility (2001) *Report of the High level Task Force on Skills and Mobility.* Brussels: European Commission.

HOPE (Standing Committee of Hospitals in the European Union) (1997) *Social dialogue in the hospital sector in EU member states.* Available at: http://www.hope.be/05eventsandpublications/publications_chronologicallist.html

HOSPEEM (2007) The hospital sector social dialogue: process, actors, results. Presentation at Social Dialogue status conference ETUCA, 4-5 June 2007, Brussels

HOSPEEM/EPSU (2006) Launch of the 33rd Hospitals' Sectoral Social Dialogue Committee on 22 September 2006. Available at: http://www.epha.org/a/2465

HOSPEEM/EPSU Hospital Partners (2009) Announcement of a European agreement, which is set to prevent over 1 million medical sharp injuries per year, for healthcare workers. 9 June 2009, Brussels. Available at: http://www.epsu.org/a/5192

HOSPEEM/EPSU (2010) Strengthening social dialogue in the hospital sector in the Baltic countries http://www.epsu.org/IMG/pdf/cover_letter_questionnaire-2.pdf

Huzzard T, Gregory D and Scott R (eds) (2004) *Strategic Unionism and Partnership: Boxing or Dancing?* London: Palgrave Macmillan.

Hyman R (2005) Trade unions and the politics of the European social model. *Economic and Industrial Democracy* 26(1): 9–40.

International Labour Organization (ILO) (2002) *Social Dialogue in Health Services: Institutions, Capacity and Effectiveness.* Report for Discussions of the Joint Meeting on Social Dialogue in the Health Services International Labour Organization. Geneva.

International Labour Organization (ILO) (2007) *Social dialogue.* Labour Law and Labour Administration Department (Dialogue) ILO. Available at: http://www.ilo.org/public/english/dialogue/ifpdial/sd/index.htm

Joint Representative Taskforce (2002) Notes of a meeting held on 12 June 2002.

Keller B (2003) Social dialogues – the state of the art a decade after Maastricht. *Industrial Relations Journal* 34(5): 411–429.

Leys C (2003) *Market-driven Politics, Neoliberal Democracy and the Public Interest.* London: Verso.

Mossialos E, McKee M, Palm W and Karl B Marhold F (2001) *The influence of EU law on the social character of health care systems in the European Union.* Brussels: Observatoire Social Européen.

Pollock A (2004) *NHS plc The privatisation of our health care.* London: Verso.

Salaman M (2000) *Industrial relations theory and practice* (4th edition). Harlow: Pearson Education.

Appendix A: Conferences – attendance and workshop topics

Date	**Organizers**	**TUs (%)**	**Employers (%)**	**Total (100%)**	**Countries**	**Workshop topics**
12–13 May 2000	DKK/ DCC, EPSU, CEEP	50 (72.5%)	19 (27.5%)	69 (100%)	15	Workforce – characteristics of hospital sector Structures, organization and privatization Quality development
4–5	DKK/	79	33 (29.5%)	112	22	Free movement of

February 2002	DCC, EPSU, CEEP	(70.5%)		(100%)		health sector personnel Differences in culture, education, organization and language Recruitment & retention
2–4 February 2004	EPSU, CEEP	69 (65%)	36 (36%)	105 (100%)	22	Recruitment & retention Assessing skill needs Ageing & the hospital workforce
2–3 December 2004	Dutch social partners	63 (70%)	27 (30%)	90 (100%)	19	Recruitment & retention Assessing skill needs Ageing & the hospital workforce Migration/cross-border mobility

Sources:

Developing the Social Dialogue within the Hospital Sector (1st Conference) (2000) Programmes, declarations, lists of participants, 12–13 May 2000, Brussels, Belgium.

Developing the Social Dialogue in the European Hospital Sector (2nd Conference) (2002) Programmes, declarations, lists of participants, 4–5 February 2002, Brussels, Belgium.

Developing the Social Dialogue in the European Hospital Sector (3rd Conference) (2004a) Programmes, declarations, lists of participants, 2–4 February 2004.

Developing the Social Dialogue in the European Hospital Sector (4th Conference) (2004b) Programmes, declarations, lists of participants, 2–3 December 2004.