SERP

SOCIALLY RESPONSIBLE RESTRUCTURING PROCESSES – REINFORCEMENT OF THE ROLE AND CAPACITY OF WORKERS' ORGANIZATIONS

CHANGE

MANAGEMENT HANDBOOK

FOR EMPLOYEE REPRESENTATIVES

Sectoral Action Plan

for Health Services

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- General Workers' Union GWU (MT)
- Federation of Public Service Employees CGIL (IT)

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The European healthcare sector is facing structural challenges of historic proportions: the accelerated digitalisation of services, the organisational and human legacy of the COVID-19 pandemic, demographic pressures resulting from an ageing population, a chronic shortage of qualified staff, the economic consequences of global conflicts, especially in the Middle East and Ukraine, and the constant pressure to rationalise public spending. These phenomena drive continuous processes of reorganisation, mergers, outsourcing and downsizing, which have a profound impact on employees and the quality of services.

In the healthcare sector, changes have a special dimension because they also affect patients and society. The restructuring of the healthcare sector is not a one-off event, but a permanent state; these processes occur almost continuously, causing organisational uncertainty and anxiety among employees.

In such conditions, the role of employee representatives is not only protective but also strategic — they are the first to notice the signs of change, understand the realities of work and are able to identify solutions that combine the interests of employees with those of patients. Trade union representatives are the closest representatives to employees: they know the realities of the workplace, recognise the signs of change, and have the mandate and legal tools to intervene.

The handbook you are holding is intended to support you in this very role: it is designed to strengthen your competences, facilitate your actions and help you build a strong, constructive social dialogue. The handbook is the result of the joint effort of many experts and practitioners of social dialogue. It is intended for trade union representatives in the healthcare sector and aims to provide workers' representatives (trade union delegates, works councils, employee committees, employee councils) with practical, law-based guidance and tools to prevent, manage and influence the adverse effects of restructuring in the healthcare sector , while protecting employment, quality of service and patient safety.

The handbook was developed as part of the SERP project ("Socially Responsible Restructuring Processes – Strengthening the Role and Capacity of Workers' Organisations"), co-financed by the European Union. The handbook is intended to serve as an **operational guide** — not only for responding to crises, but for shaping restructuring in such a way as to protect employment, the quality of services and the well-being of employees, while at the

same time defending the public interest. The models, procedures and recommendations gathered here are intended to help in conducting restructuring processes in a responsible, predictable and partnership-based manner. The handbook aims to provide trade unions with a comprehensive operational framework that will allow the healthcare sector to be restructured with competence, timeliness and a strategic vision.

Together, we are building the foundation for a more fair, safe and sustainable future for healthcare systems.

CHAPTER 1

1. Standards for responsible restructuring in healthcare

1.1. E uropean and ILO standards

The standards for responsible restructuring based on the ILO and European frameworks include:

a. Basic definitions and scope

The standards of the International Labour Organisation (ILO) emphasise that healthcare is a key segment of the economy, encompassing activities related to human healthcare, inpatient care, social work and the provision of medical services. The European Union (EU) places particular emphasis on cross-border operational continuity, infrastructure security and the secure, interoperable exchange of health data. The inclusiveness of employees adopts the ILO definition, according to which "healthcare workers" include both direct service providers (doctors, nurses) and all management/support staff (cleaners, administrators). In practice, this means that restructuring must take into account the full spectrum of professions operating in the healthcare system — not only those related to clinical activities, but also technical, administrative, support and logistics professions. Each of these groups has an impact on patient safety, the continuity of facility operations and the quality of services.

European standards also require that all forms of employment — full-time, contractual, outsourced or cooperative — be treated equally and transparently in change processes. Employment fragmentation must not lead to differences in access to information, consultation or legal protection. The inclusion of all groups of employees in social dialogue is a prerequisite for responsible restructuring. Trade union representatives should insist that international standards be applied as a minimum framework for all healthcare reforms.

b. Health and well-being in the workplace

- Preventive Environment Standards: ILO guidelines advise employers to maintain a safe, optimal physical and mental working environment.
- Holistic, well-being: EU policy is in line with the ILO to explicitly take into account technical safety and the direct impact of the working environment on social and mental well-being.
- Human-centred reorganisation: Restructuring must combine organisational changes with respect for workers' competences, working conditions and overall well-being.

ILO and EU standards indicate that the well-being of workers is the foundation for the stability of the healthcare system. This includes both physical and psychosocial safety.
Restructuring processes should take into account the risks associated with work overload, stress, burnout, shift work and pressure resulting from staff shortages.

In the context of digitalisation, technical and digital security is of particular importance: workplace ergonomics, data protection, transparency of monitoring systems and the right to disconnect. Technological transformation must not lead to an uncontrolled increase in workload or to a violation of the boundaries between work and private life.

c. Social dialogue and "just transition"

- Preventive participation: Trade unions are moving from a reactive approach to a model of active, early involvement, participating in the initial stage of problem diagnosis.
- Legal policy anchors: Protection for restructuring is strengthened by binding EU social directives (covering fair wages, wage transparency, occupational health and safety, and platform work) alongside the European Pillar of Social Rights.
- Principle of fairness: Based on the ILO's concept of "just transition" and the UN Sustainable Development Goals, restructuring is treated not only as a technical or quantitative exercise, but as a fundamental issue of social justice, where the costs cannot be borne by workers who are exposed to risks.

The above principles mean that trade unions should be involved at the earliest stage — before a draft of the changes is created. Early consultation allows for the joint identification of risks, the design of action options and the assessment of the impact on employees and patients.
European standards require full data transparency: employers must provide unions with information on workload, patient safety, the risk of staff migration and the economic impact of planned changes.
The principle of just transition means that the costs of restructuring cannot be passed on to the most vulnerable workers. Changes must be designed to protect employment, competences and working conditions, while supporting systemic objectives.

1.2. Sectoral standards in healthcare

Sectoral standards in healthcare require that restructuring decisions be based on objective indicators — such as turnover, number of vacancies, overtime or workload measured by time per patient. This data makes it possible to assess real systemic risks and prevent irresponsible staff cuts. Controlling burnout is a key element of responsible restructuring. This means the need to introduce workload limits, monitor overtime and provide psychological and organisational support.
European standards also emphasise the need to eliminate contractual dumping – a situation in which employees perform the same work under extremely different conditions. Insourcing is indicated as the preferred direction for reorganisation, as it strengthens employment stability and the quality of services. Building employee-patient alliances is also an important

element: linking working conditions to patient safety strengthens the arguments of trade unions and counteracts anti-union narratives.

Sectoral standards for healthcare restructuring:

- Data-driven employment: Employment and safety thresholds must be based on objective indicators on the dashboard (such as turnover, freedom and minutes worked per patient), not on arbitrary cost cuts.
- Burnout control: Restructuring must enforce strict workload limits and guarantee the "right to disconnect" when implementing telemedicine and digital tools.
- Uniform contractual protection: The standards call for an end to dumping and contractual fragmentation, ensuring equal protection for public, private and cooperative employees working in the same departments.
- Insourcing instead of outsourcing: Reorganisations favouring insourcing and permanent, stable employment instead of cheap external contracts.
- Employee-patient alliances: Structural links with public health outcomes, patient safety and social alliances to counter anti-union narratives.
- Strategic forecasting of the development of the healthcare system should take into account demographic and migration trends.
- Key principles: continuity of care, patient safety, maintenance of key competencies, social dialogue, a fair transition and upskilling.
- Legal references: rights to information/consultation, collective bargaining, healthcare sector standards (hospital management rules, accreditation), national collective agreements, if applicable.
- Sectoral policy objectives: maintaining access to services, optimising resources without worsening working conditions, investing in staff development.

Fundamental PRINCIPLES guiding the approach to
socially responsible restructuring:

- Expectation: the union must be informed before decisions become irreversible.
- Participation: the union does not oppose change, but demands a say in its management.
- Employment protection: any restructuring process must maintain and, where possible, improve working conditions.
- Quality of services: restructuring must also be assessed in terms of its impact on the quality of patient care.
- Fairness: the costs of restructuring must not be passed on to the most vulnerable workers.

CHAPTER 2

Implementation of the Strategy for preparing trade unions for the restructuring of the healthcare sector – practical instructions and recommendations

The restructuring of any sector, and especially sectors of particular importance to the state and citizens, such as healthcare, should take into account the role of the social partners, the various stakeholders in the system, and in particular the representatives of employees and trade unions. The development and implementation of a strategy on changes related to the restructuring of the sector should be carried out at many levels - from European to national, taking into account the specific nature of healthcare systems.

2.1. The European context

Due to staff shortages of healthcare workers, the challenges of digital transformation, technological innovations, budgetary constraints and the changing needs of patients resulting from demographic changes, healthcare systems around the world, including in Europe, are undergoing significant restructuring processes. Trade unions must be active participants in these processes so that the necessary reforms are socially responsible, with the active participation of healthcare workers. The implementation of the Strategy in the European context requires a multi-layered approach that combines a European policy framework, data benchmarking, and targeted national and regional actions.

