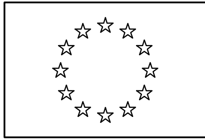

COMMISSION OF THE EUROPEAN COMMUNITIES

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GREEN PAPER

On the European Workforce for Health

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Promoting a Sustainable Workforce for Health in Europe

1. INTRODUCTION

EU health systems have to perform a difficult balancing act, firstly between increasing demands on health services and restricted supply; secondly between the need to respond to people's health needs locally but also to be prepared for major public health crises.

There are a number of challenges facing health systems in Europe.

- Policy makers and health authorities have to face the challenge of adapting their healthcare systems to an ageing population. Between 2008 and 2060 the population of the EU-27 aged 65 and over is projected to increase by 66.9 million and the "very old" (80+) will be the fastest growing segment of the population[1].
- The introduction of new technology is making it possible to increase the range and quality of healthcare in terms of diagnosis, prevention and treatment – but this has to be paid for and staff need to be trained to use it.
- There are new and re-emerging threats to health, for example from communicable diseases.
- All of this is leading to continually increasing spending on health and indeed is posing major longer-term issues for the sustainability of health systems in some countries.

To respond adequately to these challenges requires health systems to have efficient and effective work forces of the highest quality as health services are very labour intensive. Indeed, healthcare constitutes one of the most significant sectors of the EU economy, providing employment for one in ten of the EU workforce, and approximately 70% of the healthcare budgets are allocated to salaries and other charges related directly to employment of the health workforce[2].

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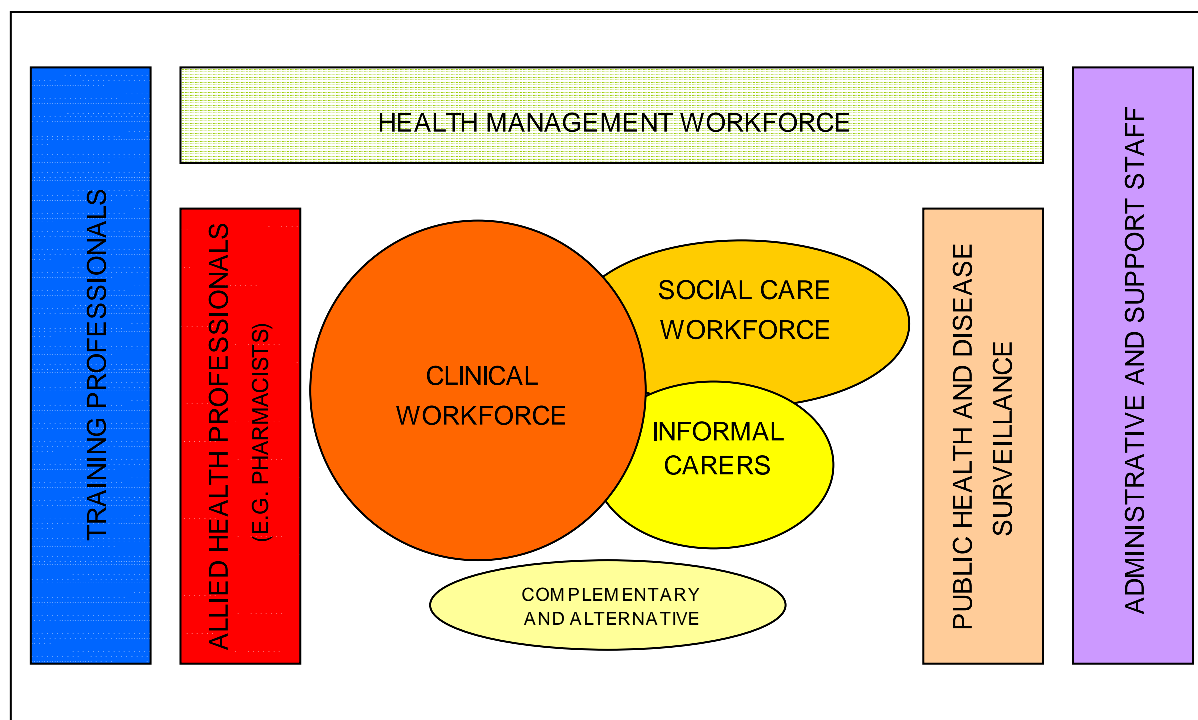
[1] 2008-based national population projections, EUROPOP 2008 convergence scenario.

