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Comité Permanent des Hôpitaux de l'Union Européenne
Ständiger Ausschuss der Krankenhäuser der Europäischen Union

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THE HEALTHCARE WORKFORCE IN EUROPE:

PROBLEMS AND SOLUTIONS

Final report of
HOPE's Study Group on Workforce Issues
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THE HEALTHCARE WORKFORCE IN EUROPE: PROBLEMS AND SOLUTIONS

1. INTRODUCTION AND SUMMARY

Healthcare staff are critical to the delivery of high quality care to patients. All healthcare systems, however they are financed or organised, need adequate numbers of well-trained staff to meet the needs of their populations. And as populations age and the range of treatments which can be provided increases, the demands on healthcare staff increase. In recent years there has been growing concern in a number of European countries about shortages of key healthcare professionals (mainly but not exclusively doctors and nurses) and the impact which this will have on the provision of healthcare.

In the light of these concerns HOPE established a Study Group to look at health workforce issues, with the following Terms of Reference.

The study will:

Collect and analyse information on the health professional workforce (covering doctors, dentists, nurses and allied health professions) in HOPE member countries, and observer countries.

Assess the implications for the workforce of demographic trends and other factors, including implementation of the European Working Time Directive for junior doctors and the draft directive on the mutual recognition of professional qualifications
Identify strategies currently being pursued to tackling labour shortages and the scope for more co-ordinated approaches.

It will concentrate on broad workforce issues and will not consider pay issues in any detail.

The study will report its findings and make recommendations on how HOPE might respond to the emerging picture in Spring 2004 to the Excom, the Plenary Assembly and the AGORA.

Membership of the study group was drawn from across the membership of HOPE and details of the members are at Annex A.

The Study Group collected a range of information on current workforce concerns by way of a questionnaire (at Annex B) circulated to all HOPE members and observer members. Replies were received from 13 delegations[1] and form the basis of the findings and recommendations in this report. In addition the Study Group met three times to discuss workforce issues, to review information from other workforce studies and to consider the report and recommendations. This is not the first time that HOPE has been concerned about the healthcare workforce and a previous report *Manpower Problems in the Nursing/Midwifery Profession in the EC*, published in 1995, arose because of concerns about a shortage of nurses and identified similar concerns and conclusions to those found in this study.

Although it is difficult to compare workforce data between countries, this report identifies a serious and worrying shortage of doctors and nurses across most of Europe. The position was worse in some specialties and in some geographical areas. Furthermore there were concerns that the position would worsen unless action was taken – the workforce was ageing; demand for healthcare was increasing and demographic change meant it may be more difficult to recruit staff through

[1] Belgium, Cyprus, Denmark, Finland, France, Germany, Hungary, Ireland, Netherlands, Portugal, Spain, Sweden and UK (England).

traditional training routes. There were a number of causes of shortages, including:

Past reductions in, or failures to increase, the number of training places for financial and other reasons

The perception that the healthcare professions were unattractive and had lost status over the years

Poor pay, particularly for nurses, and differential earning power in medical specialties. In addition some specialties carry higher risks of malpractice suits (eg obstetrics) which make them less attractive to recruits

Increased demands for healthcare and greater pressure of work which resulted in staff leaving employment either completely or for less stressful types of work

Rigid work and career patterns including inflexible shift systems and a lack of part-time posts which made healthcare less attractive for people who wish or need to work less than full-time for some part of their careers

Societal trends towards reducing working hours and earlier retirement

Many countries have started to tackle this shortage, often using similar approaches and strategies

Increasing professional training

Recruitment drives, both to encourage staff to return to the healthcare workforce and to recruit from other countries both within and outside the EU

Measures to retain staff by increasing support for staff and encouraging more flexible working arrangements

Changing skill-mix.

However, there has been little co-ordination or exchange of ideas between countries and little assessment of the impact of international recruitment on countries from which professional staff are being recruited, some of which have recently joined the EU. To improve matters the Group recommended that:

⇨ *in order to improve understanding of the healthcare workforce in Europe, countries should collect and disseminate good-quality, timely and comparable data. The European Commission can play a role in facilitating action here, as indicated in the conclusions of the High Level Process of Reflection on Patient Mobility and Healthcare Developments in the EU;*

⇨ *in order to improve workforce planning there should be a shared understanding between countries on their approach to determining trainee numbers and better exchange of information on plans to change training capacity;*

⇨ *good practice in recruitment and retention and on skill-mix changes should be shared between countries, recognising that different legal frameworks and social systems can affect the approaches that can be adopted. This might be stimulated by the European Commission;*

⇨ *information should be collected and disseminated on the extent of international recruitment;*

⇨ *research should be undertaken into the impact of international migration on the health services of those countries from which staff are recruited, with a particular emphasis on developing countries and the use of inter-Governmental agreements;*

⇨ *multi-disciplinary research should be undertaken into the effectiveness of strategies undertaken by EU member states tackling workforce shortages in order to inform future policy development.*

The Group also considered the impact of the European Working Time Directive, and particularly the European Court of Justice rulings in the SiMAP[2] and Jaeger[3] cases on health services across the EU. The Group fully supported the principles underlying the Working Time Directive, and the importance of ensuring healthcare staff receive adequate rest in order to ensure that they can work safely and effectively. However it found widespread concerns that the recent ECJ rulings may increase healthcare costs and have an adverse effect on the ability of Member States to provide high quality and accessible healthcare for their populations.

The Group made a number of suggestions on how these concerns might be addressed:

⇨ that the definition of working time for the purpose of the WTD should be amended to exclude time spent on-call, and that there should be greater flexibility in taking compensatory rest than implied in the Jaeger judgement;

⇨ that the consequences of implementing the WTD as interpreted in the SiMAP and Jaeger cases on hospital costs and organisation should be stressed;

⇨ that there should be a longer timescale for implementation;

⇨ that the need to increase numbers of hospital doctors at a time of shortage in many countries would pose real problems and might adversely affect plans to develop primary care provision.

A copy of the response sent to the Commission in response to its review of the Working Time Directive on behalf of 14 of the 15 HOPE members is at Annex C.

HOPE is grateful to all members of the Study Group for their willingness to participate in the Group's work and to all those countries which provided information in response to the questionnaire.

