REGIONAL REPORT FOR CENTRAL EUROPE:

Croatia, Czech Republic, Slovakia, Slovenia

The report was approved by the Sectoral Social Dialogue Committee for the Hospital and Healthcare Sector on 02 June 2021.

The report was prepared within the joint project of HOSPEEM – EPSU, “Strengthening social dialogue in the hospital sector in the East, South and Central Europe” (2019 and 2021).
The project has received financial support from the European Union (project NO: VS/2019/0008).

Authored by

Central European Labour Studies Institute

Table of contents

Index of tables

Index of graphs

Abbreviations

CSRs	Country-Specific Recommendations within the European Semester framework
CZ	Czech Republic
EESC	European Economic and Social Committee
EO	Employers' organisation
EPSU	European Federation of Public Service Union
EU	European Union
EUR/I	EUR per inhabitant
GDP	Gross Domestic Product
HOSPEEM	European Hospital and Healthcare Employers' Association
HR	Croatia
MS	Member States
PPS/I	Purchasing power standard per inhabitant
SD	Social dialogue
SI	Slovenia
SK	Slovakia
SSD	Sectoral social dialogue
TU	Trade unions

Introduction

The **hospital and healthcare sector's socio-economic relevance is growing and, at the same time, facing multiple challenges** to assure that "everyone has the right to timely access to affordable, preventive and curative health care of good quality" [1]. The healthcare sector is characterised by high healthcare providers' high segmentation, scaling public sector bodies at different administrative levels to non-profit and private institutions[2]. The providers' fragmentation also influences the social partners' structure; employees and employers organise themselves according to their occupational sector, subsectors, and private/public sectors.

The social partners' **representation in the European Sectoral Social Dialogue (SD) and their involvement in the European Semester became strategic relevant** to assure that the improvement of the employees' working conditions and the implementation of the market–related reforms (inevitable) across the EU are tackled at EU level.

To strengthen the social partners' role at the EU level, the European Hospital and Healthcare Employers Association (HOSPEEM) and the European Federation of Public Service Unions (ESPU) commissioned a joint project. The project aims to (a) identify and address the **capacity-building needs of the sectoral social partners**; (b) obtain quantitative and qualitative data on the **current involvement in the European Semester** and strengthen their role in this regard. Specifically, the project surveys the social partners' priorities and how these priorities could be better articulated in the future activities of HOSPEEM and EPSU. The report provides relevant and comparable data and country-specific information from four targeted countries in Central Europe: **Croatia (HR), Czech Republic (CZ), Slovakia (SK) and Slovenia (SI)**.

The findings in this report are the **results of the combined methodology,** which includes:

- A tailored online survey dedicated to social dialogue in the hospital and healthcare sector conducted from 2020;
- Desk research conducted from February to August 2020,
- Outcomes of the discussion with national social partner organisations and relevant organisations of the four targeted countries held at the third Regional Webinar on 20 April 2021.

The report is structured as follows:

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

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

1. Facts and figures of the hospital and healthcare sector

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

The Central European Member States' overall expenditure ranges from 1 800 EUR/inhabitant (EUR/I) in Slovenia to 862 EUR/I in Croatia. The average PPS per inhabitant in these countries is 1800 EUR. The percentage of health expenditure as part of the Gross Domestic Product (GDP) 7,3 but varying from 6,69% in Slovakia to 8,3 % in Slovenia.

[1] European Pillar of Social Rights
[2] Eurofound (2020), Representativeness of the European social partner organisations: Human health sector, Sectoral social dialogue series, Dublin.
[3] Based on the discussions at the Regional webinar on 20 April 2021.

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

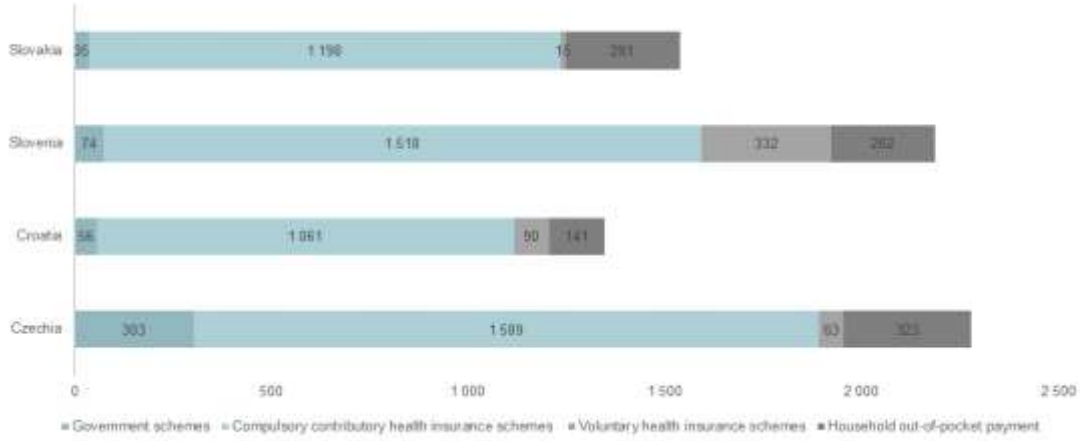
Country	Czech Republic	Croatia	Slovenia	Slovakia
Million EUR	15 872	3 524	3 797	5 991
EUR per inhabitant	1 493	862	1 831	1 100
PPS per inhabitant	2 279	1 348	2 186	1 539
% of GDP	7,65	6,83	8,3	6,69

