



Conclusions from the workshop on
Future skill needs in the health care sector
22-23 May 2008, Thessaloniki, Greece

Overview

The international workshop ‘Future skill needs in the health care sector’, held in May 2008 in Thessaloniki, was organised in cooperation with the European Social Dialogue Committee in the Hospital Sector in the European Union - European Federation of Public Service Unions (EPSU) and European Hospital and Healthcare Employers’ Association (HOSPEEM).

The workshop highlighted the critical challenges for human resources in the health care. Speakers and participants from 13 countries shared their views about future development of the sector. Contributions were presented by experts from Germany, the Czech Republic, the UK and Cedefop.

Background and rationale of the workshop

Health care and social services in all Member States are facing similar challenges: an ageing society and sweeping technological change, which in turn are affecting employment and family patterns. These trends influence the present and future tasks of people working in this sector.

As European society ages, healthcare and related social services are becoming increasingly important. This growing demand for services that are provided by the public sector in many Member States is creating unprecedented pressures on health and social care systems. To cope with these pressures, the sector needs a workforce with the right skills and competences.

Today, Europe is facing skills shortages in healthcare occupations such as nurses, medical specialists, and health technicians. To cover these shortages, vocational qualifications can facilitate entry- level career opportunities and open pathways to higher education.

Critical challenges for human resources in the health care sector in Europe

The keynote presentation of Prof James Buchan addressed critical challenges for human resources (HR) in the health sector in Europe. These were framed as the questions asked by policy makers in most countries, in Europe and beyond:

- How do we plan how many doctors, nurses, and other health workers to educate, and employ? How can we improve recruitment, retention and return?
- Which incentives are effective in motivating doctors and nurses?

- How can we determine and deploy the most effective skill mix of doctors, nurses and other staff?
- How can we improve the productivity of health workers?
- How do we maintain workload with reasonable limits, for individuals and for teams of health workers?

In turn, these policy questions were linked to specific Human Resources for Health (HRH) challenges which were common to most European countries, such as skills shortages, geographic misdistribution, fragmented planning, education, difficulties in links with employers and managing staff performance, and the challenge of achieving an effective skill mix; and issues such as migration, data availability, research and evaluation.

As there are different definitions of what constitutes a shortage, caution needs to be exercised in identifying the policy implications of any claimed staff shortage. The presentation highlighted some recent measures of skills shortage, using data from the OECD and WHO.

The presentation also noted that European health care labour markets are dynamic, that they respond to demographic change (particularly the ageing populations), general economic conditions, health sector reform and funding, relative earnings and career prospects, and regulatory change, e.g. worktime directives. It was also noted that there were other forces at work in Europe, including the impact of the accession of newer EU countries, with relatively low paid health professionals; this could encourage a flow of professionals toward richer EU countries and in turn perhaps create a “knock-on effect” further East and in the CIS.

The presentation used data from the WHO EURO HFA database to illustrate current health worker variations across Europe. Data on health professionals per 100.000 population was used to map significant variations in staff availability in different European countries. Simply looking at stocks of health workers is not sufficient; the size and direction of flows also has to be monitored. In addition, there is a need to contextualise international migration; other flows may be more important. Trends must be assessed over time. Professor Buchan noted that in relation to migration into / out of EU, the flows are variable: the main driver is the existence of “pull” factors, and flows are channelled/ moderated by: shared language, culture, historical links (post colonial), and regulation (e.g. Angola > Portugal; South Africa > UK)).

Migration within the EU, prior to the 2004 accession, was relatively low in relation to the size of the stock of health workers in EU countries, and the cross-border flows were related to: a) shared culture, language etc (e.g. France/ Belgium, within Scandinavia, UK/Ireland) or b) supply imbalances (e.g. Spanish nurses to UK). Since then, flows from new Member States have not been as high as anticipated by the OECD.

The presentation concluded by discussing a Framework for HRH Policy Solutions, with four main components: integrated workforce planning, improved recruitment and retention, improved skill mix and improved deployment.