[2] Dubois C, Mc Kee M, Nolte E (2006) Human Resources for Health in Europe, Open University Press, England.

Graph 1: Scope of the Workforce for Health



2. RATIONALE FOR THE GREEN PAPER

The European Commission's health strategy adopted in October 2007 and published in the White Paper "Together for Health" put forward a new approach to ensure the EU is doing all it can to tackle challenges such as health threats, pandemics, the burden of lifestyle-related diseases, inequalities and climate change in an enlarged Europe of 27 Member States. It aims to foster good health in an ageing Europe by promoting good health throughout the lifespan, by protecting citizens from health threats and by supporting dynamic health systems and new technologies.

This Paper aims to increase the visibility of the issues facing the EU health workforce, to generate a clearer picture of the extent to which local and/or national health managers face the same challenges and 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.

The Green Paper aims to describe as precisely as possible the challenges faced by the EU health workforce which are common to all Member States: the demography issue (ageing global population and ageing health workforce), which means that there are insufficient numbers of younger people coming through the system to replace those who leave; the diversity of the health workforce; the weak attractiveness of the wide variety of healthcare and public health related jobs to new generations; the migration of health professionals in and out of the EU; the unequal mobility within the EU – and in particular the movement of some health professionals from poorer to richer countries within the EU, as well as the health brain drain from Third countries.

The second objective of this Green Paper is to help identify where the Commission believes that further action can be undertaken and to launch a debate on it.

3. LEGAL FRAMEWORK AND BASIS FOR ACTION AT EU LEVEL

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 organization and delivery of health services and medical care". However the Article also stresses that the Community should encourage cooperation between the Member States and promote coordination of their policies and programmes.

Community action is therefore intended to complement national policies. The principal responsibility for organising and delivering health services lies with the Member States, but the EU has an important role to play in supporting Member States and adding value such as through networking and the sharing of good practice.

Moreover, the EC Treaty and secondary legislation provide for rules which have to be respected by Member States when organising their health sector.

As regards secondary legislation, relevant examples include European Community labour law directives such as the Working Time Directive, which sets maximum limits to working time, and imposes minimum daily and weekly rest periods in order to protect workers' health and safety. The Directive provides common minimum requirements for all Member States but each Member State remains free to apply rules which are more favourable to the protection of workers, if it so wishes.

The Court's decisions about on-call time and compensatory rest raise important questions for health and care services[3]. The Commission has already put forward legislative proposals[4] which are currently being discussed by the Council and the European Parliament[5].

4. FACTORS INFLUENCING THE WORKFORCE FOR HEALTH IN THE EU AND THE MAIN ISSUES TO BE ADDRESSED

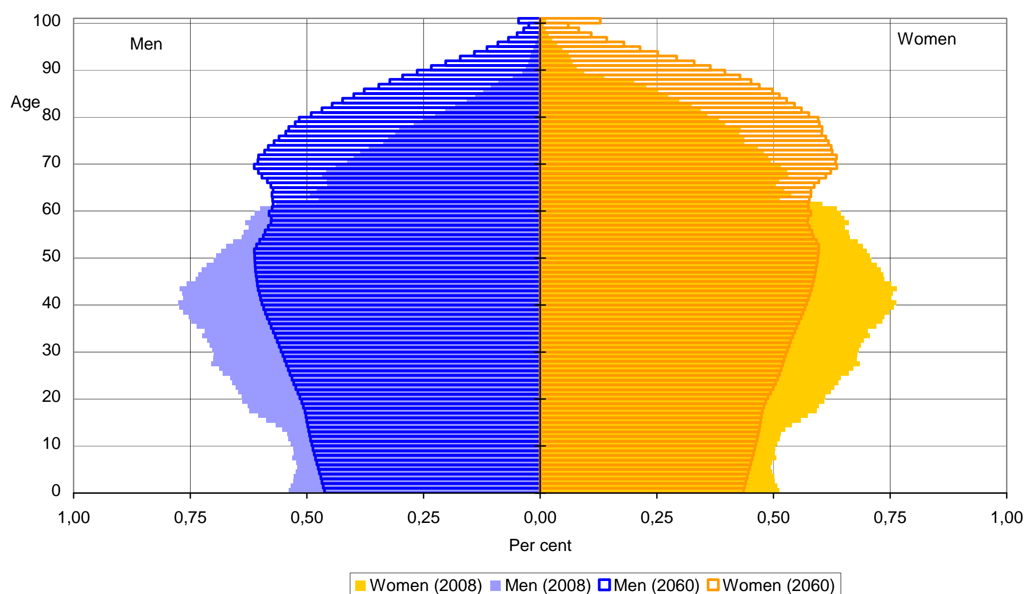
4.1. Demography and the promotion of a sustainable health workforce