In the European context, restructuring is not a process left solely to national decisions. It is embedded in a broad set of EU directives, recommendations and social policy instruments. This means that trade unions should actively make use of European directives on working conditions, work-life balance, wage transparency, minimum wages or digital governance. These instruments are not just a backdrop — they are real negotiating tools that allow workers to be protected from the negative effects of reorganisation.

a. Anchoring measures in the EU social policy framework

Implementation is based on the adoption, during negotiations, of a broad legislative framework established at EU level to protect workers from negative consequences during structural changes.

This includes the following directives:

- Working conditions and work-life balance: using *the Transparent and Predictable Working Conditions Directive (2019/1152/EU)* and *the Work-Life Balance Directive (2019/1158/EU)* to shape reorganised roles.

- Fair remuneration and equality**:** *the Adequate Minimum Remuneration Directive (2022/2041/EU)* and *the Pay Transparency Directive (2023/970/EU)* to counteract wage reductions and contract dumping.
- Digital governance: Embedding the transformation of digital tasks and automatic monitoring in work- and society-related content in *the Artificial Intelligence Act (COM/2021/206 final).*
- Just Transition Framework: *the EU Pillar of Social Rights* and non-binding instruments such as *the Council Recommendation on access to social protection* and *the Recommendation on a just transition,* adopted to adapt local restructuring to ensure that workers do not bear unjustified costs of systemic changes.
- Use of EU funds for upskilling, digital transformation and public health projects; trade unions should follow calls for funding applications and influence the design of projects to include worker protection.
- Sharing best practices through European trade union networks and social dialogue platforms in the healthcare sector.
- Advocating for EU-supported safety nets (retraining, mobility support) in the event of restructuring at the national level.

In practice, this means that trade unions need to use Eurostat data, Cedefop analyses and early warning panels. Benchmarking allows national employment rates, workloads, service availability or health outcomes to be compared with EU averages. This allows unions to demonstrate that local problems are not incidental, but part of broader European trends – which strengthens their arguments vis-à-vis governments and employers.

b. Use of EU-wide data benchmarking

Trade unions must move away from purely reactive initiatives and design credible and authoritative European data to strengthen their negotiating positions:

- Eurostat & ECHI: Use *the facts and data from Eurostat Health in the European Union* and *the European Core Health Indicators (ECHI)* to compare national healthcare funding, staffing capacity and patient treatment outcomes with EU averages. This links frontline working conditions directly to broader public health priorities in the eyes of governments.
- Early Warning Panel: Implement a standardised panel modelled on EU benchmarks to identify system fragility before restructuring begins. For example, if the number of nurses in a region falls below or vacancy rates exceed the EU average, the strategy mandates that restructuring be halted until mitigation plans are negotiated.
- Forecasting (anticipation) toolkits: Implement European labour market tools, such as the forecasting methods used in *Cedefop's competency forecasts* and task-based vulnerability analyses, to predict how technological changes will alter jobs in healthcare.

c. Navigating the realities of Member States

Moving away from the European perspective, implementation must adapt to the contrasting dynamics between different EU Member States and candidate countries:

- Addressing the "push and pull" dynamic: Solutions must take into account the fact that some countries (such as Malta) are actively attracting foreign healthcare workers to alleviate staffing crises, while other countries (such as Serbia or Bulgaria) are struggling with mass emigration due to low wages, leaving an ageing workforce working in multiple positions. Implementation means prioritising integration and retention in "pull" countries, and wage competitiveness in "push" countries.
- Bridging the digital divide: In countries lagging behind in the EU's Digital Decade goals, where basic digital skills are low, implementation requires trade unions to negotiate specific funding for local, hands-on digital training during regular working hours to catch up.

Europe is not uniform: some countries are struggling with the mass emigration of healthcare workers, while others are actively attracting staff from abroad. In some countries, basic digital competencies are lacking, while in others, the implementation of e-health is advanced. Trade unions must therefore employ different tactics — from negotiating training programmes to working towards wage competitiveness or counteracting territorial inequalities.

d. Implementation of a phased implementation timeframe

The European Union must manage the restructuring process through a strict, multi-year schedule so that changes are controlled rather than spontaneous.

MULTI-ANNUAL RESTRUCTURING SCHEDULE
is as follows:

- Short-term (0–12 months):

Identification and training phase – trade unions build internal capabilities and map the existing workforce/staff, regional technical capabilities and the actual scope of local outsourcing.

- Medium-term (12–24 months):

Offensive negotiation phase – trade unions start regional negotiations to manage the allocation of funds, launch nationwide campaigns for extraordinary employment and strongly push for the insourcing of services.

- Long-term (36+ months):

Systemic stabilisation phase – trade unions assess decentralised achievements to develop future national demands for collective bargaining, adapt employment to demographic trends, and institutionalise ongoing monitoring of patient safety.

e. Transition from confrontation to social partnership

The primary and hegemonic operational objective in Europe is the early establishment of an institutional, tripartite social dialogue.

- Early intervention: trade unions must be involved in the work at the *problem diagnosis stage,* before the final draft change is developed, ensuring equal access to data and scenario analyses.
- Legal protection against unilateralism: European unions should seek to adopt the Italian model of using a legal framework to block or modify corporate reorganisation plans implemented without union consultation, bypassing dialogue.

The main TOOLS for implementing the Strategy at the European level should include:

- **strengthening European social dialogue** through active participation in sectoral social dialogue committees and cooperation with European sectoral trade union federations,
- **monitoring European Union policies and initiatives** related to the development of healthcare personnel, digitalisation, occupational health and safety, skills development, and social protection and assistance,
- **exchange of good practices** between trade unions from different countries regarding restructuring processes, collective bargaining, employee retention and labour market planning,
- **promoting a preventive approach** that allows trade unions to identify restructuring risks in a timely manner and propose solutions before negative consequences arise,
- **utilising the possibility of financing** capacity-building training from EU funds and promoting projects in the field of social dialogue and staff development,
- **supporting the concept of lifelong learning and retraining** so that healthcare workers can adapt to technological and organisational changes,
- **advocating for high-quality employment standards** and decent working conditions in healthcare systems across Europe.

Practical RECOMMENDATION for implementation!

National healthcare trade unions should establish regular channels of communication with European trade union organisations and appoint representatives responsible for monitoring European trends and providing relevant information to trade union members and employees.

2. 2. The level of individual countries – project partners

a. Multi-layered institutional governance

At the national level, implementation requires structured coordination between the various institutional levels to prevent harmful restructuring. Selected examples from project partners include:

- Three-level model (Serbia - RS):
  - *strategic level:* The Ministry of Health defines national priorities, the regulatory framework and the overarching strategic objectives of the reform.
  - *operational level:* The funding institution manages financial flows, deals with service contracts and monitors the performance of health facilities.
  - *institutional level:* Individual health centres, clinics and hospitals implement operational activities, drive quality improvement and ensure the rational use of resources.
- Task Force Model (Italy - IT): Implementation is based on the establishment of a permanent national/regional "*Restructuring Task Force". Restructuring".* This body monitors the evolution of regional healthcare plans and provides uniform, consistent guidelines to local workplace representatives (RSUs), ensuring that individual hospitals cannot violate collective national standards.
- Tripartite Consultation Model (Malta - MT): National implementation through central bodies, including the Malta *Council for Economic and Social Development (MCESD).* This facilitates structured, tripartite cooperation between trade unions, employers' associations and government ministries to influence national economic and social policies. It shifts the country from a conflictual capital-labour relationship to a silent social partnership.

b. Examples of practical implementation tactics by country

Different national realities impose different political and organisational tactics that trade unions must adopt:

POLAND (PL): Multi-variant diagnosis and early involvement

- Co-designing reforms: National good practices require the Ministry of Health, the National Health Fund, local governments and trade unions to be involved as social partners at the stage of the initial diagnosis of the problem.
- Data-driven prerequisites: Restructuring cannot start with a "ready-made" project; instead, national authorities must provide trade unions with full access to data and impact analyses concerning workload, patient safety and the risk of staff migration.
- Rejecting "take it or leave it" proposals – The management board and local authorities must present *several variants of* the restructuring plan, not one final proposal, which allows teams to co-create safer solutions.

ITALY (IT): Legal protection and combating contractual dumping

- Legal action against "bypasses": When national or regional healthcare administrations try to unilaterally implement corporate actions or reorganisation plans without prior union consultation, unions take immediate nationwide legal action under Article 28 of the Workers' Statute to block or modify the plans.
- Fighting outsourcing: Unions focus national negotiations on creating a unique employment plan and aggressive "insourcing". This directly counteracts "contractual dumping" and the "war between the poor", caused by the coexistence of public health workers and private cooperative workers in the same departments under inferior contracts.

BULGARIA (BG) and MONTENEGRO (ME):
Addressing skills gaps and territorial injustice

- Combating the digital divide: Bulgaria ranks lowest in the EU in terms of average basic digital skills, and national implementation requires trade unions to negotiate specific funding for local, practical training entirely during working hours and paid for by the employer.
- Combating territorial inequality: In countries such as Serbia, where there are disparities in the distribution of doctors, the national strategy mandates the deployment of mobile teams and targeted incentive programmes to attract and retain staff in rural and less developed areas.
- Building national employee databases: In Montenegro, implementation focuses on creating an effective, quantitative national database that tracks employee qualifications, age profiles, health profiles and training needs in relation to the population in order to properly map requirements.
- Public alliances: To combat anti-union narratives triggered by public dissatisfaction with healthcare systems, unions must build broad civil society coalitions with patient

organisations, local NGOs and citizens' committees. By linking the well-being of workers directly to patient safety and quality of care, they present their worker demands as a defence of the wider public interest.

