CEDEFOP | European Centre for the Development of Vocational Training

SKILLSNET SECTORFLASH healthcare

WORKSHOP ON SKILL NEEDS FOR HEALTHCARE

Cedefop's international workshop 'Future skill needs in the healthcare 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, the European Federation of Public Service Unions (EPSU), and the European Hospital and Healthcare Employers' Association (Hospeem). The workshop focused on key trends and future skills and occupational requirements in the healthcare sector. Participants from 13 countries shared their views on future development of the sector, with contributions by experts from Germany, the Czech Republic, the UK and Cedefop.

DEFINING THE SECTOR

Healthcare is concerned with the provision, distribution and consumption of healthcare services and related products. It is a complex sector because differences in subsectors and between countries are often significant. In line with NACE classification, the sector includes human health activities (hospital, medical and dental practice), residential care (residential nursing, residential care for mental retardation, health and substance abuse for elderly and disabled) and social work activities.

As European society ages, healthcare and related social services are becoming increasingly important. This growing demand for services, 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.

> The health sector in the European Union (EU) employs almost 10% of the total workforce and corresponds to almost 9% of gross domestic product (GDP). Health spending is rising faster than GDP and it is estimated to reach 16% of GDP by 2020 in OECD countries.
>
> *Source: OECD, 2007.*

EMPLOYMENT IN THE SECTOR

Employment growth in the healthcare sector between 2003 and 2007 was positive for almost all Member States: the number of workers increased by 1.9 million. Denmark, Spain, France and the Netherlands created the most employment in the sector, mainly between 2006 and 2007; however, a decline in employment is documented in Hungary and the UK for the same period.

Today, Europe is facing skills shortages in healthcare positions such as nurses, medical specialists, and health technicians. According to the World Health Organisation (WHO) there was a world shortage of 2.4 million doctors, nurses and midwives in 2006. A major point of discussion was how Member

> By 2050, average public spending for health and long-term care in countries of the Organisation for Economic Cooperation and Development (OECD) may rise to 10-13% of the Gross Domestic Product. The emerging situation will not be sustainable unless action is taken at all levels to change the way healthcare is delivered.
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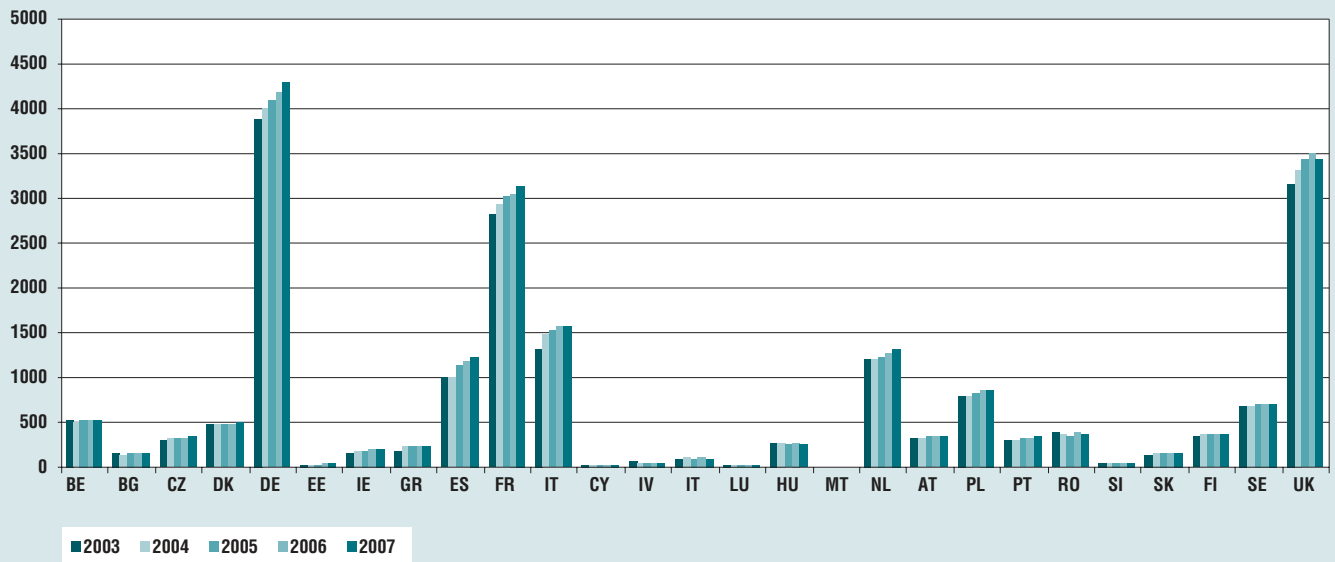
> *Source: European Commission, 2007.*

Employment in the health care sector (age 15-64), EU-27



Source: Eurostat, 2008.

