

EHMA ROUNDTABLE DEBATE:

GREEN PAPER ON THE WORKFORCE FOR HEALTH

13 February 2009

Draft report

Luca Brusati (Bocconi University School of Management) opened the meeting, welcoming participants and underlining the aim of the meeting, i.e.

- to inform key stakeholders on EU policy development impacting on health outcomes and health care delivery, in this case the Green Paper on the Workforce for Health
- to facilitate dialogue and debate between key stakeholders and engage them in EU policy development

He then passed the floor to the first speaker, **Elizabeth Kidd (European Commission, DG SANCO)**, who outlined the background and content of the Commission Green Paper. The EU health workforce – interpreted in the widest possible sense - is crucial, as developing effective and efficient health systems depend on a high-quality, efficient health workforce, equipped with the right skills.

Health systems are facing a number of challenges, such as the ageing of the population in parallel with the ageing of the health workforce, the ever-rising expectations of new treatments and new technologies and, lastly, the need to improve equity of access.

Regional disparities in availability of health care workers exist across the EU. Mobility poses challenge for some specialties and some regions within Member States. Shortages in one part of EU can have impacts elsewhere, creating regional disparities. However, information and robust data on the composition of the workforce is lacking. It is unclear why health care workers move, where they move to and whether they return (or when). In addition, it is difficult to plan properly when the true shortages are unknown. For instance, there is no clarity on the number of non-practicing professionals. Effective human resources strategies are needed to address these issues, and in some Member States, health and education ministries are getting to grips with developing strategies to face challenges in the recruitment of nurses. As the issues in relation to health workforce shortages need to be addressed by many Member States, promoting cooperation and common approaches can prove to be helpful in developing common solutions.

As far as recruitment and retention are concerned, there seem to be distinct problems in relation to different specialties. Medicine has specific regional problems due to mobility, and nursing has recruitment problems in some states, as this profession suffers from poor status, poor employment conditions and unattractive career paths.

Liz Kidd also outlined the efforts of the EU in relation to the effects of global health worker migration. The health workforce crisis is one of the major barriers to progress in relation to the Millennium Development Goals and raises a series of ethical issues. It is clear that addressing EU workforce problems should not have a negative impact on the health workforce of countries outside the EU. There is a commitment to sign up to an EU Code of Conduct in this field.

The Green paper consultation will close on 31 March 2009, and submissions received will be analysed. This analysis will then feed into a consideration of what EU can do to

support Member States in tackling health workforce challenges, e.g. recruitment and training campaigns, return to practice campaigns, training mature workers, human resources policy toolkits, fostering cooperation between Member States, or creating an 'Observatory' to assist future workforce planning. Other potential actions could be the development of a shared evidence base by improving monitoring and statistical systems and support the sharing of good practice and support networks. The Commission can also offer guidance, guidelines and recommendations. Finally, it can offer Structural Funds support and help with training and re-skilling of health workers, particularly in under-developed regions.

The second speaker was **Francois Decaillet (WHO Europe)**. He started his presentation by stating that, apparently, nothing changes: similar discussions on existing data gaps and lack of planning ahead have been held for many years. And yet, while all seems to have remained the same, there have been changes in the past years: awareness of the problems is greater and interesting initiatives on the ground have been launched.

The challenges in the field of the workforce for health are well known, and efforts are being made to address these at all levels. The WHO, for instance is working on a Code of Practice for International Recruitment. This is not intended as the solution to all problems, but it can make a serious contribution.

What else could be done? Is regulation (e.g. bilateral agreements) the answer to sorting out the migration of health care professionals? Changes need to be made to systems if sustainable solutions are to be found.

The effects of the current economic downturn are hard to predict; the implications for the health care sector are still largely unknown. How this crisis will affect the already complex human resources issues in particular is still unclear. Unemployment is rising, and it is likely that the crisis will undermine resources for health systems. Budget cuts across the board will have an effect.

The situation is changing fast, and that also applies to the migration of health professionals. Systems are not equipped to sufficiently monitor this. The crisis will bring problems and extra challenges, and will accelerate changes, but there may be opportunities as well.

The WHO is working on the crisis and its implications, and will help exchange information and good practice between countries and help to create platforms for policy dialogue.

The final speaker was **Michael Wilks (Standing Committee of European Doctors)**, who emphasized the decline of the working age population and the increase of the proportion of older health care workers. In other words, there is an increasing shortage of health care workers; this challenge needs some radical thinking.

Human resources planning is getting increasingly difficult, most notably because of migration of health workers. If EU-wide solutions need to be found, it might be worthwhile to focus on EU-wide rather than national self-sufficiency in relation to health care workforce needs. This might be a useful step forward. However, it would require Member States to relinquish some of their autonomy in this field.

The roles and responsibilities of health care workers are also changing. For instance, in acute care, the patient sees a nurse who transfers him/her to the doctor. However, in long term care the roles and responsibilities of nurses and doctors are increasingly overlapping. In relation to long term monitoring of patients, doctors and nurses work in teams. This demonstrates that a different skills mix is required, and that barriers in terms of traditional roles are being broken down.