Decisions had to be made about what policy grouping will be effective for which occupation groups. Current policy research support for HRH could include collecting, analysing and improving available data on HRH, supporting exchange of experience and expertise on HRH issues, supporting cross-national comparison of HRH assessment and

undertaking data analysis and advice/support to strengthen HRH management and policy research capacity.

Focus group discussions

The objective of the focus group discussions was to identify the key trends and future skills and occupational requirements in the health care sector. They examined in particular the interaction between technology and skill needs; management of health care; and education and training needs in the sector. Participants were assigned to focus groups addressing the following questions:

Technology, ICT and related skill needs in health care

Globalisation, innovation and new technologies have affected many areas of our life, including how we deliver health care. On the one hand, they are delivering continuous improvements in the diagnosis, administration, treatment and cure of diseases; on the other, they are capturing increasing shares of GDP in many countries and now represent an important share of health care expenditures.

Health-related ICT has created massive shifts in how health care specialists and consumers gather health and medical information to make decisions. Health ICT has the capacity to transform care delivery, improve quality, decrease costs and reduce medical errors. But planning and implementing such technology, and foreseeing its effect on the labour market, is a challenge.

Question 1. What are the main restructuring and adjustments trends and mechanisms in the health care sector in Europe, and which specific and general skills are new and emerging or declining?

Skills for the management of health care

Managing health care offers massive challenges and opportunities for businesses and their employees. Managers in the health sector have to be effective in all the traditional quantitative and qualitative skill areas of business management, e.g. influenced by New Public Management. But they must also be able to deal effectively with the role of government, and to manage the continuous transformation of the industry through innovation in technology, research and demographic developments. In order to cope with these tasks they need to possess a sophisticated and powerful combination of skills.

Question 2. What is the impact of new public management on management focus and management skills? e.g. efficiency and productivity measurements and a coherent approach on Government policies in health and other areas.

Education and training needs in health care

The knowledge triangle “research-innovation-education” is a major part of the Lisbon strategy for growth and jobs, with a particular focus on education for 2008-2010. The aim of this ‘dynamic triangle’ is to provide a framework for developments and partnerships at European, national and sectoral level, and should be considered as crucial also for the health care sector.

Education and training policies and strategies should integrate institutional based and work based learning, match the demand and supply side within occupations and qualification levels, focus on quality assurance mechanisms, recruitment, qualifications and cooperation between teachers and trainers.

To ensure integrated health care, education and training systems must provide analytical and leadership skills along with an understanding of the transformative nature of

technology. This education needs to be an effective combination of classroom teaching and real-life work in the health sector. The growing field of specialised health care education is an example of a significant critical response to these challenges.

Question 3. How can we develop an educational system which can respond quickly to continuously changing requirements? How can we bring educational and training standards closer to occupational standards and make them more responsive to employer priorities in the health care?

Reports from the focus groups

Most of the Member States have been through reforms in recent years. Although there are considerable differences in health care between European countries, participants in the workshop could distinguish some common trends and developments.

- **Change in governance and finance**

In almost all countries responsibilities and powers have shifted from one government level/body to another; in some cases this has been accompanied by large-scale restructuring, such as in Denmark and Norway. The shift in administrative responsibilities often had an impact in the way health care and hospitals were financed and controlled by governments. In the Netherlands, the objective of the reform was to privatise health care insurance and to introduce competition in health care provision and financing. Similar plans are afoot in the Czech Republic and have been discussed in Croatia - although both countries have already undergone reforms in the past decade.

In all cases, changes in legislation have had a clear impact on the organisation and management of health care services and hospitals. For instance, there is a trend in several countries to merge smaller hospitals into bigger hospitals in order to save costs.

The upcoming health services directive and the increase in patient mobility could also lead to structural changes in the way the health care is organised and delivered.

- **Growth of the private sector**

In most countries discussed, the number of private health care providers is growing - for instance in aesthetic surgery or for specific treatments like hip operations. In some cases these represent responses to demands for care which cannot be adequately met by public providers. Croatia has also seen an increase in private providers of care for the elderly. In some countries, especially in Central and Eastern Europe public hospitals and providers are in debt, making it more difficult for public health care systems to offer all the care that is needed.

