Vereinte Dienstleistungs-gewerkschaft

Green Paper on the European Workforce for Health (COM (2008) 725/3)

Opinion of Vereinte Dienstleistungsgewerkschaft - ver.di

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Summary of opinion:

On 10 December 2008, the EU Commission (DG SANCO) published a Green Paper on the "European Workforce for Health" in which it made a range of proposals concerning the introduction of an industry-wide employment policy. Although ver.di supports the aim of such a policy for the healthcare sector, we believe that the Green Paper is far from the finished article. **ver.di calls for a thorough review of the actions proposed by the Green Paper:**

- The Commission is seeking to include the healthcare sector in the single market and its implementation of the Lisbon Strategy. **ver.di calls for the Green Paper's introductory section to make it clear that healthcare services should be treated as services of general interest.** Any debate on future staffing requirements should take account of socio-political goals such as quality and equality of service provision, accessibility for the socially disadvantaged, and the principle of solidarity.

- The healthcare sector is also of considerable importance as far as economic and employment policies are concerned. The positive employment trend should not be allowed to mask the fact that the industry has undergone profound structural changes. However, the Green Paper fails to take these into account. **It is therefore necessary for the Green Paper's introductory section to take a much closer look at structural changes in the healthcare sector at the level of individual facilities and the sector as a whole.**

- Definitions and terminology are closely linked to the issue of structural change. This is particularly evident in the remarks pertaining to the term "need for care", and with regard to staffing resources (specifically the term "informal carers"). The Green Paper's introductory section needs to define these more precisely.

- The Green Paper needs to provide more detail on the legal basis of the role that the EU wishes to take on in terms of coordinating the "European Workforce for Health". Greater clarity is required with regard to the reasons for the member states being asked to surrender responsibilities to the Commission, and the areas and manner in which this is to be done. Conversely, the member states need to explain the exact nature of their participation in any employment policy programme. **ver.di is of the opinion that the main responsibility for the healthcare sector, including development of healthcare professionals, should remain with the member states. Any EU measures should be integrated into national labour market programmes.**

- The Commission uses the term "demographic change" to establish a connection between an ageing population and a similar increase in the average age of healthcare workers. We believe this understanding of the situation to be unsatisfactory. Instead, we are of the opinion that the increase in the age of health workers can be attributed to failings in the public health system's human resources and organisational development policy. **ver.di calls for a more differentiated understanding of this issue, and similarly differentiated measures to address it.** ver.di proposes that health and employment initiatives should be launched with regard to care for the mentally and chronically ill and the elderly. It further suggests the implementation of a preventive labour market and employment policy centred on the workplace and focussing on instru-

ments geared towards training, retraining, organisational and human resource development, promotion of work-life balance, workplace gender equality measures, and working conditions and hours that do not discriminate against older employees.

- Owing to the demanding working conditions in the care sector, ver.di is sceptical about the value of a labour market programme for carers over the age of 55. We believe it is more important to ensure that pay and working conditions in the industry are sufficiently good to enable people to remain in the profession on a long-term basis. **Any actions developed in this regard should focus on creating effective structures to promote good and sustainable jobs for carers.**

- ver.di believes that the action points concerning promotion of health in the workplace and in citizens' private lives are key components of a forward-looking healthcare policy. **ver.di therefore supports the Commission's call to pay greater attention to both these areas.** Notwithstanding this, we believe that here too, a more differentiated approach is required. Particularly in view of the new challenges connected with behavioural syndromes in the psychosocial area and resulting from chronic illnesses, it is our view that **focussing primarily on the promotion of scientific competences fails to address the problem adequately**.

- ver.di believes there is a need for further action in the field training and lifelong learning. In the case of Germany, the main priority is to address the failings in the development of ??qualification. **As far as the structural framework is concerned, ver.di proposes that training courses should be examined to make sure that their components are transferable. Furthermore, funding for training should be organised in such a way that that there is no cost to the trainees.** Leaving aside the debate about whether or not setting up an Observatory encroaches on member states' sovereignty, ver.di is in any case of the opinion that the Observatory's role and remit need to be precisely defined, and that the participation of the social partners and other employment policy experts in this process should be guaranteed.

- The Green Paper's main focus is on tackling the themes of worker mobility and migration both within the EU and between the EU and third countries. The key issue here as far as ver.di is concerned is the term "circular migration". **ver.di is categorically opposed to this type of approach for social and employment policy reasons.**

- ver.di proposes a data initiative aimed at assessing national databases and creating a common framework of structural data for describing the economic, employment and labour market characteristics of the healthcare sector.

