Study measuring the economic, financial and organisational implications for public health care services from possible changes to the Working Time Directive 2003/88/EC

Technical Annex

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INTRODUCTION

The assessment of the financial and organisational implications for public 24/7 health care services of possible changes to the Working Time Directive 2003/88/EC (WTD) concerns as such all EU Member States and so EU-28 as a whole. It has not been feasible, however, within the scope of the present study to make in-depth analyses for all Member States. Instead, we have selected eight Member States in which we have conducted detailed case studies[1]:

- *Denmark*
- *Germany*
- *France*
- *Italy*
- *Greece*
- *Czech Republic*
- *Hungary*
- *UK.*

We have selected the case studies with a view to ensure that different important aspects of the WTD implementation are addressed. We have thus sought to include Member States that allow the opt-out and Member States that do not; Member States that make extensive use of the opt out, and Member States that use it in a more limited way; Member States that are meeting important challenges concerning emigration and Member States that are not; and Member States that are more challenged by fiscal constraints than others. Also, when selecting the case studies attention has been paid to ensuring a good geographical coverage with case study countries from Northern, Southern, Western and Eastern Europe.

Experts from the different case study countries were contracted to carry out the case studies. To guide them in their work and to ensure consistency, relevance and comparability of case study outcomes we prepared:

- Detailed interview guides
- Detailed case study guidelines
- A template for reporting of case studies.

The results from the eight case studies are presented in the following eight chapters while the use of these results to provide EU28-wide analyses and estimates is presented in the Part 1 report. The case studies have been prepared as inputs to the overall and wider EU28 impact assessment study. Therefore, they were completed prior to the completion of the overall study. In consequence, the overall study report is always consistent with the findings of the case study, but the overall study report does in some

[1] The case studies on Denmark and Czech Republic have been elaborated by COWI and the case study on the UK by Warwich Institute for Employment Research. Other case studies have been prepared by: Angela Genova, (Italy), Platon Tinios (Greece) and Sandrine Gineste (France). The case studies on Germany and Hungary were coordinated by GVG, Germany.

instances bring the analyses further than what is presented here, and in other instances, the overall report has not made use of the information in the case studies. The latter is because the case studies were planned and framed first based on anticipated needs for the impact assessment study. However, in some cases it did not prove possible to obtain sufficient and comparable information across countries to allow for a broader analysis in the main study report. Thus, the case studies inform on some aspects (for example public healthcare expenditure and financing, the structure of the public health care sector and enforcement of the WTD) that are not explicitly taken on board in the main report of the study but is used only as background information. It should also be emphasised that the main report aims to deliver an assessment of the organisational and financial impacts of the possible introduction of changes to the WTD *at the EU28 level*. In consequence, the main report concentrates on data that are reasonably comparable across case study countries and on quantitative data.

By comparison, the case studies presented here are comprehensive and qualitative and scoped with a view to address the particular challenges and trends of the particular case study country. Also, as data availability varies substantially across case study countries, some studies have had access to a wealth of data whereas others have been more limited in that respect. :

All case studies that are presented follow a similar overall structure

- Introduction
- Implementation of the WTD
- Challenges and trends
- Implications of introducing changes to the WTD.

Case study authors have consulted with national literature, analyses, policy documents and legislation and they have consulted with national stakeholders from amongst employee and employer organisations, responsible ministries and agencies and in selected hospitals. They have sought information and opinions on a range of issues including: how the WTD is implemented and what the current practice is, what challenges are WTD implementation and the healthcare sector confronted with, what is the national structure, organisation of the public healthcare sector, the number of doctors and nurses and the salaries/labour cost levels and how is enforcement done and financed. Also, they have sought stakeholder views on the effects from possible changes to the WTD.

The case study countries differ from each other in many respects. This includes the availability of data to support the analysis, efforts needed or action taken to adjust to new challenges, such as whether *all* on-call time is to count as working time and whether compensatory rest should always be taken immediately after an extended shift. In regards to the latter, different countries have also opted for different implementation approaches. Last, the public health care sector faces different challenges in different countries.

While all case study chapters follow the same structure, they differ in scope and in the weight attached to different issues. This is a reflection of the mentioned inherent significant differences concerning data availability, implementation approaches, restructuring needs and efforts made and challenges encountered. For example, and put very simply: the situation is Greece is characterised by the crisis, a relatively weak relation between legislation and practice and a need for modernisation and restructuring; the situation in Czech Republic is characterised by a decision not to opt-out and a

widespread practice of concurrent contracts; all hospital doctors in Italy are defined as autonomous and only little knowledge exist on their working conditions; the organisation of working time in France is highly complex; Denmark does not opt-out but does not count inactive on-call time as working time either; Germany is very decentralised, has made an effort to ensure compliance with WTD among other things through quite frequent use of the opt-out; and also in UK, compliance has been provided for and largely through a substantial reorganisation of work.

1. KEY OBSERVATIONS FROM CASE STUDIES

The below sections extract what is called 'key observations' from the case studies. This part is thus not to be seen as providing exhaustive summaries but rather as a list of key and critical observations in each Member State. Thus, the focus is on identifying the most important and critical aspects of the current WTD implementation including challenges encountered.

1.1. Czech Republic

Following the SIMAP/Jaeger rulings, a transition period applied in the Czech Republic where the opt-out was allowed and used. During the transitional period that ran up to end of 2013, overtime was capped at eight hours per week on average over a 26-week period. Today, the opt-out is not used anymore.

So-called 'agreements to perform work' in parallel with the main contract are an essential contribution to overcome the challenges that arise from the WTD and the decision not to opt out. Such agreements were also in place when the opt-out was used, but the concurrent contracts were not used in some, in particular larger, university hospitals. Here, additional staff was contracted and work was reorganised. The use of concurrent contracts is most pronounced in smaller hospitals. There is an aspiration to reduce the use of the contracts, but progress is rather slow. Difficulties encountered in this respect include financial constraints, staff shortages and dependency of workers on the additional income. The contracts are mainly entered into with doctors.

Some hospitals apply a restrictive interpretation of stand-by so that doctors must be physically at the workplace or within close reach. There is, however, no shared opinion among stakeholders about the prevalence or the degree of restriction.

The average weekly working time in the transitional period of the opt-out was rather high, although there are no exact statistics on this. The interviews and the restricted data on this indicate that this is still a challenge and that working time for doctors can be between 55 and 72 hours per week.

Enforcement is limited due to shortage of resources in inspectorates. Among the five most infringed provisions of the WTD are the use of concurrent contracts (agreements to perform work, which essentially concern the same type of work as the main contract) and the length of the weekly working time exceeding the limit of 48 hours per week.

Shortage of staff is indicated as challenging. Estimates following the transposition of the SIMAP/Jaeger rulings pointed to a need to recruit between 15% and 30% more staff. However, data show that the number of staff has increased only very modestly. Shortages are particularly expressed in certain specialities, in the case of (medium) trained doctors and in smaller hospitals. While there is a trend of emigration (estimates indicate that 20% of graduated doctors move abroad), there is also an inflow of foreign doctors. Also, the long working hours can render the sector less attractive as a workplace. Many younger staff indicate a preference to leave the sector, and a number of professionals leave the sector and join e.g. the pharmaceutical industry and companies. Since 2011, remunerations have increased significantly for doctors in particular, but also for nurses.

It is difficult for smaller hospitals to attract junior doctors, and some offer a one-off payment and training commitments (on the part of the hospitals) in order to attract doctors.

1.2. Denmark

The SIMAP/Jaeger rulings have not involved changes in Denmark. Inactive on-call time is not counted as working time, and Denmark does not make use of the opt-out.

The requirement that compensatory rest should be taken immediately after an extended shift is not explicitly contained in Danish law and collective agreements. However, current practice is said to commonly align with this although there are instances of short postponements.

Concurrent contracts are used on a per worker/employer basis. However, it is difficult to delineate what constitutes an employer in this respect: it could be the hospital, which is the main workplace of the doctor in question, or it could be the region that owns the hospital in question.

While stand-by time is only used to a very little extent today, the implication of having to count all on-call time as working time could be a risk that the use of stand-by time would increase. This could be accompanied by a restrictive stand-by definition to ensure that the worker can be quickly mobilised for work.

Actual, registered working hours do not conflict with the limit of 48 hours/week on average.

Enforcement is not done with a focus on working time, and inspections tend to focus on other occupational health and safety aspects. Inspection authorities are aware that inactive on-call time ought to count as working time, but indicate that actions in this regard await a revision of the WTD.

With the given shift patterns and with compensatory rest immediately after an extended shift, it can be difficult to ensure proper handovers.

Staff shortage and composition of workforce are indicated as possible future challenges. Today, staff shortages are mainly observed in remote area public hospitals because doctors typically prefer to work at the larger and central hospitals. Difficulties are for example experienced in filling in allocated vacancies for the first-year practice in remote area hospitals, and these hospitals engage in attracting foreign doctors; an effort which also comes at an additional cost in terms of addressing the related challenges: integration of staff, integration of families, and obtaining approvals of educational achievements. Also, this effort is challenged by the global shortage of specialised staff. There is also a trend of feminisation among the Danish doctors, which it is argued can lead to an increased demand for reduced working hours and part-time employment.

Changes take place to ensure that 24/7 services can be provided in the future: for example the establishment of 'super-hospitals', envisaged to be operational from around 2020, to ensure a concentration of skills and expertise and provide up-to-date equipment and functioning of hospitals. Also, there is an ongoing trend towards shorter, optimised admissions and more outpatient treatment.

1.3. France

France allows the opt-out, and it is said to be used in almost all public hospitals. One particular hospital indicates that 50-60% have opted out. It appears, however, that in recent years the opt-out has not been fully monitored and implemented according to the WTD provisions on e.g. voluntary and written consent.

Regulations and organisations of working time in France are complex. Different detailed rules apply to public hospitals and to not-for-profit organisations, and yet another system is sometimes used in not-for-profit organisations that provide continued night care or what could be termed continued night surveillance (the 'système d'equivalence').

Different rules apply to doctors and to other staff, and a compensatory system is in place to make up for the difference between the 35 working week, which used to apply, and the 39 hours working week that is now commonly applied.

In public hospitals doctors' hours are typically not planned for on an hourly basis: rather the organisation of their work is based on half-days: 10 half-days a week reaching a maximum of 48 hours over the four-month reference period. Practice is so that half-days at daytime are 5 hours and half-days at night are 7 hours. In practice, the 10 half-days can thus come to constitute 50-70 hours of work in a week.

As regards doctors in training, their commitment is 11 half-days per week including training and on-call. Doctors in training can do additional on-call on top of that. The association representing doctors in training did a survey in 2012, which showed that doctors in training could come to work as much as 60 or even 80 hours per week. Recently, discussions have taken place with a view to reducing the number of half-days to 10.

In France, the key challenges of the current implementation of the Directive relate to: the use of half-days without having the length of a half-day fully specified and ensuring rest-periods along with staff shortages in certain areas and financial challenges in hospitals. While the number of hours worked are said to have been reduced, the length of the working week is still a challenge. Staff shortages are partly compensated through external contracting. Rough estimates brought forward through interviews with employer representatives point to a need to recruit some 40,000 additional staff to ensure that practice corresponds with the WTD. Efforts towards re-organisation and new ways of working are investigated along with possible regulatory changes. Initiatives of which some are rather experimental include e.g. a change from a half-day system to an hour-based system, a move to 12-hour shifts and task shifting. Multiple contracts where one worker has contracts with several employees is increasingly used.

1.4. Germany

Since 2004, all on-call time has been counted as working time in Germany. There was a transitional period up to 2006 during which alternative solutions could be put in use if included in a labour agreement. Prior to 2004, only the active on-call time was counted as working time. Hospital premises provided facilities where employers could sleep, relax or pursue other activities during rest periods.

The op-out is allowed in Germany with a limit of 58 hours per week, and it is estimated that some 50% of doctors have signed an opt-out. It is questioned by some stakeholders whether an opt-out can be said to be always fully voluntary.

It is mentioned that ensuring compensatory rest immediately after an extended shift can imply that it becomes difficult to ensure good handovers between shifts.

It is estimated that counting all on-call time as working time has involved additional costs. While estimates of this vary, and it is difficult to establish the exact and unique relationship between additional recruitments and the WTD, one estimate provided points to a need for an additional 10,000 doctors.

Data on actual working time (including overtime, on-call time and active stand-by time) are not accessible on a national scale. One particular survey indicated that 75% of doctors work more than 48 hours per week, and more than half indicated that their working time was not systematically registered.

Shortage of staff is indicated as a challenge, however, more pronounced in some specialities than in others and in some regions more than in others. Especially in smaller hospitals and in more remote areas this can affect not only working time, but also the ability to deliver 24/7 services. Shortage of doctors is caused by many factors; some stakeholders argue that the WTD is an important reason whereas others point mainly to financial challenges. As regards the latter, the introduction of a changed scheme for payments to hospitals, introduced in 2004 has played an important role. The new scheme replaced a per-diem based system by a system along the lines of the Austrian 'refined diagnosis related groups' system. This change is said to have put pressure on less efficient hospitals. Last, feminization of medicine and an increased focus on WLB are also mentioned as possible future challenges.

1.5. Greece

In Greece, there is a very limited availability of data to inform a case study.

Greece is confronted with a multitude of challenges as regards the WTD. First, the WTD has been transposed in a rather rigid manner, which has not made use of the possible flexibility instruments that the WTD offers, e.g. the opt-out and extending the reference period. Second, by tradition, the Greek system for organising working time has concentrated on payments rather than on controlling working hours per se. Third, overcoming the financial crisis has led to severe financial constraints in public hospitals. And fourth, the tradition and culture does not incite reorganisation of work, e.g. in the direction of task shifting and development of new roles (it should be mentioned here that Greece has a very high doctor/nurse ratio compared to other European countries). As regards the 'rigid' transposition, it is striking that the case study mentions the general low level of awareness among stakeholders about the WTD.

As said, working time regulations in Greece emphasises the payment aspect more than the need to control working time. In consequence, there is control of the latter. A distinction used to be made between 'notional' and 'genuine' overtime where the former was, put simply merely a mechanism to add to payments. Today, systems are such that fixed amounts of overtime are built into the contracts. The reference period is limited to a month, and hence there is no transfer to the next month of what could be labelled overtime. Thus, if someone on average works above the stipulated normal

week in one month, but below in another there is no levelling out of this. Again, it should be noted that this counting systems aims only to settle remunerations, but there is no separate accounting for working time per se, which could benefit from a four or six month reference period.

Rest periods can and should be taken within five days. As for compensatory rest, this should be taken on the same working day and cannot be postponed for more than five days. This is however not monitored, and anecdotal evidence suggests that rest stipulations are not always adhered concerning rest per se as well as the timing of compensatory rest.

There is no monitoring of working time, but anecdotal evidence suggests working weeks that can extend up to an average of 60 hours for doctors and 70 hours for junior doctors.

Data on enforcement are no available, but indications do point to an enforcement system with difficulties in distinguishing working time issues from occupational health and safety issues, and which does not provide the strong backbone for ensuring compliance with the WTD in full.

Fiscal constraints are the main cause for shortage of staff and arrears of overtime are building up. Other challenges, however, also relate to the organisation of work. Challenges in this area include fragmented infrastructure (duplication of services in relatively close vicinity), suspicion and non-use of flexible work arrangements, heavy 'command' structures and seasonal variation). Staff shortages are more pronounced in remote areas. Further, the financial crisis has led to a wave of retirements, to emigration of younger doctors (leading to shortages in certain specialisms), a virtual cessation of new hires, and substantial reductions in pays. These factors do 1) call for doctors and nurses to deliver more working hours, and 2) doctors and nurses may be inclined to work many additional hours to compensate for lost income.

1.6. Hungary

The WTD is implemented in Hungary, and Hungary makes use of the opt-out. At the same time, Hungary has challenges in terms of shortage of doctors.

Today, there is little information on the use of the opt-out and the working hours delivered under the opt-out. However, employers are required to keep records thereof. The best estimate available today is that the 31% of doctors are reported to work more than 48 hours per week and have signed an opt-out.

The average weekly working hours for doctors are indicated to be in the range of between 48 and 51 hours. However, these figures may be underestimated for two reasons: the fact that not all hours delivered under an opt-out may be reported and because of the use of concurrent contracts.

Concurrent contracts are reported to be used in Hungary although the extent of the use is not known. They are used for different employers, but also with the same employer. Concurrent contracts, as well as the use of self-employed, are mentioned as important means to compensate for the experienced staff shortages. Registers to keep track of activities performed under contracted services are currently under construction.

The requirement to take compensatory rest immediately after an extended shift is mentioned as a factor that can constrain good handovers.

Data on enforcement do not indicate that the healthcare sector exhibits features that are different from other sectors.

The migration of doctors is a significant challenge in Hungary and different initiatives have been taken to provide for retention within the national system. Initiatives taken include e.g. scholarship grants and wage increases.

1.7. Italy

A distinct feature in Italy is the fact that all doctors in the public healthcare system have in recent years been categorised as managers and are considered autonomous. While their working time is still agreed on through agreements, they are still to deliver a significant level of flexibility, as their key output is to 'achieve the organisation's objectives and plans. This situation will change when the new legislation designed to remedy the related infringement will enter into force in November 2015.

Doctors deliver overtime including on-call time, and estimates of the need for this is provided in their contracts. They can also be requested to do what is termed 'freelance' work in order to help reduce waiting lists. While the freelancer activities cannot come to exceed the total amount of institutional working time or workload of each doctor, there is nevertheless not adequate control of the total amount of working time of freelancers.

Opt-out is allowed for and with no limit to the total working time. No data exist on the extent of opt-out, but it is assessed to be put in actual use the most during holiday periods. Today, there is no requirement for a written consent, and if content was required it is not necessarily so that all doctors would sign it.

Immediate and compensatory rest should be taken after an extended shift, and apart from this collective agreements use the term 'adequate rest'.

Remuneration systems imply that stand-by is less costly than on-call time, and hence there is a risk that stand-by time can come to be used in situations where on-call would be more appropriate, including a risk that the stand-by conditions may be restricted for the employee. A local case indicates that as many as 48% of doctors where involved in stand-by duties.

Stakeholders indicate that working time exceeds the 48-hour limit, and also the intensity of the work is seen as increasing. An important reason for this is the limits introduced on recruitment, which is in turn due to fiscal challenges.

1.8. The UK

Following the SIMAP/Jaeger rulings and after transitional period doctors in training are not allowed to work more than 48 hours per week over a six-month reference period. This applies also to other doctors. Junior doctors that opt-out cannot work more than 56 hours/week. Junior doctors can be asked to close gaps in shifts, but they are not obligated to cover the gaps.

Information on the extent to which the opt-out is used is only available within the individual hospital. However, a 2009 survey indicated that 47% of all 'career doctors' worked more than 48 hours per week, and 9% had signed an opt-out[2]. The opt-out is seen as useful for covering unexpected demand and providing flexibility at the margin.

The public health sector in the UK has been subject to a number of reforms over the years. Reforms that has also helped to ensure implementation of the WTD including a substantial reduction in the working hours delivered by junior doctors. An increase could be observed in the number of junior doctors in training, which can be partly a result from the changes in their working time, but which is also likely to be attributable to an increased funding for NHS hospitals. Hospitals at night is another initiative that has played a role in the move away from the significant reliance on resident on-call services to full shifts. On-call resident facilities have now been removed from many hospitals.

Average working hours/week is slightly below 40 compared to a standard working week of 37.5 hours[3].

Some stakeholders argue that a key challenge of the WTD today is the compensatory rest. Having to take compensatory rest immediately after an extended shift can lead to cancellations of planned clinics and to insufficient handovers. Smaller, rural hospitals are like to have more difficulties in finding substitute staff, and hence likely to be more exposed to these impacts.

It is argued by some stakeholders that unofficial working hours can be longer than reported working hours

[2] More recent data from the Federation of Royal College of Physicians' (FedRCP) indicates that around 14% of doctors in 2011 had signed an opted-out

[3] More recent data from ASHE (2013), indicates that working hours for doctors that are opted-out is 56 hours and for doctors not opted-out is 41 hours. Similar the numbers for nurses are 48 and 38 hours respectively.

2. CZECH REPUBLIC

2.1. Introduction

Working time in the Czech Republic is regulated in the Labour Code (262/2006 Coll.). Although the collective bargaining coverage in the Czech Republic is generally relatively low (37%; Czech Statistical Office, Structure of Earnings Survey, 2011), collective agreements have been concluded in virtually all hospitals. The specific points addressed by collective bargaining relate – apart from issues of remuneration - to monitoring of working time, organisation of work (shift plans, vacation plans, etc.) and the extension of reference periods for calculating the maximum weekly working time.

In 2012, the share of health care expenditure in GDP amounted to 7.6%, which is somewhat lower than the 2011 OECD average of 9.3% (OECD Health Data, June 2013). The existing public budget constraints are among the primary factors influencing the implementation of the WTD and the capacity of the health care sector to incorporate consequential changes. These constraints implied that very few hospitals introduced far-reaching changes following the transposition of the Directive into the Czech legal order and that the vast majority of establishments opted for temporary solutions. Accordingly, as of today, there is a substantial discrepancy between the full and effective implementation of the Directive and the current implementation. Although the case study identified a positive trend towards addressing the existing challenges in the implementation of the Directive, financial constraints are likely to continue to affect the way the WTD is being implemented and will have a major influence on the way suggested changes to the WTD ('building blocks') will generate workplace implications and thereby impacts.

As will be elaborated in section 3.4 below, the stakeholders consulted identified a number of implications stemming from the WTD building blocks. Specifically, the 'on-call time', 'stand-by time' and 'concurrent employment contracts' were most frequently cited as building blocks likely to generate substantial workplace implications and thereby impacts. In a number of other cases, the suggested building blocks correspond either to the legal (e.g. 'reference periods', 'opt-out') or to the factual *status quo* ('compensatory rest') and, accordingly, are unlikely to cause further workplace implications and thereby generate impacts.

Generally, the stakeholders consulted experienced considerable difficulties in providing estimates of the costs and the benefits of the individual building blocks. This is primarily because the current extent of working time in the health care sector is not systematically monitored. Consequently, the gap between the current extent of working time and that necessary to comply with a particular building block is difficult to estimate. The final estimates, following an analysis of the data collected, are presented in section 2.4.

As regards the social impacts of the building blocks, workers' representatives have identified a correlation between the length of working time and negative social impacts of the building blocks (in terms of e.g. risk of making medical errors, mistakes in handovers, perceived workers' health, work-life balance, illness and absence from work and productivity loss). However, specific evidence in support of this assertion could not be established.

Stakeholder interviews revealed diverging views between the social partners about the impact of the WTD and possible changes thereof. Moreover, it also became apparent that there are significant differences between the views expressed by small to middle-sized hospitals and large hospitals. Instances where such differences occur are highlighted throughout the report.

2.2. Implementation of the WTD

By the end of 2012 there were 188 hospitals with a total number of 58,832 beds registered (ÚZIS, In patient care 2012, 2013). Out of these hospitals:

- 19 were founded directly by the Ministry of Health
- 5 hospitals were founded by other central institutions
- 23 were founded by a region (as subsidised organisations)
- 17 were founded by municipalities (as subsidised organisations)
- 124 were founded by another legal person, including churches.

A formal distinction can be made between *state hospitals*, i.e. those founded either by the Ministry of Health or another central institution, and *other hospitals* (i.e. those founded by a region, municipality, church, or other legal or natural person).

Although remuneration is not an issue addressed by the WTD, there is an important difference between hospitals in which the monthly salary of workers is set by valid regulations on salary ('*platový tarif*'); i.e. establishments founded by the Ministry of Health, region, municipality or other central institutions, and those in which workers are remunerated according to the valid regulations on wage ('*mzdový předpis*'); i.e. establishments founded by another legal person in the form of private companies (typically limited liability companies). Hospitals belonging to the latter category include those establishments founded and owned by a region or municipality (i.e. the region/municipality is typically the only shareholder in such establishments). Accordingly, this category of hospitals is taken into account in the analysis. At the end of 2012, this category counted 43 hospitals founded by the municipality or the region.

The average salary according to the valid regulations of salary is higher than the wage according to the wage regulations. In 2012, the average salary was CZK 61,078 and CZK 29,150 for doctors and nurses respectively, while the average wage was CZK 55,957 and CZK 23,567 (ÚZIS, Wages and salaries in health care services in 2012). This difference in the individual remuneration is a factor that affects the total labour costs of the two types of hospitals.

Hospitals can be divided into four categories depending on the number of beds:

- small-sized hospitals (i.e. hospitals with less than 100 beds): 44
- medium-sized hospitals (i.e. hospitals with 100-499 beds): 113
- large hospitals (i.e. hospitals with 500-999 beds): 20
- very large hospitals (i.e. hospitals with more than 1,000 beds): 11.

Another distinction can be made between university hospitals ('*fakultní nemocnice*') and other, e.g. local and regional hospitals ('*oblastní a okresní nemocnice*'). By the end of 2012, there were 10 university hospitals in the Czech Republic. University

hospitals are hospitals founded by the Ministry of Health, offering educational bases for medical and pharmaceutical faculties. They are fairly large and characterised by a broader array of medical services offered and a high concentration of research activities, courses, etc.

The challenges in complying with the working time limits are more pronounced in smaller hospitals, although, as will be described below, not entirely limited to those. The shortage of specialised staff is perceived as a problem primarily in smaller hospitals, which – on the one hand – have a larger share of workers affected by the working time rules regarding the maximum extent of working time (i.e. there is a lower share of workers that do not work full-time) and – on the other hand – experience greater difficulties in attracting specialised staff, especially in some specialisations. The latter challenge is closely tied up to the existing system for training junior doctors, in which training is mainly centralised in larger, in particular university, hospitals.

2.2.1. WTD implementation approach

Working time in the Czech Republic is regulated by the Labour Code (262/2006 Coll.). The predecessor of the WTD, the Directive 93/104, was transposed into the Czech legal order with effect from 1 January 2001. In connection with the adoption of Directive 2003/88, a number of substantive changes were introduced into the Czech legal order. Further changes followed with the adoption of the new Labour Code, effective as of 1 January 2007, transposing the ECJ jurisprudence regarding on-call time.

- '*Working time'* is defined as a period of time for which a worker is obliged to perform work for his employer and a period of time for which a worker is ready to perform work at the workplace according to his employer's instructions (s 78(1)(a) of the Labour Code).
- '*Rest periods*' are defined as any period outside of working hours (s 78(1)(b) of the Code).
- '*Stand-by time*' means a period during which a worker is in the state of readiness to perform work, as covered by his employment contract, and which in the event of an urgent need must be done in addition to his schedule of shifts. Stand-by may only take place at a place agreed with a worker, but it must be at a place other than the employer's workplace (s 78(1)(h) of the Code).
- '*Overtime work*' is work performed by a worker, on the order of his employer or with his employer's consent, which exceeds the weekly working hours ensuing from the predetermined schedule of working hours and above the pattern of shifts (s 78(1)(i) of the Code).

The Labour Code sets limits to issues, which may be regulated by means of collective agreements. Collective agreements of a higher degree (i.e. collective agreements applicable for the entire sector of economy, used as an alternative to laws and administrative orders) have not been utilised in the health care sector. Rather, collective negotiations take place at individual hospital level. Although, overall, the collective bargaining coverage in the Czech Republic is relatively low (37%; Czech Statistical Office, Structure of Earnings Survey, 2011), a collective agreement has been concluded in virtually all hospitals. The specific points in the collective bargaining

relate to monitoring of working time, organisation of work (shift plans, vacation plans, etc.) and the extension of reference periods for calculating the maximum weekly working time to 12 months.

In a number of cases, the Czech Republic has introduced regulation that is more favourable towards the protection of health and safety of workers than the one required as the minimum standard in the WTD. Furthermore, in implementing the Directive, the Czech Republic has not utilised all the flexibility mechanisms offered by the Directive to meet the challenges in organising working time in the health care sector (e.g. the opt-out made pursuant to Art. 22(1) from the provision on maximum weekly working time is no longer used as of 1 January 2014). On the other hand, there are a few instances in which more protective conditions have been adopted. The following main variations have been identified (Table 2-1).

Table 2-1 Variations of national implementation

Key provision	Variations of national implementation
Compensatory rest	• The minimum daily rest period is 12 hours (instead of 11 hours) • By means of derogation, the daily rest period may be limited to 8 hours provided that the subsequent rest period is extended by the time for which his/her preceding rest period was reduced
Reference periods	• The option to extend the reference period for calculating weekly working time has been used for all activities: i.e. for all activities the reference period for calculating weekly working time may not exceed 26 consecutive weeks. A relevant collective agreement may extend such a period to 52 consecutive weeks at the utmost.
Scope of the Directive	• The working time limits are applied per contract, although there is no express provision to this effect (the only limitation is that a concurrent contract for the same employer may not be concluded for the same type of work).

In addition, a number of national measures (laws and administrative regulations) applicable to the health care sector have been introduced. These measures do not deal with the regulation of working time as such, but provide a number of requirements concerning, in particular:

- Qualification of health care personnel (Laws 95 and 96/2004 Coll. for doctors and other health care personnel, respectively);
- Minimum requirements for safeguarding the provision of health care services in respect of the type and number of personnel available at the health care facilities[4] (Order 99/2012 Coll.);
- The system for financing of health care (Order 428/2013 Coll. for 2014).

[4] The requirements are provided as for each 30 beds and differentiated according to the type of care provided and specialisation. For each of the categories the Order lays down the type(s) of workers required – as a minimum - in order to safeguard the provision of health care; i.e. those whose presence at the workplace is physically required and those, who shall be merely contactable in order to provide advice and guidance; and the amount of workers (expressed in the number of full-time workers).

On many occasions, these acts give rise to additional challenges in implementing the WTD in the health care sector.

To respond to the existing immediate challenges of organising working time, a large proportion of hospitals introduced a number of *alternative solutions* (most frequently in the form of agreements to perform work concluded in parallel with the main employment relationship). Such solutions cannot always be reconciled with the scheme and the purpose of the WTD and, in some cases, constitute infringements of the applicable national working time rules, as laid down in the Labour Code. As will be explored in section 2.3.1, this poses a specific challenge in establishing a reliable baseline, and, as a result, estimating the implications resulting from potential changes to the WTD.

A more detailed overview of the implementation of the key provisions of the Directive is provided below:

On-call time
Pursuant to s. 79(1) of the Code, the maximum length of standard weekly hours should be 40 hours per week. Effective from 1 January 2007, on-call time is no longer regarded as a special category of working time, but counts fully as working time and thereby as part of the 40-hour standard weekly working time. Prior to the introduction of the current Labour Code, '*on-call time*' could amount to 400 hours per calendar year, subject to the worker's consent (65/1965 Coll.).

The Labour Code contains a detailed regulation of '*overtime work*' (s. 93(4)). This concept includes, on the one hand, overtime work ordered by the employer and, on the other hand, overtime work performed with the consent of the worker. Overall, there are three different categories of overtime:

- '*ordered overtime*': the employer may order overtime work only exceptionally and such work may not exceed eight hours within individual weeks and 150 hours within one calendar year (s. 93(2) of the Labour Code).
- '*agreed overtime*': above the limit specified above, overtime work may be carried out only with the consent of the worker and the total scope of overtime work may not exceed on average eight hours per week calculated over a period of no more than 26 consecutive weeks (or 52 if agreed in a collective agreement).

  As will be described below in more detail, an additional provision was applied in a transitional period from 1 October 2008 to 31 December 2013, but is no longer applied. Under this previous provision the agreed overtime (see above) could be extended for certain workers in the health care sector subject to a number of protective conditions, most notably the worker's consent. Such additionally extended overtime was referred to as '*additionally agreed overtime*'. The additionally agreed overtime was not to exceed on average eight hours (or 12 hours for workers within the health care rescue services) over a period that may not be longer than 26 consecutive weeks (or extended up to 52 weeks by a collective agreement).

For overtime work, a worker is entitled to the salary/wage for work done within overtime and to at least 25% of his average earnings; unless the employer and the worker have agreed that instead of the premium for overtime work, the worker will

take compensatory time off in the scope of the hours when he/she worked overtime (s. 114(1)).

Stand-by time
Pursuant to s. 95(3) of the Labour Code, stand-by time during which work is not performed ('inactive stand-by time') is not included in the working hours. Performance of work during stand-by time ('active stand-by time') is, on the other hand, included in either standard working time or, if carried out above standard weekly hours, in overtime.

The Labour Code contains specific provisions governing the remuneration of stand-by time. Where a worker performs work during a stand-by period, he/she is entitled to wage or salary (s. 95(2) of the Labour Code). For periods where the worker does not perform work, he/she is entitled to remuneration for an amount of at least 10% of his/her average earnings (s. 140 of the Labour Code). The remuneration for stand-by time can be – and in practice often is - subject to an individual agreement with the employer.

Opt-out
When implementing the provisions of the WTD, an *additional transitional period* for workers in the health care sector was provided (294/2008 Coll.). The introduction of the transitional period was conceived as a temporary solution aimed to 'compensate for' the revision of the working time rules as regards on-call time. During this transitional period (1 October 2008-31 December 2013), it was possible to agree on additional overtime of a certain maximum extent.

The Health and Social Care Workers Union issued a recommendation for the use of the instrument of additionally agreed overtime. The Union has recommended not to increase the extent of overtime and to use the opt-out opportunity only in those areas (specialisations) where this was absolutely necessary.

As of 1 January 2014, the rules for additionally agreed overtime in the health care sector were repealed and, accordingly, only general rules for calculating overtime (i.e. ordered and additionally agreed overtime) apply in the health care sector.[5]

The scope of the transitional period was limited to workers working in "*continuous operations in connection with the reception, treatment and care of patients or in connection with providing pre-hospital urgent care in hospitals, other in-patient health care facilities of health care rescue services*" by a physician, dentist, pharmacist or a health care worker of paramedic health care professions. In other words, it did not apply e.g. to nurses and other health-sector workers not expressly specified in the provision.

As outlined above, the provision allowed for additional eight hours per week within a 26-week period (52 weeks when agreed in a collective agreement) as additionally agreed overtime, worked on top of the maximum amount of 150 overtime hours per calendar year, which could be performed at the request of the employer. The working

[5] At the end of 2013, the Ministry of Health, together with the Ministry of Labour and Social Affairs started preparations for introducing a new law that would extend the transitional period for overtime rules in health care from mid-2014 to 31 December 2015, under the same conditions as before (Kroupa, 2014). However, according to the recent information obtained from stakeholders, the re-introduction of the opt-out is no longer being considered.

time of certain workers in the health care sector could thus be approximately 40 standard weekly working hours, 150 hours of ordered overtime per calendar year, 266 hours of agreed overtime in a 26-week period or –if extended by a collective agreement – 52 consecutive weeks and 416 hours of additionally agreed overtime over a period of 26 weeks or – if extended by a collective agreement - 52 weeks.

Compensatory rest
Pursuant to s. 90 of the Labour Code, the employer should distribute working hours in such a way that the worker has a minimum rest period of 12 hours between the end of one shift and the start of a subsequent shift within 24 consecutive hours. For workers providing services in health care (medical) establishments such a rest period may be reduced to a minimum of eight hours, if the subsequent rest period is extended by the time for which his/her preceding rest period was reduced.

As regards uninterrupted weekly rest for workers providing services to the population in health care (medical) establishments, the period of uninterrupted rest during the week may be limited to 24 hours, provided that the workers are granted an uninterrupted rest period of at least 70 hours within two weeks (s. 92(3)).

Reference periods
According to s. 86(3) of the Labour Code, the reference period for the calculation of working hours may not exceed 26 consecutive weeks. Only the relevant collective agreement may extend such period to maximum 52 consecutive weeks.

For a weekly rest period, a reference period is set to one week and, by derogation for certain categories of workers (including workers providing services in health care (medical) establishments), the period is extended to two weeks.

Finally, the reference period for the calculation of the length of night work is set to maximum 26 weeks, the calculation being based on a five-day working week (s. 94(1)).

Autonomous workers
The Labour Code does not contain any specific provisions for exceptions regarding the organisation of working time and working time limits for 'autonomous workers'.

Pursuant to the Companies Act (90/2012 Coll.) s. 59 et seq., the relationship between a member of the board of directors and the company is regulated by a contract for the performance of a function. This is a special type of agreement, which is not governed by the general Labour Code provisions for the organisation of working time and the working time limits.

Scope of the Directive
The Labour Code does not contain any limitations to the number of employment relationships between the employer and the worker and does not expressly address whether the working time and rest periods stipulated in the Code are to be considered absolute limits or whether they are set for each relationship separately.

As a general rule, the Code nonetheless provides that in the cases where a worker has a further basic relationship (i.e. either an employment relationship or a legal relationship based on so called 'agreements on work performed outside an

employment relationship') with the same employer, he/she cannot in such a further relationship perform "*work of the same type*" (s. 34b(2)).[6]

As an alternative to an employment relationship, the Labour Code (s. 76 et seq.) provides for the possibility to conclude *an agreement to perform work*. The conclusion of such an agreement is subject to the condition that the scope of work does not exceed 300 hours in one calendar year and that the average scope of work does not exceed one-half of standard weekly hours (i.e. 20 hours). As with agreements to perform work, the general rules of the Labour Code regarding working hours and rest periods do not apply. The only condition is that the performance of work does not exceed 12 hours within 24 consecutive hours.

Derogations
The possibility under Art. 17(3)(c)(i) of the WTD to derogate from a number of provisions of the Directive has been used for the uninterrupted daily rest period and weekly rest:

- as regards uninterrupted daily rest, the rest period may be reduced from 12 to 8 hours, provided that the subsequent rest period is extended by the time for which his preceding rest period was reduced
- as regards weekly rest, the rest period may be reduced from 35 to 24 hours, provided that the workers are granted an uninterrupted rest period of at least 70 hours within two weeks.

2.2.2. WTD enforcement procedures

The enforcement of the rules of the Labour Code was as from 2005 vested with the labour inspectorates (251/2005 Coll.). The State Labour Inspectorate and the local inspectorates carry out comprehensive controls of compliance with the Labour Code provisions, transposing the rules of the WTD, on rest periods, overtime, night work and stand-by time.

Until 2014, the compliance with the conditions for the use of the individual opt-out was also within the competence of the labour inspectorates. Pursuant to s. 93a(2) of the Labour Code, the employers were obliged to notify the competent labour inspectorate of the application of the individual opt-out. According to the Labour Inspectorates statistics, the opt-out was used by approximately 22 employers per year (but cf. estimates provided by stakeholders in section 2.3.1).

A system of sanctions is provided for infringements of the working time rules. Prior to 2014, these sanctions included the possibility to prohibit or to restrict overtime work according to an individual opt-out (s. 4 and 5 of 251/2005 Coll.).

Between 2008 and 2013, the State Labour Inspectorate carried out approximately 45-50 controls in the health care sector. These were not strictly limited to checking compliance with the working time limits, but also addressed issues such as remuneration, conclusion of employment relationships, etc.

[6] See also decision of the Supreme Court of 11 June 2013, 21 CDo 1573/2012.

Limitations on the extent to which working time rules are being enforced exist as a result of limited resources within the inspectorates (Nekolová, 2010). Moreover, stakeholders inform that inspection frequency was rather low during the time following the introduction of the Labour Code, transposing ECJ's interpretation of on-call time. Nonetheless, more frequent inspections at the hospitals in recent months have been reported by the stakeholders interviewed.

The provisions most often infringed include:

- the length of a shift exceeding 12 hours
- the length of the minimum weekly rest period
- the performance of work for the same employer of the same type as under the basic employment relationship
- the length of the minimum daily rest period
- the length of the overtime work exceeding eight hours per week within a reference period (not taking into account the additionally agreed overtime pursuant to an opt-out agreement).

The majority of the infringements were registered in case of doctors; a much lower number of infringements concerned to nurses.

The costs of the enforcement of the Labour Code provisions implementing the WTD cannot be separated from the costs of the enforcement of other provisions of the Labour Code. These costs consist of salaries, travel costs, overhead, etc. According to the information provided by the State Labour Inspectorate, the costs of enforcement have not changed following the implementation of the Directive. Similarly, in case of a potential change of the provisions of the Directive, no significant changes to the inspectorate's budget are foreseen by the State Labour Inspectorate. Generally, labour inspectorates plan their enforcement activities with reference to the current situation and problems encountered on the labour market and taking into account its resources.

The State Labour Inspectorate has had good results in conducting controls in the health care establishments that had informed the inspectorate of the use of the individual opt-out option (see above). These controls were combined with random controls of establishments that had not provided such information.

2.3. Challenges and trends

2.3.1. Workplace challenges and trends

Working time for doctors and nurses

There are no official statistics regarding the extent of doctors' working time and overtime.[7] The assessment of the current working time for doctors and nurses is therefore based primarily on the views expressed by stakeholders during the interviews.

[7] The latest data available with the Institute of Health Information and Statistics of the Czech Republic are from 2005.

The abandonment of on-call time as a special category of working time posed a great challenge to the majority of hospitals in the Czech Republic in terms of complying with the working time limits.

As the individual opt-out option was introduced in the Czech legal order only 10 months after the transposition of the on-call time rules into the Labour Code, the majority of hospitals reacted to the changes introduced by the Labour Code by the conclusion of concurrent employment contracts (typically agreements the perform work) with those workers, regarding whom the existing working time limits for overtime work could not be adhered to. As indicated above, pursuant to such agreements workers are formally obliged to perform a type of work, defined as being different from the one under the main employment relationship (e.g. typically consultation services). In practice, however, the type of work carried out according to an agreement to perform work is essentially the same as under the main employment relationship. In other words, such agreements "allowed" the extension of the working time limits per worker to compensate for the institute of on-call time. Stakeholders inform that even with the introduction of the opt-out as of 1 October 2008, the majority of the hospitals that had introduced systems of concurrent agreements retained the system.

Other hospitals, in particular large (university) hospitals, have neither utilised the opt-out option nor resorted to concurrent agreements. This was primarily because in the areas where the opt-out was necessary, the maximum limit for the additionally agreed overtime pursuant to an individual opt-out agreement did not suffice, while in other areas it was not needed. In such hospitals, organisational changes and, to a limited extent, hiring of additional staff, were introduced in order to comply with the working time limits.

In a number of cases, concurrent agreements are concluded with different employers, primarily with ambulatory care provides, but in some cases also with two or more different hospitals.[8] According to the stakeholders, this concerns approximately 20-30% of the doctors, but a more detailed estimate, distinguishing between different types of employers, could not be provided.

Apart from concluding concurrent agreements with the same employer (and in some cases different employers), new ways of solving the problem of staff shortage evolve. These include the formation of private limited companies contracting services to – in particular smaller and regional - hospitals on an external basis. This is typical for anaesthetics and resuscitation. In smaller hospitals, approximately 20% of the services are secured this way. In larger hospitals, this percentage will typically be considerably lower. As for more qualified staff, i.e. doctors and nurses, this practice is, however, rather rare.

Moreover, stakeholders state that the rules applicable to stand-by time are in some hospitals circumvented in that doctors are physically at the workplace or within short reach of the workplace. For example, in a number of cases another designated place (i.e. a place other than workplace) within the hospital's area is agreed with the employer as the place for stand-by. The exact scope of the problem is not possible to

[8] In this connection it is important to highlight that hospitals founded by a region are independent subsidised organisations and, as such, individual legal entities.

quantify. According to the workers' representatives, it occurs in approximately 30% of hospitals with local LOK-SCL organisations (Doctors' Union), but this estimate could not be corroborated by the employers interviewed and their representatives.

Stand-by time is used in some specialisations and for specific procedures (e.g. neurosurgery, endoscopy, gynaecology). The interviews with the employers indicate that on average stand-by time is used with respect to approximately 5-15% of the doctors and a rather limited number of nurses (such as specialised surgery nurses). While the use of stand-by is increasing in smaller hospitals, it is relatively stable or decreasing in larger hospitals.

The extent of active stand-by time is difficult to estimate and differs greatly across specialisations. Overall, the stakeholders estimate that it amounts to 10-30% of the total stand-by time. To this effect lump sum agreements are often being concluded for those specialisations, where the extent of active stand-by time is relatively stable (e.g. it is assumed that the doctor is working 20% of the stand-by time without a need to register each and every time the doctor responds to a call).

The total extent of stand-by time (active and inactive) differs largely across hospitals and specialisations, but normally it does not exceed 24 hours per week on average.

As regards the use of the individual opt-out, out of the hospitals with LOK-SCL (Doctors' Union) local organisations present at the workplace, approximately 50% have used the individual opt-out option.[9] However, even in such hospitals the individual opt-out and concurrent agreements could have co-exist. According to an unofficial survey in 13 hospitals concurrent employment contracts *or* a combination of an individual opt-out and concurrent employment contracts with the same employer was used in 60% of the hospitals (Voleman, 2014).

Overall, it is not possible to generalise and conclude that concurrent agreements with the same employer are limited to small hospitals, although it should be highlighted that this practice is clearly more widespread in smaller hospitals.

The extent of working time according to agreements to perform/opt-out differed significantly across hospitals, but also across medical professions. Stakeholders estimate that practically all hospitals would have to use the overtime limits to the maximum (i.e. 40 hours of standard weekly working time, 416 hours of overtime and 416 hours of additionally agreed overtime), at least with respect to some categories of doctors in order to ensure the same quality and availability of care.

A somewhat higher estimate was provided in 2011 in connection with the preparation of the Memorandum signed by the Doctor's Trade Union (LOK) and the Ministry of Health to improve the working conditions in the health care sector; i.e. the Trade Association ('Memorandum'). The memorandum stated that apart from the average 160 hours per calendar month, doctors work approximately 120-130 hours of overtime work per calendar month, and up to 150 hours in some specialisations.

[9] This estimate is considered to be more precise than the official data collected by the Labour inspectorates, which indicate that the opt-out was used in 22 health care establishments per year.

These estimates should nonetheless be interpreted with caution since they were provided in politically charged circumstances.

In conclusion, the estimates of the actual working time of doctors during the transitional period fluctuate between **56 and 72.5** hours per week on average. This estimate has been calculated based on the information provided by the stakeholders about the working time of doctors necessary to provide health care services in hospitals (40 hours of standard weekly working time, 416 hours of overtime and 416 hours of additionally agreed overtime, i.e. 40 + (416/52) + (416/52) = 56) and the information about the actual working time of doctors reported in the Memorandum (32.5 hours of overtime (130/4) in addition to 40 hours of standard weekly working time=72.5).

The interviews with the stakeholders indicate that there is a clear tendency to restrict the use of concurrent agreements with the same employer. Generally, interviewees agree that such agreements are used in approximately 50-60% of the hospitals and that the number is slowly decreasing, along with individual working time. Yet, they also highlight that there are a number of barriers in practice, both on the part of employers (lack of financial resources to hire additional staff and shortage of specialised staff) and workers (dependency on the additional income and – in that connection – unwillingness to take compensatory rest) to a broader elimination of concurrent agreements.

It should also be pointed out that agreements to perform work are in practice not concluded with all the doctors, but only with some specialisations. The estimates given by the stakeholders indicate that this practice concerns approximately 70-80% of the doctors and, generally, less than 10% of the nurses (typically specialised nurses in specialisations where it is necessary to perform emergency procedures – e.g. surgery and anaesthetics).

Doctors work typically in one-shift patterns with overtime or stand-by time. Stakeholder interviews indicate that the current average working time of doctors (calculated over a period of 52 weeks) amounts to approximately **47.5-55.6 hours per week.** This estimate is nonetheless considered to **be on the very low side** since the data available on working time in smaller hospitals are very limited.

Nurses work in shifts (usually two or three-shift patterns), and their working time does generally not exceed **37.5 hours per week** (3 shift patterns) and **38.751** (2 shift patterns). The stakeholders interviewed do not raise any particular issues related to compliance with the current working time limits for nurses.

The same working time limits apply for junior doctors as for specialised doctors. Stakeholders state that many junior doctors show an interest in working longer hours in order to build up the necessary experience, but also to increase their income since starting salaries/wages are generally rather low. On the other hand, according to the current regulation, junior doctors prior to completing the common curriculum (*'základní kmen*'), i.e. the first two years of training, cannot perform medical procedures alone. Their time at the workplace nonetheless counts as working time and, accordingly, some cost-effectiveness considerations apply as regards the presence of junior doctors at the workplace.

The amount of man-hours necessary to provide services has neither increased nor decreased significantly (e.g. as a result of an ageing population, increasing demands

on quality, more effective organisation of work, or other external factors) and, as will be described below, neither has the number of staff at the hospitals. As a corollary, the individual working time in the health care sector has not been significantly reduced, but **slight reductions in the individual working time of doctors** nonetheless took place –through reorganisation, increased use of stand-by time and compensatory rest for overtime and, to a limited extent, hiring additional staff. As regards nurses, no major changes were observed.

Number of doctors and nurses

At the end of 2012, the total number of health care professionals working in health services was 206 068 (full-time equivalents), of them almost three-fourths worked in non-state establishments; i.e. establishments not founded by the State (hospitals founded by regions and municipalities, church or another legal person). This number has not changed substantially over the past years (+0.6% compared to 2011). It includes workers on payroll, employers and contract workers.

The following table provides the total share of doctors, nurses and other health care personnel employed in hospitals in hospitals and FTE.

Table 2-2 Workers in health care services (2012)

	Total	*In hospitals*
Doctors	39,718.99	19,497.20
Nurses	83,728.13	49,383.51
ZPBD (other than nurses)	23,748.39	8,482.19
ZPSZ	10,542.52	4,021.82
ZPOD	31,443.83	17,469.38
Other professional workers and dentists	3,373.62	752.17
Total	**206,067.62**	**99,949.50**

Source: ÚZIS, Health care workers as of 31.12.2012, 2013.

In connection with the introduction of the new Labour Code effective as of 1 January 2007, the Ministry of Health had estimated that – in order to continue to provide health care services in unrestricted scope - it would be necessary to increase the existing staff (doctors and other health care personnel) by approximately 15-30% (depending on the size of the health establishment). Pursuant to the Ministry of Health's calculations, this would amount to an increase of approximately CZK 2-2.5 billion per year (Ministry of Health, 2006).

The available statistics nonetheless indicate, and stakeholders confirm, that there has not been a significant increase in the number of doctors and nurses employed in the 24/7 health care institutions. As regards doctors, while the hospitals interviewed indicated that there has been a small increase over the last few years in their establishments, the recent questionnaire of the Health and Social Workers' Union revealed that for more than 50% of employers the number of personnel has decreased. Nationwide, the number is nonetheless relatively stable.

Overall, register-based data indicate that the real increase in the number of health care personnel (doctors and other health care personnel) was approximately 6.27% from end-2006 to 2012. The table below provides detailed data for each of the professions separately.

Table 2-3 Number of workers in health care (in hospitals)

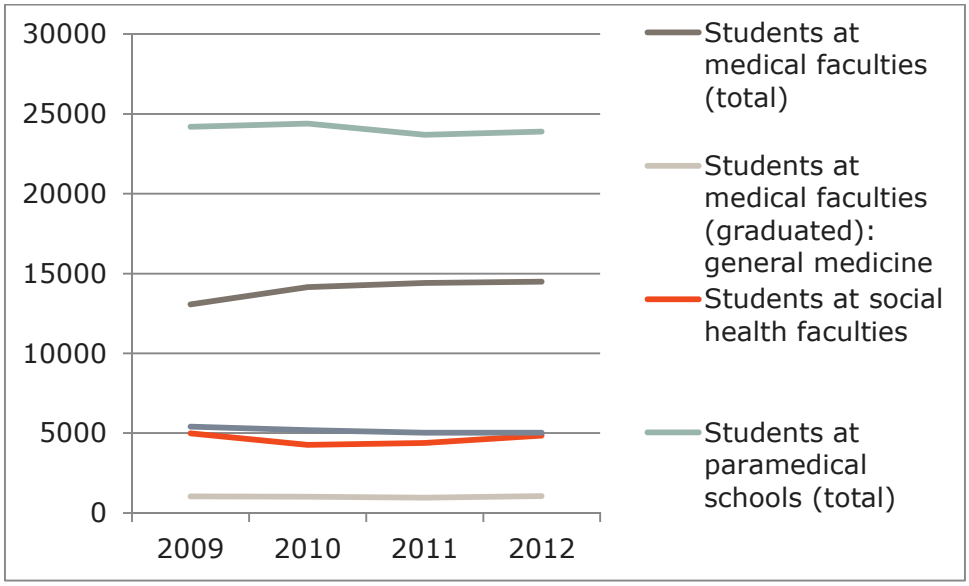
	31.12.2000		*31.12.2006*		*31.12.2012*	
Type of worker	FTE	Hospitals	FTE	Hospitals	FTE	Hospitals
Doctors (excl. dentists)	38331	15443	36394.93	17264.09	39718.99	19497.20
General nurses	64450	39480	78793.68	46657.78	79673.56	46488.82
Paediatric nurses	9826	5278	8114.53	4571.31	6749.85	3909.73
Midwives	4322	3119	3878.41	2760.24	4054.57	2894.69
Total: doctors and nurses	**116929**	**63320**	**127181.6**	**71253.42**	**130197**	**72790.44**
ZPBD (excl. nurses)[10]	Not available	Not available	22775.46	8122.98	23747	8482.19
ZPZS[11]	Not available	Not available	9405.05	3316.97	10542.52	4021.82
ZPOD[12]	Not available	Not available	26569.74	14008.47	31443.83	17469.38
Total: health care personnel other than doctors and nurses	Not available	Not available	**58750.25**	**25448.42**	**65733.35**	**29973.39**
Total			**185931.9**	**96701.8**	**195930.4**	**102763.8**

Source: ÚZIS, Health Care Workers 2000, 2006, 2012; compiled by COWI.

As the chart below indicates, **the number of graduates have been essentially stable** over the last years. Since 2009, there has been a very small increase in the number of graduates from the medical faculties and a decrease in the number of paramedics graduates.

[10] Health care personnel capable of providing health care without professional supervision with general competences (e.g. laboratory workers, paramedics, etc.)
[11] Health care personnel capable of providing health care without professional supervision with specialised competences (e.g. psychologist, physiotherapist, etc.)
[12] Health care personnel capable of providing health care under professional supervision or direct guidance (e.g. health care assistant, laboratory assistant, etc.).

Figure 2-1 Development in the number of students/graduates (2009-2012)



Source: ÚZIS, Czech Health Statistics Yearbook 2012, 2013, compiled by COWI.

In line with the development in the number of graduates, the Czech Medical Chamber registered an increase in the number of its members (46,297 in 2007 and 50,876 in 2013). The Chamber nonetheless indicates that this increase is somewhat misleading since it includes both doctors working abroad and non-active retired professionals. Accordingly, the Chamber estimates that there are currently 38,624 active doctors, out of which 12,982 work in the private sector.[13]

The hospitals interviewed have concluded that the number of graduate doctors is sufficient, but shortages are experienced with respect to doctor specialists (i.e. doctors with medium-length experience). Moreover, shortages typically apply to a limited number of specialisations (e.g. endocrinology, anaesthetics and resuscitation, gynaecology, neurosurgery, cardio-surgery, haematology, pathology and x-ray diagnostics). Yet, even in such specialisations the shortages are sometimes relative in the sense that the size of the teams of specialised doctors is determined by the demand for care within their particular specialisation. It follows that if more doctors were available, they would not have the opportunity to participate in the surgeries, the number of which is limited, and thereby to build up and maintain qualifications.

Especially in larger (university) hospitals, the total number of doctors are perceived to be sufficient, but difficulties in organising working time result as a consequence of the lack of substitutability across different specialisations. On the other hand, smaller hospitals are challenged by the current system for training of junior doctors, which is to a large degree centralised in larger hospitals (see further below).

Stakeholder views differ on general nurses and other health care professionals, however indicating that there has been a critical shortage of nurses in 2007 (mainly as

[13] Split between hospitals and other establishments is not available.

a result of low salary levels). While some hospitals inform that this shortage has been overcome in connection with the economic crisis, which induced a number of nurses to return to the sector, others however stress that there is still a shortage - especially in the capital - and that this shortage is likely to become critical in the upcoming years.

Other factors significantly influencing the availability of skilled professionals include:

- An increase in the immigration of doctors: according to the Czech Medical Chamber, the number has increased from 313 to 523 from 2008 to 2013, and the current situation is that 20% of the graduates move abroad.[14]
- An increase in the average age of doctors[15]: the average age has increased from 46.4 to 48.1 from 2005 to 2012, with 21.1% of doctors being above 60 years (ÚZIS, Physicians, Dentists and Pharmacists, 2013).
- A shift by a number of professionals from hospitals either to ambulatory care or to private pharmaceutical companies. According to a recent survey of the Health and Social Care Workers Union, 50% of health care workers in the age category as between 25-30 inform that they would leave the sector had they had the opportunity.
- A contrasting increasing dependency on the work of foreign doctors from 829 to 2631 from 2003 to 2011 (Source: Ministry of Labour and Social Affairs).[16]

The majority of hospitals do not engage into any specific activities to attract workers. The starting salaries/wages for junior doctors are low and depend only on the total amount of working time. The problems in attracting young professionals are particularly pronounced and, at the same time, rather limited to smaller hospitals. In university hospitals (which share their workplaces with the Medical Faculty), it is easier to recruit junior doctors. The recruitment and retention problems in such hospitals revolve rather around the replacement of elderly doctors with junior doctors.