In BULGARIA (BG), the tasks are organised into six areas of activity:

- Organisational capabilities – building the internal strength of the Union through training, contacts with private hospitals and international participation.
- Social dialogue and collective bargaining – most urgently, the renewal of the expired sectoral CLA (which expired in April 2024), the formalisation of the procedural rules of the Branch Council, and the negotiation of a mechanism for the automatic indexing of clinical pathways.
- Human resources, wages and working conditions – mapping staffing gaps by region, negotiating the wage increase recommended in the report at 4-5% above the average, and fighting for clear standards for employment ratios in legislation.
- Legislative and regulatory actions – striving to remove clinical pathway limits, update health regulations from before 2000 and ensure the correct national implementation of the European Directive on Adequate Minimum Wages 2022/2041.
- Monitoring and measurement – building a framework of indicators explicitly recommended in the report (employment rates, labour costs, trade union density) and publishing annual monitoring.
- Digitalisation and preparation for the future – adding digital skills to trade union training, participating in health management and starting to prepare regulations on artificial intelligence and telemedicine.

IN ROMANIA (RO) Project partners, roles and coordination

- Identification of stakeholders: Ministry of Health, hospital management, county health authorities, Ministry of Labour, employment agencies, professional chambers, trade unions, patient representatives.
- Roles of representatives: early warning, information gathering, negotiation, development of protective measures, monitoring.
- Coordination mechanisms: joint working groups, tripartite steering committees, memoranda of understanding with employers/authorities, use of sectoral action plan channels to access technical assistance and funds.

c. Building public alliances and a counter-narrative

Since public dissatisfaction with national healthcare systems can easily be used as a weapon in anti-union rhetoric, implementation at the national level requires strategic public communication:

- Linking conditions to care: Unions must develop a common, nationwide narrative that directly links poor working conditions for healthcare workers (burnout, low pay, dual employment) to reduced patient safety and long waiting times.
- Leveraging the high credibility of staff: In the example of Poland, patients have a negative perception of the healthcare system, but at the same time they highly value the competence of doctors and appreciate their commitment. The national trade union strategy must use this high level of personal trust to build strategic alliances with patient organisations, citizens' committees and local NGOs. This presents union demands not as individual issues, but as a collective national effort to defend constitutional rights to healthcare.

It is also worth emphasising that the effective implementation of the strategy requires strong cooperation between national actors involved in health policy-making, labour relations, education and human resource development. Trade unions should work with project partners to ensure that restructuring processes are transparent, inclusive and socially sustainable. The key project partners should be:

- ministries responsible for health, labour, social affairs, education and finance,
- healthcare institutions and employers' organisations operating in the healthcare sector,
- national associations of employers in the healthcare sector, as well as professional associations and chambers of healthcare workers,
- educational and research institutions, faculties and schools,
- social dialogue bodies, various types of socio-economic councils,
- civil society organisations active in the field of healthcare and workers' rights, as well as patient associations,
- international and European partner organisations involved in social dialogue and the development of health personnel.

Practical steps for IMPLEMENTING THE STRATEGY
common to partner countries - should include:

- the establishment of a national coordination group that brings together all relevant project partners,
- familiarising everyone with the current situation in the field of public health,
- regular consultations on planned reforms and restructuring measures,

- developing joint action plans with clearly defined priorities, responsibilities, deadlines and expected results,
- establishing mechanisms for the exchange of information between institutions, employers and trade unions,
- organising training programmes for trade union representatives, employees and managers in the areas of change management and social dialogue,
- monitoring the restructuring process using defined indicators related to employment, working conditions, staff retention and the quality of medical services,
- evaluating results and exchanging lessons learned to improve future restructuring processes.

Practical RECOMMENDATION for implementation!

Trade unions should demand formal inclusion
in all stages of the restructuring of the healthcare system —
from planning and consultation to implementation and evaluation — so that the interests of employees and the quality of healthcare remain at the centre of the reform processes

CHAPTER 3

3. Change management model in healthcare

3.1. Guiding principles and stages of the change process (diagnostics and early warning signals, impact and risk analysis, design of change options, negotiations and consultations, implementation and monitoring, evaluation and adjustments)

GUIDING PRINCIPLES:

Restructuring must be a matter of "just transition" and social justice, where changes are predictable, transparent and avoid imposing costs on particularly vulnerable workers. It must combine organisational changes with strict respect for the well-being of employees, competence and patient safety.

Principles: transparency, timeliness, evidence-based decisions, participation, protection of vulnerable workers, ensuring patient safety and quality of care.

STAGES OF THE CHANGE PROCESS

- *Diagnosis and early warning signals:*

Social partners must be involved at the initial diagnosis stage before final decisions are made. Trade unions use data-driven "Early Warning" to detect systemic risks and launch joint mitigation plans. Early warning signs: failure to meet targets, budget cuts, use of external providers, recruitment freezes, changes in management positions.

- *Impact and risk analysis:*

Any potential change must be preceded by an objective scenario analysis assessing its specific impact on actual workload, patient safety, service availability and the risk of staff migration. Impact and risk analysis: employee profiles, patient safety, continuity of service provision, financial/legal risk.

- *Designing change options:*

The management board and public authorities must present multiple variants and different operational options for restructuring, instead of presenting a single proposal. These are the solutions that cause the least disruption (staff redeployment, versatile qualifications, part-time options, internal reorganisation).

- *Negotiations and consultations:*

These are formal information and consultation procedures, social dialogue forums and collective bargaining. Genuine consultations cannot be restricted by statutory time limits and

must last as long as necessary. Trade unions co-create through joint working teams, negotiating social packages, securing employment guarantees and responding to employee feedback.

- *Implementation and monitoring:*

Phased projects controlled by dedicated monitoring teams that prepare periodic implementation reports, preventing spontaneous or uncontrolled restructuring. Implementation and monitoring include, for example, agreed schedules, pilot projects, key performance indicators regarding quality and effects on employment.

- *Evaluation and adjustments:*

Signed agreements and their ongoing impact on working conditions are systematically evaluated at agreed intervals, allowing for data-driven process adjustments. Evaluation and adjustments include, among other things, post-implementation review, corrective actions, and grievance mechanisms.

3.2. Tools and working methods – analytical, communication and negotiation tools

a. Analytical:

- *"Warning dashboards":*

These are used to track employment thresholds (such as vacancy rates, turnover and overtime hours) against EU averages to identify systemic risks.

- *Forecasting models:*

The use of statistical and econometric methods to predict short-, medium- or long-term trends in the labour market and competence needs.

- *Task-based analysis:*

Analysis of specific tasks within healthcare roles using quantitative and qualitative data to estimate how susceptible a given position is to technological or organisational changes.

- *Monitoring:*

An internal tracking model used to aggregate regional data on actual staff shortages, overtime and unused leave to produce comprehensive national and company-wide reports.

- *Preventive impact and scenario analyses:*

Analytical studies conducted before a final decision is made, aimed at assessing the impact of the reform on workload, patient safety and staff retention. For example, discourse analysis: as

an analytical method used to study how public narratives are created and maintained, allowing unions to understand and counteract anti-union sentiment.

- *Extraction of documents and costs:*

Rigorous audits of public financial statements, local health authority payrolls and contracts to demonstrate the economic inefficiency of privatisation.

b. Communication tools and methods:

- *Strategic public alliances:*

Building joint local mobilisations, media campaigns and structured relationships with patient associations, citizens' committees and local NGOs to promote union proposals as nationwide health solutions.

- *Extensive listening campaigns:*

Focused internal communication activities aimed at gathering frontline opinions and increasing trade union rates in affected departments.

- *Crisis Communication Bulletins:*

Regular, transparent newsletters in paper or printed form for employees, describing the exact changes and reasons for the changes, as well as the progress of negotiations, to eliminate rumours.

- *Media and press campaigns:*

Targeted public relations strategies to break the professional isolation of medical staff and directly align worker protection with public safety.

c. Negotiation tools and methods

- *Preventive negotiations and advancement agreements:*

Transition to a proactive model in which unions negotiate social packages and staff limits before restructuring begins.

- *Joint working teams:*

Tripartite and multi-layered coordination groups bringing together union representatives, management, local government and independent experts at the initial stage of diagnosing the problem.

- *Court injunctions:*

Use of statutory rights to initiate proceedings against employers who carry out reorganisations without prior trade union consultation.

- *Independent mediation:*

Engaging neutral external experts and creating dedicated crisis teams to facilitate dispute resolution and prevent paralysis in the workplace.

- *National Training Plans:*

Implementation of specialised educational programmes aimed at certifying delegates in the process of collective redundancies, corporate finance and management so that they can negotiate independently.