[2] Judgement of the Court of 3 October 2000 in case C-303/98, Sindicato de Medicos de Asistencia Pública (SIMAP) v Conselleria de Sanidad y Consumo de la Generalidad Valenciana, European Court reports 2000, p. 1-07963.
[3] Judgement of the Court of 9 October 2003 in case C-151/02, request to the Court by the Landesarbeitsgericht Schleswig-Holstein (Germany) in the proceedings pending before that court between the Landeshauptstadt Kiel and Norbert Jaeger, not yet published.

2. THE HEALTHCARE WORKFORCE: WHAT ARE THE PROBLEMS?

Without a good supply of well-trained staff it is not possible to provide high-quality, accessible, health services to meet the needs of patients and the wider public. This is true however health services are organised and financed. Over recent years there have been increasing concerns about shortages of staff to provide care for patients at a time when demands for care are increasing as populations age and the range of treatments which can be provided increases. This study was established to assess the extent of such staff shortages and what action can be taken to minimise the impact of shortages on healthcare provision.

Unfortunately it is difficult to obtain good and comparable workforce information across countries. The table at the end of this section provides some information but it is incomplete and almost certainly does not compare like with like. Nonetheless it gives a broad picture of the pattern of medical and nurse staffing across European countries. While staffing levels may seem good it was clear from responses to the HOPE questionnaire that there are serious shortages of doctors and nurses, both overall and in particular specialisms. Furthermore there were geographical variations in a number of countries with some parts of the country finding it more difficult to recruit and retain staff than other parts.

By way of example:

In England in March 2003 some 1264 hospital medical and dental posts (4.7%) and 7967 nursing posts (2.9%) had been vacant for more than three months despite active attempts to recruit staff.

In France there was a shortage of some 3000 doctors in the public sector (9%) and 10000 nurses (2.5%).

In Germany some 3000 medical posts (2.3%) and 2500 nursing posts (0.6%) are unoccupied.

In Sweden there was a shortage of 800 - 1000 specialist doctors (4%) and 1500 specialist nurses (2%).

In Finland in 2002 there was a shortage of 911 hospital doctors (19%) and 381 General Practitioners (11.3%).

In the Netherlands there were shortages of some 5% in medical specialists, 2% in intensive care nurses, 2.7% in surgical nurses and 6.2% in anaesthesia nurses.

In Hungary in 2001 there were 2727 vacant medical posts (8.2%) and 5181 vacant nursing posts (5-6%).

In Cyprus more than 500 nurses are needed to meet the needs of the private sector.

Other countries – eg Belgium, Denmark, Ireland and Portugal – also indicated shortages of either or both doctors and nurses. In addition shortages of other health professionals such as radiographers, dentists and assistant practitioners were reported by some countries. In some countries shortages were being covered by the use of temporary staff but this was often an expensive option and unsatisfactory in terms of care for patients.

Within these overall figures there were particular problems in a number of specialisms including:

Psychiatry, anaesthetics, cardiac specialties, geriatrics, radiology, paediatrics and laboratory specialties for doctors

Geriatrics, intensive care, midwifery, psychiatry and paediatrics for nurses.

Finally there was a range of geographical recruitment difficulties which included:

Areas of social deprivation, often inner city areas

Rural areas, where there were concerns about professional isolation

Areas where the cost of living was high and lower-paid workers such as nurses found it difficult to obtain affordable accommodation.

One consequence of the shortage of staff, and the difficulties of recruiting and retaining new staff, was that in some countries the workforce was ageing. Between 1995 and 2000 the number of physicians under the age of 45 across Europe fell by 20% while the number over 45 increased by 50%. More specifically:

In France the average age of doctors increased from 42.4 to 47 between 1990 and 2000, and the average age of nurses from 37.5 to 43 over the same period. Some 50% of current French nurses are expected to retire by 2015.

In Germany the average age of hospital doctors increased from 38 to 40 between 1992 and 2002.

In Sweden the average age of hospital doctors increased from 42 to 45 between 1994 and 2002 and of nurses from 41 to 44 over the same period.

In England the average age of hospital doctors remained broadly stable (falling from 39.3 to 39.2 between 1992 and 2002) while the average age of nurses increased from 38 to 40 (though within that some specialisms such as midwifery showed a greater increase). As well as being unsustainable in the longer-term an ageing workforce leads to increased costs as older staff tend to be more expensive.

There were concerns that the position could worsen in future years particularly as populations were ageing and demands for healthcare were increasing, so requiring more staff to respond to them, and demographic changes meant that fewer young people would be available to enter training.

While the approaches to measuring staff shortages, and the definitions used, vary between countries the pattern of shortages is markedly similar across Europe. And the problem is not confined to Europe. Work by the OECD has identified similar problems in other countries.

If there is to be a better understanding of the healthcare workforce in Europe it is important that countries collect and disseminate good-quality, timely and comparable data. The European Commission has a role to play in facilitating action here as indicated in the conclusions of the High Level Process of Reflection on Patient Mobility and Healthcare Developments in the EU.

WHAT ARE THE CAUSES OF CURRENT SHORTAGES?

While countries identified a range of causes for the current workforce shortages there were a number of common features. They included:

Reductions in, or failure to increase, training places in recent years, often as a result of financial pressures

The perception that the healthcare professions were unattractive and had lost status over the years.

Poor pay, particularly for nurses, and differential earning power in medical specialties which makes it more difficult to recruit into less well-paid specialties. In addition some specialties carry higher risks of malpractice suits (eg obstetrics) which makes them less attractive to recruits

Increased demands for healthcare and greater pressure of work which resulted in staff leaving employment either completely or for less stressful types of work

Rigid work and career patterns including inflexible shift systems and a lack of part-time posts which made healthcare less attractive for people who wish or need to work less than full-time for some part of their careers

Societal trends towards reducing working hours and earlier retirement

Lack of early exposure to training in some specialisms, particularly for instance radiology or laboratory specialties

Again the factors which have led to workforce shortages are not unique to European countries. Similar factors have been identified in other countries from the recent OECD work. That work also identified a move away from primary care towards more specialised careers, a trend which some countries have been actively seeking to counter in order to provide high quality healthcare which is convenient and accessible to patients (and less costly than care in hospitals).

Although the causes of workforce shortages are many and complex – and vary between countries – the policy responses, detailed in the next section, have been limited and similar between countries.