In smaller hospitals activities to attract junior doctors include one-off payments to newly employed doctors (connected with an obligation to remain working at the hospital for a certain period), possibility to complete the first part of the training (the so-called common curriculum) at the same workplace along with a possibility to obtain a secondary specialisation in the future.

Labour costs

Total labour costs include salary/wage and worker benefits and payroll taxes paid by the employer (this amounts to 34% and consists of social and health insurance contributions). Some hospitals, in particular those operating in the form of private companies, also provide additional payments to the workers as a contribution to a private voluntary pension insurance. At the hospital interviewed, this amounted to CZK 600 per month.

As outlined in section 2.2, workers in health services are remunerated either according to the valid salary (37% of all health care workers) or wage regulations. In the latter

[14] This estimate is rather accurate since doctors seeking employment abroad are required to obtain a special certificate from the Chamber, documenting that they have never been members of the Chamber.
[15] This includes general practitioners and dentists.
[16] The data are, however, not broken down according to the type of health care institution (i.e. they includes both general practitioners and doctors working in hospitals).

case, wages are agreed in a collective agreement or specified in an internal order in agreement with the union representatives. Only minor salary issues are agreed on by a collective agreement. Salaries are nonetheless typically slightly higher than wages because university hospitals keep the salaries at a certain level.

Additionally, approximately 10-15% of specialised doctors and supervisory workers have an individually agreed salary/wage. According to register-based data, a contractual salary was paid to 4.75% of the physicians and dentists. The average contractual monthly salary was CZK 88,995.

The table below compares the average salary and wage in the health care sector in 2012.

Table 2-4 Average salaries and wages within the health care sector (2012), in CZK

	Average salary/wage in the health care sector	*Average salary/wage in hospitals*
Average salary – physicians and dentists	61078	Not available
Average salary – general nurses and midwives	29150	Not available
Average wage – physicians and dentists	59686	59677
Average wage – general nurses and midwives	29158	28866

Source: Czech Health Statistics Yearbook 2012, ÚZIS, 2013 and Economic results of hospitals 2012, ÚZIS 2013

Register-based data indicate that in the average salaries of physicians and doctors, the share of overtime work amounted to 9.8% (see Table 2-5 below). However, these data should be interpreted with caution. Firstly, data are available only for the entire health care sector, but in establishments, which do not provide 24/7 care, the extent of overtime is considerably lower. Secondly, in a number of cases there is a discrepancy between official statistical data and the actual status quo because of significant deficiencies in monitoring overtime work of doctors (see above).

Concerning remuneration for overtime, pursuant to the Labour Code, a worker is entitled to the wage for work done and to at least 25% of his average earnings (on top of his average earnings, unless the employer and the worker have agreed that instead of the premium for overtime work, the worker will take compensatory time off.

For stand-by time the Labour Code provides only the minimum remuneration of 10% of the average earnings. In practice, remuneration is agreed on an individual basis and, accordingly, differs significantly across establishments.

Under an agreement to perform work, the wage is agreed on an individual basis. Hence, as with stand-by time, there are major differences. Sometimes, the wage exceeds the average salary; sometimes it is lower (typically for junior doctors). A case study carried out in a small hospital indicated that the remuneration under an agreement to perform work with the same employer is essentially the same as for overtime work.

Table 2-5 Composition of an average salaries of physicians and dentists – according to the tariff salary (2012)

	Share of the total salary
Tariff salary	51%
Performance premiums	10,2%
Personal bonus	10,5%
Overtime work including bonus	9,8%

Source: Czech Health Statistics Yearbook 2012, ÚZIS, 2013.

The register-based data indicate that there has been a **steady increase in the average salaries of doctors and nurses** in hospitals and the health care sector in general. The following table provides an overview of the development in salaries/wages from 2007 to 2012. The data have been corroborated through case studies in hospitals. The stakeholders interviewed also pointed to a significant increase in wages and salaries of in particular doctors, but, to some extent, also nurses in connection with the Union strikes in 2011.

Table 2-6 Salary levels of doctors and nurses in public health care sector (2006-2012), in CZK

Type of worker	2007	2008	2009	2010	2011	2012
Average wage (in hospitals):						
Physicians and dentists	42467	45195	48213	49841	56787	59677
Nurses	21563	22697	24726	25848	26361	26866
Average salary (in the health care sector)[17]:						
Physicians and dentists	43353	45781	48723	50235	57687	59686
General nurses	**22990**	**24221**	**26261**	**27515**	**28145**	**29158**

Source: ÚZIS, Wages and salaries in health services in 2006-2012 and ÚZIS, Economic results of hospitals 2010 and 2012, 2011 and 2013 respectively.

Regarding junior doctors, the case study conducted revealed that the average salary is approximately CZK 40-50,000/per month (a specialised doctor earns approximately CZK 70-90,000/per month on average).

Detailed data on the total annual labour costs of nurses and doctors were obtained from the University Hospital Motol (largest hospital in the Czech Republic).

[17] Data specifically for hospitals are not available.

Table 2-7 Labour Cost, University Hospital Motol (2013), in mCZK

	Costs
Labour costs of doctors	660
Social and health insurance (doctors) – 34%	224,4
Labour costs nurses	725
Social and health insurance (nurses) – 34%	246.5
Total	**1855.9**

Administrative and management costs

Stakeholders indicate that the administrative and management costs neither increase nor decrease with an increase or decrease in the number of personnel or working hours. While, according to stakeholders, a potential increase in the number of workers' employment agreements/working time would result in an increase in the amount of administrative work, i.e. the number of administrative procedures to be carried out, these administrative procedures would be undertaken by the same number of administrative staff within their standard working hours and, as a corollary, not lead to an actual increase in the administrative and management costs of the hospitals. This was attributed to the general financial situation of the health care sector. In conclusion, changes are independent of changes to the Directive (or the Labour Code).

The case study of a small hospital revealed that the administrative and management cost amount to approximately CZK 60,000 per month and CZK 720,000 per year + 34% in social and health care insurance.[18] In a large university hospital, the costs amounted in 2013 to CZK 25,000,000[19] (including 5,500,000 for qualification building).

Qualifications of doctors and nurses

Doctors, dentists and pharmacists are required to complete a six-year university education (five years for dentists). This education allows the graduates to carry out their medical profession under the supervision of a specialised doctor. To obtain a specialisation four to six years' training under the supervision of a specialised doctor is required.

The curriculum in the first 24 months of the training is common to all the specialisations and is referred to as the common curriculum and has to be obtained at a workplace with accreditation. Following the completion of the common curriculum, junior doctors obtain specialisation through a residency (normally one to two years) at a workplace with a higher accreditation level (university hospitals). During such specialisation residencies, the sending institution (typically a smaller hospital) covers the labour costs of the junior doctor. From the smaller hospitals' perspective, employing junior doctors is thus not profitable. As such, the organisation of education and training has had a profound influence upon the organisation of working time in small hospitals in terms of staff shortages and has given rise to a need for careful planning in advance.

[18] Breakdown of doctors and nurses is not possible.
[19] *Ibid.*

All the stakeholders interviewed, however, agree that the organisation of working time has not had any effect on the training of junior doctors. The existing problems are due to a series of ministerial orders and their implementing acts. The existing system is not perceived to be optimal, and there are currently initiatives for a reform. A reorganisation of the educational system ensuring that more junior doctors are available in smaller hospitals is believed to be able to contribute significantly to solving the staff shortage problem.

As far as integration of doctors in training at the workplaces is concerned, doctors in training usually start by performing tasks of a more general nature and are only subsequently allowed to perform specialised tasks. In this respect, there are differences between regional and university hospitals. At the regional hospitals, doctors in training usually get the opportunity to work independently and to specialise earlier. In contrast, university hospitals provide the opportunity for doctors in training to rotate between different specialised teams.

Junior nurses go through the so-called adaptation process. This lasts between three months to six months depending on the progress made. The process consists of a common part and an individual plan, which is drawn up in the individual case, and its progress is supervised by a supervising nurse. In addition, nurses typically participate in a number of non-mandatory courses and seminars. Since qualification building is considered to constitute working time according to the current regulation, such participation poses a challenge to the organisation of work. As nurses normally work in shifts, some additional, but in principle rather limited overtime may be accumulated.

Availability of public 24/7 health care services

The stakeholders interviewed agree that there has been **a small decrease in the availability of care** given that fewer doctors are present at the workplace because they take compensatory rest. However, working processes have been reorganised and in some hospitals a limited number of additional staff has been hired to minimise the decrease in availability. The effect has been slightly higher in smaller hospitals where there have been cut-backs. The decrease in the availability of care is perceived to result from the national implementation of the working time rules and the rules supplementing such rules, rather than from the WTD itself.

There is no system for monitoring the quality of care. Stakeholders state that although the overall aim is not to affect the quality of the services provided, some degree of deterioration nonetheless occurred (60% of the respondents in a recent Health and Social Care Union survey state that the quality has been lowered); e.g. as a result of implementing the ministerial order on minimum requirements for safeguarding the provision of health care services. These minimum standards have been adopted with the view to reducing costs to a minimum, but stakeholders perceive that standards do not correspond to the scope of work to be performed.

The current quality and availability of care was retained primarily as a result of introducing alternatives to the individual opt-out option (cf. above). Stakeholders agree that compliance with the current working time limits with in letter and spirit would lead to a significant reduction in the availability and quality of care. This reduction would likely be more pronounced in remote areas.

Service technology developments

Stakeholders have expressed that service technologies will play a role in the health care sector in the future, but this role is unlikely to be significant. At present, service

technologies are not commonly employed. A considerably bigger potential lies in introducing IT technologies (electronic data management and the use of modern information technologies in diagnostics).

While investments in technology developments have declined, this reduction was the result of the general financial situation of the health care sector, and in particular administrative orders laying down rules for the contributions from the public health insurance system, rather than the WTD itself.

2.3.2. Other pressures and trends

Financing of the public health care sector
The financial situation of the health care sector has had – and according to the stakeholders – will continue to have a major effect on the majority of the workplace indicators described above (in particular the number of doctors and nurses employed, but also labour costs (in terms of wages and salaries of doctors and nurses), the qualifications of doctors and nurses, the availability of health care services and the development of service technologies.

In 2012, the share of health care expenditure in GDP amounted to 7.6%; i.e. roughly the same as in the previous two years. This percentage is somewhat lower than the 2011 OECD average of 9.3% (OECD Health Data, June 2013).

Table 2-8 Share of health care expenditure in GDP (2000-2012)

	2000	2005	2010	2011	2012
Health care expenditure (bn CZK)	146.8	218.8	284.1	289.2	297.62,0
% of GDP	**6.7**	**7.3**	**7.5**	**7.5**	**7.6**

Source: Czech Statistical Office, Výsledky zdravotnických účtů ČR 2000-2012, 2014 (Translation: COWI).

From 2000 to 2012, three main sources of financing of the health care sector can be identified: insurance, public budgets and households. In 2012, the share of contribution of public insurance amounted to 77.4%. 6.7% were covered by public budgets. Public budgets (i.e. national and local budgets) contribute primarily to the financing of specific activities that are not covered by public insurance (medical personnel education, research, preventative programmes, but also public health care administration expenses) and cover the costs of health care for those persons, who are not contributing to the insurance system. The households account for approximately 14.7% of health care expenditure by direct payments (medicine and supplementary health care services). Between 2000 and 2012, the expenditures grew by 4.21% on average.

The table below provides an overview of the expenditure and the individual sources of financing.

Table 2-9 Health care expenditure in mCZK (2000-2012)

The source of financing	2000	2005	2009	2010	2011	2012	Average growth per year
Government expenditure	132962	191356	244754	238387	243822	245614	3.63
Public budgets	17170	21263	26034	24487	20966	19579	-1.17
National budget	8319	12334	14846	13337	11123	9151	-4.17
Local budget	8851	8930	11188	11150	9843	10428	2.24
Public insurance	115792	170093	218720	213900	222856	226035	4.15
Private sector	13873	27418	47954	45754	45358	46388	7.80
Other private insurance	-	530	627	427	377	620	2.27
Households	13873	23110	43141	41867	42275	43634	9.50
Non-profit organisations	-	3172	3258	2559	1798	1263	-12.33
Corporations	-	606	928	901	908	871	5.32
Total	146835	218774	292708	284141	289180	292002	**4.21**

Source: Czech Statistical Office, Výsledky zdravotnických účtů ČR 2000-2012, 2014 (Translation: COWI).

Health insurance statistics indicate that out of the total health care costs covered by insurance companies in 2012, 46,7% were for hospitals (Source: Ministry of Health from records of health insurance companies, in: Economic information on health care 2012, ÚZIS, 2013). Funding is allocated in accordance with the Order of the Ministry of Health adopted in advance of every calendar year ('*úhradová vyhláška*'), taking into account an agreement between the largest health insurance company ('*Všeobecná zdravotní pojišťovna*') and the representatives of the health care providers. As regards in-bed health care, the payments consist of a number of individual items depending on the type of care provided.

Ageing society

By the end of 2012, there were 1,768,000 inhabitants older than 64 years. This amounts to 16.8% of the population (16.2% in 2011). Out of these, 168,000 were more than 85 years old (1.6% of the total population). Overall, the share of persons 64+ is still below the EU average.

The problem of the ageing society is registered at national level, although itis significantly more pronounced in certain regions. The share of the 65+ population has been the highest in the Královehradecký region (17.8%), followed by the Prague region (17.6%). Only five regions were below the national average (Český statistický úřad, Vývoj obyvatelstva v roce 2012, 2013).

According to the prognoses of the Czech Statistical Office and the Faculty of Science of the Charles University, the share of 65+ population will increase. The Czech Statistical Office indicates an increase to 22.8% in 2030 and 26.9% in 2040. The study of the Faculty of Science (Burcin, Kučera, 2010) foresees an increase to 23.7% in 2030 and 26.9% in 2040. The stakeholders interviewed nonetheless indicate that the number of doctors in different specialisations (per capita) is sufficient to reflect any future developments in the ageing of society.

Urbanisation trends
Regional differences in the demographic trends have been relatively stable in the long term. The highest population is registered in the Středočeský region, followed by the Prague region and the Moravskoslezský region. The lowest number of residents is registered in the Karlovarský region. The largest population decline, in relative numbers per 1,000 inhabitants was found in the Karlovarský region (Source: ÚZIS, Czech Health Statistics Yearbook 2012, 2013).

The movement of patients from smaller hospitals to larger hospitals, observed by stakeholders, does not follow the urbanisation trends described above, but reflects – almost exclusively - the number of staff available at smaller hospitals. As such, urbanisation trends are not considered to constitute a significant factor behind the increasing demand for health care services in larger cities.

2.4. Implications of changes to the WTD provisions

The following section is based primarily on interviews with stakeholders. Instances where stakeholder opinions differ considerably are highlighted in the text.

2.4.1. On-call time

"On-call time"[20] is not relevant for all doctors, but only for approximately 70% of the doctors employed at hospitals. The vast majority of nurses work in shifts and, accordingly, would not be affected by the building block. Other types of workers are unlikely to be affected.

A provision to the effect that only part of the inactive working time would be counted as working time would lead *a significant reduction* in the total volume of working time. This would in practice mean that the individual workers' (doctors) working time would move closer to the overtime limits (the available overtime would increase) and thus contribute to a reduction in the amount of concurrent agreements with the same employer. This would improve legal certainty, predictability and reduce situations in which the applicable provisions are circumvented.

It is difficult to estimate the implications on working time since the proportion of active and inactive on-call time differs significantly (not only across workplaces and specialisations, but also with time). Moreover, the building block would be extremely difficult to implement in practice since there is no clear distinction between active and inactive on-call time. For example, active on-call time could be time during which the worker is responding to a phone call and carrying out follow-up work without physically attending to the patient. As such, active/inactive on-call time will be very challenging to monitor and, in turn, susceptible to misuse.

The number of doctors needed would in principle decrease (in the 50% alternative by approx. 25%), but it is unlikely that, in practice, less doctors would be employed. Accordingly, the number of doctors is likely to remain the same.

[20] But note that on-call time as such does not exist in the Czech legal order. All time spent at the workplace counts fully as working time. Accordingly, the extent of "on-call time" is not being monitored, but generally corresponds to working time from 3:30 pm to 7 am and weekends.

Stakeholders indicate that the total labour costs would in principle decrease (by 25/50%), but the question remains how inactive on-call time is to be remunerated.

Administrative and management costs would essentially remain the same, as these are generally independent of the number of staff on the payroll.

Qualification of doctors and nurses, the quality and availability of care and service technology developments are likely to remain unaffected by the building block.

All the stakeholders interviewed agree that the implementation of the building block could potentially lead to organisational and financial impacts. Moreover, workers' representatives agree that increasing individual working time, increases the risk of medical errors and other negative social impacts. This risk, however, could not be quantified.

Stakeholders agree that the 'on-call time' building block would be very difficult to implement. The workers' unions indicate that it would be unacceptable since all time at the workplace should be considered working time. On the other hand, employers and their representatives would in principle welcome the proposed change (the stakeholders interviewed nonetheless disagree as to whether the 75% or the 50% alternative is preferable). As outlined above, the remaining issue is how inactive on-call time is to be remunerated.

2.4.2. Stand-by time

Stand-by time agreements do not apply to all workers, but only to some specialisations (neurosurgery, endoscopy, gynaecology, etc.). Similarly as above, it is relevant primarily with respect to doctors (approximately 5-10%) and only a very limited number of nurses. There is some overlap between the type of workers on "stand-by" and "on-call". Overall, however, the two categories do not overlap and, accordingly, the implications of the on-call time would not offset the implications of stand-by time and *vice versa*.

Provided that 20%/40% of stand-by time at home not spent working is to be counted as working time would result in a *significant increase* in the total volume of working time. Unlike on-call time, the monitoring of what time is active and inactive is considerably easier. The building block would, however, not solve the problem of concurrent agreements (and the legal uncertainty revolving around such agreements).

Setting a limit on the total amount of stand-by time per week would have only very limited implications on the working time, but negative effects in terms of decreasing flexibility.

As regards the number of doctors, the building block would call for additional hiring. In a large university hospital, 140,000 hours of (inactive) stand-by time were registered in 2013. 40% amount to 56,000 hours/12= 4600 hours per month. These doctors would have to be reimbursed or compensatory rest would have to be provided. This would correspond to a need to hire approximately 30 doctors (approx. 3.5% compared to the FTE).

The administrative costs and management costs, the qualification of doctors and nurses, the quality and availability of care and service technology developments are likely to remain unaffected by the building block.

There would be no significant social impacts, only organisational and financial impacts.

As mentioned above for stand-by time, which is to be counted as working time, either financial reimbursement or compensatory rest would have to be provided. This would pose a financial challenge to the health care providers and/or potentially lead to difficulties in organising work, in particular in specialisations suffering from staff shortages.

Out of the two alternatives of the stand-by time building block, setting a limit would be a slightly better option (easier as regards administration, although active stand-by time is much easier to monitor than active on-call time). On the other hand, workers representatives' indicate that the second alternative would be unacceptable for workers since stand-by time applies only to a limited number of professionals and setting a limit would be counterproductive.

2.4.3. Opt-out

In the Czech Republic, the opt-out option pursuant to Art. 22(1) of the WTD is currently not used. Accordingly, the implementation of the building block would in principle have no workplace implications. The stakeholders interviewed were nevertheless asked to provide their views on the building block on the assumption that the opt-out is reintroduced in the future.

The strengthening of the conditions for the use of opt-out would in principle have very limited or no implications. It may lead to a very slight increase in the number of doctors, since not all doctors would necessarily provide their consent.[21] This would have a small impact on the total labour costs. The conditions guiding the individual opt-out in the Czech Republic prior to 2014 were essentially the same as those proposed by the building block. The workplace implications would thus be minimal.

Total elimination of opt-out corresponds to the current situation in the Czech Republic. Generally, the re-introduction of the opt-out would increase compliance with the spirit of the Directive. Generally, employers and their representatives find the re-introduction of the opt-out useful, but highlight as a possible drawback postponing finding a broader solution to the problems in health care. From the workers' perspective, the re-introduction of the opt-out would increase legal certainty, but as to individual working time it is unlikely to make any difference in practice.

Workers' unions state that it would be useful if protection was provided before the conclusion of the employment contract, but that it will be necessary to distinguish between different type of workers (i.e. junior doctors and more experienced professionals).

2.4.4. Compensatory rest

The provision that compensatory rest must be provided within a reasonable time, not exceeding 48 hours and within 96 hours is unlikely to have any workplace implications as it essentially corresponds to the legal *status quo* (see section 2.2.1 above) and is

[21] Note that the opt-out as implemented in the Czech legal order prior to 2014 did not apply to nurses. See section 2.2.1 above.

adhered to in practice in the majority of cases. In the remaining cases, the implementation of the building block would increase compliance with the WTD.

2.4.5. Reference periods

The reference period of 26 weeks for all activities is currently provided for in the Labour Code (see section 2.2.1 above). The building block setting a six-month reference period by legislation in all cases would thus increase compliance with the Directive, but lead to no specific workplace implications.

Similarly, the implementation of the second alternative of the building block - i.e. the possibility of stipulating a 12-month reference period by legislation - would have essentially no implications at the workplaces. In the vast majority of hospitals, collective agreements provide for a longer reference period and this part of collective bargaining works rather smoothly in practice.

The 12-month reference period is perceived to be an advantage both for workers and employers. For workers, it introduces flexibility into the amount of working time provided within a specific period, for employers it makes workforce planning easier.

2.4.6. Autonomous workers

The possible exception for 'autonomous workers' is not applied with respect to health care professionals (in principle only as regards members of the administrative board of the hospital) and, accordingly, the building block would have no specific workplace implications.

2.4.7. Concurrent employment contracts

At present, the addition of the working time pursuant to concurrent contracts is not regulated unless work is carried out for the same employer (in principle the same medical establishment). As described in section 2.4, concurrent contracts with the same employer are widespread in the health care sector. Although there are no official data on the phenomenon, estimates have been provided by the stakeholders (approximately 50-60% of the hospitals and within these approximately 70% of the doctors and a very limited number of the specialised nurses). Yet stakeholders highlight that a significant number of workers (nurses in particular) provide different types of work such as the provision of health care (e.g. cleaning) on the basis of concurrent contracts with the same employer as a means to increase their income. Such workers would, in principle, be affected by the building block as well.

While the exact extent of work performed under concurrent contracts cannot be estimated, the stakeholders interviewed indicate that in the majority of cases the weekly working time limits according to the sum of the agreements per worker are exceeded. For doctors that carry out work pursuant to concurrent agreements with the same employer, the rough estimate of the extent of work under such agreements is approximately 400 hours per calendar year per doctor. In implementing the building block for workers working under concurrent contracts for the same employer, the maximum weekly working time should be applied per worker would, accordingly, have *major workplace implications in terms of working time.*

As regards the number of doctors and labour costs, two small hospitals interviewed indicated that the implementation of the building block would mean that it would be necessary to employ an additional 20-30 doctors (approximately 20%) This would

increase the labour costs by approximately 7% (approx. 1 million per doctor). Workers' unions estimate that at least 30% of the doctors would have to be employed to compensate for the reduction in the individual working time.

The administrative and management costs are likely to remain unaffected by the building block. On the other hand, the majority of the stakeholders interviewed indicate that the qualifications of doctors and nurses, the quality and availability of care and service technology developments would be affected negatively.

2.4.8. Derogations

The building block would not result in any concrete workplace implications.

2.4.9. Reconciliation

The first alternative (i.e. obligation to inform workers, etc.) would not lead to any workplace implications since the building block already corresponds to the *status quo*.

The stakeholders interviewed stated that the second alternative (i.e. possible interruption of the daily rest period) of the building block would only be used modestly in the health care sector (e.g. by x-ray specialists and persons carrying out laboratory diagnostics). However, given the increase in the use of modern information technologies, the use potential of the building block is likely to increase. This may have s positive social impacts in terms of reconciliation of family and work life.

2.4.10. Measures increasing legal clarity and certainty

The effect of a Communication from the Commission on improving legal clarity, predictability, etc. is difficult to estimate. The potential for any concrete workplace implications depends – first and foremost – on the contents of such a document. Moreover, the effectiveness of any such Communication would require that the guidelines of the Communication are adopted by the local governments and that the governments take the initiative in following up on the Communication in collaboration with the hospitals and the workers. Accordingly, no conclusions on workplace implications or impacts can be made at this stage.

2.4.11. Conclusions

Table 2-10 summarises the conclusions on the workplace implications of the WTD building blocks.

The provided *percentages should be interpreted with caution* as (1) the current extent of working time, on-call time and stand-by time is difficult to estimate and most likely differs considerably across establishments (see section 2.3.1), (2) the stakeholders interviewed had considerable difficulties in providing estimates of the workplace implications and, in turn, quantitative estimates were provided only by a limited number of stakeholders.

Table 2-10 Implications of building blocks

	Working Time	Number of doctors and nurses	Labour costs	Adminis-trative and manage-ment costs	Qualification	Availability of health care services	Investment in service tech-nologies
On-call time (50/75%)	Significant reduction (doctors)	No implications/ reduction by 25%/37,5%	Reduction by 25%/50%	No implications	No implications	No implications	No implications
Stand-by time (20/40%)[22]	Significant increase (doctors)	Increase -if 40% by ca. 3,5%	Increase (5-10% of doctors remunerate d)	No implications	No implications	No implications	No implications
Opt-out	No implications						
Compensatory rest	No implications						
Reference periods	No implications						
Autonomous workers	No implications						
Concurrent employment contracts	Significant reduction (approx. 400 hours per year per doctor in 60-70% of the hospitals and approx. 70% of doctors)	Increase by 20-30%	Increase by approx. 7% (in 60-70% of the hospitals)	No implications	Decrease	Decrease	Decrease
Derogations	No implications						
Reconciliation (additional conditions/ interrupted rest)	No implications						

The following main conclusions can be drawn concerning the implications of building blocks:

- There is disagreement among the stakeholders (employers vs. workers' union representatives) on the best way forward for addressing the 'on-call' and 'stand-by' time issues
- The categories of workers working 'on-call'[23]and stand-by differ. Accordingly, the costs of implementing the stand-by time building block are unlikely to

[22] The setting up of a limit to the maximum extent of stand-by time per week is unlikely to result in any workplace implications.
[23] Note that the institute of 'on-call time' does not exist in the Czech legal order.

offset the savings resulting from the implementation of the on-call time building block

- The implementation of the 'concurrent employment contracts' building block would result in major workplace implications (virtually all workplace indicators would be affected)
- The implementation of the 'opt-out', 'compensatory rest', 'reference periods', 'autonomous workers', 'derogations' and 'reconciliation' would not result in any concrete workplace implications and, accordingly, the combination of the building blocks in a package is unlikely to amplify or diminish the implications of the other building blocks
- The implementation of a number of the building blocks (specifically the opt-out and reference period building blocks) is likely to increase compliance with the letter and spirit of the WTD
- Administrative and management costs will, as a rule, remain constant regardless of any possible changes to the WTD
- The extent of social impacts is dependent virtually solely on a potential increase/decrease in the individual weekly working time.

3. DENMARK

3.1. Introduction

Working time in Denmark is generally not regulated by law, but stipulated in employment contracts that in most cases rest on collective agreements. However, some of the requirements of the WTD are stipulated in Chapter 9 of Arbejdsmiljøloven [Working Environment Act] (Retsinformation, n.d.). These are the requirements for a minimum daily rest period of 11 consecutive hours per 24-hour period[24], for a weekly rest period[25], and for a maximum weekly working time[26] for younger workers.

Hence, in addition to the Working Environment Act, the working time rules for doctors and nurses are stipulated in four different collective agreements – three different for the doctors: Yngre Læger (2013) [junior doctors], Foreningen af Speciallæger (2013a) ["paid by fee" specialists], and Foreningen af Speciallæger (2013b) [consultants]; and one for nurses: Sundhedskartellet (2013). These collective agreements are biennial with the present agreements covering the period 1 April 2013 to 31 March 2015. From the outset of the analysis of the Danish working time arrangements for doctors, it is important to acknowledge that their collective agreements do not consider on-call time as working time as stipulated by the Jæger and SIMAP rulings. Such interpretation of the on-call provision has thus been accepted by both employers' and workers' organisations. For nurses, 75% of on-call time is counted as working time and so is actually one third of their stand-by time.

Enforcement of the working time rules in Denmark is formally carried out by the Danish Working Environment Authority[27], while the employers' and workers' organisations are the watchdogs that ensure that the collective agreements are complied with. Furthermore, there is a number of arbitration orders. For example, Arbejdsretten (2009) which concerns a hospital's limitations to flexibility regarding arranging working time outside the agreed work schedule for a given period. Note also that the Danish Working Environment Authority seems to be aware of the misinterpretation of the on-call time provision, but seems at the same time to await a revision of the WTD before taking any actions.

The WTD has been implemented in a changing Danish public 24/7 health care sector. It is, however, being claimed (e.g. Mogensen, 2009) that Danish doctors have the shortest working time in the world. Actually, data from Eurostat-LFS show that Danes in general have the shortest working time in the EU. Hence, from this perspective the limitations to working time have not caused that many problems.

Mogensen (2009) also suggests that there are negative consequences from the relatively short working time among the Danish doctors[28], e.g. that they are relatively inexperienced doctors, and that it contributes to a shortage of doctors. Such notions of

[24] Article 3 of the WTD.
[25] Article 5 of the WTD.
[26] Article 6 of the WTD.
[27] Stipulated in Chapter 13 of the Danish Working Environment Act.
[28] Furthermore, Danish interviewees pointed to a study (Tucker et.al. (2013)) which suggests that Swedish doctors worry about an increased risk of malpractice connected with increased workload/working hours. Furthermore, fatigue is suggested to reduce the effectiveness of junior doctors' training and so there is a limit to the value of long working hours in this context.

the need for demanding working hours as an essential feature of junior doctors' training, underpinned by the need to experience first-hand exposure to a wide variety of patient cases, are widely found in the literature, e.g. Brown et.al. (2010) and Jagsi et.al. (2005). This opinion is, however, not shared by the doctors' organisations who believe that Danish doctors in general have high qualifications that are comparable with the best in the world. This is partly argued to be the case because being a doctor in Denmark is an attractive position that appeals to many university applicants.

There are also a number of other drivers that put the large Danish public health care sector under pressure to deliver 24/7 services. For example, on the demand side, there is an increasing number of older and chronically ill people that demand a "normal life", and there is a trend towards more shorter, optimized admissions and outpatient treatment. At the same time, there seems to be rising expectations within society to the health care system and medical professionals – not only in Denmark, and it seems that society has become less tolerant of medical errors (Shirom et.al, 2006).

On the supply side, there are pressures on public budget resources – partly as a result of the recent economic crisis. However, the number of doctors and nurses are increasing and there are no outlooks indicating a shortage of staff in the coming decade or so. This said, public hospitals in remote areas of Denmark are facing difficulties in recruiting and retaining medical staff.

From the perspective that the WTD provisions have generally been timely implemented and are complied with – apart from the on-call time provision, it is assessed that any changes to the WTD in the future also will be timely implemented. Furthermore, both employers' and workers' organisations do not envisage significant administrative costs of changing the collective agreement. This will just be a part of the normal biannual negotiation process. Similarly, the public hospitals being well equipped with electronic work planning systems do not find it that cumbersome to make changes so that revised working time rules may become part of the daily planning of work of doctors and nurses. Finally, the fact that doctors and nurses in general have working hours and weeks that do not reach the limits[29] of what is allowed by the WTD – disregarding the fact that on-call time is not counted as working time – implies in itself that not all future changes may have an impact.

3.2. Implementation of WTD

3.2.1. WTD implementation approach

Working time in Denmark is as just mentioned generally not regulated by law, but stipulated in employment contracts that in many cases rest on collective agreements. However, some of the requirements of the WTD are stipulated in Chapter 9 of Arbejdsmiljøloven [Working Environment Act] (Retsinformation, n.d.). The relevant definitions in the Working Environment Act are:

- Although *working time* is not explicitly defined in the Working Environment Act, it is specified that the working time must be arranged so that the workers get

[29] On-call duties (vagtlægeordning) is also done by General Practitioners who are working as self-employed. Their working time can exceed the 48h limit, but because they are self-employed they do not fall under the WTD

at least 11 consecutive rest hours within every 24-hour period. However, the rest period may be reduced to eight hours in companies working on shifts – such as public hospitals, and when it is not feasible to have the daily or weekly rest period between the end of one shift and the beginning of the next.

- Workers must have a *weekly rest period* of at least 24 hours (as far as possible on a Sunday), which must directly follow a daily rest period. When working with caring of people, this weekly rest period may be postponed. This latter provision is of course also applicable to public hospitals.

- For younger workers – i.e. below the age of 18 – *working time may not exceed* the normal working time for the adults within the given occupation, and may not exceed eight hours per day and 40 hours per week. Since doctors and nurses all are above the age of 18, these weekly working time limits are not applicable to public hospitals.

Hence, in addition to the Working Environment Act, the working time rules of the doctors and nurses are stipulated in four different collective agreements – three different for the doctors: Yngre Læger (2013) [junior doctors], Foreningen af Speciallæger (2013a) ["paid by fee" specialists], and Foreningen af Speciallæger (2013b) [consultants]; and one for nurses: Sundhedskartellet (2013). These collective agreements are biennial with the present agreements covering the period 1 April 2013 to 31 March 2015. The key definitions of working time agreed on via collective agreements for doctors are (see also Lægeforeningen (n.d.) for a brief description in English):

- *Working time*: a week has 37 working hours. Working hours must be planned to make up an average of 37 hours per week over a reference period. The reference period is 14 weeks, but by agreement with the relevant Registrars' Council the period may be altered to not less than four weeks and not more than 26 weeks.

- *Overtime work:* At the end of the reference period, the total working hours are calculated. If they exceed an average of 37 hours per week, the excess hours are overtime. If overtime is time to be taken off in lieu of payment of overtime at a rate of 150%, that is one hour's overtime is counterbalanced by taking 1.5 hours off. If not counterbalanced by time off in the following calendar month, it is payable at the overtime rate (normal hourly rate +50%).

- *Rest periods:* Doctors must have at least 11 hours of rest between two days' main work. The Registrars' Council may agree, though, that this rest period will be reduced to eight hours. Doctors may receive three telephone calls during on-call duty without the rest period being interrupted.

- *Days off*: Doctors must have at least one day off every week. The Registrars' Council may though agree on a period of up to 11 days between each day off. A day off must last at least 35 hours. If the rest period has been reduced to eight hours, the day off must last at least 32 hours. Doctors must in any circumstances have two days off per week on average over a norm period. Only in extraordinary situations may doctors be ordered to work more frequently than every second weekend. Yngre Læger (junior doctor trade union) has created a so-called "shift frequency wheel" which junior doctors can

have free of charge by contacting Yngre Læger. This "wheel" enables them to calculate easily whether their shifts exceed those laid down in the rules on frequency of shifts.

Note that for employers and workers not covered by collective agreement, an additional law has been adopted (see Arbejdstilsynet, n.d.).

The employers' organisation, the workers' organisations, and the consulted public hospitals all agree that it is a strength that most of the WTD provisions are implemented via collective agreements. This implies that the working time arrangements are overall suitable for the different types of doctors and nurses. This said, the employers do have a preference for keeping working time rules as similar as possible across the different staff types to keep administrative costs low. With the Danish public hospitals being well-equipped in terms of electronic work planning systems, however, it is not that cumbersome to handle a number of different daily work plans for doctors and nurses.

Table 3-1 gives an overview of the Danish implementation of the key WTD provisions that are subject to analysis in the present study. These are described in more detail below.

Table 3-1 Implementation of key WTD provisions in Denmark

Key provision	Implementation
On-call time	On-call time is not considered working time in the collective agreements for doctors, while this is the case for 75% of nurses' on-call time.
Stand-by time	Stand-by time is not considered working time in the collective agreements for doctors, while this is the case for one third of nurses' stand-by time.
Opt-out	*Opt-out is not used in Denmark.*
Compensatory rest	Collective agreements for doctors and nurses do not specify that the compensatory rest must be taken immediately after an extended work period (but in practice this is the case).
Reference periods	The normal reference period is 12 weeks, i.e. within the WTD rules of four months, while the possibility to extend this period to a maximum of 26 weeks via local agreements is not widely used.
Autonomous workers	Derogations from the WTD provisions for "managing executives or other persons with autonomous decision-taking powers" are not applied for doctors and nurses.
Concurrent employment contracts	Working time rules are applied on a per-contract/employer basis and so not on a per-worker basis.
Derogations	*The system of possible exceptions and derogations does not cause problems for the collective agreements.*
Reconciliation	Obligations to inform workers and the rights of worker are already part of collective agreements and individual employment contracts.

Source: COWI.

On-call time

As underlined already, it is important to acknowledge that the collective agreements between the Danish employers' organisation and the organisations of the doctors do not consider inactive on-call time as working time. In other words, they do not follow the Jaeger/SIMAP rulings. While these rulings have of course been subject to discussions within the organisations, all organisations have evaluated that it would not be workable in practice to count inactive on-call time as working time, as this would

lead to a severe reduction in the active work input of the doctors and thus a sharp reduction in hospital services. This would in particular be a problem for the public hospitals in the remote areas of Denmark, as many of doctors employed here live in the large cities and commute to work. Hence, the organisations have chosen not to interpret inactive on-call time as working time.

Around 70% of the young doctors are subject to on-call time, where active on-call time is included in the hours worked on a one-to-one basis.

For senior doctors, on-call time on weekdays from 6pm to 11pm and in weekends from 8am to 8pm triggers an extra hourly pay (EUR 19-27 per hour). On weekdays, from 11pm to 8am and in weekends from 8pm to 8am, consultants are paid additional EUR 290-400 per shift.

In the collective agreement for the nurses, the interpretation is somewhat different as 75% of the on-call time is counted as working time. However, only a small proportion of nurses are subject to on-call time – e.g. anaesthesia, dialysis ad transplantation nurses – where over half of the on-call time is active. The number of nurses on-call seem, however, to be on the rise due to the political goal of reducing waiting lists.

Stand-by time
In-active stand-by time is not considered working time in the collective agreements for doctors, while this is the case for one third of the nurses' stand-by time. For senior doctors, stand-by time is however remunerated by EUR 170 and 270 per shift depending on the timing of the shift (weekdays or weekends). For young doctors, every hour on stand-by (active or inactive) is remunerated by one third of the normal hourly wage.

The use of stand-by time is not widespread among doctors. It is more widely used for senior doctors than for younger doctors, as specialists (senior doctors) may be on stand-by serving more than one hospital at the same time. The limited use of stand-by time is partly a result of inactive on-call time not being counted as working time, partly a result of the requirement to be present for acute treatments, which makes stand-by time inappropriate, in particular in remote areas of Denmark to which many of the doctors commute.

Opt-out
Denmark has not chosen to opt-out from the provisions of the WTD as regards the maximum weekly working time under the conditions specified in Article 22(1).

Compensatory rest
The collective agreements for doctors and nurses do not specify that the compensatory rest must be taken immediately after an extended work period.

Although in practice, most doctors and nurses leave for home after a shift, there are situations where full compliance is disturbing for the doctors and unhealthy for the patients. However, the hospitals do make sure that patients are not treated by a tired doctor. Furthermore, the hospitals' electronic work planning systems do help to pursue proper rest periods for the doctors and nurses.

Reference periods
The stipulated reference period is 14 weeks, while the possibility to extend this period to a maximum of 26 weeks by local agreement is not widely used.

In practice, a reference period of 12 weeks is mainly used, mostly because it is suitable for managing overtime payments and not so much because of the working time rules. Furthermore, it is considered impractical to apply longer reference periods, as many young doctors may only be employed at a given hospital for six to twelve months.

Autonomous workers
Derogations from the WTD provisions for "managing executives or other persons with autonomous decision-taking powers" are not applied for doctors and nurses in Denmark. This said, some of the leading consultants may consider themselves as such, as they can be argued to have autonomous working arrangements.

Concurrent employment contracts
Working time rules are in Denmark applied on a per-contract/employer basis and not on a per-worker basis.

Derogations
The system of possible exceptions and derogations does not cause problems for the collective agreements in Denmark. Actually, the Danish employers' and workers' organisations do not really find the system that complex. Most unclear issues are being made clearer during the collective negotiations.

Furthermore, any complex working time rules are coded into the electronic work planning systems used by the hospitals. Hence, "red lights" will show if the agreed complex rules are not complied with.

Reconciliation
The obligation to inform workers of their rights is already part of collective agreements and individual employment contracts in Denmark; and the use of electronic work planning systems at the hospitals enables access to information.

3.2.2. WTD enforcement procedures

Enforcement of the working time rules in Denmark is formally done by the Danish Working Environment Authority[30], while the employers' and workers' organisations are the watchdogs that ensure that the collective agreements are complied with. Furthermore, there are a number of arbitration orders. For example, Arbejdsretten (2009), which concerns a hospital's limitations to flexibility regarding arranging working time outside the agreed work schedule for a given period.

However, enforcement costs are not high and there are not many disputes about compliance with the WTD. The Danish Working Environment Authority has, for example, no records of recent cases of complaints by employers or workers.

[30] Stipulated in Chapter 13 of the Danish Working Environment Act.

Furthermore, working time rules are rarely the focus of the labour inspectors who need to check a wide range working conditions and safety and health issues during an inspection at a public hospital, e.g. heavy lifts, musculoskeletal disorder issues and psychosocial problems. Labour inspectors may investigate whether psychosocial problems could be caused by violations of the WTD, in particular the rest period provisions.

Finally, it should be noted that the Danish Working Environment Authority seems to be aware of the misinterpretation of the on-call time provision, but seems also to await a revision of the WTD before taking any actions.

3.3. Challenges and trends

This section provides the analysis of challenges and trends in the Danish public 24/7 health care sector – mainly workplace challenges and trends that may directly be affected by changes to the WTD, but also a few external pressures that may not be directly affected by the WTD.

3.3.1. Workplace challenges and trends

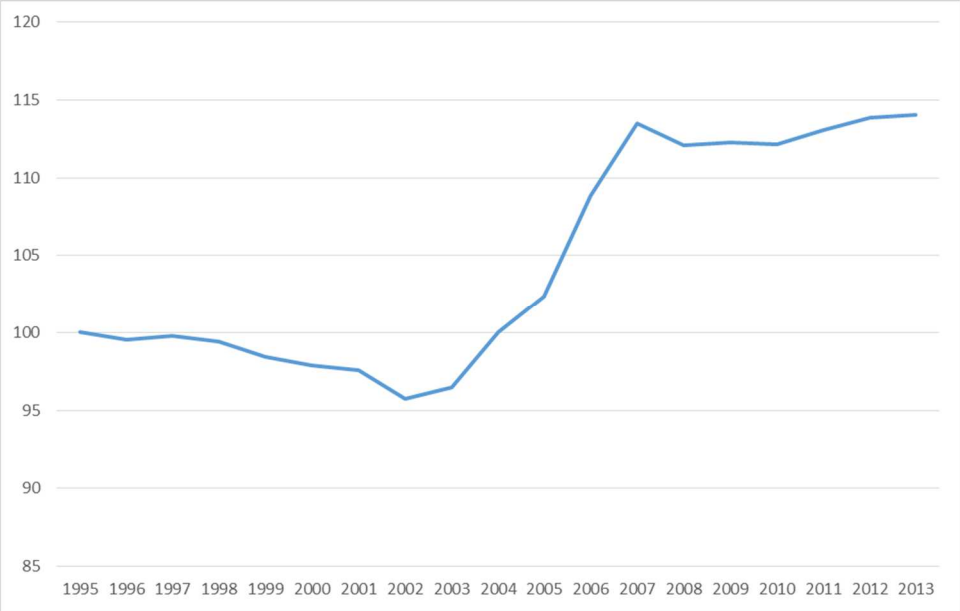
Working time for doctors and nurses
The collectively agreed working week for the younger doctors is 37 hours. They have on average three paid overtime hours a week, leading to 40 paid hours a week on average. In addition, some young doctors spend some hours every week working without being paid. However, according to surveys of self-reported working time carried out by the workers' organisation, this is only done to a very limited extent.

Consultants are in principle employed without any working time limit. However, while some consultants self-report working weeks of up to 47 hours, the 48 weekly working hour limit is not envisaged to cause that many problems.

Currently, around 40% of the nurses in public hospitals work part time – typically between 30 and 36 hours a week. This volume of the working week is due to a historical tradition of not working full-time in the sector, mainly for nurses with small children and for elderly nurses.

Although both employers' and workers' organisations acknowledge that the recent increased focus on increasing productivity and on reducing waiting lists have led to extra paid as well as unpaid work, they do not recognise the sharp increase in the average working time displayed by the official Danish statistics in Figure 3-1, which also covers other professional groups than doctors and nurses. Hence, the large increase by around 15% – mainly between 2003 and 2007 – is considered by the organisations to be a result of the fact that prior to 2003 particularly many nurses worked part-time in the public hospitals or via temporary agencies. Furthermore, the figure covers the fact that an increasingly larger share of the doctors are seniors who generally work more than younger doctors.

Figure 3-1 Average working time, Danish public hospitals, index 1995 = 100



Source: Statistics Denmark, Statistikbanken: ATR22 and ATR30.

There are, however, pressures on doctors to increase working time in the future – in particular on senior doctors. For the nurses, there are also tendencies for a move away from the part-time culture. On the other hand, the employers' organisation fears that the part-time culture may spread to doctors, where, in recent years, the share of female doctors has increased. Furthermore, during the recent collective negotiations discussions about whether to abolish the paid lunch break.

Number of doctors and nurses

The official Danish statistics do not directly distinguish between doctors and nurses. However, as shown in Table 3-2, employment data are available for Danish public hospitals by socioeconomic level and by gender. Hence, we assume that the doctors and nurses belong to the highest and the medium socioeconomic levels. Although the table below shows that there is a data break between 2010 and 2011 regarding the definitions of socioeconomic levels, there are indications of increasing employment among doctors and nurses in Denmark.

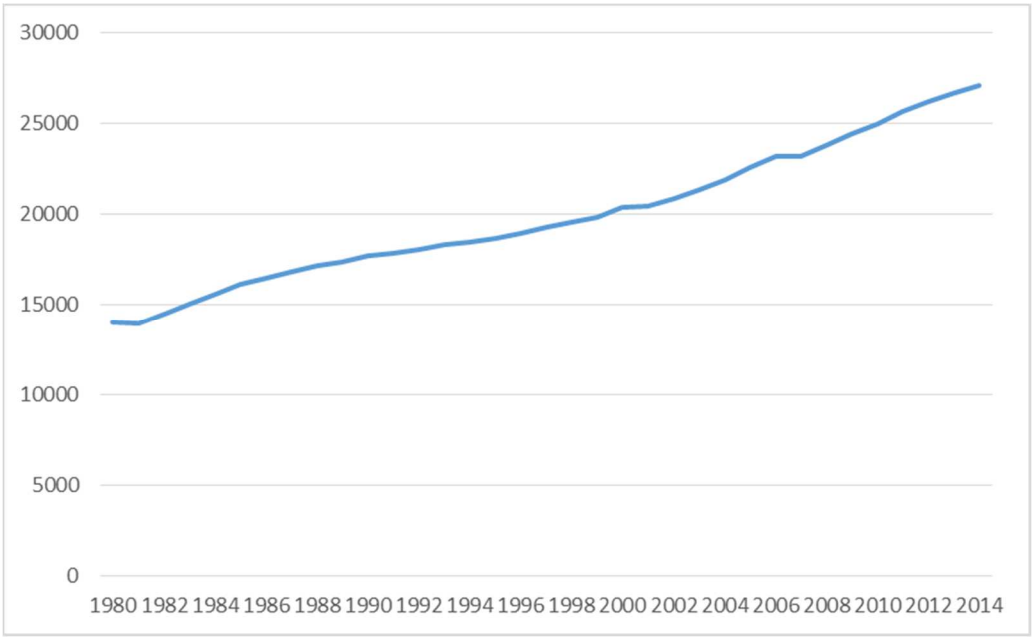
Table 3-2 Employment in Danish public hospitals, workers with highest and medium socioeconomic levels

	2001	2010	2011	2012	2013
Workers - highest level	16798	27332	61932	62197	64065
Workers - medium level	42790	45157	21205	20358	19564
Total	**59588**	**72489**	**83137**	**82555**	**83629**
Men - highest level	7709	8899	10963	10915	11170
Men - medium level	2553	3343	1933	1900	1676
Total men	**10262**	**12242**	**12896**	**12815**	**12846**
Women - highest level	9089	18433	50969	51282	52895
Women - medium level	40237	41814	19272	18458	17888
Total women	**49326**	**60247**	**70241**	**69740**	**70783**

Source: Statistics Denmark, Statistikbanken: RAS9 and RAS150.

The increasing employment of doctors is also reflected in the number of members of the Danish Medical Association. Figure 3-2 shows that the membership covering both hospital doctors and doctors in private practice has been steadily increasing in the last 35 years.

Figure 3-2 Members of the Danish Medical Association, 1980-2014



Source:
http://www.laeger.dk/portal/page/portal/LAEGERDK/Laegerdk/Om%20L%C3%A6geforeningen/ORGANISATION/LAEGEFORENINGEN_I_TAL

Furthermore, Table 3-3 shows that slightly more than half of the hospital doctors that are members of the Danish Medical Association are junior doctors, and in total there are slightly more female than male members. However, there are almost twice as

many male specialists/seniors than female, and thus in turn relatively many female junior doctors. From these figures, it is estimated that around 15,000 of the hospital doctors are employed by the public hospitals, while the most recent figures from the nurses' organisation show that 37,935 nurses are employed in basic hospital positions.

Table 3-3 Hospital doctors that are members of the Danish Medical Association, 2014, (excluding retired persons)

	Men	Women	**Total**
Junior doctors	4199	6650	**10849**
Specialists/consultants	5155	2865	**8020**
Total hospital doctors	**9354**	**9515**	**18869**

Source: http://www.laeger.dk/portal/page/portal/LAEGERDK/Laegerdk/Om%20L%C3%A6geforeningen/ORGANISATION/LAEGEFORENINGEN_I_TAL

Both the employers' and the workers' organisations claim that there is no shortage of doctors at present and that there is no risk of such shortage in the near future. This expectation is, however, not in line with the publication of the employers' organisation. Danske Regioner highlights that several forecasts point to the fact that the Danish health sector by 2020 will face a shortage of around 2,000 doctors (more precisely: medical specialists) and around 5,000 nurses. The nurses' organisation agrees to this forecast, although the magnitude of the shortage, for example, will depend on the ability to attract nurses from particularly Sweden and Norway.

However, remote area public hospitals already now face a shortage of doctors. This is simply because most doctors prefer to work at the larger central hospitals. In this context, it is difficult to fill in the allocated vacancies for the first-year practice of the younger doctors. For example, Nykøbing Falster Hospital only managed to fill 12 of its 17 training places in 2014.

The remote area public hospitals therefore particularly engage in attracting foreign doctors. This is, however, not without difficulties. There is often insufficient ability to recruit foreign medical staff. Among the reasons mentioned are e.g. difficulties in getting approvals of educational achievements, a lack of abilities to integrate foreign staff and their families in Danish society and a general international shortage of specialised staff.

Labour costs

The Danish doctors are the best paid in the Danish public sector. According to the wage data from the municipalities and regions[31], current monthly wages – including overtime, pension and holiday payment – amount on average to EUR 7,643 for junior doctors, EUR 11,384 for consultants and EUR 4,927 for nurses.

Furthermore, Table 3-4 shows that the salary part of the labour costs borne by Danish public hospitals has increased by around 18% between 2008 and 2013, which involved

[31] www.krl.dk

an increase of around 12% in the average hourly salary rate. This is slightly more than the 10% increase in consumer prices in this five-year period.

Table 3-4 Public hospital staff, salary costs, Denmark, 2008 and 2013

	2008	2013	Growth
Salaries, mEUR			
Total	**5501**	**6491**	**18.0%**
Men	1409	1656	17.5%
Women	4093	4836	18.1%
Salaries, EUR per hour			
Total	**39.2**	**43.8**	**11.9%**
Men	48.3	52.8	9.2%
Women	36.8	41.4	12.6%

Source: Statistics Denmark, Statistikbanken: ATR22.

Wages comprise, however, only a limited part of the collective negotiations, because the room for negotiation is in practice determined by the Minister of Finance. Specific salary increases are therefore mainly linked to taking upon extra duties.

Administrative and management costs
As already mentioned, Danish public hospitals are well-equipped with electronic work planning systems. Hence, there are only few administrative and management costs associated with implementing and complying with the working time rules. Similarly, the working time rules – hereunder changes to these – are part of the conventional negotiations between employers and workers. Accordingly, changes do not really involve significant, additional costs.

Actually, the main related administrative and management costs come from the hiring of foreign doctors. However, the recruitment of foreign doctors has decreased since 2007 and so have costs. Similarly, it used to be common for nurses to work for temporary employment agencies. The financial crisis seems, however, to have made the life of temporary workers unsecure leading to an increased wish for permanent employment.

Qualifications of doctors and nurses
The decrease in the employment of foreign doctors and nurses and of temporary staff is assumed, overall, to have raised the average qualifications of doctors and nurses. Hence, there is a preference for permanent staff that participates in the development of the workplace and that helps improve the quality of the hospital services.

Training of doctors is a highly centralised system where the young doctors are recruited to introduction jobs at the various public hospitals. These introduction jobs last one year, after which the doctors enter another training position.

Mogensen (2009) suggests that there may be negative consequences of the relatively short working time among Danish doctors, e.g. that they are relatively inexperienced doctors, and that it may contribute to a shortage of doctors. Such notions of the need for demanding working hours as an essential feature of junior doctors' training,

underpinned by the need to experience first-hand exposure to a wide variety of patient cases, are widely found in the literature, e.g. Brown et.al. (2010) and Jagsi et.al. (2005). This opinion is, however, not shared by the doctors' organisations who believe that Danish doctors in general have high qualifications that are comparable with the best in the world. This is partly because being a doctor in Denmark is an attractive position that appeals to many university applicants.

Availability of public 24/7 health care service
At present, there are 53 public hospitals in Denmark[32] employing 106,870 persons (on a full-time basis) of which 14% are doctors, 33% are nurses, 10% are social and health assistants, 12% are other health professionals, and the remaining 30% are psychologists, administrative staff, cleaners, technical staff and others.

A political agreement from 2011 regarding "super-hospitals" implies that the public hospital sector in the future will consist of fewer but larger hospitals. Hence, in the future there will be 18 "super-hospitals", some of which will consist of entirely new hospitals that are expected to be operative between 2019 and 2021.

Hence, there will be a change in the geographical location of Danish public hospitals, which is directly linked to the objective of providing services within reasonable geographical distances, and which has strong links to the trend of urbanisation – in particular the growth of the major Danish cities in especially Copenhagen – leading to local shortage of staff in e.g. remote areas. It must be emphasised, however, that Denmark is a small country and compared with many other countries no citizen will experience long travel distances to a public hospital.

Furthermore, the doctors' organisations consider that the core objective of delivering 24/7 services when needed of high quality and to all citizens is in agreement with the establishment of the "super-hospitals".

Service technology developments
Service technologies are not really seen as replacements for doctors and nurses and thus not as a means to reducing staff numbers. Some new technologies, however, result in a reduced need for daily care at the hospitals, but mainly for the services rendered by social and health workers.

Instead, service technologies are seen as a means to improving productivity and, at the same time, improving the quality of the hospital services. The possibilities are manifold: electronic patient journals, tools that follow operations so that a doctor can treat one patient while keeping an eye on other operations, tools for heart operations, etc.

3.3.2. Other pressures and trends

This section provides a few figures for external pressures on the public 24/7 health sector that may not be directly affected by the WTD.

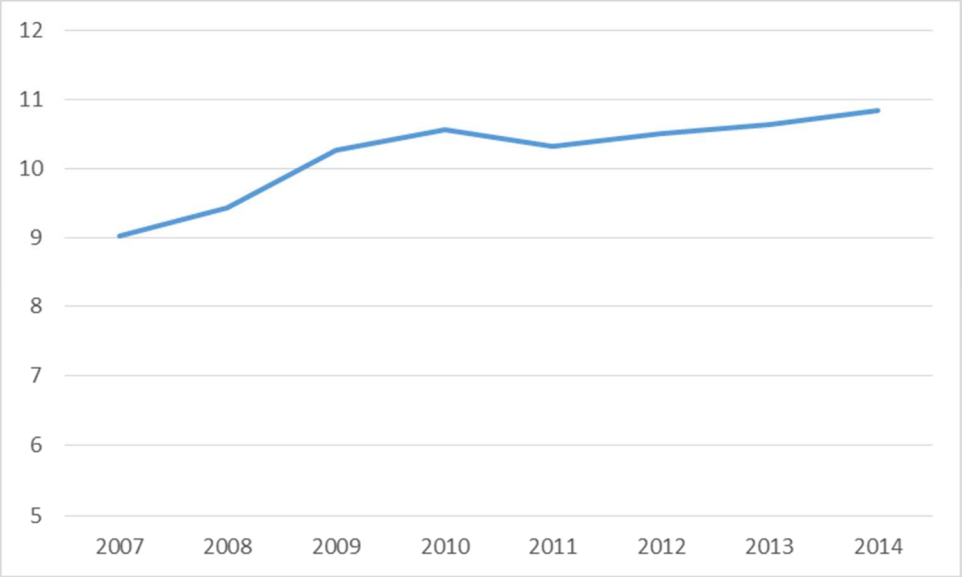
[32] Danske Regioner, 2014

Public health care costs and financing

Although Danish public budgets are constantly under pressure, Figure 3-3 shows that the regional hospital budgets have increased during the recent economic and financial crisis. Hence, the budgets have been able to absorb any increased staff numbers and health care costs.