CHAPTER 4

4. Operating procedures for employee representatives

4.1. Early detection / identification of changes

Effective representation begins long before formal restructuring decisions are made. The ability of employee representatives to detect signs of impending change early is crucial to ensure that employees are not faced with fait accompli situations and that their meaningful participation remains possible.

Employee representatives and trade unions should develop mechanisms to quickly identify organisational, technological and financial changes that may lead to the restructuring of healthcare institutions. Early identification allows trade unions to react in a timely manner and participate in the decision-making process. The competitive advantage of a trade union in managing restructuring depends not only on negotiating power, but on the ability to read early warning signs before company decisions become irreversible.

a. Transition to a preventive role:

Early detection allows trade unions to move from a reactive approach to a preventive role, enabling them to influence and shape healthcare restructuring before it is officially finalised.

b. Prediction toolkits:

Trade unions use labour market forecasting and task analysis methods (in line with ILO, IMF and OECD tools) to calculate the level of vulnerability of specific healthcare professions to upcoming technological or organisational changes.

c. Early warning dashboard:

A continuous tracking system that monitors key indicators such as vacancy rates, staff turnover and overtime. If these indicators point to "red" critical thresholds, the strategy requires that restructuring be halted until mitigation plans are jointly negotiated.

d. Use of practical knowledge:

Trade unions act as the main line of detection, actively monitoring workplace stressors in real time, such as significant increases in the length of junior doctors' shifts or accumulated unused holiday pay, which are early signs of burnout and system fragility.

e. Integration of problem and diagnosis:
Implementation of multiple scenario analyses to assess the impact of proposed changes on staffing levels, patient safety and staff retention.

f. Introduction of monitoring:
Regular review of financial statements, public procurement notices, minutes of management meetings, tender notices, IT procurement, and workforce data.

g. Creating an early warning checklist:
Factors requiring escalation (e.g., proposed transfer of services, contracts with external suppliers, employment freeze).

h. Building information networks:
Internal networks (colleagues, management) and external networks (local authorities, trade union federations).

Key early identification activities include:

- monitoring the strategic plans and policies of healthcare institutions and relevant authorities,
- analysis of changes in finance, work organisation and employment policy,
- monitoring legislative changes that may affect the position of employees,
- establishing regular communication with management and employees,
- identifying potential threats to employment, working conditions and the quality of medical services.

What may signal an upcoming restructuring: WARNING SIGNS
→ the sudden and unexpected appearance of organisational consultants or auditors
→ confidential meetings between management and heads of operational units
→ sudden suspension of purchases, staff replacement or recruitment
→ unexplained changes in patient flows or activity levels
→ announcements of an "organisational review" or "efficiency plan" in company communications
→ notices of tenders for the outsourcing of services traditionally provided internally → deterioration of employment indicators

→ legislative or political changes

Practical RECOMMENDATION for implementation!
Establish trade union teams to monitor changes and prepare periodic reports on potential risks associated with restructuring

4.2 Access to information

Effective participation of employee representatives in restructuring processes is only possible with timely access to information, in accordance with the rights arising from applicable legislation or collective labour agreements, if such are in force in the healthcare sector. The right of workers' representatives to timely, accurate and comprehensive information is the basis for real participation in restructuring processes.

Workers' representatives have the right to request:
→ information on planned organisational changes,
→ financial indicators affecting the functioning of the institution,
→ data on changes in the employment structure,
→ assessments of the impact of restructuring on the quality of healthcare, patients and employees,
→ information on plans for digitisation, automation and reorganisation of work,
→ access to statistical and comparative data,
→ the use of measurable indicators in social dialogue
The Implementation Strategy indicates:

a. **Elimination of information asymmetry:**

Access to data is a prerequisite for transforming trade unions from a reactive approach to an active role, ensuring that they are not invited to the table after restructuring decisions have been made.

b. **Early integration of diagnosis:**

True transparency requires that unions have full access to operational assumptions, data and analyses already at the stage of the initial diagnosis of the problem, before the final draft is even developed.

c. **Mandatory impact assessments:**

Access to information must explicitly include preventive impact and scenario analyses assessing how proposed changes will affect staffing levels, patient safety, access to services and the risk of staff migration.

d. **Obtaining financial and corporate data:**

Unions must have legal and structural mechanisms in place to extract internal documents, such as the actual costs of private contracts and wages, in order to independently analyse employers' claims regarding financial problems and prove the ineffectiveness of privatisation.

e. **Data aggregation and monitoring:**

The strategy requires the establishment of permanent bodies to monitor data collection (e.g. the Permanent Observatory in Italy) and national databases to track actual staff shortages, qualification levels, age profiles and regional institutional capacities.

f. **Mitigating internal rumours:**

Trade unions must establish constant communication with members through regular newsletters to share progress in accessing documents and protocols, otherwise the lack of information causes anxiety and spreads rumours.

Employees often notice organisational changes before they are disclosed: informal reorganisations, new IT procedures, the appearance of external consultants.

The trade union representative must establish channels for collecting these reports:

- regular meetings of departmental or operational units (at least quarterly),
- direct channels (WhatsApp messengers, dedicated email) for confidential individual reports,
- anonymous surveys on the perception of the organisational climate and expectations related to changes,
- regular discussions with representatives of regions who are open to dialogue.

How to exercise the right to information in practice? providing information

- **SPECIFY THE SUBJECT:**
  Specify precisely the required documents or information (e.g., the plan for reorganising the radiology unit, the three-year plan for staffing requirements for 2025–2027, the draft tender specification for outsourcing canteen services)
- **SUBMIT A WRITTEN REQUEST**:

Use registered email or a registered letter with confirmation of receipt addressed to the company's Management Board, and for information to the Human Resources Department. Always keep the acknowledgement of receipt.

- **INDICATE THE LEGAL BASIS**:
  Refer to a specific article, e.g., the Collective Labour Agreement or the relevant law regulating access to documents.
- **SET A DEADLINE:**
  Ask for a response within, for example, 15 days or within the period specified in the relevant regulations.
- **IN THE EVENT OF NO RESPONSE OR REFUSAL:**
  Consider applying for access to administrative documents (for public institutions), appealing to the Ombudsman or initiating a trade union dispute.

Practical RECOMMENDATION for implementation!

The validity of formal information and consultation procedures must be respected, in accordance with the law, collective agreements and the principles of social dialogue

4.3. Assessment of the effects of restructuring

Before and during restructuring processes, employee representatives should assess the potential consequences for employees, services and the system as a whole. This analytical function is becoming increasingly important due to the multidimensional nature of restructuring in healthcare. It is therefore necessary to carry out a comprehensive assessment of the possible consequences.

In general, the assessment should include, among other things,

- **the impact on the number of employees**

Given the already critical staff shortage, any restructuring that does not take into account existing shortages risks accelerating the collapse of the system. Representatives assess whether the proposed changes assume realistic employment scenarios.

- **changes in work organisation, workplaces and job descriptions**

The common practice of compensating for staff shortages with overtime and paid on-call duty is documented as a cause of premature exhaustion and early departure from the profession. Representatives monitor and assess restructuring measures that could worsen this dynamic.

- **impact on occupational health and safety**

This includes monitoring compliance with medical standards, reporting incidents, adhering to labour law and health and safety regulations, performing work in a way that improves care or merely increases the administrative burden without adequate staff support.

- **financial and social consequences for patients – quality and availability of medical services**

Taking into account the geographical differences in the distribution of staff and medical facilities – with specialists concentrated in large cities and severe shortages in rural and remote areas – the representatives assess the restructuring measures in terms of their varying regional impact. Closures, mergers or reclassifications of facilities in underserved areas can have disproportionate consequences for the communities these facilities serve. Restructuring that shifts costs more onto patients is assessed for its impact on equal access and long-term use of the systems.

- **the need for additional training and professional development**

The lack of intergenerational continuity is considered a key structural risk. Restructuring proposals are assessed in terms of their ability to attract and retain younger professionals, including through appropriate mentoring structures, investment in training and additional remuneration.

Practical Recommendation for implementation

Take into account the opinions and role of experts in the fields of labour, healthcare, economics and occupational safety, as well as employee representatives, in the assessment of the effects of restructuring –
for the broadest possible context of the changes being introduced

When the effects are managed through early social dialogue, this process provides stable employment guarantees, protected career paths, a measurable reduction in work-related stress and the maintenance of clinical knowledge.

The strategy in this area emphasises:

a. Mandatory preventive analyses:

Restructuring plans can never be finalised without a preliminary assessment carried out at the stage of the initial diagnosis of the problem to measure the impact on staffing levels, patient safety, access to services and staff retention.

b. Documented negative consequences:

Uncontrolled, cost-cutting restructuring must be linked to employee burnout and "contract dumping", which divides employee rights and separates public employees from low-contract employees in cooperatives.

c. Social stratification of care:

When restructuring directs patients to the private sector, clear social inequalities arise, limiting access to healthcare for vulnerable groups who cannot afford such costs.

d. Quantitative tracking tools:

The strategy uses tools such as Early Warning and Permanent Observatories to continuously monitor system failure points in real time, such as a critical increase in staff turnover or excessive overtime.