WORKFORCE DATA

	Number	Number/1000,000 pop
Hospital Doctors		
Belgium (2003)	17700 (est)	170.9
Cyprus (2002)	1800	
Denmark (2001)	10722	200.4
England (2002)	77031	156.0
Finland (2002)	7000	135.0
France	56851	94.0
Germany (2001)	130822	
Hungary (2001)	26375	263.75
Ireland (2003)	5674	145.0
Netherlands (2001)	13300	83.0
Spain (1998 – public sector)		110.0
Sweden (2002 – specialists)	13500	150.0
GPs		
Belgium (2003)	17543	169.4
Cyprus (2002 – public sector)	108	
Denmark (2001)	3459	64.7
England (2003)	33082	66.8
Finland (2002 - municipal health centres)	3000	58.0
France	81812	134.0
Germany (2002)	40000	
Hungary (2001)	6713	67.1
Ireland (2003)	2400	61.0
Netherlands (2001)	7932	50.0
Spain (1998)		60.0
Sweden (2002)	4900	55.0
Nurses		
Belgium (2001)	56996	552.8
Cyprus (2002)	2894	
Denmark (2001)	32897	615.0
England (2002)	367520	742.0
Finland (2002)	70000	1,346.0
France	410859	679.0
Germany (2001)	415000 fte	
Hungary (2001)	94963	949.6
Ireland	N/A	N/A
Netherlands (2002)	135000	844.0
Spain (1998)		250.0
Sweden (2002 – hospitals only)	66500	745.0

* Figures not available for Portugal

3. HOW HAVE COUNTRIES SOUGHT TO TACKLE WORKFORCE SHORTAGES?

In recent years, as the extent of workforce shortages has become apparent, most EU member states have taken action to try and tackle the problem. They have used four main strategies:

Increasing professional training

Recruitment drives, both to encourage staff to return to the healthcare workforce and to recruit from other countries

Measures to retain staff by increasing support for staff and encouraging more flexible working arrangements

Changing skill-mix.

Again work by the OECD suggests that European countries are not alone in adopting these approaches to try to tackle staff shortages.

INCREASING PROFESSIONAL TRAINING

One of the main causes of current workforce shortages is the failure to train adequate numbers of staff in earlier years. In some countries professional training seems to have been regarded as an economic cost rather than an investment in the future, and it has been reduced, or at best not expanded, as a response to economic difficulties. In some cases this has been justified on the grounds that changes in skill mix means that fewer doctors and nurses will be needed as other staff take on more of their work. In other cases it has been argued that there is a need to improve the productivity of clinicians before considering increasing numbers. In others, low doctor: population ratios have been regarded as a badge of honour – a sign that health care was being provided efficiently.

More recently the need to increase training capacity has been acknowledged in a number of countries both to tackle obvious workforce shortages and to reduce reliance on doctors from other countries (in England about a third of hospital doctors trained outside the UK, the majority outside the EEA). As a result:

In the UK medical school intakes are planned to rise by almost 45% to over 7300 by 2005, the largest sustained increase since the inception of the NHS. At the same time nurse training places increased by 4429 between 1999/2000 and 2002/03 and further increases are planned.

In France medical school places have increased from 4700 to 5100 between 2002 and 2003 with plans for further increases to between 7 and 8000. Places for nurse training have increased from 18000 in 1998 to 30000 in 2003.

In Sweden training capacity has increased by 25% for doctors and 30% for nurses since 2001/02. In the Netherlands specialist medical training capacity is being increased from 650 to 1100 places a year and there is increased training capacity for shortage nursing specialties.

In Finland medical training capacity has doubled from 300 to over 600 students.

In Cyprus the capacity of the school of nursing is being doubled from 100 to 200 places per year.

In other countries – for example Germany and Belgium – capacity issues are less critical and there are no plans to increase training numbers.

Two key issues arise from the planned expansion of training. The first is the ability to recruit sufficient students to fill the places available. Experience to date suggests this may not be an issue. However as the number of school-leavers reduces it is likely that countries will need to look to a wider pool of recruits to professional training, for instance recruiting from older people, those already in the healthcare workforce and those without traditional academic qualifications. There is already evidence of this happening in some countries. The development of access courses, more work-based learning and the recognition of vocational training will all play their part here. It will also be important to seek to recruit from under-represented groups, eg from ethnic minorities.

The second is the need to match training numbers to future requirements for trained staff. Because of the length of professional training, particularly for doctors, increases in training places take time to increase the size of the professional workforce. In recent years there is evidence that too few doctors and other professional staff have been trained leading to workforce shortages. Equally, however, training significant numbers of doctors who are then unable to use their skills is wasteful both of the money spent on their training and of their skills. It will be important for Member States to seek to train adequate staff for their future needs rather than relying on recruiting staff from other countries. In this context it will be necessary to maintain and develop long-term models of the healthcare workforce which can identify potential under or over-capacity and enable policy-makers to respond quickly.

It would help workforce planning across Europe if there was a shared understanding between countries on their approach to determining trainee numbers and better exchange of information on plans for changing training capacity.

RECRUITMENT DRIVES

Increasing the numbers training for professional careers in healthcare takes time to increase the number of trained staff. In the short term a number of countries are seeking to recruit more staff into their hospitals and other healthcare facilities by:

Action to attract back staff who are not currently working,
Recruiting staff from other countries both within and outside the EU.

A range of measures has been taken to attract back professional staff including:

Targeted recruitment drives by writing to all registered staff not currently working in the healthcare sector

Funding return to practice courses

In England, introducing a centrally funded Flexible Careers Scheme which has enabled almost 2000 hospital doctors and GPs at various stages in their careers to work more flexibly

Providing more flexible, family-friendly, working arrangements for staff including less rigid shift arrangements and term-time only contracts. In England this forms part of the *Improving Working Lives* initiative.

These have been supported by wider action to improve pay and to improve the image of healthcare professions through advertising and other campaigns. Such action can be aimed at a wider audience than simply staff who are currently not working in healthcare. For example in England much effort has gone into making the health service an attractive career choice for schoolchildren by showing the range of possible careers which can be pursued and developing a national careers helpline for the NHS.