Citizens are living longer and in better health. Life expectancy has increased consistently since the 1950s by around 2.5 years per decade and is expected to continue to increase.

[3] By stating that the time that health professionals spent on call had to be counted as working time, even if they are resting and provided that they need to remain at their work place, the Court acknowledged that doctors, for instance, work more than 48 hours a week in most Member States. To conform themselves to this ruling, some Member States would need major recruitment efforts, which is not always possible.

[4] COM(2004) 607 (proposal to amend Directive 2003/88/EC); COM(2005) 246 (amended proposal, taking account of the views of the European Parliament).

[5] Common Position of the Council, 15th September 2008; Communication from the Commission to the European Parliament on the Common Position - COM(2008) 568.



Graph 2: Population projection 2008 - 2060

With an ageing population it is crucial that people grow older in good health. Healthy Life Years must be maximised. Nevertheless, as people live longer, it is expected that there will be increasing numbers of older people with a severe disability and in need of long-term care[6]. As multiple chronic conditions are more prevalent in old age, this will have implications for care provision. Moreover, demand for formal care is likely to increase given the likely reduction of availability of informal carers for example as a result of changing family structures.

As the population ages, so does the workforce. Between 1995 and 2000, the number of physicians under the age of 45 across Europe dropped by 20%, whilst the number aged over 45 went up by over 50%. For nurses as well, average ages are rising; in five Member States nearly half the nurses are aged over 45[7]. As these staff approach retirement age there need to be sufficient younger recruits to replace them.

The participation of women in the health workforce has historically been significant and is increasing. Overall, women make up about three quarters of the health workforce in the EU and in some Member States intake of women to medical schools is now over 50%.[8] The promotion of gender equality measures in human resource strategies is therefore particularly important

The Roadmap for equality between women and men 2006-2010[9] sets out a number of actions with a view to achieve equal economic independence and equal participation in decision-making of women and men and proposes measures to improve the reconciliation of work, family and private life.

The key to maintaining a sufficient workforce, in the face of the impending retirement of the "baby boom" generation, is to educate, recruit and retain young practitioners while reinvesting in mature workforce.

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6 OECD: Trends in Severe Disability among Elderly People DELSA/HEA/WD/HWP (2007).

7 WHO Observatory Policy series 2006.

8 WHO Observatory Policies series 2006.

9 COM(2006) 92.

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 large range of careers in the health and care sectors

4.2. Public Health Capacity

The public health function consists of a range of diverse activities to protect and improve the health of the general population, tackle health inequalities, and address the needs of disadvantaged and vulnerable groups. Tasks include carrying out health needs and health impact assessments for service planning, prevention of diseases, for example through vaccination and screening programmes, health promotion and education, securing the blood supply, epidemiological surveillance, and planning and response to health threats from outbreaks of infectious diseases, pandemics, and man-made and natural disasters, including those arising from climate change.

Health promotion and disease prevention are not only important in their own right, but can significantly reduce future demand for treatment and care services. The public health workforce throughout the EU must be properly skilled and have sufficient capacity to be able to carry out these activities effectively, and this needs to be built into training and recruitment plans.

