



European Economic and Social Committee

SOC/331
European workforce for
health

Brussels, 15 July 2009

OPINION

of the
European Economic and Social Committee
on the
Green Paper - European workforce for health
COM(2008) 725 final

Rapporteur: **Mr Metzler**

On 10 December 2008, the European Commission adopted a Communication addressed to the Council, the European Parliament, the European Economic and Social Committee and the Committee of the Regions, entitled

Green Paper on the European workforce for health
COM(2008) 725 final.

The Section for Employment, Social Affairs and Citizenship, which was responsible for preparing the Committee's work on the subject, adopted its opinion on 25 June 2009. The rapporteur was **Mr Metzler**.

At its 455th plenary session, held on 15-16 July 2009 (meeting of 15 July 2009), the European Economic and Social Committee adopted the following opinion by 104 votes to 29 with 29 abstentions.

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1. **Committee's comments and recommendations**

- 1.1 The EESC welcomes the publication by the European Commission of the Green Paper on the European workforce for health. Demographic change and its impact on the workforce and workload in the healthcare sector are described by the Green Paper.
- 1.2 The EESC feels that measures should be taken to make jobs in the health care sector more attractive to young people, so that later on, more of them take up jobs in the sector.
- 1.3 The Committee recommends that sufficient staffing capacity be created in health care systems to meet health care needs, boost health care, health promotion and disease prevention.
- 1.4 The Committee believes that the undesired emigration of healthcare personnel to other countries can be countered by higher pay and better working conditions and, where applicable, new responsibilities. New responsibilities require the appropriate qualifications. This would also enhance the attractiveness of the sector generally.
- 1.5 The amount of data concerning healthcare workers in the EU, especially in relation to migration and mobility, must be significantly improved, as decisions are based on them.
- 1.6 The use of new technologies in healthcare is to be encouraged where these reduce the workload of healthcare staff, improve the quality of care and support patients. The EESC is aware that this may lead to a re-examination of how the division of tasks among health care staff works in practice.

- 1.7 The EESC underscores the key role of social standards in ensuring a high quality of patient care and patient safety, and is unequivocally opposed to any attempt to undermine these (no race to the bottom).
- 1.8 The EESC emphasises the key part the professions play in the health care sector, alongside hospitals and publicly-run health services, which form the central hub, since it is in large part through these professionals that personal treatment and care can be secured in an environment of competence and safety. Such professionals are highly qualified thanks to the efforts made by civil society in the Member States to support public education. EESC members, who represent said civil society, are cautious about the Commission's wish to encourage healthcare workers to practice as self-employed persons. At the same time, the EESC is critical of the increasing trend towards apparent self-employment where this is problematic for the particular activity concerned (e.g. nursing and care of the elderly).
- 1.9 The EESC is concerned at the discussion about a new division of tasks in healthcare with the aim of replacing treatment by qualified staff with cheaper alternatives. The EESC takes the view that structural considerations regarding the division of tasks among the healthcare professions should be focused on clinical need, skill levels and the needs of patients.
- 1.10 The EESC is of the firm belief that healthcare institutions and their staff provide services of general interest and that more use should therefore be made of the Structural Funds for their training. The EESC stresses that it is vital to ensure conditions which can enable healthcare professionals to participate in continuous training programmes, thereby ensuring they can extend the breadth and depth of their skills, and also helping to remedy the under-provision of healthcare in structurally weak regions.
- 1.11 The EESC stresses the outstanding role the social partners and social dialogue play in determining pay, working conditions and skills for healthcare workers.
- 1.12 The EESC considers that social professions play a key role in patient welfare and care and thus have a significant role in healthcare.

2. Summary of the Commission's paper

- 2.1 The Green Paper is intended as a basis for in-depth debate between the EU institutions, EU Member States and the key social and economic players involved at European and national level. It provides a framework in which needs can be considered over the long term.
- 2.2 The Green Paper concentrates on nine key areas:

- Demography
- Public Health Capacity
- Training
- Managing mobility of health workers within the EU
- Global Migration of Health Workers
- Data to support decision-making
- The impact of new technology: improving the efficiency of the health workforce
- Strengthening the principle of self-employment
- Cohesion policy.

