GASTEIN SESSION - PREPARATION PAPER
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Questions to the speakers

Is there such a thing like a "European health workforce"

How realistic is it to forecast and plan this workforce?

Are the internal market and the planning of health systems aligned or is the distribution of the health workforce contradicting health systems needs?

There is a European health workforce as much as there is a European workforce.

Europe shares workers for centuries now, with a huge increase quince the creation of the EU. Europe shares a common base ground of history of medicine and medical practices, exchange of scientific knowledge, that the political and territorial evolution of Europe has create. Ancient greek (with the famous figure of Hippocrates) and roman medicine have been spread by Greek settlements, and Roman Empire[1]. Modern medicine, arising in the 19th century, found its origin on western european scientists, giving birth to a European Medicine.

Of course professions with very specialised and context dependent skills are less mobile, but EU has set a good framework for mutual recognition - the well Directive on professional qualifications[2] known EU/2005/36 amended by EU/2013/55. Health Workforce are such specialised profession, also with specific risk on population, but are way more mobile than lawyers or notaries. In fact, according to the EU DG Internal Market database, the health care professions are among the top 5 with the most registrations.

Also, Europe is setting many mechanism to improve the international qualifications of our young professionals, e.g. through the [3]Erasmus+ processes, and through the standardisation of curricula and of training processes and their accreditation.
All european countries have medical and health care training capacity, targeting foreign students, and full academic training in english all over Europe. As past-general manager in charge of Health Professions in Belgium, I could countersign many professional recognitions for physiotherapist. 50% of all of the french speaking schools students were French Students studying in a neighbouring country, and planning to return home. Last week, working at the Medical University of Varna in Bulgaria, I enjoyed listening at the cafeteria to numerous German born students in medicine and even US students.

Not withstanding the various nuances and open doors for long discussion that are migration of health professionals (and its dominant east to west and south to north flows), difference in training options and even training level in some case (e.g. german vocational nurses), I answer very positively. We have also had to some extend a European medicine, and we are increasing this,

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[1] See The Western Medical Tradition: 800 BC to AD 1800, Volume 1 - Lawrence I. Conrad, Michael Neve, Vivian Nutton, Roy Porter & Andrew Wear.

[2] In the belief that the difference in training and professional practice can be overcome, the EU Directives EU/2005/36 and EU/2013/55 put in place the mechanism for applying and make easy the mechanism to ensure a mutual recognition of acquired skills and professional titles, and allowing in practice free movement of protected professions (incl. healthcare professionals), and proportional measures for closing any gaps in knowledge.

[3] Regulation of the European Parliament and of the Council establishing"ERASMUS+": the Union programme for Education, Training, Youth and Sport and repealing decisions No 1719/2006/EC, No 1720/2006/EC AND No 1298/2008/EC

and other professions follow, with many imperfections though, especially on employment of nurses..

The first question is maybe “How realistic is it **not** to forecast and plan this workforce ?”.

Our world has globally driven by enhanced competition, search for innovation, personal well being at (almost all price). Today, the role of the States is reduced, as most governments have with limited budget and narrow space for solitary legal initiative. This role is limited to the management of the negative effects of imbalances, especially those threatening the solidarity within their society and impacting public services and economic growth[4].

If we don’t plan we could assume that somehow the ‘market’ will adapt the supply to the demand of healthcare. This is generally true.

Still, and there comes an ethical reflexion, there is a huge amount of time when an imbalance is detected and the increase of the production and the delivery of the necessary amount of health workers to close the gap. In the best case scenario, this cannot be less than 3 to 5 years for nurses and 9 to 12 years for medical doctors.

With a overall shortage of mental care specialist for children's, can we accept to let it flow and expect the market to produce those specialists ? What in the meantime with or patients ? With anaesthesiologist flowing from east to west, do we accept to wait for a spontaneous reverse movement when the western market may become saturated? Or maybe wait until when the local shortage will have pushed a private medical circuit to arise with wages to a level that attracts anaesthesiologist from elsewhere and retains new locally produced professionals ? How many nurses or junior doctor will be in charge of the anaesthetises in the meantime ? How many patients will keep sequels, operations canceled ?

It is not ethical not to pay ***best effort*** on forecasting, as it is not realistic to not ***plan*** alternative ways to fasten the closure of the gap, is it through production, attractiveness strategies or re-engineered health care systems.

Now beside the “must do” answer, is it feasible as many believe the effort is not worth the poor response of those processes, and the huge error on the measurement?

Together with the partners of the [5]Joint Action on Health Workforce Planning and Forecasting, I say YES.