Workplace-related health will require a special focus since safety and health at work issues are important determinants of overall public health. Problems such as accidents at work will continue to be addressed, but new considerations such as changes in working rhythms, new technologies at work, achieving a work-life balance, job mobility and workplace related stress, call for a special focus on health at work as an important determinant of overall public health. The recently adopted safety and health at work strategy 2007–2012 (COM (2007)62) sets out a series of ambitious objectives which EU Member States agreed to embrace and support. However, achieving these objectives is strongly dependent on the availability of the necessary specialised health workers, such as occupational health physicians and nurses and health and safety inspectors.

Influencing factors and possible areas for action:

- Strengthening capacity for screening, health promotion and disease prevention
- Collecting better information about actual and potential population health needs in order to plan the future development of the public health workforce

- Promoting scientific vocations in schools by highlighting career options in lesser known public health jobs (biologists, epidemiologists, etc.)
- Giving the Agency for Safety and Health at Work (OSHA) more visibility in the Member States by publicising its existence directly at workplaces
- Promoting the work of occupational health physicians and giving incentives to doctors to join this area

4.3. Training

Training capacity is also an issue to be considered as part of workforce planning. If more doctors and nurses and other staff are needed, more university places or training schools will need to be created and more teaching staff to train them. This will require both planning and investment.

Member States will have to assess what types of specialist skills will be needed, taking into account that healthcare treatments change with the introduction of new technology, the effects of the ageing population on the pattern of disease, the increase of elderly patients with multiple chronic conditions. A specific problem is that increased travel and mobility have also increased the risk of spread of diseases hitherto more prevalent in tropical countries. This is creating a new training requirement for clinicians and for those engaged in communicable disease surveillance.

Influencing factors and possible areas for action:

- Ensuring that training courses are designed to take into account the special needs of people with disabilities (they should receive the same quality of care as non-disabled patients and be provided with the specific health services they need[10]).
- Focusing on health professionals' continuous professional development (CPD). Updating professional skills improves the quality of health outcomes and ensures patient safety.
- Developing training courses to encourage the return to the workforce of mature workers.
- Providing management training for health professionals
- Fostering the cooperation between Member States in the management of *numerus clausus* for health workers and enabling them to be more flexible.
- Developing possibilities for providing language training to assist in potential mobility
- Creating an EU mechanism e.g. an Observatory on the health workforce which would assist Member States in planning future workforce capacity, training needs and the implementation of technological developments.

[10] As stated by Article 35 of the UN Convention on the rights of persons with disabilities signed by all Member States and the European Community.

4.4. Managing mobility of health workers within the EU

Free movement of persons is one of the fundamental freedoms guaranteed by Community law. Free movement of workers is laid down in Article 39 EC and further developed in Regulation 1612/68[11]: it provides for the right of EU citizens to work in another Member State as an employee or civil servant. The right of establishment is laid down in Article 43 which provides for the right to work as a self-employed person in another Member State. Article 49 enshrines the right of free provision of services. Regulation 1408/71 and implementing Regulation 574/72[12] coordinate the various social security schemes in order to facilitate this fundamental right of free movement. EU citizens also have the right to study in other Member States under the same conditions as nationals.

Directive 2005/36/EC provides for the recognition of professional qualifications in view of establishment in another Member State and in view of facilitating the provision of cross-border services in a Member State other than the one of establishment. The Directive has also introduced a requirement for the competent authorities of the host and home Member States to exchange information regarding disciplinary action or criminal sanctions taken or any other serious, specific circumstances. Outside the regulatory framework, some initiatives linked to the mobility of health professionals have been taken by professional organisations such as the Health Professionals Crossing Borders initiative and the professional card pilot initiative which both aim at improving access to information where conduct has been brought into question. The progress of these initiatives will need to be kept under review.

Free movement of students and workers helps to ensure that health professionals go where they are most needed. But health professionals move for a variety of reasons - to achieve improved career and training opportunities or for better pay and working conditions. Mobility can affect disparities –positively or negatively- within and between countries. In this context, some Member States may be unwilling to risk investment in training more health professionals if there is poor retention and return on the investment.

The response to tackling the effects of increased mobility is not to introduce legal restrictions to the free movement of students or workers, but rather to address these issues through appropriate policies and in a coordinated manner with EU authorities and other Member States. The increased mobility of the workforce may therefore require workforce managers at local and/or national level to review the adequacy of their recruitment and professional development measures.