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

Analysing the expenditure by financial schemes, in most Central countries, **the highest PPS per inhabitant is paid from compulsory contributory health insurance schemes** ranging from 1589 PPS/I in Czechia to 1061 PPS/I in Croatia. **The house-of-pocket payments are relatively high in all countries** scaling from 141 PPS/I in Croatia to 323PSS/I in Czechia.

During the COVOD-19 pandemic, the cost of healthcare services increases in all countries due to the necessity to establish new Covid-19 departments or re-profile the old ones. Social partners, pointing to the crucial role of the health care sector during the pandemic, call for more investments to the sector assured by the higher share of finances from the Recovery and Resilience plan.[4]

Graph 1: Healthcare expenditure by financial schemes (PPS per inhabitant, 2018)



Source: Eurostat, Healthcare expenditure by financing scheme [online conde: hlth_sha11_hf]
Note: out-of-pocket are estimates

Based on the health personnel employed in hospitals in 2018, the number of medical doctors per 100 000 inhabitants is the highest in Czechia (249) and the lowest in Slovakia (171). The number of nursing professionals and midwives per 100 000 inhabitants varies tremendously, from 535 in the Czech Republic to 131 in Croatia.

Table 2: Health personnel employed in hospitals (2018)

Country	Czech Republic	Croatia	Slovenia	Slovakia
Hospital employment (headcount)	157 775	47 834	26 143	42 287
Nursing professionals and midwives (headcount)	56 914	5 368	3 798	21 352
Nursing professionals and midwives/100 000 inhabitants	535	131	183	392
Medical doctors (headcount)	26 521	8 714	3 878	9 309
Medical doctors/100 000 inhabitants	249	213	187	171
Hospital beds/100 000 inhabitants	662	561	443	570

Source: Eurostat 2018, Health personnel employed in hospital [online code: hlth_rs_prshp1]

[4] Based on the discussion at the Regional Webinar 20 April 2021.

Note: Full-time equivalent (FTE) measure for Slovakia available only

Despite the overall lack of healthcare professionals that became even more apparent during the COVID-19 pandemic, the health crises also brought positive development in this term. The interest in becoming healthcare professionals increased in some countries in 2021 (e.g. CZ). The reasons for this development is the governmental extra payments and benefits to healthcare workers during the pandemic, negotiated and pushed forward also by the national social partners.[5] In Croatia, additional payments for the healthcare professionals during the crisis have been issued, but due to the overall and long-term unfavourable economic situation of the healthcare force, it did not bring financial satisfaction to nursing professionals. In some countries, the number of medical doctors is relatively sufficient but hampered by regional disparities (CZ, SK, HR).[6]

2. Social partners in the hospital and healthcare sector

Based on the desk research and a shared database between HOSPEEM, EPSU and CELSI, the following social partners representing employees and employers in the hospital and healthcare sector in the Central EU countries were identified.

[5] Based on the discussion at the Regional Webinar 20 April 2021.
[6] Based on the discussion at the Regional Webinar 20 April 2021.

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

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

The importance of the European social dialogue is anchored in the Treaty on the Functioning of the European Union (TFEU) by several articles[7]. There are plenty of instances where the **social partners played an active role in the EU-wide agreements**.

