Case Studies
Health and Hospital Professions

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The hospital sector in Europe

Executive summary of the introductory report

1. Hospital systems across most of the EU have changed considerably since the early 80s. This has come about in particular through the introduction of technical support hubs which have maximized the rational use of facilities and least-cost profitability of material resources and labour employed. Advances in medicine, the emergence of new medical conditions, the resurgence of diseases thought to have been stamped out, but also the new needs thrown up by population change, along with cuts in health and social services budgets, have radically changed the structures and organization of the hospital care environment. This means the effects of hospital restructuring around planned highly-specialized units, a greater focus on the hospitals' treatment roles and the outsourcing of patient care for certain categories (dependent older people, psychiatric patients, drug addicts, etc.), and the emergence of newly-acquired industrial-style management methods.

More practically, it has meant cuts in hospital beds and the length of patient stays (with adverse outcomes for patients discharged too early) and a sharp rise in patient turnover, going in hand with deep cuts in health spending all round.

2. Hospitals are a *highly professionalized sector* with a wide range of responsibilities and functions focussed on individualized patient provision (intake, diagnosis, prescription, care, accommodation, etc.), but also other more collective/institutional tasks (maintenance, hygiene, education, research); carrying out all these tasks - some of which need to be coordinated - necessarily involves a large number of professionals from different training backgrounds, professions and statuses : managers, doctors, medico-technical support services staff, nurses, nursing assistants, ambulance support services, clerical staff, etc.

The *health sector* is a net *job creator* and one of the biggest employers in Europe; on average, it employs between 7 and 13% of the European workforce. Obviously, the exact figure varies with the services included in the health sector, which differ widely between Member States; the hospital sector alone employs between 2.9% and 5.5% of the Member States' workforce.

3. This introductory report focuses mainly on *hospital nursing and patient care staff* who were and still are the driving forces behind a wave of strikes and protests which have swept various European and non-European countries since the early 80s. This is not to say that other health sector workers are undeserving of attention. Be it doctors or medico-technical (laboratories, medical

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imaging, etc.) or logistical (catering, laundry, environmental support, patient transport, etc.) support staff, each class of worker in their own work environment has their own specific problems stemming from work organization, risk assessment and by extension, workplace health and safety, which need to be looked at.

The Dublin-based European Foundation for the Improvement of Living and Working Conditions' Eironline databank for the period 1998-2000 holds reports of a spate of strikes and protests over the past three years by nursing and patient care staff, but also other categories of hospital staff (laboratory technicians, doctors, etc.) up in arms *against working conditions* which are inconsistent with proper standards of patient care and comfort, and the personal lives of staff, *against work intensification* and the stress it causes, *against insecure jobs and terms of service, low pay and pay discrimination at a time of nurse and care staff shortages* in many European countries (Germany, Belgium, Denmark, Portugal, Greece, United Kingdom, Switzerland, Sweden, Norway).

These converging labour actions across northern and southern Europe are important in many respects; above all, it raises the question of setting up a *formal*, European-level *social dialogue* in the hospital sector. That said, what is certain is that the number and mix of players involved - trade unions and employers' organizations, public and private sector employers - does not simplify matters, not least given the initial hurdle to overcome of identifying the relevant representative organizations at European level.

4. General work organization in hospitals is characterized by different parallel organizations - clinical services, A&E, patient care units, medical laboratory services, logistical services, administrative services - whose work must be seamlessly joined-up or at least closely coordinated, while patient care units differ by speciality, type of patient treated, and work environment (staff resources, working hours, planning, working methods, certification).

In the hospital system, *time is a key organisational issue* on several levels. For the hospital as a whole, addressing the development of its services, economic strictures, emerging patient needs, advances in technology and treatments by adapting the time aspects of its organization : optimizing available resource use, extending the service life of costly equipment, reducing processing times, reducing the length of hospital stays, revamping services (meal and visiting times...). For patient care units, too, where it is a major concern for the workers stemming from the constraints of hospital activity and a tightly-organized work process.

Hospital activity is bound by multiple *constraints* : round-the-clock continuity of public service, staffing needs varying by the time of day, day of the week, time of year, imponderables and contingencies of all kinds : emergencies, individual needs and care requirements, changes in patients' conditions; the organizational and operating needs of round-the-clock shifts, therefore, has often made for hard working conditions and disruptions to staff's personal lives.

Women hospital workers are subject to specific working time constraints : irregular hours, night work, weekend work and over public holidays, early morning and evening shifts clash with family and social obligations. Unsocial working hours are compounded by other difficulties of physical, mental and psychic stress.

Time is a major issue in patient care units, because *it dictates the entire organization of the working day*. So, there is no consistency in working time over the day, week, or year. In a given morning's work, some periods will have more of an *organizational value* than others : doctors' rounds are a case in point. For example, in the fixed shift system, the morning shifts have more information than the others, and all important decisions are left to them. In the same way, a measure of consistency is imposed on the days of the week by the very way the service is organized, its type of activity, the dictates of its administrative or teaching requirements. Shift management is cardinally important both to structuring work and the personal life of caregivers.

Time management is also the source of deep-seated conflicts felt by workers : the desire to develop the relational aspects of caring and the lack of time which results from continual re-prioritizing and emergencies which re-define their short-term work allocation.

5. In this context, a major focus must be put on *work intensification* and *changing work content* as they affect the running of hospital services and patient care units. Work intensification affects the running of hospital services by preventing much essential coordination from being effectively carried out. Work intensification can significantly impact the transmission and acquisition of know-how, knowledge and skills in patient care units. Efficiency pressures, for instance, may leave incumbent staff no time to induct young and new employees. But the experience developed in nursing (especially in direct patient care), adeptness in care techniques (observing care techniques before using them properly) and being pitted against a wide range of situations are of incalculable value.

When added to the known hazards to which hospital workers are exposed and the potential interactions between these different risk factors (physical strains, exposure to biological and chemical agents, work-related mental, psychological and emotional stressors), work intensification leaves little time for getting on top of these occupational risks; it leaves little time for getting to grips with the workers' work activity, for communication and exchanges within work teams, especially during pre-shift handover briefings.

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