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Green Paper On the European Workforce for Health

The Commission of the European Communities has asked all interested organisations in the EU Member States to submit responses to the issues raised in the Green Paper on the European Workforce for Health by 31 March 2009.

Contrary to earlier practice, this Green Paper refers right from the outset to "factors influencing the workforce for health in the EU and the main issues to be addressed", rather than asking specific questions around which to structure the response.

The Federal Chamber of Labour agrees with many of the conclusions drawn. We welcome in particular the idea of securing better working conditions for health workers and increasing staff motivation and morale. On the other hand, the fact that this objective was included only after "assessing levels of expenditure on the health workforce" gives some cause for scepticism. The reference to the high proportion of total expenditure represented by staffing costs also unfortunately suggests that making these occupations more attractive is unlikely to be associated with the need for better pay.

Proposals such as promoting mobility, training and recruitment according to ethical principles are also to be welcomed. Making them work, however, will always depend on the willingness of Member States to undertake comparison, exchange best practice projects and reform their own systems.

The following suggestions of the Federal Chamber of Labour (hereinafter: Chamber) to a large extent reflect experience in Austria, but are in most cases nevertheless of sufficient general relevance to be applied to other EU Member States as well.

Our view on certain points differs from that of the Commission. In particular, the current debate on the Working Time Directive and what is going on in the EU in the matter of opting out of the working time minimum standards make clear that the Chamber cannot, for reasons of social policy, subscribe to some of the health policy

objectives pursued by the EU. Similarly, concerns of security of healthcare provision mean that the idea of promoting entrepreneurship in the health sector could also, in our view, be a step in the wrong direction.

The Federal Chamber of Labour's comments on the individual sections of the Green Paper are set out below.

Demography and the promotion of a sustainable health workforce

The introduction to the Green Paper refers to demographic trends and suggests that continually increasing spending on health is inevitable. According to this logic, a higher life expectancy and falling birth rates in all Member States will result in a demographic development which will sooner or later push the health and care systems beyond the limits of financial viability. In our view the extent of this development will depend on factors such as future economic and labour market developments and, above all, whether a society wishes to have a high level of state-funded social security or not. This in turn is the result of a political process and not necessarily a consequence of demographic processes. The degree to which the population is ageing, moreover, does not find general consensus in academic circles. The future trend will also depend largely on what is done to create an environment favourable to health. The labour-intensive nature of the sector is seen in the Green Paper only as a cost-generating factor, and not as an opportunity for the European labour market. Expanding health services mean more jobs and more revenue, which will generate further resources for financing social security and health services.

In its Green Paper, the Commission assumes increasing demand for health services in the future due to an ageing population, socio-structural changes (more women in employment, more single-person households, etc.), better services on offer, new technologies and new forms of health risk. Against this background, increasing emphasis is being placed at national and European level on the question of future financing needs (most recently EPC/DG ECFIN, Impact of ageing on public expenditure. Special Report/2006). Even if the Chamber does not consider that public health financing should be the central focus of the Green Paper, the need for regular assessment of the effectiveness and cost-efficiency of these systems is not disputed. That also implies that they must operate efficiently and have a highly qualified workforce. It would be a waste of public resources to provide state-funded training for care personnel without ensuring that they do not then leave the profession within a relatively short time, thereby creating a care provision shortage. It is clear that this phenomenon, which can be observed in most EU Member States, has mainly to do with working conditions (work organisation, working time, job satisfaction), particularly in the case of in-patient care, and with the lack of recognition and excessively low pay in health and care occupations. In our view the emphasis

should therefore be on improving working conditions in the health sector.

The chronically sick and care-dependent should receive care at home, since professional home-based services in the form of short-term, day or intermediate care are preferable to moving the recipient to a care home. This means expanding the supply of extramural social services. In order to ensure well organised, high-quality care services in the future it is essential to iron out coordination problems in the sector by developing integrated forms of care.

Public health capacity

The most important aspect concerning public health capacity is the objective expressly mentioned in the Green Paper of "carrying out health needs and health impact assessments for service planning, prevention, etc.". Most national health systems have the problem that policymakers and health authorities lack comprehensive (empirical) data on the quality of health services (over-, under- or incorrect provision of care). Studies of this nature could make a real contribution to rationalising health policy and should be expressly recommended by the EU in the final version of the Green Paper.