Citizens also enjoy rights to access healthcare in other Member States. The proposed Directive for cross-border healthcare aims to ensure application of common principles for cross-border healthcare in the EU. One pillar of the Directive is that of realising the potential of European cooperation in areas where this is useful, including in border regions, through European reference networks of specialised centres, through EU network for Health technology assessment or through e-health.

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[11] Regulation (EEC) No 1612/68 of the Council of 15 October 1968 on freedom of movement for workers within the Community.

[12] Council Regulation (EC) No 1408/71 of 14 June 1971 on the application of social security schemes to employed persons, to self-employed persons and to members of their families moving within the Community; Council regulation (EEC) No 574/72 of 21 MARCH 1972 laying down the procedure for implementing Regulation (EEC) No 1408/71 on the application of social security schemes to employed persons, to self-employed persons, to self-employed persons and to their families moving within the Community.

Influencing factors and possible areas for action:

- Fostering bilateral agreements between Member States to take advantage of any surpluses of doctors and nurses.
- Investing to train and recruit sufficient health personnel to achieve self-sufficiency at EU level.
- Encouraging cross-border agreements on training and staff exchanges, which may help to manage the outward flow of health workers while respecting Community law.
- Promoting "circular" movement of staff (i.e. staff moving to another country for training and/or to gain experience, and then returning to their home countries with additional knowledge and skills).
- Creating an EU-wide forum or platform where managers could exchange experiences.

4.5. Global Migration of Health Workers

The shortage of health workers is global, but the problem is most acute in Sub-Saharan Africa, where the problem has reached crisis level[13]. The shortage is worsened by increased demand and competition for medical and nursing staff across the developed world.

Action on health within the EU also has important policy implications for the EU's external and development policy. Unless the EU takes appropriate steps to produce and retain sufficient numbers of its own health workers, the negative impact of migration on the health systems of developing countries is not likely to decrease[14].

The EU Strategy for Action on the Crisis in Human Resources for Health in Developing Countries[15] adopted in December 2005, and the Programme for Action (PfA) to tackle the shortage of health workers in developing countries (2007 – 2013)[16] adopted a year later, recognised that the EU has a responsibility to take steps to meet its own objective of providing high quality healthcare without having a negative impact on the situation in non-EU countries.

The EU is developing a common immigration policy[17]which includes approaches to avoid undermining development prospects of third countries through, for example, exacerbating "brain drain", by instead promoting circular migration. These are a component part of the Global Approach to Migration[18]. Additionally, in 2007, the Commission produced a proposal for a Directive to facilitate the admission of highly-qualified migrants into the EU[19]. Within this proposal, a clause is foreseen specifically requiring ethical recruitment in sectors, such as the health sector, experiencing a lack of personnel.

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13 A critical health workforce shortage is experienced in 57 countries, 36 of which are in Africa.

14 It is not just those in developing countries who migrate: there are doctors and nurses who leave the EU to take up posts for example in the USA, Canada, Australia and New Zealand.

15 COM(2005) 642

16 COM(2006) 870.

17 See COM(2008) 359 on "A Common immigration policy for Europe: principles, actions and tools".

18 See COM(2006) 735 and COM(2007) 247.

19 COM(2007) 637. At the same time, a proposal - COM(2007) 638 - for another directive on a single application procedure and common rights to all legally-resident third-country national workers was adopted.

Over the past decade, Codes of Practice for ethical recruitment have been produced which aim to reduce the negative impact of migrant flows on vulnerable health care systems in developing countries. The UK has a Code of Practice for International recruitment[20] and Norway[21]and the Netherlands[22] have both issued workforce strategies which include ethical recruitment policies by setting limits for active state recruitment or by promoting recruitment via bilateral agreements. At EU level in 2008, the European Social dialogue committee in the Hospital sector, composed of HOSPEEM and EPSU acting as European social partners, adopted a common "Code of Conduct and follow-up on Ethical Cross-Border Recruitment and Retention",[23] which aims to promote ethical behaviours and stop unethical practices in cross-border recruitment of health workers.