- The section on promoting new technologies once again reveals the Commission's failure to adequately take into account structural changes at the level of individual facilities and the sector as a whole. We call on the Commission to recognise that the promotion of new technologies must also take into account their impact on jobs and working conditions in the healthcare sector. Furthermore, it is essential for the promotion of new technologies in the healthcare

sector to be accompanied by a targeted impact assessment, development of data protection standards, and measures to ensure patient safety.

- **ver.di calls for greater clarity regarding development of the role of "health professional entrepreneurs".** Even if statutory health insurance outpatient services are provided by private companies, the private service provision is regulated by a legal framework. However, the situation is somewhat different in the case of non-essential healthcare services, where the market is characterised by insecure and inadequately protected jobs. It is important to ensure that measures to promote freedom of establishment or free movement of workers do not end up validating "illegal" healthcare.

- As far as programme planning and funding are concerned, ver.di proposes a Community Initiative to be funded through the ERDF and ESF. Participatory bodies should be created for the implementation phase, in order to ensure that the social partners, in particular, are able to influence programme design and implementation.

1. Introduction

On 10 December 2008, the Commission published a Green Paper on the "European Workforce for Health". The aim of the Green Paper is to address a potential shortage of healthcare professionals. It establishes a link between an ageing population and the need to ensure high quality healthcare services through an "efficient and effective work force" (COM 2008, 725/3, Green Paper, p. 3). By focussing on the public health system, the Green Paper is effectively pursuing a sectoral employment policy approach. The document is divided into an analytical section where the Commission outlines the requirements and framework for common co-ordinated actions to promote the workforce for health, and a section that concentrates on concrete measures identified by the Commission for the development of the workforce for health.

ver.di, and the entire European trade union movement have always argued for the development of a social Europe that **offers workers high quality and secure employment and living conditions in their own countries.** ver.di supports the Green Paper's aim of creating a sectoral employment policy for the healthcare industry. Such a policy should seek to guarantee high quality and safe healthcare services for the citizens and workers in the member states. In view of the shortage of healthcare professionals and the structural changes affecting the healthcare sector, it should also endeavour to provide a sufficient number of high quality jobs, to improve working conditions, pay and social security cover for healthcare workers, and to integrate the proposed measures into the member states' domestic labour market and employment policies in order to ensure their sustainability. The remainder of this document will take a closer look at the Green Paper's underlying principles and the measures it proposes for tackling the shortage of healthcare professionals, in order to assess whether these goals can be achieved through the measures that are currently proposed.

2. The Green Paper's basic principles

2.1. Healthcare services are in the public interest

The Green Paper on the "European Workforce for Health" addresses the issue of how to meet the growing demand for healthcare services in view of the limited number of healthcare professionals potentially available. The Commission links this question to three main trends: the rise in the number of people requiring healthcare services as a result of demographic change, the introduction of new technologies and the associated changes in diagnostic and treatment methods, and the emergence of new and recurrent health risks. The Commission regards healthcare as one of the most dynamic sectors in the European economy. It is on the basis of this approach that the Commission understands the healthcare sector to form part of the Lisbon Strategy and the Single Market. It views the healthcare sector primarily as a market with the potential to act as a driver and source of innovation for other sectors of the economy. This predominantly economic approach can also be observed in the measures geared towards development of healthcare professional staffing resources, as will be seen elsewhere in this opinion. However, it is our view that reducing the healthcare sector to nothing more than a market and only taking economic considerations into account when attempting to develop the supply of healthcare professionals fails to do justice to the com-

plexity of the regulatory issues involved in a public health system. After all, despite all their differences, a number of common basic principles have emerged in the member states that form a fundamental part of the European social model. These share the following characteristics: health is not regarded as an economic commodity, access to healthcare is a fundamental right, and public health systems are based on the principle of solidarity, with different funding models where the State nonetheless always has a key role e.g. in regulation, funding or service provision.

In this regard, ver.di insists that healthcare services should not be primarily regarded as economic commodities, nor should patients be viewed as customers, owing to the limitations on their freedom of choice and the complexity of their relationship with providers. Healthcare, care and social services are often of existential importance to their users, with their particular need for protection. Although it may well be possible that an ageing population offers opportunities to drive innovation and open up new areas of employment, the development of the "health economy" should not occur at the expense of social policy goals such as quality and equality of service provision, accessibility for the socially disadvantaged, and the principle of solidarity.

ver.di's first demand is therefore that the Green Paper's introductory section should establish that public health systems and healthcare services have a **public interest** dimension and are a fundamental part of basic services of general interest throughout Europe.

2.2. The public health system has an economic dimension and is undergoing a process of structural change

Notwithstanding the above, the public health system is undoubtedly also of economic importance, with its various different facets and economic sectors ranging from medical technology and the pharmaceutical industry through to the core activities of hospital and community care. The industry's importance is evidenced by employment data from Germany. According to recent figures published by Germany's Federal Statistical Office, some 4.4 million people were working in healthcare in December 2007, accounting for one in ten of the entire German workforce. Furthermore, healthcare is an industry where employment levels are forecast to increase.