These initiatives have had varying success. In England over 16000 nurses and midwives have returned to practice since 1999, over 1500 therapists, scientists and other healthcare professionals since 2001 and, to date, some 486 hospital doctors and GPs have returned to the NHS using the Flexible Careers Scheme since 2000. However a French initiative to encourage nurses to return to practice in 2001 was not seen as successful. And in any event the pool of staff willing and able to return to work is finite so that it will not be possible to sustain high levels of return to practice indefinitely provided that those staff who do return to practice can be retained in the workforce.

There is scope for sharing good practice in recruitment between countries to the benefit of all. The European Commission could help to stimulate work in this area.

In addition to domestic recruitment there has been substantial overseas recruitment to increase capacity quickly. In some countries, eg the UK, international recruitment particularly of doctors has been a long-standing strategy but this is not the case in other countries. Specific examples include:

France recruiting some 650 nurses and physiotherapists from Spain

Sweden recruiting 300-400 nurses annually, mainly from Finland, and 300- 500 doctors split evenly between other Nordic countries, other EU countries and non-EU countries

England recruiting 300 consultants and 170 GPs through national initiatives, together with 840 nurses from Spain, 431 from India and 176 from the Philippines through Memorandums of Understanding and Government to Government agreements.

Other countries – eg Finland, Cyprus, Denmark, Germany, Hungary, Portugal and the Netherlands – also report overseas recruitment. And of course individual hospitals may recruit staff direct from overseas.

There has been considerable emphasis on the need for ethical recruitment from overseas countries in order not to undermine health services in developing countries such as those in Southern Africa. However there are, not unreasonably, concerns among those countries which joined the EU in May that the Directives on the Mutual Recognition of Professional Qualifications[4] will lead to the migration of skilled staff to countries with better rates of pay and facilities to the detriment of their health services. For example, a Lithuanian survey showed that 26% of practising doctors and 60% of medical students plan to work abroad following EU enlargement. Similarly, 33.5% of GPs surveyed in Poland said they planned to move to a Member State in the West after enlargement. This comes at a time when many of these countries have shortages of professional staff – for example, Slovenia estimates a need to recruit 700 doctors and 2000 nurses over the next 7 years. If migration occurs at this level it would have severe consequences for the countries concerned.

[4] Council Directives 89/48/EEC and 92/51/EEC and Directive 1999/42/EEC of the European Parliament and Council on the general system for the recognition of professional qualifications., Council Directives 93/16/EEC for doctors, 78/686/EEC and 78/687/EEC for dentists, 80/154/EEC and 80/155/EEC for midwives, 77/542/EEC and 77/453/EEC for nurses responsible for general care and 85/432/EEC and 85/433/EEC for pharmacists.

While it may be possible for these countries to make good any shortfall by recruiting from other, non-EU, countries this merely pushes the problem to those countries. This loss of staff might be more acceptable if it was a managed process in which staff were supported to move to other countries for a short period for specialist training before returning to their home state. Such an initiative, which might be co-ordinated by the European Commission, would be of benefit to all parties – the migrant, the home state and the host state.

There is relatively little information on the full extent of overseas recruitment, where recruits come from or the impact on health services in their native countries and this is an area which would benefit from further study. Nor is it clear how long it will be possible to continue overseas recruitment at current levels especially if EU countries are looking to the same sources for recruits. Sharing information on recruitment plans, rather than regarding international recruitment as a competitive exercise, may help here. To obtain a better understanding of the extent and impact of international recruitment:

There is a need for the collection and dissemination of information on international recruitment, which might be stimulated by the European Commission

There should be research into the impact of international migration on the health services of those countries from which staff are recruited, with a particular focus on developing countries, and the use of inter-Governmental Agreements.

RETENTION

While recruitment is, and will continue to be, an important tool for increasing workforce capacity it is also important to seek actively to retain existing staff – doing so is both cheaper than recruiting new staff and retains skills and experience in the healthcare sector. A range of approaches have been adopted to improving retention, some of which overlap with recruitment strategies. These include:

Developing flexible, family-friendly, working patterns.

Providing childcare and other support such as subsidised housing in high-cost areas.

Adjusting workloads to retain older staff and allowing older staff to work fewer hours for the same pay.

Introducing greater flexibility over retirement ages and ending early retirement initiatives.

Allowing greater flexibility for staff over the package of rewards – higher pay/shorter hours/higher pension contributions.

Maintaining contact with staff during periods of maternity leave.

Improving maternity leave and pay and sick leave provisions.

Tackling issues such as violence to staff.

Improving occupational health services.

Providing staff with learning and development opportunities to enable them to develop their

careers in ways which will benefit them and their employer. In England lifelong learning is an integral part of the *Skills Escalator* approach which supports initiatives to bring people into the healthcare workforce from unemployment; to identify their potential and to support them to realise that potential including through professional training and development where appropriate.

While recruitment and retention initiatives are important across the healthcare sector they are particularly important in areas where it has been difficult to attract staff and where healthcare employers can have success by packages of measures such as:

- ⇨ building links between employers and students to encourage them to remain in the area after completion of their studies;
- ⇨ providing targeted support for staff including cheap housing, support for transport costs;
- ⇨ improved induction and support for staff, eg anti-violence measures and stress counselling;
- ⇨ use of pay flexibilities;
- ⇨ better careers information for schoolchildren and those considering a change of career;
- ⇨ providing improved training opportunities.

There are potential benefits from sharing good practice, on effective approaches to retention, between countries, recognising of course that different legal frameworks and social systems can affect the approaches that can be adopted. The European Commission could help to stimulate work in this area.

CHANGING SKILL-MIX

Finally a number of countries, including Belgium, Cyprus, Denmark, Finland, Ireland, Sweden, the UK and to an extent France are looking at the scope for using changes to traditional skill-mix to tackle shortages of professional staff. This can involve:

Transferring work between different professional groups – eg doctors and nurses – to make best use of their skills. One example here is nurse-led treatment in some Swedish GP centres.

Developing new roles such as those of assistant practitioner in the UK to take on work previously undertaken by professional staff. In Ireland the recently published report of the National Taskforce on Medical Staffing (the Hanly report), stressed the importance of enhancing the roles of non-medical staff and of multi-disciplinary team working and identified the scope for introducing or further developing new roles such as Operating Department Assistant and Healthcare Assistant. And in Belgium new roles have been created between nurse and assistant practitioner and may in future be developed between doctor and nurse.