2.3 **Background**

- 2.3.1 EU health systems have to deal with constantly increasing demands on health services, respond to changing health needs and be prepared for major public health crises. At the same time, there is a high level of expectations with regard to the quality of healthcare services. It must be recognised that the sector is labour intensive, employing one in ten of the European workforce, and on average 70% of healthcare expenditure goes on wages and salaries.
- 2.3.2 Article 152 of the EC Treaty states that "Community action in the field of public health shall fully respect the responsibilities of the Member States for the organisation and delivery of health services and medical care" and that, at the same time, cooperation between the Member States should be encouraged with a view to promoting the coordination of strategies and programmes and the exchange of information about successful programmes in individual Member States.
- 2.3.3 In the Green Paper, the European Commission sets out key questions relating to the problems and challenges of healthcare provision so as to encourage discussion. These key questions include:
- the ageing population;
 - new technologies;
 - the need for healthcare services to be more accessible;
 - service quality and, with that, more cost-intensive treatments;
 - the outbreak and potential of epidemic diseases, and
 - local availability of healthcare.

Definition of "Healthcare workers": all those working in the healthcare sector who provide services in patient care and welfare, nursing care, social and welfare services, and all those belonging to specialised professions.

- 2.3.4 In all Member States a debate is now under way on the extent and availability of workforce potential that will be required for the next decade and beyond. In some Member States there is a significant lack of young blood coming in to work in the sector, as well as a shortage of skilled employees, especially in those areas where predominantly older service staff are employed.
- 2.3.5 In addition to the labour shortage resulting from the age structure, there is a workforce "drain" from the EU to other countries such as the USA and Switzerland, particularly in the highly skilled sectors of health care.

Within the EU, too, the rate of migration and mobility is high. There are significant migratory flows between the individual Member States.

The migration of healthcare workers is a matter of vital interest. Discrepancies in pay and differences in working conditions underlie this development. The difference in system structures has a major impact on the service provided and on skills structures.

- 2.3.6 With this Green Paper and through public consultation on the future of the health workforce in Europe, the Commission raises the profile of the issues facing the EU health workforce and paints a clearer picture of future challenges. It takes into account the fact that health care is an important, fundamental requirement for all Europeans. It also takes into consideration the fact that, without adequate health care, basic freedom of movement within the European Community can rapidly be restricted.
- 2.3.7 Preventive and curative healthcare both have an economic component. The healthcare sector requires trained and experienced staff with recognised qualifications. These make up a significant part of the knowledge society.

3. **The EESC's comments on the solutions proposed in the Green Paper:**

3.1 **The Commission's proposed solutions:**

Because competence in this sphere is limited, the Commission is cautious about putting forward solutions. It has noted that the proportion of women working in the health care sector has risen over the last few years, and therefore suggests measures to make it easier to reconcile professional, family and private life in order to secure the supply of health service employees and skilled workers in the sector. It is also promoting a sound planning strategy and is suggesting that investment be increased to expand further education in all Member States so as to prevent situations where people undertake their health training in only a few countries and then go to others just for employment; such situations could ultimately lead to a further reduction in training capacities. Improved qualifications opportunities, especially in further and continuous training, would also give employers the incentive to employ people and provide training.

- 3.2 The European Economic and Social Committee (EESC) welcomes the Green Paper as a comprehensive discussion paper on the major challenges facing the health system, the health sector and the labour force in Europe. It will encourage a public debate within the context of the Lisbon Strategy with a view to fostering knowledge-based services. It sees healthcare as an integrated whole.
- 3.3 The EESC takes the view that the market in healthcare services should be seen as a market with special rules, as it has a direct impact on the health of the population. The EESC therefore proposes a discussion about the problems caused by the fragmented nature of healthcare provision in some countries, in particular those systems not directly controlled by the state, which makes it very difficult to ensure uniform standards in the development of qualifications and further training.
- 3.4 **Demography and the promotion of a sustainable health workforce**
- 3.4.1 The EESC stresses that women already account for a large proportion of those working in the healthcare professions and that their number is very likely to increase further. This applies across the board. Equal treatment is necessary to ensure gender equality in accordance with the Equal Treatment Directives and also to encourage more men to go and work in the various parts of the healthcare sector. This would include measures to help reconcile work and family life, recognising skills used and the onerous nature of the work involved, and to help women stay in employment and support those re-entering the labour market after extended periods looking after families.
- 3.4.2 Unsurprisingly, good working conditions, health and safety at work have an impact on employees in the healthcare sector. Staff who are satisfied and secure in their work are more caring about patients. If high skill levels, patient safety and security of service provision are to be ensured, workplace and job quality care for staff and the handling of the particular stresses and strains at the workplace in this health sector are particularly important. The Green Paper barely touches on this.
- 3.4.3 The EESC notes the research being undertaken by the social partners on 'Return to Work' schemes. The EESC believes that such schemes can play a vital role in bringing health workers, and especially women, back into the workforce and keeping them there, and that these schemes will become increasingly important in addressing the shortage of skilled workers.
- 3.4.4 The EESC feels that measures should be taken in some Member States to make jobs in the health care sector more attractive to young people, so that later on, more of them enter the healthcare professions or look for jobs in the sector. If more young people, and more men, are to be encouraged to choose careers in healthcare, nursing care and social care, such

employment must be made more attractive through better pay and working conditions throughout the whole of their career.