The health care sector is continuously changing towards shorter, optimized admissions and more outpatient treatment. This has implications for hospital costs.

Figure 3-3 Regional hospital budgets, 2007-2014, billion EUR, (2007 prices)

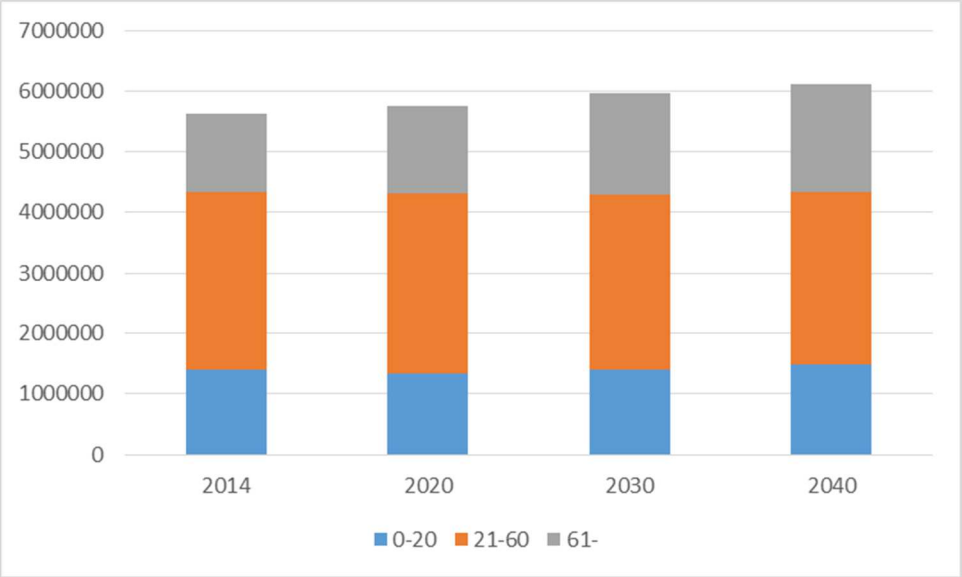


Source: Statistics Denmark, Statistikbanken: BUDR3.

Demographic trends

Like many other countries, Denmark has a demographic challenge of an ageing population. Figure 3-4 shows that both the absolute and the relative number of the age group 60+ is on the increase.

Figure 3-4 Population forecast by age, 2014-2040, Denmark



Source: Statistics Denmark, Statistikbanken: FRDK.

In general, the Danish public hospitals find themselves ready to cater for an ageing population. However, it may prove to be a challenge for the remote area hospitals, which may face a shortage of doctors and which may have a particularly high number of elderly patients.

3.4. Implications of changes to the WTD provisions

3.4.1. On-call time

When trying to assess the implications of reducing the share of inactive on-call time at the workplace to be counted as working time from 100% to 75% or to 50%, it must again be underlined that the collective agreements between the Danish employers' organisation and the organisations of the doctors do not consider inactive on-call time as working time. Hence, if they continue to be allowed to do so in practice, the proposed changes will not have major implications.

However, if collective agreement are not allowed to do so in the future, interviewees assess that this will lead to a serious shortage of doctors, particularly in the remote areas of Denmark, and thus a sharp reduction in hospital services. This would the case when 75% or to 50% is to be counted as working time. In this context, it is envisaged that the problems would not solely be resolved by increasing finances, as additional doctors, hereunder foreign doctors, will be difficult to attract.

Doctors are likely to be put under pressure to increase their average working time if (part of) the inactive on-call time is to be counted as working time, and this will probably lead to a two-five hour increase of their working week and result in the employment of more doctors. A rough estimate is a need to employ 10% more doctors if 50% of on-call time is to be counted as working time, and 15% more doctors if 75% of the on-call time is to be counted as working time. This increase in the number of employed doctors would, to a high extent, need to take place through the recruitment of foreign doctors and so lead to a significant an increase in administrative costs.

It would furthermore imply a reduction in the time spent by senior doctors in the hospitals for training young doctors and for research. This said, seniors only have few on-call time periods, which are inactive, which would put a limit to the implications.

Since the nurses already count 75% of their inactive on-call time as working time, it would only have limited financial and organisational implications if this percentage was reduced to 50%. This should also be seen in the light of the fact that only a small proportion of nurses are subject to on-call time.

3.4.2. Stand-by time

As long as Denmark is allowed to not to count on-call time as working time, the doctors will continue not to make much use of stand-by time. Furthermore, if inactive stand-by time must partly – i.e. 20% or 40% – be counted as working time, its use will disappear.

Since both the hospitals and the doctors find stand-by time inappropriate because of the requirement to be present for acute treatments, its use is unlikely to be significant in the future whether or not it is counted as working time.

This said, if inactive on-call time is to be counted as working time (50% or 75%), more stand-by time will be counted as working time (20% or 40%), and some undesirable incentives to make use of stand-by time may , e.g. by arranging rest accommodation for doctors outside the hospital areas. It is questionable, however, if such an arrangement may be approved in practice.

Since one third of the inactive stand-by time for the Danish nurses are already counted as working time, the proposed option will have little implications, not least because the use of stand-by time is very limited at present.

3.4.3. Opt-out

Since Denmark does not make use of the opt-out provision for a maximum working week, there will not be any implications of having to accompany an opt-out with added requirements of keeping records of working hours, of not being allowed to use opt-out simultaneously with longer reference periods, or of suppressing or phasing out the provision.

In particular, the nurses are against Denmark deciding to make use of such changed opt-out provisions. They believe that employers would press them to accept longer working weeks with resulting adverse social impacts.

Danish hospitals with their electronic work planning systems are, however, well-prepared for any added requirements to keep records of working hours and of how these may conform/conflict with other WTD provisions.

3.4.4. Compensatory rest

To assess the workplace implications of allowing the compensatory rest to be taken within a reasonable time – i.e. 48 or 96 hours – instead of immediately after the extended work period, it must be acknowledged that the Danish collective agreements for doctors and nurses at present do not specify that the compensatory rest must be taken immediately after an extended work period.

However, in practice both the hospitals, and the doctors and the nurses assess that most compensatory rest periods are taken immediately after an extended work period. This is considered to be most suitable to secure well-rested staff. Furthermore, the rest periods are guided/monitored by the electronic work planning systems. Hence, it is unlikely that extending the period for compensatory rest to 48 or 96 hours would be exploited.

3.4.5. Reference periods

Since a period of 12 weeks is considered the most suitable for managing overtime payments, this reference period is also used in practice in connection with complying with the working time rules. Furthermore, it is impractical to apply longer reference periods, as many young doctors may only be employed at a given hospital for six to twelve months.

Hence, a change in the WTD to allow reference periods of up to 12 months will not be implemented or used in practice in Denmark.

3.4.6. Autonomous workers

Since derogations from the WTD provisions for "managing executives or other persons with autonomous decision-taking powers" are not applied for doctors and nurses in Denmark, there will be no workplace implications of limiting/clarifying the option.

3.4.7. Concurrent employment contracts

At present, working time rules in Denmark are applied on a per-contract/employer basis and thus not on a per-worker basis. It is difficult, though, to assess the implications of applying the maximum weekly working time per worker when working under concurrent contracts for the same employer. This would require a clear definition of what is meant by employer, e.g. hospital, region or state.

3.4.8. Derogations

Since the Danish employers' and workers' organisations do not really find the present WTD that complex and since most unclear issues are made clearer during the collective negotiations, the workplace implications of formulating simpler and clearer rules for derogations are likely to be very limited.

3.4.9. Reconciliation

As the obligation to inform workers of their rights is already a part of the collective agreements and individual employment contracts in Denmark, additional obligations to do so will not have any significant effect.

Furthermore, it is very difficult to assess the workplace impacts of introducing the possibility for a worker not to take an uninterrupted rest, but instead giving him or her the possibility to interrupt the rest for a maximum of three hours and reassume his or her work during this period. This option is unlikely to be much used, but will be feasible to implement in the electronic work planning systems of the hospitals.

3.4.10. Measures increasing legal clarity and certainty

As mentioned above, the Danish employers' and workers' organisations do not really find the present WTD that complex and so measures to enhance legal clarity and certainty would have no significant effect.

3.4.11. Conclusions

The present arrangements of working time for doctors and nurses in Denmark are very rarely subject to disputes between the employers and the workers. There are at least two reasons for this. Firstly, there is no shortage of doctors and nurses in Denmark apart from in remote area hospitals, and the average working hours do not often conflict with the limitations set by the WTD. Secondly, the employers' organisations, the workers' organisations and the consulted public hospitals all agree that it is a strength that most of the WTD provisions are implemented via collective agreements. This implies that the working time arrangements generally suit the different types of doctors and nurses.

This said, it should be acknowledged that the collective agreements for the doctors do not consider on-call time as working time as stipulated by the Jaeger/SIMAP rulings, i.e. such interpretation of the on-call provision has thus been accepted by both employers' and workers' organisations, and it has not been enforced in practice by the Danish Working Environment Authority.

From the perspective that the WTD provisions have generally been timely implemented and are complied with – apart from the counting of inactive on-call time, it is assessed that possible changes to the WTD in the future will also be timely implemented. Furthermore, both employers' and workers' organisations do not envisage significant, administrative costs as a result of changes to the collective agreement. This will just be part of the normal biannual negotiation process. Similarly, being well-equipped with electronic work planning systems, public hospitals do not find it that cumbersome to make the changes that would ensure that revised working time rules become part of the daily planning of the doctors' and nurses' work. Finally, the fact that doctors and nurses in general have working hours and weeks that do not exceed the limits of the WTD – disregarding the fact that on-call time is not counted as working time – implies in itself that not all future changes may have an impact.

However, if on-call time or 75% or 50% of the on-call time in the future must be counted as working time, it would lead to a severe shortage of doctors, particularly in the remote areas of Denmark, and so a sharp reduction in hospital services, as the additional doctors needed, hereunder foreign doctors, will be difficult to attract.

4. FRANCE

Working time in France is generally regulated by law (Labour Code applying for all sectors). In 1982, the length of the working week was set at 39 hours per week. This was reduced in the late 1990's to 35 hours/week. In 2008, increased opportunities for working overtime were introduced. Up to 405 overtime hours per year can be agreed at enterprise level. For designated autonomous workers (e.g. executives, board members), the working time is set on an annual basis, and fixed through collective agreements.

Key elements of the French legislation on working time key provisions are:

- A maximum of 48 hours per week, and over a period of 12 weeks, the average should be a maximum of 44 hours (exceptionally, this can be 46 hours): some exemptions to the 48 hours as a maximum are possible but, in this case, there is still a limit (60 hours) and it is conditioned by a requirement that the administrative authority in question must validate the revised ceiling and the representative body of the employees must be consulted. There is no limit for employees under annual working time (autonomous workers as defined above).
- Maximum of 10 hours per day, exceptionally it can be 12 hours
- Minimum daily rest of 11 consecutive hours, but possibility to reduce this to a minimum of 9 hours through collective agreement
- Weekly rest of minimum 35 consecutive hours (an entire 24hours day and followed by another 11 consecutive hours).

4.1. Implementation of the WTD

The working time rules of doctors and nurses in the French public 24/7 healthcare sector are specific, but framed in respect of the Aubry I & II Acts on the mentioned reduction of working time. It should be noted that the organisation of working time in hospitals in France is very complex and difficult to overview[33]. Additionally, the rules are different for nurses and for doctors. The latter have a specific status. Furthermore, also the rules for public hospitals and non-profit hospitals differ.

The hospital civil service constitutes the framework for all agents (including nurses) working in hospitals or elsewhere in the public 24/7 healthcare sector. Inside the hospital civil service, there are different categories of agents. Nurses can be included in Category A (direction and management branches, supervision jobs) if in possession of a postgraduate diploma (3 years minimum) or category B (production jobs). Working time is defined for the hospital civil service with differing arrangements according to the categories. The DGOS[34] is in charge of regulating status and HR policy (wages, status) within the given framework.

[33]An HR Director interviewed confirmed this view and stated that he found it much more complex than working organisations in industry for example.
[34] Direction générale de l'offre de soins, Ministry of Health

The main working time provisions for the hospital civil service agents are laid down in a decree of January 2002. Since 2002, the weekly working time has been 35 hours per week for all agents (1607 hours per year). Night working agents are an exception to this; here the working week is reduced to 32.5 hours/week (1476 hours on annual basis). According to the decree, the maximum duration of daily working time must not exceed nine hours per day for nurses working on a daily basis and 10 hours for nurses working on a nightly basis. Concerning rest periods, the decree sets out that that rest must be provided for 12 consecutive hours per day and 36 consecutive hours per week. Agents working more than 35 hours per week accumulate compensatory rest period (in French: 'RTT' meaning: 'reduction du temps de travail').

Doctors are included in a specific classification called 'hospital practitioner' (HP). The status was defined in 1984 and the main provisions for working conditions are consolidated in the public health code (articles voted by Laws are included in Labour code). Key provisions have been specified in a legal order of 30 April 2003 in relation to the organisation and compensation of continuity of care in public healthcare sector.

HP (i.e. hospital doctors) must work 39 hours on a weekly basis. They are entitled to 19 RTT days (compensatory rest periods) per year plus annual days leave (25 per year). The RTT days compensate for the gap between 35 and 39 hours (previously commonly applied weekly working time). Just as executives designated as autonomous, they must work 208 days a year (annual working time).

In most hospital activities, and because it is the main rule, the obligation of service for HP's is calculated on a half-day basis. It constitutes 10 half days per week. The number of hours in a 'half-day' is however not defined. In practice, it is 4 hours or more. On-call time is counted in the compulsory services. Some specific activities can have special working time arrangements to take into account of the need for continued medical cover, e.g. anaesthesia, urgency, intensive care, and gynaecology. In those cases only, the calculation can be based on hours per week.

In theory, the implementation of WTD is reinforced by the public health code. In practice however, 48 hours are becoming normal hours weekly working time for hospital practitioners in some establishments, more so for doctors in training who cannot benefit, unlike others, from the Time Saving Account (CET) for additional hours. A specific survey made in September 2012 showed that 60 hours per week were very common for this category (surgery, gynaecology, anaesthesia) and, in some cases, work time could amount to 80 hours per week.

Furthermore, since the implementation of HPST[35] Act of July 2009, the pressure on HPs for a 48-hour weekly working time has been increasing.

In non-profit hospitals, there is more flexibility regarding working time arrangements. The framework is defined through collective arrangements at the national level and applicable to all establishments; however, each agreement can apply different working time models. There is thus a multitude of models.

The above HSPT Act (2009) is the main reform that has been implemented for the public health care sector over the past years. It aims to strengthen hospitals and to

[35] HPST means Hôpital patients santé territoire (hospital, patients, health, territories)

improve the attractiveness of jobs in hospitals. The law introduces the flexibility to delegate some assignments to private entities and it sets out to enhance coordination of the health care sector at territorial level and to strengthen cooperation among the involved actors. An example of an area where cooperation can be developed is telemedicine (e-health). Under the chapter of Hospital Relevance, there is an introduction to governance changes (e.g. the law reinforces the role of the head manager delegating more power to him/her in matters of decision-making). Also improved flexibility for health care establishments in term of organisation is provided along with an intensified development of the contract agreements method. Finally, the law requests that public health care establishments balance their budgets as compared to developments over recent years where deficits have accumulated.

Successively, in September 2012 and in September 2013, the European Commission has requested France to make up certain deficiencies in the transposition of the WTD for HPs. A new legal order was thus established in November 2013 and an application decree was published in 2014 as a response to the request from the European Commission. Recently, a new request was issued to France by the European Commission asking France to respect the WTD provisions for working time for doctors in training ('internes') – this followed from the ISNI study produced end of 2012.

Overall, a large majority of public hospitals respect the implementation of the WTD as it is transposed into French legislation. It should be noted that more than one third of hospitals have renegotiated their RTT working time agreements since the 2002 implementation. In practice, each public hospital determines within its own organisation, the weekly working time. This is done under local agreements and in the context of the 2002 decree and in respect of the WTD. The Ministry of Health has set the weekly working time to 35 hours and established that working time in excess of 35 hours per week must be recovered (compensatory rest period called in France RTT). Each agent has a time saving account under which he/she can deposit RTT days.

For some types of units, the WTD can be complex to implement. For instance, in some places the working time for nurse anaesthetists or midwives is organized such that they work 24 hours of successive shifts with rest breaks. In those particular professions, the existing skills shortages do not give any room for negotiating alternatives.

According to a recent study conducted on the Paris region (Ile de France), at the beginning of 2013 up to 18% maintained a 24-hour model for organisation of working time, including nurse anaesthetists, midwives, operating room nurses, emergency nurses, and radiology technicians. According to employers' representatives (ADRHESS), maintaining this model may contradict with the WTD and can incite people to become multiple jobholders.

Nevertheless, over the last years, some new organisational orientations have emerged for agents' working time at hospitals. This is a consequence of different factors: implementation of 35 hours as the weekly working time reference, shortage of nurse skills, increasing budgetary constraints and a need to create more attractive workplaces. Thus, some hospitals experimented with a working day based on 12-hour shifts (night and day). Article 7 of the 2002 decree states "*in case of continuum of work, the daily working time cannot exceed 9 hours for daily team and 10 hours for nightly team. Nevertheless, when constraints of public service mission need it, the chief of the hospital can, after advice of the hospital technical committee, derogate to*

the daily working time, without exceeding 12 hours. Under the experiment, hospitals reduce the number of people needed to ensure a continuum of services. Calculations show, for instance that with 7h30 as the daily working time, the number of employees needed to operate 24/7 services are evaluated at 6.04 against 5.83 with a 12 hours working day basis instead.

According to the same study, the practice of 12-hour model was seen in 71% of hospitals covered. Medicine-surgery and obstetrics are the main units in which it is observed. It should be noted that the 12 hours is becoming an important model whereas it was intended as an exception.

The different studies conducted underlined various qualitative impacts of the 12-hour model. On the quality of health care and full medical care, positive important aspects include better monitoring of patients, a more autonomous feeling for agents and more cooperation between doctors and nurses. Nevertheless, some negative aspects are also pointed out, such as cuts in transmission time, lack of cohesion team, and fatigue during the last hour as well as some level of "relearning" after rest periods. On the question of social impacts, agents appreciated very much the new organisation. It is considered to give them more time for personal life, a decrease in transport (commuting) and reduction in child care spending as well as a decrease in working weekends. On the other hand, there is a reluctance on the part of night agents who must work after 7 pm until 7 am. On the question of agents' health, they gain an increase in their personal time but experience a loss in terms of mental fatigue. To conclude, moving to a 12-hour organisation can be interesting from a budgetary perspective, but it is necessary to take into account various other impacts, such as risks assessments, and to define monitoring indicators and evaluation procedures before taking any decision on whether to move forward in this direction.

Last, it is worth mentioning that a civil servants survey conducted by the end of 2011 concluded that working conditions had worsened during the last 5 years for almost 71% of respondents. Furthermore, 66% of them declared that the workload was the main cause of working conditions deterioration. For more than 62% of respondents, human resources are missing at the workplace and 42% declared to be recalled during their rest time. Also, more than 55% of respondents often worked overtime (40% sometimes).

Doctors (Hospital Practitioners: HP) have a unique status. Their hours are not counting, but rather it is more typical to base the organisation of working time on half-day counting[36]: 10 half days per week reaching maximum of 48 hours per week over the reference period of four months. Thus, over one year, it amounts to 416 half days of work per year to fulfil their obligations of services.

The number of hours for a half day (in French called 'vacation') is not clearly defined. The French Ministry of Health does not provide a clear framework. In practice, public hospitals calculate the daily service from 8h30 to 18h30, equivalent to 10 hours, for two half days of service and the night service (18h30 to 8h30, equivalent to 14 hours) for two half days of service. This implies that the half day delivered at daytime is

[36] As mentioned previously: HP must work on weekly basis of 39 hours with 19 RTT days (compensatory rest periods) plus annual days leave (25 per year). The RTT days compensate the gap between 35 and 39 hours (previous weekly working time). Like executives in the competitive sector, they must work 208 days a year (annual working time).

considered as five hours of work, and the half-day delivered at night corresponds to seven hours of work. In practice, the 10 half days per week can thus represent between 50 and 70 hours of working time per week depending on day or night service. This appears as the main problem of the French transposition of the WTD.

When a unit needs a continuum of services, the working time can be calculated on an hourly basis with the maximum of 48 hours over a period of four months. It is possible also for the HP to work consecutively for up to 24 hours but compensatory rest must be taken immediately after, and so that this amounts to the same number of working hours as the working time, i.e. also up to 24 hours.

The working time organisation for HP is established on an annual basis by the board of directors after advising of the Permanent organisation healthcare Commission. A summary table is elaborated each month, approved by the chief of pole. Work 'half-days' are managed by specific software developed for few years for hospitals.

In practice, under the pressure of budgets, most hospitals try to normalize the weekly working time at 48 hours for HPs, which is no longer not considered as a maximum. It means an annual working time of 1997 hours (with 19 RTT days) and 2189 hours if the HP does not take the 19 RTT days. It is not compulsory to take the 19 RTT days each year. The days can instead be allocated to the Time Saving Account[37].

As regards doctors in training, Directive 2000/34/CE has been transposed into the decree 2002-1149 of September 2002 (which modified the decree no 99-930 of 10 November 1999), which sets out the status of doctors in training including their inclusion in the Code of Public Health.

Until August 2011, doctors in training were considered public agents that dedicate all their time to medical activities and training. Service obligations are organized on the basis of 11 half days per week of which two are dedicated to training that can be grouped and accumulated up to a limit of 12 days per semester. The maximum average of 48 hours/week was introduced in 2011 with a reference period of 4 months (decree of 2011-954).

On-call time is organised by the Code. 'Normal service' for on call time is based on: 1) one on call duty per week and 2) one Sunday or bank holiday per month. This corresponds to five on-call duties per month. Each on call duty is counted as two half days. After each on-call time period, doctors in training benefit from a rest period immediately after. It is possible for doctors in training to do additional on call time and stand by time. According to the French ministry, this is however possible only for activities that are in need of a continuum of services (decided at legal level) and if it can be considered as a pressing need. Some limits are still fixed: a maximum of 16 on-call duties over four weeks, i.e. four on-call duties per week.

As a result, with the calculation of half days per week (9 per week dedicated to medical activities) and the obligation to make one on call time per week (equivalent to

[37] Compte Epargne Temps (CET)

two half days), doctors in training work close to 50 hours a week (this does not include possible additional on-call time and the two half days of training). A question that is currently open is how active the working hours of doctors in training are, when the system is based on half days. The half-day system does not reveal whether hours are active or inactive.

It should be noted that the limit of 48 hours only applies to the nine half days dedicated to medical activities and the normal service for on call time. It does not apply to additional on call time and to training time. If these elements were included, it is clear that the WTD limit of 48 hours per week on average does not apply to doctors in training in public hospitals.

To illustrate this, the French organisation (called ISNI) of doctors in training made, at end of 2012, a national survey (7000 answers) to evaluate the working time of doctors in training. The study concluded that working time amounted to 60 hours per week and in some specialties, the number of hours could increase to as much as 80 hours per week (surgery, obstetrics and gynaecology, anaesthesia). Furthermore, 25% of doctors in training indicated that they had made medical mistakes due to lack of rest.

In June 2013, the European Commission formally requested France to respect the working time of doctors in training and, moreover, issued a reasoned opinion in March 2014, giving France a few months to present a text which is compatible with the WTD (before end of July). In the request, the European Commission questioned:

- The principle of the half-day calculation principle (5 to 7 hours according to day or night period), which obligates doctors to work up to the limit of 48 hours
- excluding the two half days training from calculated working time
- excluding additional on-call time from the calculation of working time.

In consequence, a reform was proposed by France (Ministry of Health) at end of July 2014 after meetings held with the national organisations of doctors in training. The proposed reform suggests decreasing the number of half days from 11 to 10 out of which 8 are dedicated to medical activities and two to training, and so that on-call time counts for two half days. A number of other proposals (integrating one half training day as working time…) have been also formulated. However, at this moment, ISNI is not entirely satisfied with the proposed amendments. According to them, the proposals formulated by the Ministry do not respond to the EC concern about the WTD *"the average week of a training doctor still exceed 48 hours even with the decrease from 11 to 10"*. INSI has suggested that the total training time (two half-day) is considered as working time whereas the Ministry would consider only part of it is to be considered as working time. Moreover, according to INSI, if on call time is to be counted as working time, it is not the case for stand by time which currently represents a major part of the working time for some doctors in training, and more particularly according to the fact that some public hospitals are moved from on-call to stand by time to avoid the problem of rest period and reduce labour costs. Nevertheless, ISNI supported the proposal to reduce the number of half days from 11 to 10 for doctors in training.

In the not-for-profit health care sector, social partners have defined an intervention framework that includes:

- Daily rest
- 20 minutes break every six hours
- 44 hours maximum per week
- 12 hours maximum per day.

Under this framework, working time in the non-profit health sector is based on three main models, very similar to the one described for the French competitive sector in general. Employees sign working contracts that are based on the "labour code". The status is equivalent to the competitive sector employees. The three models can be combined in the same non-profit establishment.

More precisely, one model is based on 35 hours per week, the second one is based on a monthly working time (35 hours per week as an average for the month). For instance, at Groupe Hospitalier de l'Institut Catholique of Lille, the organisation of daily working time is based on 2 x 8 hours, and for night work on 3 x 8 hours. Thus, this is similar to the industrial sector. In this type of organisation, alternating teams during the day each week is the rule and they are shuffled every 12 weeks. The organisation can be based on specific teams at night or on alternative teams. As in public hospitals, the night working time is less than daily working time (1479 hours per year against 1568 hours). Some very technical units can organise alternating teams for night and day in order to maintain a high service level (resuscitation or emergency unit).

The last type of organisation is based on an annual mode of calculation for the working time (called "forfait heures" or "forfait jour"), which includes rights for compensatory rest periods (RTT days). It should be noted that implementation of "forfait hours" method is very expensive for non-profit establishments. All working hours in excess of 35 hours per week must be paid for. Therefore, the trend is to move to other less costly models, in particular in the case of doctors.

The system d'équivalence can be used in the non-profit health sector. The « heures d'équivalence » are working hours delivered by the employees beyond the legal obligation, but they are not defined as additional working hours on a 1-1 basis.

This system can be applied to some categories of jobs and sectors: in the health care sector, there is no collective agreement on the system but a decree that has codified it, i.e. the code of social action and family action. The code defines the categories of health care establishments to which it applies. In the field of non-profit organisations, establishments which provide 24/7 (constant) night surveillance (at the workplace) can apply this system.

Employees that fall under the system are educational agents, nurses and caregivers that provide all-night surveillance.

The social action code declares that night surveillance periods are counted, with regard to payments, with three hours of work for the first nine hours and half an hour for each of the hours that exceed nine hours. The period of nigh surveillance can be increased, but not up to more than 12 hours. With a view to the above collective agreements for the not-for-profit health care institutions, the employers' representative, the FEHAP, does *not* recommend the use of this system anymore.

The Ministry of Health has also specified some limits:

- In case of employees, stand-by time cannot as a rule exceed 10 nights per month and one Sunday for employees (not applying to doctors)
- In case of doctors, they can deliver, in addition to the normal duration of working time (35 hours): on-call time with 2 limits (2 nights per week and 2 Sundays or bank holidays per month) and stand-by time with 2 limits (3 nights per week and 2 Sundays or bank holidays per month)

To conclude, there are different approaches to the organisation of working time: one in the non-profit health sector (annual working time, hourly working time, annual working days…) and one in the public hospitals (based on half days), and inside of each, a diversity of situations can exist.

4.1.1. WTD enforcement procedures

The labour inspection does not have any authority to intervene at public hospitals. Regulation and monitoring are done inside the public hospital by the board of directors. Working time is monitored through dedicated working time software and through unit-based forecast tables validated by the head of unit and addressed to the head of Pole. The wages of the doctors are based on validated tables. Two bodies can exercise pressure on the hospital board with regard to working time: 1) the permanent organisation healthcare commission, which has the possibility to make proposals concerning the WTD and 2) employees' organisations who are currently the most active on the question of respecting the WTD. The Permanent organisation healthcare commission is mainly composed of representatives from the human resources management and pole representatives from both sides (directors and doctors).

In the not-for-profit organisations, the labour inspection can intervene. Also, employees' representatives as well as individual employees can ask the labour inspection to visit the establishment.

In September 2012 and again in September 2013, the European Commission pointed to some deficiencies in the transposition of the WTD for Hospital Practitioners (doctors) and doctors in training.

The new Ministry of Health thus decided to review two articles of legal order of 30 April 2003, which were translated into a new legal order of 8 November 2013: 1) concerning the opt-out, the legal order specifies the possibility provided that three conditions are fulfilled: contractual arrangement, a voluntary arrangement and payment (or compensatory rest periods, allocation to CET). Documentation for this must be recorded and monitored in a specific register opened in each hospital unit. 2) concerning stand-by time, travel time as well as intervention time at the workplace should be considered working time. Finally, the legal order underlines that the rest period of 11 consecutive hours by each 24-hour period should be respected. In case of active stand-by, the rest period begins just after the last travel time.

In the case of junior doctors, the EC sent a reasoned opinion in March 2014 and let France prepare a project before end of July 2014. The two half-day training periods are not considered as working time and supplementary in call time is not taken into account. At the end of July 2014, France submitted to the EC a project addressing the shortcomings pointed out by the EC (see doctors in training above).

4.2. Challenges and trends

4.2.1. The health care sector

Public hospitals (not the non-profit one) keep personnel accounts where people can deposit holidays that have not been taken during the year. Many days have been accumulated (in December 2010, 2,900,000 days). Today, the challenge is how to pay for all the accumulated deposits. The deposit days can be a 'bombe à retardement' according to some experts even if parts of it can be paid each year.

Demands are increasing as a result of more people with new pathologies and the needs of the ageing population. There is already a high demand by the French population for emergency services: the number of transits in urgency services is said to be 40% higher than in Germany; something which cannot be explained by the age distribution as the share of elderly is higher in Germany.

France spends 12% of the GNP on healthcare services. 35% of the healthcare expenditure are used for hospitals (29% is an average in OECD countries). There are 17,88 public hospitals per 1000 inhabitants where the comparable figure is 10,99 for Germany. Implementing social reforms is a great challenge in the public sector in France, and a particularly sensitive one when it comes to health care services.

The public health care services sector is highly indebted; 47% in 2010 (long term debt in proportion to permanent capital). Some hospital mergers have been organised over the last 10 years. The restructuring trend will have to be pursued for the next years. This could also be a means by which to address the observed job vacancies. Some experts have pointed out that part of financial difficulties could be the consequence of difficulties to control payroll spending because of generous terms (conditions at work), excess replacement or interim costs. 68% of the total spending of a public hospital go to HR (wage and social contributions).

Staff shortages are observed, and some hospitals respond to the challenge by using temporary resources. However, job vacancies at public hospitals are unequally opened over the country. One explanation is the fact that junior doctors do not necessarily, when finishing their training, apply for a job in hospitals that are in need of staff, but rather in hospitals in areas where they want to live and work.

There is clearly a discrepancy, in some regions, between the population needs and the public health care services offered. Regions like Picardie (North of France), Centre or Franche Comté thus face some difficulties in attracting doctors.

This is the main challenge of the future hospital reform.

A trend can be observed by which hospitalisation (inpatient treatment) is decreasing, reflected in a reduction in the number of hospitals and a consequential development of outpatient medicine/surgery (ambulatory). This trend has an impact on night work and weekend work and on the wages of health care professionals, as they are better paid during these periods.

4.2.2. Summary of key observations

Most of the rules defined for public hospitals also apply to non-profit hospitals. There are however two important differences:

- The working time for doctors is based on "forfait jours" in most of the time and exceptionally on "forfait heure" in non-profit organisation while the working time at public hospital is organised by a half-day system. The limits of the 'forfait- jours' as well as the 'half-day system' are not defined, except the one posed by the daily rest period.
- On-call time is included as working time for doctors at public hospitals, but not necessarily fully counted as such in non-profit organisations.

Respecting the WTD, and more particularly the compensatory rest periods and the daily rest period are currently the main challenge for both public and non-profit hospitals.

Due to the budgetary situation of non-profit and public hospitals, there is no room for negotiations about working time. The trend is to look for a better organisation of work that optimizes the working time of doctors and nurses and that finds solutions to the increasing working time while respecting the WTD, more so in non-profit organisations.

It is clear than in some hospitals, working 48 hours per week for doctors and more hours for doctors in training is a common situation, but doctors work less than before. Non-profit hospitals are more vigilant in respecting the WTD than public hospitals.

The pressure on closing the skills shortage gap is not as important as it was a few years ago. Nevertheless, one sees the phenomenon of multiple jobs increasing (public and non-profit).

The opt-out system is widespread in public hospital but not very well known in non-profit organisations.

4.2.3. Workplace challenges and trends

Working time issues regularly generate debates at hospitals between the board of directors and employees representatives, at the branch level for non-profit organisations: and at ministerial level for public hospitals.

In hospitals, in practice, 48 hours per week are no longer the maximum but are becoming the normal weekly working time for hospital practitioners in most establishments. For agents (nurses), the implementation of the 12-hour model is increasing, but controversial. Furthermore, in practice, with the transmission time (handover) between teams, agents cannot respect the 12-hour model. Only few hospitals offer compensatory rest periods (3 or 4 days). Models implemented in private organisations could be studied in more depth and lessons learnt transferred to public hospitals if relevant, e.g. the practice of a 13-hour workday followed by 11 hours of rest period could be investigated.

In the health care non-profit organisations, in practice, the working time of nurses and doctors comply with the WTD provisions in most cases. However, employers' representatives (FEHAP) as well the board of directors (Hospital group of Catholic institute of Lille, Hospital Group Paris Saint Joseph) estimate that working time will

need to increase in the future to meet the financial challenges. According to them, doctors are very well paid compared with the active number of working hours. At the moment, all hospital groups in the non-profit sector investigate more flexible working time models, especially in some units like surgery in which the working time model must be better linked to the use of capacity (equipment). For instance, some hospitals create standby teams to ensure a better use of equipment even if this option has an additional cost for them (as compared a situation where the equipment is completely idle and cannot be put in use due to non-presence of staff).

In this context, the Hospital Group Paris Saint Joseph (2100 employees) recently, in July 2014, revisited its collective agreements on working time. Here, for agents (including nurses except executives ones), the working time is now based on the annual modality (1568 working hours a year), planned on a yearly based, and reviewed each quarter for adjustments. For doctors and autonomous staff, they have to work 208 days per year. The previous agreement for doctors was based on 37.5 working hours per week with 16 days of compensatory rest period (RTT days) plus 25 holidays. The new organisation is more flexible and better adapted to the medical activities. The daily working hours can vary and depends on the needs of each unit. The needs are not the same for surgery or geriatric units. For instance, looking at the organisation of working time for the emergency unit, the annual number of working days is 166 and not 208 but this involves longer working days framed as four days of work and one on-call time per week. Here the reference for calculating the working time of doctors is neither the hours nor the half day, but the work day.

Also in the Hospital Group of the Catholic institute of Lille (2900 employees), there is a pressure from managers to modify the working day hours and adopt the 12-hour model (see before). This is also seen as a means to meet demands from employees to have more days off. It is currently implemented only for midwives. According to the board of directors, this model could be developed in emergency and resuscitation units for which it may be efficient but for other units, its benefits are seen as more questionable. Doctors are not affected as their working time is organised on the "forfait jour" model (209 days of work) except for emergency and resuscitation units for which doctors are organised on the "forfait heure" model (1607 hours), mainly to ensure continuum of services

Moreover, in some new collective agreements recently negotiated in non-profit organisations, on call time and standby time are no systematically included in the regular working time for doctors. Moreover, there are two types of on-call time: normal on call time paid at 200 euros/on call period and additional on-call time paid at 470 euros/on-call period. In the case of standby time, it depends on whether the active stand by time reaches three hours or stays below.

According to HP representative organisation (INPH), over the past year, the working time at the workplace in public hospitals has decreased and more so than in private hospitals. This is a factor of attractiveness for the public hospitals.

However, it is currently a big challenge to implement the rest periods, and even more so with the recent change introduced by the Ministry of health under the 'EC pressure' (legal provision of 13 of November 2014 following by a circular note of 30 March 2014). It is clearly becoming difficult to implement both compensatory rest periods and deal adequately with on-call time.

According to the HP representative organisation, the way the different units are organised is not compatible with the implementation of the French transposition of the WTD. Moreover, they argue that it cannot be applied within current organisation of hospitals and it would be more effective to restructure the organisation.

According to the managing boards at the hospitals interviewed, it depends on the size of the hospital; smaller hospitals are more likely to face staff shortages.

4.2.4. Number of doctors and nurses

The public health care services sector is composed of public hospitals and by non-profit organisations. The hospital civil service agents count nearly 1 million people in France. Nurses, doctors and similar professions account for 619 135 jobs in public organisations and 84 173 jobs in non-profit organisations (last data end of 2010).

Categories (in full-time equivalents)	Public organisations (2010)	Non-profit organisations (2010)
Hospital practitioners employees	93 693	12 758
Medical students, training doctors (interns)	24 006	1477
Managers of health care professionals	23 117	3710
Nurses	243 475	33 160
Others health care professionals	234844	33 068
Total	619 135	84 173

When the reduction in working time was introduced at the beginning of the 2000's years, the impacts on the need for nurses and doctors were significant. Public hospitals as well as non-profit organisations needed to recruit more nurses and more doctors.

Today, according to employers' representatives, the skills shortage is currently not as pronounced as it was five years ago. Efforts have been made to meet the problem. However, skills shortages still exist in some areas but it depends on the specialities or/and regions. Some regions are less attractive than others (for instance, south of France is preferred to the north of France or rural areas are less preferred than metropolitan areas). It also depends on hospitals: some establishments are more attractive than others. For instance, the model of annual working days at "forfait jour" (208 days) is less attractive than an hourly working day. Nevertheless, some specialities like nurse anaesthetists, radiologists, and emergency doctors are currently hard to recruit according to all organisations interviewed. The liberal sector is particularly attractive for radiologists. For this reason, it has been very difficult in the year to recruit them at hospitals.

On other hand, an increase in the number of agents and HP at hospitals is considered necessary to respect planning and working time rules; estimates put forward indicate a need for some 40,000 additional staff (an increase of less than 5 %).

4.2.5. Labour costs

On average, labour costs (based on information provided by three hospitals - public and non-profit) are the following:

- For junior doctors: EUR 32,000
- For young doctors: EUR 100,000
- For senior doctors: EUR 140,000-150,000
- For nurses: EUR 45,000.

At public and at non-profit hospitals, the board of director observe a pressure on wages for some specialities like radiologist or nurse anaesthetists.

To meet skills shortages, hospitals can recruit under temporary contracts. This does however generate administrative and management costs, as well as additional labour costs. Doctors and nurses can also assume on-call and stand-by time in different hospitals. In public hospitals, some 'hospital practitioners "attaché"' work on a part time basis delivering their services to the hospital in an ad hoc manner. Their number is quite stable and the use is particularly developed in certain medical activities. In most of cases, these doctors work partly as liberally employed (self-employed) and partly as HP. In emergency units, the use of the HP "attaché" can be quite important in order to ensure the continuum of services.

However, according to the organisations interviewed (Creteil Hospital as well as Groupe Hospitalier Paris Saint Joseph), there are no increasing labour costs due to the development in external contracts. It is still very specific and cannot be considered as a trend as such.

In non-profit organisations, wage pressures have recently been observed for operating nurses, nurse anaesthetists and doctor managers (doctors, chief of services). Also, job vacancies have been observed for night time positions in some non-profit hospitals. To face this problem, a decision was taken to increase wages to become more attractive to future employees, especially compared with public hospitals.

4.2.6. Administrative and management costs

Administrative costs are estimated to constitute EUR 600 per employee at the Hospital Group of Lille. This estimate does not include management costs. The Hospital group manages 8000 short-term contracts per year and temporary assignments for all types of employees. Costs have been increasing over the years mainly because of workplace absenteeism.

4.2.7. Qualifications of doctors and nurses

Each hospital must draw up an annual training plan for the public hospital agents. One third of employees are involved in training actions each year in the Hospital group Paris Saint Joseph and in the Hospital Group Catholic Institute of Lille. The latter organises three annual training days for its agents.

For doctors, a number of days is dedicated each year to medical training. For instance, at the Hospital Group of Lille, doctors must work 209 days but this includes 10 days of training such as participation in conferences.

4.2.8. Availability of public 24/7 health care service

In France, some hospitals experiment with 'inter-professional task shifting'. The purpose is to ensure that doctors focus on their core competences and thereby safeguarding against possible negative impacts from a shortage of doctors. In non-profit organisations, there are no real difficulties in organising the permanent health care services. The idea of inter-professional cooperation is to delegate part of the activities to non HPs, e.g. to nurses. It should be noted that only few hospitals are currently in this experimental phase, and its future remains uncertain. But the mere launch of these initiatives indicates a need to ensure efficient use of doctors' time.

4.2.9. Service technology developments

The development of telemedicine is a strong trend in France and significant resources have been dedicated to its implementation. But from a working time point of view, the possible relationship to working time is not discussed. The main question addressed under the development of telemedicine is how to take into account activities that will not be implemented at the workplace. On other hand, the implementation of telemedicine could rationalize the intervention of the HP which could be very positive. According to the HP representative organisation (INPH), hospitals will have to take into account new models of work organisation to enable delivery of services without the patient's physical presence.

4.3. Implications of changes to WTD provisions

4.3.1. On-call time

100% of on call time is counted as working time at public hospitals. In non-profit hospitals, the situation can vary depending on the organisation at the workplace and the units found at the workplace.

Practices on the use of on-call are very different. Active on-call time is more developed in emergency and maternity anaesthesia units. Active on call time can go up to 80% while in others units (cardiac section, anaesthesia, obstetrics, etc.), it will typically be as low as 10% or less.

For non-profit hospitals not including on-call time as regular working time considering 100% of on call time as working time would have a strong impact on labour costs (need more doctors) and on administrative and management costs (new recruitment).

According to FEHAP, which represents the non-profit health employers organisations, hospitals are facing difficulties mainly concerning on-call time. It would be interesting, in its opinion, to treat on-call time like stand-by time so that only active on-call time is taken into account as it is the case with stand-by time. It is said that inactive on call time is rather expensive.

Some establishments have solved the problem by considering on-call time outside of regular working time (not included in the obligation of service) Other establishments have introduced specific organisations: In emergency units where continued service is important and where the question of on-call time is therefore particularly important, a special organisation of working time was recently introduced, doctors work on the basis of 166 working days (and not 208), but the working days are longer and organised in specific cycles: four days of work + one on call time per week (as compared to five working days + one on call time per week).

4.3.2. Stand-by time

For agents, at hospital, some rules have been defined; the stand-by time is limited to one Saturday, one Sunday and one day off per month. The duration of stand-by time cannot exceed 72 hours in a 15-day period.

For HPs at public hospitals, the recent change implemented by the French Ministry of Health under the 'pressure' of the EC is currently posing some big problems of implementation to hospitals' board of directors especially when stand-by time is active. Hospitals have to find new solutions to respect daily rest periods of 11 hours with active stand-by time.

For non-profit hospitals, and according to FEHAP and the interviewed boards of directors (2 Hospital Groups), the stand-by time is not a major difficulty in the organisations since stand-by time is not included in working time. It is considered as additional time and paid as such. In the non-profit organisations, active stand-by time is paid according to two approaches; more than three hours of active work including transport time to the workplace and less than three hours of active work including transport time to the workplace. Stand-by time is currently remunerated as 25% on top of the payment for a normal working hour. Active stand-by time represents less than 30% at the Hospital Group of Lille, but it varies very much across units.

For non-profit hospitals, the fact that stand-by time is not included in working time provides flexibility.

Introducing 20% or 40% of stand-by time as working time will have financial impacts (increasing the labour cost, management and administrative costs of implementing this decision). With 20% stand-by time as working time, one of the hospitals interviewed estimates that the number of doctors must be increased by 4%. Furthermore, from an organisational point of view, it could be complex to implement.

4.3.3. Opt-out

In the case of hospital agents, additional working time can be maximum 15 hours per month, i.e. 180 hours per year, except for nurses, midwives, radiology technicians and managers for which the maximum can reach 220 hours. Additional working time can be paid out or compensated for through rest periods.

In the case of doctors, the opt-out is mainly practiced in public hospitals; for instance, around 50 to 60% of HPs have opted out in the Creteil Hospital. Almost all public hospitals implement the opt-out system. Its use is also stimulated by the fact it constitutes an additional source of income for HPs.

Conversely, the opt-out system is not very well known in the non-profit sector. Nevertheless, when on-call time and stand-by time do not take into account service obligations for doctors, the system of opt-out is, in practice, used by non-profit hospitals but it is not named opt-out. In practice, doctors calculate their annual working hours and can ask for payment of additional hours. As an example, at the Hospital Group of the Catholic Institute of Lille, 25% of doctors have additional working hours that represent between 10 and 15 days paid by the hospital (around 5% of their working time).

Both the public and non-profit hospital representatives interviewed (Creteil Public Hospital, Hospital group Paris Saint Joseph, Hospital Group of Lille, FEHAP included HP representatives) do not point to any problems linked to the opt-out system.

4.3.4. Compensatory rest

This compensatory rest period can recover two types of rest periods; one under RTT days and one under the security rest period taken immediately after the active stand-by time both in public and non-profit hospitals.

On the one hand, it could introduce some flexibility if the security rest period was not taken immediately after the active stand-by or the on-call time. On other hand, it will not solve the problem. And there is a major risk in this case that the daily rest will not be respected. Implementation of compensatory rest periods as well as respecting daily rest periods after active stand by time seem to be rather complex at public hospitals.

4.3.5. Reference periods

No opinions were provided on this possibility.

Nevertheless, increasing the reference periods would give more room to use the Opt-out system.

4.3.6. Autonomous workers

More and more of autonomous workers (doctors) are under "forfait jours' in the non-profit hospital sector; that is they must work between 208 and 209 days per year. In this context, stakeholders do not identified any impact of implications of changes.

4.3.7. Concurrent employment contracts

In the non-profit organisations, both the HR managers of Hospital Group Paris Saint Joseph and Catholic Institute of Lille made remarks about the development in multi-contracts among doctors and nurses.

To conclude, while each establishment negotiate with their social partners to obtain an organisation of work that limits working hours at the workplace and respects both the sector recommendations and the WTD, people themselves can enter into multiple contracts with other hospitals (both in private or public hospitals). The phenomenon is becoming more and more widespread. The decrease in working time over the years has given workers the time to work 'for themselves'. Doctors and nurses are able to make on call time or stand by time in concurrent hospitals, and can work more than 48 hours per week in total. The development of the multi-contracts is clearly the consequences of the working time decrease implemented for the beginning of the 2000 decade.

Conclusions :
The working time for doctors is based on "forfait jours" in most of time and exceptionally on "forfait heure" in non-profit organisation while the working time at public hospital is organised by half day. The limit of the "forfait jours" as well as the "half day" are not precisely defined, except the one posed by the daily rest period.

On-call time is included as working time for doctors at public hospital and not included in non-profit organisations.

Non-profit hospitals are more vigilant in respecting the WTD than public hospitals. But the budgetary situation at non-profit and public hospitals do no give room for negotiating on working time at the moment. The current trend is to look for better organisations that optimize the doctors and nurses time and that find solutions to their increased working overtime while respecting the WTD, more particularly in non-profit organisations.

It is clear than in some hospitals, working 48 hours per week for doctors and, surely more hours for doctors in training is a common situation, but for most of doctors at hospital, working time has been decreased over the last 15 years.

Improvements were made over the last years to diminish the pressure on skills shortages. But the phenomena of multiples jobs is increasing (public and non-profit).

The opt-out system is used significantly in public hospital without any problem pointed out but not very well known by non-profit organisations.

Respecting the WTD provisions, and more particularly organizing the compensatory rest periods and the daily rest periods, are currently the main challenges for hospitals including non-profit.

5. GERMANY

5.1. Introduction

Working time in Germany is generally regulated by the law, the so-called Arbeitszeitgesetz (ArbZG "working time law"). The ArbZG regulates inter alia the maximum permissible daily working time, the required rest periods and adequate rests as well as the protective provisions for night workers. It serves as implementation for the EU directive 93/104/EU (23.11.1993) and directive 2003/88/EU. Since 1.1.2004, on-call duty/service has been accounted for as working time as a result of the jurisdiction of the European Court of Justice concerning on-call duty although there was a transitional period up to 31.12.2006 allowing for alternative solutions if included in a labour agreement.

Health care in Germany is funded by a statutory contribution system that ensures free health care for all via health insurance funds. Insurance payments are based on a percentage of income, shared between employee and employer. Health insurance in Germany is divided between statutory and private schemes. The statutory health insurance, the so-called Gesetzliche Krankenversicherung (GKV), occupies a central position in the health care system in the Federal Republic of Germany. About 90% of the population are covered by statutory health insurance, which is compulsory for all with a gross income below EUR 4,462.50 per month. Private health care schemes either provide a complete health service for those who opt out of the GKV, or top-up cover for those who remain within it.

According to the Federal Statistic Office of Germany, the annual health expenditure in 2012 were EUR 300.4 billion, corresponding to EUR 3,740 per inhabitant and to 11,3% of the GDP (2011: 11,2%). 26,2% of the annual health expenditure were for hospitals (EUR 78.8 billion), EUR 65.1 billion (82.6%) were covered by the statutory health insurances and EUR 7.9 billion (10.1%) by private health insurances. The share of health expenditure for hospitals increased from 2005 to 2012 by 27.4 and therefore proportionally more than the general average increase in health expenditure during the same period (25%).

5.2. Implementation of the WTD

In Germany, the provision of health care is broadly divided into outpatient and inpatient sectors. This study focuses on public hospitals and hence on the inpatient sector.

Hospitals which provide mainly inpatient services are grouped into three main types:

- Public hospitals (Öffentliche Krankenhäuser) run by local authorities, towns and the Länder
- Voluntary, non-profit hospitals (Frei gemeinnützige Krankenhäuser) run by the Catholic or Protestant churches or non-profit organisations, such as the German Red Cross
- Private hospitals (Privatkrankenhäuser) run as free commercial enterprises.

In 2012, there were 2017 hospitals for acute cases in Germany providing acute care on a 24/7 basis. All together, the share of ownership is 29.8% publicly owned, 35.6%

private non-profit hospitals and 34.6% private for-profit. In addition to the acute hospitals, there are also clinics for rehabilitation, but as they do not provide a public 24/7 services they are not considered in this study.

"*Whether public or private, a majority of medical facilities are still not-for-profit and staffed by salaried doctors, although senior doctors may also treat privately insured patients on a fee-for-service basis. Non-profit or community hospitals are usually run by religious orders affiliated with the Catholic or Protestant churches and are partially funded by the German church tax, though some are run by other organisations, such as miner's associations"*[38].

To be eligible for public financing, hospitals in Germany have to be registered in the respective "hospital plans" of the Länder.

The number of physicians in Germany rose again in 2013. Out of a total of 470,422 physicians living in the Federal Republic at the end of 2013, 357,252 were professionally active; 181,012 working in hospitals and 145,933 in a practice. The proportion of physicians in the population is around 3.4 per 1,000 inhabitants.

5.2.1. WTD implementation approach

Working time in Germany is generally regulated by the law, the so called Arbeitszeitgesetz (ArbZG "working time law"). The ArbZG regulates inter alia the maximum permissible daily working time, the required rest periods and adequate rests as well as the protective provisions for night workers. The ArbZG implements the EU Directive 93/104/EU (23.11.1993) and Directive 2003/88/EU. Since 1.1.2004, on-call duty/service is accounted for as working time as a result of the jurisdiction of the European Court of Justice concerning on-call duty although, there was a transitional period up to 31.12.2006 allowing for alternative solutions if included in a labour agreement.

Until the beginning of 2004, the on-call duty/service was the time performed at the employer's request outside the regular working time in a place determined by the employer in order to be able to provide services on call. Only the active on-call time counted as working time. During rest periods, the employee was present at a different place than the one of work; most hospitals provided sleeping facilities in doctors' rooms where the employee could relax, pursue private activities, or sleep; and the call for his services was made by telephone or personally by another employee.

The ArbZG aims to ensure the safety and health protection of the employees and to improve the conditions for flexible working time. It is compulsory for employees and employers and affects all employees except the group of persons which are defined in Section 18 ArbZG. These are executive employees (defined by the characteristic that essential employers' competencies have been transformed to them, e.g. autonomous ability to hire/dismiss employees), heads of departments and administrative offices and some other occupational groups not relevant to the public hospitals.

[38] CIVITAS Healthcare Systems: Germany Based on the 2001 Civitas Report by David Green and Benedict Irvine - Updated by Emily Clarke (2012) and Elliot Bidgood (January 2013) http://www.civitas.org.uk/nhs/download/germany.pdf

The ArbZG builds the minimum framework, which can be extended by trade or company agreement. For instance, Section 7 of the ArbZG allows, if the bargaining partners agree, for the maximum daily working time of 10 hours to be extended, if regularly and to a broad extent, on-call duty/service falls into this time period.

As regards collective agreements regarding working time for public health care services, there are a number of different collective agreements and laws due to the different forms of ownership of the hospitals. For example, there are special collective agreements for physicians working in community hospitals ("Tarifvertrag für Ärzte und Ärztinnen an kommunalen Krankenhäusern im Bereich der Vereinigung der kommunalen Arbeitgeberverbände (TV-Ärzte/VKA)), for physicians working in university hospitals ("Tarifvertrag für Ärzte und Ärztinnen an Universitätskliniken (TV-Ärzte)"), for physicians working in hospitals owned by the German Caritas ("Arbeitsvertragsrichtlinien des Deutschen Caritasverbandes (AVR-Caritas)) or other religious institutions (e.g. Arbeitsvertragsrichtlinien für Einrichtungen, die dem Diakonischen Werk der Evangelischen Kirche in Deutschland angeschlossen sind (AVR-Diakonie)) as well as for private for-profite hospitals (e.g. Entgelttarifvertrag/Manteltarifvertrag für Ärzte und Ärztinnen in Einrichtungen der Asklepios Verwaltungsgesellschaft mbH (TV-Ärzte Asklepios).)

According to the ArbZG, the following activities are counted as working time: regular working time, "Bereitschaftsdienst" (on-call duty/service), overtime and the periods of "Rufbereitschaft" (stand-by, to be on call) which are actually spent working.

- **Bereitschaftsdienst (On-call service)** is defined as the time period where the employee has to be prepared to work if necessary. In contrast to Rufbereitschaft (stand-by, to be on call), the employee has to stay at a place determined by his employer. The whole period of on-call service/Bereitschaftsdienst is counted as working time.
- **Rufbereitschaft (stand-by, to be on call)** in contrast is the time period in which an employee is prepared to work outside his regular working time but where the employee does not have to stay at a place determined by his employer (e.g. the employee can stay at home, with friends, etc. and will be informed if he has to start work). Only the period of time actually spent working within the stand-by time/Rufbereitschaft is counted as working time.
- **Regular daily working time** according to the ArbZG:

  The regular daily working time is 8 hours/day. This can be extended up to 10 hours/day if during six months, the hours hours/day are not exceeded. In addition, Section 7 of the ArbZG allows workers to work more than 10 hours/day if agreed in a labour agreement or, if based on a regulation in a labour agreement on the basis of an employment agreement.

- **Regular weekly working time** according to the ArbZG.

  The weekly maximum working time of 48 hours can be extended (with compensation) if the bargaining partners agree and the average amount of 48 hours/week is not exceeded within a period of 12 months.

- **Opt-out**

The ArbZG allows workers to exceed the weekly working time of 48 hours without compensation (e.g. without limitation to an average maximum weekly working time of 48 hours within 12 months) on the condition that regular and to a broad extent on-call service is necessary and that it is agreed on in a collective or labour agreement. In this case, the individual employee has to give his written consent. In this case, a typical working pattern is eight hours of regular working time followed by 16 hours of on-call duty. However, there are also some hospitals which have agreed to have no on-call time at all but regular working shifts.