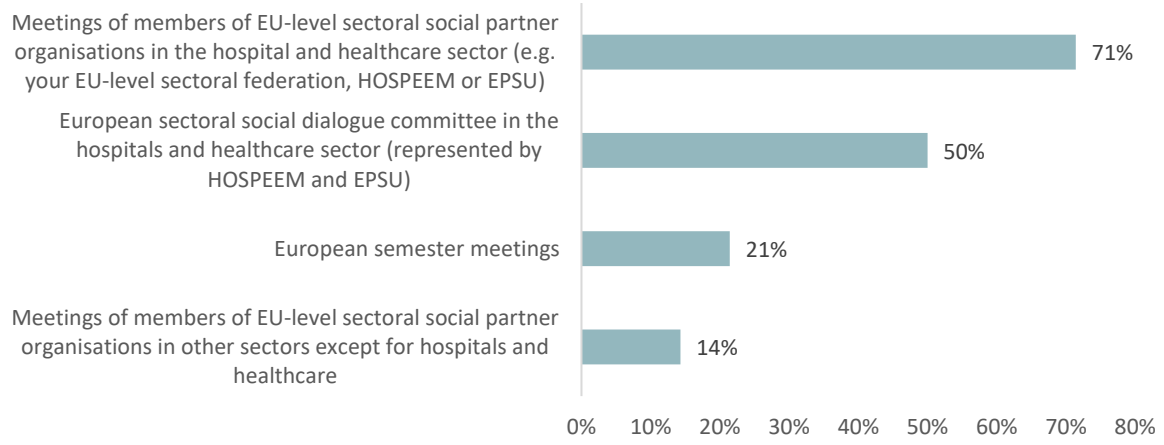
The support for promoting EU social dialogue is also reflected in the Action Plan on the European Pillar of Social Rights by concrete initiatives, such as a new supporting frame for social partner agreements at the EU level and a new award for innovative social dialogue practices. In terms of promoting Health and Occupational Safety and Health at Work, particular activities are proposed: (a) Propose new tools better to measure barriers and gaps in access to healthcare; (b) Present an EU report on access to essential services and (c) Encourages the Member States to invest in health workforce, improving working conditions and access to training.[8]

> **I am a firm believer in the value of social dialogue between employers and unions, the people who know their sector and their region the best.**
> *Ursula von der Leyen, European Commission President (2019)*

The findings related to the involvement of the social partners in the EU social dialogue presented below are based on the online survey circulated to relevant social partners/organisations in the four targeted countries between February and August 2020.

Most of the social partners involved in the survey participate directly at meetings within the EU social dialogue structures. Worth saying that the majority of respondents are trade union representatives.

Graph 2: Direct participation at the committee meetings of EU level social dialogue structures since 2015 (%, N = 14)



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

The most frequent reasons for non-participation in any EU level social dialogue structures is the lack of personal and financial capacities. Some do not see added value and progress in improving the social and economic status after long-term membership in one EU organisation (Slovenia) [9]. The non-involvement of the social partners from the Central EU countries into the EU level social dialogue might be **hampered by their fragmentation at the national level and/or the currently limited presence of independent employers' organisations**.

Table 3: Reasons for non-participation in EU level social dialogue structures (%, N= 8)

Reasons for non-participation	Per cent
Lack of personal capacities, lack of time to participate in meetings	38%

[7] Mainly by Art. 152: The European Union recognises and promotes the role of social partners at Union level respecting their autonomy; Art. 154: Consultation of EU level social partners by the Commission; Art. 155: Agreements concluded by social partners.
[8] Presentation of Jan Behrens (DG EMPL A2 Social Dialogue): Social dialogue at EU level, at Regional webinar 20 April 2021.
[9] Finding from the survey.

Reasons for non-participation	Per cent
Lack of financial resources (high travel costs, high membership fees)	38%
Language barrier	13%
Barriers of the entry (not meeting representativeness criteria)	13%
Low importance of EU-level social dialogue to the activities of our organisation	13%
Difficulties in understanding the role and functioning of EU-level social dialogue	0%
Barriers of the **entry (another organisation from our country is a member and is not supporting our participation)**	0%

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

EPSU represents most of the trade unions at the European level. However, other European organisations operating in the healthcare and hospital sector exist, to which some of the trade unions might be affiliated. Yet, it has to be noted that these organisations are mostly professional organisations, not recognised EU level social partners, as is the case for EPSU.

While other European hospital associations exist, HOSPEEM is the only recognised European sectoral social partner representing national hospital employers' organisation's interest[10].

