

Green Paper European Workforce for Health

HOPE position

HOPE is the acronym of the European Hospital and Healthcare Federation, an international non-profit organisation, created in 1966. HOPE includes national associations of public and private hospital and of owners of hospitals. Today HOPE is made up of organisations coming from 26 Member States of the European Union and Switzerland as observer member.

HOPE welcomes the European Commission proposal's aim of trying to put together some elements on the migration and mobility issues. In enlarging the scope to all workforce issues, the European Commission is however taking the risk of giving a simplistic perspective on a highly complex issue. By embracing too many aspects, the green paper might be missing the point. It only partly addresses the rather confusing patchwork of EU influence on the health workforce. In other words, it explicitly shows the dispersion of the issue at EU level, in particular in the Commission, certainly more than it usually happens at national level.

There are major tensions and sometimes contradictions between the organisation of health care services and the EU policies and principles. Mobility of professionals is one good example of this. The European Union is pushing mobility without being able to prevent the negative impacts it has at national and local level. More generally, there is a limited explicit EU agenda for health professionals, which means directly focused on health professionals. The implicit agenda is however increasing and is having a major impact on the European health workforce, the working time directive being one obvious example.

HOPE has a long experience in trying to understand workforce issue at European level. It developed in 2004 a report "The Healthcare Workforce in Europe". The key issue yesterday as it is today is the need of indicators, of sound valid and reliable data. Indicators on the use of workforce are still missing. They should be the priority before envisaging anything at European level. The same goes for mobility and migrations.

Once the pre-condition is met, HOPE would broadly supports opportunities of sharing experience between healthcare systems and of coordinated action throughout the EU. Actions should however be built on existing mechanisms at European, national and regional level. The diversity of Member States experiences is a source of lessons but also of misinterpretations. It is critical to engage stakeholders from health and beyond to get the most of this diversity.

HOPE believes however that any action taken at European level must fully recognise the differences between healthcare systems and not undermine in any way the capacity of the Member States to plan, fund and organise patient care for their citizens.



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 whichever way 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 population's age and the range of treatments which can be provided increases. HOPE, has been working 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. Even when staffing levels may seem good, it is clear for HOPE members that there are serious shortages of doctors and nurses, both overall and in particular specialties. Furthermore there were geographical variations in a number of Member States with some parts of the country finding it more difficult to recruit and retain staff than other parts.

There are also particular problems in a number of specialties including:

- Psychiatry, anaesthetics, cardiac specialties, geriatrics, radiology, pediatrics and laboratory specialties, for doctors;
- Geriatrics, intensive care, midwifery, psychiatry and pediatrics, for nurses.

There is a range of geographical recruitment difficulties which include:

- Areas of social deprivation, often inner city areas;
- Rural areas, where there are concerns about professional isolation;
- Areas where the cost of living is high and where some healthcare workers find it difficult to obtain affordable accommodation.

One consequence of the shortage of staff, and the difficulties of recruiting and retaining new staff, is that in some countries the workforce is ageing fast. There are concerns that the position could worsen in future years particularly as population is ageing and demands for healthcare is 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.

What are the causes of current shortages?

While HOPE members identify a range of causes for the current workforce shortages there are a number of common features. They include:

- Reductions in, or failure to increase, training places in recent years, often as a result of financial pressures;
- The perception that the healthcare professions are unattractive and have 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 specialties, particularly for instance radiology or laboratory specialties

How have HOPE members sought to tackle workforce shortages?

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

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.

There is scope for sharing good practice in recruitment between countries to the benefit of all. 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.



What about international recruitment?

There has been considerable emphasis on the need for ethical recruitment from non-EU countries in order not to undermine health services in developing countries. At the same time there are, not unreasonably, concerns among those countries which joined the European Union in 2004 and 2007 that the Directive on the Mutual Recognition of Professional Qualifications has been and is still leading to the migration of skilled staff to countries with better rates of pay and facilities to the detriment of their health services. This comes at a time when many of these countries have shortages of professional staff. Migrations have severe consequences for the countries concerned.

There is a need for the collection and dissemination of information on international recruitment.

The on-going research into the impact of international migration on the health services of those countries from which staff is recruited, with a particular focus on developing countries, and the use of inter-Governmental Agreements will be most welcomed when available.

DETAILED REMARKS ON THE GREEN PAPER

In the following pages, the Green paper “Influencing factors and possible areas for action” are commented based on exchanges and debates within HOPE.

1. Demography and the promotion of a sustainable health workforce

Assessing levels of expenditure on the health workforce

This assessment requires first sound indicators.

Ensuring better working conditions for health workers, increasing staff motivation and morale

Members of HOPE have already adopted a wide range of strategies to address those challenges. The European added value would be limited here as motivation and morale are highly dependent on national and even more local situations.

Considering recruitment and training campaigns, in particular to take advantage of the growth in the proportion of over-55s in the workplace and those who no longer have family commitments

This is where good practices exchanges are valuable to share; not only on what has been done but if it worked or not.

Organizing chronic disease management practices and long-term care provision closer to home or in a community setting

It is surprising to find here this element concerning the general organisation of healthcare. Is there evidence that this does reduce the need of health workers? There is some evidence of the contrary.

Providing for a more effective deployment of the available health workforce

This cannot be done at EU level. On the contrary, in several Member States the EU free movement policy has played against the attempts for a sound deployment of the available workforce.

Considering "return to practice" campaigns to attract back those who have left the health workforce

This is where good practices exchanges are valuable to share; not only on what has been done but if it worked or not.



Promoting more social and ethnic diversity in recruitment

This has to be dealt with at national and local level.

