Deutscher Caritasverband

Opinion on the Green Paper on the European Workforce for Health

[COM(2008) 725]

1. Introduction

A central objective of the *Deutscher Caritasverband* is to facilitate, promote and ensure voluntary inclusion for all. By "voluntary inclusion" we mean giving all people access to the social, cultural, economic and political opportunities offered by their society, including access to healthy and health-promoting living and environmental conditions and health services. Even in the highly-developed European Union, such access is distributed unevenly – for example, in Germany, those belonging to the bottom fifth of the population (in terms of income and level of education) are significantly more likely at any age to fall seriously ill or die prematurely than those in the top fifth. The difference in life expectancy is still around seven years.

The commitment to voluntary inclusion as an objective of health policy goes beyond the traditional healthcare system. Health and illness are not just related to the individual – their material, cultural and societal causes and framework conditions must be considered as a priority and incorporated in any integrated health policy. This means that the responsibility to promote health lies not only with the health sector – rather, all areas of policy must contribute to facilitating and encouraging healthier lifestyles. People must be empowered to sustain and structure their own health and environment and to choose health-promoting living conditions.

2. The Green Paper

The European Commission's Green Paper on the European Workforce for Health [COM(2008) 725] assumes that EU health systems have to perform a difficult balancing act, because the demands on health services are set to increase and the health services of the Member States are heading towards difficult times because of predicted demographic developments. The Green Paper mentions an important way of tackling the situation: "To respond adequately to these challenges requires health systems to have efficient and effective work forces of the highest quality" (page 3). The Commission therefore highlights **just one factor** for discussion, whilst the reality is that there are many more.

The aim of the Green Paper is to throw more light on problems relating to the health workforce in the EU, describe the challenges and create a better foundation for proposing solutions. It also describes the influencing factors and the areas for action.

To give an idea of the quality of the description of these influencing factors and the need for action, here is a list relating to "Demography and the promotion of a sustainable health workforce" from page 7 of the Green Paper:

"**Influencing factors and possible areas for action:**

- Assessing levels of expenditure on the health workforce
- Ensuring better working conditions for health workers, increasing staff motivation and morale

- 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
- Organising chronic disease management practices and long-term care provision closer to home or in a community setting
- Providing for a more effective deployment of the available health workforce
- Considering "return to practice" campaigns to attract back those who have left the health workforce
- Promoting more social and ethnic diversity in recruitment
- Raising awareness in schools of the wide range of careers in the health and care sectors".

3. Overall assessment

All the subjects listed in the Green Paper and the "Influencing factors and possible areas for action" are certainly sensible when considered individually, but most of them are self-evident ("Strengthening capacity for screening, health promotion and disease prevention") or perfectly reasonable aspirations ("Ensuring better working conditions for health workers, increasing staff motivation and morale") for which it is unclear where the money is to be found.

4. More comprehensive approach needed

If the goal is "to provide a better basis for considering what could be done at EU level to address these problems effectively, and in a manner which does not have a negative impact on health systems outside the EU" (page 4), the social health system and therefore the health system itself and the initial and in-service training given to health professions must be considered systematically. "Systematically" means that the following questions must be looked at in parallel and answered in a logical, mutually compatible way:

- **Prevention and health promotion:** What can be done so that as few health workers as possible are needed, because citizens in the EU are staying healthy for as long as possible?
- **Health policy, beyond the health system:** What can be done to mainstream the promotion of healthy living and environmental conditions in all areas of policy and ensure that all possible measures are being taken?
- **Creativity and efficiency:** What can be done so that resources which are available or potentially to be discovered as a result of synergies and creative action can be used efficiently to promote healthy living and environmental conditions and to combat and alleviate the consequences of disease?
- **Additional resources:** What can be done so that, where necessary, additional resources can be made available to promote healthy living and environmental conditions and to combat and alleviate the consequences of disease?
- **Staffing:** What can be done to ensure that staff, as a fundamental resource to promote healthy living and environmental conditions and to combat and alleviate the consequences of disease, are prepared, supported and properly trained for their work?

5. Staffing

The following measures are proposed, in addition to a general listing of the influencing factors and areas for action in this field:

The occupations and fields of activity for the promotion of healthy living and environmental conditions and to combat and alleviate the consequences of disease must be defined – the Member States must clarify where, in what kind of organisational unit and under which developmental and implementing organisations staff are to work in the medium term. Only when the activities to be performed are clear can the associated **requirements** be recognised and defined. As these requirements can be formulated as **qualification criteria**, they can form the starting point for teaching and methodological concepts, the content and organisation of training and for deciding where skills are to be mastered (within and/or outside the education system, which type of training establishment, what status of training establishment in the hierarchy of the system).