Representatives from national trade unions appealed to national employers' organisation to become a member of HOSPEEM with the aim to establish effective EU-level social dialogue as many trade unions in the targeted countries within the region do not have their counterparts represented to discuss and agree on EU-level instruments.[11]

In some countries (e.g. CZ), the national social dialogue has slowed down during the COVID-19 pandemic, and in other countries the communication and negotiations between the social partners minimised. This was also due to the relatively frequent personal changes in the responsible governmental bodies (e.g. CZ) or even whole governments (SK, SI). In Croatia and Slovenia, the social dialogue with the Ministry sustained of relatively high quality.[12]

4. Social partners' participation in the European Semester

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

The European Semester's Country-Specific Recommendations (CSRs) reflects the relevance of the healthcare sector and social dialogue for fiscal consolidation, social cohesion, addressing (in-work) poverty, and increasing the resilience and functioning of the health system.

Since the pandemic outbreak, March 2020, the European Semester mechanisms adjusted to the crisis and set up a Recovery and Resilience Facility to guide the Member States to cope with the health crisis. The Member States are encouraged to submit their recovery and resilience plans. The current procedure of the assessment with the Country-Specific Recommendations will be replaced with the assessment procedure of the Recovery and Resilience Plans in 2021.[13]

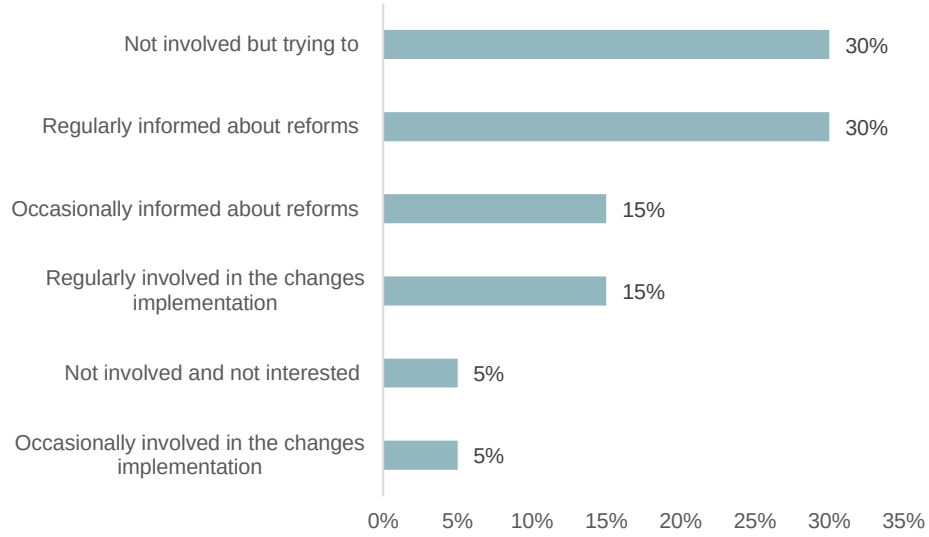
The recent country reports provide a brief overview of the challenges that the countries face. For example, in the Czech Republic, primary care should be strengthened to relieve the hospital care. In Slovakia, there is a need to protect the financing of long-term care. This is the case also for Slovenia, where the unmet need for long-term care for elderly people and persons with disabilities was identified as a challenge.

Even though the social partners' current involvement is limited, 30% of organisations are regularly informed about the recommended reforms. The other 30% are interested or trying to be involved either in the European Semester

[10] Based on the discussion at the Regional Webinar 20 April 2021.
[11] Based on the discussion at the Regional Webinar 20 April 2021.
[12] Based on the discussion at the Regional Webinar 20 April 2021.
[13] Egbert Holthuis, European Commission, The European Semester process: actions to develop and foster the involvement of national sectoral social partners; contribution at the Regional Webinar 20 April 2021.

process. These finds can be supported by the reoccurring research conducted by Eurofound on the involvement of national social partners in policymaking[14]

Graph 3: The ways the social partners are involved in the European Semester procedure (%, N=25)



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

The Regional Webinar discussion revealed that the primary responsibility for good involvement at the national level remains with the Member State. However, in some countries, social partners only have limited possibility to be part or intervene in the European Semester process and noted to be left out.[15] The Croatian employers' organisation welcome the Country-Specific Recommendations for healthcare as a guide for further improvement.

HOSPEEM and EPSU provide a space for good practices sharing and strengthen; thus, the national and EU level social dialogue. In this regard, the Slovenian social partners call for more intensive support of EPSU to national partners to be included in the EU Semester procedure.

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

The social partners listed their priorities to be expressed at the EU level, for example, through their membership in the respective EU level social partner organisation in the hospital and healthcare sector.

In the survey, social partners revealed their priorities that they would like to communicate at the EU level social dialogue. The topics range from comprehensive, overall structural problems, such as safety and health at work and working conditions, to discussions on the European Minimum Wage Directive. Health workforce shortages, addressing the profession's attractiveness, and improving the recruitment and retention policies for all health workers are the common topics for most social partners from all four Central European countries surveyed.