Two major structural changes underlie these trends. The first has to do with changes in public health legislation, particularly with regard to outsourcing of services, increased use of co-payment, and the expansion of private health insurance, all of which promote the individualisation of healthcare costs. The second is that issues such as hospitals' difficulty in attracting investment, the ageing population and the associated increase in the burden on inpatient and outpatient care for the elderly, or the trend towards a rise in chronic illnesses, are resulting in efforts to restructure and cut jobs at the level of individual facilities and the sector as a whole. Examples include reducing the number of hospitals through centralisation, a shift towards private service providers, the trend towards privatisation of key employment areas such as laboratories, pharmacies and long-term care, and initiatives to use integrated service models to do away with the existing boundaries between the public health system's different sectors. This trend is also characterised by attempts to improve quality and efficiency in healthcare facilities by implementing new strategies for the divi-

sion of labour between different employee groups, by policies on individualisation and standardisation of treatment, or through the introduction of new treatment methods.

ver.di's second demand is that the Green Paper's introductory section should address **structural changes in the healthcare system** in greater detail. Only once a thorough analysis of this issue has been undertaken will it be possible to make jobs in healthcare more attractive or to make statements about the required number and quality of jobs. Furthermore, proposals need to be developed with a view to influencing arrangements pertaining to working conditions and finding solutions to staff training and qualification requirements in the public health system's various sectors.

2.3. The need for care and occupational groups in the healthcare sector

Guaranteeing service provision and the issue of structural change at company and sectoral level are both closely linked to the Green Paper's understanding of the term "need for care" and to the occupational groups that it includes in the "workforce for health" (COM 2008, 725/3, Green Paper, p. 6).

This point illustrates the Commission's failure to adequately take into account the nature of the health system, its economic sectors and the structural changes affecting it. It fails to draw a clear distinction between healthcare, community care and social services. Moreover, the reference to the ageing population falls well short of properly describing all the new challenges confronting care provision. In particular, it is guilty of overlooking the rise in mental and chronic illnesses. In addition, the occupational groups listed in the diagram (COM 2008, 725/3, Green paper, p. 4) on the scope of the workforce for health only cover workers in the core areas of "hospital care" and the "public health system" or professions that provide support functions to these areas, such as trainers, pharmacists, administrative staff and management. The diagram completely overlooks outpatient and day care/inpatient care and assistance for people with mental or chronic illnesses, people with physical and mental disabilities, and the elderly. And it does so in spite of the fact that action is urgently needed for people working in these areas, as is rightly pointed out elsewhere in the Green Paper. Lastly, the term "informal carers" is used without a definition being provided of who this term refers to. It could be taken to refer to family members who act as carers for their relatives, but could equally well be interpreted as meaning legally or illegally employed carers or home helps who take on care duties.

ver.di's third demand is that the Green Paper's introductory section should provide **precise definitions of the need for care and of the occupational groups** at which employment policy measures are to be targeted.

2.4. Legal framework

As far as the legal framework and basis for action for meeting the need for healthcare professionals is concerned, the Commission makes an explicit reference in the Green Paper to **Article 152** of

the EC Treaty (COM 2008, 725/3, Green Paper, p. 5). This article stipulates the areas where the EU can take over responsibilities pertaining to public health policy (Article 152, 1 and 4) while at the same time describing the subsidiarity principle (Article 152, 5) according to which "Community action in the field of public health shall fully respect the responsibilities of the Member States for the organization and delivery of health services and medical care". What this means is that the EU may only step in if common goals and measures are not being successfully implemented at member state level, or if it has been specifically empowered to do so.

What Article 152 **does not do is to stipulate a coordination role** for the EU with regard to the development of the workforce for health. Whether or not the content of the Green Paper is taken forward will therefore depend on the extent to which the member states accept its proposals and authorise the Commission to develop further measures. It is up to the member states to decide the priorities and format of any package of measures, and how such a programme would be implemented. Although the Commission does refer explicitly to Article 152 of the EC Treaty and the principle of subsidiarity, the section on the legal framework nonetheless also hints at other legal principles without actually mentioning them by name. For example, it alludes indirectly to Article 95 of the EC Treaty, which deals with the establishment of the single market, as well as to the current debate on working time regulation in the healthcare sector. ver.di would question whether either of these is relevant to the design and development of employment policy measures. As we have already clearly stated in our opinion on the draft directive on patient mobility, ver.di categorically rejects Article 95 of the EC treaty as a legal basis for the healthcare sector.

ver.di's fourth demand is that the Green Paper's introductory section **should clarify the legal framework for the transfer to the EU of responsibilities concerning co-ordination of the European health workforce.** ver.di is of the opinion that the member states' primary responsibility for their public health systems should include the development of healthcare professionals, and that the implementation of any relevant measures should be integrated into member states' national employment policies.