GOOD PRACTICE

STEPS FOR A RAPID IMPACT ASSESSMENT

→ Identify the positions and services affected by the restructuring
→ Identify skills gaps and critical positions
→ Patient safety and continuity of care checklist
→ Economic impact on staff (loss of income, commuting)
→ Legal and collective agreement consequences

Result: a concise report on risks and risk mitigation measures, including options (transfer to other positions, training, reduction of working hours, voluntary transfers, early retirement, outsourcing with safeguards).

4.4. Negotiation of changes

Negotiations are the central operational mechanism through which employee representatives transform their information and analyses into specific safeguards and improvements for employees affected by restructuring. In healthcare, this happens at many levels: sectoral, company, legislative, and even political or European.

When restructuring is unavoidable, employee representatives should participate in negotiations aimed at protecting the rights and interests of employees. Trade union negotiations in healthcare restructuring cannot be purely defensive. A trade union that actively participates in change management through its own proposals and concessions achieves better results than one that merely objects.

The scope of negotiations may include:

→ preserving jobs where possible
→ measures to prevent forced redundancies
→ transfer of employees to suitable positions
→ additional training programmes and the possibility of retraining
→ severance pay and remuneration for employees affected by the changes
→ measures / tools to maintain the quality of healthcare

The key tools presented in the Strategy include:

a. Intervention at the diagnosis stage:

Negotiations must begin at the initial stage of diagnosing the problem, before ready-made restructuring projects are finalised, rejecting management's "take it or leave it" proposals.

b. Co-design through multiple options:

Trade unions must require employers to present multiple organisational options and scenarios instead of a single plan, allowing collaborative teams to cope with change.

c. Data-driven leverage:

Negotiating power strengthened through access to internal corporate documents (e.g., actual costs of private contracts) and the use of Early Warning Dashboard benchmarks to halt restructuring if system thresholds enter the "red" zone.

d. Mandatory protection in the workplace:

Negotiations must ensure social packages, including fixed-term employment guarantees, clear rules for employee transfers, a contractually enforceable "right to disconnect", and employer-funded training during working hours.

e. Legal protection against unilateralism:

If employers try to bypass social dialogue, trade unions should resort to national legal mechanisms to block or modify unilateral reorganisation plans.

f. Strategic Public Coalitions:

Trade unions must counter anti-union narratives by building broad alliances with patient associations and local NGOs, effectively presenting employee demands as a collective package for quality of care and patient safety.

Practical RECOMMENDATION for implementation!
Negotiations should be based on evidence, analyses and arguments showing the consequences of the proposed changes
for employees, patients and the healthcare system

Negotiating changes – the most important principles:

- PREPARATION: establishing objectives, alternatives, legal bases, limits that cannot be exceeded and desired compensatory measures.
- TACTICS: insist on joint impact assessments, phased implementation, pilot projects, binding commitments for retraining and redeployment, severance or compensation packages.
- EXAMPLE CLAUSES to be sought: guaranteed offer to take up a vacant position first, training plans with paid training leave, protection of terms of employment in the event of outsourcing, gender-sensitive measures, timetable with review points.
- If negotiations reach a DEADLOCK: use mediation, public campaigns, legal action and political engagement through industry bodies.

Decentralised negotiations at company level – *the Italian example*
In the event of restructuring, it may regulate:

- Managing redundancy: priority internal relocation pathways before redundancies, with a guarantee of maintaining qualifications
- Shift allowances: providing additional remuneration for employees subject to a significant reorganisation of the operating unit
- Training and retraining: mandatory company-funded training programmes for employees affected by a change of role or the introduction of new systems
- Working hours and shifts: review of schedule criteria during reorganisation, with a guarantee of consultation
- Flexible work / smart working: rules governing access for administrative and technical staff, with transparent and non-discriminatory criteria
- Enhanced trade union rights: additional hours of leave for trade union activities during periods of active restructuring

Negotiations at company level – *the Bulgarian example*

In individual healthcare facilities, trade union sections negotiate additional provisions, including, for example:

- Reimbursement of transport costs: at least 90% of commuting costs for employees whose place of residence differs from their place of work
- Financial assistance in difficult situations: support financed by the employer in the event of serious illness, major surgery or the death of a spouse, child or parent
- Professional liability insurance: compulsory "Professional liability of doctors and medical personnel" insurance financed by the employer
- Occupational safety rules: co-creation of rules and instructions on workplace safety with trade unions and occupational health services
- Severance pay rights: statutory severance pay upon retirement (2 months' gross salary or 7 months if the employee has worked for the same employer for the last 10 years) confirmed by collective agreements

4.5. Support for employees

The primary task of employee representatives is to provide practical support to employees affected by restructuring — whether through job loss, transfer to a more distant position, changes in working conditions or institutional transformation. During the restructuring process, trade unions should provide employees with continuous support in various forms.

Support can be individual (counselling, legal advice, job search assistance, CV workshops, mental health support) or group-based: collective retraining programmes, negotiation of transitional benefits, job fairs, support for occupational mobility. It is important to try to use public funds, e.g. from active labour market measures and EU retraining grants, and to encourage employers to co-finance training. It is also crucial to monitor the implementation of support measures and ensure binding commitments.

Practical RECOMMENDATION for implementation!
Building the capacity of the trade union activist base

The basic element of effective support for employees during restructuring is the competence of the trade union representatives themselves. The need to continuously improve the leadership, communication, knowledge and expert skills of trade union representatives, as well as to deepen their understanding of change management processes and the socio-psychological aspects of organisational transformation, should be emphasised.

This capacity-building programme includes:

a) lifelong learning programmes for trade union activists

b) the development of quality standards for social dialogue at the plant, national and transnational levels
c) creating a real-time data monitoring algorithm that uses measurable indicators as a tool for negotiation and decision-making
d) initiating a debate on an integrated quality management system for social dialogue at the transnational level

The aim of these activities is to ensure that union representatives not only react to restructuring decisions, but are proactive, well-informed and technically prepared participants in shaping the future of the healthcare sector in a socially responsible direction.

The main support mechanisms (examples) included in the Strategy:

a. Fully funded on-the-job training:
Mandatory refresher courses and training in digital applications should take place during regular working hours; the costs are borne by the employer.

b. Digital contract safeguards:
To protect workers from work intensification and the blurring of boundaries in telemedicine or smart working, unions must secure a contractually guaranteed "right to disconnect".

c. Comprehensive social packages:
Support must include fixed-term employment guarantees, clear rules for employee transfers, and structured retraining to ensure secure career continuity during the transfer.

d. Psychological and wellbeing care:
As organisational changes cause high levels of stress and burnout, the restructuring framework must include direct psychological support to help employees cope with the anxieties associated with changes in the workplace.

e. Protection of groups and regions for vulnerable people:
Unions must commit to defending highly vulnerable sectors (women, young people, migrants, atypical workers) and implement decentralised incentive programmes and mobile teams to support staff facing territorial inequalities.

f. Anxiety reduction and local empowerment:
Maintaining constant, transparent internal communication that eliminates rumours and anxiety, and intensive training of employees from the labour department in labour law and finance, ensures strong, local protection for employees.

CHAPTER 5

Scenarios and practical examples in individual countries

5.1. Hospital mergers / consolidations – risk analysis, options, negotiations, communication

Merging healthcare institutions/facilities is often done to rationalise costs, improve work organisation and ensure more efficient use of resources. This measure is particularly useful where there is a short distance between hospitals. However, caution should be exercised, taking into account the road infrastructure and accessibility for all users in the local community.

It is important to consider:

- risk analysis: job loss, increased workload, transfer of employees to other locations, reduced availability of medical services, decreased employee motivation.
- possible options / variants: voluntary transfers of employees, natural outflow of employees without the possibility of taking up a new job, internal redistribution of employees, additional education and professional development programmes.
- negotiations - employee representatives should request, for example, clear criteria for reorganisation, guarantees of continued employment, transparent procedures for the induction of employees, taking into account the distance between the place of work and the place of residence, family needs and the availability of other public services, e.g. for the youngest family members, and measures to protect working conditions. Negotiating points may concern elements such as: protection of workers' rights, recognition of length of service, rules for changing job grades, a policy guaranteeing employment in vacant positions as a priority, a clear timetable, and counselling for staff.
- communication: keeping employees regularly informed reduces uncertainty and resistance to change. These can be coordinated public announcements emphasising patient safety and staff protection, or meetings with employees.

There are examples of good practice in several European countries where trade unions have participated in the development of social plans enabling the redistribution of employees without forced redundancies.

a. Country-specific risks and scenarios – selected examples

In Poland (PL), hospital mergers/consolidations are the result of serious and systemic indebtedness in the hospital sector and financial liquidity imbalances, which make the public system inefficient. This creates situations in which procedures are financed below cost, which threatens to deteriorate the quality of services and underestimate the value of health services.

Trade unions in healthcare operate at two levels in the processes of ownership change and restructuring: at the local level – they negotiate social packages, oppose privatisation, and cooperate with local governments; and at the national level – they influence legislation, formulate demands in the Social Dialogue Council, and protect the public nature of the system and patients.

In Italy (IT), on the other hand, restructuring is based on staff facing limits on personnel expenditure. Consolidations risk professionals leaving the National Health Service (the public system) to re-employ themselves as freelancers, under contract agreements, with a significant increase in costs for the system.