The role of patients is also changing. 'Literate patients' are becoming a partner in their own healthcare (which may diminish the strain on health care workers), and their family circumstances/social surroundings are increasingly being taken into account as well: social care is more and more becoming part of health care. This has consequences for the need for information on the patient, his/her circumstances and background. Electronic health records can help: these provide the link between all stakeholders involved with health (and social) care provision for a given patient. A 'summary care record' should contain all relevant medical information (GP and hospital records) as well as information on significant medical events, prescribed medicine, dental records and – where possible – social care. Obviously, in order to make this work across Europe, interoperability of ICT systems will be required.

Migration is a crucial issue. The US is one of the main 'poachers' of health staff in developing countries. This should stop; the aim should be self-sufficiency. In Europe, the migration from east to west has consequences too and this needs to be carefully handled. Ethical recruitment practices should become the norm; however, the EU's right to free movement is – paradoxically – a barrier in this respect. Incentives should be put in place to motivate health staff to return to their countries of origin, after acquiring new knowledge and skills in the host countries.

In terms of regulation, tracking the movements of doctors seems to work. Standards should now be put into place in relation to appraisal, revalidation and relicensing of health workforce.

The EU has a positive track record in terms of a number of public health issues, such as alcohol, tobacco, and nutrition – EU added value in those areas is abundantly clear. The Green Paper provides a wonderful opportunity to start thinking about fundamental challenges in the health arena.

Discussion

Lack of data:

What are the true challenges in terms of health work force shortages? The demand for health staff will depend on health delivery patterns. Information and communication technologies might well have a positive impact and support health services delivery.

There are no data on non-practicing practitioners; in other words, there may potentially be more health care professionals than we are aware of.

Differences and commonalities:

What level of healthcare should be put in place? There are different health systems in Europe, with (huge) differences in levels of access and resources. The EU has a limited competence in health, and cannot regulate in this area: there are no uniform healthcare systems and that will not change. What needs to be done is to identify common areas where cooperation is possible.

Qualifications:

What about the qualifications and skills of a migrating health workforce? These are not the same across the EU. Patient safety comes into play here.

Staff retention:

What is being done about the retention of staff? In some countries (e.g. UK) the policy is to actively strive towards self-sufficiency. One of the measures to this effect is to expand training and education facilities, another to provide incentives, such as higher wages. An example was given of Estonia, where trained GPs were all poached by the pharmaceutical industry. This was countered by offering GPs three times their salaries. However, it is easy to talk about expanding wages as for many countries this will not be possible – especially in these times of crisis.

The motivation and personal attitudes of health staff also come into play.

Recruitment in developing countries:

As far as the US is concerned, health care staff is needed, and active efforts to recruit staff from other parts of the world are common and widespread. This current 'brain drain' is unacceptable, given that the Millennium Development Goals are far from being fulfilled. In order to put a halt to this, countries that are being targeted for this recruitment can try to improve the status and the pay of health workforce, in order to retain them or get them back. Much more resources are needed for these countries, which badly need their health workforce. We need to act now, rather than wait for instances such as the WHO to reach international agreements on these issues.

Regulation:

While regulation and bilateral agreements can help, this is a slow process. On the other hand, the problems are well-known and a regulatory approach is needed now.

There is no magic bullet. A Code of Conduct will help but is not the final and only solution. A range of measures will be needed.

One of the pillars of the EU is freedom of movement, so restricting health staff migration is quite difficult. In other words, it will be difficult to regulate on the one hand side, but a 'laissez-faire' approach is also not acceptable. The answer must lie in the middle somewhere.

Voluntary approaches and exchange of experience and good practice between countries will help. Maybe in some cases, protectionism should be allowed.

Other players should be engaged in the policy debate as well; the national level is not always the most appropriate. Regional authorities and stakeholders have a role to play as well.

Migration:

If migration inside the EU is a problem, then maybe we should try to focus on achieving EU-wide rather than national self-sufficiency? Professionals do not just move for financial reasons. There should be regulatory measures to protect developing countries to be totally drained of their health workforce. The EU – as a world player – needs to put pressure on the US to become more self-sufficient rather than 'steal' health workforce from those countries where they are most needed.

Training and development:

Training needs to be expanded, and qualifications need to be comparable (i.e. quality and skills standards). In addition, there need to be incentives for continued training and development. This might also help retain health staff.

The proposed Observatory:

The role and remit of an 'Observatory' – as a potential area for EU action - should be carefully thought out; it should do more than merely observe; it should become a centre to stimulate activity and facilitate the development of new models rather than merely observing the activities and shortcomings of the old ones. In these times of chaos, we should look at chaos theory to help us out.

Risks and opportunities of the current crisis:

The financial crisis will affect developing countries even more than the developed ones. Issues in relation to health workforce shortages risk dropping of the policy agenda because of scarce resources. On the other hand, the current recession may also create opportunities, as unemployed workers may retrain and become engaged in the field of health care.

Christine Marking, 17 February 2009