3. Factors influencing the workforce for health and main issues to be addressed

In the main part of the Green Paper, the Commission identifies "factors influencing the workforce for health in the EU and the main issues to be addressed". This section will present a critical appraisal of these factors and issues.

3.1. Demography and the promotion of a sustainable health workforce

As already seen in the Green Paper's general provisions, the Commission's approach is focussed primarily on demographic change (COM 2008, 725/3, Green Paper, p. 6). It is this issue and its repercussions for Europe's health workforce and public health systems that form a common thread

running right through the Green Paper. The Commission uses the term “demography” to establish a connection between an ageing population and a similarly ageing workforce.

There is no denying that the population is getting older. In Germany, this is manifested in three trends: the proportion of elderly people as a percentage of the population as a whole is rising, there has been a marked increase in the actual number of elderly people, and more and more people are living beyond the age of 80. However, the demographic change forecasts presented in the Green Paper are not sophisticated enough in their analysis of this trend, and tend to present it in a negative light – old age is equated with sickness and frailty. A look at the statistics, however, reveals that the majority of older people today are in fact staying healthy as they get older. These changes are no accident – advances in medicine, better living conditions and greater awareness of the importance of a healthy lifestyle have all contributed to improving people’s health and life expectancy. In addition, it is important to remember that the ageing process can differ very much from one person to another, and is often influenced by lifestyle and environmental factors. Consequently, a differentiated approach needs to be taken to the issue of demographic change and its repercussions for long-term care requirements and for the nature of care and support services in the realms of housing, social contacts, illness, or any of the other areas where older people can encounter difficulties, including the need for care. By the same token, this issue will also place a variety of new demands on the development of the health workforce in terms of its activities and the qualifications required to perform them.

In our view, the rather simplistic assumption that an ageing population inevitably means an ageing workforce is a generalisation that we cannot agree with. The fact that in Germany the average age for hospital staff is now 41, and 45 for people working at facilities providing outpatient or day care/inpatient geriatric care, can instead be put down to inadequate human resource and organisational development in the facilities themselves, as well as poor working conditions and pay. One of the contributory factors to this situation is the fact that the usual response to calls for hospitals to cut their costs is for management to cut jobs. While initially this only affected financial and supply services, more recent approaches to the division of labour and streamlining have not only involved staff cutbacks in the core activities of long-term care and medical support services, but have also resulted in a heavier workload for remaining staff. This restrictive human resources policy has also had an impact on the number of nurse training centres – those attached to hospitals fell from 87 in 1999 to 67 in 2005. A further consequence is that many of the nurses trained at these centres were subsequently not given jobs at the hospital. A related issue has to do with changes in the realm of vocational training – people have questioned the need for the standard three years’ specialist training, and some foundation courses have been shortened. In view of the above, if the Commission wishes to initiate plans and actions geared towards developing the workforce for health, these should focus on workplace issues such as training, retraining, organisational and human resource development, gender issues, promotion of work-life balance, and working conditions and hours that do not discriminate against older employees. Our assessment of the actions proposed by the Commission is as follows:

(1) The Green Paper identifies three issues that need to be addressed with regard to what we view as the key issue of systematic staff development: assessment of staff costs, promotion of better working conditions, and a more effective deployment of the workforce. However, these actions

are not enough to achieve a balanced age structure within healthcare facilities. Instead, **ver.di calls for a paradigm shift in healthcare facilities' HR policies.** This would not only involve modifying healthcare facilities' training, qualification and recruitment policies, but also providing working conditions and pay that would make a long-term career in the health service more attractive. The most appropriate way of tackling these issues would be through national initiatives. In Germany, for example, the obvious candidates would be the federal government's "Gute Arbeit" (*good work*) (INQUA) initiative or the German trade unions' "Index Gute Arbeit" (*good work index*).

(2) While a workplace-centred training programme for the over-55s could prove to be a valuable staff development instrument insofar as it would prepare older staff members for a change of job within their existing workplaces, ver.di is rather sceptical about the value of labour market policy programmes aimed at recruiting over-55s for labour-intensive and demanding nursing jobs. A closer look at initiatives of this type raises questions about the kind of work and working conditions that are suitable for older workers in terms of promoting their employment and health. These questions need to be addressed in order to avoid unnecessary sickness-related costs arising from staff being deployed in jobs that are unsuitable for them.