Planning is NOT put forward a perfectly calculated and trustable value of the future needs according the most economically favourable scenario. Planning is building a dialogue between the stakeholders leading to several policy options and deriving from those a range of prognoses together as a calculation of the potential error. Fed by such quality material and which transparent assumption, the policy maker may then agree on actions for the future, and take the difficult bow of reaching a society affordable strategy, which may be quite different from the ideal viewed from a health care perspective.

This is feasible and many countries have created years of evidence of this feasibility. We have more data then we need even is poorly coordinated today. We have experience and good practice, and most of all we have democratic peace and willingness of all health professions to dialogue.

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[4] see “La Révolution de l'amour. Pour une spiritualité laïque” by Luc Ferry and “Le capitalisme est-il moral ?” by André Conte-Sponville.

[5] www.euhwforce.eu

Finally, about the complexity of planning using so many parameters, we acknowledge that many data and various scenario building must take place for enabling policy maker to take decisions on the most plausible or the most desired options. Still, planning is implemented using measures and we now have experience in the positive and negative effects of some of them. Action on the production is the most used, together as an action on budget and wages. Also the promotion of some professions and the provision of grants for establishment are well known. This knowledge will be made available to all.

Still, the future of healthcare may necessity reengineering of the current systems, and good assessment of the current and future trends of how the work of our health professionals will evolve. Our Joint Action programme plans to produce a report on future skills needed as one of the major researches needed.

We all know that there are numerous types of imbalances, and that most of them are currently increasing. The health care market is not in a phase were we could say it is balanced. An overall shortage of health professionals has been identified already some years ago, and detail analysis reveals real local crisis, even though perceived through various local culture lenses.

There are currently more shortages than oversupply. Some eastern european countries lost two digit percents of their medical and nursing demography theses last years, but also part of their population, leaving elderly people with reduced health coverage. Highly demanded medical specialists, with long and costly trainings are working abroad, and this outflow also impairs the capacity to train locally new specialists.

But the situation is or will be also acute in the countries with the highest income. The effect of the retirement of the so called baby-boomers[6] is widely documented, especially on the primary care, where the practice are (proportionally) less attractive on the financial and professional recognition aspects. Also, the imbalances between countryside and cities is subject to many publications.

In countries like mine, Belgium, some sectors are in crisis with no real improvement despite policies. Internal medicine is suffering from what is considered as poor working conditions and many young doctors flow as a consequence to so called super-specialisations. Emergency care medicine cannot recruit more high skilled professionals that what is simply requested to counter the turn-over. But more frightening, mental care is at real risk, with consistent acute shortage of child psychiatrist and absence of treatments for the weakest, with the specific scandal of the many mental impaired people untreated and kept in jail.

There is a war for talent all over the world, and even England, a traditional attraction country, with an not to underestimated dependance on the international migration for supplying the healthcare system[7], is at risk of losing many skilled professionals in a further migration to the West.
So obviously, many indicators show that the market is not responding the needs, or at least not fast enough if responding.

To be complete and balanced, I need to mention that also some specific threat of oversupply exists. Due to budget reduction, some southern countries have now more health professionals that they can afford, which is also sort of an oversupply with a boomerang effect on the quality and accessibility to health services. Also IT development and scientific progress impact some professions if they do not reform their scope of action and their place in the health care system and bring them at risk of oversupply.

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[6] Many retirement of health professionals, and increased number of elderly patients.

[7] see many articles like “Most hospital trusts have raided EU for nurses in past four years”
19 September, 2014 By Steve Fordand on http://www.nursingtimes.net, but also and primarily DH stats

As a matter of fact, the ‘cattle cycle’ well known by economist is likely to apply if the production of health care worker would be merely economically profitable and/or if a State respond to shortage would increase the overall capacity. Currently, this occurs at micro level, not haven’t at macro level yet. Again, planning the production of Health Care Workers is of major importance for the sector of education.

Still, oversupply is currently anecdotic at the scale of Europe, and of course then at the scale of the World.

The situation at World level is of course broader debate with clear numbers and very few solution. As an example, imagine that last year there were 88 ENT’s in Congo, among which 87 in Kinshasa. Knowing the early detecting of audition and balances sicknesses, due to local parasites, are key for reducing the disabilities at early ages, … I leave it to you to draw conclusions.

Therefore, together, EU Members States took the engagement to address the HWF issues by sharing knowledge and improving the capacity to collect numbers and asses future trends. The result is the Action Plan for EU Health Workforce[8], out of which our Joint Action on health workforce planning and forecasting. This is no as such solution, but it is the ground on which solution may grow.

[8] Action Plan for the EU health workforce adopted as part of the Commission Communication for a job rich recovery in Europe (http://europa.eu/rapid/press-release_IP-12-380_en.htm?locale=EN)