Table 4: Priorities to be communicated to the EU level

Country	Priorities	
	Trade unions	**Employers' organisations**
Croatia	• Recruitment and retention policies for all health workers • Safety and health at work • Salaries in health care and of nurses specifically • Working conditions • Staff training • Material rights of health professionals´ • Rights and obligations • Overtime • Collective agreements • Lack of health workers	• All the topics surveyed • Synergy of private and public healthcare • Occupational safety

[14] Eurofound (2020), Involvement of national social partners in policymaking – 2019, Publications Office of the European Union, Luxembourg.
[15] Based on the discussion at the Regional Webinar 20 April 2021.

Czech Republic	• Remuneration of employees in health and social services • Safety and health protection at work • Staff protection and security • Social dialogue with employers and the creation of agreements and guidelines • Recruitment and retention policies for all health workers • Working conditions	• Directive on Working Conditions • European minimum wage • Recruitment and retention policies for all health workers • The attractiveness of the sector for young workers
Slovakia	• Woking conditions and • Reconciliation of work and family • Continuing professional development and life-long learning • Recruitment and retention policies for all health workers • Lack of personnel and increasing the value of nurses' work	• To promote the interests of its members in the distribution of EU structural funds (ASN) • Creating decent conditions for employees (ASN) • Increase in payments for state insured persons (ASL SR)[16]
Slovenia	• Recruitment and retention policies for all health workers • Safety and health at work • Working conditions • The attractiveness of the sector for young workers • Ensuring effective public health • Care personnel norms in health care • Remuneration system in health care • Working time	• No information available

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

The highest-rated topics are working conditions (4,9), recruitment policies (4,8) and safety and health at work (4,7). Even though the number of employers' organisations taking part in the survey was limited, they prefer to communicate more the attractiveness of the sector and recruitment policies than working conditions and safety at work. The less rated topic is the cross-border recognition of the professional qualification, although most of these countries suffer from health workforce shortages.

Table 5: The organisations' priorities with the highest rating (in %, N = 18)

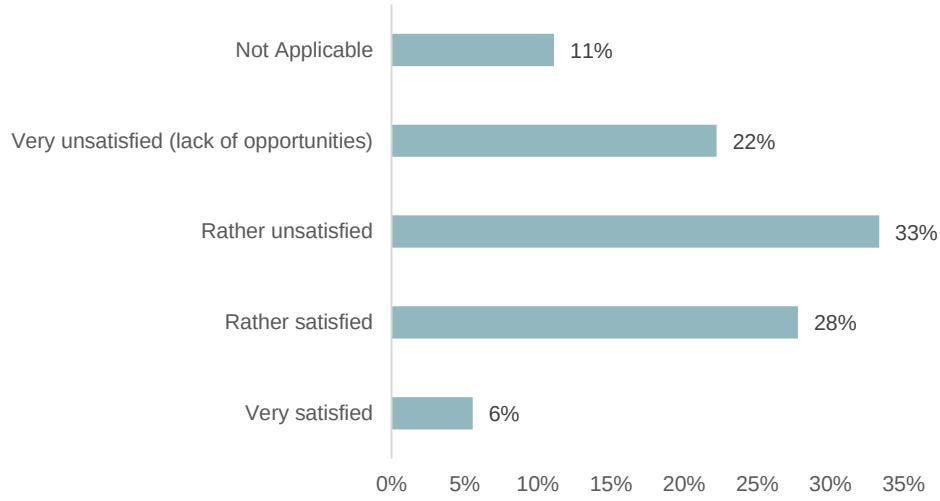
Priority	Rating at 4	Rating at 5	Weighted average
Working conditions	11%	89%	4,9
Recruitment and retention policies for all health workers	17%	83%	4,8
Safety and health at work	17%	78%	4,7
The attractiveness of the sector for young workers	22%	67%	4,6
Reconciliation of work and family	11%	78%	4,6
Ageing workforce	50%	44%	4,4
Vocational education and training	50%	39%	4,3
Continuing Professional Development and Life-long learning	33%	50%	4,3
Recognition of skills at the national level	28%	44%	4,1
Mobility of health professionals in the EU	39%	33%	4,1
Digitalisation of workplace / digital skills	33%	39%	4,1
Cross-border recognition of professional qualifications	22%	33%	3,8

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

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

Findings show room for improvement regarding national organisations' involvement, creating a more engaging and participatory environment for the national partners at the EU level.