(3) The section on "Organising chronic disease management practices and long-term care provision closer to home or in a community setting" addresses the issue of home care and the relationship between informal and professional carers. In this regard, it is important to recognise that within the care provision system carers are divided into two groups: family members who provide care to relatives in their homes, and professional carers who provide their services in an outpatient or inpatient setting. However, the relationship between the two groups is increasingly fragile. Changing values, demographic change, the rising number of women in work and financial pressures all point to the fact that a number of gaps have opened up between the demand and need for care, the number of people available to meet this demand, and the requisite funding. These gaps need to be addressed. In order for the relationship between informal care and professional care services to be successfully developed, ver.di believes that there are three key areas where action is required:

- In order to develop appropriate ways of improving the situation with regard to home care, it will first be necessary to **collect information** about the current situation. This would involve clearly identifying physical, medical and social care requirements, identifying the pool of carers, i.e. informal carers and their care situation within the home, and also gathering information about working conditions and stressors for both informal and professional carers.
- At least in Germany, the term **"*Pflegebedürftigkeit*" (need for long-term care) as per Art. 145 of the German Social Security Code Book (SGB) XI needs to be redefined** (see also 1.3.). It is necessary to get away from the almost exclusive focus on the provision of care services to people with physical conditions. Furthermore, in order to achieve a balance in care provision that addresses the current weaknesses and failings, it will be necessary to provide assistance, counselling and support for carers themselves. In this respect, there are a number of positive legislative initiatives in Germany, for example the introduction of community care access centres (*Pflegestützpunkte*), the Nursing Leave Act (*Pflegezeitge-*

setz), and case management counselling services provided to family members. However, these services need to be complemented by integrated service provision plans.

- **Local authorities should have greater responsibility** for the organisation and quality assurance of care services. It is impossible to talk about integrated service provision plans without taking into account the specific care requirements and corresponding counselling and care services available in a given region. Rather than simply providing welfare services, what is needed is an integrated approach that takes into account the lifestyles and housing situations of elderly people and people requiring care and asks them what they need in order to be able to lead independent lives. Local authorities should have a management role in these initiatives, since the long-term care market is mostly comprised of private companies. It is important for both oversupply and undersupply to be avoided.

(4) The recommended actions designed to attract workers to the healthcare sector contain proposals geared towards recruiting young people, promoting ethnic and social diversity in the health workforce, and considering "return to practice" campaigns to attract back those who have left the health workforce. However, campaigns aimed at improving the sector's image will only succeed in attracting new groups of employees if they are accompanied by a sustained improvement in pay and employment and working conditions for care workers (see Point 2). The fact that the majority of carers are women is also significant as far as efforts to improve jobs within the sector are concerned. Attempts to improve the image of the health professions would undoubtedly benefit from gender equality measures.

In summary, it can be said that the recommended actions in the areas of demographic change and the ageing workforce fall short of what is required in many respects. ver.di is particularly keen to stress the importance of a differentiated approach to healthcare and long-term care service requirements. As far as employment creation is concerned, employment initiatives should focus particularly on services for people with mental and chronic illnesses and services for the elderly. As far as human resource development is concerned, it is necessary to promote a preventive labour market and employment policy. Such a policy should be workplace-centred and be based on instruments for promoting training, retraining, organisational and human resource development, performance-related pay, workplace gender equality measures, and working conditions and hours that do not discriminate against older employees. It would also need to take account of the increasing integration of different care sectors.

3.2. Public health capacity

The Commission uses the term "public health function" (COM 2008, 725/3, Green Paper, p. 7 ff.) to cover two issues. On the one hand, it refers to public service planning, disease prevention, health education and health promotion, while on the other the Commission uses it to address the broad issue of health in the workplace. ver.di considers both of these areas to be key elements of any forward-looking health policy and health promotion measures. These aspects do not always receive the attention from the member states that is needed to ensure a healthy population. ver.di therefore welcomes the Commission's call for greater emphasis to be placed on both issues and to encourage the member states to be more active in these areas. With regard to the detail of the

Commission's actions in the areas of prevention and health promotion, ver.di would make the following proposals:

1. The Commission wishes to **collect better information** about actual and potential population health needs both at home and in the workplace. This information would be used as the basis for planning future employment initiatives. This approach is especially important for the public health service, since in this area it is not uncommon for the boundaries to become blurred between healthcare services covered by insurance and private products and services bought by individuals to cater for their own healthcare requirements. These include a huge range of products and services from barrier-free housing for people with disabilities, alarm and security systems and preventive measures right up to health holidays. Economists often use the term "secondary health market" to refer to these non-essential healthcare services. In order to develop employment measures in this area, a clear distinction needs to be drawn between the different sectors. This market is also characterised by insecure and inadequately protected jobs. Part-time work and on-demand working hours are widespread, as are stressful working conditions, and in many cases the jobs in this sector are at the bottom end of the pay scale. In short, we welcome the Commission's plans to collect better information on prevention with a view to introducing measures to promote public health at home and in the workplace. These actions should target the real requirements of the population for the services in question. A regional approach to this process should be adopted, in order to gather information on service requirements, service quality, and the infrastructure required for service delivery.