Extending the range of work which can be undertaken by different professional groups, for example by allowing nurses to prescribe drugs rather than seeing this solely as a medical responsibility.

Encouraging staff to develop new skills outside their traditional competence to provide quicker and more holistic care for patients.

Training and developing staff without professional qualifications to take on new responsibilities.

It is important that skill-mix changes are taken forward sensitively with staff in order to avoid giving the impression that changes are being made solely for financial reasons or are being used as an excuse to dump less interesting work onto other staff. They need to be seen as ways to improve patient care and to enhance the experience of staff. In many countries skill-mix initiatives are being taken forward at hospital or regional level but in England there is a national initiative (the Changing Workforce Programme) helping hospitals to test, implement and spread good practice in role redesign and linked to changes in services design, using a range of pilot sites.
Skill-mix changes are also being supported by education and training initiatives including moves to develop multi-professional training, to accredit training where individuals wished to change careers and to provide conversion training. For example in Belgium, where there had been a surplus of physiotherapists, bonuses were paid to therapists who stopped working in that profession and support was provided for conversion training for nursing.

There is scope for sharing of good practice and experience of skill-mix changes between countries, which might be stimulated by the European Commission.

CONCLUSION

In short, European countries, in common with other countries, have adopted a number of approaches to tackling workforce shortages. These approaches have much in common and many potential benefits. However relatively little is known about which of these policies are the most or least effective in ensuring an adequate health professional workforce which is sensitive to changing demands nor about the effect of a number of different countries following similar policies at the same time. **It would be valuable to ensure proper multi-disciplinary research into the effectiveness of the strategies adopted by EU member states in tackling workforce shortages in order to inform future policy development.**

4. HOW IS THE IMPLEMENTATION OF THE EUROPEAN WORKING TIME DIRECTIVE AFFECTING THE HEALTHCARE WORKFORCE?

The European Working Time Directive[5] was introduced in 1993 as a health and safety measure. It set a maximum working week of 48 hours, with provision for proper rest periods and annual leave, while allowing employees voluntarily to sign a waiver to "opt out" of the maximum hours limits. The Directive already applies to most employed healthcare staff (it does not cover independent workers). The remaining group – doctors in training – will come within its provisions progressively, starting with a requirement for a maximum working week of 58 hours from August 2004[6]. The Directive is of benefit both to healthcare staff, who will work fewer hours and receive proper rest, and to their patients, who are less likely to be treated by overtired staff.

However two recent judgements of the European Court of Justice in the SiMAP and Jaeger cases have interpreted the Directive in ways which are of concern to hospitals and other healthcare institutions. In particular they have ruled that:

> The time that a doctor spends in hospital "on call" – available for work but not actually working – is to be classified as working time regardless of whether the doctor is working, resting or sleeping. This time now counts towards the maximum working time.
>
> Where a worker receives compensatory rest to make up for lost rest time, this has to be taken immediately the period of duty finishes, so restricting the ability of employer and worker to take compensatory rest at more convenient and acceptable times.

The effect of these two rulings is to interpret the original Directive more restrictively then had originally been expected and to put at risk the stability of healthcare provision in some Member States as current patterns of service could not be sustained without a significant injection of financial and staff resources. The impact varies between countries. Some such as Belgium, where most doctors are independent rather than employed staff and so outside the provisions of the Directive, anticipate fewer problems than those where most or all medical staff are employed. In the UK the combination of the ECJ judgements and the inclusion of doctors in training within the scope of the Directive poses particular problems given the heavy reliance on such doctors to provide services at night and weekends, and the relatively low rate of medical staffing to population.

[5] Council Directive 93/104/EC of 23 November 1993 concerning certain aspects of the organisation of working time.
[6] Following Directive 2000/34/EC of the European Parliament and of the Council of 22 June 2000 which amended its 1993 Directive.

IMPACT OF IMPLEMENTING THE WORKING TIME DIRECTIVE

It was clear from the HOPE survey that the major impact of the Working Time Directive was on medical staff. While there were some concerns about the impact of the Directive and particularly the ECJ rulings on other staff groups – eg nurses and ambulance paramedical staff – these were not major issues. For doctors, while most countries had reduced working hours to within the Directive limits there were a number of exceptions. For example in the UK some 5% of doctors in training were reported as working more than 56 hours a week. In Ireland the average working time of non-consultant hospital doctors is 75 hours per week on-site. In Belgium, where most doctors are not subject to the hours limits in the Directive, the average working week was some 80 hours. In a number of countries hours worked varied significantly between specialties.

There were concerns about excluding workers from the provisions of health and safety legislation solely on the basis of their employment status. Furthermore the current approach can work to the advantage, or disadvantage, of parts of the healthcare economy in countries, such as France, where some sectors are staffed predominantly by salaried doctors and others predominantly by independent doctors.

Responses to the questionnaire identified a range of effects arising from implementing the Directive. At an individual level there were some reports of behavioural change in doctors themselves – a greater consciousness of hours worked particularly among doctors in training, more interest in flexible working arrangements and more awareness of the extent to which time was spent on non-medical work. But there was a view that overall professional ethics and the needs of patients came first for doctors and were unaffected by reductions in working hours.

There were some concerns that reduced working hours would adversely affect post-graduate training as doctors would be available for fewer hours. Such training is already long in most countries, ranging from 3 to 10 years depending on the country and the specialty, and there were fears that it might need to lengthen further. However there might also be scope to reorganise training to improve its quality and so maintain or reduce current training times (for example in Ireland plans to increase the number of fully-trained doctors and reduce reliance on training grades were expected to improve the quality of training).

More generally, in some countries there were likely to be organisational changes as a result of implementing the Directive. At the hospital level this might involve increasing use of fully trained doctors and non-medical staff to undertake work at night and weekends, and to take on work formerly undertaken by doctors in training. Beyond this there might be a need to reorganise the services provided within and between hospitals with the risk that services might have to be reduced or closed because it was not possible to continue to provide safe, high-quality, services in some locations.

The Directive was seen as benefiting patient care as patients would be seen by:

Fully-trained doctors rather than doctors in training

Properly rested doctors, so reducing the risk of errors arising from fatigue

Appropriately skilled non-medical staff where medical skills were not required.