An estimated 50 % of all physicians working in hospitals have agreed to opt-out. It is estimated that about two thirds of physicians working in a discipline/hospital where on-call service is necessary have agreed to opt-out.

5.2.2. WTD enforcement procedures

The enforcement of the working time rules in Germany is carried out by the competent state institution. In most cases, these are the labour inspectorates. Therefore, the overall responsibility for the enforcement of the ArbZG in Germany in general and in hospitals is under the responsibility of the Federal Ministry of Labour and Social Affairs and not the Federal Ministry of Health.

It provided impossible for organise meetings with enforcement authorities during the time of the case study. Most likely, it was partly due to the time period (summer time/holiday time) during which the interviews had to be conducted, the fact that an additional EU study on the EU Working Time Directive already had been submitted to the Federal Ministry of Labour and Social Affairs as well as different opinions on the lead responsibility between the Länder. Two different labour ministries of certain Länder claimed that the responsibility for expressing such general opinions lay somewhere else. This was probably exacerbated by the time period (summer/traditional vacation period) during which this request was made.

5.3. Challenges and trends

5.3.1. Workplace challenges and trends

Changes and trends within the hospital sector in Germany
In the last 10 to 15 years, the number of hospitals and registered hospital beds have been reduced considerably (2002: 2221 hospitals, 2012: 2017) (2002: 547,300 beds; 2012: 501,500 beds). At the same time, the bed occupancy days has been reduced considerably (2002: 159.9 million days; 2012: 142 million days) whereas the number of cases have increased (2002: 17.4 million; 2012:18.6 million). These changes have been induced mainly by a change of the underlying payment mechanism.
"*Traditionally, payment to hospitals was based on per-diem rates that were independent of diagnosis, amount of care, or length of stay. However, it was agreed in 2000 to apply the Australian AR-DRG system (Australian refined diagnosis related groups). This system was made obligatory in 2004 and is revised annually to account for new technology changes in treatment patterns and associated costs. This system, whereby hospitals are paid the same for the same 'type' of patient, puts pressure on*

inefficient hospitals to perform procedures quickly and at minimal cost, without compromising quality.[39]"

Traditionally, there is a split financing mechanism for the hospitals in Germany, the so-called dual system, which distinguishes between investment costs and operational costs. Whereas investment costs (e.g. new construction, reconstruction, plant and equipment) are paid by tax money, the operating costs (e.g. labour costs) and therapy costs are paid by the health insurances.

A considerable number of German hospitals claim that they are under huge financial pressure. According to the "Krankenhausbarometer 2013", which is based on an annual survey of hospitals, about 51 % claim to incur a financial loss in 2013. Only 13% of the interviewed hospitals assess their financial situation as good. Another problem stated by the survey is the difficulties to recruit the necessary staff. 58% of the hospitals claim to have difficulties in filling vacancies for physicians and 34% claim to have not been able to fill all vacancies in the care sector.

The implementation of the WTD and especially the counting of stand-by time as working time have resulted in a considerable additional demand for physicians although it is difficult to quantify the exact numbers. From 2000 to 2008, the number of physicians working fulltime in hospitals increased by about 27,700 or by 25% to 139,300 physicians. This growth has been influenced also by statistical effects like the abolishment of the junior house officers ("Arzt im Praktikum") and a resulting change in official statistics (+10,378), a rise in part-time jobs (+ 12,200).

Especially the fact that inactive on-duty time has to be counted as working time has increased the number of physicians needed. The additional costs attributed to the more than 10,000 physicians that have been employed is estimated to 500 million EUR/year, based on average labour costs per physician (incl. employer's contribution) of 90,000 EUR/year.

For a single big university hospital, this can amount to about additional 3 million EUR/year, which have to be spent on the work force. Although the number of doctors employed in hospitals have risen, the staffing shortage may endanger the 24/7 service, especially in smaller hospitals and when physicians refuse to choose the opt-out-option.

Hospital staff

Physicians: According to the statistics of the German Medical Association, in 2012 there were 348,700 physicians working in Germany. 174,800 were working in hospitals, of whom 14,600 were senior physicians.

Slightly different numbers are presented by the Federal Census office. According to their figures, there were 142,874 full-time physicians working in the hospitals in 2012. Since 2003, the number of physicians working in hospitals has risen considerably, from 114,105 in 2003 to 142,874 in 2012.

[39] CIVITAS Healthcare Systems: Germany Based on the 2001 Civitas Report by David Green and Benedict Irvine - Updated by Emily Clarke (2012) and Elliot Bidgood (January 2013) http://www.civitas.org.uk/nhs/download/germany.pdf

Table 5-1 Development in staff numbers from 2003-2012

Year	Physicians hospital	Non-medical staff	Nursing staff
2003	114105	709834	320158
2004	117681	688307	309510
2006	123715	668200	299328
2008	128117	669437	300417
2010	134847	681411	304708
2011	139068	686127	310817
2012	142874	694872	313478

Federal Statistics Office

Nursing staff: In contrast, the number of nursing staff (full time) has been relatively stable during this period, with a minor reduction from 320,158 in 2003 to 313,487 in 2012. Combined with the above-mentioned rise in cases and a reduction in available hospital beds (1993: approx. 630,000, 2010: approx. 500,000), it seems obvious that the workload especially of the nursing staff has increased considerably. One explanation to the different development in the numbers of nursing staff (slight reduction) and medical staff (considerable growth) is a trend to increase medical interventions (e.g. more surgery) whereas as nursing interventions are reduced, which is illuminated by the decrease in the average length of hospital stays.

The changes of the structure of employees support this. In 1991, 11% of full-time jobs in hospitals were manned by physicians. This share was about 17% in 2010. In the same time period, the share of non-physicians was reduced by approximately 13%.

All stakeholders agree that one of the positive effects of the national implementation (ArbZG) of the EU Working Time Directive is the possibility to deviate from certain regulations if this is set out in a collective agreement by both social partners. This gives the needed flexibility to adapt the regulations to the existing needs of hospitals and their employees, even if there is no agreement on whether the extent of flexibility is sufficient. Whereas some state that more flexibility is needed (e.g. if eight –hours of is followed by 16 hours of on-call service, there has to be a break after that; a fact that makes it difficult to organize a proper handover to the next working shift), others claim that the given flexibility is already negatively affecting the health of some employees.

Regardless of the flexibility given by the ArbZG, the realised 'flexibility' depends on the individual agreement to the opt-out possibility. One remaining challenge is the fact that eight hours of work followed by 16 hours of on-call service must be followed by a break. This makes it difficult to organize a proper handover to the next working shift.

Even if, as mentioned above, it is difficult to quantify the costs incurred by the adaption of the regulations of the EU Working Time Directive and the ArbZG, it can be said that the related administrative and management have risen as well (some hospitals claim to have more than 100 different working time models). In addition, the efforts and costs to recruit physicians inside and outside of Germany have increased.

This shows that the implementation of the EU Working Time Directive and of the national ArbZG has had financial, organisational and social implications on the public

hospital sector in Germany. However, it is difficult to attribute and quantify these impacts as other factors and trends influence the work and staff situation in acute hospitals as well, which will be illustrated later in this chapter.

WTD enforcement procedures
As stated above, enforcement of the working time rules in Germany is done by the competent state institution. In most cases, these are the labour inspectorates or their subordinates.

Although most rules as set by the EU Directive are implemented via collective agreements, the majority of stakeholders still feel that it is necessary to control compliance externally. As the responsible enforcement institutions are also under personal and financial pressure, some stakeholders claim that the existing control mechanism is not sufficient in terms of frequency/coverage as well as in the applied sanctions. One suggestion put forward was to implement a regulation enforcing regular checks, e.g. every hospital has to be checked at least every second year, including checks of the necessary documentations as stated in the ArbZG.

Reports on the results of the control of working time in hospitals are rare. In one report of the Land Baden-Württemberg, the labour inspectorates state that the preparation of inspections is time consuming due to the different social agreements and organisational structures of the hospitals. A check of 179 departments in 43 hospitals identified issues were in more than one third of the cases, mostly because the daily working time exceeded 10 hours (without on-duty) or the rests were insufficient. [40]

Working organisation and time for doctors and nurses
The shift schedule of the different hospital departments are normally drawn up by the physicians and nursing staff themselves and agreed upon by the general management, which is usually also responsible for the general structure of the working plan (e.g. general change/replacement from on-duty time to shift work). Organisational changes are rare, occurring about every four to six years in succession of overall organisational (e.g. merging of departments) changes, financial (e.g. introduction of DRGs) or other changes. Changes in the service schedule/between different shifts (e.g. due to illness, private reasons) are much more frequent and happen regularly.

According to the TVöD-K bzw. dem TV-Ärzte/VKA, the average, regular working time per week is 40 hours, and there is no distinction between junior and senior doctors. For nursing staff, the average weekly working time is 38.5 hours (pay scale area Germany West, except Baden-Würtemberg (39h) or 40 hours (pay scale area Germany East).

The amount of over-time, on-duty time and stand-by time differs significantly between different specialities/departments and hospitals and cannot be generalized, and example: the amount of needed on-duty time in surgery is much higher than in urology. An approximation can be given by the results of a survey conducted on behalf

[40] The costs related to these enforcement procedures cannot be quantified because, as mentioned above, none of the enquired institutions responsible for the enforcement of the ArbZG agreed to participate in the study.

of the Marburger Bund in 2013. Of the 3,309 answering physicians working in hospitals nearly three thirds stated that the working time arrangements affect their health.

Approximately 75% worked more than 48 hours/week (including overtime, on-duty time), 47% in between 49 and 59 hours/week and 24% 60 to 79 hours/week. More than half (53%) claimed that working time is not always systematically recorded. 21% stated that overtime is not compensated with money or free time. Asked if they would prefer shorter working time, 57% stated that they would prefer a weekly working time of 40 to 48 hours, only 11% claimed to be willing to work more than 48 hours/week.

The high average working time is probably a result of the existing escape clause for an individual agreement to extend the weekly working time (regular working time in combination with on-call service/Bereitschaftsdienst) up to a total 58 hours/week.

Some stakeholders claim that the anticipated reduction in working time is the result of the considerable increase in the number of employed physicians (>10000 doctors since 2004).

In the same period, the workload of the nursing staff (average number of cases +9.6% from 2004 to 2012) increased.

Opt-out:
It is estimated that about one third to half of the physicians working in an acute hospital have agreed to opt-out although there is some doubt whether this agreement is always voluntary. A few hospitals have replaced Bereitschaftsdienst by regular shift work.

The Krankenhausbarometer 2013, a survey conducted by the Deutsche Krankenhausinstitut, states that about half (47%) of the physicians use the opt-out possibility. In comparison with 2007 (49%), the share remains almost constant.

Except for nursing staff working in functional services (e.g. operation theatre, anaesthesia), opt-out is not relevant for nursing staff as they normally do not do on-service time.

On-Duty Time/Bereitschaftsdienst
On-duty time is usually done only by physicians; nearly all doctors (junior and senior) participate. Normally, nurses only do on-duty time if employed in functional services (e.g. operation theatre).

No data on the hours available, only to the number of on call duties. However, according to the "MB Monitor 2013"[41] 50% of the physicians had 1-4 on-duty calls per months, 45%had 5-9 and 5% had 10 or more.

[41] Marburger Bund, MB-Monitor 2013

Stand-by service/Rufbereitschaft
Stand-by services are usually only carried out by senior doctors (specialist registrars, doctors and heads of department), and the amount differs individually. Only the actual time worked is counted as working time.

Social trends:
Nearly all stakeholders agree that the demand for a better work-life balance will increase in the future. This, especially in combination with other trends like the 'feminisation of medicine' will lead to more employees aiming for part-time employment, especially among women. Leisure time will come to be considered increasingly important. Combined with an assumed rise in the work intensity/load, this could lead to an even more pronounced staff shortage, especially of physicians, who might then prefer to work in other areas than in hospitals.

Number of doctors and nurses
For the figures please see above.

There are different opinions if there is a considerable shortage in physicians as well as in nursing staff, depending also on the geographical region as well as the size of the hospital. According to the Krankenhausbarometer 2013, 34% of the hospitals claimed to have problems to fill vacant job positions in normal nursing. Projected on all acute hospitals in Germany this equates about 2300 vacant full-time (normal) nursing jobs. This is a slight reduction in comparison to 2011 (3000, 37%) but compared with 2009 (16%) the number has more than doubled (1250).

In intensive care, about 40% of the hospitals claim to have problems in filling vacant nursing jobs, an unbroken trend in the last years (2009: 22%, 2011: 33%). Projected on all acute hospitals in Germany, this equates about 1,600 vacant full-time jobs in intensive care.

For physicians, there is a different picture, especially if the trend is considered. In 2013, 58% of the hospitals had problems in filling vacant positions for physicians. Although this is a high percentage, the trend is regressive.

Table 5-2 Overview of hospitals experiencing staff shortage problems (doctors)

Year	Hospitals with problems finding physicians
2006	28.4%
2008	67.3%
2009	80%
2010	80.3%
2011	74%
2013	58%

It has to be added that the extent of the problem differs across regions as well as medical specialities. Some believe that other reasons than the lack of qualified staff (e.g. financial constraints of the employer) may contribute to the challenge of staffing vacant positions. Budget caps due to reduced investment financing can lead to a

misuse of budgets originally allocated to labour and working costs as well as to attempts to reduce labour costs by reducing staff numbers.

Labour costs
The labour costs differ, depending on qualification, duration of employment as well as the labour agreement. As the example, the following tables show the costs for different levels.

Nursing after 10 years of employment (pay group 7, which is the most frequent pay group among nurses)

Table 5-3 ***Specialist, 10 years of employment*** *(Fachärzte , EG II Stufe 4 TV-Ärzte/VKA)*

Payment (monthly)	6,373.97 Euro
Bereitschaftsdienst*[1]	1,503.94 Euro
Supplementary benefits *[2]	630.23 Euro
Complete costs (without social security costs)	8,508.14 Euro
Complete working costs	11,060.58 Euro

*[1] two 16-hour service, one 24-hour service (grade III).

*[2] Pay scale area West.

Table 5-4 ***Senior house officer*** *(3 years of employment) (EG I Stufe 4 TV-Ärzte/VKA)*

Payment (monthly)	4,696.31 Euro
Bereitschaftsdienst*[1]	1,296.79 Euro
Supplementary benefits *[2]	479.45 Euro
Complete costs (without social security costs)	6,472.55 Euro
Total working costs	8,414.32 Euro

*[1] two 16-hour service, one 24-hour service (grade III). tufe III.

*[2] Pay scale area West

Table 5-5 ***Nurse*** *(EG 7a Stufe 4 TVöD-K)*

Payment (monthly)	2,836.57 Euro
Achievement orientated payment	2.36 Euro
Annual special payment	212.74 Euro
Bereitschaftsdienst*[1]	288.54 Euro
Supplementary benefits *[2]	267.22 Euro
Complete costs (without social security costs)	3,392.33 Euro
Total working costs	4,410.03 Euro

*[1] Ein 24-Stunden-Dienst der Bereitschaftsdienststufe II.

*[2] Pay scale area west.

Other figures presented by the interviewed stakeholders for the average monthly costs are:

- Specialist: 7100 EUR/month (first year: 5300 EUR/month, up to 13th Year: EUR 6800) excluding payment for Bereitschaftsdienst (max. 29,84 EUR/hour)
- Senior house officer: 5400 €/month (1st Year 4000€ up to 6th Year 5170 €/month), excluding payment for Bereitschaftsdienst (max. 25,73 EUR/hour)
- Nurse: 3300 EUR/month.

Qualifications of doctors and nurses
The framework for postgraduate training of physicians is regulated by law and/or regulations of the Medical associations as well as labour and individual agreements. Doctors acquire the qualifications needed by appropriate integration in the regular organisation of work. Therefore, it is not possible to differentiate between work and further training. The individual organisation of further training normally depends on the individual arrangement, which is supervised by the head of department. Therefore, training can also be used to increase the attractiveness of a work place/employer. Postgraduate training is centralised only in some of the big university hospitals.

Availability of public 24/7 health care service
In general, all hospitals and nearly all stakeholders agree that the above-mentioned changes and trends in the working environment lead to increasing difficulties in providing an appropriate 24/7 service, especially in smaller hospitals or in more remote areas of Germany. Absence from work, increase in the workload or vacant job positions can lead, especially in smaller hospitals or departments, to situations where it can be difficult to maintain a regular 24/7 service.

There is no agreement on the factors that are the main contributories contribute to this problem, e.g. if it is changes in labour or changes in the financing mechanism (DRGs).

Service technology developments
Most stakeholders agree that service technology (e.g. tele-medicine, electronic documentation) are used to ease the pressure on staff, although it has to be mentioned that not all staff categories perceive these developments as easing the workload.

5.4. Implications of changes to WTD provisions

The analysis of the implications of changes to the WTD provisions is in particular developed on the basis of the stakeholder interviews.

As a general remark, it can be said that nearly all stakeholders found it difficult to give a well-founded estimation/quantification of the exact impacts of changed regulations in the EU Directive. Too many other exogenous factors and trends influence the working situation in hospitals so that it would be too simple to make guesses on the basis of an assumed monocausal connection. Therefore, no exact numbers/percentages are given, only the estimated trends (e.g. increase, decrease, constant). The same applies consequently for an estimation of the connected costs related to those impacts.

It is obvious that any measurement which will affect the way of calculating the actual individual working time (e.g. counting overall only 75/50% of on-call duty time, and counting of some percentage of stand-by time as working time) will also result in a

change of the number of physicians needed, at least as long as the workload will remain identical. However, it is difficult to estimate if this will lead to an increase/reduction of less or more than 10% of working time/numbers of physicians needed, as other factors (organisation of work flow, etc.) have an impact on this issue as well. If more physicians in hospitals are needed it is also not clear if this will lead to inevitable shortage of physicians. The attractiveness of hospitals as a workplace is the result of different influences such as pay, working conditions, alternative work opportunities, etc. These conditions in turn are influenced by many additional social and other factors.

It is also reasonable that all changes of measures influencing the possibilities of work organisation (e.g. reference periods, new/narrow definitions) affect the alternatives for drawing up different work schemes and organisational models. It also seems fair to presume that more freedom/flexibility in these matters are more appreciated from the employer side as it allows for more alternatives in e.g. keeping up an 24/7 service. On the other hand, more flexible organisation of work could increase stress and pressure on staff and intensify and condense the average workload. However, it is difficult to estimate and quantify these effects as this is more a question of occupational health. The same applies to the impact of 'over-worked' physicians on all matters of patient safety. Obviously, the individual conditions of a physician can affect all matters of patent safety but this applies also to matters of work organisation, such as coordination, workflow, etc.

5.4.1. On-call time

Most stakeholders agree that the fact that on-call time has to be counted in total as working time involved a shortage of doctors (as mentioned above, nursing staff, with a few exceptions, is normally not engaged in on-call time). Others attribute the staff shortage to the financial constraints of the hospitals, mainly related to the introduction of a payment mechanism based on DRGs and not primarily to the ArbZG.

Therefore, most stakeholders agree that, if only a certain percentage of the inactive on-call time is counted as working time, it would result in lower working hours per doctor. Consequently, the number of doctors could be reduced. Nearly all agree that, due to other factors and trends such as the feminisation of medicine, time and effort spent on medical documentation, etc., the resulting number of doctors would not decline to the same extent. Nearly all stakeholders agree that, except for more flexibility in the organisation of working time (e.g. organisation of hand-over after 8/16 hours shift), which would also provide a better guarantee of 24/7 services, the effects on qualification, administrative input would not be that heavy.

As it is not clear whether the resulting reduction in individual working time due to a changed calculation system (e.g. only 50 or 75% of on-call duty count as working time) would lead to an overall reduction in the individual working time (in fact it could increase the average time spent at the work place), such a change could also fuel the discussion about the challenge of exhausted physicians and the resulting risks to patients, which would be very difficult to communicate from a political perspective. In addition, it could also lead to disturbance among the hospital staff/physicians, who might feel disadvantaged, resulting in an additional shortage of staff as hospitals would not be considered attractive employers.

Therefore, some stakeholders mainly perceive the potential negative effects of such a change to be a higher risk of medical errors or insufficient hand-over, a poorer work-

life-balance and an increased risk of jeopardising the health of the employees, leading to absenteeism, etc.

5.4.2. Stand-by time

Presently, stand-by time, which is normally only done by senior doctors, is not regarded as a problem. Stand-by time is defined as time where work only rarely occurs, rendering the employee in a position where he can choose where to stay during stand-by. Only the time actually working is counted and paid for as working time.

Workplace implications of stand-by and on-call
All stakeholders assess that the existing solution is sufficient and satisfactory, especially as the existing regulation has created/resulted in clarity. Any change, especially a partial, overall counting of stand-by time as working time as well as a weekly limitation is viewed with scepticism and considered unnecessary. Some assume that the above-mentioned changes could lead to a change as working time is currently supposed to be the exception in stand-by time, resulting in an increase in weekly working time. It would also increase the shortage of experienced senior physicians.

5.4.3. Opt-out

Nearly all stakeholders agree that the possibility to derogate from the regulations by means of collective agreements and the opportunity to opt-out if foreseen in a collective agreement has been proven and tested, although some claim that a general limitation of the maximum weekly working time is needed. Others issues mentioned were the need to reduce the maximum allowed working time over the years and the need not to allow any exception from the weekly maximum working time.

The aligned effects related to the obligation of documentation, etc. do not seem to affect the actual medical work of the physicians although it requires some additional administrative efforts.

As such, a limitation of the opt-out possibility and the resulting effect are mostly viewed negatively, especially in terms of being able to maintain a 24/7 service. Some claim that a change in or abolition of the opt-out possibility would only be feasible against some sort of compensation, such as only counting part of on-call duty as working time, etc. Others fear that such a compensation would not be sufficient to guarantee a 24/7 service or that a 'compensation' by extending the reference period or only a partial counting of on-call time would lead to prolonged working hours in hospitals with all the associated negative effects.

5.4.4. Compensatory rest

Most stakeholders agree that the existing regulations on compensatory rest have lowered the flexibility of work organisation. An example given is that the obligation to take a rest immediately after a maximum daily working time of eight hours' work followed by 16 hours on-call duty has reduced the flexibility of work patterns considerably, especially as there is no time for a successive hand-over. Others attribute an improvement in health protection of the employees as well as an improvement in patient safety to that regulation.

Consequently, opinions differ on the implications of an extension of the period in which compensatory rest has to be taken. Some consider the implicated effect of such an extension as positive (e.g. by adding more flexibility to the organisation of work). Others believe that the existing regulation has been proven and tested and that any modification/extension would lead severely jeopardise patient safety and the occupational health of physicians as it is predicted that such changes would lead to prolonged working hours with the resulting negative effects. It was mentioned that such a change to the regulation would also reduce the freedom of action of the social partners.

5.4.5. Reference periods

Opinions on the reference period differ slightly. Most stakeholders indicate that the current system works satisfactorily. If, due to local conditions, exceptions are required, it is possible to incorporate such changes in labour agreements (extension of the reference period up to 12 months).

Others assess that the rules for compensatory rest have improved employee health protection and increased patient safety as it prevents overlong shifts.

Most stakeholders fear that an extension of the reference periods for compensatory rests would jeopardise occupational health and increase the risks of patient errors as it could lead to high concentrations of work in a given period. Others state that an extension of the reference period would provide more flexibility in organizing work patterns which could also positively affect patient's health (e.g. improved/proper hand over) as well as a reduced organisational effort. A generally extended reference period would also have a negative effect on the possibilities of management and trade unions to agree on alternative ways of increasing the health protection of the staff.

5.4.6. Autonomous workers

Most stakeholders agree that the existing regulations on autonomous workers and the possibility to deviate from the specifications of the EU Working Time Directive has been approved and that there is no need for a change.

Only one stakeholder claim that this regulation has excluded this group from the protective measurements of the Directive and highlighted the necessity to further define and regulate this group. One argument in favour of this is the fact that, although this group consists of senior physicians, they are supposed to be role model for their subordinates.

All others state that a further containment or a stricter definition would lead to problems, e.g. in terms of maintaining an adequate 24/7 health service in hospitals.

5.4.7. Concurrent employment contracts

The ArbZG stipulates that working time has to be calculated on the basis of all working contracts per person regardless of the number of employers. In general, the use of concurrent contract is not very widespread with the exception of office-based specialists with special admitting rights ('Belegärzte') or fee-based physicians ('Honorarärzte').

As the calculation of working time also in case of more than one working contract is legally defined in the ArbZG no stakeholder sees the necessity or relevance to change or further concretize this topic in the EU working time directive.

5.4.8. Derogations

The majority of stakeholders assess that the existing possibilities for derogations are necessary and useful to maintain high-quality and sufficient 24/7 health care services and allow for necessary adaptations.

Further clarification or simplification is considered acceptable only if the existing flexibility is maintained. Only one stakeholder found it necessary to reduce the possible derogation in article 17 of the EU Directive relating to family workers and managing executives.

5.4.9. Reconciliation

Germany already has a regulation, which requires employee participation in case of fundamental changes to working patterns/organisation. The employer has some degree of discretion when it comes to determination of working time/patterns for the individual, although he has to have an objective reason if an employee is treated differently than other employees. If the employees ask for certain work patterns, such a request would only be feasible within the limits of the operational needs and is already considered as much as possible. Therefore, such a change has to be in accordance with the existing regulation of employee's participation.

The possibility to break the rest period for a certain period of time (e.g. three hours) is judged differently. It could lead to more flexibility in work organisation but on the other hand it could be used by employers to introduce split shifts with negative effects on the employee health as an uninterrupted rest period is needed for proper recreation.

5.4.10. Measures increasing legal clarity and certainty

Opinions on measures to increase legal clarity and certainty are heterogonous. All stakeholders agree that most ambiguities in the EU Directive and the consecutive ArbZG have been removed by means of judgement and interpretation. Most stakeholders already participate in the exchange of good practice models, etc., at least at regional or national level. As a result, there do not seem to be major unmet needs in terms of measures to increase legal clarity and certainty.

It was stated that the introduction of additional measures, which are not statutory, would not contribute further to the protection of employees. This could be only done by measures such as increased monitoring of the compliance with the existing regulations.

5.4.11. Overall conclusions and best practice

As illustrated by the statements above, stakeholder assessment of the effects of the EU Working Time Directive and possible changes to some of the regulations differs. It seems obvious that the assessment is affected by the party the stakeholders represent friendly. Therefore, it is not possible to provide an unambiguous conclusion. There seems to be mutual consent that the possibility to deviate from some regulations by mutual agreements under a collective labour agreement is proven and tested as well

as necessary to maintain adequate 24/7 services and to adapt to special, local conditions. Even if some claim that the regulations in a mutual agreement between the social partners still need to be monitored externally, these agreements still represent a balance between the different parties.

The biggest impact of the EU Working Time Directive in Germany has probably been the new way of calculating working time, which means that 100% of on-call duty is to be counted as working time making this regulation the most. Therefore, this regulation is probably the most controversial; however experience gained over the last decade has shown that there are ways of coping with the regulation and still maintaining adequate health care provision.

By now, there is sufficient experience with and clarity of the existing regulations and rules in the EU Working Time Directive as well as with the German ArbZG. It seems obvious that any changes to the existing regulations have to be well balanced. It is difficult to estimate the impacts of particular changes of regulations as many other trends and factors influence the health sector in general and the working situation in acute hospitals in particular. The demographic change with an ageing population and 'new morbidity', social changes like the 'feminisation of medicine' and a bigger focus on the 'work-life balance' as well as financial constraints of the health sector all affect the working situation and organisation in health care. As such, it must be acknowledged that it is difficult to assume a mono-causal relationship between certain regulations and its impact on the working situation in hospitals.

6. GREECE

6.1. Introduction

Greece has a universalistic National Health System built on a pre-existing system based on compulsory occupational social insurance. The attempt to introduce such a new system at a time of high inflation in the 1980's explains many of the problems and dysfunctions that still influence the system. Indeed, it is perhaps no exaggeration to say that the blueprint for a national health system is, in many respects, still incomplete.

Furthermore, it is important to bear in mind the severe sovereign debt crisis that Greece has encountered since 2009.Below, we provide a short analysis of these circumstances, focusing on the implications for the healthcare sector, before going into detail concerning the specific aspects of the Working Time Directive (WTD).

In the process leading to near-bankruptcy in 2009 and the bailout in 2010, macroeconomic imbalances were driven by microeconomic and structural behaviours and disequilibria, which can be thought as 'Microfoundations of disaster' (Lyberaki and Tinios, 2012[42]). Health care was one such area, showing a combination of rapid expenditure growth, coupled with an exacerbation of underlying structural problems. As necessary health reforms had not been implemented before the crisis, the health care sector met the crisis in a deeply dysfunctional state. The reforms to health provision that have been implemented since 2010, under the supervision of the 'troika' of the IMF, the ECB and the Commission, have had to take place in the context ofa highly restrictive fiscal environment as well as a deep social and economic crisis. The interplay of micro structural and macro fiscal factors is a theme to which this case study will often return.

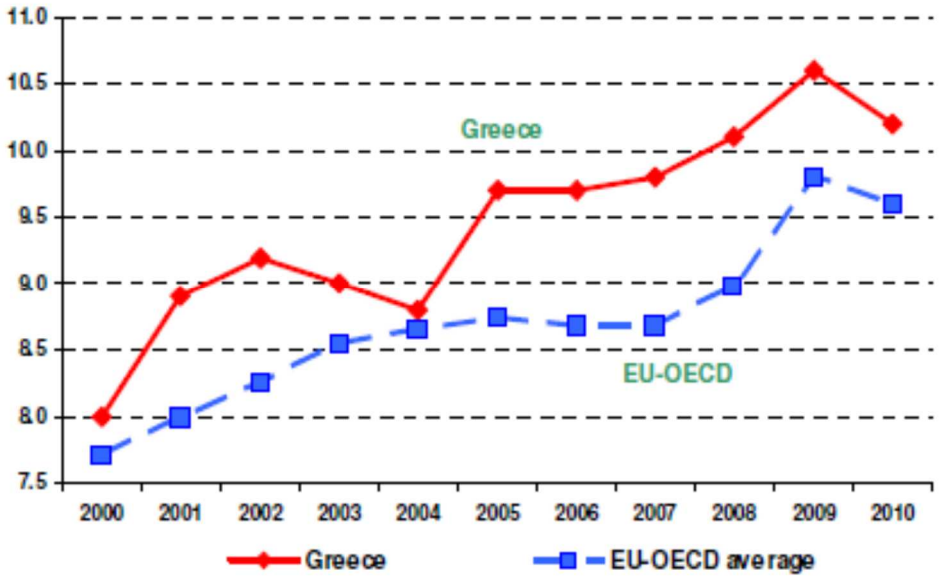
Taking a closer look at Greek expenditure trends, it can be seen that health expenditures were derailed between 2004 and 2009, increasing cumulatively by 47%. This rather rapid increase was fuelled by a quantum rise in pharmaceutical expenditures, though personnel expenses of the State hospital sector were also a strongly contributing factor (OECD, 2012[43]). Personnel expenses were also a contributing factor to the overruns of the public sector deficit of 2009 (projected at 2.9% of GDP in late 2008 but finally closing at 15.3% of GDP). Health expenses reflected a rapid increase in the earnings of health professionals reflecting, among other factors, an increase of personnel entitled to directors' pay.

Efforts to tackle the fiscal challenge have meant that public spending has been reduced in each of the years since 2009.Health spending, being one of the areas to exhibit the strongest growth as well as one of the largest categories of government spending, was central to the retrenchment efforts. Total current health expenditure as a percentage of Gross Domestic Product (GDP) amounts to 10.0%, 9.3% and 9.7% and 9.2% of GDP for the years 2009, 2010 2011, and 2012 respectively, at a time

[42]Lyberaki, A. Tinios, P, 2012, Labour and pensions in the Greek crisis: The Microfoundations of Disaster, *Südosteuropa. ZeitschriftfürPolitik und Gesellschaft*, (60) 3 , pp 363-386.
[43] OECD 2012 Economic Surveys:Greece

when GDP itself was falling rapidly. Although no comparable data have been produced as of yet for the subsequent years, the decline is likely to have continued.

EU-OECD counties' average and Greece's total health expenditure as a share of GDP between 2000 and 2010 is shown below.



Source: OECD Health data, 2012.

The reduction in *real* expenditures is underestimated by these figures, as real GDP in Greece fell between 2008 and 2013 cumulatively by more than a quarter and is still falling. So, Greece saw double-digit percentage reductions in health expenditure in both 2010 and 2012, leaving the overall level of expenditure around 25% below its peak in 2008. (OECD Health Statistics, 2014, ELSTAT, 2013). This was part of a deep and broad-based crisis, which was felt more keenly by the private sector, which was hit by falls in wages and widespread unemployment (especially amongst the young and women). Aspects of the crisis were an exodus to retirement of the over-50's and migration for the younger. So the crisis affecting the health system must be seen against a backdrop of a general recession of a magnitude not seen in advanced countries since the Second World War.

Thus, in interpreting developments in Greece, one must make a sharp distinction between the pre-crisis situation, and that pertaining after 2010. The latter must be seen as comprising attempts to adapt under severe constraints and can be interpreted as part of a search for a new post-crisis equilibrium. Such an equilibrium must entail both macro sustainability in public finances and micro/structural value for money and citizen satisfaction for the health care sector. The search for such a new equilibrium is ongoing and may be delayed by the need to reform while needing to maintain a highly restrictive fiscal stance.

In consequence, one must be wary of static interpretations of the current situation, and should instead attempt to project developments and look for future trends.

The WTD was transposed in Greece by two Presidential Decrees, which are still in force (88/1999 and 76/2005.). No formal attempt was made to use the opt-out, other derogations or modes of flexibility foreseen in the Directive, while collective agreements played little role. Right from the start, a feature of implementation was ambitious statements (often going beyond the minimum requirements of the WTD). These were however combined with very little monitoring of implementation and decentralised structures discouraging an overall evaluation. This type of 'legalistic formalism' (Lyberaki 2010[44]) allowed what were (reportedly) widespread departures from the WTD to remain.

Pressure from doctors' unions led to a collective agreement between doctors (OENGE - Federation of Unions of Hospital Doctors) and the Ministry of Health. The agreement formed the basis of Law 3754/2009. It dealt briefly with working time issues (art 2) but was primarily concerned with pay structures and with positions of responsibility in hospitals. Subsequent laws 3868/2010, 3984/2011 also dealt with working time issues – without however interacting explicitly with the stipulations of the WTD, but in some cases stipulating working time lower than the maximum of the WTD.

The financial and pay scale implications of the 2009 Law lay behind some of the expenditure overruns and, according to the OENGE, were fully reversed a part of the bailout process; the working time legal stipulations were, however, not affected.

On the basis of Law 3205/2003 ~~(GG I/297)~~ and Law 3868/2010 ~~(GG I/129),~~ doctors are requested to perform on-call duties in addition to their normal working time. The combined application of these two laws implies that there is no upper limit to doctors' average weekly working time (while the duties defined by Law 3205/2003 are a maximum, there can be unlimited additional duties on the basis of Law 3868/2010). This does not correspond with the requirement under Article 6(1) WTD to have a limit to working time, and in any event does not transpose the limit as set in Article 6(2) WTD of 48 hours of weekly working time on average.

On the basis of the sectoral collective agreement incorporated into Law 3754/2009 ~~(GG I/43)~~, after each period of "active on-call duty" (which means all the time spent at the workplace whether actively performing duties or not, which is compatible with the definition of 'working time' under the Directive as interpreted by the Court), doctors shall be given a 24-hour rest period on a working day, which may be postponed for one week from the day on which the on-call duty was carried out. While this Law has therefore introduced a procedure for granting a compensatory rest period for missed daily rest, it does not fully meet the requirements under Article 3 and 17(2) and (3) WTD. Firstly, the compensatory rest has to be granted immediately on the day following the on-call duty, and not within a week. Secondly, such compensatory rest also has to be granted in cases where doctors were on stand-by at home and responded to a call.

It is unclear from the national law and agreement whether/how missed weekly rest is to be compensated and within what timeframe. This does not ensure that doctors

[44]Lyberaki, A. 2010: "The Record of Gender Policies in Greece 1980-2010: legal form and economic substance", GreeSE Paper No 36, Hellenic Observatory Papers on Greece and Southeast Europe, The London School of Economics and Political Science.

receive their weekly rest or the appropriate compensatory rest within a period that respects the objective of protecting their health and safety (and that of patients).

On this basis, the European Commission has referred Greece to the Court of Justice for failing to properly transpose and apply the Working Time Directive regarding hospital doctors (C-180/14). The case is currently pending before the Court. The need to react to the legal challenge is currently adding new momentum to re-examine the place of the WTD in the overall scheme of health care in future years.

We may ask in what way the requirement to conform to the WTD can be integrated in an overall rationalization and quality upgrading of the health sector consistent with the new post-bailout realities.

In 2012, the share of health care expenditure in GDP amounted to 9.3%, which is comparable to the OECD average (OECD Health Data, 2014). The existing public budget constraints are among the primary factors influencing the implementation of the WTD. Although the case study identified a positive trend towards addressing the existing challenges in the implementation of the Directive, financial constraints are likely to continue affecting the way the WTD is being implemented and will have a major influence upon the way suggested changes to the WTD ('building blocks') will generate workplace implications and thereby impacts.

The key dilemma the Greek system faces is how to provide full high-quality health care in the face of severely curtailed resources. This dilemma is being faced in a particularly stark form since 2009.

Supply is curtailed through exit (retirements, emigration) and non-replacement of staff, budget allocations for all types of expenditure are reduced, while *demand* is in many cases rising as it is displaced from less-affordable private outlets to the public system.

Operating in a deep crisis in many respects makes the situation harder to handle, whilst making reforms more pressing. In this context, the health care system needs to address accumulated imbalances, where working time is only one among many factors. In such situations, decision makers must balance long-term structural considerations with short term exigencies. In such dilemmas, adjusting working time may often appear the simplest possible and most immediate way to keep services at a required standard.

The Greek case may also hold important lessons for other countries in a number of dimensions, some positive, some negative:

- Rigid centrally determined pay scales in which overtime is used to play a large part in determining total earnings, may lead to an overemphasis on the financial aspect of working time role in determining incomes over other issues of regulating working time. The WTD is incorrectly but still frequently understood as a mechanism for financial remuneration. Indeed, regardless of the fact that the WTD does not contain any stipulations as regards remuneration, this is considered its main importance, probably due to a lack of proper understanding/information on what the WTD entails.
- A striking imbalance exists between the large number of doctors and the smaller number of nursing staff. Combined with rigid organisational structures

and a very widespread scepticism regarding flexible working arrangements (e.g. task and role shifting), this makes substitutions between different types of healthcare professionals very difficult and highly uncommon.

- A pervasive lack of data and indicators, especially regarding hours worked, where information is frequently limited to citing particular cases rather than any kind of representative analysis.
- Seasonality. Tourism creates a very marked seasonal pattern of demand.
- Geographical exclusion in the sense that large parts of the territory (islands, remote mountain areas) experience difficulty of access, especially in the winter months.

There is general agreement among all stakeholders that working time is only one among many factors that together constitute a very complex health care challenge. In this way, problems in implementing the WTD can be seen as *symptoms* of a more general problematic situation. In this sense, all agree that immediate and full compliance with the requirements of the WTD would exacerbate problems of operation and would seriously affect the provision of quality health care. Meeting the WTD requirements should thus be formulated as a medium term objective, which must be pursued as part of an action plan. The necessity to formulate such an action plan is beginning to be accepted more widely among health care actors. Discussions on this field are ongoing and were (to some extent) encouraged by the necessity to respond to the legal challenge in the European Court.

Differences between actors arise, however, once discussions are opened on the scope of concurrent structural changes that must accompany working time changes. Some organisations representing workers lay almost exclusive emphasis on hires (recruitment of more staff); POEDIN (Hellenic Federation of Employees of Hospitals of Public Sector) talks of an immediate need for 20,000 new hires (doctors, nurses and other personnel). Doctors' organisations mention 6,000 new hires of doctors plus replacement of vacancies. The Ministry wants to bring into the picture the need for reorganisation and consolidation, as well as for emphasising the links between possible extra hires and overtime earnings of existing staff. The Ministry is also aware of the necessity for health to continue contributing to overall public expenditure retrenchment. However, as discussions are ongoing, no crystallised views have yet emerged from any side. Nevertheless, it is fair to say that compliance with working time requirements is seen as one among many objectives and challenges, and perhaps not the most pressing one. The impression is also that discussion comes at an untimely moment regarding the possible changes to the WTD considered in this study.

6.2. Implementation of the WTD

On the applicability of the WTD, acute care (secondary and tertiary provision care) in Greece can be divided into the following sectors:

First, the **National Health System** is by far the largest group of hospitals whose staff fall under the directive. **NHS Doctors** who have completed training have a Public Law employment relation and (as all civil servants) are paid directly by the General Accounting Office of the Ministry of Finance (thus their salaries do *not* form a direct part of hospital budgets). This jurisdictional arrangement applied to overtime until 2011, where overtime payments were transferred to hospital budgets and hospital managements became legally liable for paying overtime. **Junior NHS Doctors** (still in

specialty training) are employed by hospitals on a *Private* law (fixed term) basis, a fact which is of some importance in monitoring the WTD. Since 2010,**adjunct** (επικουρικοί[45]) **doctors** on annual contracts have been employed in limited numbers to cater for areas where staff shortages are considered acute. **Nursing staff** are under Public law employment and come under the WTD. Other staff (laboratory assistants, ancillary staff, etc.) do not come under the ambit of the WTD. Hospitals may be tertiary hospitals or large hospitals in the main urban areas and smaller prefectural hospitals in smaller urban areas; frequently for historical reasons there is more than one hospital within easy reach, which gives rise to fears of duplication[46]. A country-wide system of **Health Centres,** which are administratively allied to hospitals, provide the first port of call for rural and smaller town ('semi-urban') residents.

The public system also includes other kinds of institutions. Until recently, social insurance providers (e.g. IKA, the largest providing for private employees) had separate hospitals; these and their staff have since 2010 been incorporated in the NHS system. University teaching hospitals are, as in other countries, distinct, as staff combine teaching with care under the aegis of the University. The Military hospital system also serves sections of the general (non-military) population; their staff are not subject to the WTD.

Finally, there are private hospitals and clinics, which might cater for individuals insured by public social insurance institutions. These hospitals close gaps in the public system. Medical and other staff are employed on the basis of individual contracts and are not considered to be under the scope of the WTD.

By the end of 2010, there were 313 hospitals, with a total of 53,888 beds registered (ELSTAT, 2011). Out of these hospitals, 185 are general, 117 special and 11 combined.

The relationship between the private and public systems is a contentious issue. The private sector has always been extensive and operated in parallel and even in competition with the public sector. Private health expenditure amounted to almost 40% of total health expenditure before the crisis. Since the crisis, a significant reduction of demand for private health care has been reported. Nevertheless, the effects of public funding cuts for the NHS keep the private healthcare sector as a significant player in the health market, even in an environment characterised by severely reduced household disposable income.

6.2.1. WTD implementation approach

All partners interviewed agreed with the following description of the overall approach to implementing the WTD:

"In contrast to other countries, WTD matters are not dealt with in Greece by collective agreements. The directive is unilaterally implemented by the employer (Hospital management/ Regional Health Authorities) who balances competing considerations on

[45] Alternative translations could be 'auxiliary 'supplemental'.
[46] The Lasithi prefecture in Crete has four hospitals, some of which are less than 30 minutes' drive. Infrastructure investment since the 1990s has not been accompanied by an equivalently pervasive hospital reorganization.

an ad hoc basis. The resulting variety, while increasing flexibility, renders collective/ aggregate solutions of problems more difficult".

Thus while details are decided centrally, their implementation is decentralised. This *inter alia* implies the non-existence of overall indicators that can be used to monitor implementation. The way the directive is implemented can be judged on the basis of casual empiricism or anecdotal evidence only.

The NHS was founded in 1983 at a time of high inflation (between 15-25%), when earnings were subject to tight incomes policy which also extended to paying differentials. The need to attract and remunerate medical staff whilst keeping to the letter of the incomes policy, led to the institution of 'notional overtime' (πλασματικές εφημερίες) as a way of increasing doctors earnings while in employment (that is, without increasing the pension to which they would be entitled when retiring)[47]. This meant that doctors who were theoretically on stand-by, were paid as if they were actively present and introduced a distinction between 'genuine' and 'notional' overtime[48]. No statistics were ever produced and the two types of overtime were treated (for the purposes of pay) equivalently and not differentiated. A decisive move to phase out the practice of notional overtime was made in 2001; after this date the practice was severely curtailed, until its final elimination by the late 2000's.

As a result, one can safely say that the introduction of the WTD is unlikely to have had a meaningful direct effect of increasing the need for labour input. Its implementation was not being monitored and implementing the WTD was only one among many factors affecting the equilibrium of supply and demand. The WTD should have reduced the time available, but this effect was not perceived. The WTD and its impact have started to be taken seriously only after the crisis of 2010 – when, however, the problems of the system were very different from what they were before.

Overall, there is an oversupply of doctors and the opposite for nurses (see the next section). Nevertheless, artificial 'shortages' always existed due to a suboptimal allocation of resources in the system (e.g. large number of hospitals and clinics, reserving types of work for doctors over nurses, etc.). Dealing with the issue of the WTD, therefore, has always been a secondary consideration; its resolution has historically always had to await decisions on other outstanding issues. Notional overtime inaugurated the practice of treating overtime as primarily a determinant of earnings both in absolute and relative terms, and can be said to characterise the way the majority of interviewees approached the subject of overtime – as a feature of pay rather than something with innate significance.

The below textbox illustrates the overtime that is built into contracts, i.e. the overtime that can be paid for (law 3868/2010). For example, junior doctors in zone A can be paid for up to seven active overtime hours per month. If overtime exceeds the amounts stated in the table, arrears may accumulate. Today, however funds do often

[47]NHS doctors receive two full primary pensions. One from the Doctors' fund and another in their capacity as civil servants from the Ministry of Finance. Thus increasing pensionable earnings by doctors would ultimately be translated to greater expenditure on pensions. Given that overtime earnings are not part of pensionable pay, paying a given sum in overtime is 'cheaper' than adding the same fund to normal earnings.

[48] The practice of notional overtime was cited by judges in order to vastly increase their own pay and pensions in the 1990s and on. The rationale appealed to the constitutional equality of the legislative and executive branches of the State to argue that judges and medical pay scales must be equal.

not even allow for the payment of overtime within the limits indicated in the table, which adds to the building up of arrears.

The legal framework in place in 2014

EU regulatory framework

1. 93/104/EC
2. 2000/34/EP

National regulatory framework

1. Presidential Degree (PD) 88 (Gov. Gazette94/99 part.A) regarding «minimum specifications for working hours planning according to the directive 93/104/EC».
2. Presidential Degree (PD) 76(Gov. Gazette117/05part.A) regarding «minimum specifications for working hours planning according to the directive 93/104/EC as it has been amended by the regulation 2000/34/EP».
3. Law3754/2009: Framework for the terms of employment of ESY doctors, according to the PD 76/2005 and other regulations.
4. Law 3868/2010: Development of National Health System and other regulations related to the Ministry of Health.

Law3868/2010:

Zone A (Metropolitan and large urban centres):

- Junior doctors (doctors in specialty training) paid for 7 active overtime per month
- Coordinating Directors paid 6 overtime of which 3 active and 3 on call
- Other doctors: 6 overtime of which 4 active and2 on call

Zone B Urban centres

- Junior doctors paid for 7 active overtime every month
- Coordinating Directors paid 7 overtime of which 4 active and 3 on call
- Other doctors: 7 overtime of which 5 active and 2 on call

Zone C: Smaller towns

- Junior doctors paid for 7 active overtime every month
- Coordinating Directors paid 7 overtime of which 5 active and 2 on call
- Other doctors: 11 overtime of which 7 active and 4 on call

(overtime= εφημερία; comprising with normal working one 24-hour period. Given a working day is 7 hours, overtime would count for 24-7=17 hours).

Nurses working in hospitals of circular ('rolling') rota without applying restrictions provided by Community Directives (12 hours rest between two shifts, two days off and one night a week), alternating between morning, afternoon and night. The normal working week have been 40 hours since September 2011.

There are three different types of overtime for doctors:

1. **Active overtime** also known as 'genuine' overtime. Starts after the normal daylight shift and exhausts the remaining period to 24 hours (i.e. 17 hours), and takes place in hospital premises. It is counted and paid fully regardless of whether active services are provided during that time.

2. **Stand by** (on call[49]) or simple **overtime** also starts after normal shifts; doctors are not required to be physically present. It is remunerated by 40% of the active overtime pay[50]
3. '**Mixed overtime**" is an intermediate mode. It lasts for six hours as active overtime (i.e. at the workplace) and continues for 11 hours on standby subsequently, until 24 hours are completed. It is paid as 70% of the active overtime. This new form of overtime is not yet fully operational as details such as additions for working weekends, etc. are still indeterminate.

Rest periods can be taken within five days. However, according to many informants, doctors may frequently not exercise their right of taking rest immediately. This may be out of a sense of obligation to patients, or (in the common cases of staff shortages) out of concern for not burdening colleagues. In practice, rest periods may vary with type of employee, specialty, location, etc. As no monitoring or indicators exist, it is not possible to be more precise. Anecdotal evidence of exceeding the prescribed periods is based chiefly on complaints – hence it must be presumed to involve outliers. So, even though contravening the WTD as far as rest periods is commonplace, its exact extent is unknown, as is also the extent to which it does not represent a voluntary choice on the part of the individuals concerned.

It is significant that the opt-out has not been considered as means to accommodating situations where the pre-existing situation was at variance with the requirements of the WTD. This goes hand in hand with a widespread ignorance of the details of the WTD and the means to which it can be adapted to accommodate special features. This as a practice is reminiscent of what has been called 'legalistic formalism (originally applied to gender balance - Lyberaki 2010), i.e. the tendency to 'solve' issues by legislation without taking practical steps to implement them.

The reference period to calculate average weekly working time is set at 6 months, thereby making use of the derogation available to services in need of continuity of services provided in the Directive under Article 17.

The situation regarding overtime is radically **different pre and post crisis**. Before the crisis, the regulations regarding overtime were said to be one of the reasons for expenditure increases. Given that overtime was seen as a key component of total earnings, and that doctors' pay scales were controlled by the Ministry of Finance, the distribution of overtime was used to increase incomes and to ensure the equitable treatment of diverse medical specialisms. This in practice meant that specialisms not normally thought as serving acute care were allocated overtime on a *paripassu* basis to boost incomes. *Post* crisis (and especially after early 2013), overtime and overall doctors' pay were severely cut, in line with other occupations of the public sector. Whereas for some of the earlier periods there were reports of notional overtime, post crisis the opposite issue of overtime *arrears* began to be very common. (The issue of arrears was made worse when responsibility for overtime was transferred to individual hospitals from the Ministry of Finance).

[49] No distinction is made between stand by and on call, which are used colloquially interchangeably, using the same word in Greek for both (ετοιμότητα).

[50] As no separate accounting is kept for time (as opposed to remuneration), it is unclear whether inactive *time* stands for 40 per cent of active pay.

Particular problem areas and infringement by the Greek authorities and previous experience that have affected the implementation of the WTD include:

1. Lack of standardized methodology on overtime planning at hospital/clinics level based on actual and not nominal needs
2. Lack of objective criteria in the overtime planning approval process on behalf of the Regional Health Authority (YPE) as the competent authority
3. Complex financial process for the remuneration of overtime
4. Strict budget control - difficulties in reallocating finances between different lines of the budget.

A striking feature of the early history of the WTD was the absence of collective agreements. Some stakeholders explained this by lack of representation of junior doctors (who faced the greatest challenges). Unions and collective bodies are (naturally) dominated by more senior grades for whom the question of working time was chiefly a question of managing earnings rather than working time *per se*[51]. This was combined with a complex framework of recourse and appeal and encouraged the informal (if any) resolution of issues.

The case of junior doctors in Elis was brought to the Court of Audit (Ελεγκτικό Συνέδριο[52]) Case 144/2006. The Court decided to authorise payment of all overtime to 2006. It also excused the Hospital authorities, judging that they had not acted with an intention to overrule the requirements of the WTD, but to ensure continued service in a very sensitive sector. Partly due to this judicial activism, a collective agreement was negotiated in 2008 between doctors (OENGE) and the Ministry of Health, which was incorporated in law 3754. It is notable that the law makes no mention of the WTD (though it does not contradict it). Working time issues are dealt with briefly in article 2 (reducing daytime work to 35 hours and ensuring that rest takes place within a week of overtime work). The collective agreement (though not the law) provided for a maximum of 48 hours for doctors and 58 for junior doctors per week. The remainder (3 pages) of the law deals with procedures for hiring and advancement of medical staff in hospitals, envisaging in particular a multiplication in the number of staff with the grade of director (necessitating the introduction of the title of 'coordinating director' for the person who actually directs as opposed to being paid as a director)[53].

The legal case pending against Greece in the European Court is encouraging renewed activity as between doctors' unions and the Ministry of Health, which is currently ongoing. In 2013, OENGE submitted a proposal focusing on extra hires and increased budget allocations, seen as prerequisites for clearing arrears. It proposed that (a) no doctor can work more than four full active overtime shifts per month without explicit agreement (b) all doctors must supply at least four shifts for each calendar month, mixed for senior staff, and active for the rest. Working beyond the minimum should be paid 25% extra (c) other, more detailed provisions.

Discussions are ongoing on these issues.

[51] For instance doctors' unions maintain overtime work should comprise part of pensionable earnings.
[52] Equivalent to the Cours de Comptes.
[53] The proliferation of directors was never utilized, e.g. by citing the autonomous worker clause.

Table 6-1 Variations of national implementation

Key provision	Variations of national implementation
Opt-out	• None, never considered
Compensatory rest	• Provided for – must be supplied within five days • Frequent infringements
Reference periods	• No smoothing is applied for *payments; i.e. the period of reference is implicitly monthly*. No separate system of tracking time other than overtime payment exists.
Autonomous workers	• No separate treatment exists (despite the rise in number of directors)
Scope of the Directive	• Excludes military, ex- IKA

Overtime is defined legally in article 45of law 3205/2003, as amended by article 43 of Law 4264/2014. Law 3754/09 sets out the obligation for the safe operation of hospitals, while the procedure for ensuring oversight of the rotas for hospitals is described by law 3329/2005.

A striking feature of many stakeholder interviews was the low awareness of the detailed provisions of the WTD.

For a limited period, Articles 5 and 6 of the WTD were suspended – from February 2007 to December 2008, which was not compatible with the requirements under the Directive which does not allow an entire suspension of the application of its provisions. Some of the gaps caused by the suspension of new hires and exits were compensated for by the introduction of adjunct doctors on annual contracts. It is unclear, however, how the distribution of adjunct doctors between hospitals or medical specialties is made.

The doctors' association mentions that extra hires of medical staff on islands and in geographically isolated areas (as a better geographical distribution of medical staff) would economise on the widespread (and costly) use of air transfers of patients to deal with more difficult cases.

A more detailed overview of the implementation of the key provisions of the Directive is provided below.

Stakeholders are in general suspicious of moves towards greater flexibility in labour practices. The 2008 collective agreement and law 3754 that implements it mention explicitly that "*flexible working and labour relations should not be implemented in formulating hospital rotas*". This attitude is characteristic of a more widespread stance among trade unions and in the wider society; labour market flexibility has proved one of the most contentious areas in implementing the bailout process in Greece since 2010.

On-call time

There is anecdotal evidence that total working time is routinely exceeded. For instance, specialist doctors may exceed an average of 60 hours (35 hours normal working+ 25 hours on-call) plus 17 hours of stand-by; junior doctors may exceed an

average of 70 hours (35 hours + 35 hours on-call) – no stand-by hours, while nurses may exceed an average of 60 hours.

In planning rotas, care is taken for a financially equitable distribution of overtime and on-call time, given that compensation for overtime is an important part of overall earnings. This applies to all medical specialisms. Problems of compliance are reportedly greater outside of the large urban centres.

The distinction between on call and stand by time under the WTD as interpreted by the Court of Justice corresponds to the key distinction used in Greek law between active overtime (within hospital premises) and inactive (outside hospital premises). Mixed overtime applies a combined shift where a first part is served on-call in the hospital and the rest on standby at home.

Overtime is, moreover, used to plug gaps in the provision of 24/7 service. This has led to the phenomenon of overtime beyond that foreseen in the originally budgeted rota. This is linked to the existence of (reportedly) large arrears on overtime, which accumulate and are periodically settled. At a time of fiscal austerity, this practice has given rise to concern over budget discipline and financial planning. The decision in 2011 to transfer responsibility for payment of overtime to hospital management and to hospital budgets has improved monitoring but increased tensions between doctors and hospital management.

Awareness of how the opt-out could add flexibility is generally limited. Whilst in practice Greece used an opt-out for junior doctors in the initial period, the authorities did not appropriately notify it.