2. As far as the issue of health in the workplace is concerned, the Commission calls for existing resolutions to be implemented. These include training initiatives and incentives for people to return to the healthcare professions. Although we agree in principle with this approach, we believe it to be too general, as explained above. It is particularly important to take specific account of the demands of different jobs when promoting health in the workplace. There is evidence of a shift from physical injuries to stress-related conditions associated with an increased workload, and there has also been a rise in the percentage of chronic and psychosomatic disorders. Consequently, healthcare professionals promoting health in the workplace need a broader set of skills, since a purely medical science background is inadequate in this arena. We are also of the opinion that, in addition to the proven worth of the work undertaken by the statutory accident insurance institutions (*Berufsgenossenschaften*), the development of this area would benefit from greater efforts to implement existing regulations on health and safety in the workplace as well as the federal government's "Gute Arbeit" (INQUA) initiative or the German trade unions' "Index Gute Arbeit".

3.3. Training

As far as training is concerned (COM 2008, 725/3, Green Paper, p. 8) the Commission's rather simplistic conclusion is that training is to be considered as part of workforce planning, more university places and teaching staff are required, and that the member states need to assess what types of specialist skills will be needed to meet the needs arising from the ageing of the population. As already alluded to under points 2.2., 2.3. and 3.1., the definitions of healthcare and long-term care

needs and the structural changes affecting the sector are crucial when it comes to setting priorities for training healthcare workers. Germany in particular urgently needs to address the failings that have been witnessed in the field of training over recent years and to develop relevant training programmes that learn from the mistakes of the past. The recommended areas for action include the following proposals:

(1) Firstly the Commission makes proposals (COM 2008, 725/3, Green Paper, p.8) related to professional development. These include improving professional skills, additional qualifications related to certain patient categories – in this case individuals with disabilities – and the acquisition of language and management skills. This list of future training needs should clearly not be regarded as exhaustive and only represents a partial response to the structural change described above. **ver.di's suggestion is that the focus should be on training specialists in the care of older people and those with chronic conditions (diabetes, heart/circulatory disorders, mental disorders).** A combination of expert carers and the use of new technologies would also be a way of remedying deficits in care provisions in rural regions with inadequate medical and outpatient provisions. Here, for example, the concept of a "community medicine nurse", the development of which ver.di has been supporting in collaboration with the University of Greifswald and Neubrandenburg University of Applied Sciences, could be helpful.

(2) The Commission also wishes to encourage collaboration between member states to ensure freedom of movement of health workers. The main focus is to be on a system of "management of *numerus clausus*" that encourages mobility of highly specialised, usually academic professional groups. In addition, the Commission is proposing setting up an Observatory on the health workforce which would assist Member States in future human resources planning. In the opinion of ver.di both these proposals are only of limited relevance when it comes to developing training. **ver.di suggests that training in the health system and training provisions for carers should be examined to make sure their components are transferrable.** This applies both to basic training of carers and to possible specialisations which should also lead to recognised qualifications. It also applies to academic training in the fields of medicine and health system management. It makes sense for initial training especially to be backed up with internships abroad. At the same time, training should be funded in such a way that there is no cost to the trainees. Leaving aside the question of whether the establishment of an Observatory for health workers and the information required to make this possible might not constitute an infringement of member states' freedom to design and manage their own health systems, ver.di is of the opinion that the remit and scope of such an Observatory should be clearly defined and involvement of the social partners and other experts, e.g. vocational training or manpower administration specialists should be guaranteed.

3.4. **Mobility and migration of health workers**

One central focus of the Green Paper (COM 2008, 725/3, Green Paper, p. 9ff) is the issue of mobility and migration of health workers within the EU and between EU states and third countries. On this point the Commission claims regulatory rights , quoting the EC Treaty, the right of free move-

ment of workers, Directive 2005/36C on recognition of professional qualifications, Regulation 1408/71 on coordination of "social security schemes" and – in the case of migration from third states – the EU strategy adopted in 2005 "to tackle the shortage of health workers in developing countries" (COM 2006 / 870).