However there were some concerns that there would be a loss of continuity of care and a poorer doctor-patient relationship as a result of reduced working hours.

IMPACT OF THE SiMAP AND JAEGER JUDGEMENTS

In general terms the SiMAP and Jaeger judgements change the scale rather than the nature of the challenges arising from implementing the Directive and particularly make organising effective rosters of staff more difficult. However in some countries (eg Germany, Sweden, and the Netherlands) the definition of working time to include time spent on call at the hospital will require changes to current legislation.

More importantly the judgements were seen as increasing the financial costs associated with the implementation of the Directive itself, at least in some countries (not all respondents had yet fully worked through the implications of the judgements for them). Cost increases could arise both from the need to recruit more doctors or other staff in order to reduce working hours for doctors in training and from increased payments to doctors on call. For example, assuming that more doctors were recruited to comply with the judgements, estimates of the workforce and financial impact were:

- ⇨ France — 10 – 15% more doctors and an additional 200m Euros.
- ⇨ Germany — 27000 more doctors (25% of the current medical workforce) and an additional 1.75bn Euros (5% of current total hospital budget)
- ⇨ Hungary — 20 – 50% more doctors and a similar increase in hospital medical staff budget.
- ⇨ Netherlands — 10% more doctors and a similar increase in hospital medical staff budget.
- ⇨ Sweden — 10 – 15% more doctors and an additional 200 – 250m Euros.
- ⇨ UK — Several thousand more doctors and several hundred million Euros.

In addition to direct costs there are likely to be indirect costs, eg. from reduced medical productivity, and a potential unplanned reduction of services if it proves impossible to provide adequate cover in some specialties in smaller hospitals.

Apart from the financial implications it was far from clear where additional medical staff in such numbers could be recruited from, especially given the workforce shortages reported earlier in this report, nor whether the doctors would have an acceptable and satisfying job to do. Also for doctors in training there are real issues about the quality of training which could be provided. For all these reasons increasing doctor numbers is likely to be only part of the solution to problems arising from Directive implementation in many countries.

ACTION BEING TAKEN TO TACKLE PROBLEMS CAUSED BY WTD IMPLEMENTATION

Countries reported a range of actions being taken to mitigate the impact of the WTD in addition to recruiting additional doctors. These included:

- ⇨ Changes to rotas and work schedules to make the most effective use of staff, including more use of shift working and piloting new ways of staffing hospitals at night and weekends to reduce the number of doctors required.
- ⇨ Introduction of cross-cover arrangements between specialties and reducing tiers of cover. However there were concerns about the impact on quality of care if this was taken too far.

- ⇨ Making more use of fully trained doctors to replace doctors in training. For example the recent report of the National Taskforce on Medical Staffing in Ireland recommended a significant reduction in junior doctor numbers and an increase in the number of consultants. While this was expected to reduce medical staff costs, associated changes to working arrangements required to deliver a consultant-provided service were expected to increase costs by 39m Euros in 2005 rising to 111m Euros in 2013.

- ⇨ Transferring work traditionally undertaken by doctors to other, appropriately trained and skilled, staff by pushing forward skill-mix changes.

- ⇨ Reducing non-medical work undertaken by doctors, enabling them to use their working time most effectively.

- ⇨ Re-organising patterns of service provision.

- ⇨ Reforming medical education and training to ensure continued delivery of high quality training in reduced working hours.

- ⇨ Increasing pay for long hours.

RECOMMENDATIONS TO HOPE

A number of suggestions were made in relation to the attitude which HOPE should take in commenting on the Commission's recent communication on the Working Time Directive in relation to the SiMAP and Jaeger judgements and their impact on healthcare. In particular:

- ⇨ that the definition of working time for the purpose of the WTD should be amended to exclude time spent on-call, and that there should be greater flexibility in taking compensatory rest than implied in the Jaeger judgement;

- ⇨ that the consequences of implementing the WTD as interpreted in the SiMAP and Jaeger cases on hospital costs and organisation should be stressed;

- ⇨ that there should be a longer timescale for implementation;

- ⇨ that the need to increase numbers of hospital doctors at a time of shortage in many countries would pose real problems and might adversely affect plans to develop primary care provision.

A copy of the letter sent to the Commission on behalf of 14 of the 15 delegations to HOPE is at Annex C.

5. CONCLUSION AND RECOMMENDATIONS

This study has identified a range of concerns with the state of the health professional workforce in the EU and made a number of suggestions for responding to them in a more concerted and co-ordinated fashion. In particular it recommends that:

- **If there is to be a better understanding of the healthcare workforce in Europe it is important that countries collect and disseminate good-quality, timely and comparable data. The European Commission has a role to play in facilitating action here as indicated in the conclusions of the High Level Process of Reflection on Patient Mobility and Healthcare Developments in the EU.**

- **It would help workforce planning across Europe if there was a shared understanding between countries on their approach to determining trainee numbers and better exchange of information on plans for changing training capacity.**

- **There is scope for sharing good practice in recruitment between countries to the benefit of all. The European Commission could help to stimulate work in this area.**

- **There is a need for the collection and dissemination of information on international recruitment, which might be stimulated by the European Commission.**

- **There should be research into the impact of international migration on the health services of those countries from which staff are recruited, with a particular focus on developing countries, and the use of inter-Governmental Agreements.**

- **There are potential benefits from sharing good practice, on effective approaches to retention, between countries, recognising of course that different legal frameworks and social systems can affect the approaches that can be adopted. The European Commission could help to stimulate work in this area.**

- **There is scope for sharing of good practice and experience of skill-mix changes between countries, which might be stimulated by the European Commission.**

- **It would be valuable to ensure proper multi-disciplinary research into the effectiveness of the strategies adopted by EU member states in tackling workforce shortages in order to inform future policy development.**

We are clear that action needs to be taken, and taken soon, if across Europe the current workforce crisis is to be averted and we call on the European Commission, governments, professional organisations and other interested parties to work together on this issue.