The EU has made a commitment to develop a Code of Conduct for the ethical recruitment of health workers from non-EU countries and to take other steps to minimise the negative and maximise the positive impacts on developing countries resulting from the immigration of health workers to the EU[24]. The need to deliver on these commitments is reiterated in the Progress report on the implementation of the PfA adopted in September 2008.[25]

Influencing factors and possible areas for action:

- Putting in place a set of principles to guide recruitment of health workers from developing countries and introducing methods for monitoring
- Supporting the WHO in its work to develop a global code of conduct for ethical recruitment
- Stimulating Bilateral and Plurilateral agreements with source countries and developing mechanisms for support of circular migration[26]

4.6. Data to support decision-making

All the issues described present challenges to planners, providers and managers of health care systems. The situation is made more difficult because of the lack of up-to-date, comparable data and information, for example on numbers of health workers, in training and in employment, their specialisations, their geographical spread, age, gender and country of provenance. Given the potential for shortages in one part of Europe to have an impact elsewhere, Europe-wide information is important for planning and providing health services for all health authorities throughout the EU.

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[20] www.nhsemployers.org

[21] (Recruitment of Health Workers: towards Global Solidarity) 2007.

[22] "Working on Care" action plan 2007.

[23] www.hospeem.eu/content/download/313/1631/version/2/file/EPSU-

[24] European Parliament: EU Strategy for Action on the Crisis in Human Resources for Health in Developing Countries, and COM(2006)870, Communication from the Commission to the Council and the European Parliament: a programme for action to tackle the critical shortage of health workers in developing countries (2007 – 2013).

[25] SEC(2008) 2476.

[26] Circular migration refers to staff moving to another country for training and/or to gain experience, and then returning to their home countries with additional knowledge and skills. Attractive incentives could take the form of an agreed career pathway, so that the person returning comes back to a post and receives a salary which recognises the experience gained.

A 2006 report produced for the WHO[27], comprising 5 country case studies – Estonia, Germany, Lithuania, Poland and the United Kingdom - found that none of them could provide accurate, complete information on international flows of health professionals. The most common measure of flow is from certificates issued to competent authorities ("verifications"). This gives an overall annual measure of the number of professionals, who consider moving to another country, but not all of them actually move, and others may apply more than once. For example, the Estonia country report notes that only 182 doctors actually emigrated out of the 344 who took out certificates.

The European Commission collects data on the decisions on recognition of qualifications covered by the sectoral systems of recognition. These data are summarised at the following website:

http://ec.europa.eu/internal_market/qualifications/regprof/index.cfm.

They show movement to, or the intention to practise, in another Member State. However, since there is no further information on whether the professional did in fact take up a post in another Member State, whether the professional moved on to a third country or returned to the home country, these data can be used only as a proxy in the absence of more detailed information.

Other data collected by EUROSTAT on numbers of health professionals relies upon what different Member States collect. These data are available on the following website:

http://ec.europa.eu/health/ph_information/dissemination/echi/echi_en.htm.

In addition an EU-supported OECD project on the migration of doctors and nurses in the OECD/EU-25 countries is underway and will in future look also at other health professionals. This project will provide useful information, but can not ensure full comparability of the data used because of different registration processes and the differences between Member States in the degree of central data collection.

The European Migration Network (EMN)[28] undertook a study of managed migration in the health sector in November 2006 involving eleven of its National Contact points. It found that data, particularly on third country national health workers in the EU, was limited and often distributed across several sources, even within the same Member State.

Influencing factors and possible areas for action:

- Harmonising or standardising health workforce indicators
- Setting up systems to monitor flows of health workers
- Ensuring the availability and comparability of data on the health workforce, in particular with a view to determining the precise movements of particular groups of the health workforce

[27] Health Worker Migration in the European Region: Country Case Studies and Policy Implications Buchan J, Perfilieva G.