A suspension (which is not an opt-out) of the WTD was made from 9/2/2007 to 31/12/2008 (Art. 6 of law 3527/2007). The period of suspension (possibly linked to the first judicial decisions of the Court of Audit in 2006), was not followed by the use of the opt-out. In any case, the Greek government in its legal rebuttal of the Commission's argument, states unequivocally that any transitional arrangements[54] that might have been in force are no longer applicable as from July 2012.

Compensatory rest is an area where the WTD has had an appreciable added value. Law 3754 transposes a collective agreement to the effect that compensatory rest must be granted. However, by providing that this rest can be postponed for up to a week this does not comply with the WTD as interpreted by the Court. Moreover, it is held to be widespread practice by doctors not to make use of the right to compensatory rest. Thus, though the law specifies that compensatory rest cannot be postponed for more than a week, in many cases it might still be, partly due to choices of those directly concerned.

Before the crisis, there was a frequent accumulation of unused rest periods, which was paid in cash, increasing incomes (especially for nurses). In recent years, the phenomenon of arrears in payment for completed overtime has been very common as doctors and nurses still prefer to exercise their rights in cash (partly to make up for

[54] Transitional arrangements were in force for junior doctors between 2004 and 2009, equal to 58 hours, reduced to 52 hours to 31/7/2012.

cuts in earnings as a result of the crisis). Fiscal reasons imply that arrears build up, which are cleared periodically.

As no indicators are published and no statistics appear to be produced within hospitals on the average hours of work, it is unclear which reference period is used (if any). For the purposes of financial remuneration, no smoothing is applied to monthly entitlements, and as no separate accounting is used for time (as opposed to financial payments), the length of the reference period is a moot point. The law in any case follows the derogation provided in the WTD by specifying a six-month reference period.

So, in terms of pay, no smoothing is enforced. So, if someone works above the stipulated normal week in one month and less than that in the next month, so that on average the overtime threshold is not exceeded, overtime is paid for the first month and normal pay for the second. (This is an important point in cases where seasonal needs vary[55)]. For the purposes of the WTD, if a separate time-accounting existed, it would have to average hours over six months (the reference period). But, as no separate time accounting system apparently exists, one cannot be sure of the relevance, if any, of the theoretical reference period of six months. Concurrent contracts could be held to hold in the case of University doctors, who are both teaching and providing care, as well as other categories of medics who have the right to provide afternoon care in hospital premises. In those cases, the WTD is in practice enforced per contract, as there is no separate accounting for time spent in the afternoons.

Doctors who have the right to a separate private practice are not controlled for the latter. Doctors employed in IKA (social insurance) hospitals fell in this category; however, they have recently been included as normal NHS staff, so the issue is of lesser importance.

Adjunct doctors are employed on private law annual contracts to close gaps in hospitals and health centres. There are concerns that their distribution across specialisms and locations is not fully attuned to the needs for care. In a very highly constrained system in a fiscal sense, the use of adjunct doctors adds some needed flexibility and allows the system to cope in the short to medium term, while more profound structural changes are being discussed and implemented. Though by its nature a temporary stop-gap solution, adjunct doctors, however imperfectly, address a vital need.

6.2.2. WTD enforcement procedures

The overall description given to stakeholders, and to which all agreed, is as follows:

"*Controls are mostly conducted by the mechanism of the Ministry of Health. The Labour Inspectorate is responsible for the working conditions of the junior doctors (since it is a private-law type of employment) while the Labour Ministry (ΣΕΠΕ) is responsible for the Health and Safety of all workers in both private and public sectors.*

[55] No consideration appears to have been given to using the reference period as a way to answer challenges of seasonality in demand (e.g. in tourist areas)

Therefore there exists an issue of pinpointing local or even systematic contraventions of the Directive."

Thus, there is a two-layer system:

- For workers subject to private law (junior doctors), recourse as for working time (a part of working conditions) can be made to the same mechanism that exists for private employees – the Labour Inspectorate (Σώμα Επιθεωρητών Εργασίας – ΣΕΠΕ).
- Workers with *public* law contracts (NHS doctors, nursing staff) can refer to the Labour Ministry mechanism only insofar as working time can affect (their own) health and safety. (However, this is the remit of an inspection body separate from working conditions issues – the Inspectorate of Labour relations formerly known as the Social Committee).For working time issues, they are subject to the mechanism existing for the civil service – they can complain hierarchically to hospital management, regional health authorities and thence to the Ministry of Health.

There is also a body of Health Inspectors (Σώμα Επιθεωρητών Υγείας-Πρόνοιας ΣΕΥΠ) answerable to the Ministry of Health. Their remit is directed primarily to ensure safety issues of the public or investigating disciplinary issues in hospitals. In terms of working time, they would be more concerned about ensuring overtime rotas and that on-call obligations are not skipped, rather than ensuring compliance with the WTD as to the maxima. In any case, due to staff shortages, they primarily limit themselves to investigating complaints rather than enforcing a programme of regular checks.

As no regular indicators exist, interventions take place after notifications of the concerned individuals themselves. These are more likely to be those of junior doctors (who are subject to the Labour Inspectorate, which is external to hospital administration) rather than NHS doctors and nurses who must complain to the same bodies who are responsible for formulating rotas. For health and safety issues to justify an intervention, hospitals need to have filed a written assessment of risk, which most do not possess. Partly due to these two reasons, hospitals are not subject to regular inspections by the Labour inspectorates

Health authorities must balance, on the one hand, requirements of the WTD, and, on the other hand, the obligation to provide full health care to patients, combined with the Hippocratic oath, setting the responsibility to patients above all else. Such a trade-off almost invariably leads to working time considerations taking second place in any specific instance (The 2006 Court of Audit decision bears this out). Thus, any system prioritising individual cases can be expected to be biased in favour of letting working time contraventions pass.

From the point of view of the Labour Inspectorate, two concerns and observations were noted. Firstly, the difficulty of separating working conditions from health and safety considerations. Secondly, the practical implementation of the WTD in hospitals can be a source of disagreement between staff and hospital management.

Given the above comments, there are no statistics on the number of controls carried out in hospitals (data to 2007 do not separately identify hospitals), neither on the number of infringements. Similarly, the cost of enforcement is not available (as interventions are only ad hoc following formal complaints).

In consequence, a possible conclusion is that existing enforcement procedures are sufficiently lax and elastic so as not to form a substantive impetus towards enforcing the WTD in its entirety. In any system that aims to enforce WTD as part of health reorganisation, active consideration ought to be given to a radical redesign of monitoring and enforcement structures and procedures.

6.3. Challenges and trends

6.3.1. Workplace challenges and trends

Absence of register-based data.

Working time for doctors and nurses
As of 2006, there are no official statistics regarding the extent of working time and overtime of doctors or nurses. The individual hospitals may have this information but it is not publicly available. The assessment of the current working time for doctors and nurses is therefore based primarily on the views expressed by stakeholders during the interviews, on anecdotal evidence and on casual empiricism. However, there is consensus among stakeholders that working time has become more of a problem in recent years, reflecting among other things the delays in restructuring and consolidating the hospital system.

As part of moves since 2010, personnel issues are beginning to be incorporated in an overall long-term strategy.

Hospitals of the 1st Health Region in Athens are involved in the preparation of a pilot basis of a new, flexible decision support system (DSS) for administrative monitoring of 'shifts' in hospitals. Similarly, the introduction of a Performance Management System is underway, based on agreed KPIs and benchmarking and definition of strategic targets based on international experience (i.e. UK NHS) as well as the integration of DSS and Performance Management System. In recent years, authorities have also begun developing a single payroll system for all medical staff, and evaluation of medical staff. Similarly, the need has been flagged for mergers of hospitals to create units with organisational and financial sustainability, normalisation of working time and availability of hospitals on call.

The need for an overall reorganisation as a prerequisite for treating working time issues in a decisive manner is apparent to all. However, there is also widespread recognition that current reorganisation and consolidation moves are timorous and fall short of addressing needs.

Geographical mobility is frequently cited as a factor affecting overall personnel needs. In particular, health units away from major urban centres find it difficult to attract staff, even in the height of the crisis and in the face of widespread medical unemployment. Stakeholders blame insufficient incentives, though possibly other factors such as social infrastructure, housing issues, work/life balance and proximity to family support networks could also play a part.

A number of operational issues lead to labour supply problems: (a) Fragmented infrastructure leading to duplication of services among hospitals. (b) A new hospital programme financed by structural funds leading to many new facilities, which created new demands; these were not counterbalanced by reorganising existing facilities. (c)

Suspicion and non-utilisation of flexible working arrangements. (d) A heavy command structure with a large number of directors. (e) Pay scales not linking salary to productivity. (f) Seasonality in the summer months.

Post crisis impacts also affect the ability of the healthcare sector to balance supply and demand: (a) A wave of retirements as individuals tried to shield themselves from the crisis. (b) A virtual cessation of new hires. (c) A tendency among younger doctors to emigrate to Northern Europe or the Gulf (evidenced in a shortage of junior doctor applicants for specific medical specialisms). (d) Pay and earning reductions due to pay cuts and reduction of earnings through smaller amounts available for overtime. Given that pay reductions are a general phenomenon in an 'internal devaluation' process, it is unclear whether medical pay has fallen by more than average earnings in Greece. (e) The crisis may be leading a shift of patient demand from the private to the public hospital sectors.

Sharp reductions in staff have led hospital managements to frequent 'improvisations' in working time, some of which may contravene the WTD. Similarly, budgetary considerations may increase the use of on-call time as a means of curtailing total expenditure. (OENGE). Staff shortages are partly met by ad hoc adjunct doctor hires.

The balance between overtime and stand-by time used to be affected historically by the presence of 'notional overtime'. This, by all accounts, has now been eliminated and has been replaced by the opposite issue of widespread *arrears* of overtime payments. Thus, the current mix between normal and overtime work (including stand-by) does not reflect any kind of equilibrium or balance, but is the result of budgetary factors, namely trying to supply a given level of service with severely limited budget appropriations.

The overall description given to stakeholders, and to which all agreed strongly, is as follows:

"There are distinct situations pre and post 2010. After the Memorandum, budgetary constraints imply that only limited funds are available even for realized overtime. Before the Memorandum there was an issue with the large number of directors, with the result that management had to be exercised by coordinating directors. The issue of notional overtime' declined steadily since 2001, so that by now it is fully eliminated. However, the trends both before, and with greater intensity after 2010, ***tend to increase average working hours****. However, in this context, the implementation of the Directive is of secondary importance."*

Thus, working time is a kind of derived (non-exogenous) variable in a complex set of equations. Being a factor that can be altered in the very short term, working time is called on as a means to adapting and hence accommodating to other factors. Prior to 2010, an important consideration in this regard was doctors' overall earnings. Since 2010, the dominant considerations appear to be fiscal exigencies and meeting the hospitals' part in the overall public sector retrenchment. In neither case can we say that the observed working time reflects an equilibrium, which balances competing considerations in a well-considered way.

Number of doctors and nurses

At the end of 2010, the total number of health care professionals working in health services was 70864. This number has declined since then due to a very small number of newly recruited professionals and due to the retirement of older professionals. The

following table provides the total share of doctors, nurses and other health care personnel employed in hospitals.

Table 6-2 Workers in health care services (2010)

	In hospitals
Doctors	25,965
Nurses	36,240
other	8,659
Total	**70,864**

Source: ELSTAT, 2011.

A key characteristic of the health care system – applicable to the decades after 1970 – is a very large number of medical staff and a corresponding small number of nurses. This is evidenced in comparative information expressing these as per head of population.

Nursing professionals point out that medical procedures - that internationally are recognised as part of the duties of nursing staff- require, in Greece, the presence of doctors. This limits the responsibilities of nurses and can be seen as an instance of a device 'guaranteeing' a demand for medical services.

An important feature to be taken into account is the increase in health infrastructures with new units financed by structural funds since the 1990's.

What many consider an oversupply of medics is not reflected in lower recruitment of new graduates. The table below indicates the enrolment over the last 14 years. Since 2013, there has been a very small increase in the number of enrolees. As a consequence, many graduates are pursuing an international career outside Greece. In 2007, 535 doctors from the Athens Medical Association went abroad to pursue a career, and in 2012 the number increased to 1808 (an increase of 238% in five years).

*Table 6-3 Enrolment of students in Faculty of Medicine **2001-2002, 2011-2013***

Year	2001	2002	2011	2013
Enrolment	1,010	975	763	855

Source: Athens Medical Association

Table 6-4 Unemployment rate for doctors in Greece

Year	Percentage
2009	36.39
2010	35.0
2011	35.19
2012	37.51

Source: Athens Medical Association

The unemployment rate is probably overstated as it may include individuals who migrated to Northern Europe and the Gulf, who also keep up their dues to the AMA[56]. In the years up to 2010, 6,000 physicians reportedly emigrated, while in the first half of 2014 the Athens Medical Association issued 830 certificates to physicians wanting to emigrate.

While on the waiting list for specialisation in a hospital, many junior doctors already work in hospitals outside the country. This leads to delays in filling places, as places need to be re-advertised, leading to a hiatus in specialisation places. This partly explains the paradox of vacancies being unfilled for a long time, while there are doctors waiting to take the place five to six years after their graduation.

In 2010, Greece had the highest number of doctors per 100,000 citizens of all EU Member States (6.1/100,000). According to the number of graduates from Medical Schools, Greece holds the fourth position after Austria, Ireland and Denmark in 2010.

Despite the large number of doctors in the country, hospitals are characterized by understaffing. This is due to the uneven distribution of doctors, but (especially after 2010), it is due to the recruitment freeze and the large number of departures. This fact is partially addressed by recruiting adjunct doctors. In **nursing,** there were shortages even before 2010, which were handled by recruitment. In any case, the immediate impact of the WTC is considered secondary. There was unanimous agreement among stakeholders that a possible full implementation of the Directive would substantially exacerbate staff shortages.

The actions taken were limited to recruiting a sufficient number of adjunct doctors with annual contracts and salaries paid by the budget of the hospitals. Consolidation of hospital units was undertaken to a very limited extent (and mainly in Athens) resulting in a very modest contribution to minimising staff shortages.

[56] 3.821 doctors are officially unemployment list, while 1.259 of them are drawing unemployment benefit (επίδομααανεργίας).

Labour costs

Public hospitals in Greece did not produce or publish accounts before 2010. Double entry bookkeeping was introduced in late 2011. Accounts are still not published, but (under the encouragement of the troika) are made available to the Ministry of Health to be used for planning purposes. Selected data are added to an online system (ESYnet), which is being operated on a trial basis. –ESYnet is open in a limited fashion to researchers on request and is still code-protected. Thus, though the quality of data produced has reportedly been vastly improved, the availability of a basic health system data to the public is still severely curtailed.

The payroll cost decreased due to the implementation of the single payroll system and other cuts from 2010, in line with overall labour cost reductions in the Greek economy, a part of the 'internal devaluation process'. The health sector is not affected more than other areas of the State sector, and probably less than the private sector. The WTD has played little direct role in changing the payroll. **Full implementation, however, could have major budgetary implications, possibly leading to full budgetary derailment**. As a result, a full implementation of the WTD must only be considered as part of a medium-term strategy comprising other matters such as hires, reorganisation, flexible working, technological means, etc.

Generally, there is lack of types flexible working, such as cyclical timesheets, use of locums and part-time. Often, this results in failure of 24-hours operation of infrastructure (e.g. scanners).

The following two tables give an indication of the extent of labour retrenchment (derived from Ministry of Health data).

Table 6-5 Average salaries and wages in the health care sector per year (Euros)

	2010	2013
Earnings range – physicians according to years of experience (in Euros per annum)	22,080-55,997	16,275-36,825

Source: Greek Ministry of Health

Table 6-6 Total Administrative and management costs, Euros

Health District	Labour cost 2009	Labour cost 2010	Labour cost 2011	% Change 2010-2011	% Change 2009-2011
1st	891,770,163	778,648,.964	709,518,336	-8.88%	-20.44%
2nd	528,937,201	484,099,012	454,130,533	-6.19%	-14.14%
3rd	332,344,278	334,741,737	318,579,993	-4.83%	-4.14%
4th	462,946,216	436,585,320	399,774,870	-8.43%	-13.65%
5th	324,844,052	275,.040,573	259,931,707	-5.49%	-19.98%
6th	605,349,525	514,275,822	485,780,976	-5.54%	-19.75%
7th	232,61,002	211,808,.621	192,950,628	-8.90%	-17.17%

Source: Greek Ministry of Health, 2013

Qualifications of doctors and nurses

Doctors, dentists and pharmacists are required to complete a six-year (for doctors), and five-year for dentists and pharmacists) university education. This education allows the graduates to carry out medical acts under the supervision of a specialised doctor. To obtain a specialism, four to six years training under the supervision of a specialised doctor is required. Dentists can practice right after they graduate. Undergraduate nursing education exists both at university (four-year course) and at technical university (four-year course) level.

Life-long learning and retraining are essentially absent as an activity of the public sector. Doctors keep abreast of developments by participating in conferences and workshops financed by pharmaceutical companies and other health suppliers (for which attendance credits are awarded and records are kept). There is no procedure for revalidating qualifications once gained – neither for doctors nor for nursing staff.

Stakeholders agree that the organisation of working time has not had an effect on the training of junior doctors. The existing problems arise as a result of a series of ministerial orders and their implementing acts. The existing system is not perceived to be optimal and there are currently initiatives for a reform. A reorganisation of the education system ensuring that more junior doctors are be available in smaller hospitals is believed to be able to contribute significantly towards solving the staff shortage problem.

The training policy (which may affect the temporal merits of doctors) is limited mainly by the lack of funds. Exploiting adjunct doctors and the need of staffing services could lead to the accumulation of fewer qualifications in total.

The CPD for nurses is essentially unknown. The possibility of renewing licences was contained in an Act passed in 2010 but was recently withdrawn by the Ministry of Health (ENE).

Availability of public 24/7 health care services

The overall description given to stakeholders, and to which all agreed strongly, is as follows:

"There are pressures on the availability of services 24/7 both quantitative and qualitative (possibility of errors, responsiveness). The full implementation of the Directive will deteriorate the situation."

Most stakeholders primarily view matters of working time as issues of remuneration; apparently limited efforts have been devoted to examining the implications of contraventions to working time on the quality of health care provided to the public, but also on the health and safety of hospital staff themselves. Contravention of the WTD is seen (in practice) as preferable to no (or partial) service; the consideration of quality does not form part of this – partly due to difficulties to measure the latter.

Unpublished (as yet) research by Xenos et al[57]. conducted on a representative sample of nursing staff in three Athens paediatric hospitals in 2014, applies an established

[57]Xenos, P, Palaiologos, Poulakis, Chouzouris, Prezerakos2014. Measuring occupational burnout of nursing staff of three Paediatric hospitals with the BCSQ-36 method, Mimeo, Athens

occupational 'burn out scale' used widely in social psychology and finds high correlation between categories of burnout syndrome symptoms and working conditions (working years, hospital department). Also, it found that demographic characteristics (gender, age) have a direct impact on the level of burnout.

All stakeholders agree on the difficulties in applying the WTD, citing that full implementation will mean closing units and curtailing service in others. The workers' organisation (POEDIN), however, stresses the need to fill gaps with new staff, rather than acquiesce in not fully implementing the WTD.

Other stakeholders are more circumspect, stressing that working time is one among many factors. Whilst not denying the importance of aiming for full implementation, this must be done considering adapting other factors entering the overall equation.

Service technology developments
The overall description given to stakeholders, and to which there was a mixed response, is as follows[58]:

"Although there are examples of use of telematics and new technology, the extent of adoption is such that there is no overall effect of their use in meeting working time challenges. Greater use of technological capabilities may be prevented by rigidities in labour relations, among other things".

Telematics and other technological improvements, as well as treatment at home, have the potential to tackle issues such as geographical isolation and obviate the need for physical presence of some kinds of medical professionals. However, though the potential is certainly present, the scale of application has not been such as to make an important difference. Full utilisation of the technological potential frequently necessitates organisational adjustments and demarcation changes between different grades and specialities of staff, which can be prevented by a very wary attitude towards flexible working relations. The simple existence of technology does not guarantee its most efficient use without further change. An example could be the reluctance to assign to nursing staff responsibilities they exercise in other countries.

6.3.2. Other pressures and trends

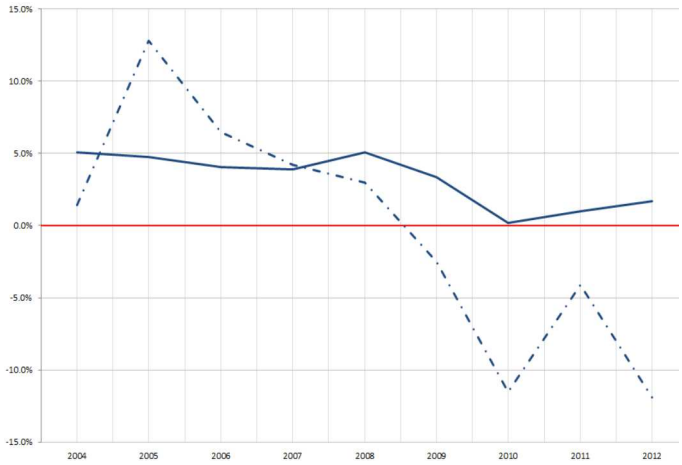
Financing of the public health care sector
The financial situation of the health care sector has had and - according to the stakeholders – will continue to have, a major effect on the majority of the workplace indicators described above (in particular the amount of doctors and nurses employed, but other workplace indicators are being affected as well).

Over the period 2003-2009, total health expenditure grew much faster in Greece than in the EU countries of the OECD. After 2009, a decrease is observed and in 2012 health expenditure was 9.16% of the GDP (OECD Health Data, June 2014). This must be seen against the background of a falling GDP to the tune of 25% from 2007. The increase in current expenditure must be seen in the context of a major upgrade in health infrastructure largely financed by structural funds since the 1990's. It is

[58] In particular the Ministry disagreed thinking that there is a significant (potential) application

significant that, despite the increases in expenditure, public satisfaction with health services remains low and shows no sign of increasing correspondingly.

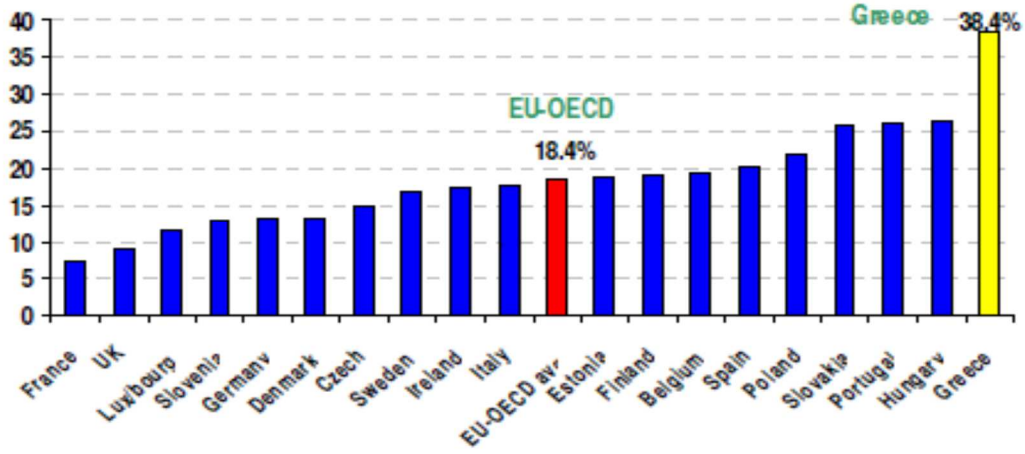
Figure 6-1 Health expenditure growth rates (in real terms) since 2004, Greece and OECD average



Source: OECD, 2014

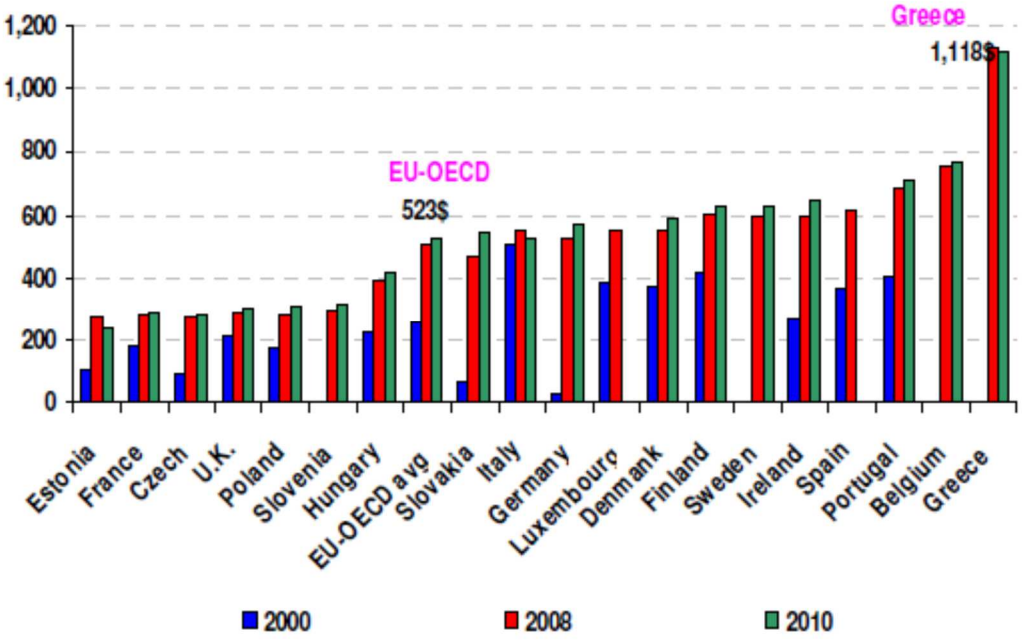
In Greece, the share of private health expenditure is large, by the standards of advanced countries. It constitutes a 38% of total health spending, the largest among the EU countries of the OECD. Private health expenditure per capita was more than twice as high compared with corresponding EU-OECD average in 2010. The private sector has a symbiotic relationship with the public sector, filling gaps and providing an outlet for when the public system is supply constrained.

Figure 6-2 Private health expenditure as a share of total spending on health in 2010



Source: OECD, 2012

*Figure 6-3 Private Health Expenditure per **capita US $ PPP in OECD countries during 2000, 2008, 2010***



Source: OECD Health Data, 2012

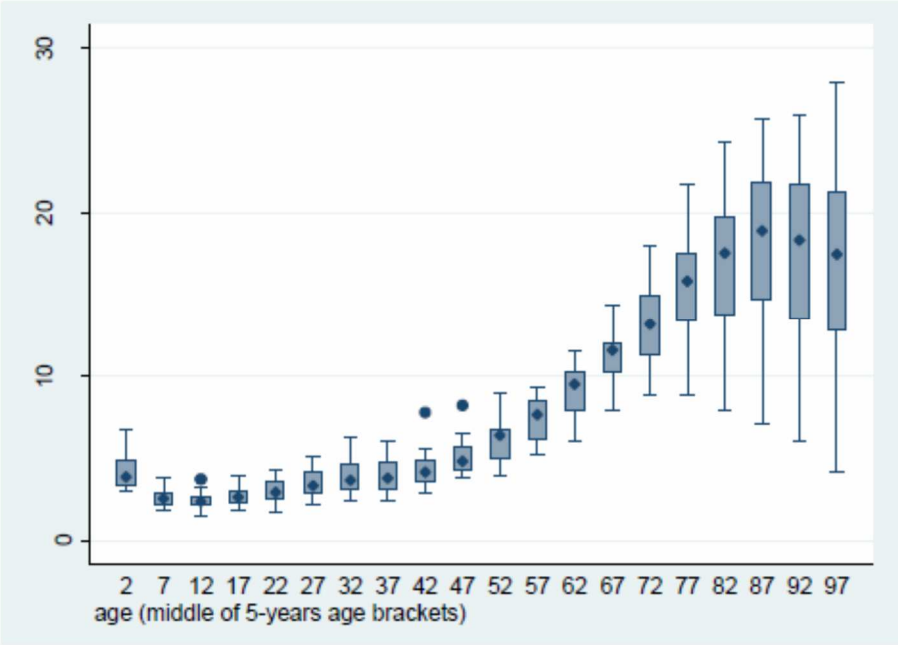
Allocation of public funding between hospitals is done on an informal ad hoc basis. Even though it has been the declared intention since 1996 to proceed with health planning using formal social, demographic and epidemiological indicators, this is still pending. As a result, health infrastructure and its funding reflect historical factors, such as the result of local pressure groups and balancing local interests. Very little adjustment followed major infrastructure and transport investment, which alter transfer time between locations. Many stakeholders mentioned the existence of two full hospitals in Kilkis prefecture within a 20-minute drive from each other.

Ageing society

Greece is, among the EU-15, the country facing the greatest ageing challenge after Germany and Italy. However, ageing is seen almost exclusively as a challenge to pension systems, to the exclusion of examining effects on other factors. Such factors are health care and long-term care. The latter is likely to take off as the number of **individuals over 80** is expected to triple in coming years. Long-term care is currently assigned to the family, while the more serious problems are medicalised by being treated in hospitals, in the absence of specialised infrastructure. Long-term care (if at all) falls within the remit of local authorities and hence is not examined together with health care in exercises of joint minimisation.

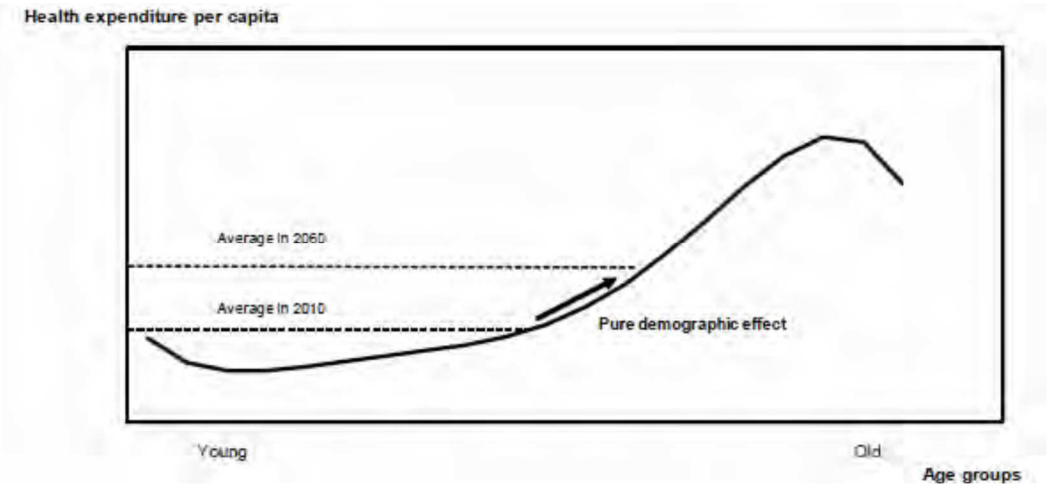
The EU Ageing working group has projected health by age group. An increase in the proportion of older people can be expected both to increase health care expenditures, and to make them less predictable. The following two diagrams are from the ageing report and the allied work of the OECD:

Figure 6-4 Health care costs by 5-year age brackets



Source: European Commission, 2009 Ageing Report: Economic and budgetary projections for the EU-27 Member States (2008-2060).

Figure 6-5 The demographic impact on health care costs 2010-20260



Source: OECD, Public Health Spending on Health and Long-Term Care: a new set of projections, (2012),

Urbanisation trends
The Greek population rapidly urbanised in the 1960's and 1970's, affecting today's 65+ population. As migration did not mean severing of ties to the rural sector, there is a currently a discernible trend of recent retirees relocating to their villages of origin. This may be aided by the crisis, whose impact has been cushioned by the operation of the CAP to lead to smaller impacts for primary producers in rural areas. Improvements in transport infrastructure are, on the other hand, reducing the salience of the rural/urban distinction, as rural areas are more easily accessible from urban centres.

6.4. Implications of changes to the WTD

The overall feedback from stakeholders, from the authorities, to workers and to patients, was that the challenge facing Greece was to adapt fully to the *present* WTD. Any advance beyond that would, naturally, lead to even greater implementation difficulties. While the changes envisaged cannot but be deemed in principle desirable, the possibility of their implementation seemed extremely remote.

The lack of data and indicators on the current implementation precluded any informed speculation by stakeholders interviewed of the hypothetical impact of further changes. The absence of indicators and the fact that even fully implementing the WTD in its current form is seen as a challenge beyond the scope of immediate action, mean that the implications of the building blocks must be omitted.

Lack of data and a relatively low level of awareness of the WTD has rendered a detailed assessment of the possible changes to the WTD impossible. Below, the key considerations and challenges that have emerged from this case study are briefly summarised – they do play an important role in assessing the feasibility and challenges in Greece of ensuring a practice that is consistent with the existing WTD.

The case of Greece involves a multitude of problems and challenges, many of which are interrelated. The apparent low level of awareness of the WTD and the observed shortcomings in its practical implementation today renders it challenging even to ensure a situation with better correspondence between the WTD (and national law)

and actual practice. The challenges are further accentuated by the current difficult financial situation as well as by the inherited structure and culture, which makes organisational changes difficult, which may not provide for cost-efficiency and which considers overtime issues more a matter of pay than a matter of the protection of health and safety of workers (and of patients).

Up to 2010, overtime was seen mainly as a means of managing pay, and its direct implications as well as independent importance of time worked were little appreciated. This was changed after 2010 when the necessity to adapt was brought to the fore forcibly. This is due, on the one hand, to the need to answer a court case brought at the European Court, and on the other hand, by the fact that the crisis has exacerbated and shown the limits of structural weaknesses of the Greek health system.

This case study can be seen to illustrate three key considerations:

1. The importance of monitoring time worked directly and of stressing its importance independently of financial remuneration.
2. Working time is only part of a wider and complex amalgam of forces. Being the one most easily adaptable in the very short term, it may compensate for rigidities elsewhere in the system.

   For any attempt to meet the WTD to be considered serious, it must be as part of a medium term action plan comprising actions in other complementary fields, such as pay scales, labour practices, hospital and clinic reorganisation and consolidation – to name but a few.

7. HUNGARY

7.1. Introduction

Working time in Hungary is regulated in the *Labour Code* (*Act 1 of 2012*). In addition, the *Act 84 of 2003 on certain aspects of performing healthcare activities* has specific regulations related to working time and rest periods applicable to the health sector. Although the collective bargaining coverage in Hungary is generally relatively low, collective agreements have been concluded in virtually most of the hospitals. The specific points addressed by collective bargaining relate – apart from issues of remuneration - to monitoring of working time, organisation of work (shift plans, vacation plans, etc.) and the extension of reference periods for calculating the maximum weekly working time.

Public budget constraints are one of main factors that influence the implementation of the WTD and the capacity of the health care sector to absorb changes stemming therefrom. In 2011, the share of health care expenditure of GDP amounted to 7.96%, which is somewhat lower than the 2011 OECD average of 9.3% (OECD Health Data, June 2013).

Another factor greatly affecting the implementation of the WTD provisions in hospitals is the shortage of workforce, which is due mainly to migration to Western European Member States following the principle of free movement and mutual recognition of medical diplomas within the European Union.

7.2. Implementation of the WTD

Responsibility for public health services lies with the *Ministry of Human Resources, State Secretariat for Healthcare*, through the *National Public Health and Medical Officer Service* (Állami Népegészségügyi és Tisztiorvosi Szolgálat, *ÁNTSZ*) and its national institutes.

Efforts to improve public health were supported by the opening of 58 health promotion agencies in different locations across the country in 2013. The agencies target the health of the local population and organise health promotion programmes for the communities. The *National Institute for Health Development* (Országos Egészségfejlesztési Intézet, *OEFI*) under the ÁNTSZ is responsible for the management of the health promotion agencies and the provision of methodological consultation.

In recent years, the most important change to the *health care system* has been the transfer of inpatient care providers from local and county government ownership to state ownership, along with the associated tasks such as coordination and development, restructuring of care, wage development of doctors and health professionals. From January 2012, the provision of inpatient and outpatient specialist care has thus become the responsibility of the state. From that date on, hospitals and their integrated outpatient departments previously owned by the county councils and the capital passed to state ownership, and from May 2012, hospitals owned by city authorities were also taken over by the state. The transfer of the institutions was managed by the *National Institute for Quality- and Organisational Development in Healthcare and Medicines* (Gyógyszerészeti és Egészségügyi Minőség- és

Szervezetfejlesztési Intézet, *GYEMSZI*). The national institutions (mostly providing tertiary care in a given profession) also fell under the supervision of GYEMSZI, which coordinates operation tasks and asset management. Following several institutional integrations, by the spring of 2013 a total of 101 health service providers were part of GYEMSZI.

Religious and charity hospitals and some private providers of diagnostics and dialysis care contracted by the *National Health Insurance Fund* (Országos Egészségbiztosítási Pénztár, *OEP*) are also part of the publicly financed health care.

By the end of 2012, the *number of hospital beds* in operation in Hungary were 68,845, the share of acute beds being 61%, the share of chronic beds being 39%. The number of beds per 10,000 population was 69.5. The number of beds in publicly owned institutions constitute 97% of the total number of beds. Religious institutions have 2% of the total number of beds; other private institutions have close to 1%.

With the nationalisation of hospitals, the capacities that provide specialist outpatient care is mainly available in centrally operated, state-owned institutions: at the outpatient departments of hospitals, or in outpatient institutions integrated into hospitals. Autonomous outpatient care providers working independently from hospitals remained mostly in local government ownership.

In 2011, Hungary spent 7.96% of its GDP on health (WHO). Public expenditure on health amounted to 65% of total health spending that year. The share of private expenditures was 35% (Table 7-1 and Table 7-2).

In the final accounts, the 2012 budget of the Health Insurance Fund had a revenue of HUF 1744 billion, an expenditure of HUF 1791 billion and a deficit of HUF 47 billion which is HUF 37 billion less than in 2011. According to preliminary data, in 2013 the Fund's revenue was HUF 1848 billion, its expenditure HUF 1848 billion so the budget balanced in year. For 2014, the Parliament set the estimated amount of both expenditure and revenue of the Health Insurance Fund to HUF 1884 billion.

2012 saw a significant increase in expenditures compared with the previous years. The main reason was the takeover of disability and rehabilitation provisions from the Pension Insurance Fund with the paid value of HUF 358 billion. This amount decreased by nearly HUF 10 billion in 2013 and in 2014 (estimated), but still this is the most significant item of cash benefits. Due to this transfer, the proportion of cash benefits rose to around 30% of all expenditures.

The total estimated expenditures of the Health Insurance Fund increased by HUF 149 billion from 2012 to 2014 (9%, 2% in real spending). One of the most important reasons for the growth in expenditures was a wage increase implemented in 2013 (HUF 61 billion). The expenditures of curative-preventive provisions amounted to HUF 842 billion in 2012 increasing to HUF 908 billion to 2013.

The estimated expenditure of the Fund for 2014, HUF 1884 billion, is HUF 80 billion more than the last estimated budget and HUF 40 billion more than the preliminary spending of the previous year. In addition to the increase in the expenditure on curative-preventive provisions, there is a significant growth in expenditures resulting from international agreements and from care outside the domestic territory. This is a result of the European Union Directive making it easier for patients to gain access to cross-border health care, which came into force at the end of 2013.

The reimbursement of acute hospital care takes place based on contracts with the National Health Insurance Fund (OEP) according to the *Homogeneous Disease Groups* (Homogén Betegségcsoportok, HBCS, *Hungarian DRG*). Reimbursement of chronic and rehabilitation care is based on weighted patient days. Outpatient specialist service providers are reimbursed according to a *point system* linked to performed interventions. There is a financing cap on acute hospital care and outpatient specialist care defined in DRG points and outpatient points respectively, called output volume limit.

Before 2012, specialist care was the shared responsibility of the counties, the local governments and the central government. Large multi-speciality county hospitals were owned by county governments, while policlinics, dispensaries and hospitals with main specialities were owned by municipalities. The national institutes providing highly specialised tertiary care, the university hospitals, and a few institutes of rehabilitation care belonged to the central government (their ownership has not been changed).

Table 7-1 Financing the health care sector in Hungary 2003-2011

	2003	2004	2005	2006	2007	2008	2009	2010	2011
General government, total	**1141.4**	**1182.2**	**1302.3**	**1364.1**	**1289.9**	**1328.3**	**1302.1**	**1384.4**	**1430.6**
of which:									
in-patient and day cases of curative and rehabilitative care	367.6	379.3	417.2	431.8	434.7	449.8	425.3	466.9	478.1
out-patient care	197.7	207.0	213.1	218.2	215.7	230.5	228.3	244.2	252.5
long term care	50.7	52.3	57.4	53.3	63.5	68.8	66.9	70.0	67.4
clinical laboratory, diagnostic imaging	29.0	31.6	32.3	32.8	31.7	35.2	34.0	43.0	43.7
patient transport and emergency rescue	23.6	24.7	25.9	32.4	33.6	35.6	36.7	38.3	40.0
Pharmaceuticals	271.5	283.3	347.3	378.6	305.0	301.9	312.0	321.9	337.9
therapeutic appliances and other medical durables and non-durables	35.0	43.0	44.1	48.5	36.6	41.9	46.4	44.2	50.8
prevention and public health services	51.1	49.0	52.9	53.1	49.5	50.8	47.6	52.1	54.7
Investments	45.5	52.4	48.2	55.2	51.0	40.9	32.3	49.6	52.9
Households and voluntary health funds	**419.0**	**441.9**	**485.4**	**503.7**	**526.3**	**551.2**	**555.9**	**619.1**	**629.7**
of which:									
in-patient and day cases of curative and rehabilitative care	45.5	46.2	48.6	47.2	38.6	39.6	41.2	51.6	49.3
out-patient care	163.4	170.6	183.8	200.9	184.8	171.2	174.2	209.8	215.5
Pharmaceuticals	157.1	170.3	195.6	195.6	242.5	271.0	281.5	297.8	307.3
therapeutic appliances and other medical durables and non-durables	28.1	29.8	30.4	35.1	36.2	34.3	29.3	32.1	31.0
Non-profit institutions and organisations	**45.2**	**74.5**	**71.9**	**87.4**	**101.7**	**101.5**	**124.4**	**133.1**	**139.3**
Private sector, total	**464.3**	**516.3**	**557.3**	**591.1**	**627.9**	**652.7**	**680.3**	**752.2**	**769.0**
Health expenditure, total	**1605.7**	**1698.5**	**1859.6**	**1955.2**	**1917.8**	**1980.9**	**1982.4**	**2136.6**	**2199.6**
Total health expenditure as % of Gross Domestic Product (GDP)	**8.6**	**8.2**	**8.4**	**8.3**	**7.7**	**7.5**	**7.7**	**8.0**	**7.9**
General government health expenditure as % of GDP	6.1	5.7	5.9	5.8	5.2	5.0	5.1	5.2	**5.1**
Households' and voluntary health funds' health expenditure as % of GDP	2.2	2.1	2.2	2.1	2.1	2.1	2.2	2.3	2.3
Health expenditure per capita (thousand HUF/per capita)	158.5	168.0	184.4	194.1	190.7	197.3	197.8	213.7	220.6
General government health expenditure per capita (thousand HUF/per capita)	112.7	117.0	129.1	135.4	128.3	132.3	129.9	138.4	143.5

Source: KSH 2014

Table 7-2 Financing the health care sector in Hungary 2012-2014

HUF million	2012 (budget estimate)	2012 (final account)	2013 (budget estimate)	2013 (preliminary data)	2014 (budget estimate)
Expenditure of Health Insurance Fund	1 735 412.1	1 791 503.6	1 804 273.9	1 847 768.0	1 884 177.5
Provisions in cash of the Health Insurance Fund	555 524.5	553 309.9	557 664.3	553 049.6	561 900.0
Provisions in kind	1 166 355.5	1 223 208.2	1 223 610.2	1 271 719.5	1 300 275.4
Curative-preventive provisions in kind	824 906.4	842 053.9	880 606.2	908 011.4	931 870.2
Primary care	121 346.5	122 798.5	130 048.6	136 191.3	146 192.5
Special nursing at home	4 097.6	3 979.0	4 337.6	4 276.5	4 479.8
Inpatient and outpatient specialist care + CT. MRI (with laboratory fund)	638 573.6	624 040.0	651 498.9	615 313.9	636 073.7
Other curative preventive provisions in kind	60 888.7	91 236.4	94 721.1	148 802.5	145 124.2
Expenditures on pharmaceuticals	277 700.0	315 129.5	279 981.0	296 026.9	294 114.0
Pharmaceutical reimbursement	219 000.0	295 987.0	220 981.0	281 532.4	222 414.0
Reimbursement of therapeutical appliances	43 313.0	51 304.2	43 313.0	51 459.3	51 300.0
Other provisions in kind	14 200.0	8 800.9	14 100.0	9 211.4	13 440.0
Expenditures resulting from international agreements and from care outside of domestic territory	6 236.1	5 919.7	5 610.0	7 010.5	9 551.2
Other expenditures of the Health Insurance Fund	4260.0	5 024.8	13 860.0	12 725.8	13 125.0
Health insurance budgetary agencies and centrally managed estimates	9 272.1	9 960.7	9 139.4	10 508.0	8 877.1

Source: GYEMSZI 2014

The *migration of doctors* and health care constitute a challenge to the human resources situation in the health care sector. Measures have been taken to retain the skilled health workforce migrating abroad in the hope of creating better income opportunities and working conditions.

According to the *Office of Health Authorisation and Administrative Procedures* (Egészségügyi Engedélyezési és Közigazgatási Hivatal, *EEKH*) in the first half 2014, 514 doctors and 237 nurses left Hungary, while the 2013 figures were 1218 doctors and 555 nurses. According to the *Hungarian Central Statistical Office* (Központi Statisztikai Hivatal, *KSH*). The health care sector is short of 1,634 more doctors and 3433 more nurses.

In 2011, Hungary had 295.8 doctors (EU-average 345.8) and 638.4 nurses (EU-average 835.9) per 100,000 inhabitants.

Scholarship grant programmes have been launched for several years to support the retention of young doctors. Specialist residents and specialist pharmacist candidates can demand for a net extra remuneration of HUF 100,000 per month on condition that they take a job in the publicly funded health system and reject informal payments. Paediatrician residents, who take a job in a vacant GP practice, can receive a net monthly allowance of HUF 200,000.

From 2013, the scholarship programmes for residents was expanded by a scholarship programme for emergency medicine specialist residents. The residents who provide emergency care on location defined by the Hungarian National Ambulance Service, and do not accept informal payments, can receive a net monthly allowance of HUF 200,000. In January 2014, 600 specialist residents gained support under the framework of these scholarship programmes.

In 2013, the wage increase programme for healthcare workers continued. In 2011, nearly 71,000 healthcare workers received a one-time subsidy of totally HUF 5.6 billion. In 2012, 90,000 healthcare workers got a retrospective and ongoing wage increase of totally HUF 30 billion. In 2013, wage increase affected 95,000 healthcare workers and amounted to nearly HUF 50 billion. In 2013, the wage increase was 10-11% on average for doctors (following an increase of 20% in 2012) and 8% for healthcare workers (following an increase of nearly 16% in 2012).

The immediate effect of these measures on the retention of health professionals is still difficult to prove. In any case, in 2013, the number of doctors and dentists who applied for a certificate for working abroad decreased (2011: 1419, 2012: 1363, 2013: 1218). At the end of 2013, the average gross monthly wage of doctors working in a specialist health care institution was HUF 462,662, double the 2013 average gross wage of salaried Hungarian employees (HUF 230,664), the average gross monthly wage of allied health workers was HUF 203,591, however, informal payments still pose a big challenge to the health care system.

Health care workers have been affected by changes in the pension policy made in the public sector by the government to improve the budget balance. Following the changes, budgetary institutions may not hire a public sector employee who is eligible for pension. Individual exemptions from the regulation may be requested in health care (and public education), which suffers great shortages and employs many elderly workers. However, a change in the pension law effective as of 1 January 2013 applies also to the exemptions. This means that the granting of old-age pension must be stopped if the pensioner has a civil servant or public servant status. There was a transition period of six months to prepare for the change in regulation for those pensioners who was employed in public service on 1 January 2013. Therefore, from June 2013 a pensioner employed in public service is only entitled to wages. To compensate for the income loss, the pensioner and the worker who are granted permission for further employment instead of public pension, receive a compensation payment (corresponding to the amount of the pension).

7.2.1. WTD implementation approach

Working time in Hungary is regulated in the Labour Code (Act 1 of 2012). The predecessor of the WTD, the Directive 1993/104/EU, was earlier transposed into the Hungarian legal order, while following the adoption of Directive 2003/88/EU, a number of substantive changes were introduced into the Hungarian legislation. The most recent changes to the corresponding legislation resulted in the adoption of the new

Labour Code (the previous one, Act 22 of 1992 had been in force before), also transposing the ECJ jurisprudence regarding on-call time.

In addition, Act 84 of 2003 on certain aspects of performing health care activities has specific regulations related to working time and rest periods applicable to the health sector.

'*Working time'* means the duration of work from the start until the end of the period, covering also any preparatory and finishing activities related to working (subclause 1 of Section 86 of the Labour Code). According to subclause 2 '*preparatory or finishing activities'* mean operations comprising a function of the worker's job by nature that is ordinarily carried out without being subject to special instructions. Working time should not cover rests, and travel time from the employee's home or place of residence to the place where work is in fact carried out and from the place of work to the employee's home or place of residence (subclause 3).

'*Working day'* means a calendar day or an uninterrupted twenty-four hour period defined by the employer, if the beginning and end of the daily working time as scheduled to accommodate the employer's operations falls on different calendar days (subclause 1 of Section 87 of the Labour Code).

'*Daily working time'* means the duration of working time fixed by the parties or specified by employment regulations for full-time jobs or part-time jobs (subclause 1 of Section 88 of the Labour Code). According to subclause 2 '*scheduled daily working time*' means the regular working time ordered for a working day. '*Scheduled weekly working time*' means the regular working time ordered for a week (subclause 3).

'*Night work'* means work carried out between 10 PM (22:00) and 6 AM (6:00) (subclause 1 of Section 89 of the Labour Code).

'*Stand-by job'* means jobs where, due to their nature, no work is performed during at least one-third of the employee's regular working time based on a longer period, during which – however – the employee is at the employer's disposal; or in light of the characteristics of the job and of the working conditions, the work performed is significantly less strenuous and less demanding than commonly required for a regular job (Section 91 of the Labour Code).

The *daily working time* in full-time jobs is eight hours (regular daily working time). Based on an agreement between the parties, the daily working time in full-time jobs can be increased to not more than twelve hours per day for employees working in stand-by jobs, or who are relatives of the employer or the owner (extended daily working time). The regular daily working time may be reduced in full-time jobs pursuant to the relevant employment regulations or by agreement of the parties. The daily working time applicable to a specific full-time job may be reduced by agreement of the parties (part-time work) (Section 92 of the Labour Code).

The employer may define the working time of an employee in terms of the 'banking' of working time or working hours. Where working time is established within the framework of working time, banking of the period covered by the banking of working time should be arranged based on daily working time and the standard work pattern. Where working time is defined within the framework of working time banking, the

start and end dates must be specified in writing and be made public (subclause 93 of the Labour Code, and Section 12/A of Act 84 of 2003).

The maximum duration of working time banking (reference period) is four months or sixteen weeks. The maximum duration of working time banking is six months or twenty-six weeks in the case of employees working on continuous shifts; working on shifts; or working in stand-by jobs. The maximum duration of working time banking fixed in the collective agreement is twelve months or fifty-two weeks, if justified by technical reasons or reasons related to the organisation of work (Section 94 of the Labour Code).

The employer must lay down the rules for work schedules (working arrangements). '*Flexible working arrangement*' is a situation where the employee permits – in writing – the employer to schedule at least half of his daily working time in the light of the unique characteristics of the job. In the case of flexible working arrangements, the above-mentioned sections do not apply in general (there are a few exemptions, however) (Section 96 of the Labour Code).

Employers must ensure that the work schedules of employees are drawn up in accordance with occupational safety and health requirements and in consideration of the nature of the work. Work must be scheduled for five days a week, from Monday to Friday (standard work pattern). Where working time is defined within the framework of working time banking or payroll period, working time may be determined irregularly for each day of the week or for certain days only (irregular work schedule) (Section 97 of the Labour Code).

The scheduled daily working time of an employee may not be less than four hours, with the exception of part-time work. According to the work schedule, the daily working time of employees must not exceed twelve hours, or twenty-four hours in the case of stand-by jobs; and the weekly working time of employees must not exceed forty-eight hours, or seventy-two hours in the case of stand-by jobs, if so agreed by the parties. The scheduled daily working time of employees includes the entire duration of on-call duty, if the duration of work cannot be measured (Section 99 of the Labour Code, and Section 12/F of Act 84 of 2003).

If the scheduled daily working time or the duration of overtime work exceeds six hours, twenty minutes of break must be provided; if it exceeds nine hours, and additional twenty-five minutes break must be provided. The duration of overtime work must be included in the scheduled daily working time. The break provided to employees by agreement of the parties or agreed on by a collective agreement may not exceed sixty minutes. During rest, work must be interrupted. The break must be provided after not less than three and before not more than six hours of work. The employer is entitled to schedule breaks in several lots. In this case, derogation from the above-mentioned provisions is allowed, however, the duration of the break provided must be at least twenty minutes (Section 103 of the Labour Code).

Employees must be given at least eleven hours of uninterrupted resting time after the conclusion of daily work and before the beginning of the next day's work (daily rest period). At least eight hours of daily rest must be provided to employees working on split shifts; continuous shifts; multiple shifts; in seasonal jobs; and in stand-by jobs. The daily rest must be at least seven hours if it falls on the date of switching to summer time. After an inactive stand-by period, the employee is not entitled to any rest period (Section 104 of the Labour Code)

Workers are entitled to two rest days in a given week (weekly rest day). In the case of an irregular work schedule, the weekly rest days may be scheduled irregularly. After six days of work, one rest day must be allocated in a given week, with the exception of employees working on continuous shifts, in shifts or in seasonal jobs. At least one weekly rest day in a given month must be on a Sunday (subject to certain exceptions) (Section 105 of the Labour Code).

In lieu of weekly rest days, workers must be given at least forty-eight hours of uninterrupted weekly rest period in each week. The weekly rest period of workers must be on a Sunday at least once in a given month (subject to certain exceptions) (Section 106 of the Labour Code).

'*Overtime work'* means work performed outside regular working hours; or in excess of the hours covered by the framework of working time banking; or in excess of the weekly working time covered by the payroll period, where applicable; and the duration of on-call duty (Section 107 of the Labour Code).

At the request of the employee, overtime work must be ordered in writing. Overtime work may be ordered without limitation to prevent or mitigate of any imminent danger of accident, natural disaster or serious damage or any danger to health or the environment. Overtime work on public holidays may be ordered if the employee can otherwise be required to work on such a day (Section 108 of the Labour Code).

For a full-time job, two hundred and fifty hours of overtime work can be ordered in a given calendar year (Section 109 of the Labour Code).

An employee may be required to stand by and remain available beyond the regular daily working hours scheduled. Stand-by for a period of more than four hours may be ordered to safeguard the uninterrupted provision of basic services for the general public; or to prevent or mitigate any imminent danger of accident, natural disaster or serious damage or of any danger to health or the environment; and to ensure proper maintenance and safe operation of technological equipment. When on stand-by duty, the employee is obliged to remain in a condition suitable for work and perform work as instructed by the employer. The employer is entitled to designate the place in which the employee is required stay (be on-call), other than that the employee may choose the place where he is to remain provided that he is be able to report for work without delay when so instructed by the employer (stand-by). The duration of availability should be made known at least one week in advance, for the upcoming month. The employer is entitled to derogate from this provision under certain circumstances (Section 110 of the Labour Code).

The duration of on-call duty may not exceed twenty-four hours, covering also the duration of scheduled daily working time and overtime work on the first day of on-call duty (Section 111 of the Labour Code).

The duration of *stand-by duty* may not exceed one hundred and sixty-eight hours, which should be taken as the average in the event that banking of working time is used. The employee may not be ordered to stand by more than four times a month if it covers the weekly rest day (weekly rest period) (Section 112 of the Labour Code).

Employers must keep records of the duration of regular working time and overtime; the durations of stand-by duty; and periods of leave. The records must be updated

regularly and must contain features that can identify the starting and ending time of any regular and overtime work and stand-by duty (Section 134 of the Labour Code).

Concurrent agreements are often concluded with different employers, primarily with ambulatory care providers, but in some cases also with two or more different hospitals. In one calendar week, the combined/total amount of time provided by a worker for health services for a 24/7 health care provider in six months, for other health care providers in four months must not exceed on average 60 hours per week (along with on-call time 72 hours). Within one calendar day the maximum is 12 (along with on-call time 24) hours. This is regardless of the type of working relationship (self-employed, entrepreneur, member of company, civil servants, employee, church staff, volunteer) and the number of places worked in parallel. If a health worker has more than one type of working relationship, he/she has to report to each employer that the working time does not exceed the above-mentioned limit/s.

