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ЕВРОПЕЙСКА АСОЦИАЦИЯ НА СТАРШИТЕ БОЛНИЧНИ ЛЕКАРИ**

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Abstracts of the

DRAFT Green Paper on the European Workforce for Health

Promoting a sustainable workforce for Health in Europe

The issues the Green Paper covers can be grouped as follows: the challenges such as demography, managing mobility, recruitment and retention strategies and what data we need for evidence based policy-making.

Definition for the term "workforce for health": doctors, nurses, pharmacists and dentists, public health specialists and medical scientists, health service managers and teaching staff.

Health services are extremely labour intensive. Health workers in its widest sense constitute one of the most significant sectors of the EU economy, providing employment for 9.7% of the EU workforce. While healthcare consumes between 7% and 11% of the GDP in Western European Countries, approximately 70% of the European budgets are allocated to salaries and other charges related directly to Employment.

The health workforce is ageing and this will compound existing shortages in some Member States. 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%.

Feminisation of the workforce is an issue which impacts on workforce capacity and needs to be taken into account. The participation of women in the health workforce has historically been significant and is increasing. Women account for up to 77% of the health workforce in Europe and in some member states intake to medical schools is now over 50%).

Migration of health workers – the European Perspective

Many health professionals took the opportunity to move to other countries in the EU, seeking better salaries and conditions of service as well as the enhancement of their professional experience.

The result for those Member States unable to contain this exodus is that it is difficult to ensure good distribution of health professionals, especially in rural and outlying areas.

Mobility and migration still represents a serious risk for health systems across the Union, with the impact being felt hardest in the poorest Member States and regional disparities being exacerbated.

It is important to understand first the factors which explain why health professionals migrate, commonly known as the "push" and "pull" factors. As has already been described, health professionals are attracted to move by factors in other countries such as salaries, recruitment standards, working conditions, a way of upgrading qualifications, career development, better standard of living, a means to send money back home. These are "pull" factors. "Push" factors can be poor working conditions and pay or as extreme as war.

Questions on which the Commission invites contributions include;

What should be the roles of EU and Member States in ensuring the protection of human resources for health in developing countries

What do you consider to be an effective way to reduce the pull on health workers from developing countries?

Should ethical considerations be extended to recruitment from one Member State to another?

Health Care Training Capacity

Training capacity is also an issue to be considered as part of workforce planning.

The Bologna Process (started in 1999) aims to create a European Higher Education Area by 2010 and to make European Higher Education more compatible and comparable in Europe. One of the areas covered by the Bologna Process is health qualifications. The Commission is also developing the European Qualifications Framework for lifelong learning (EQF). The EQF is a reference tool to compare the qualifications levels of different countries and different education and training systems which examines the learning outcomes rather than at training hours.

The issue of health professionals' continuous professional development (CPD) is a matter which is as important as professional qualifications. It is through the record of CPD that a prospective employer can tell how up-to-date a professional's skills and knowledge are. But different CPD standards in Member States make it difficult for prospective employers to gauge the level of experience and raise concerns about health workers' professional ability and quality and the safety of care that they provide. Increased cooperation at EU level is required to address this issue.

Question

Should a European forum be created within which to hold this important debate?

Public Health Capacity

As well as clinical health care and underpinning the planning of health services is the public health function. This carrying out health needs and health impact assessments, health promotion and education, health economics, epidemiological mapping and planning for the control of infection. Public health doctors, virologists, epidemiologists, and microbiologists, amongst many others, are needed to plan for health emergencies, to tackle the spread of infectious diseases and pandemics, as well as planning for the public health responses to disasters. Public health capacity needs to be built up and this will involve increasing training capacity and of course, increasing the number of trainers.

The European Working Time Directive

In August 2004 the Working Time Directive (WTD) came into force to protect the health and safety of workers by restricting hours worked (to a maximum of 58) and imposing minimum rest requirements (with a maximum of 13 hours of work in any 24 with at least 11 hours of rest between shifts). In 2009, the maximum working hours will reduce further to 48 hours.. In the health sector, the Working Time Directive helps to ensure both the health and safety of health professionals and patients but because it reduced the working hours of those professionals, such as doctors in training who have traditionally been used to working long hours, it impacts on the numbers of staff needed to provide a 24 hour service.

For example, counting 'on-call time' as working time can in practice reduce the availability of health professionals and thus cause an additional financial burden for health sector. This also has an impact on workforce planning, for example, it can influence the type of contract offered to health professionals, which could create a tendency to offer them shift work or a contract as a self-employed worker which would allow them to work longer hours. Moreover, the 'opt-out' provision which allows an individual worker voluntarily to opt-out of the 48-hours average weekly working time limit (including on-call time) may lead to health professionals demanding salary increases in exchange for signing the opt-out clause.

The impact of new technology

The introduction on new technology may help to produce workforce solutions in areas where there are shortages of health workers. Telemedicine (also known as telehealth) is defined as the delivery of healthcare services for patients, using communications technologies, in situations where the clinician and patient are not at the same location. Telemedicine includes the transmission of medical images, audio, video or other data to support the diagnosis, monitoring and treatment of patients."

Evidence for decision-making - Lack of comparable data on health professionals

The lack of comparable data on health professionals currently impedes the development of evidence-based policies. Given the potential for shortages in one part of Europe to have an impact elsewhere, Europe-wide information on the number of health professionals, their specialisations, age, working time and their distribution is key for planning and providing health services for all health authorities throughout the EU. The lack of data on health professionals is not only an issue at EU level, but it is also impeding the development of evidence based policies by those deciding on health workforce policy in Member States.

Questions on which the Commission invites contributions include:

- How can the availability and comparability of data on health professionals be improved, in particular with a view to determining the precise movements of particular groups of health professionals?

Do we have sufficient and accurate data on professionals within countries in terms of numbers, shortages, training capacity, skills and needs?

- What would be appropriate for a minimum dataset on health professional migration?
 - What level of data collection would be considered too great an administrative burden ?
- What can the EU do to help the sharing of good HR practice and recruitment and retention strategies?
- What can the EU do to support Member States?