Graph 4: Satisfaction with the opportunities to address the priorities at the EU level social dialogue (%, N= 18)



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

The COVID-19 pandemic changed the priorities of the social partners in a way that intensified the urgency of the problems relevant already before the health crises. The difficulties not addressed for a long-time were exaggerated during the pandemic in all targeted countries. Specifically, addressing the lack of staff, in particular of nurses became critical. Health and safety issues have acquired additional dimensions in terms of protecting employees from infection and being adequately supplied with personal protective equipment.[17] According to Trade Union representations, support on nursing staff stabilisation was lacking from national employers and in a broader context, the European institutions.[18] In Croatia and Slovenia, the psychological stress and physical exhaustion of health workforce intensified during the crisis.[19]

The pandemic forced to adapt fully to the COVID-19 patients only, and the financing needed to be changed. Most countries had to invite medical students to fill staff shortages. At the same time, the healthcare provision was stalled or minimised for non-COVID-19 patients, thus intensifying the healthcare needs after critical waves.[20]

The regional workshop discussion uncovered a new topic to be communicated to the EU level. Social partners from Croatia and Slovakia called for a bigger funding share from the Recovery and Resilience Plans. The workshop participants considered the consultation process of developing the recovery plan as insufficient. The opportunities to negotiate the proper share in social dialogue at the national level was not utilised.

The recruitment and retention policies have been revealed as one of the most important priority to be communicated at the EU level. The national social partners shared good practices in this regard ranging from scholarships and how to address health workforce brain drain.

Table 6: The organisations' expectations from the EU level social dialogue structures (%, N= 18)

Expectations	Per cent
Support of EU-level social partners to our organisation to make a stronger impact on the policies in the health sector in our country	67%
Capacity building – providing specific guidance on how to strengthen social dialogue and collective bargaining in our country's hospitals and healthcare	67%
Support for us in domestic collective bargaining (e.g. wage-related bargaining)	56%

[17] Based on the discussion at the Regional Webinar 20 April 2021.
[18] Case from Slovakia, where the trade unions and professional associations pushed through a new category of nursing professionals „practical nurses" to increase their nurses. These have been challenged by the EU-level bodies and Slovak Health Ministry implies counteractions (Based on the discussion at the Regional Webinar 20 April 2021).
[19] Based on the discussion at the Regional Webinar 20 April 2021.
[20] Based on the discussion at the Regional Webinar 20 April 2021.

Expectations	Per cent
Greater acknowledgement of our organisation´s interests and incorporation into the EU-level agenda of social dialogue	56%
To provide space for networking and exchange of experiences	56%
Support for us in domestic collective bargaining (e.g. wage-related bargaining)	56%

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

Based on the survey, the social partners expect the following from the EU level: support to make a stronger impact on the national policies in the health sector and provide specific guidance on strengthening social dialogue at the national level. These two most vocal expectations reveal that national social partners need to increase their influence at the national level. EU level social dialogue structures are expected to be supportive in these terms.

To improve working conditions of healthcare professionals during the pandemic in the EU Member States, national social partners would be interested to receive support from the European Social Partners to be included in the European Semester and Recovery and Resilience Plans process.[21]

Conclusion

The report shows how the social partners from Czech Republic, Croatia, Slovenia, Slovakia are involved in the EU social dialogue structures and European Semester process and what priorities do be communicated to the EU level are of high importance.

The social partners from all four countries revealed that the pandemic exaggerated existing limitations in the sector. The staff shortages, medical deserts, intensified the workload and mental health. Health and safety topics gained new importance, such a s provision of adequate personal protective equipment and psychological support for the staff. The changed working conditions due to pandemic highlighted the necessity of the EU level social dialogue. The European Semester as a coordination mechanism among the EU Member States is the suitable space to communicate the difficulties that countries are facing. The recent reports for the four targeted countries provide challenges that the countries currently face, from the lack of access to healthcare and facilities to the depiction of the structural challenges that need to be addressed in the reform plans.

Despite that the role of social dialogue in these circumstances is crucial, it is often hampered by the fragmentation of the trade union representations and the absence of the independent representative at the employer's side. The situation is also complicated by the privatisation of health care providers who offer more advantageous working conditions than public providers.

A positive finding is that most healthcare trade unions taking part in the survey are already directly involved in EU level social dialogue structures, mostly represented by EPSU. Suppose that employers' organisation from the region were to be a member of HOSPEEM, the agreement on common EU-wide policies could positively impact policies at the national level.

The involvement of national sectoral social partners in the European Semester process is currently limited. The interest to be involved, expressed by 30% of the organisations, creates a potential for improvement. While the recommendations do not specifically address social dialogue in the health sector, some recommendations address the national health systems' most crucial problems, such as health workforce shortages.