The employer may define the working time of an employee in terms of the 'banking' of working time or working hours. The maximum duration of working time banking is four months or sixteen weeks. The maximum duration of working time banking is six months or twenty-six weeks in the case of 24/7 health care providers, where employees work on shifts, or in on-call/stand-by jobs.

In addition to the 40-hour normal working hours a week, health workers may be ordered overtime work up to 416 hours each calendar year (52 weeks x 8 hours = 416 hours), This may be on-call time, or other overtime work. In addition, based on a separate agreement made in writing, the health worker may be assigned additional volunteer overtime work, however, not exceeding working time banking on average 12 hours per week (per year 52 weeks x 12 hours = 624 hours). If the overtime work exclusively consists of on-call time, it may not exceed 24 hours a week. Employers must keep records of the duration of regular working time and overtime; the duration of stand-by duty; and periods of leave (Section 12/F of Act 84 of 2003).

The Labour Code sets limits to issues that may be regulated by means of collective agreements[59]. The instrument of collective agreements of a higher degree (i.e. collective agreements applicable for the entire sector of economy, used as an

[59] Section 35 of Labour Code
(1) In the agreement of the parties or in the collective agreement no derogation is allowed:
from Subsection (5) of Section 122;
from Subsections (1)–(2) of Section 127;
from Section 134.
In the collective agreement derogations:
from Sections 86–93;
from Section 95;
from Subsection (1) of Section 97;
from Section 99;
from Sections 101–102;
from Sections 104–108;
from Subsection (2) of Section 109;
from Section 111;
from Sections 113–116;
from Sections 118–121;
from Sections 124–126;
from Subsection (5) of Section 127;
from Sections 128–133;
are allowed only to the benefit of workers.

alternative to laws and administrative orders) has not been employed in the health care sector. Rather, collective negotiations take place at the individual employer level.

The collective agreement may contain provisions for employers operating in the health care sector by allowing derogation from the above-mentioned subclause of Section 99, with the proviso that the weekly working time of employees not working in stand-by jobs or on-call is limited to sixty and seventy-two hours respectively (Section 135 of Labour Code).

Although, overall, collective bargaining power in Hungary is relatively low, collective agreements have been concluded in virtually most of the hospitals. The specific points in the collective agreements relate to monitoring of working time, organisation of work (shift plans, vacation plans, etc.) and the extension of reference periods for calculating the maximum weekly working time to 12 months.

Regarding the main implementation cost items (administrative and management costs) from implementing the WTD, less specific references were made by stakeholders. No assessment or central monitoring of the implementation costs of the WTD have been made in Hungary so far. The extra costs for health care providers have not been monitored either. The implementation of the WTD has resulted in administrative burdens for some institutions (revision of internal protocols, new mechanisms for the organisation of the schedules of medical staff, etc.), however, institutions have not reported that such costs have resulted in a notable effect on their budget or financing.

Hungary has introduced various measures to apply the WTD such as the recently revised Labour Code, which entered into force in 2012 and a number of other legislative instruments. In these, some of the derogations provided for in the WTD were applied. To respond to the existing immediate challenges of organising working time, some of the hospitals introduced a number of alternative solutions (most frequently in the form of agreements to perform work in parallel with the main employment relationship). Such solutions cannot always be reconciled with the scheme and the purpose of the WTD and, in some cases, constitute infringements of the applicable national working time rules, as laid down in the Labour Code.

7.2.2. WTD enforcement procedures

In many cases, the new Labour Code of Hungary allows derogations from its provisions in collective agreements (see above).

Collective agreements may be concluded by employers, and by employers' interest groups by authorisation of their members and trade unions. A trade union is entitled to conclude a collective agreement if its membership reaches 10% of all workers employed by the employer or 10% of the number of workers covered by the collective agreement concluded by the employers interest group.

Consequently, both workers and employers – and their respective associations – can potentially play a significant role in the implementation and enforcement of WTD provisions.

Nevertheless, the labour authority has a special role in the enforcement of WTD provisions in that it enforces the provisions of the Hungarian Labour Code. According

to *Paragraph 1 of Section 3 of the Act 75 of 1996 on Labour Inspection*, it falls within the scope of the labour authority to inspect compliance of employers' actions with the provisions of the Labour Code concerning working time and rest periods.

The Labour Inspectorate and the local inspectorates carry out comprehensive controls of compliance with the Labour Code provisions transposing the rules of the WTD, on rest periods, overtime, etc.

According to the statistical data and the practical inspection experiences, the violations of the provisions of the Labour Code in the health care sector in Hungary are not special or substantially different from those in other sectors. In this regard, there no special characteristics can be identified (Table 7-3, Table 7-4, Figure 7-1).

Table 7-3 Labour Inspections in Hungary between 2011-2013

	National Data/Health Care Sector Specific Data	2011	2012	2013
National Data	Employers where inspection completed	21 931	19 080	18 468
	Employers where infringements found	12 595	13 123	12 905
	Ratio of employers with infringements (%)	57%	69%	70%
	Employees under inspection	199 118	185 801	111 137
	Employees with infringements found	98 939	106 722	75 363
	Ratio of employees with infringements (%)	50%	57%	68%
Health Care Sector	Employers where inspection completed	171	175	142
	Employers where infringements found	97	123	91
	Ratio of employers with infringements (%)	56.7%	70.3%	64.1%
	Employees under inspection	4 244	4 672	3 184
	Employees with infringements found	1 850	3 362	1 844
	Ratio of employees with infringements (%)	43.6%	72.0%	57.9%
	Ratio of inspections completed in health care sector	0.8%	0.9%	0.8%

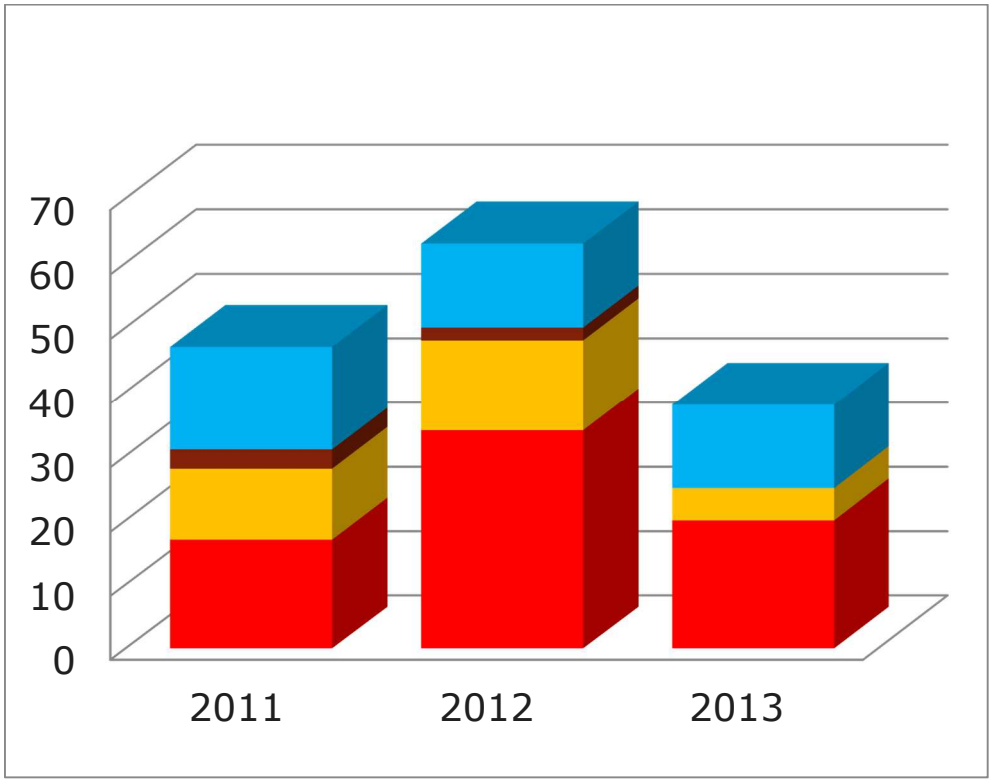
Source: MMI, 2014

Table 7-4 Labour Inspections in the Health Care Sector Hungary between 2011-2013

Infringements in Health Care Sector	2011	2012	2013
Infringements related to working time (employers)	17	34	20
Infringements related to working time (employees)	250	345	1016
Infringements related to rest period (employers)	11	14	5
Infringements related to rest period (employees)	73	59	29
Infringements related to overtime work (employers)	3	2	0
Infringements related to overtime work (employees)	11	16	0
Infringements related to vacation (employers)	16	13	13
Infringements related to vacation (employees)	284	243	240

Source: MMI, 2014

Figure 7-1 Labour Inspections in the Health Care Sector Hungary between 2011-2013



Source: MMI, 2014

The inspection regarding legislation on work related legislation is partly carried out by the labour inspectorates and partly by the offices of the National Public Health and Medical Officer Service. The latter inspections are dealt together with other statutory inspection tasks of the Office, therefore, no separate budget has been allocated for these inspections. Consequently, no data are available on the budget for such inspections. Regarding the former, the costs of the enforcement of the Labour Code provisions implementing the WTD cannot be separated from the costs of the enforcement of other provisions of the Labour Code. These costs consist of salaries, travel costs, overhead, etc. Nevertheless, it can be mentioned that the costs of enforcement have not changed following the implementation of the Directive.

The Labour Inspectorate has had good results in conducting random controls in health care institutions. Apart from these, no general analysis/review aiming at making a comprehensive assessment of the implementation of the WTD has been carried out so far. Yet, legal preconditions have been set for preparing such databases that may provide data on the working shift of health professionals in the future. These databases may provide the basis for the studies that can make complex analyses of the effects of the WTD.

7.3. Challenges and trends

7.3.1. Workplace challenges and trends

Working Time for doctors and nurses

Concerning how working time is generally planned and organised at public hospitals, the rules for the planning of working time are set out in subclause 1 of Section 12/A and subclause 1 of Section 12/B of Act 84 of 2003 on certain aspects of performing health care activities. In subclause 1 of Section 12/A, it is stipulated that as a derogation from the general rule laid down in the Labour Code (Act 1 of 2012) (four-month working time banking), a six-month working time banking can be established for health care providers operating uninterruptedly. This provision being permissive, the service providers are free to benefit from this legal possibility/preference. Working time banking may be fixed in shorter terms as well.

The rules set out in subclause 1 of Section 12/B also have an effect on the organisation of working time. According to this provision, the employed health professional may perform work ("volunteer additional work", opt-out) in excess of the weekly 48-hour work calculated on the average of the working time banking. The extent of the volunteer additional work cannot exceed 12 hours of weekly work calculated on the average of the working time banking, or 24 hours weekly work, if the additional work exclusively consists of on-call health care duties.

Further to the above-mentioned concurrent agreements concluded with the same employer or different employers, many health care providers have found new ways of solving the problem of staff shortage. These include the contracts signed with private companies to provide services and cover overtime periods.

The average working time for (full-time) employed resident doctors is 48.4 hours/week, which consists of 40.4 hours of work, 3.1 hours of overtime, 3.5 hours of on-call time and 1.5 hours of stand-by time. 46.3% of employed resident doctors fulfils on-call time, 34% performs overtime and 10.8% executes stand-by time. Altogether, around 80% of resident doctors are involved in on-call, stand-by and overtime activities.

The average working time for employed specialists (full-time employment) is 51.5 hours/week, which consists of 40.5 hours of work, 2.6 hours of overtime, 3.2 hours of on-call time and 5.2 hours of stand-by time. 42.3% of employed specialised doctors fulfils on-call time, 32.4% performs overtime and 28.1% executes stand-by time. Altogether around 60% of specialised doctors are involved in on-call, stand-by and overtime activities. Actual working time can however, exceed this average: first, because records are not necessarily kept of how many hours are worked under the opt-out, and second, because information of work delivered under concurrent contracts may be not correctly allocated and summarized on a per worker basis. A similar observation applies to the above category of resident doctors.

The average working time for (full time) allied health personnel is 42.3 hours/week, which consists of 40.3 hours of work, 1 hour of overtime, 0.4 hour of on-call time and 0.5 hour of stand-by time. The average working time for nurses employed at hospitals (full-time employment) is 41.4 hours/week, which consists of 40.3 hours of work, 0.9 hour of overtime, no on-call time and 0.1 hour of stand-by time.

Furthermore, data from the National Institute of Quality and Organisational Development in Healthcare and Medicines indicate that 30.6% of the doctors and 3.4% of the nurses work more than 48 hours per week on average. Similarly, data shows that the working time for doctors is 57.1 hours per week - for doctors working more than 48 hours per week on average - and 39.8 hours per week for doctors working below 48 hours on average. For nurses working more than 48 hours per week, the working time is 54 hours and for nurses below 48 hours, the working time is 39.7.

0.5% of nurses fulfils on-call time, 18% performs overtime and 0.4% executes stand-by time. Altogether, 18.5% of nurses are involved in on-call, stand-by and overtime activities.

The *assessment of the current working time for doctors and nurses* is based primarily on the views expressed by stakeholders during the interviews. Even though there was agreement that the introduction of the WTD had reduced working time for both doctors and nurses, and that it would require recruitment of more staff, current practice shows that employers try to solve the problem by applying in-house solutions, such as shifts, and other administrative measures. Further, as the health care system lacks the sufficient number of doctors and nurses due to emigration of staff (see above), it is difficult to meet the need for additional doctors and nurses solely by recruiting more from the labour market. Stakeholders called for a long-term policy to overcome the shortage of medical professionals. Among the policies considered and proposed, some address education and training and some aim at keeping the doctors in the country. Naturally, a consequence of making domestic employment attractive is an increasing salary level and other financial consequences.

Many specialties are concerned with on-call time as form of overtime. Considering the inactive part of on-call time, it may vary specialty to specialty, however there is no data available on that according to specialties, and no study has been done since the directive entered into force.

While health workers may wish to create a better work-life balance, it appears that some still work overtime or take extra jobs to compensate for the low level of wages. Further, for the time being, according to interviews, no facts or indications can confirm any conclusion on changing working time patterns. However, some respondents were optimistic about the expected results from a number of policies related to capacity building and health workforce training that have been implemented recently.

Number of doctors and nurses:
In order to allow for a flexible organisation of working time, and facing shortages of staff, institutions make use of the services of self-employed doctors, and the practice of multiple employment is also present in the institutions. No data are available regarding the exact proportions of such employment, but according to the new legislation, which entered into force on 1 January 2014, the National Public Health and Medical Officer Service must establish a registry containing data on health activities performed under contracted services, or liberal professional employment. The deadline for fulfilling the reporting obligation was 1 July 2014, the National Public Health and Medical Officer Service must draw up the registry by 31 December 2014. The data necessary for making conclusions related to the aforementioned questions will be available after that date.

Several measures have been taken to make it attractive to work in the domestic health care sector. For resident doctors, several forms of support (allowances for vacant professions, reimbursement of material expenditure) and a system of scholarships have been introduced. In 2012, a new wage scale, being higher than the general wage scale for public servants, was introduced for allied health personnel, and in 2013 the wage scale amounts were raised. The financing of the difference between the amounts under the overall wage scale and the special wage scale (for allied health personnel) is financed through the central budget. The mandatory postgraduate academic courses have repeatedly been offered free of charge since 2012 and central budget financing has been allocated for this purpose. Health professionals entitled to pensions or other cash benefits that are employed may receive income supplements equalling the amount of cash benefits suspended (not awarded) with regard to their employment. Within the framework of European Union projects, special emphasis is put on promoting the participation in health sector training and employment in the health sector.

The *number of doctors and nurses* are presented in Table 7-5 below. Data on health workers employed on contracts are excluded.

Table 7-5 Number of doctors and nurses

Period	Number of health workers (person)				Changes to previous year (person)			
	Doctors	Allied health specialists	Other health workers	Total	Doctors	Allied health specialists	Other health workers	Total
2003	19 503	58 133	51 412	129 048				
2004	21 675	59 506	51 660	132 841	2 172	1 374	247	3 793
2005	21 178	58 830	50 346	130 355	-497	-676	-1 313	-2 485
2006	19 850	58 680	47 274	125 805	-1 328	-150	-3 072	-4 551
2007	19 398	55 979	44 160	119 537	-452	-2 701	-3 114	-6 267
2008	18 050	52 702	39 681	110 434	-1 347	-3 277	-4 479	-9 103
2009	17 360	51 961	39 196	108 517	-690	-741	-486	-1 917
2010	16 451	52 282	38 484	107 218	-909	321	-711	-1 299
2011	16 327	54 777	35 541	106 645	-125	2 495	-2 943	-573
2012	16 943	57 327	34 785	109 056	617	2 550	-756	2 411
2013	16 559	58 847	33 035	108 403	-384	1 521	-1 751	-652

In 2013, the average wages[60] of health workers increased by 9.5%, while the number of health workers decreased by 0.6%. In 2013, the average gross salary of full-time employees was HUF 224,324, which is 8.9% higher (HUF 18,337 per person per month) than a year ago. The basic salary is 9.6% higher (HUF 14,484 per person per month), while overtime payment is 17.1% higher (HUF 1,045 per person per month) than a year ago (Table 7-6).

In 2013, gross salaries were as follows:

[60] It is noted that the below amounts contain net salaries and the taxes, contributions to be paid by the allied health personnel. The amounts do not comprise contributions paid by the employer, equalling 27% of the gross salary.

- A doctor's gross wage was HUF 467,399 per month, which is 12.4% higher (HUF 51,488 per person per month) than a year ago
- An allied health specialist gross wage was HUF 204,780 per month, which is 9.5% higher (HUF 17,751 per person per month) than a year ago
- The gross wages of other health workers were HUF 163,576 per person per month, which is 7.2% higher (HUF 11,026 per person per month) than a year ago.

In 2013, average net wage was HUF 143,712 per person per month, which is 7.6% higher (HUF 10,116 per person per month) than a year ago. In 2013, net wages were as follows:

- A doctor's net wage was HUF 308,177 HUF per month, which is 15.8% higher (42,130 HUF per person per month) than a year ago
- An allied health specialist's net wage was HUF 134,314 per month, which is 9.3% higher (HUF 11,461 per person per month) than a year ago;
- The net wages of other health workers were 107,330 HUF per person per month, which is higher by 6.4% (6,469 HUF per person per month) than a year ago.

Data on average monthly gross salaries in 2013 for full-time employed allied health personnel in Hungary are as follows.

- Resident doctors: HUF 337,155 (approx. EUR 1,088[61])
- Specialist doctors: HUF 512,848 (approx. EUR 1,654)
- Allied health personnel: HUF 205,079 (approx. EUR 662)
- Nurses: HUF 207,035 (approx. EUR 668).

Resident doctors (at beginning of their professional career) are entitled to a monthly salary of at least HUF 205,320 (approx. EUR 663) in accordance with current national legislation and the wage scale for allied health personnel. In case the resident doctor receives a scholarship or financial support (please see above), the amount of his/her monthly basic wage may be EUR 387,553 (approx. EUR 1,250).

61 Rate of currency exchange: 310 HUF/1 EUR

Table 7-6 Average gross salary of full-time employees between 2004-2013

Health care	Average gross salary of full-time employees (HUF per person per month)									
	2004	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012.**	**2013.**
Doctors	269	296856	315	336	361	341	346	349	**417**	**467 399**
Allied health specialists	128 183	140884	148 713	155 790	168 631	162 504	164 235	162 914	**188 335**	**204 780**
Other health care workers	102 238	114002	122 553	129 132	137 940	132 482	136 942	133 221	**154 274**	**163 576**
Average gross salary	135 904	150783	161 121	170 738	181 214	172 945	176 166	175 178	**205 923**	**224 324**

Most stakeholders confirmed that the shortage of doctors in Hungary puts an upward pressure on labour costs as the trade unions manage to raise salary levels during collective negotiations. The financial sources available from the central budget present a certain barrier to the governmental measures aiming at raising the salaries of allied health personnel. Nearly HUF 70 billion (approx. EUR 225,800,000) have been allocated on a yearly basis to enhance the training of specialist doctors, to raise wages in the health sector and to ensure the wage supplements.

Administrative and management costs

According to the interviewees, no study has been prepared on statistics related to the costs of external/temporary workers or the hiring of workforce as yet.

The practice of hiring external manpower is not particularly relevant for the health sector in Hungary, as vacant jobs for civil servants or public employees must be published on the website of the body responsible for governmental human resources administration; therefore all job offers of health service providers in state/municipal property are published here. It is also statutory that job offers for resident doctors are published on the website of the Office of Health Authorisation and Administrative Procedures.

Qualifications of doctors and nurses

Medical doctors, namely general physicians and dentists are required to complete six and five-year university education programmes respectively. The Medical Programme covers six years, i.e. is 12 semesters. The first two years provide the foundation for basic medical knowledge. From the third year, theoretical training is supplemented with clinical practice, where students take part in the work of the clinical departments and the teaching at hospitals. In the last two semesters, students perform clinical rotations of 37 weeks. At the conclusion of the programme (State Board Examination), the title Doctor of Medicine is granted for those who have met all the requirements of the training. After the six-year programme, candidates can specialise in different fields. Graduates are allowed to carry out medical activities under the supervision of a specialised doctor. To obtain a specialisation, additional four to six years' training is required (so-called resident period).

The basic rules for the system of qualification of specialist doctors changed in 2010. Some of the objectives of the new regulation aimed at strengthening the relationship between resident doctors and health service providers and involving health care institutions into the training. In order to achieve this goal, during the entire course of specialist training, the resident doctor must be employed by one health care provider accredited for such special postgraduate training. Before 2010, the first two years of postgraduate training had to take place at universities. Any health service provider fulfilling the legal requirements may train doctors. It is obvious that larger hospitals contribute to the qualifications of more resident doctors, but their dominance cannot be stated as smaller size hospitals (in the province) also make use of significant number of resident doctors.

During the postgraduate specialist training, the resident doctor fulfils his professional activities under control and survey, the extent and modalities of which, also having an effect on the organisation of the work, are regulated under *Section 12/A of the Order of Ministry of Health, Social and Family Affairs 47 of 2004 on the organisation of continuous provision of health care services*. According to this provision, the resident doctor can only be involved in on-call activities after having accomplished the so-called emergency practice module of the training. During the first two years of postgraduate specialist training, the presence of the controlling specialist doctors must be ensured during the on-call activities of the doctor in training.

Stakeholders interviewed do not support the hypothesis according to which changes in working time patterns and mix of in-house and external doctors have led to changes to both formal qualification levels and the experience levels.

The organisation of working time in health institutions has no effect on the qualification, consequently the training of junior/resident doctors.

Availability of public 24/7 health care services
Regarding availability of public 24/7 health care services, there are some concerns about the doctors taking compensatory rest period after on-call time. As it was mentioned, it may have effect on the availability of services provided. However, it does not affect the quality of services, which are not very much dependent on the implementation of the WTD but on other legal measures, such as the minimum requirements while providing health care services.

Service technology developments
Stakeholders interviewed agree that service technologies are increasingly substituting the personal services provided by doctors and nurses, and are so helping to relieve staff shortage problems.

However, according to stakeholders, service technologies are currently not commonly employed. Instead, there is a greater focus on introducing IT technologies (health data management systems and modern diagnostic/treatment technologies).

7.3.2. Other pressures and trends

The *health status* of the Hungarian population is poor by international comparison. Though life expectancy at birth is increasing – 71.6 years for males, 78.7 years for females in 2012 – it is 5.9 and 4.4 years below the average of EU countries, respectively. In 2011, the standardised death rate (SDR) for circulatory diseases per 100,000 population was 402.1 (double the EU average), the SDR for ischaemic heart diseases per 100,000 population was 207.5, while the EU average was 77.9. Standardized mortality caused by malignant neoplasms was 238.7 per 100,000 population, within this group the mortality rate for trachea, bronchus and lung cancer was the highest in Hungary among the EU countries.

The *migration of doctors* and health care workers also imposes a high burden on the situation of health care human resources in Hungary. Measures have been taken for years to retain the skilled health workforce migrating abroad hoping for better income opportunities and more favourable general working conditions.

7.4. Implications of changes to the WTD

7.4.1. On-call time

"On-call time" is not relevant for all doctors; approximately only for 60-80% of specialist doctors and junior doctors (residents) respectively, working in hospitals (see above). The vast majority of nurses work in shifts and, accordingly, and they will not be affected by the building block. Other types of workers are unlikely to be affected. On-call time should be counted 100% as working time, in line with the current community legislation developed by the Court's decisions[62]. There may be some

[62] In October 2002, the European Court of Justice ruled on a case brought by Spanish doctors against their employers (SiMAP case). The Court's ruling clarified the meaning of working time within European Law for medical practitioners and essentially means that, under the terms of the Directive, all hours that are spent resident on-call will be counted as work no matter whether the doctor is 'resting'. Further, according to the Court of Justice, in its judgment of 9 September 2003 in Case Jaeger, the Directive concerning certain aspects of the organisation of working time must be interpreted as meaning that on-call duty performed by a doctor where he is required to be physically present in the hospital must be regarded as constituting in its totality working time for the purposes of that Directive even where the person concerned is permitted to rest at his place of work during the periods when his services are not required.

situations, though, where the work load is extremely low, but there is still a need for 24/7 on-call. Then, on-call time may be paid less, or may partly/not be counted as working time.

Introducing a change to the effect that some of the inactive on-call time is not count as working time will lead to a decline in the number of working hours needed to deliver the same service as before. It is assessed that it would not have significant impacts on administrative costs, and that there could be a positive impact on the public health care services.

The risks of making medical errors and mistakes in handovers may increase. Also, the perceived health of workers and the work-life balance may deteriorate. Absence and illnesses may increase, and productivity losses may occur. Presumably, these effects are anticipated as a result of a more intense working day.

7.4.2. Opt-out

The opt-out is used today. However, it needs to be mentioned that there are no reliable data on how many workers sign an opt-out, the circumstances in which they sign or the number of hours they work. This is despite the requirement in the Directive to keep such information and submit it to the relevant authorities. As written above, the National Public Health and Medical Officer Service must establish a registry of data on health activities performed under contracted services, or liberal professional employment. The data necessary for making conclusions related to the number of medical professionals opting-out will be available afterwards.

However, the National Institute of Quality and Organisational Development in Health Care and Medicines estimates that around 31% of the doctors and around 3% of the nurses work more than 48 hours per week.

Concerning the workplace implications of keeping records of all working hours, and having to obtain consent for opting-out regarding maximum weekly working time, stakeholders estimate that this will result in an increase of more than 10% in working time. Presumably, this increase is caused by hours that are not registered today, but which will be entered into such a system. Stakeholders have also indicated a consequential slight decline in the availability of services. This *could* follow from increased costs of remunerating hours delivered under the opt-out, which are not registered today, but the underlying reasons have not been indicated.

7.4.3. Compensatory rest

According to the representative organisations of employees, the compensatory rest period has to be provided immediately after work, i.e. nurses/doctors must be given rest right after overtime work, not in 48 or 96 hours. The same organisations have underlined that it is unacceptable not to give compensatory rest after extended work.

The above-mentioned stakeholders explicitly indicated that they disagree with any changes to the compensatory rest period, such as allowing the compensatory rest to be taken within a reasonable time – i.e. 48 hours or 96 hours – instead of immediately after the extended work period.

Stakeholders seem to agree that, in both cases, the risks of making medical errors and the mistakes in handovers would increase, while in both cases the perceived

health of workers and the workers' work-life balance would deteriorate, and the illness and absence from work and productivity losses would increase.

7.4.4. Reference periods

According to the Labour Code (Act 1 of 2012), the maximum duration of working time banking is four months or sixteen weeks. The maximum duration of working time banking, however, can be six months or twenty-six weeks in the case of employees working on continuous shifts; working on shifts; or working in stand-by jobs. Thus, it should be applied in case of doctors and nurses working at 24/7 hospitals. Further, the maximum duration of working time banking fixed in the collective agreement can be twelve months or fifty-two weeks if justified by technical reasons or reasons related to the organisation of work.

Yet, representative organisations of employees would prefer to reduce the reference period to three to four months, mainly because of financial considerations. It is namely so that employers tend to use reference periods when paying off overtime work (i.e. overtime work is often paid off at the end of the reference period only).

Otherwise, changes to the length of the reference period would have no significant implications.

7.4.5. Autonomous workers

As the derogations from the WTD provisions for managing executives or other persons with autonomous decision-taking powers are only used for health managers, the building block would have no specific workplace implications.

7.4.6. Concurrent employment contracts

Stakeholders interviewed confirmed that the use of concurrent employment contracts have had implications for Hungary as they may affect the weekly working time.

Concurrent agreements are often concluded with different employers, primarily with ambulatory care provides, but in some cases also with two or more different hospitals. Regardless of what kind of working relationship (self-employed, entrepreneur, member of company, civil servants, employee, church staff, volunteer helper) and how many places a health care worker works in parallel, in one calendar week, the combined/total amount of time worked for a 24/7 health care provider over six months, for other health care providers over four months must not exceed on average 60 hours per week (along with on-call time: 72 hours) and 12 hours within one calendar day (along with on-call time 24 hours). If the health worker works in more than one or more than one type of working relationship, he/she has to report to each employer that his/her working time does not exceed the above-mentioned limit/s. The case study also points to a certain (the extent of which is not known) use of concurrent contracts with the same employer.

7.4.7. Derogations

Without knowing more about the specific policies/measures considered to be introduced/included in the directive, formulating simpler and clearer rules for derogations as a general rule (i.e. simplifying the complex system of possible exceptions and derogations), it cannot be estimated if such changes would have any workplace implications.

7.4.8. Reconciliation

Current legislation includes regulations corresponding to the proposed change of the directive (i.e. obligation to inform workers in advance about any substantial changes to their work pattern). Thus, there would be no workplace implications.

7.4.9. Measures increasing legal clarity and certainty

Without knowing more about the contents of these non-legislative measures, it is difficult to consider its potential workplace implications. However, if the communication from the Commission would further clarify and interpret the WTD, the workplace implications would be in line with those mentioned above.

8. ITALY

8.1. Introduction

The Italian national health system is publicly financed by tax revenue allocated by the central government. The 19 regions and the two autonomous provinces are in charge of managing and delivering health services at local level. The national health system is implemented at regional level. Since 1992, regional autonomy in organizing and offering the health services has increased. There is a national minimum statutory benefits package, which is offered to all residents in every region, the so-called 'essential levels of care' (livelli essenziali di assistenza, LEA).

In Italy, access to health system is based only on citizenship. In the last four years, the austerity package, overseen by the European Union, has decreased public expenditure for health systems to 6% of GDP bringing leading to a rise in unmet medical needs[63].

Working time in Italy is regulated by law and collective agreements. The WTD was transposed in 2003 (legislative decree 8 April 2003, no. 66 'Attuazione delle direttive 93/104/CE e 2000/34/CE concernenti taluni aspetti dell'organizzazione dell'orario di lavoro') concerning maximum weekly working time of 48 hours, overtime included; and the daily rest of at least 11 hours, guaranteeing a minimum level of protection to all workers.

Nevertheless, in 2007 and 2008 new regulative acts (art.3, com85, law of 24 December 2007, no. 244 - financial law for 2008 - and the following art. 41, com 13, legislative decree of 25 June 2008, no. 112, converted and modified in the law of 6 August 2008, n.133) introduced the possibility of derogating from the maximum weekly working time for doctors, classifying them as managers/directors in the sense of Article 17(1) of the WTD without looking at their real level of autonomy.

Working time and conditions were therefore defined by two National Collective Agreements: one for doctors who were all considered as directors, the other for the rest of national health service staff (comparto del Servizio Sanitario Nazionale[64]), including nurses, rehabilitation professionals, social workers, technical sanitary professionals, childcare workers, health care assistants and other persons working in hospitals, such as drivers, cooks and cleaning staff.

In February 2014, Italy was referred by European Commission to European Court of Justice due to failure to meet the working time regulations for doctors in the National Health System.

In the meantime, the national authorities have introduced an amendment to the relevant national legislation in order to resolve the incompatibility that has given rise to the infringement. In particular, on 21/10/2014, the Italian Chamber of Deputies adopted the "*Legge europea 2013-bis*". Article 14 of the new law abrogates the two legislative rules that are incompatible with Directive 2003/88/EC (i.e. Article 41, para

[64] http://prontoinfermieri.it/wp-content/uploads/2012/11/CCNL-2006-2009.pdf

13 of Decree 112/2008 and Article 17, para 6bis of Decree 66/2003). By this repeal, Article 4 of Legislative Decree No 66/2003, which sets a maximum average working time of 48 hours and entitles workers to a rest period of 11 consecutive hours per 24-hour period, will apply to all staff in the National Health Service. This brings the situation in line with the WTD.

According to the amendment, the provisions which are non-compliant with EU law will be repealed twelve months after the date on which the Law enters into force, i.e. November 2015. The national authorities have explained that this is necessary in order to enable the regions to reorganise their health services to ensure the provision of essential levels of health services, which are an essential obligation under Article 32 of the Constitution.

Since the new legal situation has not entered into force yet, the analysis below will look at the situation as it stands at present.

In 2012, the total health expenditure amounted to 9.2% of GDP, and public-sector expenditure on health was 7.42% of GDP (WHO, Health for all database[65]).

Public budget constraints are the main cause for the reorganisation of the health care system over the last decade, including the decision to consider medical doctors as directors and the introduction of a more flexible organisation of shifts in order to guarantee adequate health services in a context of reduced recruitment.

Another important reason is the recruitment system, which has been on hold since 2004 to curb expenditures (Law of 30 December 2004, no.131). According to most interviewees, limitations on personnel replacement and recruitment are some of the main reasons affecting the implementation of WTD.

On 10 July 2014, the new 'patto per la salute'[66] ('health agreement') was passed. It specifies all agreements between national and regional governments regarding cost containment, expenditures, monitoring systems, and staff costs. Any changes to be implemented will require adequate financial support. Financial constraints are likely to continue to affect the way the WTD is being implemented, and they will have a major influence on the way suggested changes to the WTD ('building blocks') will generate workplace implications and thereby impacts.

As will be elaborated in Section 8.4 below, the stakeholders consulted identified a number of implications stemming from the WTD building blocks. Specifically, the 'on-call time', 'stand-by time', 'opt-out', 'compensatory rest', 'reference periods', 'derogations' were among those building blocks most frequently cited as those likely to generate substantial workplace implications and thereby impacts. 'Concurrent employment contracts' and 'reconciliation' are unlikely to cause further workplace implications and thereby impacts.

Generally, the stakeholders consulted experienced considerable difficulties in providing estimates of the **costs** and the **benefits** of the individual building blocks, even if some general comments were provided during the interviews. Difficulties in estimating

[65] http://data.euro.who.int/hfadb/
[66] http://www.statoregioni.it/Documenti/DOC_044351_82%20CSR%20PUN

details of costs and impacts are due to the regional management of national health systems and to the local level of collective agreements.

Concerning the **social impacts** of the building blocks, the majority of the stakeholders stressed that there is clear correlation between the length of working time and negative social impacts of the building blocks (in terms of e.g. risk of making medical errors, mistakes in handovers, perceived workers' health, work-life balance, illness and absence from work and productivity loss).

Stakeholder interviews revealed diverging views among the social partners on the impact of the WTD and possible changes thereof.

8.2. Implementation of the WTD

By the end of 2011, there were 145 local health care companies (Aziende Sanitarie Locali) and Hospital Companies, 692 local health districts for community health care (distretti sanitari), 15,087 beds in hospital for acute health needs, 35,317 beds for rehabilitation and long-term care funded by the National Health System.

In 2011, the percentage of public health care expenditure of total health care expenditures was 79.38%[67].

Although remuneration is not addressed by the WTD, analysis of remuneration is important to understand better the impact of changes to the WTD.

Remuneration systems in Italy considers doctors as managers (or directors). Remuneration is based on national, **collective agreements** and **integrative, collective agreements** at local level based on specific needs of each health care public company or public hospital company.

In Italy there are 1,771 public hospitals[68] and 1,590 private hospitals mostly by the public authorities.

In addition, there are 158 university hospitals[69], which offer a broader array of medical services and a high concentration of research activities, courses, etc.

The restrictions on recruitment and replacement of specialised staff are perceived as a problem for the regional health care systems.

8.2.1. WTD Implementation approach

Working time in Italy is regulated by legislative decree if 8 April 2003, no. 66 'Attuazione delle direttive 93/104/CE e 2000/34/CE concernenti taluni aspetti dell'organizzazione dell'orario di lavoro' and some derogations managed through collective agreements mainly concerning working time. When the WTD was introduced, the number of hours available for work by doctors and nurses were substantially affected, since the WTD foresaw that a number of opt-outs and derogations would be

[67] Data base Healthforall, Istat, 2014. http://www.istat.it/it/archivio/14562
[68] http://www.salute.gov.it/portale/temi/p2_6.jsp?lingua=italiano&id=1439&area=tracciabilita%20farmaco&menu=vuoto
[69] http://pso.istruzione.it/index.php/ospedali

regulated by collective agreements at national and local level (aggregated bargaining). In Italy, working time for doctors is mainly regulated by collective agreements and this is one of the main reasons for the infringement procedure and for being Italy referred to the European Court of Justice.

The implementation of WTD has not affected the number of doctors and nurses and recruitment needs since a minimum working time has been set, and the rest of the working hours are considered 'functional' to reach the objectives of local health companies by collective agreements.

According to the Legislative Decree of 8 April 2003, no.66, 'Working time' is defined as any period a worker spends at work, at the employer's disposal carrying out his activities or duties; 'rest period' is defined as any period which is not working time; overtime as the work done in addition to the normal working time. 'Adequate rest' means that workers must be given regular rest periods, the duration of which is expressed in units of time, and which are sufficiently long and continuous to avoid that, as a result of fatigue or other factors that impact working patterns, they cause injury to themselves, to fellow workers or to others and that they do not damage their health, either in the short term or in the longer term.

In Italy, national collective agreement regulates working time for medical directors and for non-medical professionals in health care systems, as foreseen in the D.Lgs 66/2003. Apart from the national collective agreements, there is decentralised integrative collective bargaining in each health company on the following:

- General criteria for allocation of results fund
- Distribution and allocation of funds managed at local levels (results fund, positional remuneration fund, special allowances fund, fund for the directors of other medical professions)
- Definition of working time and plan of shifts to guarantee emergency services.

The Italian regulatory framework for 'reconciliation' already includes an obligation to inform workers in advance about any substantial changes to their work pattern and 'right of workers to request changes to their working hours and patterns'.

Workers, in fact, have to be informed about their rights and the possibility of changing their working time to better meet family needs. Moreover, they are entitled to all the benefits under the national law concerning[70]:

- assistance to family members with disabilities (National Law 104/1992)
- parental leave (D.Lgs. 151/2001[71])

Provisions foreseen by the collective agreements cover the following aspects:

- Annual holidays

70https://www.aranagenzia.it/attachments/article/5795/Area%20III_Raccolta%20sistematica_dicembre_2013.pdf
71http://www.inps.it/bussola/VisualizzaDOC.aspx?sVirtualURL=/docallegati/Mig/Doc/Informazione/Prestazioni_sostegno_reddito/Maternita_Paternita/DL151_2001TUmaternita.pdf&iIDDalPortale=5689

- Weekly rest days
- Time off
- Leave of absence.

Time off and leaves of absence are connected with parental duties, care of sick relatives and training needs. Eight days of time off each year are allowed for training or attendance of exams. Doctors with permanent contracts can ask for a maximum of 12 months of leave of absence over a three-year period. This period is equal to the length of the contract in case of fixed-term contracts. Among the additional leaves of absence foreseen, it is worth noting that a doctor can request a two-year during his lifespan for serious and documented family reasons.

Other main rights contained in collective agreements are the obligation to take an adequate rest period immediately after a night work shift; a weekly-daily rest (normally on Sunday), 32 days of annual leave (28 in case the working time is distributed on five weekly working days instead of 6)[72], paid sick leave, guarantees of preservation of the job place in case of severe illness, physical and health problems. Additional measures are also in place to safeguard the employment and support rehabilitation of doctors with disabilities or with psychophysical problems (drug or alcohol addictions).

Table 8-1 Variations of national implementation

Key provision Variations of national implementation	
Opt-out	The opt-out is widely used in collective agreements as foreseen by the law (D.Lgs.66/2003).
Compensatory rest	The minimum daily rest period is not set in hours, but collective agreements state 'adequate rest time'.
Reference periods	The option to extend reference period for calculating weekly working time has been used for all activities.
Autonomous workers	The possibility to derogate from certain provisions of the Directive for autonomous workers has been broadly utilised, for all doctors considered as directors/managers.
Scope of the Directive	*De facto*, working time limits have not been guaranteed due to the fact that doctors are considered autonomous workers and due to the substantial power of aggregated bargaining and collective agreement.

- In addition to D.Lgs 66/2003, financial law and collective agreements have strongly affected working time regulation.
- The Finance Act for 2008, (art.3, com85, law of 24 December 2007, no. 244, and the following art. 41, com 13, legislative decree of 25 June 2008, no. 112, converted and modified in the law of 6 August 2008, no.133) made

72 These amounts are reduced by 2 days for doctors having practised their profession for less than three years.

derogations from the maximum weekly working time for medical doctors considered as 'directors' and left it to collective agreement to define their working time and adequate rest to collective agreements.

- Working time and conditions are therefore defined by the **National Collective Agreements**: one for medical doctors considered as directors[73] and one for the remaining part of health care professionals (comparto del Servizio Sanitario Nazionale[74])

- **D.L. 158/2012 'Disposizioni urgenti per promuovere lo sviluppo del Paese mediante un più livello di tutela della salute'** reorganised community health care stressing the integration with social services[75]**.**

- Moreover, in July **2014**, the new 'Patto per la salute 2014-2016' was passed. It concerns an agreement between the national government and regional governments on a strategic plan for health services, including a recruitment policy for professionals and working time organisation.

The main challenge of working time organisation in local health systems – local health companies – concerns organisational changes and related limits to the recruitment of professionals. This is due to the cost containment policy that affects the organisation of working time for workers.

A more detailed overview of the implementation of the key provisions of the Directive is provided below:

Working time for medical professionals
Doctors[76] are considered 'autonomous workers – directors/managers'. As such, their working time is flexible and must satisfy the working needs of the organisation and they must carry out the tasks entrusted to them in accordance with organisation's objectives and plans. The working time of doctors required to reach organisational objectives is estimated yearly.

The necessary overtime work to reach organisational objectives is also agreed annually between workers' unions and employers, also in relation to waiting lists for health services.

To reach the organisation's objectives, overtime is compulsory for workers ('ordered overtime'). The minimum working time for directors is 38 hours a week, including four hours for training, researching or teaching. Training time can be cumulated on a yearly basis.

Working hours exceeding the minimum 38 hours limit may be either counted as overtime and thus paid out, considered as additional rest time, or considered as time necessary to achieve company objectives (for instance, reaching a specific number of childbirths or reduce recovery days) and paid on a payment-by-results scheme.

[73] https://www.aranagenzia.it/attachments/article/5792/Area%20IV_Raccolta%20sistematica_dicembre_2013.pdf
[74] http://prontoinfermieri.it/wp-content/uploads/2012/11/CCNL-2006-2009.pdf
[75] http://www.quotidianosanita.it/allegati/allegato2019884.pdf
76 Art. 14 CCNL 3.11.2005

Directors of complex structures do not have a time limit but must ensure the correct functioning of their structure and the achievement of fixed targets.

Moreover, doctors can work as freelancers within the public health company, out of their working time. However, the working time of freelancers or the total work load cannot be higher than foreseen in the aggregated, local collective agreement between the workers and the employer.

The working time of doctors is regulated through shifts defined by the health company.

Working time for nurses[77] is regulated using a reference periods of six months, while derogations can be made from daily rest time if required to meet the employer's organisational needs, still adequate protection has to be considered for workers according to collective agreements.

The collective agreement stipulates an annual limit of 180 hours to the overtime worked by nurses. In particular and exceptional circumstances, the limit may be extended to 250 hours per year, but not for more than 5% of the staff. However, derogations may occur at company level.

Overtime work is remunerated according to collective agreements and aggregated bargaining at local level.

The minimum weekly working hours for doctors is 38, but in order to meet the objectives of health companies doctors need to work longer hours in most cases.

For doctors, overtime is also defined as working time spent as on-call time[78] or as stand-by time.

For nurses and other non-medical professionals working in hospitals, all working time in excess of the 36 hours agreed on the collective agreement is considered overtime and remunerated accordingly.

On-call time 'Servizio di guardia'
Based on Art.16 CCNL 3.11.2005[79] on-call time guarantees continuity of care as well as emergency and urgent hospital services, and/or local health district services.

This is part of the normal working time and such services have to be offered by all medical directors apart from those heading a complex organisation. An additional allowance of EUR50,00 is paid for each shift of on-call time. Both on-call and stand-by time is counted as overtime and is either paid out according to local agreements or accumulated as compensatory rest, which should be taken by the next month[80].

77 Contratto Collettivo Nazionale di Lavoro del Personale del Comparto del Servizio Sanitario Nazionale – Quadriennio Normativo 2006-2009 e Biennio Economico 2006-2007, art. 5.
[78] For on call time in bank holidays during the week.
[79] This article disposed the cancellation of art. 19 CCNL 5.12.1996.
[80] Articlo 28 CCNL 10-2-2005 come modificato dall'articolo 24 CCNL 3.22.2005, articolo 16 CCNL 6.5.2010 integrativo

Stand-by time 'pronta disponibilità' (*Reperibilità')*
Stand-by time[81] is defined as time where the doctor must be immediately available, i.e. where there is a requirement that the doctor can reach the workplace at the agreed time.

Stand-by time substitutes 'on-call working time' and concerns only work done at night or during holidays, which lasts 12 hours. In a month, the permitted maximum is two shifts of 'stand-by time' on Sundays or on public holidays, and 10 shifts of stand-by time for each doctor.

Allowances for stand-by time are approximately EUR 20,00, but the amount can be increased through integrative bargaining. Stand-by time is only considered as working time when the worker is in the workplace after having been called in the health company.

Opt-out
According to the Italian regulatory system, collective agreements play a crucial role in the use of the opt-out option. The 48-hour working week limit is not guaranteed by the regulatory framework, since working time is regulated by collective agreements also at the local level. This is why the European Commission referred Italy to the European Court of Justice, leading to infringement proceedings.

The opt-out provision are contained in the national collective agreement and its use should be motivated by objective reasons of technical or organisational nature (D.Lgs. 66/2003)

The limit on recruitment due to cost containment has led to a shortage of doctors, which has increased the working time of the doctors in employment. The working time of doctors must be commensurate with the objectives of local health companies as stipulated by collective agreements at national and local level. It has been stressed by employees' unions that the Italian regulative system does not guarantee the maximum 48-hour working week. There are no data on the percentage of doctors that have opted out, nevertheless to meet the objectives of local health companies and to guarantee 24/7 health services, especially during holidays, such as during summer, the opt-out option is widely applied.

Compensatory rest
The national collective agreement[82] states that health companies define, in the context of integrative bargaining, the rest in the 24 for hours in respect of the need to guaranteeing adequate working conditions, the full recovery of mental and physical energy and prevention of clinical risk.

After on-call time or night shifts, collective agreements prescribe that immediate, continuous and adequate rest time must be provided to guarantee that rest is taken between working hours. According to Italian law, compensatory rest after extended shifts should be taken immediately after the shift. However, due to organisational needs and according to local agreement, compensatory rest can be postponed.

[81] Art. 17 CCNL 3.11.2005, as modified by art. 16, comma 6 CCNL 6.5.2010 integrativo
[82] Art. 21 CCNL 5.12.1996, art. 6 CCNL 10.2.2004, art. 24, comma 1 CCNL 3.11.2005, art. 28 CCNL 17.10.2008

Collective agreements do not specify the minimum number of hours of such compensatory rest, but just mention 'adequate rest'. Employee unions see as critical, while employers' organisations stress that this provision increases flexibility and contributes positively towards guaranteeing 24/7 health services. Within this regulatory framework, the issue of missed rest (daily or weekly) is not mentioned. As far as the local health companies consider the rest as 'adequate', there is no 'missed rest'.

Reference periods
Reference periods during which to consider working time must be four months[83], however, collective agreements might increase the reference periods to six or 12 months if the increase can be substantiated by objective reasons of technical or organisational nature[84].

Autonomous workers
As indicated above, Italy has qualified all doctors as managers and has argued that they all fall within the scope of the autonomous worker derogation of Article 17 WTD. This situation will change when the new legislation designed to remedy the infringement will enter into force in November 2015.

Scope of the Directive – concurrent contracts
Medical directors working in the National Health System are considered as employees of the public administration, and therefore they are not allowed to enter into concurrent employment contracts. Nevertheless, they can work as freelancers and there is no adequate control of the total amount of working time provided by those working as freelancers, even if a pilot system has been adopted[85].

Doctors employed in public health companies might work as freelancers outside the institutional working time, in the context of a company agreement (attività libero-professionale intramuraria, intra ed extra ospedaliera) in specifically targeted rooms within the company or outside the company[86].

Freelance activities must not exceed the total amount of institutional working time or work load of each doctor, which is agreed on with the health company.

To reduce waiting lists, a health company can request doctors to carry out freelance activities in case of staff shortages or the similar.

In Italy, about 50% of doctors work as freelancers within public health companies (libera-professione intramuraria). Between 20 and 30% of such freelance activities are carried out outside public health companies.

In addition, about 4-5% (5,000) of the total number of doctors (about 110,000) are engaged in freelance activities outside public health companies.

83 art.4, com.3, DLgs 66/2003
84 art.4, com.4, DLgs 66/2003
85 D.L. 158/2012: Disposizioni urgenti per promuovere lo sviluppo del Paese mediante un più livello di tutela della salute.
86 Art. 54 CCNL 8.6.2000 I biennio economico.
D.L. 158/2012: Disposizioni urgenti per promuovere lo sviluppo del Paese mediante un più livello di tutela della salute.

Nurses are also considered employees of the public administration, and therefore they are not allowed to have concurrent employment contracts.

Due to the limits on recruitment, health care companies have applied 'non-typical' working contracts such as 'temporary contracts' or employed health care workers through employment agencies.

Derogations
The legislative decree no. 66 of 2003 (art.4) stipulates that collective agreements must define the maximum weekly working time, which, in any case, cannot exceed 48 weekly hours, including overtime. Working time is considered over a four-month reference periods, but collective agreements can extend this period to six or 12 months.

Overtime (art.5) is regulated by collective agreements.

8.2.2. WTD enforcement procedures

The WTD enforcement procedures have been quite complex as they have been governed by several regulative acts. Enforcement of D.Lgs. 66/2003 has been affected by the Finance Act (2007) and by the wide regulative power of collective agreements that have been updated several times in the last decade.

Presently, working time regulations for medical directors are based on the following collective agreements recently summed up by Aran[87]. Working time regulations for non-medical professionals are based on a number of collective agreements that have been systematically collected by ARAN[88].

Despite visits by labour inspectors, sanctions are not frequent.

The local Directorates of Labour, in charge of monitoring and sanctioning infringements, mostly intervene following complaints from trade unions or single workers seeking mediation among parties.

In the case of the Marche Region, the Directorate of Labour carries out periodical controls especially in private hospitals, where there is a major risk of infringement of labour rules. Two weak points are highlighted. First inspection roles are divided among Health Agencies (in charge of ensuring work safety) and the Directorate of Labour. Second, the Ministry of Labour has provided limited direction on planning and modalities of controls and of enforcement of rules about working time and, more generally, about provisions concerning work in the health sector.

There are no specific data on the infringements of the provisions concerning working time in the health care sector. However, data released by the Ministry of Labour show that, in 2012, most of the violations occurred in the service sector (18,760 out of 25,807)[89].

[87] https://www.aranagenzia.it/attachments/article/5795/Area%20III_Raccolta%20sistematica_dicembre_2013.pdf
88https://www.aranagenzia.it/index.php/contrattazione/comparti/sanita/contratti
[89] Ministry of Labour and Social Policies, 2013, Rapporto annuale sull'attività di vigilanza in materia di lavoro e previdenziale, Anno 2012, p. 11, available at: http://www.lavoro.gov.it/Ministero/Trasparenza/Documents/Rapporto_vigilanza_2012.pdf

8.3. Challenges and trends

8.3.1. Workplace challenges and trends

Working Time for doctors and nurses
Working time for doctors and nurses is registered by each employee (local health company), but there is no systematic analysis of working time. Unions have critised the misuse of the 'opt-out' for medical directors and for non-medical professions, exceeding the 48-hour working week.

Employer organisations stress that the recent reorganisation of the health care system has intensified working time and not the duration of working time. In the future, due to the limits on recruitment, the reorganisation of the health system might affect the duration of working time.

Employee organisations stress that the rest time provided is not adequate and that the 48-hour working week is commonly exceeded.

Data from the local case study, in the Marche region, show that the 48 weekly hours are exceeded only in a few weeks every year to guarantee the offer of health services 24/7, considering 12 months as period of reference,.

To overcome the shortage of doctors, local health companies have increased the 'stand-by' time instead of the 'on-call time'. Stand-by time does not affect the regular working time and is less expensive.

The opt-out option was introduced, delegating to collective agreement the definition of working time, also in the aggregated bargaining at the level of each health care company at the local level.

Reorganisation of the health care system in Italy has taken place over the last two decades. It has been characterised by an increasing focus on primary care and rehabilitation services, reducing hospitals beds for acute cases and limiting recruitment and replacement. This reform process has affected working time for employees fostering a more flexible organisation of work and de facto introducing the opt-out to the WTD specifically with regard to the weekly maximum working time.

Reorganisation of health care systems to improve its efficacy and efficiency has brought about an increase in 'the intensity of work': less staff must to maintain the same service level.

Increasing use of stand-by-time has reduced on-call working time leading to reductions in personnel costs.

In fact, on-call time is fully remunerated (100% as working time) independently of whether it is active or inactive time with an additional allowance (EUR 50), while stand-by-time is remunerated only in case of active time, as overtime or is considered compensatory time work, and the additional allowance is quite limited (EUR 20).

The extent of active stand-by time is difficult to estimate and differs greatly across local hospitals and within hospitals according to medical specializations.

A local case study, in the Marche Region, shows that stand-by time involves 48% of doctors in the local health company.

In Italy, there has been a slow and limited investment in technological development due to cost containment policy of the last decade.

The Italian regulatory system on working time for health care professions does not guarantee the 48-hour working week and the provision of adequate rest time, delegating these aspects to collective agreements.

Moreover, shortage of doctors increase the risk that the 48-hour working week is exceeded and that rest time provided is inadequate.

Stakeholder interviews indicate that there is a clear tendency to increase working time to guarantee the provision of health services, specifically during holidays, such as during summer.

It should be noted that working time and rest time are regulated by collective agreements at national level as well as through integrated, local bargaining that allow derogations from the WTD to guarantee 24/7 health services.

Number of doctors and nurses
The following table provides the total number of doctors, nurses and other health care personnel employed by the national health system in Italy.

Table 8-2 Workers in health care services (2010)

Category	*Permanent employees*	*'Flexible workers[90]'*	*University Personnel*
Doctor	110732	7192	6467
Dentists	157	9	36
Pharmacists	2621	n.a.	52
Biologists, chemists, Physicists	5106	n.a.	879
Psychologists	5788	n.a.	32
Directors of health professions	339	n.a.	65
Nurses	274600	13119	2413
Technical-sanitary professionals	35284	1615	1129
Health inspectors	10269	512	14
Rehabilitation medicine specialists	20337	1343	66
Technical professionals	120202	8716	1719
Directors with technical functions	1068	132	42
Administrative workers	73378	4260	1704
Directors with administrative functions	2740	105	219
Other personnel (veterinary, religious assistant, ...)	8182	1565	37
Total	**670803**	**38568**	**14874**

Source: Ministry of Health, 2013

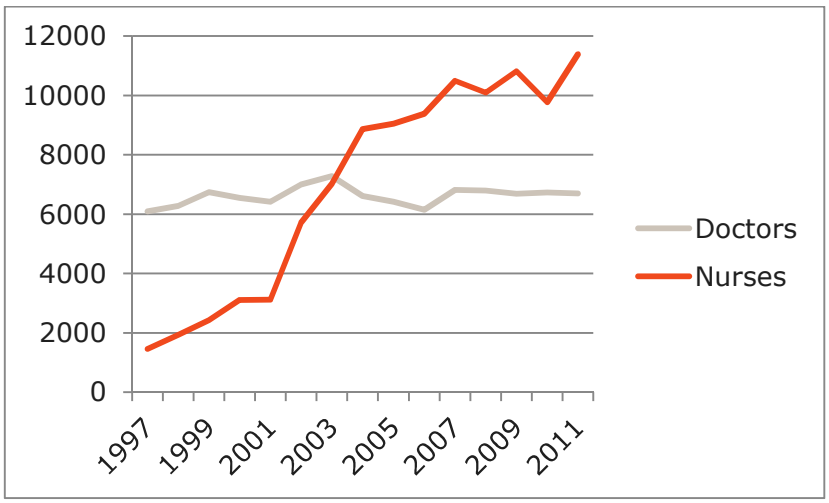
According to stakeholders representing employee organisations and health care services, limits on recruitment of staff have affected working time and the quality of work thus increasing the intensity of work and working hours of professionals.