ANNEX A

HOPE STUDY GROUP ON WORKFORCE ISSUES - MEMBERS

Martin Staniforth, Chairman	(UK)
Barbro Emriksdotter	(Sweden)
George Harmat	(Hungary)
Renate Pereira	(Portugal)
Emmanuelle Quillet	(France)
Hans Schirmbeck	(Netherlands)
Tommy Van der Borght	(Belgium)
Martin Walger	(Germany)
Kris Schutyser, Adviser to the President	(HOPE)

ANNEX B

STUDY GROUP ON WORKFORCE ISSUES
OF THE
STANDING COMMITTEE OF THE HOSPITALS OF THE EUROPEAN UNION
(HOPE)

Q U E S T I O N N A I R E

COUNTRY : .....
RESPONDENT IDENTIFICATION
NAME : .....
FUNCTION : .....
ADDRESS : .....
.....
.....
EMAIL : .....

PLEASE SEND ALSO REFERENCES OF RELEVANT DOCUMENTATIONS ON A, B, C AND D.

A. EUROPEAN WORKING TIME DIRECTIVE – EWTD (93/104/EC November 1993)

For a good and short description of the EWTD, see the enclosed text from "Guidance on Working Patterns for Junior Doctors of the NHS Confederation and British Medical Association (2002), which of course describes at the same time the UK transition option of a staged implementation until August 2001.

1. What is the option in your country concerning the inclusion of junior doctors in the EWTD?

□ full application from January 1, 2003
□ option for staged implementation (please describe the stages)
.....
.....

2. 1. What is the average number of working hours per week/day of doctors in the hospitals in your country?

.....

2.2. Is there a difference between salaried or independent doctors? Please explain, including the percentage of both of them in the hospital sector.
.....

2.3. What is the number of years of training for medical specialists? Give, if possible, the differences between the specialties.
.....

3.1. Does the Working Time Directive cause a "cultural change" (e.g. medical doctors really counting more their working hours) in your country ?
.....

3.2. Could this increase the financial problems in the hospital sector of your country?
.....

4. What will be the impact on the (organisation of) training of specialists in your country?
.....
5. Will there be an impact on the quality of patient's care and on psychological feelings of patients, e.g. because more doctors will be involved during every 24 hours of his care?

.....
6. Are there specific problems related to the EWTD concerning other professions than medical doctors, especially nursing?
.....

7. What actions are being taken in your country to tackle the problems caused by implementing the EWTD for:

    1. Doctors.....

    2. Other staff.....

8. <u>SIMAP CASE : RESIDENT DOCTORS ON CALL = WORKING TIME</u>

For a short description of this Spanish case before the European Court of Justice (C-303/98 EC) see also the annex mentioned in A.
A new German case C 1.7/02 is pending before the ECJ and the Advocate-General gave already in 2003 a same opinion as for the SIMAP case.

1. Does the interpretation of the ECJ fit with the present national law in your country? If not, give some explanations.

.....
2. What will be the workforce and financial consequences of this interpretation of the EWTD in you national hospital system?

<u>A. and B.</u>
Does your national delegation have specific recommendations to HOPE concerning its lobbying role to the EU concerning these topics ?

.....

C. HUMAN RESOURCES

1. Are there shortages of doctors or nurses in your country? If so :
   In which staff groups/specialisms?
   .....

   What is the extent of the current shortage – numbers of staff and percentage?
   .....
   What, in general, are the causes of the shortage?
   .....
2. If there are shortages, what action is being taken to tackle them? And with what success?
   In particular, are you :
   1 Taking steps to attract back trained staff
   .....
   2 Recruiting staff from :
   other EU countries
   outside the EU
   Increasing training capacity in e.g. medical or nurse training schools?
   .....
3. One approach to tackling staff shortage is by changing skill-mix in order to make better use of the skills of staff. What work are you aware of in your country to change skill-mix for example by :
   transferring work from doctors to nurses
   transferring work from nurses to assistant practitioners

4. As well as increasing staff through recruitment initiatives it is important to retain existing staff. What work are you aware of in your country to improve staff retention for example by :

   introducing flexible working arrangements for staff

   providing childcare or other support such as subsidised housing

   tackling issues such as violence against staff

5. What is the average age of doctors and nurses in your country and how has it changed over the last 10 years:

   1 Doctors in hospital .....

   2 Nurses .....

6. Do you expect shortages in future as a result of demographic change for example because of the ageing of healthcare staff?
   .....

7. Are there other staff groups where your country is experiencing shortages? .....

B. KEY DATA

Please provide the following information (year.....)

HOSPITAL DOCTORS/SPECIALISTS

Number of hospital doctors and full-time equivalents, total and per 100,000 population, for 2002 or the most recent year available.

.....

Please give total and show trainees and trained staff separately.

.....

GENERAL PRACTITIONERS

Number and full-time equivalent, total and per 100,000 population, for 2002 of the most recent year available.

.....

NURSES

Number and full-time equivalents, total and per 100,000 population, for 2002 of the most recent year available. Please give total and show hospital and non-hospital (community/primary care) nurses separately.

.....

.....

Please return this questionnaire to the HOPE secretariat-general before the end of September 2003.

HOPE
Secretariat-General
Bd. A. Reyers 207-209, b7
B – 1030 BRUSSELS
Tel. +32-2-742 13 20
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Email : sg@hope.be

QUESTIONNAIRE – ANNEX

The Working Time Directive

BACKGROUND

The European Working Time Directive (EWTD)4 initially excluded junior doctors across Europe. However, after a process of negotiation, a timetable of staged implementation was agreed by Member States in May 20005– on the back of a clear intention that the hours limits in the Directive *should* apply equally to junior doctors. This is to be welcomed as an important measure aimed at improving the quality of patient care and safeguarding the health and safety of both doctors and patients. The staged implementation means that the full '48 hour week' does not have to be introduced before August 2009; but that an interim position of a 58 hour week, with significant changes in rest requirements, will come into force from August 2004. Junior doctors should in any case be working no longer than 56 hours a week after August 2003 under the new contract, but until 2004 may continue to provide on-call cover for up to 72 hours provided that their actual working hours do not exceed 56.