It is important to emphasise that the survey data have been collected mostly at the beginning of the pandemic and might not reflect the change circumstances that the health crisis brought later in 2020. It has to be assumed that the priorities revealed through the survey did not change substantially but instead intensified further and became even more urgent.

The national social partners' priorities for the EU level relate mostly to the working conditions and safety issues by the trade unions and recruitment by the employers. The problems in terms of working conditions range from low work value of the nursing professionals to overtimes, workload and reconciliation of the work and family.

The Sectoral Social Dialogue Committee for the Hospital sector has to support national social partners in improving national policies and guidance on how to benefit from the EU level social dialogue structures. It is assumed that these expectations might win on their urgency in light of the health crisis and its long-term impact on people's health.

[21] Based on the discussion at the Regional Webinar 20 April 2021.

Annex

A. Methodology

A combined methodology design was used:

a) Desk research conducted from February to August 2020 focusing on identification of the social partners in the hospital and healthcare sector, their characteristics and studies on the national social dialogue and European Semester,

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

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

The survey was translated into the four national languages (Croatian, Czech, Slovakian and Slovenian) and distributed online via the Survey Monkey systems from February to August 2020. Approximately different organisations, both trade unions and employers' organisations, have been repeatedly invited to complete the survey. The structure of the respondents participating in the survey was as follows:

	Per cent	**Number**
Total number of respondents	100%	25
Country		
Croatia	40%	10
Czech Republic	16%	4
Slovakia	28%	7
Slovenia	16%	4
Type of organisation		
Employers' organisation	8,00%	2
Trade union	80,00%	20
Other	12,00%	3
Position of the respondent within the organisation		
President	40,00%	10
Vice-President	12,00%	3
General Secretary	4,00%	1
Member of the Presidium	8,00%	2
Member of staff	20,00%	5
Other	16,00%	4

c) Analysis of the discussion at the Regional Webinar on 20 April 2021
The workshop's discussion was facilitated by structure prepared in advance; notes have been taken and consolidated into summary findings, complementing the survey and desk-research results.

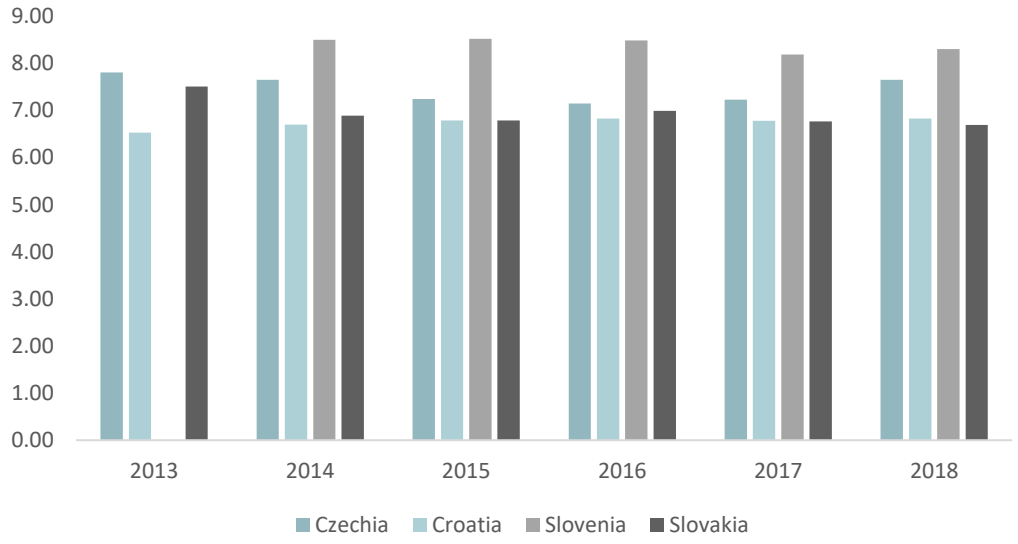
B. Statistical annexe

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

Country	2013	2014	2015	2016	2017	2018
Czechia	7,81	7,65	7,24	7,15	7,23	7,65
Croatia	6,53	6,70	6,79	6,83	6,78	6,83
Slovenia	:	8,50	8,52	8,49	8,19	8,30
Slovakia	7,51	6,89	6,79	6,99	6,77	6,69

Source: Eurostat, Healthcare expenditure by financing scheme [online conde: hlth_sha11_hf]
Note: ":" means that the data are not available