Raising awareness in schools large range of careers in the health and care sectors

This is where good practices exchanges are valuable to share; not only on what has been done but if it worked or not.

2. Public Health Capacity

Strengthening capacity for screening, health promotion and disease prevention

This will not reduce the need for more health professionals.

Collecting better information about actual and potential population health needs in order to plan the future development of the public health workforce

This requires developing better health needs indicators than those existing today and more research on the link between needs and all health workforce and not only the public health workforce.

Promoting scientific vocations in schools by highlighting career options in lesser known public health jobs (biologists, epidemiologists, etc.)

Do we have a problem here or more generally in healthcare and in some Member States in all scientific careers?

Giving the Agency for Safety and Health at Work (OSHA) more visibility in the Member States by publicizing its existence directly at workplaces

The purpose of this is not clear. Would this concern all workplaces or is it focused only on healthcare workplaces? Can (at least in terms of resources) OSHA deal with direct micro-level issues?

Promoting the work of occupational health physicians and giving incentives to doctors to join this area

Again does this relate to the healthcare workplace or is it the promotion of one category of health professionals?



3. Training

Ensuring that training courses are designed to take into account the special needs of people with disabilities (they should receive the same quality of care as non-disabled patients and be provided with the specific health services they need).

It is surprising to find this element here. Why focusing on this population when we are talking about health workforce?

Focusing on health professionals' continuous professional development (CPD). Updating professional skills improves the quality of health outcomes and ensures patient safety.

Does this help for the workforce issues? Are not we outside the scope of the Green Paper?

Developing training courses to encourage the return to the workforce of mature workers.

This is where good practices exchanges are valuable to share; not only on what has been done but if it worked or not.

Fostering the cooperation between Member States in the management of *numerus clausus* for health workers and enabling them to be more flexible.

Numerus clausus is not in place in all Member States. Much has to be done on health workforce indicators before trying any cooperation in this field.

Developing possibilities for providing language training to assist in potential mobility

This is a conflicting aim with the other objectives. Why would we need more mobility when the present difficulties have been created by this mobility ?

Creating an EU mechanism e.g. an Observatory on the health workforce which would assist Member States in planning future workforce capacity, training needs and the implementation of technological developments.

Is this useful at this stage? Is there scope for one more platform? Should not we learn from the existing "platforms"?



4. Managing mobility of health workers within the EU

The present system of mutual recognition does not provide sufficient safeguards concerning the exchange of information on possible disciplinary action or criminal sanctions.

Fostering bilateral agreements between Member States to take advantage of any surpluses of doctors and nurses.

Surpluses and shortages have to be defined. Surpluses seem limited and volatile. Bilateral agreements are interesting tools but since there are few surpluses...

Investing to train and recruit sufficient health personnel to achieve self-sufficiency at EU level.

This does not only concern healthcare but all the education system. How far will education ministries be involved in this consultation will matter a lot.

Encouraging cross-border agreements on training and staff exchanges, which may help to manage the outward flow of health workers while respecting Community law.

This would help but not significantly, considering the free movement principles.

Promoting "circular" movement of staff

Creating an EU-wide forum or platform where managers could exchange experiences.

Again, is this useful at this stage? What sort of managers are targeted? From the context, one can assume that it is human resources managers? Is there scope for one more platform? Should not we learn from the existing "platforms" at national, regional and local level?

5. Global Migration of Health Workers

Putting in place a set of principles to guide recruitment of health workers from developing countries and introducing methods for Monitoring

Supporting the WHO in its work to develop a global code of conduct for ethical recruitment

Stimulating Bilateral and Plurilateral agreements with source countries and developing mechanisms for support of circular migration



For such a global issue, the EU should take a global approach and join the existing mechanisms, with the WHO, instead of creating new ones.

However, concerning the recruitment code, on one hand there is already general legislation protecting all workers in place, and on the other there is the recent initiative of the Blue Card. How do they fit with this discussion at WHO level. Such a code raises the issues of competence, ownership and monitoring: who recruits the workforce? Who owns the code? Who will control it?

6. Data to support decision-making

Harmonising or standardising health workforce indicators

Setting up systems to monitor flows of health workers

Ensuring the availability and comparability of data on the health workforce, in particular with a view to determining the precise movements of particular groups of the health workforce

This should be the starting point for any development on this workforce issue at EU level. To get sound information a common methodology for assessing workload is needed.

7. The impact of new technology: improving the efficiency of the health workforce

Ensuring suitable training to enable health professionals to make the best use of new technologies

Taking action to encourage the use of new information technologies

Ensuring inter-operability of new information technology

Ensuring better distribution of new technology throughout the EU

This part is unclear. Is this just the promotion of health technology? Should we have a passive approach by talking about “impact” or about the use of new technology? Is it the old concept that machines will replace the human workforce? The health sector has already for decades been developing and been using “new” technologies.



8. The role of health professional

Entrepreneurs in the workforce

Encouraging more entrepreneurs to enter the health sector in order to improve planning of healthcare provision and to create new jobs

This is a surprising statement. Individual entrepreneurs might on the contrary increase shortages, for example when they decide to develop their activity in niche, for example a targeted population outside social coverage.

Examining the barriers to entrepreneurial activity in the health sector

Is this aiming at a new Services Directive, but specific to health care?

9. Cohesion Policy

Making more use of the support offered by structural funds to train and re-skill health professionals

Improving the use of the structural funds for the development of the health Workforce

Enhancing the use of structural funds for infrastructures to improve working conditions

Structural funds are more and more mentioned in Commission's documents as a solution but there is limited evidence that accessing them has improved in the health sector. It would be useful to capitalise on the existing projects financed through structural funds, both on content and methodology.

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