The occupational system and therefore the institutions and organisations of the health system must transparently define which skills are expected. The "client", i.e. the beneficiaries of (support/help/care) activities or their representative(s) must be involved in these analyses of activities and requirements. The participation of those affected in initial and in-service training should also be provided for.

Finally, any restructuring of the occupations or fields of activity (duties and activities) must be geared primarily to the **needs** of clients/patients/people requiring care and to the **efficiency** of the care process. To this end, both research and systematic dialogue with the persons affected or their direct representative(s) are required. The question of how best to structure the support, help or care process can be geared to these needs. Analyses of the activities, requirements and qualifications can then be performed on the basis thereof.

Once an occupation or field of activity has been analysed in terms of its activities, requirements and qualifications, a detailed description of the necessary skills can be drawn up. The implementation of the European qualification framework at national level is in line with this approach. One of the benefits of the European qualification framework is the potential for improving the comparability of the qualifications or skills of practising healthcare workers. The national qualification framework can give HR managers in healthcare organisations an important initial indication of whether an applicant has the necessary skills for the job. In the same way, people interested in working in the health system will be able to make better decisions about which occupation to choose.

Under this concept, which, according to the European qualification framework, can also be implemented in the national training, further training and in-service training system, skills can also be acquired outside formal training centres. The European qualification framework is outcome-orientated – in other words, the success of the training is determined by its outcome, i.e. empirically demonstrable skills, however acquired. Accordingly, what counts primarily is not the number of years you have spent at a particular type of educational establishment but the proof of skills acquired. In this way, some of the proposals in the Green Paper can also be implemented (e.g. "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", p. 7 of the Green Paper).

The social work and healthcare occupations and fields of activity will, in future, have to rely on a mixture of employees and assistants with different types of qualifications from the non-vocational assistance system (staff mix). The term "non-vocational" here includes more than and is slightly different to the term "voluntary". It means forms of assistance positioned somewhere inbetween the individual helping him- or herself and large-scale, institutional, public, State and professionally organised assistance systems, in other words assistance within the family, between neighbours, formal and informal self-help groups at local level and voluntary work. In this context, people's motivation, their

choice of the type of assistance to give, its content and the specific commitment are usually the result of needs personally experienced, a sense of responsibility towards fellow citizens and the resources available.

A professional understanding is needed for this collaboration, where qualified carers take on more leadership functions and assistants and auxiliary helpers take on more development and implementation work. Qualified carers would thus be increasingly responsible for managing the care process (case management), with planning, monitoring, coordination and interface responsibilities.

Assistants and other helpers would perform mainly practical duties, autonomously or under supervision. A clear division of tasks and ongoing communication between all those involved in the process are necessary for the system to work optimally. Moreover, qualified carers would have to be skilled in involving people without a formal position in the organisation structure (non-vocational system) in all areas.

We would like to present the following further considerations and measures:

It is already becoming clear that, because of demographic change, and even without performing the activity analysis described above, the focus of the healthcare profession will be shifting ever more in the direction of care, rather than medicine. Page 8 of the Green Paper proposes "Promoting scientific vocations in schools by highlighting career options in lesser known public health jobs (biologists, epidemiologists, etc.)". Social skills should be promoted in the same way, because, in addition to scientific and medical skills, employees in care roles in particular require certain personal characteristics and skills having their source in ethics and the social sciences.

As far as care in society and within the family is concerned, it is important to look at the entire organisation of work. Up until now, the issue of reconciling work and family life has been considered almost exclusively in terms of families with young children. However, elderly care must also be taken into account. In Germany, for example, two thirds of elderly people requiring care are still looked after by family members. If relatives are still taking on the lion's share of support and care for these elderly people, it is important to discuss the reorganisation of working life from this angle, too.

The Green Paper proposes different kinds of training in various places. However, more research is needed so that the knowledge, skills and competences necessary for looking after elderly people can be taught. The general issue is: how can participation be facilitated up until very old age, even during illness and dependency, and eventually death. Specific research should be conducted into, for example, the impact of medicines and treatment (and their side effects) in elderly people. The use of the Structural Funds as a possible source of funding for employee training is mentioned in the Green Paper ("Under the current legal framework it is possible to use Structural Funds to develop the health workforce", page 15). It should be possible to support research in the same way.

Lastly, it should be noted that the EU has contributed to a massive tightening of the supply of the labour – in particular in the field of medicine – with its Working Time Directive. The provisions of existing working time law cannot be implemented in practice because of a lack of staffing, and the problem is set to worsen significantly.

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Theresia Wunderlich

Head of Department

Contact:

Dr Franz Fink, Head of the Elderly Care, Disability Care and Health Promotion Department

Tel. 0761 200 366, email: franz.fink@caritas.de