Graph 5: Evolution of the healthcare expenditure – all financial schemes (% of GDP)



Source: Eurostat, Healthcare expenditure by financing scheme [online conde: hlth_sha11_hf]
Note: 0" means that the data are not available

Table 8: Evolution of the number of physicians (number)

Country	2010	2011	2012	2013	2014	2015	2016	2017	2018
Czechia	37 661	38 171	38 624	38 776	:	:	:	:	42 919
Croatia	12 304	12 490	12 772	12 906	13 302	13 430	13 504	13 885	14 075
Slovenia	4 979	5 121	5 228	5 416	5 712	5 830	6 224	6 408	6 591
Slovakia	18 110	17 849	18 193	18 355	18 574	18 719	18 864	18 608	19 178

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

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

Country	2010	2011	2012	2013	2014	2015	2016	2017	2018
Czechia	112839	112656	113262	112686	112830	115006	117160	117439	118818
Croatia	25417	25979	26359	26897	26591	26617	28477	29152	29505
Slovenia	19985	20384	20689	21446	21766	22075	21891	22769	23608
Slovakia	:	:	:	:	:	:	:	:	:

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

C. European Semester Country-Specific Recommendations

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

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

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

D. Participant list of Regional Webinar: Central Europe

Last name	First name	Organisation	Affiliation	Country
Alkema	Tjitte	Hospeem	HOSPEEM	Belgium
Bartlet	Céline	HOSPEEM	HOSPEEM	Belgium
Behrens	Jan	European Commission	Other	Belgium
Bergman	Nina	Vårdförbundet	EPSU	Sweden
Berislavic	Marija	Croatian Trade Union of nurses and medical technicians	EPSU	Croatia
Boieiro	Emanuel	SE - Sindicato dos Enfermeiros	Other	Portugal
Branca	Marta	HOSPEEM	HOSPEEM	Italy
Břeňková	Ivana	TUHSS CR/OSZSP ČR	EPSU	Czech Republic
Dechorgnat	Elisa	FEHAP	HOSPEEM	France
Fasoli	Sara	HOSPEEM	HOSPEEM	Belgium
Filipic	Marijana	CEA	OTHER	Croatia
Gae	Razvan	SANITAS Federation	EPSU	Romania
Grgić	Ida	Crotaian Trade Union of nurses and medical Technicians	EPSU	Croatia
Griskonis	Sigitas	Lithuanian national association of health care organizations	HOSPEEM	Lithuania
Hnykova	Jana	OSZSP ČR	EPSU	Czech Republic
Hodak	Marina	Croatian Trade Union of nurses and medical technicians	EPSU	Croatia
Holthius	Egbert	DG EMPL	EC	Belgium
Holubová	Barbora	CELSI	Other	Slovakia
Horechy	Jiri	UZS	Other	Czech Republic
Howe	Samantha	EPSU	EPSU	Belgium
Ilešič Cujovic	Irena	Trade Union of Health and Social Security of Slovenia	Other	Slovenia
Kahancova	Marta	CELSI	Other	Slovakia
Kalejs	Jevgenijs	Latvian Hospital association	HOSPEEM	Latvia
Kersnič	Boštjan	The Medical Chamber of Slovenia	Other	Slovenia
Kobeščak Rožić	Ivana	Croatian Trade Union of nurses and medical technicians	EPSU	Croatia
Lazič	Vladimir	Health union in PERGAM	EPSU	Slovenia
Malapitan	Christopher	Graphic artist	Other	Belgium
Matejaš Brlić	Nataša	Croatian Trade Union of Nurses and medical Technicians	EPSU	Croatia
Michelutti	Paolo	ASL Roma 3	HOSPEEM	Italia
Papp	Katalin	Chamber of Hungarian Health Care Professionals, University of Debrecen Faculty of Health	Other	Hungary
Počivavšek	Jakob	PERGAM	EPSU	Slovenia
Prasnjak	Anica	Croatian Trade Union of nurses and medical technicians	EPSU	Croatia
Rogalewski	Adam	EPSU	EPSU	Belgium
Scarparo	D'Emanuele	UIL FPL	EPSU	Italy

Schriefer	Jan	FNV the Netherlands	EPSU	The Netherlands
Szalay	Anton	Slovak Trade Union of Health and Social Services	EPSU	Slovakia
Váňová	Miluše	OSZSP ČR	EPSU	Czech Republic
Vîrlan	Alexandra	Health Trade Union Federation „Sănătatea”	EPSU	Republic of Moldova
Vytisková	Soňa	OSZSP ČR	EPSU	Czech Republic