3.5 **Public Health Capacity**

- 3.5.1 Successful prevention, health promotion and improved healthcare management can reduce the need for treatment and care services. The Committee therefore recommends that sufficient capacity be secured in health care systems to boost health care, health promotion and disease prevention. One precondition must be, however, that there should be a scientific basis to measures, which can then be financed comprehensively on a long-term basis. The Committee believes that the Community should also target health promotion amongst health care practitioners themselves so that they remain healthy and effective (burn-out syndrome). Particular attention should be paid to the fitness of workers at the end of their careers so that they are more able to work without health problems, and to take account of the onerous nature of their working life when determining the conditions for their entry into retirement.

3.6 **Training**

- 3.6.1 The EESC suggests that there be a discussion about the problems caused by the fragmented nature of health care provision structures in certain countries, especially those not directly controlled by the state, making it quite difficult to secure a high standard of uniform skills development and further and continuous training. The Committee thinks it would be useful to look at the extent to which these fragmented structures could be given support with a view to job creation. It also raises the question of mandatory further and continuous training and the application of high standards, as well as greater transparency through certification and uniform standards at European level, together with corresponding measures to achieve this. It wonders to what extent countries have been given incentives to make progress on this front.
- 3.6.2 The Committee wonders about dovetailing the qualifications recognition directive with a possible directive on qualifications in health care. How would this tie in with the existing special directives applying to certain professions? It wonders how this directive has influenced the consistency of qualifications and skills and further and continuous training in Europe, as well as determining the extent to which working conditions in everyday life are standardised.
- 3.6.3 The EESC wishes to broach the cost/benefit considerations relating to a corresponding requirements structure for further upgrading the skills of European health care service providers.

3.7 **Managing mobility of health workers within the EU**

- 3.7.1 The Committee raises a question about the impact of the services on offer and the effect of support programmes; it also asks that it be shown scientifically how far national borders,

language borders and perhaps even cultural differences impact on employee migration in this particular type of work for which so much empathy and knowledge is required.

3.8 Global Migration of Health Workers

3.8.1 As called for in the Green Paper, ethical principles should be respected when hiring staff: thus, for example, in addition to staff being hired from other countries, young people should also be encouraged to stay in their home countries and work in the health care sector. Countries should not try to make up for insufficient encouragement of new generations at home by wooing staff away from other countries. Given the plethora of existing voluntary commitments and the EU's participation in drafting the WHO code of conduct, the EESC queries the additional value of an EU code of conduct.

3.8.2 It is also necessary to prevent the brain drain of developing countries. Recruitment of health workers should take place as much as possible in an institutionalised context, where workers mobility will be supported with bilateral or multilateral cooperation programmes. This can be done through investments in health training infrastructures and improvements of working conditions. Without addressing the reasons for migration, i.e. huge inequalities in pay and working conditions, migration will continue and create further shortages in health staff in developing countries.

3.9 Data to support decision-making

3.9.1 The EESC calls for national statistics to be comparable across Europe. One obstacle is the fact that some health care professions are classified differently in the various Member States. Distinctive national features relating to competence and descriptions of healthcare professions should not be concealed for the sake of achieving uniform indicators. The Committee suggests that corresponding statistics be compiled on health professions in Europe and on migration between states. With regard to the idea proposed in the Green Paper of setting up an observatory on the development of the health workforce, the question arises as to whether this is really necessary and/or whether existing bodies, such as Eurostat or the Dublin Foundation, could be used to achieve the same objectives.

3.9.2 In general terms, data should be improved by establishing a data register. The Committee would suggest that the monitoring of health care professions referred to in the Green Paper be tied in with other EU projects, such as steps to promote health care information systems and to improve the communication between national registers – where these exist – for all professions.

3.9.3 Since in most Member States health care systems are organised or regulated by the state, the EESC welcomes European Commission support, which will generate better planning. To this end, it suggests that the European Union make resources available for carrying out an analysis

of health care provision in the Member States. This analysis would provide the basis for building up a comprehensive system of locally available medical and health care provision.