Serbia (RS) and Montenegro (ME) - consolidations face serious geographical risks. In Serbia, the distribution of doctors is very uneven, and hospital mergers may cut off access for rural or declining populations.
Malta (MT) is dealing with the consequences of failed consolidations of public and private hospitals. For example, a large, 30-year concession of three large public hospitals collapsed after just 7 years, which highlights the risk of outsourcing basic infrastructure.

Bulgaria highlights very important risks for employees, patients and the entire system.
Risks for employees include:

- Job losses: A merger usually involves the rationalisation of duplicate administrative and support functions, which carries an immediate risk of redundancies for non-clinical staff.
- Demotion: Employees may be transferred to lower positions or to departments with a higher workload without a corresponding adjustment to their remuneration.
- Loss of protection resulting from a collective agreement: If the operating entity has a different collective agreement or none at all, the merged employees may lose their negotiated entitlements (seniority allowance, additional leave, reimbursement of transport costs).
- Geographical relocation: Consolidation of services in one area may require further travel by employees, which particularly affects rural and suburban employees.
- Increased workload: The remaining staff take on the number of patients from the merged facility without a proportional increase in staff numbers — which exacerbates the already critical dynamics of the shortage.

Risks to patients and services:

- Limited geographical access: The closure or downgrading of a facility in an area with insufficient service removes a key safety net, especially for emergency care.
- Quality disruptions: Transition periods carry the risk of misunderstandings, system incompatibilities and loss of institutional knowledge.
- Concentration risk: Excessive centralisation of services in large urban hospitals without adequate referral infrastructure exacerbates unequal access.

Systemic risks:

- Financial instability during the transition: Merger processes generate one-off costs (IT integration, legal restructuring, physical adaptation) that are rarely fully compensated within the public healthcare system.
- Political interference: In the Bulgarian context, hospital management is often subject to political pressure and ownership disputes, which may distort the rationale for consolidation.

b. Practical options and negotiations

In Poland (PL), during consultations on proposals for hospital reorganisation/consolidation, trade unions are legally obliged to express their opinion, especially at the initial stage of diagnosing the problem. In recent years, however, they have often been overlooked in consultations, which is a breach of social dialogue.

Italian Legal Veto: Italian trade unions (FP CGIL) use existing legal blocking mechanisms to stop or modify unilateral hospital reorganisations carried out without trade union consultation. They also mandate that digital/AI training take place during paid working hours.

Serbian-Montenegrin adaptation: Instead of completely closing facilities during mergers, practical proposals include transforming facilities in declining regions into smaller primary care centres supported by decentralised mobile medical teams.

Bulgaria highlights the options available to employee representatives:

→ Option A — Full opposition (refusal to engage)

A position of fundamental objection is justified when: the merger has no coherent clinical or financial justification. The consultation process is insufficient or the main factor seems to be a politically motivated transfer of assets rather than an improvement in services.

Risk: Opposition without constructive alternatives may lead to a loss of influence on the terms of implementation.

→ Option B — Conditional involvement

This is the most common and most productive approach. Representatives engage in the merger process provided that:

- a formal impact assessment covering employment, access to services and working conditions is commissioned and made available before any decision is taken;
- a binding social plan (a plan for the social consequences of restructuring) is negotiated, covering the terms of redundancies, retraining priorities and retraining entitlements;
- the existing terms of the collective agreement are maintained or improved in the merged entities;
- deadlines are extended to allow for genuine consultation, not just formal approval.

→ Option C — Proposals for alternative restructuring

Representatives may propose alternatives to a full merger, including:

- Functional integration without legal merger: joint specialisations, joint procurement or unified management while maintaining the legal existence and staffing of both facilities;
- Hub-and-spoke models: One main hospital providing highly complex services, with satellite facilities providing basic and emergency functions in under-served areas;
- Municipal co-investments: Involvement of local governments in subsidising services and recruiting specialists not covered by the public system framework.

c. Strategic communication

A negotiation strategy for employee representatives and preparation before negotiations are important.

Practical RECOMMENDATION for implementation ¡

Municipal hospital consolidation scenario - *good practice in Bulgaria*
COMMUNICATION STRATEGY

Internal communication (with members):

→ Early, honest communication about what is known and what is uncertain — silence breeds anxiety and rumours

→ Regular updates via the union newsletter, digital channels and district-level meetings

→ A clear explanation of the negotiation process and what the representatives expect on behalf of the members;

→ Individual support for members with specific concerns about relocation or change of role

External communication (with the public and authorities):

- Joint press releases with employers' organisations, if possible — presenting restructuring as a managed, responsible process rather than a crisis
- Cooperation with the city council and the regional health inspectorate on the implications of access
- Use of measurable access indicators (travel time to the nearest emergency facility, nurse-to-patient ratio) to highlight the human costs of poorly managed consolidation
- Participation in public consultations on the revision of health maps

Internal Crisis Bulletins: Lack of constant communication during hospital mergers leads to misinformation and misunderstandings. Unions must regularly inform employees by sending or distributing paper newsletters detailing what is changing and why.

Polish-Italian public narrative: Public dissatisfaction with healthcare systems is high in Poland, but trust in frontline staff remains high. Italian and Polish unions are successfully exploiting this by building strategic alliances with patient NGOs and social groups, clearly communicating that protecting employment standards and improving working conditions directly affects the quality of care and the health safety of patients.

5.2. Outsourcing of support services – assessment of the impact on quality, safety and working conditions.

Support services such as maintenance, cleaning, hospital laundry, catering or technical support are often outsourced. The impact assessment should cover: the quality of services provided, the safety of patients and employees, costs and long-term sustainability, the working conditions of employees transferred to a new employer, compliance with collective agreements (if any) and employee rights.

Trade unions can and should make demands, including: the protection of existing workers' rights, guarantees of employment stability, the maintenance and control of the quality of services, or precisely and transparently defined contractual obligations of service providers. In some countries, outsourcing contracts allow for the transfer of employees while maintaining basic rights and the continuity of long-term employment. For example, in Serbia, the outsourcing of these jobs took place in large hospitals, while at the same time preserving the jobs of employees and, in some cases, even increasing their wages.

a. Impact on the quality of services

The most common problems encountered in medical organisations after outsourcing concern:

- Canteen and catering services: Reduction in portion size, quality of ingredients, adherence to therapeutic diets and personalisation for patients with specific conditions (diabetes, coeliac disease, allergies).
- Cleaning and disinfection: Reduced frequency of disinfection, use of non-compliant products and insufficient training of contract staff in the performance of procedures and control of hospital-acquired infections; direct impact on patient safety.
- Support staff: Reduction in the overall level of employment, leading to an increase in the workload of the remaining support staff, fragmented coordination with permanent medical staff, and disruptions in patient relations.
- IT and infrastructure services: Reliance on external providers for the maintenance of clinical systems, with the risk of downtime, loss of internal knowledge and difficulties in managing cybersecurity incidents.
- Fragmentation of responsibility: When a cleaning company is contracted to manage infection control protocols, responsibility for compliance may be unclear or challenged during inspections or incidents.

- Lack of staff familiarity: Outsourced workers who rotate across multiple facilities have lower institutional knowledge and less familiarity with patients than permanent staff.
- Reduced investment in training: Contractors operating on low margins typically invest less in ongoing training and quality management than in-house departments.
- Risk of service disruptions: Labour disputes or contractor insolvency can cause sudden interruptions in service provision without an equivalent risk when services are provided internally.

Uncontrolled outsourcing through the cheapest contracts fragments the workforce. External contract workers with unfair, deteriorating or inferior contracts are introduced into the same departments as public employees. This creates a "war among the poor", undermines the general protection of employees and leads to the weakening of trade unions.

b. Impact on working conditions

Contract workers in medical services are among the most vulnerable groups in the labour market:

- The remuneration is different, often lower than that of a permanent employee in a healthcare organisation for equivalent positions; loss of benefits at the sectoral or company level under the collective agreement (seniority allowance, additional leave, transport subsidies, holiday bonuses).
- Contract instability: high frequency of forced part-time work, fixed-term contracts and agency work.
- Exclusion from company benefits: company nurseries, employee canteens, performance bonuses
- The risk of losing one's job with every change of contract, despite the social clause.
- Exposure to occupational risks that are sometimes not adequately assessed in the contractor's risk assessment document.
- Difficulties in gaining access to continuous professional development and career development.
- Medical support work involves contact with infectious materials, hazardous cleaning agents, the risk of manual handling and working independently in high-risk environments.
- Outsourced workers are often excluded from hospital-wide safety committees and incident reporting systems.
- Lower safeguarding of protective equipment and less rigorous monitoring of exposure are documented risks in outsourced medical support services.
- Contract fragility: Outsourced workers are typically employed on short-term or part-time contracts with less security.
- Social isolation: Outsourced workers are excluded from the organisational life of the hospital, professional development and occupational health services.

- Gap in trade union representation: Trade union rates among external workers are low, and trade unions' access to contractors' workplaces may be limited.