The number of graduate doctors has been stable over the last years and on a lower level compared to the level of the 1980's. The number of doctors are constrained by the presence of limits to the numbers of students that can subscribe to universities each year.

In contrast, the number of nurses increased, perhaps driven by the trend on increased demand for nurses observed in the latest years[91].

90 The source defines flexible workers as socially useful workers or as employees with a temporary contract, a work/training contract, employed through a temporary employment agency work, performing teleworking)
91 Almalaurea, 2014, Condizione occupazionale dei laureati, XVI Indagine 2013, March, available at: https://www.almalaurea.it/sites/almalaurea.it/files/docs/universita/occupazione/occupazione12/almalaurea_indagine2013.pdf

Figure 8-1 Development in the number of students/graduates (1997-2012)



Source: World Health Organisation (HealthForAll Database)

The mismatch between the number of university graduate doctors and the demand for them in the labour market leads to unemployment among young doctors. One of the most critical aspects is the limited number of grants to access specialization courses (4,360 in 2013-2014) that is lower to graduate students (5,136 in 2013). Junior doctors, attending specialization training take part in hospital activities but with the constant supervision of a doctor.

Moreover, due to cost containment, recruitment and replacements processes have been strongly limited.

The main issue concerning staff in health care is the limits on recruitment, which has led to increases in working time and working load, 'intensity', for all medical and non-medical professions.

Moreover, Italy is characterised by a lack of comprehensive planning on health care professions. Universities are in charge of education and training, whereas local health care companies have recruited less staff, in particular over the last years, due to cost containment. There planning and coordination between the supply and demand sides of medical professions have been insufficient.

Currently, the number of nurses still does not match the number of hospital beds, while the offer of graduate doctors is higher than the demand. Shortages are seen into a limited number of specialisations (e.g. anaesthetics and resuscitation, gynaecology, neurosurgery, cardio-surgery, haematology, pathology and x-ray diagnostics).

Looking at the average age of doctors in medical professions in the next seven or eight years, a fair amount of them will retire during that period, leading to an increasing demand for doctors in a number of medical professions. Presently, part of the younger medical professionals are hired through 'non-typical contracts', with limited working rights. This increases the advantage of companies as they can lower staff costs.

Labour costs

Total labour costs include salary/wage and worker benefits and payroll taxes paid by the employer. The share of taxes and social contributions of wages depends on many factors. The following table is an example of the envisaged labour costs of a professional in the central part of his career.

Table 8-3 Labour costs of professionals per year (Example)

Profession	*Gross income*	Social security contributions	IRAP (Regional Tax on productive activities)
Doctor	80,309.72	21,426.63	6,826.33
Nurse	40,203.00	10,726.16	3,417.26

Given these gross incomes, the net wage of a doctor is approximately EUR 52,000 while the net wage of a nurse is roughly EUR 26,000.

Workers in health services are remunerated according to national collective agreements and aggregated local bargaining.

The yearly **gross salary** [92]for medical doctors is EUR 43,310.90. Moreover, there are a number of specific medical benefits, EUR 2,065.83 for managers of complex organisations, and EUR 1,032.92 for other managers.

The salary also includes:

- 'position remuneration' related to the role and function in the organisation within each health company. According to the national collective agreement 'position remuneration' is as follow

Table 8-4 'Position remuneration' for medical directors with a 'rapporto di lavoro esclusivo' (i.e. a contract that binds them to practise their autonomous profession only within the structures of the health where they are employed) (€)

Position	*Minimum position remuneration (31/12/2007)*	Annual increase	*New minimum position remuneration (since 01/01/2009)*
Director – 'complex structure'* – surgery category	13,546.08	714.68	14,260.76
Director – 'complex structure'* – medicine category	12,141.53	714.68	12,856-21
Director – 'simple structure'**	8,653.74	456.56	9,110.30
Director – 'professional with high specialization'***	4,235.53	223.46	4,458-99

[92]https://www.aranagenzia.it/attachments/article/5795/Area%20III_Raccolta%20sistematica_dicembre_2013.pdf

Equiparated Director	3,163.81	166.92	3,330.73

Source National Collective Contract [93]

* Doctors with mainly managerial duties
** Doctors performing duties mainly connected with their profession
*** Professional performing highly specialized medical tasks
**** Doctors with at least five years of experience reporting a positive evaluation from a technical committee

Remuneration also includes '**result remuneration**', which is a variable amount according to integrative collective agreements, which is locally determined.

Cost of the workforce	ASUR	A.O. MARCHE NORD	A.O. OSPEDALI RIUNITI	*INRCA*	*TOTAL REGION*	*Variation on the precedent year (%)*
Year 2009	**836.,26,451**	**69,013,913**	**184,620,325**	**35,963,611**	**1,125,824,301**	**4.96%**
Directors (DOCTORS)	324,394,270	26,981,911	66,284,096	14,205,747	431,866,024	3.70%
Employees of the National health service	483,924,959	38,687,363	102,688,387	20,734,941	646,035,649	6.66%
Other costs related to subordinate workers	16,374,517	2,455,820	6,075,648	460,690	25,366,674	8.41%
Corrections	-3,,093,705	-155,633	-549,841	-45,129	-3,844,308	5.97%
Costs of workers that are not subordinate	1,4626,411	1,044,452	10,122,036	607,363	26,.400,262	-13.89%
Year 2010	**846,477,725**	**71,415,658**	**189,056,617**	**43,226,088**	**1,,43,671.522**	**1.59%**
Directors (DOCTORS)	332,493,452	28,633,.691	69,022,900	18,322,511	445,309,.950	3.11%
Employees of the National health service	485,982.822	39,712,249	104,508,800	24,118,316	651,128,419	0.79%
Other costs related to subordinate workers	17,345,819	2,273,436	6.255.652	275.061	26.101.233	2.90%

[93] https://www.aranagenzia.it/attachments/article/5795/Area%20III_Raccolta%20sistematica_dicembre_2013.pdf

Cost of the workforce	ASUR	A.O. MARCHE NORD	A.O. OSPEDALI RIUNITI	*INRCA*	*TOTAL REGION*	*Variation on the precedent year (%)*
Corrections	-2,575,723	-166,289	-513,406	-33,617	-3,.276,480	-14.77%
Costs of workers that are not subordinate	13,231,354	962,571	9,782,671	543,817	24,408,400	-7.54%
Year 2011	**788,435.603**	**113,488,394**	**186,860,218**	**43,705,038**	**1,125,377,913**	**-1.60%**
Directors (DOCTORS)	310,481,306	47,327,776	68,523,.515	18,910,302	441,639,734	-0.82%
Employees of the National health service	455,563,125	62,292,901	104,753,579	23,.438,849	642,959,544	-1.25%
Other costs related to subordinate workers	14,505,149	2,936,405	5,880,315	882, 54	23,974,820	-8.15%
Corrections	-2,761,989	-222,324	-451,406	-1,048,930	-3,533,573	7.85%
Costs of workers that are not subordinate	10,648,011	1,153,636	8,154,215	577,962	20,337,.388	-16.68%
Year 2012	**764,349,920**	**114,011,100**	**185,081,020**	**43,205,019**	**1,099,367,231**	**-2.31%**
Directors (DOCTORS)	301,414,785	47,569,221	67,862,991	18,813,624	431,722,408	-2.25%
Employees of the National health service	442,775,658	63,073,001	105,231,004	23,526,607	631,514,222	-1.78%
Other costs related to subordinate workers	12,890,363	2,950,344	4,557,133	407,468	20,735,169	-13.51%
Corrections	-2,785,886	-288,455	-404,.982	-246,454	-3,725,776	5.44%
Costs of workers that are not subordinate	10.055,000	706,989	7,834,874	703,772	19,121,208	-5.98%

Cost of the workforce	ASUR	A.O. MARCHE NORD	A.O. OSPEDALI RIUNITI	*INRCA*	*TOTAL REGION*	*Variation on the precedent year (%)*
Year 2013	**748,825,795**	**111,987,947**	**182,001,304**	**43,091,968**	**1,085,907,014**	**-1.22%**
Directors (DOCTORS)	295.388.110	47.360.450	68.127.810	18.760.330	429.636.699	-0.48%
Employees of the National health service	435,334,644	62,055,051	105,208,032	23,760,431	626,358,158	-0.82%
Other costs related to subordinate workers	12,133,303	2,240,120	2,211,381	242,208	16,827,012	-18.85%
Corrections	-2,481,252,	-221,453	-327,804	-412,973	-3,443,482	-7.58%
Costs of workers that are not subordinate	8,450,990	553,779	6,781,885	741,972	16,528,626	-13.56%

Moreover remuneration is affected by specific '**exclusive public employment allowances**' for all medical doctors employed full time in the national health system as follows:

Table 8-5 Exclusive public employment allowances (€)

Position	*Years of experience in NHS*	*Exclusive public employment allowances*
Director – 'complex structure'	-	17,052.27
Director – 'simple structure' and professional with high specialization	> 15	12,791.61
Director – 'simple structure' and professional with high specialization	5-15	9,385.84
Professional	<5	2,325.41

Source: National Collective Agreement[94]

For non-medical professions in the health care system, the remuneration systems is based on the Collective Agreement of 2009[95].

Remuneration for overtime is regulated through aggregated local bargaining based on available resources.

Since 2011, there have been pay freezes for public administration employers, including those in the health care system.

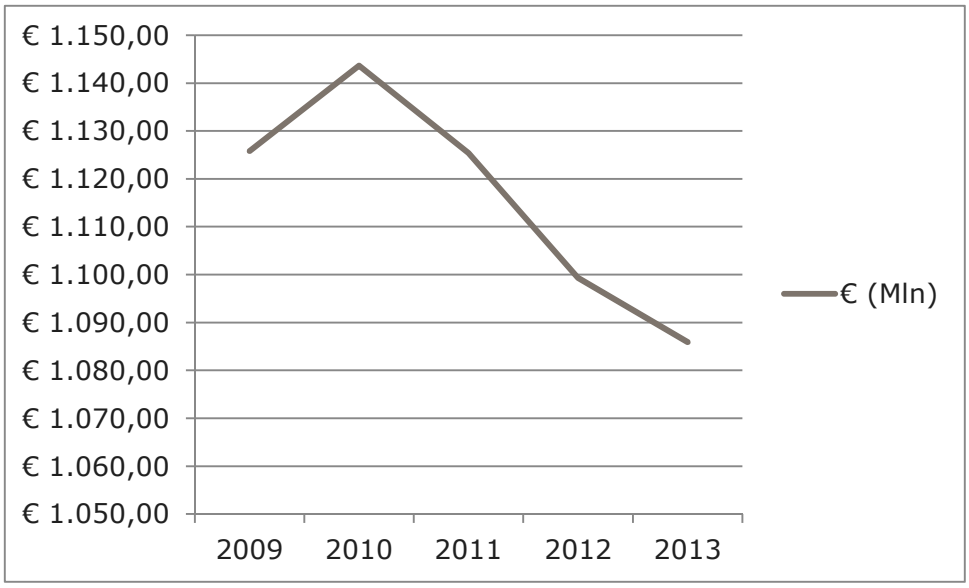
[94]https://www.aranagenzia.it/attachments/article/5795/Area%20III_Raccolta%20sistematica_dicembre_2013.pdf
[95]https://www.aranagenzia.it/attachments/article/446/CCNL_comparto%20Sanita_31.07.09.pdf

During their specialization training time, junior doctors are entitled to a grant of approximately EUR 1,500 per month.

In analysing data on labour costs, we focus on the Region Marche as case study. There has been a marked decline in the total costs of health care personnel. Regional health care costs are divided between:

- ASUR (azienda sanitaria unica regionale), which is the regional health company. Due to the regional dimension, in fact, Region Marche has just one regional company.
- A.O. Marche Nord – Ospedali Riuniti (Azienda Ospedaliera), which are the two hospital companies in the region.
- INRCA (istituto nazionale ricerca e cura anziani), which is specifically targeted to research and care for the elderly and is part of the national network.

Figure 8-2 Aggregated costs of the workforce (2009/2013) (€ Million)



Data are expressed in €

Source: Operating budget approved by Marche Region, Elaboration: Corte dei conti - Sezione Regionale di controllo per le Marche

Administrative and management costs
Stakeholders indicate that the administrative and management costs do neither increase nor decrease with an increase or decrease in the number of staff or amount of working hours. In other words, a potential increase in the number of workers/agreements would result in an increase in administrative work, but this work would be performed by the same number of workers. In conclusion, any changes are independent on changes to the Directive.

Qualifications of doctors and nurses
Doctors are required to complete six-year university education and a specialization course the duration of which ranges from four to five years according to the Decree of

the Ministry of Education, University and Research of 1 August 2005[96]. During the course, the doctor is enrolled in a hospital where he works under the supervision of a tutor.

A State examination is also foreseen, including a practical exam consisting of the evaluation of a post-lauream internship of three months and a written exam (Decree 445/2001).

Dentists and pharmacists must complete a university degree course (lasting six years for dentists and five for pharmacists) and attend a State examination. Internships are embedded into the degree courses.

Doctors in training are fully integrated in the workplace; they act as doctors but under the supervision of senior doctors. Nevertheless, once they have completed the training, there is no guarantee that they can find a workplace due to the lack of adequate planning between the parties offering and demanding doctors in Italy.

In 2014, there will be about 5,000 places for specialization training, but about 9,000 graduate doctors applying for them.

Junior nurses go through a three-year university degree course, including a period of internship.

Availability of public 24/7 health care services
The stakeholders interviewed agreed that the process of health care reorganisation is still ongoing in most of the regions, and in this phase there are highly differentiated regional experiences.

The Minister of Health has implemented a complex system of monitoring of quality of health services concerning the implementation of LEA (essential levels of care) in 16 regions[97] according to 44 indicators. Eight out of 16 regions performed well[98], while the others there were critical aspects[99] concerning the data monitoring system, offer of health services and assistance needs with a specific focus on community care for long term care, people with disabilities, quality of health services (clinical risk and waiting lists), efficiency and appropriateness of the services provided.

The analysis shows that there are highly differentiated regional experiences, which may increase the risk of exacerbating present inequalities in health services and in quality of health care.

Service technology developments
Stakeholders have stated that service technologies will play a role in the health care sector in the future, nevertheless at the moment budget constraints strongly affect the possibility of investing in such technology development.

In February 2013, the national government and local regional governments signed a protocol on investments in technologies and in health care construction adding up to

[96] According to Law 128/2013, a Ministerial Decree should settle a reduction of the duration of specialization courses.
[97] http://www.salute.gov.it/imgs/C_17_pubblicazioni_1988_allegato.pdf
[98] Basilicata, Emilia Romagna, Liguria, Lombardia, Marche, Toscana, Umbria e Veneto.
[99] 21criticalities for Calabria, 19 for Campania, 13 for Lazio, 12 for Molise, 10 for bruzzo, 8 for Apulia, 5 for Sicily, 4 for Piedmont.

162 actions for a total amount of EUR 1,457,020,958.53. Part of this will be funded by the State, EUR 989,082,072.02, part by the Regions EUR 150,315,908.86, and part by the local health companies or other stakeholders EUR 317,622,977.65[100].

Nevertheless, during the last years investments in technologies have declined in Italian health companies. In 2012, hospital investments in technologies had declined by 12% compared to the previous year[101].

8.3.2. Other pressures and trends

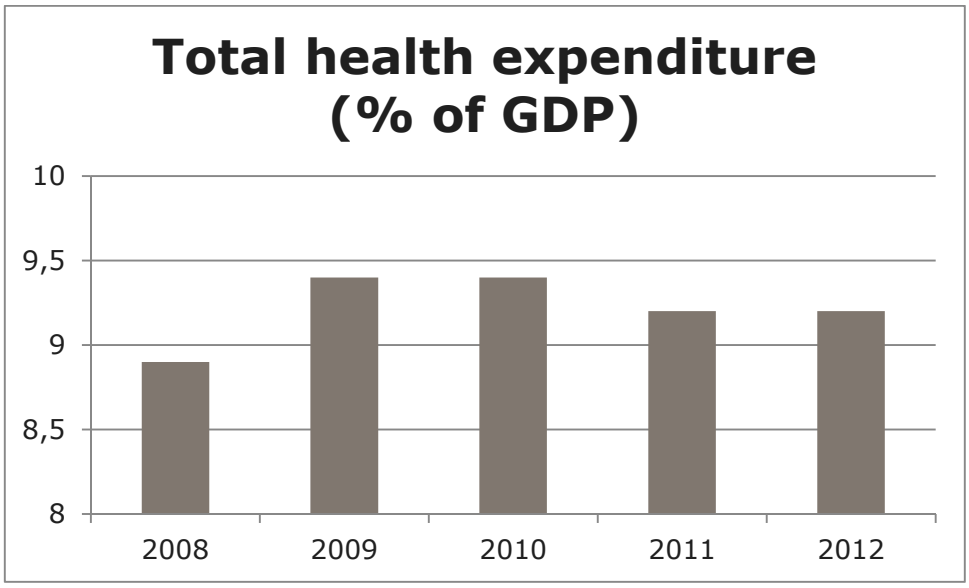
Financing of the public health care sector
The financial situation of the health care sector has had – and according to the stakeholders – will continue to have a major effect on the majority of the workplace indicators described above (in particular the number of doctors and nurses employed, but other workplace indicators are also affected).

In 2012, the share of health care expenditure of GDP amounted to 9.2% of total health expenditure, which is roughly in line with the level of the previous three years.

In 2012, public sector health expenditure was 78.18% of total health expenditure (WHO estimates, health for all database), with not significant differences compared with the previous four years.

Table 8-6 Health expenditure as % of GDP, in Italy

	2008	2009	2010	2011	2012
Total health expenditure	**8.9**	**9.4**	**9.4**	**9.2**	**9.2**



[100] http://www.salute.gov.it/portale/news/p3_2_1_1_1.jsp?lingua=italiano&menu=notizie&p=dalministero&id=1180
[101] http://www.osservatori.net/dati-e-pubblicazioni/dettaglio/journal_content/56_INSTANCE_VP56/10402/1524064

Source: WHO, Data base HealthforAll, 2013.

The 'healthcare requirement', i.e. the gross amount of the resources of the National Health Service, is determined each year by National Law and benefits from the following sources[102]:

- Incomes generated by National Health Service companies' activities (tickets, and incomes deriving from 'intramoenia' activities of employees). These amounts are defined according to an agreement between the State and Regions
- General taxation of Regions
- Regional Tax on Productive Activities (IRAP)
- Income Tax (IRPEF)
- Cofounding from Autonomous Regions with Special Statute and from Provinces of Trento and Bolzano: these institutions participate to the funding of health services up to the amount of the need not fulfilled by the previous sources, except from the Sicily Region
- State budget: it funds the healthcare requirements not covered by other sources of funding mainly through incomes from V.A.T. (devoted to Regions with ordinary statute), excise tax on fuel and the National Health Fund.

The table below shows the amount of funding for selected years (2001, 2005 and the 2009-2012 period). Most of the funding is derived from income tax and excise tax, while only a minor share comes from activities (like from tickets). Recent changes in budgets and law provisions have reduced the growth rate of public health expenditure, while the 'piani di rientro' and the new methods for the calculation of health needs are likely to contain health expenditures also in the following years[103].

Table 8-7 Health care expenditure in Italy (selected years) (Bn €)

The source of financing	2001	2005	2009	2010	2011	2012
Regional Tax on Productive Activity and additional tax on Income	30.3	36.4	39.2	36.9	38.1	39.9
VAT and Excise taxes	27.2	39.1	49.2	53.5	53.8	53
Additional funding from Public and privates	4.7	7.6	10.8	11	10.7	10.4
Income	2.3	2.7	3	3	3.1	3.1
Health National Fund and quota charged to the State	6.9	4.9	4	4.2	4	4

[102] http://www.salute.gov.it/portale/salute/p1_5.jsp?lingua=italiano&id=66&area=Il_Ssn

[103] Ministry of Economic and Finance, 2013, Relazione generale sulla situazione economica del paese 2012 – Il servizio sanitario nazionale, p. 14, available at: http://www.quotidianosanita.it/allegati/allegato1474921.pdf

Capitalized costs	-	-	-	-	1.1	1.6
Total Regional and Public Administration expenditure	71.5	90.6	106.2	108.6	110.9	112
Other National Health Service institutions	0.4	0.4	0.6	0.6	0.6	0.6

Source: Ministry of Economic and Finance[104]

Ageing society

In Italy[105], **20% of population is above 65 years**. Elderly over 75 years represents almost 10% of the population with a higher rate of women 62.8% (men represent 37.2%).

According to ISTAT[106] forecast, the Italian population is expected to increase only by 0.5 million in the next 50 years as a result of a negative birth rate and a positive migration rate. However, significant changes are envisaged in the pyramid of population, with a growing elderly population, shifting the average age from 43.5 years (2011) to 49.8 years (2059), when the growth in the average age is expected to come to a halt. This shift will result in the increase of the share of 65+ population from 20.3% to a peak of 33.2% in 2056.

8.4. Implications of changes to the WTD

The following section is primarily based on stakeholder interviews. Where the stakeholders' opinions differ considerably, this has been highlighted in the text.

8.4.1. On-call time

"On-call time" is relevant for approximately 70% of the doctors employed at hospitals. Directors of complex units are excluded from 'on call time' work.

In the Italian regulative system, 'on-call time' is considered fully as working time, moreover doctors are entitled to a specific allowance of EUR 50,00 for each 'on-call time' shift[107].

The vast majority of nurses work in shifts and, accordingly, will not be affected by the building block. Other types of workers are unlikely to be affected.

A provision to the effect that only part of the inactive working time would be counted as working time would lead ***a significant increase*** in the total volume of working time for the employer as it would in practice mean that the individual workers' (doctors) time spent on workplace would further increase. Although doctors are considered autonomous, they work in shifts meaning that counting only part of the in-

[104]http://www.quotidianosanita.it/governo-e-parlamento/articolo.php?articolo_id=20533
105 Report http://www.sciencesystemfvg.it/upload/file/Sintesi_Rapporto_2009.pdf
106 Il futuro demografico del paese Previsioni regionali della popolazione residente al 2065, Istat 2011 http://www.istat.it/it/archivio/48875
107 Aran, raccolta sistematica, p.217

active on-call time, as working time would result in doctors working more shifts and hence longer hours.

It is difficult to estimate the extent of the implication on working time since the proportion of active and in-active on-call time would differ significantly, not only across workplaces and specialisations, but also with time.

Moreover, the building block would be extremely difficult to implement in practice since there is not a clear line between active and inactive on call time. For example, active on-call time could be time during which the worker is responding to a phone call and carrying out follow-up work without physically attending to the patient. As such, active/inactive on-call time will be very challenging to monitor and, in turn, susceptible to misuse.

The number of doctors needed would in principle decrease, but it is unlikely that in practice less doctors would be employed due to the shortage of doctors that structurally affects the Italian health care system due to limits on recruitment caused by the cost containment policy.

Total labour costs would in principle decrease, but it depends on how inactive on-call time is remunerated.

The local case study shows how 'on-call time' involves about the 52% of 'simple structure' directors for about 9,946 hours per year. If 'on-call time' is considered as working time only for the 50% (70%), it would result in a reduction in working hours counted of 1% (2%).

Administrative and management costs would essentially remain the same, as these are generally independent of the number of staff on the payroll.

The qualification of doctors and nurses, the quality and availability of care and service technology developments are likely to remain unaffected by the building block.

Organisational and financial impacts would prevail substantially over any potential social impacts. Generally, stakeholders agree that with the increase of individual working time, the risk of making medical errors and other negative social impacts increases.

Stakeholders highlight the following main critical aspects in considering 75% or 50% of inactive on-call time at the work place as working time:

- According to the D.Lgs.66/2003 'Working time is the time in which employer is in the working place available to work'; therefore the possible change in this building block will not be coherent with national law.
- Difficulties in distinguishing between inactive and active 'on-call time' and the inherent risk of misuse.
- Changes in the well-consolidated work time organisation that will meet much resistance from employer organisations.

Differences in active and inactive working time could be implemented in a more standardized fashion according to the different typologies of hospitals. Within large acute hospitals, on-call time could be considered active working time at 100%, while

in long-term care or rehabilitative hospitals on-call time could be considered as 50% of the working time. Alternatively, differences could be linked to specializations.

Stakeholders agree that the 'on-call time' building block would be very difficult to implement. The worker organisations indicate that it would be unacceptable because all time spent at the workplace must be considered as working time. On the other hand, employers are concerned over the effective distinction between active and inactive working time, highlighting the issue of how inactive on-call time would be remunerated.

8.4.2. Stand-by time

Stand-by time concerns all doctors in hospitals, excluding directors of complex units. As above, it is relevant primarily for doctors and only a very limited number of nurses working in emergency units. The local health companies endeavour to reduce 'on-call time', which is more expensive, and tend to prefer 'stand-by' time.

In Italy, stand-by time is not considered as working time. Stand-by time is working time only when the doctors have been called to the hospital and are physically present there.

Therefore, calculating 20%/40% of stand-by time at home not spent working is to be counted, as working time would result in a ***significant increase in the total volume of working time*** for the employer, leading to an increase in the demand for doctors.

Unlike on-call time, monitoring of what time is active and inactive is considerably easier.

The Italian regulative system states defines stand-by time as night work and holiday work only stipulating that, monthly, a doctor cannot work on more than 10 stand-by shifts. Each 'stand-by time' shift last 12 hours.

As regards the number of doctors, the building block would call for additional hiring. In the local case study in the Marche region, 12,258 hours of stand-by time were registered in 2013. 40% amount to 4,903 hours/12 (months) = 408 hours per month. For these doctors, it would have to be reimbursed or compensatory rest would have to be provided. This would correspond to a need to hire approximately two to three doctors, about the 3% of 'simple structure' directors.

The administrative costs and management costs, qualification of doctors and nurses, quality and availability of care and service technology developments are likely to remain unaffected by the building block.

There would be no significant social impacts, only organisational and financial impacts.

Stakeholders state that the implementation of the building block would have a significant financial impact and therefore it would face some opposition on the part of employers.

According to the Italian regulatory system, stand-by time is considered working time only when it is active working time, i.e. only when the doctor is working in the

hospital. A quite modest allowance is paid for being available at work (about EUR 20.00 for every 'stand-by' shift lasting 12 hours).

Moreover, stakeholders argue that setting a limit of either 12 or 24 hours a week to the volume of hours that can be worked in a stand-by mode, as a minimum standard with the possibility to derogate from this provision by collective agreement would not have relevant impact due the reduced flexibility in organising working time. Stakeholders suggest introducing a maximum hours a week which can be worked in stand-by mode.

8.4.3. Opt-out

In Italy, the opt-out option pursuant to Art. 22(1) of the WTD is currently used at the request of workers and for employer needs. The Italian regulatory framework states that *'in case that working hours exceed the maximum 48-hour work week, the employer has to inform the competent provincial department, and that collective agreements define such modalities*' (D.Lgs. 66/2003 Art4, com 5).

Accordingly, the implementation of the building block would in part affect workers as well employers.

- Reinforced conditions have been already implemented :
  - Record keeping of all working hours is already implemented in Italy.
  - Consent cannot be requested prior to an employment contract, at the signature of the contract, during a probationary period, or within one month after the conclusion of the contract. The Italian Collective Contract does not require any worker consent, since all overtime work time is regulated by collective agreements and local integrative bargaining- agreements. Moreover, overtime (also exceeding 48 weekly working hours) is required on the part of the employer to guarantee continuity of health services in a context of structural staff shortage and workers have no options to avoid the opt-out.

This change will have a positive effect in reducing the opt-out without the worker's consent.

- Written proof of the informed consent is not foreseen by the Italian regulatory system and would have a positive impact reducing the opt-out option.
- National authorities compiling information, evaluating and informing the Commission would have a positive impact on reducing the opt-out option.

Limitations to the use of the opt-out would have a positive impact on reducing the opt-out

Suspension of the opt-out has been welcomed by worker organisations while employers have had negatively views on this possibility.

Tightening the conditions for the use of opt-out would strongly affect the number of doctors and nurses, bringing about a relevant shortage of personnel and increasing the demand for doctors and nurses.

Therefore, it would substantially increase the number of doctors, since not all doctors would necessarily give their consent. It is difficult to estimate the impact on the total labour costs. The conditions on which the individual opt-out is available in Italy are essentially regulated by collective agreements. Changes in the building block would affect national law and related collective agreements leading to significant implications for the workplace.

Considering this building block in conjunction with stand-by time would have a negative effect on employers, while, in conjunction with the increasing reference periods, it would have a positive effect on employers, in that it increases the flexibility of organising working time to guarantee quality and continuity in health services.

Worker organisations stress that limiting the opt-out options would reduce the risk of making medical errors, mistakes in handovers, increase the perceived health of workers, improve the work-life balance, and reduce illness and absence from work and productivity loss.

8.4.4. Compensatory rest

According to Italian regulations, compensatory rest must be provided immediately after the work time shift (Art. 7, com.2, CCNL 17.10.2008). The provision that compensatory rest must be provided within a reasonable time, not exceeding 48 hours or within 96 hours would have a relevant impact on employers and workers. Employers would benefit from an extension of the period during which compensatory rest is to be taken (not exceeding 48 hours), even more if the period is extended to 96 hours. This would increase flexibility and reduce cost of overtime.

Worker organisations stress that changes in time during which compensatory rest is to be taken would negatively affect workers. It would increase the risk of making medical errors, mistakes in handovers, reduce the perceived health of workers, deteriorate the work-life balance, and increase illness and absence from work and productivity losses.

8.4.5. Reference periods

The Italian regulatory framework states that working time must be considered within a reference period of four months, nevertheless, collective agreements might extend the reference period to six or 12 months.

For employers, changes to this building block would have a positive impact, increasing the flexibility of organising working time.

The 12-month reference period is perceived to be an advantage both to workers and to employers. To workers, it gives flexibility of working time within a specific period, to employers it makes workforce planning easier.

8.4.6. Autonomous workers

The possible exception for 'autonomous workers' is a controversial issue in Italian regulation context due to the fact that doctors are considered ‘autonomous workers’ even though their autonomy is strongly limited by the health company. Codifying the tighter definition of autonomous workers will correspond to the changes that have been made by the new legislation that remedies the infringement proceedings against

Italy on this issue and will strongly affect the workplace and the working time of doctors in Italy.

8.4.7. Concurrent employment contracts

According to Italian regulation, most workers in public health services are public administration employees. Therefore, they have an exclusive contract with a local health company.

Nevertheless, the working time of 5000 doctors working as freelancers is not registered and monitored. The freelancers provide services according to a contract with one specific hospital or with several hospitals. The freelancers can be young doctors who – due to the limits on recruitment – have never been offered temporary contracts. Furthermore, these freelancers can work on different contracts with private hospitals. There is no of the working time of these freelancers as Italian legislation offer no possibility of doing this.

Working time of public administration employees is registered and monitored, while there is no system that controls the working time of freelancers.

No important impact of the building block is envisaged on the number of doctors and labour costs.

The administrative and management costs are likely to remain unaffected by the building block.

8.4.8. Derogations

The building block will not lead to any concrete workplace implications.

Wider derogation options would be welcomed by employers. Worker organisations stress that derogations should be regulated at national level and that it should not possible to introduce derogations unless they are backed by a clear national framework.

8.4.9. Reconciliation

As regards the first alternative (i.e. the obligation to inform workers, etc.), no workplace implications are envisaged since the building block already corresponds to the *status quo*.

The stakeholders interviewed ´state that the second alternative (i.e. possible interruption of the daily rest period) of the building block would affect working time negatively, increasing the risk of making medical errors, mistakes in handovers, reducing the perceived health of workers, deteriorating the work-life balance, increasing illness and absence from work and productivity losses.

8.4.10. Measures increasing legal clarity and certainty

The effect of a Communication from the Commission on improving legal clarity, predictability, etc. is difficult to estimate. The potential for any concrete workplace implications depends – first and foremost – on the contents of such a document. Moreover, the effectiveness of any such Communication would be subject to the condition that the guidelines of the Communication are adopted by the local governments and that the governments take the initiative in following up on the

Communication in collaboration with the hospitals and the workers. Accordingly, no clear conclusions can be made on workplace implications or impacts at this stage.

Nevertheless, stakeholders stress that they would appreciate deep involvement of all stakeholders in the process of developing non-legislative measures seeking to increase legal clarity and certainty.

The following main conclusions are made on the implications of building blocks:

- Changes to **'on-call time'** would be difficult to introduce and implement; nevertheless it seen as a change which would increase the working time for the employer with the risk of overloading doctors and nurses who are already working without adequate control on working time (see the infringement procedures of the European Court of Justice on this topic).

- Changes to '**stand-by time'** would not benefit employers but would improve working time conditions of doctors. Still it would have a significant impact on labour costs and therefore such changes would be strongly opposed by employers.

- The possibilities of **'Opt-out'** and '**derogations**' would be welcomed by employers, while employee organisations would prefer to avoid opt-out options and derogations.

- Changes to '**compensatory rest'** would be appreciated by employers since it would increase working time flexibility, while such a change would be strongly contested by employee organisations on the grounds that the risk of inadequate rest would increase the risk of medical errors.

- Changes to the **other building blocks** would not have any relevant implications.

- The main **challenges faced by the Italian health system** is to guarantee the quality of services, while limiting costs and respecting the WTD.

- **Support to the communication** of changes to the building blocks is positively considered by interviewees.

- **Administrative and management costs** would remain constant regardless of any possible changes to the WTD.

- The extent of **social impacts** depends solely on the potential increase/decrease in the weekly working time of the individual worker.

9. UK

9.1. Introduction

The national case study for the UK is concerned solely with the publicly funded part of the health sector that is delivered through the National Health Service (NHS). The provision of public health care in the UK is the responsibility of the devolved administrations in Northern Ireland, Scotland and Wales, and in England it is responsible to the UK Parliament. In general, regulations relating to working time are ones which apply to the UK and, as such, the commentary below is one which is, for the most part, generally applicable to the UK.

In order to provide context for the national case study, an overview is presented of the health sector as a whole and the place of the NHS within it. The UK health sector can be divided into three principal sub-sectors (Skills for Health, 2011):

- publicly funded services via the NHS;
- services delivered by independent sector organisations (including private companies and not-for-profit organisations);
- services delivered by voluntary organisations.

The services provided in the health sector, by the NHS and other organisations, include:

- hospital care
- general practitioner (GP) surgeries
- dental care
- medical nursing homes
- ambulance service
- other health services including opticians and complementary medicine.

The National Health Service was launched in 1948. The founding principles of the NHS were that healthcare should be available to all regardless of their wealth and this remains a guiding principle to this day. In practice, this means that the NHS remains free at the point of use, though charges are made for prescriptions, optician, and dental services.

The NHS is the world's largest publicly funded health system. In 2011/12, the NHS's budget for the UK was just under GBP 130 billion. As a percentage of GDP, the UK spends below the OECD average. Health expenditure in the UK was 9.27% of GDP in 2012. This compares to 16.90% in the USA, 11.77 per cent in the Netherlands, 11.61 per cent in France, 11.27% in Germany, 10.98 per cent in Denmark, 10.93 per cent in Canada and 9.19% in Italy. The NHS is considered to be relatively efficient compared with other countries.[108]

[108] http://www.kingsfund.org.uk/topics/nhs-reform/mythbusters/nhs-performance

The NHS continues to face a number of funding challenges. In part, this stems from the increasing demand for healthcare – in part as a result of an ageing population but also reflecting the ability to treat a wider range of ailments – and the costs of investing in new medical technologies and meeting the costs attached to prescribing new medicines. The share of GDP spent on the NHS has risen from 3.5% of GDP in 1950, to 5.5% in 2000, and 8.2% in 2010 (House of Commons Library, 2012).

The NHS has been subject to a number of reforms over the years, which have sought to increase the efficiency of medical services provided given increasing demand. In England, for example, the Health and Social Care Act (2012) introduced the latest set of reforms which has seen, from April 2013 onwards, amongst other things, local clinical commissioning groups – comprising doctors (GPs), nurses and other professionals –purchasing services for their patients from, for instance, hospitals (Department of Health, 2012).

This case study is concerned mainly with medical staff. As will be revealed below the majority of NHS employees are engaged in jobs other than doctors and nurses.

9.2. Implementation of WTD

9.2.1. WTD implementation approach

The European Working Time Directive (WTD) was enacted into UK law by the Working Time Regulations 1998, which, in turn, have been modified by Amendment Regulations in 2003, 2006, 2007 and 2009.

The Working Time Regulations (1998) contain, among other things, the following:

- Part I sets out the definition of the various terms used in the regulations such as 'employment', 'rest period', etc.
- Part II stipulates right and obligations concerning working time, including:
  - stipulating the maximum hours to be worked - 48 hours - over a reference period of 17 weeks
  - the method of calculating average weekly working hours over the reference period
  - voluntary exclusion by workers to work longer than the maximum (the opt-out)
  - specifying a limit of eight hours night work over a 24-hour period
  - a limit of eight hours worked in every 24-hour period for night work
  - a weekly rest period of 24 hours every week
  - an entitlement to 11 hours consecutive rest per day
  - an entitlement to a minimum 20-minute rest break where the working day is longer than six hours
  - a requirement on the employer to keep records of hours worked
  - entitlement to paid annual leave of four weeks.
- Part III sets out various exceptions, including among others:
  - doctors in training

- the exemption of autonomous workers from certain provisions, such as the maximum number of working hours, where a person is a managing executive or other person with autonomous decision-taking power
- the role of collective bargaining in establishing a different reference period.

In 2003, the 1998 regulations were modified in particular those relating to doctors in training:

- from 1 August 2004 to 31 July 2007, the maximum number of hours to be worked over the reference period were 58 hours
- from 1 August 2007 to 31 July 2009, the maximum number of hours to be worked over the reference period were 56 hours
- a reference period for calculating average weekly hours, from 1 August 2004, of 26 weeks.

Further amendments were made in 2006 (on unmeasured work) and in 2007 and 2009 relating to annual leave.

By 2009 junior doctors were in scope of the 48 hour maximum working week over a reference period of 26 weeks.

Following the SiMAP and Jaeger rulings of the ECJ, doctors who are resident, on-call (e.g. in the hospital available for work but who may be resting) have all of the time they are on-call classified as working time, and compensatory rest is to be taken immediately following the end of a shift.

Doctors, no matter how senior, are generally not considered autonomous workers. General practitioners (GPs), who are partners in a medical practice, operate under a service contract from the NHS and are exempt from the working time regulations.

Collective agreements in the public part of the sector are concluded on at the national level on topics such as working time and training. Certain other issues are negotiated at a lower level, usually the individual Trust. Eurofound describes industrial relations in the UK's public health care sector as being characterized by "*...high levels of social dialogue and joint regulation, particularly in the public part of the sector. Numerous trade unions exist and, in the public part of the sector, a range of collective agreements and social dialogue mechanisms are used at the sectoral and trust-level to regulate industrial relations within the sector*"[109]. The employer side is represented by NHS Employers (in England) and a number of employee associations representing doctors (such as the British Medical Association) and nurses (such as the Royal College of Nursing), and trade unions such as UNISON, for other grades of employee.

The Junior Doctors contract (sometimes referred to as the 'New Deal') currently manages the terms and conditions of employment, including working time, of junior doctors in training. The New Deal specifies a maximum working week of 56 hours, so if junior doctors opt out of the WTD, they are still subject to a weekly limit of 56 hours.

[109] Eurofound, 2011

In relation to junior doctors, gaps in rotas can occur. If a gap occurs, under the terms and conditions of employment in the NHS, the employer can ask for the gap to be covered. Junior doctors are not obliged to cover the gap, but are required to provide cover on rotas with prospective cover.[110]

Doctors – including junior doctors (see below) – are eligible to opt-out of the WTD. The Independent Task Force on the impact of the WTD on health professionals commented "*Such individual opting-out does not necessarily lead to more flexible arrangements for working hours for the NHS as a whole since these are affected by the overall design of rotas, affordability considerations and other factors. Even where this does facilitate more training-friendly work patterns, all doctors still have to comply with the compensatory rest requirements and with the requirements in the junior doctors' contract.*"[111].

Data for 2012 from the Annual Survey of Hours and Earnings indicate that health professionals do work relatively long hours. The median for medical practitioners was 40 hours (37.5 for all employees and 37.0 for all professionals) and a mean of 39.8 hours (39.0 for all employees and 37.0 for all professionals).

9.2.2. WTD enforcement procedures

Part IV of the Working Time Regulations (1998) sets out the regulations regarding enforcement. The principal responsibility lies with the Health and Safety Executive to ensure that adequate arrangements are in place for enforcement. The Health and Safety Executive (HSE) is the independent regulator of health and safety issues in Great Britain.

Local authorities have responsibility for enforcing the WTR in those premises for which they are responsible.

An employee may also make a complaint to an Employment Tribunal.

Individual Trusts are responsible for monitoring hours of work, and individual doctors are also responsible for recording and reporting their hours of work to their employer.

9.3. Challenges and trends

9.3.1. Workplace challenges and trends

Working time for doctors and nurses

The standard working week for full-time employees in the NHS in England – except for doctors, dentists and senior managers - is 37.5.

The WTD is a politically contentious issue in the UK. The UK Government during the early 1990's saw the Directive as running against the grain of national labour market policy at the time, which was very much oriented towards creating a flexible labour market. The UK Government obtained a right for employees to opt-out from certain

[110] see: http://bma.org.uk/practical-support-at-work/contracs/juniors-contracts/rotas-and-working-patterns/rota-glossary.

[111] P. 7, Royal College of Surgeons, 2014

provisions contained in the Directive (e.g. the maximum weekly average of 48 hours over the reference period).

A study from the early 2000's indicated that around 22% of all workplaces across all industry - accounting for around 19% of employees – employed people who had signed the opt-out (Hogarth et al., 2003). The report noted that employers sought the opt-out because it gave them flexibility with respect to how they organised their work, even though there was often no need for people to regularly work in excess of 48 hours a week. Employers also recognised that that long hours working was often counter-productive with worker fatigue resulting in mistakes and sub-standard work. To some extent the debate in the UK surrounding the WTD has crystallised around the availability of the opt-out. Employer organisations want to retain the opt-out because of the flexibility it offers at the margin, whereas trade unions are critical of the opt-out because, in their view, it potentially opens the door to long hours working and the concomitant health and safety risks.

Historically, junior doctors in training have been trained via an apprenticeship style model of training where off-the-job training and practice on-the-job have been mutually reinforcing. This resulted, however, in junior doctors in training working relatively long hours; sometimes 90 hours or more including standby and resident, on-call time.

When they were first introduced, the Working Time Regulations (1998) provided an exemption to junior doctors in training (see Part III, paragraph 18). The exemptions related to the maximum hours to be worked over the reference period; restrictions on night work; and daily rest of 11 consecutive hours within a 24-hour period. This was amended in 2003 such that the average hours worked by junior doctors in training would be gradually reduced so that by 2009 the average number of hours worked over the reference period of 26 weeks would not be in excess of 48 hours.

The impact on the medical workforce was affected further by the ECJ rulings on the SIMAP and Jaeger cases. In 2003/4 the UK Government noted in select committee that *"These judgements [SIMAP and Jaeger] about 'on-call' time being considered as working time and the timing when compensatory rest should be taken may have a serious effect on the NHS when the Working Time Regulations apply to junior doctors from 1 August 2004...".*[112] The increase in the number of doctors in the NHS following the implementation of the WTD took place at the same time as Government increased its funding of the NHS – which led to an increase in the number of doctors - in order to meet its commitment to improving health care. So care needs to be taken in attributing the increase in doctor numbers to the implementation of the WTD.

At around the same time as the WTD was implemented the New Deal for Junior Doctors was also introduced. The Junior Doctors contract (sometimes referred to as the 'New Deal') is a contractual agreement between NHS Employers and the British Medical Association (BMA) which represents doctors. It agrees pay levels based on total hours worked and the proportion of antisocial hours within that total. It sets a maximum working week of 56 hours where a full shift is being worked. Where junior doctors opt-out of the WTR/WTD these may, in practice, have little impact upon their

[112] http://www.publications.parliament.uk/pa/cm200304/cmselect/cmeuleg/42-ix/4206.htm (para. 4.25)

hours of work, because they will still be subject to the conditions set out in the New Deal. The Junior Doctors contract was currently being re-negotiated in 2014 between the BMA and NHS Employers but negotiations ended without agreement in October 2014.[113]

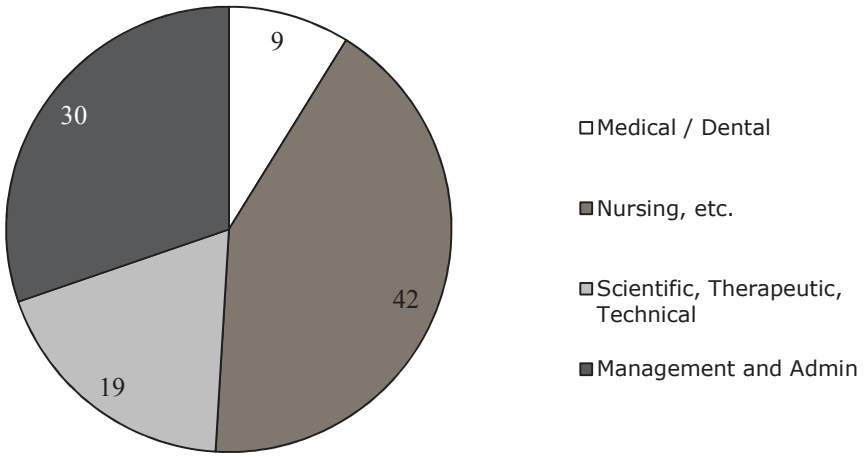
Number of doctors and nurses

The NHS Confederation for England provides the following information about employment in the NHS in England:

- in 2013, the NHS employed 147,087 doctors, 371,777 qualified nursing staff, 154,109 qualified scientific, therapeutic and technical staff and 36,360 managers;
- there were 37,843 additional doctors employed in the NHS in 2013 compared to 2003. The number has increased by an annual average of 3.0 per cent over that time.
- there were 23,531 more NHS nurses in 2013 compared to ten years earlier. While the total employed in 2013 was an increase on the previous year.

A more detailed picture for England, relating to the NHS Hospital and Community Health Service is provided in Figure 9-1 shows the distribution of employees by broad occupation (accounting for around 1.3m employees). This excludes general practitioners (around 43,000), dentists (around 26,000), and opticians (12,000). [114]

Figure 9-1 Employment by Occupation in UK NHS Hospital and Community Health



Source: ONS Health Statistics 2010 (Table 8.2)

[113] The governments in England, Wales, Scotland and Northern Ireland have asked the Doctors and Dentists Review Body (DDRB) to make observations and recommendations by July 2015. The BMA, NHSE, Department of Health and other parties have been asked to submit evidence by the end of 2014 - see https://www.gov.uk/government/publications/special-remit-letter-of-30-october-2014-from-department-of-health

[114] From Table 8.3 ONS Health Statistics 2010

A more detailed breakdown of employment in NHS Hospital and Community Health in England is provided in Table 9-1 below.

Table 9-1 NHS Hospital & Community Health Service (HCHS) monthly workforce statistics - February 2014, Provisional Statistics – Headcount and Full-time Equivalent (FTE)

England	Headcount	FTE
Total	**1,205,370**	**1,058,263**
Professionally qualified clinical staff [1]	**639,943**	**572,305**
All HCHS doctors (incl locums)	**111,221**	**104,925**
All HCHS doctors (non locum)	**109,016**	**102,854**
Consultants (including Directors of public health)	41,900	39,655
Registrars	40,116	38,996
Other doctors in training	14,064	13,896
Hospital practitioners & clinical assistants	1,375	319
Other medical and dental staff	11,901	9,988
All HCHS doctors (locum)	**2,392**	**2,071**
Consultants (including Directors of public health) - locum	1,831	1,588
Registrars – locum	272	259
Other doctors in training – locum	61	59
Hospital practitioners & clinical assistants - locum	29	8
Other medical and dental staff – locum	201	157
Total HCHS non-medical staff	**1,094,272**	**953,337**
Qualified nursing, midwifery & health visiting staff	**354,120**	**314,173**
Qualified Midwives	26,564	21,875
Qualified Health Visitors	11,771	9,838
Qualified School Nurses	1,490	1,191
Total qualified scientific, therapeutic & technical staff	**156,032**	**135,328**
Qualified Allied Health Professions	77,203	65,389
Qualified Therapeutic Radiography Staff	2,666	2,395
Qualified Diagnostic Radiography Staff	15,005	13,132
Qualified Speech & Language Staff	7,772	6,222
Qualified Healthcare Scientists	29,083	26,785
Other qualified scientific, therapeutic & technical staff	49,848	43,154
Qualified ambulance staff	**18,811**	**17,878**
Support to clinical staff	**354,459**	**300,640**
Support to doctors & nursing staff	277,242	234,281
Support to scientific, therapeutic & technical staff	63,430	53,277
Support to ambulance staff	14,341	13,081
NHS infrastructure support	**213,579**	**185,319**

England	Headcount	FTE
Central functions	105,672	94,780
Hotel, property & estates	71,071	55,340
Senior managers	11,114	10,467
Managers	25,969	24,731

Notes (1) Includes all Doctors and all qualified non-medical staff / Headcount totals are unlikely to equal the sum of components / These statistics relate to the contracted positions within English NHS organisations and may include those where the person assigned to the position is temporarily absent, for example on maternity leave / Full Time Equivalent (FTE) refers to the proportion of each role's full time contracted hours that the post holder is contracted to work. 1 would indicate they work a full set of hours, 0.5 that they worked half time.

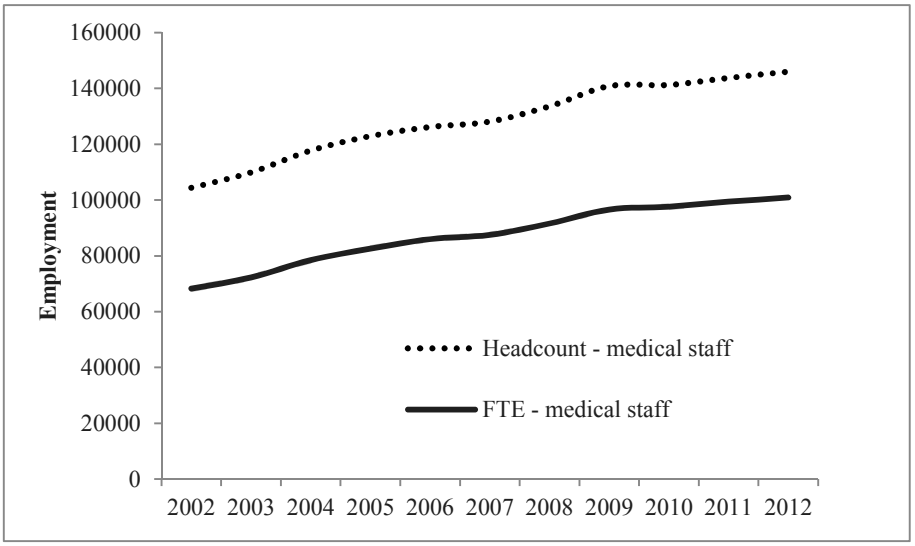
Source: Health and Social Care Information Centre, Provisional NHS Hospital & Community Health Service (HCHS) monthly workforce statistics

With the election of the government in 1997, there was a commitment to increasing substantially expenditure on the NHS. Consequently, there was a substantial rise in the number of people employed. In England, for example, 956,000 full-time equivalent people were employed in the NHS in 2002 and this had risen to 1.15 million in 2012, an increase of nearly 200,000 full-time equivalents. The growth in the number of doctors is shown below in Figure 2-3. As noted above, other changes taking place at the same time makes it difficult to gauge what the financial cost of this may have been in practice. Other data presented in the Ninth Report of the House of Lords Select Committee on the European Union, in 2004, (in Chapter 3, Reactions to the Jaeger and SiMAP rulings, paragraph 3.32), said that the BMA "*...claimed that if the Jaeger ruling remained unchanged the effect would be tantamount to losing the equivalent of 3,700 junior doctors by August 2004 and between 4,300 and 9,900 junior doctors by 2009 when the full 48 hour limit would come into effect.*"[115]

The increased investment in the NHS since 1997 coincides with the period over which the impact of the WTD and the New Deal for Junior Doctors were fully implemented. While some of that additional investment may have been required to meet the costs of complying with the WTD and New Deal, the decision to increase spending on the NHS was driven by Government.

[115] House of Lords, 2004

Figure 9-3 Employment of doctors by UK National Health Service, 2002 to 2012 in England (NHS Hospital & Community Health Service)



Changes in the NHS over recent years have included changes in the occupational structure of employment. Between 2003 and 2013, in England, there was an increase in the number of professionally qualified clinical staff within the NHS of 16%. This includes an increase in doctors of 34.4% and a rise in the number of nurses of 7%; and in more qualified ambulance staff of 17%. The changes have also seen a concomitant increase in Medical School intake from 5,062 in 1997/98 to 8,035 in 2011/12 - a rise of 59%.[116] At the same time, the share of people employed in management roles has declined.

Skills for Health (2011) points out that the sector as a whole has introduced measures to reduce its dependence upon non-EU migrant labour, but skill shortages continue to be experienced. The Migration Advisory Committee (MAC) report Skills Shortages Sensible (MAC 2011) lists a number of health sector related roles where there are skill shortages including medical roles practitioners, specialist nurses, and therapists.

Labour costs

NHS net expenditure has increased from GBP 64.173 billion in 2003/04 to GBP 109.721 billion in 2013/14.[117] The Nuffield Trust estimates that around 50% of all spending is on employment/staffing but this is likely to be a low estimate because certain categories of staff are excluded (Nuffield Trust, 2013).[118]

The Annual Survey of Hours and Earnings for 2013 shows that average annual earnings for all medical practitioners (not just those in the NHS) was GBP 70,648 (all employees) and GPB 79,494 (full-time employees). For nurses, annual average pay was GBP 26,391(for all employees) and GBP 32,067(for full-time employees).

[116] http://www.nhsconfed.org/resources/key-statistics-on-the-nhs (accessed September 2014)
[117] See http://www.nhsconfed.org/resources/key-statistics-on-the-nhs (accessed September 2014).
[118] See p.22, Chart 2.9 in Nuffield Trust, 2013

The long-term trend has been for employees in the NHS to experience real wage increases. In the 35 years to 2009/10, the Nuffield Trust estimated that wage increased by 2% annually in real terms for hospital and community health service staff in the UK (Nuffield Trust, 2014).

Wage rates are centrally agreed. There is a basic element and an element for working unsocial hours (e.g. overnight, weekends).

Administrative and management costs
It is difficult to identify administrative and management costs in the NHS. Over time, the trend has been to reduce the number of senior managers working in the NHS. The NHS confederation notes the following:

- the number of managers and senior managers has declined in each of the past four years and stood at 36,360 in 2013, the lowest total since 2003
- in 2008/09, the management costs of the NHS had fallen from 5.0% in 1997/98 to 3.0%.[119]

Qualifications of doctors and nurses
In order to be qualified as a doctor, a person must obtain a medical degree that takes on average five years to complete.[120] In the UK, a medical degree is obtained from a medical school many of which, but not all, are part of a major university. The number of places available at publicly funded medical school is determined by Government. After completion of a medical degree, doctors will then enter a period of postgraduate training. They will spend two years as a foundation doctor, and then enter specialist training which may take a further five to seven years, before becoming a consultant. Training to become a GP takes a further three years after completion of foundation training and this may be extended in the future to four years.

To become a nurse, a person must complete a degree in nursing (which generally comprises 50% theory and 50% practice) and takes three years to complete. Following completion of a degree, individuals must register with the Nursing and Midwifery Council, which enables them to practice.

Availability of public 24/7 health care service
Over recent years, there has been increasing pressure on accident and emergency centres to treat patients. The factors underlying the increasing pressure on accident and emergency centres are complex.

The NHS has experimented with various forms of organisational change to ensure that the provision of 24/7 health care services is efficiently and effectively delivered. One example is the Hospital at Night initiative that looked to ensure that the care overnight in hospitals was more effectively delivered via a nurse triage system, and that there was effective handover from daytime to night-time activities. Another example is the Better Training Better Care initiative, which followed on from Hospital at Night, which has also sought to ensure that care overnight is effectively delivered in a way that does not overly rely on junior doctors and thereby constraining the time they have to train (see below for further details).

[119] These data are taken verbatim from http://www.nhsconfed.org/resources/key-statistics-on-the-nhs (accessed September 2014)
[120] There are medical programmes that are based on graduate entry that take four years to complete.

Service technology developments
There are a number of developments in IT and the use of new medical technologies which assist with both the administrative aspects of healthcare (such as apps for handovers between shifts) and in the delivery of medical care.