The same applies to health promotion and preventive health care. In reducing demand for treatment and care services, enhancing the preventive element of health policy has an important role in both humanitarian and economic terms. While prevention and health at work are given greater priority in some Member States than others, they are often quite underdeveloped (as is the case in Austria, for example), which can be put down in part to problems of financing, but also to the attitude, difficult to dispel, that prevention and occupational health are not cost-effective either for the economy as a whole or for individual businesses. At the same time, a whole series of international studies show a return on investment for workplace health promotion of 1:3. The EU could certainly increase its role in this area, provided this does not encroach on the sovereignty of Member States. Social security systems, the persons covered by them and undertakings should at all events be encouraged to take an interest in preventive health care.

We would point out in this connection that social and care services in Austria (where not provided in residential establishments) are a regional responsiblility, which is precisely why there are considerable disparities in care provision and divergence from politically agreed social standards. Then there is the question of care coverage. Even if the care provision situation at any given time is known, it does not necessarily correspond to the official care demand estimate. What is needed in Austria, and no doubt in other countries as well, is therefore the "better information about actual and potential population health needs" recommended in the Green Paper.

The Green Paper is also right to highlight the need to improve staffing in the occupational health services (in particular, incentives to attract people into jobs in this sector) and to enhance the role of the Agency for Safety and Health at Work (OSHA) in the Member States. The proposal to give the OSHA "more visibility" is hardly likely to prompt a mass influx of staff into the health sector. Rather, the Agency needs to launch more initiatives to promote occupational health for workers in the health sector and raise awareness among both employers and employees.

In the same line of argument, a legal basis is also required for Europe-wide worker protection, and safety officers should be introduced at EU level.

The Chamber rejects the idea of privatising and "marketising" public health and care services. Neither will lead to cheaper systems or better quality, and certainly not to better working conditions for employees, as the UK's and Germany's experience has shown. If the EU wishes to maintain an adequate workforce in the care sector in the future, this issue cannot be left off the agenda.

New sources of financing must be found for state or parafiscal health systems (assets, asset growth, value creation) which are non-payroll related. The EU could also make an active contribution in this area through recommendations and studies.

Training

The Chamber is in favour of mutual recognition of healthcare occupations on the basis of a "Rasterzeugnis" (training logbook detailing the content of training successfully completed, attached to the obligatory professional identity card), from which the nature of the qualification can be clearly established. The national authorities must be given the option of providing for supplementary training giving entitlement to pursue an occupation. The obligatory training curricula for individual health occupations should be laid down in all EU countries and entered in the logbook once the national examination has been passed. In this way, each individual occupational qualification would be registered in detail. As well as ensuring quality, this would also serve to identify needs.

In-depth discussion is needed on which specific tasks should be performed by a given occupational category. Implementation should be left to the Member States. In many areas (such as common diseases), performance quality and efficiency could be improved by entrusting an EU institute with the definition of standardised treatment approaches. Answers need to be found to the following questions: How should health care provision be apportioned between the various occupational categories in the future? How can care provision be integrated?

Basic training, retraining, continuing training and the exercise of a profession depend on the provision of particular basic conditions. Work and family life must be more closely reconciled. Since this occupational category is overwhelmingly female and many women go back to it after a career break, Member States should ensure that appropriately conducive conditions are in place. Alternative work and working time arrangements such as sabbaticals and periods away should be encouraged. Language courses could help reduce language barriers.

The working time issues raised in the European Court of Justice Jäger, Simap, Pfeifer, etc. cases concerning the regular exceeding of maximum working hours in the health sector have not, in our view, been adequately addressed by the Commission in its review of the Working Time Directive, but in fact exacerbated by the proposal to exclude standby duty from working time. More favourable working hours are an obvious way of making the health sector more attractive.

Only if the right working conditions are created will any campaign targeting older workers and returnees to work have a chance of success. Working conditions in the health sector must be manageable for older workers and generally not harmful to health. Generally speaking, work organisation appears too inflexible when it comes to offering alternative activities to workers to offset any age- or job-related adverse health effects.

The more legal, administrative and commercial rules and procedures there are to follow and medical, psychological and psychosociological knowledge and innovations to be assimilated, the greater the need for competent and self-reliant staff. Work structures are therefore needed that help to exploit these qualities. Error management and the development of "magnet hospitals" should be promoted.