It is still difficult to assess what exactly the effects of all these developments will be on the organisation of health care in general, and specifically on the training and qualifications of health professionals. It seems that most of the private providers focus on just a few specialist diagnostic or treatment services.

- **Increase in administrative tasks, for both medical and non-medical staff**

Because of the political demand for accountability and controllability, health care staff is required to do much more administrative tasks than in the past. Treatments all need to be specified and labelled with different codes before they can be invoiced; costs need to be specified according to the different accounting structures; referral systems for specialised or follow-up treatment become more formalised and complicated; and everything needs to be archived and filed in different systems and programmes. These tasks are time-

consuming and often become a burden. We need to organise these systems better, and to make sure the best skill mix is available in order to free up staff time for the treatment of patients. Generally, the finance, management and economic aspects of health care have become much more influential; that medical considerations are not always seen as the main priority.

- Growth in outpatient care

Most countries try to reduce the duration of the hospital stay. The focus of care services therefore shifts gradually from in-patient to outpatient care. The way outpatient care is organised varies very much from country to country, but care provided at home is becoming more important in all the countries discussed – a trend toward individualised treatment but using generalised care pathways. Healthcare, not just hospitals, emphasises the “whole patient care”-perspective. Patients often need highly skilled care, both before and after hospitalisation. More specialised medical skills have to meet the patients’ needs of integrated and complex care both within the hospital and outside.

This leads to the question on how to organise the healthcare system to follow the patient, rather than have the patient ‘follow the system’. The key concept here is integrated care, and integrated management. Which leads to the question: how do you train staff to fulfil the tasks associated with such integrated care? As doctors become more specialised, and more than one doctor is needed, the patients need guidance through the system to get proper and appropriate care and treatment. Thus, employees at different skill levels need to focus on how to guide the patients through the system. A pilot project in Norway aims at giving nursing students, physiotherapy students and others, specialised training in how to follow a patient through the system. This requires cooperation between the hospital, institutions in the municipality and nursing schools.

In Austria a new position has been created in hospitals, the so-called ‘after-care manager’, or ‘after-care planner’.

- Finding and keeping personnel

Most countries find it difficult to recruit and retain people, especially in specialist professions like midwifery where there are significant shortages in staff. The reasons for this problem vary but usually they are related to working conditions and the long period of training required for many jobs. Aging health workers (an example mentioned was that of dentists in the Czech Republic) are a problem in several countries. The Czechs also mentioned problems that personnel faced in operating new advanced machines. In most countries governments are facing these problems by making an effort to increase training opportunities in the health professions, and to develop workforce planning models.

Several countries, such as Denmark, are also experiencing an increase in the numbers of temporary agency workers. Other countries are facing the outward migration of their health workers. Many Czech doctors and nurses are leaving to work in e.g. Germany. As a result, Czech employers are now trying to recruit Slovakian and Ukrainian staff.

- Improvements in education and training

In almost all countries governments, social partners and professional bodies work towards an improvement of education and training for health care workers.

As health care workers - especially medical specialists, but also many nursing and technical professionals –, need many years of training before they are fully qualified, investment in training is a critical factor in the development of high-quality health

services. The development of training usually goes hand in hand with the development of job classification and qualification systems. These specify the tasks and responsibilities of each job but also the skills needed to fulfil them. It is not clear exactly what the right balance between theoretical and practical training should look like, but it has been recognised that practical and on-the-job training and the involvement of mentors is and should be a very important part of curricula.

In 2007, Lund University Hospital of Sweden introduced a new working method, known as “Lean Production”. The method, which originated at the vehicle manufacturer Toyota in Japan, has been used internationally in health care for 6-7 years with very good results, and is spreading rapidly. Lean is about doing more with less: less time, inventory, space, labour and money. In the case of health care, this involves learning what it is that really benefits the patients. Anything that does not benefit the patients is removed. The role of managers also changes under Lean Production: their most important task becomes that of creating activities with ever-improving quality, productivity and employee satisfaction.