9.3.2. Other pressures and trends

The main drivers of change in the NHS relate to:

1. an ageing population, which is placing greater demands on the health care sector;
2. the increasing demands being made on the NHS resulting from funding struggling to keep pace with the demand for various health services;
3. reorganisation of the NHS to ensure that services are efficiently provided;
4. difficulties ensuring that resources can be deployed such that there is round-the-clock provision of medical services;
5. problems relating to various exigencies that can result in an unforeseen demand for medical services and the pressures this places on health care workers;
6. technical change – for instance, enabling greater use of remote and virtual service provision – that allows a wider range of ailments to be treated in new ways.

The above are in many respects generic drivers of change across the health care system in the UK. Consideration also needs to be given to how the organisation of working time has affected the NHS.

9.3.3. The role of the Working Time Directive (WTD)

Since the introduction of the WTD, junior doctors' average weekly hours have fallen substantially (Skills for Care, 2010). This cannot be wholly attributed to the WTD because there were other developments taking place at the same time, such as the introduction of the New Deal.[121]

With reduced working hours, there has been concern that junior doctors will have less time to engage in education and training whilst, at the same time, fulfilling their clinical duties. Following the removal of the exemptions from the WTD, the Temple report undertook a review of the impact of the WTD on the training of junior doctors (Temple 2010). Its findings indicated that:

- the main impact of the WTD on the training of doctors had been in hospitals;
- there are often gaps in hospital rotas and these gaps were more prevalent during evenings and nights such that junior doctors could be moved at short notice from daytime work where there were more opportunities to engage in

[121] Note that the pay banding system in the Junior Doctors contract provides an incentive to employers to reduce hours of work.

elective training, to evenings and nights where there were less opportunities to train;

- the increase in demand for emergency care further reduces the opportunities for elective training for junior doctors;
- the increase in the number of junior doctor posts has tended to reinforce traditional methods of working rather than making best use of the training available within a 48-hour working week;
- despite significant expansion in the number of consultants, junior doctors in training are still responsible for delivering the majority of out of hours service often with limited supervision. In particular, the flexibilities introduced in to the contracts of consultants were not being used to the benefit of training.

The Temple Report identified a number of positives too. It noted that good rota design and management enables compliance with the WTD and an improved work–life balance. Enhanced supervision of trainees out of hours leads to safer patient care and reduces the loss of daytime training opportunities. International comparisons confirmed that high-quality training can be delivered within reduced working hours. It recommended a move to a consultant led system and a number of other organisational changes. The proposed changes included introducing hospital at night schemes to ensure that training opportunities can be delivered at night, multi-disciplinary team working so that doctors in training can have better access to training and reduce their workloads, and formal accreditation of consultants involved in training with time allocated to doing this.

9.3.4. The latest review of the Working Time Directive

In 2013, the Royal College of Surgeons led the Taskforce , reviewed, at the request of the Minister of Health, the impact and implementation of the European Working Time Directive (Royal College of Surgeons). It addressed two questions.

7. What impact had the UK working time regulations (WTR) and court judgments associated with the WTD had on the training of doctors in the UK, and by extension on the delivery of high quality patient care?
8. If significant problems were identified, could solutions be recommended that would allow different specialties in medicine the flexibility to provide streamlined and appropriate treatment for patients, and in a manner, which was practical for the NHS?

The key findings from the Taskforce are summarised below.

Patient care

- There has been a fragmentation of handovers between shifts which can cause disruptions in the continuity of care.
- Where doctors take part in on-call rotas for their speciality and are required to attend out-of-hours emergency procedures, they need to take compensatory rest the next morning, which can result in clinics being cancelled, which imposes a cost on patients.
- Working long hours can cause fatigue and affect patient care. On the other hand, the WTD has reduced the hours available for training and thereby has an adverse effect on patient care.

On balance, the review concludes: *"Overall, it is clear that patient safety is protected by ensuring that doctors do not work very long hours. However, patients are also disadvantaged by a large number of cancellations of elective clinical activity and the transfer of care between medical colleagues."*

Morrow et al (2004) note that the relationship between long hours working and fatigue is not straightforward, and it important to take into consideration when the hours are worked - e.g. at night.

Areas of speciality most affected

- The implementation of the WTD has affected different specialities in different ways with the highest percentage of respondents working longer than 48 hours per week coming from the neurosurgery profession, and the lowest from audio-vestibular medicine. Surgery, in general, appears to an area with particularly long hours of work

Training and education

- Evidence provided to the Taskforce reported that those in specialties that require experiential learning of practical procedures are markedly less likely to believe that training can be delivered within a 48-hour week. Surgeons are least likely to report that all training can be completed within the confines of the WTD.
- The Royal College of Surgeons reported to the Taskforce that the WTD had reduced the number of hours available for training. It suggested that doctors beginning their surgical training today will have 3,000 fewer hours to learn throughout their training, the equivalent of 128 whole days.
- Despite these misgivings about the impact of the WTD on education and training, the Taskforce noted that the rates of successful progression through the recognised postgraduate training programmes and the achievement of Certificates of Completion of Training have not been affected to date. This may have been achieved, it noted, by junior doctors in some specialities working extra hours that are unrecognised.
- Not all specialities believe that the implementation of the WTD has had a detrimental effect on training. The Royal College of Anaesthetists, for instance, told the Taskforce that there was currently no strong evidence to suggest that the WTR/WTD had a negative effect on anaesthesia training in the UK.

Rota design

- The WTD has resulted in a move away from on-call to full shift working patterns. This will mean that a doctor works a 12-hour shift and then has a break until the next day. In the past, they may have been on an on-call rota for 24 hours but sleeping or resting in the hospital during at least part of the quieter night-time period. This is not to say that these periods of rest and sleep were never disrupted.
- Health Education England, in its evidence to the Review, expressed concern that rotas are insufficiently staffed by trained doctors and that this leads to an over reliance on junior doctors who spend a significant number of hours working without direct supervision.
- Much of the evidence submitted indicated that there was concern that some rotas were not compliant and that doctors were working more hours,

unofficially, and in some cases not being paid for it. NHS Employers, for instance, noted that some Trusts had been slow to comply with the New Deal agreement despite financial incentives to do so (NHS Employers, n.d.)

The Taskforce noted that: *"Overall, if rotas are designed well and best practice followed, it is clear that the impact of the WTD can be mitigated to a certain extent but it is recognised that this does not remove all the problems in certain specialisms and that the situation is more challenging for some, mainly smaller, NHS trusts."*

SiMAP and Jaeger Court Judgments

The Taskforce reported on the way in which the WTD, the SiMAP and Jaeger court judgments, and the junior doctors' New Deal contract cut across one another. This created tensions relating to (i) the need to have highly trained doctors who have been able to develop the necessary skills and experience to progress in their training, and (ii) the importance of ensuring that care is delivered safely by doctors who are not suffering from fatigue owing to long hours of work.

The organisations representing surgeons are concerned about the operation of the WTD in practice and the effect this has on access to training (Shatta, 2011; Jacques, 2013). As noted above, there are concerns that surgeons in training are working in excess of their contracted hours of work. Datta et al (2011) note that the BMA supports the principles of the WTD as it currently stands (in 2011), but recognises that there are problems related to education and training. These are potentially resolvable through the design of training programmes and hospital rotas/shifts. It does not want the Jaeger and SiMAP rulings diluted.

9.4. Implications of changes to WTD provisions

Interviews were conducted with a wide range of stakeholders in the NHS at national and local levels. It is immediately evident that there is little consensus about the impact of the WTD on the NHS or how it should be reformed. There is consensus that there should be no return to the long hours working in place before the introduction of the New Deal and the WTD. Several respondents pointed out that, in retrospect, working 80, 90, or 100 hours a week was probably not conducive to good patient care. There was, however, no consensus about how long the average working week for doctors in training, or any doctor for that matter, should be. On the one hand, professional ethics and standards are seen as sufficient safeguards to ensure patient care such that doctors should be allowed to determine their own hours of work. On the other hand, the pressures of meeting the demands for patients care could, without contractual or statutory safeguards being in place, result in long hours being worked resulting in fatigue and mistakes being made.

The evidence from the review of the literature and the interviews with stakeholders suggests that doctors should not be seen as a homogenous group of workers. The time pressures on doctors in, for instance, acute medicine are different from those in other areas. Any discussion of the way the WTD affects the organisation of work needs to be cognisant of the different pressures that affect different specialist areas of practice.

9.4.1. On-call time

The SiMAP is considered to have had a substantial impact on the design of shift systems.

With respect to resident on-call, respondents said that the in some cases many on-call resident facilities in hospitals had been removed. Following the SiMAP ruling, they had moved over to new patterns of shift working in order to be compliant with the regulations. It was considered expensive to reintroduce resident on-call facilities where they have been removed such that in some hospital environments any move which may make being a resident on-call more cost-effective would need to be set against the cost of reintroducing on-call rest facilities. This also needs to be considered with respect that hospitals had introduced shift-systems such that there would be organisational costs to consider too.

9.4.2. Stand-by time

Some respondents said that if an element of standby-time, where the doctor is not working, were to be considered working time, the cost implications would be large in relation to both doctors and district nurses. Some respondents said the costs of this could be very high indeed and it was difficult to see how the additional cost could be accommodated within existing budgets without it having an impact on the delivery of health careThat said, some respondents said that whilst doctors and nurses were non-resident, on-call, they were prevented from engaging in a variety of non-work activities.

9.4.3. Opt-out

The opt-out was seen by some respondents as being important in providing some flexibility in meeting unpredictable levels of demand, especially in acute services. Others pointed out that because of the way the New Deal operates, and the way in which shift patterns are structured, the impact of removing the opt-out could be modest in relation to doctors in training. Moreover there was an issue of what to do when one doctor on a shift opted out and another did not since the shift systems would struggle to accommodate this. For more senior doctors the use of the opt-out was seen as one way of increasing labour supply at times of unexpected high demand.

It is not clear how many doctors have signed the opt-out as records are kept at the level of the individual hospital. A report from 2009 by the House of Commons Library (2009) indicated that a BMA survey of its members reported that "nearly half (47 per cent) of all career grade doctors surveyed reported that they worked more than 48 hours per week, of those 9 per cent reported they had signed an opt-out." Career grade doctors includes everyone except specialists/consultants and trainee / junior doctors. A BMA survey of junior doctors in 2010 reported that:[122]

- 47 per cent of respondents thought junior doctors in training should be allowed to opt-out and 22 per cent of respondents thought that junior doctors should not be able to opt out (p.37);
- 79 per cent of respondent said they had not been pressured into opting-out. Overall, 13 per cent said they had been pressured by their employer, and 11 per cent by consultants to sign the opt-out (p. 42).

Without knowing how many doctors have signed to opt-out and how many additional hours have been worked it is difficult to provide an estimate of the workplace

[122] BMA Junior Doctors Committee (2010) *BMA survey of junior doctors' working arrangements 2010*. London: British Medical Association

implications of having or not having the opt-out in place. Several respondents, however, pointed out that it was a useful provision to have in meeting demand.

9.4.4. Compensatory rest

Compensatory rest was seen as important by all respondents. There was a view shared by several respondents that more flexibility surrounding when compensatory rest should be taken would be welcome. There was also a need to consider, for example, when additional work was being undertaken. For example, some respondents said that the impact of working an extra hour at the end of a shift was different to that of being woken up in the middle of the night to deal with an emergency. Some respondents pointed out that taking compensatory rest as soon as practicable within a shift system rather than immediately would provide greater flexibility in meeting unanticipated peaks in demand. At the same time, it was recognised that by moving the compensatory rest period too far away from when the additional hours were worked, the issue of fatigue would not be addressed. And as noted elsewhere in this report the current regulation of compensatory rest was seen as satisfactory from the union side because it reduced working time pressures on workers in the NHS.

Some respondents, consistent with reports by organisations such as the Royal College of Surgeons (2014), pointed out that the need for compensatory rest immediately could result in clinics or procedures being cancelled because the doctor needed to take their compensatory rest even though the amount of additional extra time worked at the end of a shift may have been modest. Some respondents noted that the need to take compensatory rest immediately in small, rural hospitals, in some specialities, and in acute services, could pose a particular problem because it was not possible to have substitute staff readily available.

There is also an issue, raised by some respondents, and mentioned in the Royal College of Surgeons report (2014), about whether doctors actually request compensatory rest.

9.4.5. Reference periods

Respondents in some instances found it difficult to think of the organisational impact of extending the reference period to 12-months from the current reference period of six months. There was some concern that moving to a 12-month reference period may make it difficult to monitor working hours effectively over such an extended period and there was a danger that hours could become front-loaded with long hours over, say, the first six months.

9.4.6. Autonomous workers

Doctors are not considered to autonomous workers in the NHS. Some respondents thought there was some inconsistency with other professional workers who are considered to be autonomous workers. On the other hand, some respondents said that the nature of medicine means that such comparisons are not comparing like with like.

9.4.7. Concurrent employment contracts

In relation to concurrent contracts it was said that these are per worker. It was further noted that professional standards and ethics - plus the contract with the primary employer - should ensure that NHS workers were compliant with the WTD.

Several respondents noted that employees in the NHS may work for several employers, for example, as locums.

All doctors in hospitals, even the most senior clinicians, are classified as not being autonomous workers when working in the NHS. Where they engage in private practice in addition to their NHS role they are either autonomous workers or self-employed.

9.4.8. Derogations

Respondents for the most part had no particular view about whether there should be derogations for the health sector or the NHS, though some respondents reported that the requirement for the NHS to deliver continuity of service at all times and meet whatever demand for it services might materialise, made it different from other sectors of the economy . Some respondents pointed out that policy in the UK was not keen on derogations being available to particular sectors.

9.4.9. Reconciliation

In relation to work-life balance views were mixed. There are several surveys of doctors where they report that their work-life balance has been improved due to reductions in their working time, though they were concerned about their opportunities for training. And several respondents said that reduced working time had made it easier for doctors, especially junior doctors in training, to reconcile family and working life. This was particularly important with respect to having a more diverse workforce and encouraging, for example, more women to enter and remain in the medical profession.

It was noted that even with reduced working time, there was still a need for all employees in the NHS to work what may be termed unsocial hours so that the impact on work-life balance could be limited. The WTD also allowed relatively long shifts to be worked (i.e. up to a maximum 13 hours a day - subject to the overall limit of an average of 48 hours a week over the reference period – so that in a given week working hours could amount to 91).[123]

9.4.10. Measures increasing legal clarity and certainty

There was a general view that greater legal clarity is always welcome. Some respondents suggested that the directive had been interpreted in a particular way, such as the even senior doctors were not considered to be autonomous workers whereas comparable professionals in other sectors may be considered autonomous workers.

9.4.11. Overall conclusions and adaptive measures taken

It proves exceedingly difficult to estimate the impact of the WTD on the health service in the UK. The costs of implementing the New Deal / WTD were reported by several

[123] Note that there is also an issue of long hours working and fatigue. Limits on doctors working hours in short defined periods are beginning to be introduced in the UK and, in 2016, Scotland will introduce a limit on the number of consecutive day and night shifts that can be worked – see http://bma.org.uk/news-views-analysis/news/2014/june/end-to-seven-night-shifts-in-a-row .

respondents to be large. One respondent estimated that it may have added around 1.5 per cent to the overall NHS budget in England.[124] But it is difficult to disentangle the impact of the WTD from other factors bringing about change in the NHS. There are clearly enormous pressures within the NHS to ensure that increasing patient demand can be met within a budget which the country can afford. Inevitably this places pressures on doctors - and others within the NHS such as nurses, laboratory services, ambulance services, etc. – to meet the demands being made on the NHS. The role of WTD in all this is difficult to gauge.

As noted in the introductory sections the NHS over recent years has been subject to a number of reforms which have sought to improve the efficiency with which medical care is delivered. One initiative, which stems in part from the introduction of the WTD and the removal of the derogations relating to junior doctors from the 1 August 2009, was Hospital at Night (HAN). In summary, HAN aimed to ensure that hospitals were appropriately staffed at night. This included training nurses so that they were better able to deal with issues which arose at night such that they did not need to call a junior doctor. Therefore the number of doctors on duty out-of-hours could be reduced and staffing arrangements were more efficiently deployed without risk to patient safety. It also assisted hospitals ensure that they were compliant with the WTD. HAN also paid more attention to the handover between day and night shifts in order to ensure that problems did not occur overnight. One of the respondents to this study suggested that HAN was a successful initiative but had not been embraced by the NHS despite initially positive results from those hospitals which had introduced it. In part because it required a substantial amount of culture change in the way hospitals were staffed it was to work effectively.

Following on from HAN has been the Better Training Better Care (BTBC) initiative led by Health Education England.[125] This sought to tackle two issues:

1. the desire to improve the training of foundation doctors (i.e. those who have recently qualified as doctors) as outlined in the Foundation for Excellence study (Collins, 2010); and
2. how to introduce the recommendations of the Temple Report about how training can be delivered whilst being compliant with the WTD (see above).

The BTBC initiative included 16 pilot projects which have now drawn to a close with the evaluation results to be published in 2014.

Pilot projects within BTBC tackled issues such as:

- handover/ care transition;
- out of hours and 24/7 services;
- technology and simulation to enhance training and education;
- communication and quality improvement;
- front door / A&E;
- patient rotas and scheduling; and
- multi-disciplinary working.

[124] It has not been possible to independently confirm this figure.
[125] See http://hee.nhs.uk/wp-content/blogs.dir/321/files/2012/09/BTBC-News-March-April-V19-Final.pdf for further details

Initial findings from the evaluation of BTBC suggest that it has been successful in meeting a number of objectives in ensuring that the quality of training provision improved within the working time limits in the WTD. In order to give an insight into what BTBC included examples are provided below. Further examples can be found at: http://hee.nhs.uk/wp-content/blogs.dir/321/files/2012/09/BTBC-News-March-April-V19-Final.pdf

East Kent Hospital University NHS Foundation Trust

Establishing hot 'emergency-based' and cold 'ward-based' teams to enhance the trainee experience, improving patient care at weekends

East Kent has had great success in demonstrating a reduction in the overall length of stay across long term conditions and urgent care representing savings of up to £663k annually and an increase in Saturday and Sunday discharges by 20% and 6% respectively. There has been a significant impact on trainees who recorded experiencing better supervision and support in both the hot and cold blocks of working. In addition, the introduction of the enhanced multidisciplinary cold team has enabled nurses to provide much needed and valued support to trainees and to make a significant difference to the patient experience. The success of this pilot has seen the roll out of this model across all three hospital sites.

Source: http://hee.nhs.uk/wp-content/blogs.dir/321/files/2012/09/BTBC-News-March-April-V19-Final.pdf

Leeds and York Partnership NHS Foundation Trust

Maximising and enhancing training opportunities and clinical time with patients by changing working patterns.

100% of the trainees at Leeds and York have reported more confidence in their work since the pilot and 83% agree or strongly agree that they have benefitted from the change in rota. The pilot saw an increase in productivity with weekday activity increasing by 37.7%, weekend activity rising by 29.1% and night shift activity by 22.1%. Patients also experienced benefits from this pilot as trainees were able to spend more time with each patient. Furthermore 54% of staff agreed that the initiatives and changes implemented had a positive impact on patient care and satisfaction.

Source: http://hee.nhs.uk/wp-content/blogs.dir/321/files/2012/09/BTBC-News-March-April-V19-Final.pdf

Airedale NHS Foundation Trust and Western Sussex Hospitals NHS Foundation Trust

Using telemedicine to enhance training and improve supervision and support

The Airedale and Western Sussex telemedicine pilot provided an innovative way of using telemedicine to enable remote supervision and handover across disparate locations. This helped maximise resources as well as delivering a service with increased senior input into medical education and patient care. Qualitative data from trainees showed that they felt more supported as well as more engaged in the hospital night team. Trainers also felt that although technical issues did provide some challenges, once resolved, the system would allow better use of time by sharing resources for training and education, and thereby freeing up clinician time elsewhere. 73% of consultants and doctors in training fed back that they felt remote consultant input would improve the quality of care to patients. In addition, the pilot highlighted the importance of putting more standardised procedures in place to further improve the handover process across the Trusts.

Source: http://hee.nhs.uk/wp-content/blogs.dir/321/files/2012/09/BTBC-News-March-April-V19-Final.pdf

At the very least the WTD has pushed in the same direction as other reforms such as the New Deal which sought a reduction in the hours of doctors in training. There seems to be a general consensus that the long hours doctors worked pre-New Deal / WTD were too long.

10. APPENDICES

Appendix A - Literature

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Appendix B Stakeholders consulted

Country	Type of stakeholder	Stakeholder proposed	Contact person
Czech Republic[126]	Workers organisations	Odborový svaz zdravotnictví a sociální péče ČR [Health and social care workers Union] http://osz.cmkos.cz/	Name: Bc. Dagmar Žitníková Position: Předsedkyně odbrového svazu [Chairman] Address: Koněvova 54 130 00 Praha 3 e-mail: zitnikova.dagmar@cmkos.cz Name: Ing. Jana Břeňková Position: Místopředsedkyně odbrového svazu [Vice chairman]
		Lékařský Odborový Klub/Česká lékařská komora [Doctors Union/Czech Medical Chamber] http://www.lok-scl.cz/ http://www.lkcr.cz/aktuality-322.html	Name: MUDr. Miloš Voleman Position: Místopředseda Odborového klubu, [Vice Chairman of the Union] Člen představenstva Komory [Member of the Executive Board] Address: Drahobejova 52 190 00 Praha 9 e-mail: voleman@lok-scl.czmailto:zitnikova.dagmar@cmkos.cz
		Česká asociace sester [Czech Nurse Association] http://www.cnna.cz/	Name: Mgr. Dita Svobodová, Ph.D Position: Pracovní skupina pro kvalitu péče [Member of Working Group for quality]Náměstkyně pro nelékařská zdravotnická povolání Všeobecné fakultní nemocnice [Deputy for health care professionals other than doctors of the General University Hospital] Address: U Nemocnice 2 128 08 Praha 2 e-mail: dita.svobodova@vfn.cz
	Employer organisations	Asociace českých a moravských nemocnic [Czech and Moravian Hospitals Association] http://www.acmn.cz/	Name: MuDr. Lukáš Velev Position: Místopředseda Asociace [Vice chairman of the Association] Ředitel nemocnice Jihlava [Head of the Jihlava hospital] Address: Vrchlického 59 586 33 Jihlava e-mail: velevvl@nemji.cz
	Public 24-hour health and care institutions	Okresní nemocnice Jičín [Local Hospital Jičín] http://www.nemjc.cz/	Name: Ing. Dana Kracíková Position: Ředitelka nemocnice [Head of the hospital] Address: Bolzanova 512 506 43 Jičín e-mail: dana.kracikova@nemji.cz

[126] The Czech Ministry of Health was also included in the list of stakeholders and approached with a request to be consulted, but eventually indicated no interest to participate.

Country	Type of stakeholder	Stakeholder proposed	Contact person
			Name: Mgr. Jana Kučerová Position: Manažerka kvality [Head quality manager]
		Fakultní nemocnice Motol [University Hospital Motol] http://www.fnmotol.cz/	Name: Ing. Jindřiška Feldmanová Position: Personální náměstkyně [Personnel deputy manager] Address: V Úvalu 84 150 06 Praha 5 e-mail: jindriska.feldmanova@fnmotol.cz
	Labour inspectorates	Státní úřad inspekce práce [National Labour Inspectorate] http://www.suip.cz/	Name: Ing. Jana Bělíková Position: Inspektorka [Inspector] Address: Kolářská 451/13 746 01 Opava e-mail: jana.belikova@suip.cz
Denmark	Ministry of Health	Ministeriet for Sundhed og Forebyggelse [Danish Ministry of Health] http://www.sum.dk/	Name: Svend Særkjær Position: Afdelingschef [Head of Department] Address: Holbergsgade 6 DK-1057 København K e-mail: svs@sum.dk Tel: +45 72 26 94 20
	Workers organisations	Yngre Læger (YL) [Danish Association of Junior Hospital Doctors] http://www.laeger.dk/portal/page/portal/LAEGERDK/Laegerdk/Y_L	Name: Lene Esbensen Position: Forhandlingschef [Negotiation Manager] Address: Kristianiagade 12 DK-2100 København Ø e-mail: le.yl@dadl.dk Tel: +45 35 44 84 34
		Foreningen af Speciallæger (FAS) [Danish Association of Medical Specialists] http://www.laeger.dk/portal/page/portal/LAEGERDK/Laegerdk/F_A_S	Name: Helle Bjørnstad Position: Afdelingschef [Head of Department] Address: Kristianiagade 12 DK-2100 København Ø e-mail: heb.fas@dadl.dk Tel: +45 35 44 84 26
		Sundhedskartellet [`health cartel´] http://www.sundhedskartellet.dk/msite/frontpage.asp?id=46	Name: Helle Varming Position: Forhandlingschef [Negotiation Manager] e-mail: shk-hva@sundhedskartellet.dk Tel: +45 46 95 42 74 Name: Ulla Åkerlund Thomsen Position: Forhandlingsleder [Negotiation Manager] Address: Sankt Annæ Plads 30 DK-1025 København K e-mail: UllaThomsen@dsr.dk

Country	Type of stakeholder	Stakeholder proposed	Contact person
			Tel: +45 46 95 40 64
	Employer organisations	Danske Regioner [Danish Regions] http://www.regioner.dk/	Name: Signe Friberg Nielsen Position: Forhandlingsdirektør [Negotiation Manager] e-mail: sif@regioner.dk Tel: +45 35 29 82 35 Name: Ole Lund Jensen Position: Kontorchef [Head of Section] Address: Dampfærgevej 22 DK-2100 København Ø e-mail: olj@regioner.dk Tel: +45 35 29 81 97
	Public 24-hour health and care institutions	Rigshospitalet [main Danish hospital] http://www.rigshospitalet.dk/menu/	Name: Mette Risak Position: Personalechef [HR head] Address: Personaleafdelingen Afsnit 5212 Blegdamsvej 9 DK-2100 København Ø e-mail: personaleogjura.rigshospitalet@regionh.dk Tel: +45 35 45 52 12
		Nykøbing Falster Sygehus [regional hospital] http://www.regionsjaelland.dk/sundhed/geo/nykoebingfsygehus/Sider/default.aspx	Name: Michael Værnhøj Jørgensen Position: Stabschef [Head of Administration] Address: Ejegodvej 63, 2. sal DK-4800 Nykøbing F Fjordvej 15 e-mail: mvjo@regionsjaelland.dksif@regioner.dk Tel: +45 56 51 68 20
	Labour inspectorates	Arbejdstilsynet [Danish Working Environment Authority] https://arbejdstilsynet.dk/da/	Name: Anne-Marie von Benzon Position: Jurist [Lawyer] Address: Arbejdsmiljøfagligt Center – 4. kontor Landskronagade 33 DK-2100 København Ø e-mail: avb@at.dk Tel: +45 72 20 89 77
France	Ministry of Health	Ministère de la santé [French Ministry of Health]	Name: Isabelle Couaillier, Martine Hébard Position: Assistant director, HR hospital Head of Department] Address: e-mail: isabelle.couaillier@sante.gouv.fr
	Workers' organisations	INPH (Intersyndicale Nationale des Practiciens	Name: JM Badet Position:

Country	Type of stakeholder	Stakeholder proposed	Contact person
		Hosptaliers)	Address: e-mail:
		ISNI (Intersyndical Nationale des Internes)	Name: Emmanuel Loeb Position: Président Address: e-mail: secretariat@isni.fr
		Infirmières	Name: Position: Address:
	Employer organisations	FEHAP	Name: Sylvie Amzaleg Position: work relation director Address: e-mail: Sylvie.Amzaleg@fehap.fr http://www.fehap.fr/ Tel:+33
		ADRHESS	Name: Jérôme Sontag Position: DRH hopital de creteil Membre de l'ADRHESS Address: e-mail: jerome.sontag@chicreteil.fr Tel: +33
	Organisations	APHP	Name: Christian POIMBOUEUF Position: DRH Address: e-mail: christian.poimboeuf@sap.aphp.fr
Germany	Federal Ministry of Health	Bundesministerium für Gesundheit http://www.bmg.bund.de/	Name: Dr. Hiltrud Kastenholz Address: Rochusstraße 1 53123 Bonn e-mail: hiltrud.kastenholz@bmg.bund.de Tel:+49 228-99441-0
	Workers organisations	Marburger Bund Verband der angestellten und beamteten Ärztinnen und Ärzte Deutschlands e.V. (Association of Employed Physicians) http://www.marburger-bund.de/	Name: Ruth Wichmann & Christian Twardy Address: Reinhardtstraße 36 10117 Berlin e-mail: wichmann@marburger-bund.de Tel:+49 30 746846-0
		ver.di (United Services Trade Union) http://www.verdi.de	Name: Dr. Margret Steffen Address: Paula-Thiede-Ufer 10 10179 Berlin e-mail: margret.steffen@verdi.de Tel:+49 30 69 56-1811
	Employer organisations	Vereinigung der kommunalen Arbeitgeberverbände (VKA) (Municipal Employers' Association)	Name: Dirk Reidelbach Address: Allerheiligentor 2-4 60311 Frankfurt/Main e-mail: dirk.reidelbach@vka.de

Country	Type of stakeholder	Stakeholder proposed	Contact person
		www.vka.de	Tel:+49 69 92 00 47-57
		Deutsche Krankenhausgesellschaft (DKG) (German Hospital Association) http://www.dkgev.de/	Name: Marc Schreiner Address: Wegelystraße 3 10623 Berlin e-mail: dkgmail@dkgev.de Tel:+49 30 3 98 01 - 0
	Public 24-hour health and care institutions	Univeritätsklinikum Hamburg- Eppendorf (University Medical Center Hamburg–Eppendorf) http://www.uke.de/	Name: Gerhard Mentges Address: University Medical Center Hamburg-Eppendorf Martinistraße 52 20246 Hamburg e-mail: mentges@uke.de Tel:+49 40 741 05 65 06
Greece[127]*	Ministry of Health	Ministry of Labor, Social Security and welfare	Pantazis K. Special Secretary, Labour inspectorate
		Ministry of Health	Kontozamanis V., General Secretary, Formerly Governor of 1st Health area
		Ministry of Health	Raidou, F, (contacted) General director for administration
	Regional healthcare	Regional Authority	Zotos S., Deputy Governor of 1st Health District
	Employers' and scientific organisations	Panhellenic Medical association	Vlastarakos M., President
		Greek Union of Private Clinics	Sarafianos, G, President
	Public 24-hour health and care institutions	Large Hospital (Σωτηρία)	Senior Doctor (anonymous)
		Large Hospital (Sismanoglio)	Senior Doctor (anonymous)
	Workers' organisations	Greek Union of Nursing staff (ENE)	Daglas, A, (Bizas, L), General Secretary
		Hellenic Federation of Employees of Hospitals of Public Sector (ΕΙΝΑΠ)	Pagoni, A., President, Coordinating Director of Pathological Clinic, G Gennimatas Hospital
		Hospital Workers Federation (ΟΕΝΓΕ)	M. Varnavas, President
		Public Hospital Federation (ΠΟΕΔΗΝ)	Giannakos M., President
	Individual healthcare experts	Health Expert	Elpida Pavi, National School of Public Health
		Health Expert	Kyriopoulos J., National School of Public Health
		Health Expert	Filalithis T., University of Crete

[127] The questionnaire was also sent to individuals from 3 large hospitals (2 in Athens 1 in Herakleion), the Regional Health Authority in Crete, a Health Centre near Herakleion and the Presidents of the Athens and the Herakleion Medical Associations. Due to absences for the holiday period and despite repeated reminders, it was not possible to complete interviews in the allotted time.

Country	Type of stakeholder	Stakeholder proposed	Contact person
		Health Expert	Polyzos N., Professor of health policy / former General Secretary of the Ministry of Health 2009-2011
Hungary	Department of Health	Ministry of Human Resources (Emberi Erőforrások Minisztériuma)	Dr Gábor Zombor, Secretary of State Responsible for Healthcare 1051 Budapest, Arany János u. 6–8., tel: +36 1 795 1100
	Workers' Organisations	Hungarian Medical Chamber (Magyar Orvosi Kamara)	Dr István Éger, President 1068 Budapest, Szondi u. 100., tel: +36 1 269 4391, email: elnok@mok.hu
		Association of Resident Doctors (Rezidensszövetség)	Dr Tamás Dénes, President 4032 Debrecen, Móricz Zsigmond krt. 22., tel: +36 52 411 717, email: rezidens@gmail.com
		Democratic Trade Union of Hungarian Employees Working in Health and Social Sector (Egészségügyben és Szociális Ágazatban Dolgozók Demokratikus Szakszervezete)	Dr Ágnes Cser, President 1051 Budapest, Nádor u. 32., tel: +36 1 269 1235, email: info@mszeddsz.hu
	Employers' organisations	Hungarian Association of Hospitals (Magyar Kórházszövetség)	Dr György Velkey, President 1113 Budapest, Ibrahim u. 19., tel: +36 1 214 5118, email: korhazszovetseg@invitel.hu
	Public 24-hour health and care institutions	Uzsoki Hospital (Uzsoki Utcai Kórház)	Dr Andrea Ficzere, General Director 1145 Budapest, Uzsoki u. 29-41., tel: +36 1 467 3700, email: uzsokihospital@uzsoki.hu
		Saint John and North-Buda Hospitals (Szent János Kórház és Észak-budai Egyesített Kórházak)	Dr Tibor Kázmér, General Director 1125 Budapest, Diós árok 1-3., tel: +36 1 458 4500, email: foig@janoskorhaz.hu
	Labour inspectorates	Hungarian Labour Inspectorate (Nemzeti Munkaügyi Hivatal Munkavédelmi és Munkaügyi Igazgatósága)	Dr József Bakos, Deputy General Director 1106 Budapest, Fehér u. 10., tel: +36 1 433 0402, email: mmi_foigazgato-helyettes@lab.hu
Italy [128]	Workers organisations	CGIL Confederazione Generale Italiana del Lavoro [Italian General Confederation of Work][129] www.cgil.it/	Name: Enzo Bernardo Position: Responsible for International policies Name: Nadia Pagano Position: CGIL international policies Name: Massimo Cozza

[128] The Italian Ministry of Health was also included in the list of stakeholders and approached with a request to be consulted, but eventually indicated no direct involvement in the topic.
[129] Due to the importance of the topic CGIL organized a meeting with all people in the list, therefore data were collected through an interview to a grous of people: a focus group.

Country	Type of stakeholder	Stakeholder proposed	Contact person
			Position: General secretary CGIL medical doctors Name: Denise Amerini Position: CGIL bargaining in health sector Name: Antonio Marchini Position: CGIL expert on health policy Address: Via Leopoldo Serra 00153- Roma - Italy e-mail: bernardo@fpcgil.it
		CISL Confederazione Italiana Sindacati Lavoratori [Italian Confederation of Unions Workers] http://www.fp.cisl.it/	Name: Daniela Volpato Position: National secretary Name: Biagio Papotto Position: Medical doctors CISL Address: Via Lancisi, 25 - Roma e-mail: daniela.volpato@cisl.it
	Employer organisations	ARAN Agenzia per la Rappresentanza Negoziale delle Pubbliche Amministrazione [Italian Public Administration Agency for Collective Bargaining] https://www.aranagenzia.it/	Name: Elvira Gentile Position: General Director Name: Marta Branca Position: National expert on public health sectors Address: Via del Corso, 476 00186 ROMA e-mail:branca@aranagenzia.it
		AICCRE, CEMR Italian Section.	Name: Samuel Dal Gesso Position: Regions Conference, health sector Address: Piazza di Trevi 86 00187 Roma e-mail: samuel.dalgesso@aomelegnano.it
	Public 24-hour health and care institutions	Azienda ospedaliera ospedali riuniti umberto I, Lancisi, Salesi – ancona [Local Hospital Ancona] http://www.nemjc.cz/	Name: Nadia Storti Position: Hospital Health Director [Head of the hospital] Address: Via Conca 71 60126 Torrette di Ancona, Regiona Marche. e-mail: n.storti@ospedaliriuniti.marche.it
		Marche Region, Health care sector	Name: Paola Maurizi Position: Regional coordinator for health services personnel Address: Via Gentile da Fabriano 3 Ancona e-mail: paola.maurizi@regione.marche.it
	Labour inspectorate	Ispettorato regionale del lavoro [Regional Labour Inspectorate] http://www.lavoro.gov.it/DRL/Marche/Pages/default.aspx	Name: Giovanni De Paulis Position: General Director of Marche Region regional labour Inspectorate Address: Via Ruggeri, 3 – 60131 Ancona

Country	Type of stakeholder	Stakeholder proposed	Contact person
			e-mail: drl-Marche@lavoro.gov.it
	Workers organisations	CGIL Confederazione Generale Italiana del Lavoro [Italian General Confederation of Work][130] www.cgil.it/	Name: Enzo Bernardo Position: Responsible for International policies Name: Nadia Pagano Position: CGIL international policies Name: Massimo Cozza Position: General secretary CGIL medical doctors Name: Denise Amerini Position: CGIL bargaining in health sector Name: Antonio Marchini Position: CGIL expert on health policy Address: Via Leopoldo Serra 00153- Roma - Italy e-mail: ernardo@fpcgil.it
		CISL Confederazione Italiana Sindacati Lavoratori [Italian Confederation of Unions Workers] http://www.fp.cisl.it/	Name: Daniela Volpato Position: National secretary Name: Biagio Papotto Position: Medical doctors CISL Address: Via Lancisi, 25 - Roma e-mail: daniela.volpato@cisl.it
	Employer organisations	ARAN Agenzia per la Rappresentanza Negoziale delle Pubbliche Amministrazione [Italian Public Administration Agency for Collective Bargaining] https://www.aranagenzia.it/	Name: Elvira Gentile Position: General Director Name: Marta Branca Position: National expert on public health sectors Address: Via del Corso, 476 00186 ROMA e-mail:branca@aranagenzia.it
		AICCRE, CEMR Italian Section.	Name: Samuel Dal Gesso Position: Regions Conference, health sector Address: Piazza di Trevi 86 00187 Roma e-mail: samuel.dalgesso@aomelegnano.it
	Public 24-hour health and care institutions	Azienda ospedaliera ospedali riuniti umberto I, Lancisi, Salesi – ancona [Local Hospital Ancona] http://www.nemjc.cz/	Name: Nadia Storti Position: Hospital Health Director [Head of the hospital] Address: Via Conca 71 60126 Torrette di Ancona, Regiona Marche. e-mail: n.storti@ospedaliriuniti.marche.it
		Marche Region, Health care	Name: Paola Maurizi

[130] Due to the importance of the topic CGIL organized a meeting with all people in the list, therefore data were collected through an interview to a grous of people: a focus group.

Country	Type of stakeholder	Stakeholder proposed	Contact person
		sector	Position: Regional coordinator for health services personnel Address: Via Gentile da Fabriano 3 Ancona e-mail: paola.maurizi@regione.marche.it
	Labour inspectorate	Ispettorato regionale del lavoro [Regional Labour Inspectorate] http://www.lavoro.gov.it/DRL/Marche/Pages/default.aspx	Name: Giovanni De Paulis Position: General Director of Marche Region regional labour Inspectorate Address: Via Ruggeri, 3 – 60131 Ancona e-mail: drl-Marche@lavoro.gov.it
The United Kingdom	Authorities	Department for Business Innovation and Skills, https://www.gov.uk/government/organisations/department-for-business-innovation-skills	Anonymous
		Health Education England	Anonymous
	Workers Organisations	British Medical Association (doctors), http://bma.org.uk/	Dr Mark Porter BMA council chair
		Royal College of Nursing (nurses), http://www.rcn.org.uk/	Kim Sunley RCN Senior Employment Relations Adviser
		Royal College of Surgeons of England, https://www.rcseng.ac.uk/	Anonymous
		Royal College of Physicians, https://www.rcplondon.ac.uk	Dr Andrew Goddard RCP registrar and senior officer
		UNISON (trade union representing miscellaneous workers in NHS), http://www.unison.org.uk/	Sampson Low – Head of Policy Alan Lofthouse - UNISON National Officer for ambulance members Gavin Edwards - National Officer
	Employers' organisations	NHS Employers, http://www.nhsemployers.org/	Eleanor Pattinson
		NHS European Office, http://www.nhsconfed.org/regions-and-eu/nhs-european-office	Kate Ling
		University Hospital Birmingham NHS Foundation Trust, www.uhb.nhs.uk/	Rona Miller, Head of Medical Resourcing

Appendix C Comments to the report

Czech Republic

The respondents in the Czech Republic have not provided comments to the report. Some have confirmed that they did not have comments and others have not come back with comments.

Denmark

The respondents in Denmark have not provided comments to the report. Some have confirmed that they did not have comments and others have not come back with comments

France

Comments to the report from respondents in France are listed below.

Madame,

Nous faisons suite à votre mail en date du 18 mars dernier. Nous avons bien pris connaissance du document que vous nous avez transféré et nous souhaitons attirer votre attention sur plusieurs points :

- Opt-out : le législateur français n'a pas utilisé la mise en œuvre de l'opt-out dans le Code du travail. En effet, les articles L. 3121-35 et L. 3121-36 du Code du travail prévoient que la durée hebdomadaire moyenne de travail ne peut excéder 44 heures sur une période de 12 semaines consécutives et en aucun cas la durée hebdomadaire sur une même semaine ne peut dépasser 48 heures. L'accord de branche UNIFED (la branche dont fait partie la FEHAP) prévoit une durée hebdomadaire de travail de 44 heures.

  Toutefois, en cas de circonstances exceptionnelles, certaines structures peuvent être autorisées à dépasser pendant une période limitée le plafond de 48 heures, sans toutefois que ce dépassement puisse avoir pour effet de porter la durée du travail à plus de 60 heures par semaine (article L. 3121-35 du Code du travail). Dans ce cas-là la dérogation à la durée maximale hebdomadaire absolue du travail est accordée par « directeur régional des entreprises, de la concurrence, de la consommation, du travail et de l'emploi ». Elle ne peut l'être qu'en cas de circonstance exceptionnelle entraînant temporairement un surcroît extraordinaire de travail. La demande de dérogation est adressée par l'employeur à l'inspecteur du travail. Elle est assortie de justifications sur les circonstances exceptionnelles qui la motivent et précise la durée pour laquelle la dérogation est sollicitée. Elle est accompagnée de l'avis du comité d'entreprise ou, à défaut, des délégués du personnel, s'il en existe (art. R. 3121-23 du Code du travail).

  L'article D. 3121-17 du Code du travail prévoit également qu'en cas d'urgence, l'employeur peut de sa propre initiative déroger à la durée maximale quotidienne de travail. Il doit immédiatement adresser une demande de régularisation à l'inspecteur du travail, en l'accompagnant :

  - de l'avis du comité d'entreprise ou des délégués du personnel ;
  - des éléments justifiant que la durée quotidienne de travail ait été allongée sans autorisation.

  Ainsi, les dispositifs précités sont très contraignants et en pratique il est quasi-impossible pour les employeurs de faire recours aux articles L. 3121-35 et D. 3121-17 du Code du travail précités. On ne peut donc pas dire que l'opt-out existe en droit du travail français.

- Dans notre secteur le temps de garde est entièrement assimilé à du temps de travail effectif (cf affaires SIMAP, Jaeger et Pfeiffer). Les horaires d'équivalence, tels qu'ils sont prévus par le Code de l'action sociale et des familles et le Code du travail, ne s'appliquent pas dans le secteur hospitalier et ne s'appliquent pas aux médecins. En pratique, très peu d'établissements adhérents font recours à ce dispositifs qui est, par ailleurs, très contraignant.

- Le Code du travail et les accords de branche UNIFED prévoient la même durée du travail pour les salariés de nuit et de jour.

- En ce qui concerne les forfaits en jours sur l'année, le recours à ce type de forfait n'est pas largement repondu dans le secteur car outre la nécessité de la conclusion préalable d'un accord collectif, la jurisprudence de la Cour de cassation en la matière a rendu ce dispositif très contraignant. Les employeurs qui y ont recours se font régulièrement condamner par les juges pour le non-respect de la réglementation relative à la durée maximale de travail, à l'amplitude, au repos …

Nous nous permettons également d'émettre une réserve sur les données chiffrées présentées dans votre étude car il n'est pas possible pour nous d'en vérifier l'exactitude.

Nous vous prions d'agréer, Madame, l'expression de nos sincères salutations.

Olga VILLE
Direction des relations du travail

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FÉDÉRATION DES ÉTABLISSEMENTS HOSPITALIERS & D'AIDE À LA PERSONNE PRIVÉS NON LUCRATIFS

Germany

Comments to the report from respondents in Germany are listed below.

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Bundesverband

Hauptgeschäftsführung

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Berlin, 9th February 2015

Study measuring the financial and organisational implications for public health care services from changes to the Working Time Directive 2003/88/EC

Comment of the Marburger Bund – Trade Union of salaried physicians in Germany

The Working Time Directive is an essential piece of health and safety legislation and is therefore of utmost importance for salaried doctors in Germany. Last summer the Marburger Bund participated in the above study even though we had the impression that the main focus of the survey is not on the health and safety aspects of employees and patient safety but on financial and organizational implications of possible changes to the directive. Furthermore we were concerned that the survey is conducted during the summer break with a tight deadline for responses.

We know that many trade unions in Europe had similar problems with the study and the European Federation of Public Service Unions (EPSU) sent a letter to the Commission on 15 October 2014 and voiced our concerns. Much to our surprise the Marburger Bund received the German report of the study (14 pages) on 2 February 2015 after office hours (07:35 p.m.). We were given the opportunity to send in comments, preferably in English, until 9 February(!). With such a tight deadline an in depth analysis of the report is not possible.

After our first reading we identified several points where our opinion was not given enough space, especially knowing how controversial certain aspects of the European Working Time Directive are between the social partners. Furthermore, we think that it is also difficult to assess the report not knowing more about the underlying research methodology.

We would be glad, if the Commission would give us a chance to discuss the conclusions of this study and possible changes of the Working Time Directive.

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Ressort 9 / Fachbereich 03
Gesundheit, Soziale Dienste
Wohlfahrt und Kirchen
Betriebs- und Branchenpolitik

Vereinte Dienstleistungs-gewerkschaft

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Datum 9. Februar 2015
Ihre Zeichen
Unsere Zeichen St/ögg

Kommentar zum Länderbericht Deutschland

Study measuring the financial and organisational implications for public health care services from changes to the Working Time Directive 2003/88/EC

Sehr geehrte Frau Sandow, zum Länderbericht Deutschland geben wir folgende Rückmeldung.

Organisatorische Anmerkungen

Bereits bei der Beantwortung des Fragebogens im Sommer hatten wir darauf hingewiesen, dass aufgrund der kurzen Frist und der Befragung während der Sommerpause, wo relevante Fachleute zu diesem Thema im Urlaub waren, nicht alle Fragen in der angemessenen Ausführlichkeit beantwortet werden konnten. Gerade wegen der großen Bedeutung, die die Arbeitszeitrichtlinie für die Beschäftigten in den Akutkrankenhäusern hat, ist dies höchst bedauerlich. Wir hatten gehofft, dass diese Einschränkungen im Rahmen der Studie offen angesprochen werden, da sie die Ergebnisse maßgeblich beeinträchtigen, was jedoch leider nur für die „enforcement authorities“ geschehen ist. Die Frist für diesen Kommentar ist mit vier Werktagen ebenfalls äußerst knapp, weshalb uns auch hier die nötige Zeit fehlt, den Bericht in der nötigen Tiefe zu kommentieren.

Inhaltliche Anmerkungen

Ebenfalls bereits im Sommer haben wir darauf hingewiesen, dass wir die Intention der Studie missbilligen, nur nach den finanziellen und organisatorischen Auswirkungen einer möglichen Revision der Arbeitszeitrichtlinie zu fragen. Regelungen zum Schutz der Beschäftigten sind teilweise komplex und die Einhaltung ist für die Unternehmen aufwändig und teuer, aber anders wären sie nicht wirksam (was den Unter- nehmen überdies anderweitig Kosten verursachen würde). Es handelt sich oft ab- - 2 - sichtlich um eine Begrenzung oder Verhinderung von Wettbewerb. Die Europäische Union hat zum Ziel, die Lebens- und Arbeitsbedingungen der Beschäftigten zu verbessern, in der Grundrechtecharta ist ein Recht auf gerechte und angemessene Arbeitsbedingungen mit begrenzten Höchstarbeitszeiten und Ruhezeiten festgeschrieben. Mit Blick auf die Arbeitszeitrichtlinie hat der Europäische Gerichtshof klar gesagt, dass die Ziele der Richtlinie – Sicherheit und Gesundheit der Arbeitnehmer – weit ausgelegt werden müssen, „dass sie sämtliche körperlichen und sonstigen Faktoren, die die Gesundheit und die Sicherheit der Arbeitnehmer in ihrem Arbeitsumfeld unmittelbar oder mittelbar berühren, insbesondere bestimmte Aspekte der Arbeitszeitgestaltung, erfassen. ...eine solche Auslegung kann sich zudem auf die Präambel der Satzung der Weltgesundheitsorganisation stützen, der sämtliche Mitgliedstaaten angehören; diese definiert Gesundheit als den Zustand des vollständigen körperlichen, geistigen und sozialen Wohlbefindens und nicht nur als das Freisein von Krankheiten und Gebrechen“ (Urteil Jaeger, Rn 93). Insofern muss die Änderungsnotwendigkeit der Richtlinie an diesen Zielen gemessen werden und nicht an ihren administrativen Kosten.

Neben dieser grundsätzlichen Kritik an der Ausrichtung der Studie zeigt sich nun, dass die Kosten der Umsetzung der Arbeitszeitrichtlinie unseres Erachtens insbesondere im ersten Teil der Studie (5.3) nicht nachvollziehbar dargelegt werden – und die finanziellen Vorteile überhaupt nicht berücksichtigt werden, wie die folgenden Beispiele zeigen:

Auf S. 79f wird behauptet, dass die in Folge des EuGH-Urteils zur Bereitschaftszeit notwendigen Änderungen zu einem deutlichen Anstieg der Krankenhausärzte und der Kosten geführt haben. Der Anstieg wird jedoch für den Zeitraum 2000-2008 dargestellt, obwohl die Neuregelung erst 2004 bzw. mit Übergangszeitraum erst Ende 2006 in Kraft getreten ist. Überdies wird bei der Berechnung weder beachtet, dass viele Ärzte einem Opt-out zugestimmt haben noch, dass die Kosten sinken würden, wenn der Fachkräftemangel durch attraktivere Arbeits(zeit)bedingungen entschärft würde. Auch die Kosten durch Krankenstand oder Kunstfehler, die – wie viele Studien zeigen – bei längeren Arbeitszeiten zunehmen, müssten in eine seriöse Berechnung einbezogen werden.

Die Erhöhung der Management- bzw. Verwaltungskosten durch die Umsetzung der Arbeitszeitrichtlinie werden ebenfalls nicht nachvollziehbar dargestellt, warum sollten die genannten über 100 verschiedenen Arbeitszeitmodelle einzelner Krankenhäuser auf die Richtlinie zurückzuführen sein? Auch unser Hinweis, dass die Organisation und Planbarkeit erleichtert wird, wenn in Folge guter Arbeitsbedingungen die krankheitsbedingten Fehlzeiten zurückgehen, wurde nicht aufgegriffen.

An verschiedenen Stellen wird darauf hingewiesen, dass die Regelung, dass die Anschlussruhezeit direkt im Anschluss an eine verlängerte Schicht genommen werden

muss, die Übergabe erschwert (z.B. S. 81 oben gleich zweimal hintereinander) – dies ist jedoch ein organisatorisches Problem und keines, das durch längere Arbeitszeiten gelöst würde, im Gegenteil, Übergaben durch übermüdete bzw. überarbeitete Beschäftigte sind sehr fehleranfällig, worauf wir in unseren Antworten verwiesen haben.

Schließlich ist der Hinweis, dass die Rekrutierungskosten für Ärzte durch die Umsetzung der Richtlinie gestiegen sind, ebenfalls mit einem deutlichen Fragezeichen zu versehen: Der Fachkräftemangel ist – wie wir in unseren Antworten ausführlich dar- 3 -

gelegt haben – nicht auf die Begrenzung der Arbeitszeit zurückzuführen, im Gegenteil: Einem Mangel an Beschäftigten im Gesundheitswesen kann am besten durch gute Ausbildungs- und Arbeitsbedingungen begegnet werden. Dazu gehört auch eine begrenzte, nicht gesundheitsgefährdende und verlässliche Arbeitszeit.

Bezüglich der finanziellen Vorteile begrenzter Arbeitszeiten wird nicht einmal der Versuch einer Schätzung unternommen, auf S. 85 wird nur darauf verwiesen, dass dies mehr eine Frage von „occupational health“ sei – wozu es allerdings eine Reihe von Studien und Daten geben würde, ebenso wir zur Frage der Patientensicherheit, die nachfolgend ebenfalls nur erwähnt wird. Es entzieht sich unserer Kenntnis, ob diese Fragen bereits bei der Beauftragung durch die EU-Kommission ausgeschlossen wurden, unseres Erachtens gehören sie jedoch zu einer seriösen Abschätzung von Kosten und Nutzen der Arbeitszeitrichtlinie notwendig dazu.

Insofern stimmen wir dem letzten Satz der Studie, dass es schwer ist mono-kausale Verbindungen zwischen bestimmten Richtlinien und der Beschäftigungssituation in Krankenhäusern herzustellen, nachdrücklich zu und fordern die Kommission auf, die vorliegende Studie bei ihren Überlegungen bezüglich einer Revision der Arbeitszeitrichtlinie nur unter großen Vorbehalten einzubeziehen.

Mit freundlichen Grüßen

Niko Stumpfögger

Greece

The respondents in Greece have not provided comments to the report. Some have confirmed that they did not have comments and others have not come back with comments.

Hungary

Comments to the report from respondents in Hungary are listed below.

NEMZETGAZDASÁGI
MINISZTÉRIUM
MUNKAERŐPIACÉRT FELELŐS HELYETTES ÁLLAMTITKÁR

Iktatószám: 71.../2015/Foglalkoztatás-felügyeleti Főosztály
Ügyintéző: dr. Járai József Krisztián
Telefonszám: 1 433 0396
Tárgy: 2003/88/EK Munkaidő-irányelv hazai végrehajtásáról szóló jelentés véleményezése

Kovács Lajos részére

European & Global Health Development Consultant
Managing Director at Derkon Management Consulting

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Tisztelt Kovács Lajos!

2015. február 1-jén kelt levelére való hivatkozással tájékoztatom, hogy az Európai Parlament és a Tanács a munkaidő-szervezés egyes szempontjairól szóló 2003/88/EK Irányelve (2003. november 4.) magyarországi végrehajtásáról szóló jelentéssel kapcsolatban a munkaügyi hatósági ellenőrzés tárgykörét érintően észrevételt nem kívánunk tenni.

Kérem tájékoztatásom szíves tudomásul vételét.

Budapest, 2015. február 03.

Üdvözlettel:

MINISZTÉRIUM * NEMZETGAZDASÁGI MINISZTÉRIUM JOGÜGYI FŐOSZTÁLY

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From: **Bencze László Tamás dr.** <tamas.laszlo.bencze@emmi.gov.hu>
Date: 2015-02-09 14:54 GMT+02:00
Subject: FW: FW: Member State Case Study - Working Time Directive 2003/88/EC
To: "lkovacs.derkon@gmail.com" <lkovacs.derkon@gmail.com>
Cc: "Páva Hanna Dr." <hanna.pava@emmi.gov.hu>, "Cserháti Zoltán dr." <zoltan.cserhati@emmi.gov.hu>, "Horváth Melinda dr." <melinda.horvath@emmi.gov.hu>,
"Mészáros Árpád Dr." <arpad.meszaros@emmi.gov.hu>, "Gellérné Dr. Lukács Éva Dr." <eva.lukacs.gellerne@emmi.gov.hu>

Tisztelt Tanácsadó Úr !

Köszönjük szépen, hogy rendelkezésünkre bocsátotta a tanulmány tervezetét. A tanulmánnyal alapvetően egyetértünk, csak néhány észrevételünk van, amelyeket az alábbiakban küldök angol nyelven.

Thank you for sending us the draft report. In general we find this analysis a correct one. We would only like to make a few comments:

In point 7.4.2 related to the opt-out where it is mentioned that no reliable data are available we would rather say that the information available is not complete. In our view this wording could be more balanced.

As regards points 1.6 and 7.4.2 we would like to note that Act No. XI of 1991 on the public administration of healthcare as amended in 2014, section 6 para 4 (points eb, ec, ed) requires healthcare service providers to send detailed information to the health authority on the type of employment of all healthcare workers as well as their working patterns and working hours, including the opt-out. Still, in practice these data are not yet up-to-date.

Amennyiben további kérdése van, kérjük, forduljon hozzánk bizalommal.

Üdvözlettel

Dr. Mészáros Árpád főosztályvezető-helyettes úr megbízásából

Dr. Bencze László

EU és nemzetközi referens

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Italy

The respondents in Italy have not provided comments to the report. Some have confirmed that they did not have comments and others have not come back with comments

United Kingdom

The comments received from respondents in the UK have been integrated into the chapter on the UK.

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