3.10 The impact of new technology: improving the efficiency of the health workforce

3.10.1 The EESC suggests that research look into whether new technologies can, in the interests of the workforce, be used together with new opportunities for treatment, tied in with electronic communications networks and provided comprehensively in very remote areas, including arrangements for self-diagnosis and patient participation. To this end experience in other Member States can be helpful. Before new technologies can be introduced, they do need to be accepted by the medical professions. To secure such acceptance, those working in this domain must be involved in developing the e-health technology, to make sure that the electronic tools used in everyday practice can be used in a straightforward, safe manner. Proper, optimal training of medical staff in the new technologies is essential if they are to be successfully introduced. The Committee would point out that there are also always risks associated with benefits of new technologies, such as data protection issues. The introduction of new technologies must be geared to the different national health systems. It could trigger a change in the national laws on medical accountability applying in every Member State. The Committee wonders to what extent the measures and pilot projects promoted by the European Commission will hamper moves to build up national IT structures, or even align them downwards.

3.11 The role of health professional entrepreneurs in the workforce

3.11.1 In some countries of the European Union self-employed healthcare professionals, who put the concept of entrepreneurship into practice, play a major role in the provision of healthcare in the Member States. The Green Paper recognises the role the healthcare professions fulfil, alongside the public sector. It is often through these professionals that personal treatment and care can be secured in an environment where competence and safety are guaranteed. However, the Committee points out that, in the EU, most self-employed healthcare workers acquired their skills over long periods thanks to society's efforts in supporting free public education. Civil society is entitled to expect a return (price and costs) and its representatives cannot but look with caution upon the Commission's wish, expressed in point 6 of its paper, which seems to encourage an increase in private provision of this aspect of healthcare. At the same time, the EESC is critical of the increasing trend towards apparent self-employment where this is problematic for the particular activity concerned (e.g. nursing and care of the elderly).

3.12 Cohesion policy

3.12.1 The EESC recommends making more use of the Structural Funds for the education and training of health care personnel. The scarcity of such workers in structurally weak regions could, for example, also be remedied by building up and supporting education and training in

those regions where trained staff are most urgently needed. This suggestion is based on the observation that health care professionals mostly end up working where they train and qualify. Cohesion policy could also offer a framework for fostering pilot projects to tackle any questions arising. The Committee would further suggest releasing Structural Funds resources to improve health care infrastructures and, where appropriate, to improve communications or new treatment standards (evidence based medicine).

3.12.2 The EESC views with concern the essentially economically motivated debate, above all involving management and the professional groups concerned by this matter, on new task allocations in the health care sector, designed to replace qualified staff with cheaper alternatives in medical practice. Improved coordination, process optimisation and networking, together with greater flexibility in the division of tasks, would in fact provide a better solution. In this context, the EESC considers it to be of the utmost importance that appropriate training be provided to prevent a fall in care standards.

3.12.3 The EESC considers that the attribution of qualifications or professions to tasks should be based on:

1. clinical necessity;
2. training, job description and responsibility, and
3. patients' needs.

3.12.4 The EESC holds the view that, even during the financial crisis, Member States should still be willing to provide adequate funding for their health care systems (financial management), not least to ensure that there are adequate staff resources that can provide high-quality services. This also involves improving the working conditions of employees in this sector.

3.13 **Social partnership**

3.13.1 The EESC stresses the key role and responsibility of the social partners in shaping the working conditions of staff in the healthcare sector and the great diversity of the healthcare professions and refers to the preparatory work already carried out by the social partners in this area.

3.13.2 Demographic change, which is leading to a shortage of new staff, must not lead to the level of skills and wages being lowered (race to the bottom). The EESC considers that Member States have a duty to take responsibility for this.

3.13.3 The EESC welcomes the establishment of social dialogue in the European Hospital Sector and notes that the Work Programme agreed by the social partners covers all the issues discussed in the Green Paper. The EESC therefore regrets the failure of the Green Paper to refer to this process.

3.13.4 The EESC underscores the important role of the principle of equal pay for equal work, regardless of gender.

3.13.5 The specific 24/7 working conditions require specific compensation mechanisms (payment for overtime and night work, time off in lieu) in order to compensate for the high pressure on the workforce. In this context, the EESC is very critical of the increasing incentives in many Member States to promote apparent self-employment and thus the loss of social security and employment protection.

Brussels, 15 July 2009.

The President
of the
European Economic and Social Committee

Mario Sepi

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