In the case of Europe and third countries the Commission bases the need for action on the primacy of freedom of movement of workers and their mobility. This can exacerbate employment problems in the health sector in individual EU member states and third countries, but especially in developing countries, where it can endanger health provisions for the population. The fears expressed by the Commission about the impact of mobility and migration are realistic, but the action it proposes in terms of controlling mobility and migration processes at least needs to be supplemented, if not questioned in its entirety.

ver.di is operating on the assumption that an effective employment policy in the European health sector must result in jobs and working conditions in those European countries with a high degree of mobility being developed in such a way as to offer health workers in those countries good career prospects. Secondly, member states' labour market and employment strategies must take into account the realities of mobility and migration in Europe. And thirdly, in this context, migrants wishing to remain in a country must be helped to integrate and granted full social and economic rights. The recommendations made by the Commission are based above all on the following strategies:

The Commission intends to support the maintenance of an adequate health workforce in Europe by investing in training in all member states. In addition to this approach – which ver.di regards as the correct one –the Commission also proposes fostering bilateral agreements between Member States to take advantage of surpluses of doctors and nurses or excess training capacity. Even though one can assume that such surpluses do not currently exist in member states, cross-border exchanges of specialist health workers during training could, for example, be a useful way of familiarising those involved with the particular circumstances and cultures of the neighbouring country. However this must not be allowed to result in circular migration being specifically encouraged.

(1) In the case of migration of specialist personnel from third countries the Commission proposes analysis of migration processes, conclusion of agreements on ethical recruitment and bilateral agreements between EU member states and third countries. Important though such agreements on ethical recruitment may be, experience also shows that their voluntary implementation is of limited effectiveness as no sanctions apply if they are not adhered to. Bilateral agreements can therefore only be regarded as a first step and do not replace the need for legally established rights.

(2) **ver.di rejects the concept of circular migration** for the following main reasons: It does not meet the needs of the health system in terms of employment. Circular migration encourages both highly-qualified, flexible health workers and less well-qualified ones to migrate. In the case of the former, this represents a brain drain from the health systems of developing and threshold countries; in the case of the latter, it leads to insecure and inadequately protected jobs in the host country. The concept of "circular migration" means that migrants are not

granted the full range of social and economic rights – they do not have the same workplace rights and are in danger of exploitation because their residence permit is usually bound to a particular place of work. Linked to this is a danger of infringements of human rights and a failure to protect workers and their families from discrimination. Furthermore, short periods spent working in the other country are usually not enough to guarantee the desired transfer of qualifications and expertise that would benefit the employment and economic situation in their country of origin.

What ver.di does support is the concept of temporary migration proposed by the United Nations in 2005. This includes the following requirements: flexible residence permits and the possibility of gaining a permanent right to residence/integration, the freedom to change employers, application of national working conditions, unemployment and social standards and related insurance schemes, transfer of acquired rights to social benefits on return to the country of origin and, last but not least, language and cultural training to facilitate integration, together with appropriate vocational training measures.

3.5. Data to support decision-making

Under the heading of "**Data to support decision-making"** (COM 2008, 725/3, Green Paper, p. 13) the Commission raises a central issue for the health system. Even if we can assume that the relevance of some data sets in this area is highly debatable, ver.di nevertheless proposes an initiative that would examine how national and Europe-wide data is collected and would also create a common framework for describing structural data in the healthcare sector in terms of economic, employment and labour market aspects.

3.6. Impact of new technology

The Commission's Green Paper devotes an entire section to the question of new technologies (COM 2008, 725/3, Green Paper, p. 14), setting out the advantages of widespread use of these technologies for quality of care and an improved flow of information between health sectors. It points to a possible need for action in the field of training of health professionals, encouraging the use of new technologies and ensuring inter-operability. This point again reveals how the Commission has failed to take adequately into account the structural changes in individual organisations and the sector as a whole described in points 2.2 and 3.1. We would also like to add that promotion of new technologies in the health sector must be accompanied by parallel development of data protection provisions and activities aimed at ensuring patient safety.

3.7. The role of health professional entrepreneurs in the workforce

Taking up the subject of developing the role of "professional entrepreneurs" in the workforce (COM 2008, 725/3, Green Paper, 14f.) the Commission looks at healthcare services to outpatients – which in Germany, for example, are largely provided by the private sector. It sees particularly good

prospects of realising a single market for this “entrepreneurial sector” and proposes the sort of approach already used to support SMEs from the structural funds (ERDF).

Here again ver.di suggests that a closer look should be taken at this issue. Even if outpatient services are provided on a private basis, they are largely financed from the statutory insurance schemes. Private provisions are not only subject to a system of statutory social regulations and social and sickness insurance schemes, but are also provided within the framework of a coordinated process of patient treatment. In other words, EU policy on the development of SMEs is not only constrained by its statutory remit – the services provided also cannot be classified as goods that are freely tradable on the market (cf. Point 2.1.). The situation is even more problematic in the case of services provided on the “secondary” health market (cf. Point 3.2.). These areas of the healthcare sector are not only characterised by insecure and inadequately protected jobs – the quality of the products and services supplied are also often questionable. This is especially true where home care for individuals is concerned. Here the promotion of freedom of establishment or free movement of workers must not be allowed to result in legitimation of “illegal” care.