The strategy directly links the fragmentation of contracts and the destructuring of work organisation to a reduction in the quality of care and patient safety. It also notes that trade unions are often the first to signal that these restructuring measures actively threaten patient safety and the stability of medical teams.

c. Negotiating safeguards

Where outsourcing cannot be ruled out, employee representatives should negotiate the framework of the service level agreement included in the outsourcing contract, which includes:

- Minimum wage levels for transferred employees not lower than the applicable collective agreement of the company or sector.
- Retention of seniority and statutory leave entitlements for transferred employees.
- Access rights for trade union representatives to contract workers on hospital premises.
- Mandatory inclusion of external workers in the hospital's Working Conditions Working Conditions Committee of the hospital.
- Re-internalisation clause: if the contractor's performance falls below specified thresholds, the hospital is obliged to return the service to the company within a specified time.

Practical RECOMMENDATION for implementation ¡
Assessment framework for employee representatives
Before deciding on outsourcing — Preventive assessment

→ Request full disclosure of the cost analysis underlying the outsourcing proposal, including hidden costs (management costs, transition costs, quality monitoring, contractor margin), which are often overlooked in initial forecasts

→ Commissioning an independent quality benchmark comparing the standards of in-house and contracted services in comparable Bulgarian facilities

→ Assessment of the proposed contractor's infection control history in other contracts for healthcare facilities

→ Review the status of the contractor's collective agreement — whether it is valid and what its minimum wages are

d. Communication priorities

- Present the argument of quality and patient safety — this affects both hospital management and staff, as well as local communities and patients.

- Build alliances with medical and non-medical staff.

5. 3. Digitisation and AI implementation – changing roles, training, data protection, monitoring

The digitisation of healthcare systems and the introduction of artificial intelligence technology are the most common form of organisational restructuring in the coming decade. Clinical diagnosis support systems, next-generation electronic medical records, support robots in operating theatres, automated triage systems and chatbots for administrative functions in the administration office – these technologies are profoundly redefining tasks, processes and work organisation. Unlike traditional restructuring, digitisation is often gradual and quiet, making it difficult to recognise when a union needs to intervene. Digitalisation has been used for many years in healthcare facilities, especially in the fields of imaging and laboratory diagnostics, right up to interventional surgery procedures.

Thanks to good management, this has led to the optimisation of staff and the ability to provide health services in conditions of reduced interest in hospital jobs – thus compensating for staff shortages. In this area, it is worth pointing out the key issues: changes in job descriptions and work processes, the need for new digital skills, the protection of personal and health data, the transparency of algorithms, the impact of automation on employment, and the use of digital systems to monitor employees.

The priorities of trade unions should focus in particular on: involving employees in the planning of digital changes, providing appropriate training tailored to the capabilities of employees, protecting the privacy of employees and patients, clear rules and information provided to employees regarding the use of artificial intelligence, and maintaining human control over key decisions resulting from the use of artificial intelligence.

a. Training and strengthening professional competences

To prevent redundancies, unions must negotiate agreements that provide mandatory digital training and refresher courses during working hours, with the costs borne by the employer. Support in adapting to new technologies must make the adoption of technology a driver of salary increases and professional development.

Employee representatives should negotiate the following minimum standards in each digitalisation agreement:

- The employer's obligation to finance and conduct training before the launch of a new digital system — not after,
- Paid training time counted as working time, not as development volunteering,
- Differentiated training paths according to role and existing digital competences — without a one-size-fits-all approach,
- Retraining of employees whose roles have been significantly transformed by automation,

- Continuous refresher training as systems are modernised,
- The right to an appropriate transition period during which both the old and new systems operate in parallel.

b. Data protection and trust

In highly digitalised regions, cross-border data exchange and "e-health" platforms are strictly dependent on robust information security. Protection against data leaks is considered crucial for maintaining public trust, especially among vulnerable or older people who are already struggling with gaps in digital competences.

Employee representatives must negotiate explicit agreements regulating:

→ what employee data is collected, stored and for how long,
→ who has access to data on employee activity in the management hierarchy,
→ a ban on the use of automatic performance monitoring as a basis for disciplinary action without human control,
→ the employee's right to their own digital activity records,
→ collective agreement provisions explicitly addressing electronic monitoring

Training in the handling of patient data should be a prerequisite for access to any new digital system. Contracts with AI providers must include data processing agreements in accordance with the GDPR, with explicit restrictions on the secondary use of Bulgarian patient data.

The implementation of digital systems in healthcare creates new categories of employee data that did not exist before:

→ Activity logs: Electronic systems record every activity undertaken by an employee — login times, access to records, task completion. This data can be used to monitor productivity in a way that was not previously possible;
→ Location data: Mobile devices and electronic access systems generate continuous location data within the facility;
→ Performance metrics: AI systems can generate automatic assessments or performance flags based on employee behaviour patterns.

c. Monitoring and management

Trade unions must actively demand a regulatory and ethical framework for data rights, transparency and human oversight. The strategy assumes an interdisciplinary approach in which workers have a collective voice in shaping how AI systems are implemented and monitored to protect fundamental workers' rights and decent work.

For example, in Bulgaria, the aggravating factors are the low level of digital infrastructure in some public hospitals, the age profile of the workforce (a significant proportion approaching retirement age with limited digital experience) and the lack of a dedicated framework for the development of digital skills for healthcare workers.

The key elements of the current landscape are:

- Electronic health records: although an electronic health card system has been introduced, progress towards fully digital patient records in all institutions is slow and unstable,
- Telemedicine: use is uneven, with significant differences remaining between large urban hospitals and rural facilities,
- Patient records versus nursing reports: the introduction of patient records as a replacement for traditional nursing reports is a current and controversial issue — clinical staff are concerned that additional administrative requirements will reduce the time available for direct patient care,
- Artificial intelligence: AI applications in diagnostic imaging, clinical decision support and patient flow management are emerging in more technologically advanced private and university hospitals, raising questions about changing roles, responsibilities and monitoring, which are not yet sufficiently addressed by the regulatory framework.

In Italy, a trade union management strategy for technological innovation has been developed, based on four pillars: information, training, negotiation and monitoring – an example.

Professional profile	**The impact of digitalisation and the reactions of trade unions**
Administrative staff	Automation of booking, invoicing and document management processes. Reduction in the number of repetitive tasks, but risk of redundancies if not accompanied by retraining for supervisory, exception management and public relations roles.
Nurses and healthcare assistants	Introduction of remote monitoring systems, devices for collecting vital sign data and robots to support patient care. New responsibilities in data management and interpretation, the need for specialised training.
Healthcare technicians (radiology, laboratories)	AI systems for automatic reporting (e.g. automatic X-ray readings, digital histopathological analysis) significantly change the nature of the work.
Doctors and healthcare managers	Clinical Decision Support Systems integrate clinical knowledge with the analysis of large databases.

Professional profile	The impact of digitalisation and the reactions of trade unions
	The National Collective Labour Agreement must regulate responsibility for decisions supported by AI.
Support staff (canteen, cleaning)	Service robotics and order automation reduce the need for staff in some areas. The trade unions' response is to retrain staff for supervisory roles and patient contact.

5.4 Employment reduction – alternatives, protection packages, the right to retraining.

Before planning to reduce the number of employees, all possible solutions should first be considered, a survey should be conducted, and the most optimal solutions for employees should be chosen. Reducing employment should be a last resort, after exhausting all options for maintaining employment and professional development, but it is worth emphasising that in conditions of reduced interest in jobs in hospitals, digital transformation has had a positive effect. With natural turnover, if the restructuring process is carried out in a planned and systematic manner, there will be no redundancies. Some employees will opt for severance pay and reduced working hours. Employees usually do not want to leave a familiar environment in which they feel accepted and have support. Regular staff turnover should be an established practice in pre-restructuring circumstances, leading to an acceptable practice of changing jobs.

Before accepting a reduction in employment as a result, employee representatives should systematically explore and formally propose alternatives.

What employee representatives should negotiate – examples:

→ Retraining financed by the employer as a prerequisite — not an alternative — to redundancies: employees should not have to choose between retraining and a redundancy package,

→ Paid retraining leave: time spent in retraining programmes funded by the employer or agreed by employers should be remunerated at no less than the employee's average pay,

→ Access to programmes funded by national employment offices or employment agencies.

→ Recognition of qualifications: Retraining should lead to recognised qualifications (formal certificates),

→ Targeted retraining for shortage specialties: given the huge shortage of nurses, medical assistants, geriatric caregivers and emergency technicians, retraining programmes in these areas serve both individual and systemic interests.

In terms of restructuring alternatives, protection and retraining rights, the Strategy suggests:

a. Alternatives to staff reductions - The "last resort" principle

Adherence to the principle that collective redundancies and job cuts must be a last resort, to be implemented only after all available alternatives have been exhausted. This position is not ideological, but based on practical considerations: the loss of professional skills in the healthcare sector is difficult and costly to rebuild, and cyclical crises in this sector can lead to serious shortages of qualified personnel in the medium term.