TIMETABLE OF IMPLEMENTATION

DATE	**DEADLINE**	
May 2000	Timetable set	
August 2004	Interim 58 hour week	Rest and break regulations apply with any derogations
August 2007	Interim 56 hour week	
August 2009	48 hour week	May have an interim 52 hour week for a further 3 years until 2012

In addition to the overall hours limit, the EWTD requires the following rest and break entitlements:

1 11 Hours Continuous Rest in every 24 hour period
2 Minimum 20 minute break when working time exceeds 6 hours
3 Minimum 24 hour rest in every 7 days OR
Minimum 48 hour rest in every 14 days
4 Minimum 4 weeks annual leave
5 Average of no more than 8 hours work in 24 hours for night workers (if applicable)

Under the EWTD it is permissible for individual countries to derogate from certain requirements of the Directive. In the case of junior doctors, the overall hours limit cannot be varied, but the potential exists to derogate from aspects of the rest requirements, in particular the minimum daily rest. The UK is seeking to derogate from the rest requirements so they no longer apply in their current form, in order to minimize compliance difficulties such as conflicts between long shifts and minimum rest periods. However even with derogation, junior doctors will be entitled to 'compensatory rest' equivalent to that lost when minimum rest is not achieved.

ANNEX C

RESPONSE TO EUROPEAN COMMISSION COMMUNICATION ON THE WORKING TIME DIRECTIVE

This response is made on behalf of 14 of the 15 delegations to HOPE (the Standing Committee of the Hospitals of the EU). The exception is the Austrian delegation, which was not able to comment.

We welcome the opportunity to comment on the Commission's recent communication re-examining Directive 93/104/EC on certain aspects of working time (the working Time directive).

In commenting, we do so, not as social partners because some delegations are not, but at least as highly interested parties in this important communication process.

In commenting, we wish to make clear our commitment to ensuring that employees do not work excessive hours and have proper rest periods. This is particularly important for healthcare workers given their responsibility for caring for ill patients and the increased risks of adverse outcomes when patients are treated by tired staff. The specific comments made by us should be seen in this context.

The Commission communication sought comments on five issues:

- the reference periods for calculating working time;
- the Court of justice's interpretation of the concept of working time in the SiMAP and Jaeger cases;
- the conditions of application of article 18.1 b)I) (opt out);
- measures to improve the reconciliation between work and family life;
- whether an interrelated approach to these issues would allow a balanced solution capable of meeting the criteria set by the Commission.

These criteria were that any approach should:

Give workers a high level of health and safety protection in respect of working time

Give firms and Member States more flexibility in the way they manage working time

Make it easier to reconcile work and family life

Avoid imposing unreasonable constraints on firms, particularly small and medium-sized businesses.

In this context, we regret that the criteria have been framed solely in terms of the impact on the business sector and have not recognised the importance of the wider social and healthcare sectors which are also affected by the Working Time Directive and which have the ability to demonstrate exemplary behaviour in its application.

REFERENCE PERIOD

We would welcome an extension of the reference period so that working hours could be averaged over a period of up to twelve months and believes that there should be flexibility for longer reference periods – up to two years – to be negotiated by collective agreement. A longer reference period would permit a more realistic approach to calculating working time particularly where this may fluctuate over the period.

THE COURT OF JUSTICE'S INTERPRETATION OF THE CONCEPT OF WORKING TIME IN THE SIMAP AND JAEGER CASES

We are seriously concerned about the impact of these judgements on healthcare services across Europe and regrets that the Commission's communication does not fully address the implications of the rulings, particularly the Jaeger ruling that compensatory rest must be taken immediately.

The Court's interpretation that working time should include all time spent by staff when on call at their place of work has profound implications for the way in which medical services are delivered in many countries, an impact which will be still greater when the Directive applies to doctors in training from 1 August 2004. This is because it is common for medical work to be organised in such a way as to include regular periods of residential on-call duty and for healthcare staff to be required to be available for work during rest periods. In order to comply with the Court's interpretation of the Directive it will be necessary for some countries to recruit significant numbers of additional doctors or to make major changes to the way in which hospital services are organised at a time when healthcare budgets are already under strain.

Furthermore, the Jaeger judgement's ruling that compensatory rest should be taken immediately creates potential difficulties whenever (for example) doctors on call overnight who are called out and are due compensatory rest as a result are also scheduled to work the following day. This requirement could disrupt the effective management of hospitals and adversely affect patients.

We consider that it is important that there should be an urgent and sustainable solution to the problems caused for the healthcare sector – and to other sectors – by these rulings. In relation to the definition of working time we would propose that, the directive should be amended so that time which staff spends resident on-call when they are not actively working (eg, when they are sleeping) does not count as working time. It would be possible either to define this time as resting time or to introduce a new concept of "inactive time" for these periods, which would be classified as neither working time, nor resting time.

In relation to compensatory rest, we would propose that this should be taken as soon as is possible but in any event within a limited period after the end of the period of work. This period could either be specified in the Directive or be determined by collective agreement within each Member State. Such an approach would ensure that the worker is afforded compensatory rest soon after the interruption whilst minimising the risk of disruption to services.

THE CONDITIONS OF APPLICATION OF ARTICLE 18.1 B) 1) (OPT OUT)

We recognise the concerns, which have been raised about the use of the individual opt-out and particularly about the potential for the current provisions to be abused to the detriment of workers. However, we believe it is important that the opt-out facility is retained to provide both employers and workers with flexibility in the organisation of services and working time. In particular, we are

aware that some countries are considering its use in the healthcare sector to mitigate the impact of the SiMAP and Jaeger rulings. However we believe that it is essential that there are proper safeguards over the use of the opt-out to avoid the exploitation of workers and particularly considers that workers should not be required to sign an opt-out before she or he takes up employment or to make signing an opt-out part of a worker's contract.

MEASURES AIMED AT IMPROVING THE RECONCILIATION BETWEEN WORK AND FAMILY LIFE

We are committed to ensuring that healthcare workers have a proper balance between work and family life. Ensuring this is very much a matter for individual member states and there is undoubtedly much good practice, which can be shared. More generally we believe that the work-life balance could be enhanced if there were flexibility to allow workers who undertake on-call work to receive additional holiday time in lieu of payment if they so choose.

WHETHER AN INTERRELATED APPROACH TO THESE ISSUES WOULD ALLOW A BALANCED SOLUTION CAPABLE OF MEETING THE CRITERIA SET BY THE COMMISSION

We believe it is important that there is an early and lasting solution to the problems faced by health services arising from the SiMAP and Jaeger rulings. We do not, however, believe that such a solution should be achieved at the expense of the provisions allowing workers to opt out as such a facility is important to enable healthcare organisations and their staff to manage services effectively to the benefit of the employer, staff and patients.