4. Cohesion policy

In terms of programme design and funding the Commission proposes applying ESF and ERDF funding to employment initiatives in the health sector. Such a move has a certain plausibility, but we would point out that the conditions laid down for both schemes mean that most of the funding flows to Objective I areas and there is only limited support for equally necessary structural change in areas with specific problems that are not categorised as Objective I. ver.di therefore calls for the launching of a Community Initiative that would be funded from the two sources mentioned. Care should be taken to ensure that the Commission establishes a framework that each member state can then adapt to the specific challenges of structural change in the sector and to national employment programmes. Bodies should be set up that ensure involvement of groups within society, particularly the social partners, in drawing up and implementing the programme.

5. Summary

On 10th December 2008 the Commission published its Green Paper on the “European Workforce for Health”. By focussing on the public health system, the Green Paper is effectively pursuing a sectoral employment policy approach. Although ver.di supports the idea of a sectoral labour market policy in the health sector, we believe that the Green Paper is far from the finished article in that it is still expressed in very general terms and in some cases adopts a rather superficial approach to the situation in the health sector. **In view of the comments made above, ver.di calls for a thorough review of the actions proposed by the Green Paper:**

As far as the basic approach of the Green paper is concerned, ver.di is of the opinion that health services should be treated as services of general interest and when the measures proposed are being further developed there should be a focus on social policy objectives such as quality and equality of service provisions, accessibility for the socially disadvantaged, and the principle of soli-

darity. One of the weaknesses of the Green Paper has been demonstrated to be its failure to adequately take into account structural change in the health sector, and this has lead to considerable inconsistencies in terms of definition of concepts, target groups or problems. The need to define the legal basis for Commission action in co-operation with the member states should also be seen in this context. This is particularly true in the case of the proposals made on training, employment initiatives or the setting up of an Observatory, all of which are, in ver.di's view, classic tasks for the member states themselves. Keeping in mind the principle of subsidiarity, ver.di's basic position is that responsibility for the health system should remain in the hands of the member states even when it comes to developing a skilled workforce, and that any European employment initiative should be integrated into national employment and labour market policies.

This failure to adequately consider structural change in the sector is reflected in the individual measures proposed. It is therefore not surprising that the packages suggested for the individual areas do not go far enough. This is especially true in the case of the following areas:

- Under the heading "Demography" the Commission creates a connection between an ageing population and a similar increase in the average age of healthcare workers. We believe this understanding of the situation to be unsatisfactory. Instead, we are of the opinion that the increase in the age of health workers can be attributed to failings in the public health system's human resources and organisational development policy. ver.di calls for a more differentiated view. Above all it is important for employment policy initiatives to be taken in the field of care for the mentally and chronically ill and the elderly. Only in this way is it possible to develop measures targeted at specific groups and problems that cover questions of training, adaptation of qualifications, organisational and human resources development, institutional gender policy and working conditions/working hours suitable for older people.

- ver.di regards prevention and health promotion to be important areas for any forward-looking health policy and supports the Commission's desire to put greater emphasis on these two areas. However here, too, a more differentiated view of the changes in the sector and a regional approach based on the particular care needs of patients and the population at large are called for. In terms of workplace health promotion there is a shift towards treatment of stress-related conditions associated with an increased workload, so a primary focus on improving scientific skills in this field is unproblematic.

- ver.di sees a need for action in the field of training. In the German context, there is a need to compensate for omissions in the development of initial training and to develop appropriate programs for training at all levels. With regard to the structural conditions for training, ver.di suggests that training courses should be examined to make sure that their components are transferrable.. At the same time, funding for training should be organised in such a way that that there is no cost to the trainees.

- One of the central elements in the Green Paper (COM 2008, 725/3, Green Paper, p. 9ff) concerns mobility and migration of workers within the EU and between the EU and third countries. In this section of the Green Paper the central focus is on the concept of circular

migration. ver.di is categorically opposed to such concepts for social and employment policy reasons.

- The section on new technology once again reveals the Commission's failure to adequately take into account structural changes at the level of individual facilities and the sector as a whole. In addition to the need not to view technologies independently of the issue of jobs and working conditions in the health sector, promotion of new technologies should be accompanied by development of data protection standards and measures to ensure patient safety.

- ver.di recommends taking a closer look at the question of developing "health professional entrepreneurs". Even if outpatient services are provided by the private sector, this still occurs within a context of statutory regulations. The situation is rather different when it comes to the "secondary" health market, where measures to promote freedom of establishment or free movement of workers must not be allowed to validate "illegal" healthcare practices.

- As far as programme planning and funding are concerned, ver.di proposes a Community Initiative to be funded through the ERDF and ESF. The Commission should lay down a framework that would then be adapted by the individual member states to the particular challenges of structural change in the healthcare sector. Participatory bodies should be created for the implementation phase in order to ensure that the social partners are able to influence programme design and implementation.