- Redeployment and change of positions: redeploying employees to new, fair roles or reconfiguring service models instead of reducing positions, natural employee turnover, limiting new hires, voluntary departure with financial security, reduced working hours, internal redistribution of employees.
- Insourcing: launching strategic campaigns to reverse outsourcing in favour of stable jobs.
- The role of AI: using automation to handle routine tasks, which can reduce staff workloads and eliminate burnout without reducing employment.

b. Redundancy packages and employee protection

Before proceeding with compulsory redundancies, voluntary redundancy packages are negotiated, offering attractive terms for employees who choose to leave voluntarily.

Examples:

- Severance pay: a one-off amount negotiated under a trade union agreement, usually calculated as an additional monthly salary above the statutory severance pay. Trade unions should negotiate: fair criteria for determining which employees are made redundant, severance pay amounts exceeding the minimum conditions, additional financial resources or social security for vulnerable groups of employees.
- Maintenance of supplementary health insurance: extension for a specified period (6–12 months) of sectoral supplementary health insurance for the departing employee and their family.
- Outplacement: (CV preparation, coaching, access to corporate networks) paid for by the company for a period of 6–12 months.
- Early retirement: for employees approaching retirement, appropriate pension preferences agreed with the state insurer.
- Social packages: negotiating comprehensive social and protective programmes aimed at safeguarding existing employment conditions and career paths.
- Fixed-term guarantees: implementation of fixed-term employment guarantees to secure employment during organisational changes.
- Clear transfer rules: enforcing strict, transparent rules on employee transfers to prevent unfair contracts and the fragmentation of employee rights.

- Psychological support: providing a dedicated mental health and counselling framework to support employees struggling with the stress of restructuring.
- Continuation of occupational health protection: extending access to occupational health services for a specified period after employment

c. Right to retraining

Professional retraining is a fundamental tool for maintaining employment by adapting the skills profile of employees affected by restructuring.

This means:

- Learning during working hours: mandatory refresher and updating courses, as well as training in digital applications, take place during working hours.
- No costs on the part of employees: all training costs must be fully covered by the employer, secured in company funds.
- Assistance in the transition to a new career: establishment of structured career counselling and long-term continuing education systems to ensure employment stability.
- The right to professional retraining: employees should receive, for example, free training programmes, professional counselling, the opportunity to acquire new qualifications or be given priority when recruiting for new positions.
- Contractual recognition of the right to retraining as an alternative to dismissal
- Obligation for the company to submit, at the same time as the notice of dismissal, a retraining plan specifying the target roles.
- Priority access to retraining programmes for redundant employees over external recruitment.
- Guarantee of continued remuneration during training periods.
- Assessment of new skills acquired for the purposes of classification within a new professional profile.

d. Voluntary reduction of working hours (solidarity hours)

One of the most effective alternatives to downsizing is an agreed reduction in working hours applied to the entire workforce or within specific organisational units. A trade union agreement on working time solidarity may provide for:

- temporary reduction of working time under contracts with partial supplementary remuneration.
- conversion of full-time contracts into horizontal part-time contracts on a voluntary basis, with the right to return to full-time work after the end of the state of emergency.
- the use of training funds (at national or company level) to finance reduced working hours through training programmes.
- company incentives for employees who accept voluntary restrictions (bonus for participation, additional flexibility).

e. Financial and structural alternatives

- Revenue optimisation: are all available clinical pathways reported? Are eligible applications for national programmes being used?
- Consolidation of procurement: joint procurement with neighbouring facilities can reduce operating costs without affecting the number of employees.
- Debt restructuring: cooperation with the Ministry of Health or the municipal owner to restructure debt in order to reduce liabilities due
- Employment programmes: subsidies for employers to maintain at-risk employment are available under active labour market policies or National Employment Action Plans.

f. Communication in situations of staff reduction

Internal — support for affected employees:

- immediate, individual communication with each affected employee — do not allow management to be the only source of information,
- explain clearly what the consultation process means and what it can achieve — employees must understand that the outcome is not yet determined,
- organise individual counselling sessions on individual rights, options and next steps,
- connect affected employees with the relevant Employment Agency office for individual career advice as soon as possible.

External — managing the broader narrative:

→ present the situation as a systemic policy failure (underfunded clinical pathways, political instability in hospital management), rather than the failure of individual employees or a local facility.

→ involve local media in specific human stories, but only with the explicit consent of the employees;

→ inform local municipal structures about the consequences of reducing access to patients — especially if emergency functions are compromised.

Summary and final remarks:

IMPLEMENTATION NOTES for EMPLOYEE REPRESENTATIVES

- Capacity building: training in rights, negotiation, basic financial knowledge, human resources and change analysis.
- Network of contacts: coordination of activities with federations, other hospital representatives, patient groups and local authorities.
- Use of evidence: basing positions on data (workforce maps, quality indicators) and proposing practical alternatives.
- Escalation scheme: internal negotiations → sectoral dialogue → labour inspection/mediation → public accountability → legal action.
- Record-keeping: documenting all requests, responses, protocols and agreements for enforcement purposes.

RECOMMENDED IMMEDIATE ACTIONS for WORKERS' REPRESENTATIVES

- Establish or strengthen early warning monitoring systems and internal whistleblowing channels.
- Prepare rapid response and negotiation toolkits (templates, legal checklists).
- Establish or join a tripartite working group to deal with each planned restructuring proposal.
- Seek technical support (legal, human resources, financial) and sign up for training in negotiation, financial analysis and the effects of digitalisation.

STRATEGIC PRIORITIES

- Demand early, substantive information and consultation to shape options before final decisions are made.
- Prioritise alternatives to redundancies (transfer to another position, retraining, gradual changes) and demand measures to protect key competencies and continuity of service provision.
- Enforceable safeguards should be provided in any outsourcing, merger, digitalisation or cost reduction plan: employment protection clauses, training guarantees, monitoring mechanisms and remedial measures.

PRACTICAL GUIDELINES

- Actions should be based on evidence: employment maps, financial data, patient safety impact assessments and key performance indicators (KPIs). Data is the basis for credibility in negotiations.
- Use clear, phased processes: early detection, impact analysis, proposing alternatives, negotiating binding measures, monitoring implementation and evaluating results.
- Combine individual and collective support: legal and psychosocial assistance for employees affected by the change, as well as sectoral retraining and mobility programmes.

MANAGEMENT and ACCOUNTABILITY

- Efforts should be made to establish formal coordination structures (tripartite committees, joint steering groups, sectoral monitoring) with a clear remit and published timetables.
- Provide arguments and justification in the event of failed negotiations: formal complaints to labour authorities, use of mediation, and strategic public engagement to protect patients' interests.

POTENTIAL and RESOURCES

- Investing in human potential: knowledge of law, human resources, financial analysis, negotiation skills, and digital and artificial intelligence competencies. Partnerships with trade unions, federations and external experts are crucial.
- Proactively seeking and influencing the acquisition of funding (national and EU) for transitional measures – retraining, pilot projects and the implementation of technology while maintaining safeguards for employees.

SUCCESS INDICATORS

- Timely access to comprehensive information and genuine consultation processes.
- Adoption of negotiated alternative solutions that reduce or eliminate forced redundancies.
- Binding safeguards in outsourcing/merger agreements (maintenance of terms and conditions of employment, retraining commitments, monitoring).
- Stable or improved key indicators for patient safety and quality of service after changes are implemented.
- Effective implementation of measures for retraining and redeployment of employees, with a low level of involuntary unemployment among the staff affected by the changes.

RISK and MITIGATION MEASURES

- Risk: delayed or insufficient information → Risk mitigation measure: formal early warning systems, rapid escalation of cases to regulatory authorities.
- Risk: making decisions based solely on financial aspects, ignoring clinical risk → Risk mitigation measure: insisting on a clinical risk assessment and involving patient groups in the decision-making process.
- Risk: weak enforcement of agreements → Mitigation measure: demand for binding clauses, establishment of monitoring committees and sanctions for non-compliance.

CONCLUSION

Employee representatives play a key role in ensuring that restructuring is carried out with respect for employee rights and patient safety.

The stages, tools and templates in this guide should be used to demand early information, credible alternatives, enforceable safeguards and monitoring measures. Social dialogue and evidence-based negotiations reduce the negative impact on staff and patients. Well-prepared and adequately resourced employee representatives who take action at an early stage, rely on facts and demand enforceable safeguards can significantly reduce the social and health impacts of restructuring. The methods and templates contained in this handbook should be treated as tools subject to continuous evolution – they should be adapted, tested in real cases and improved as part of an ongoing industry dialogue.

We would like to express our sincere thanks to all partners of the SERP project — European and national institutions, trade union organisations, project partners, subject matter experts and employee representatives — for their commitment, knowledge and cooperation, without which this Handbook could not have been created.

Thanks to your contribution, this document combines a practical perspective with a legal framework and international standards, offering a tool that is useful in everyday trade union work. We encourage all partners to continue their cooperation: to implement recommendations, share experiences and jointly monitor the effects of changes. Only through constant dialogue, the exchange of good practices and joint action is it possible to achieve sustainable, fair and safe solutions for the entire healthcare sector.

Together, we can ensure that restructuring processes are transparent, socially responsible and focused on the well-being of both employees and patients.

SERP

SOCIALLY RESPONSIBLE RESTRUCTURING PROCESSES – REINFORCEMENT OF THE ROLE AND CAPACITY OF WORKERS' ORGANIZATIONS

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