[28] http://emn.sarenet.es/

5. THE IMPACT OF NEW TECHNOLOGY: IMPROVING THE EFFICIENCY OF THE HEALTH WORKFORCE

Progress in healthcare depends upon scientific and technological advances. New technology affects what can be achieved and how healthcare is organised and provided. New technology is now allowing health workers more easily to share information and to work more closely together, improving overall care. For certain diseases and patients, technology may allow shifting the bulk of care away from hospitals into community and primary care settings and even into patients' homes, which can improve the quality of life and contribute to better use of resources.

In the short term, new technology such as telemedicine, can ensure better healthcare coverage in remote areas or in areas with shortages of health workers. For example, there are areas in the EU where telemedicine enables distant diagnostic services, and the distant diagnosis of mammography screening results help to improve access and services to patients.

The introduction of new technology requires that health workers are properly trained, and if necessary re-skilled, to use it. Moreover, it will also be necessary to gain the acceptance of the health workforce for its use, which may sometimes disturb established working methods and structures. The Commission Communication on "Telemedicine for the benefit of patients, society and the economy" proposes a European framework to tackle some of these challenges.

Influencing factors and possible areas for action:

- Ensuring suitable training to enable health professionals to make the best use of new technologies
- Taking action to encourage the use of new information technologies
- Ensuring inter-operability of new information technology
- Ensuring better distribution of new technology throughout the EU.

6. THE ROLE OF HEALTH PROFESSIONAL ENTREPRENEURS IN THE WORKFORCE

Some health professionals, such as physicians, psychologists, dentists, podiatrists, physiotherapists and occupational therapists, work as entrepreneurs running their own practices or medical centres and employing staff. Commission policies to improve the business environment in Europe and to support and encourage entrepreneurship have an impact on these activities. A recent Commission Communication was published on "Small and medium-sized enterprises (SMEs) - Key for delivering more growth and jobs. A mid-term review of Modern SME Policy" (4 October 2007) recognises the importance of the contribution of SMEs to realising the goals of the Lisbon Strategy - to foster economic growth and create new and better jobs. Such entrepreneurs can contribute to the strengthening of European growth and acting as a driving force for innovation, local development, training and employment, as well as helping to improve access to healthcare.

The Small Business Act (SBA) is a key element in the EU's Growth and Jobs Strategy (Commission Communication "Think Small First –A Small Business Act for Europe" – COM(2008)394). It comprises a set of common principles to guide SME policy as well as proposed actions to translate the principles into practice. It focuses on promoting entrepreneurship, anchoring the Think Small First principle in policy-making and supporting SMEs' growth.

Influencing factors and possible areas for action:

- Encouraging more entrepreneurs to enter the health sector in order to improve planning of healthcare provision and to create new jobs
- Examining the barriers to entrepreneurial activity in the health sector

7. COHESION POLICY

Development of the EU health workforce is also linked to Cohesion Policy. Under the current legal framework it is possible to use Structural Funds to develop the health workforce. The Community Strategic Guidelines for Cohesion, which defines the priorities for the Structural Funds for the 2007-13 period, contains a section describing the aim to “Help maintain a healthy labour force”. The Regulation on the European Social Fund (ESF) of July 2006 (Regulation 1081/2006) identifies prolonging working lives and "better health" among the priority areas of the ESF. In this context some Member States (mostly new ones) plan major investment in the education and training of health professionals by using the ESF. In addition, some €5.2 billion will be invested in health infrastructure by the European Regional Development Fund. The effective use of the Structural Funds to improve skills and competencies of the health workforce and develop health infrastructure can effectively contribute to the improvement of working conditions and increase quality of health services, thus reducing the health gaps and strengthening cohesion within and between Member States.

Influencing factors and possible areas of action:

- Making more use of the support offered by structural funds to train and re-skill health professionals
- Improving the use of the structural funds for the development of the health workforce
- Enhancing the use of structural funds for infrastructures to improve working conditions

8. CONSULTATION

The European Commission calls on all interested organisations to submit responses the issues raised in this Green paper, no later than 31 March 2009, preferably to the following e-mail box SANCO-health-workforce@ec.europa.eu

or to the following address:

European Commission, B-1049, Brussels, Belgium

Unless respondents make a declaration to the contrary, the Commission services will assume that they do not object to having their responses, or parts thereof, published on the Commission's website and/or quoted in reports analysing the outcome of the consultation process.