To achieve the necessary high standard of health care, binding staffing standards and recruitment methods must be introduced. In view specifically of the impending shortfall of qualified personnel, minimum safeguards are needed to prevent an exodus into other branches.

The Green Paper mentions as a possible area for action strengthening capacity for screening, health promotion and disease prevention. This includes ensuring a comprehensive supply in the fields of occupational rehabilitation and geriatric remobilisation. Mental stress, in the heath and care occupations in particular, leads to burn-out.

Women employed in the heath services have fewer promotion and career opportunities than men. Given the high percentage of women in the workforce, their representation in management positions is poor. It is therefore imperative to encourage female applicants when filling posts. Efforts should also be made to make the health occupations more interesting and attractive for men.

Managing mobility of health workers within the EU

The Commission rightly emphasises that the recognition of professional qualifications in the past has significantly increased mobility within the EU. The idea of setting up an EU monitoring point which could identify personnel supply problems within the EU is constructive. On the basis of the observations of such an institution, bi- or multilateral agreements could be concluded on utilising any surplus medical and nursing staff in a given country, or exchanging specialist staff. The information could also serve as a basis for a common investment policy for promoting training or improved "circular" mobility. The observatory could recommend new training content to the Member States.

In any event, planning appropriate action requires reliable sources of reference data. Equivalence certificates, surveys to assess the demand for working abroad, and country-based studies do not at present provide sufficient information on actual professional activity. The data sources therefore need to be harmonised and standardised and made more available and comparable.

Global migration of health workers

Working conditions aside, a particular factor presenting an (ethical) problem is the uneven global mobility within the health professions in the form of an outflow from the poorer countries into the richer ones. In order to make up the levels of qualified staff in the health services, the European countries often recruit personnel from African countries who are later reluctant to return home. This creates a massive shortage of qualified professionals in the developing countries.

The Commission rightly suggests remedying this problem by means of a worldwide Code of Conduct and global circular mobility mechanisms. A further step forward would be to improve the integration of migrants living in the country for a sustained period.

The "numerus clausus" problem, which is only touched upon in the Green Paper, and which in Austria has led to a disproportionate increase of – mainly German – students at Austrian medical faculties, requires an urgent solution at EU level. While this student mobility, provided for in EU legislation, is essentially to be welcomed, in the case of medicine it could jeopardise the sustainability of Austria's health provision because the majority of places at medical schools are taken up by students from other EU countries who return home after completing their studies.

At the moment, up to expiry of the transitional periods for new Member States, Austria is still applying special admission criteria intended to protect employment and pay standards as far as possible. Maintaining Austria's pay and social security standards after 2011 will, however, in view of the rules on freedom of

movement, present a serious challenge.

The impact of new technology: improving the efficiency of the health workforce Telemedicine can help to secure healthcare coverage in remote areas or in the case of home care, but will require intensive training campaigns in the new skills in the Member States. "Pharmaceutical efficiency" can only be improved when there is a central drug authorisation and pricing system in the EU.

The role of health professional entrepreneurs in the workforce

This section addresses the matter of "encouraging more entrepreneurs to enter the health sector" ("examining the barriers to entrepreneurial activity in the health sector"). The Commission refers to the "Small Business Act" for Europe and proposes promoting entrepreneurship in the health sector by reducing all barriers to entrepreneurial activity in individual job categories.

The Federal Chamber of Labour is against this proposal. Entrepreneurship can neither improve the planning of service provision nor create new jobs. It is far more likely to destabilise healthcare institutions. In order to protect patients, independent workers must be bound by the same rules on duty periods as employed workers.

The debate on round-the-clock care in Austria has demonstrated that entrepreneurial activity can lead to the uncontrolled use of unqualified staff creating competition of a nature to cause wage dumping.

The Chamber welcomes the possibility referred to in the Green Paper of using the EU Structural Funds to support the health services. The resources available to Austria under the European Social Fund (ESF) have been drastically cut back for the current programming period (2007 – 2013). This has so far meant, particularly in view of the labour market situation, that we have had to focus on a few target groups (e.g. promotion of older workers, women and people with migrant backgrounds) and measures of particular relevance, for maximum effectiveness. Obviously, in this situation, it was not possible to target any more resources specifically at the health sector.

In conclusion, the Federal Chamber of Labour requests the Commission of the European Communities to consider these proposals for inclusion in the Green Paper.

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on behalf of the Director