Action is required at all levels to change the way healthcare is delivered. The proportion of people over 65 is expected to be almost double by 2050. More elderly people will require prolonged medical care and assistance to ensure they live independently.

Source: European Commission, 2007.

States can cover skill shortages. Vocational qualifications that can facilitate entry-level career opportunities and open pathways to higher education may offer a solution.

HUMAN RESOURCES CHALLENGES IN THE SECTOR

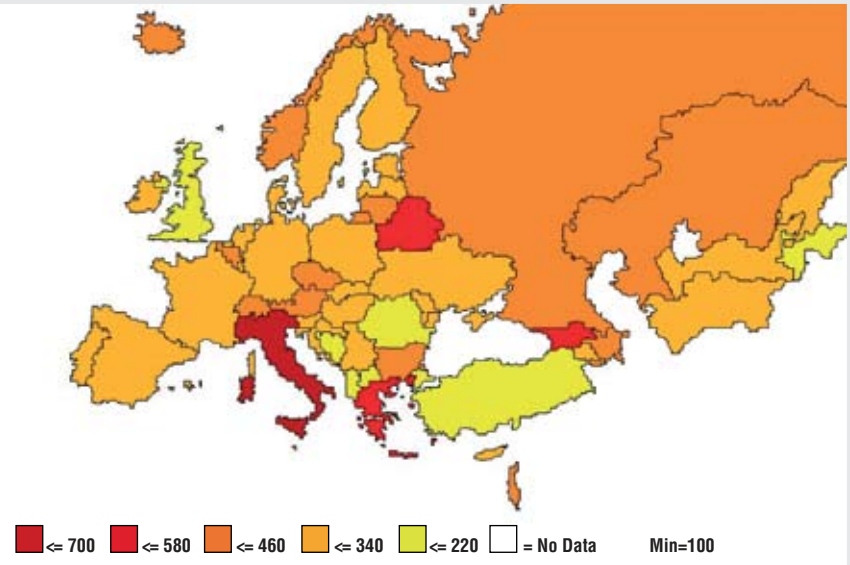
The keynote presentation of Prof. James Buchan addressed critical challenges for human resources (HR) in the health sector in Europe.

European healthcare labour markets are dynamic. They have to respond to demographic change, general economic conditions, health sector reform and funding, relative earnings and career prospects, and regulatory change, such as worktime directives. It was also noted that there were other forces at work in Europe, including the impact of 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 Commonwealth of Independent States.

Data from the WHO database illustrate current health worker variations across Europe. Data on distribution of physicians per 100 000 population show significant variations in staff availability in different European countries.

Simply looking at numbers of health workers is not sufficient; the size and direction of flows also have to be monitored. In addition, there is a need to contextualise international migration; other flows might be more important. Trends must be assessed over time.

Distribution of physicians for 100 000 inhabitants in the European region



Source: WHO, 2007.

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

It was agreed that the framework for HR policy should comprise four main components: integrated workforce planning, improved recruitment and retention, improved skill mix, and improved deployment.

Decisions have to be made about what policy grouping will be effective for which occupation groups. Current policy research support for HR could include collecting, analysing and improving available data, supporting exchange of experience and expertise on related issues, supporting cross-national comparison of assessment, and undertaking data analysis and advice/support to strengthen HR management and policy research capacity.

Inflow of healthcare workers to UK, Ireland, Finland and Sweden:

UK (2004-06): 530 doctors (hospital), 340 dental practitioners, 950 nurses (including 300 dental nurses) and 410 nursing auxiliaries and assistants;
Ireland (2004-05): employment doubled from 700 to about 1 300 in total;
Finland (2005): 432 authorisations were issued to physicians and dentists;
Sweden (2003-04): the number of authorisations increased by 510.

Source: OECD, 2007.

Outflow of healthcare workers from Member States:

Estonia (2006): 4.4% of all healthcare professionals applied for a certificate to leave;
Latvia (2005): more than 200 doctors expressed their intention to leave;
Poland (2004-06) more than 5 000 certificates were issued to doctors and 2 800 to nurses.
Anaesthetists and surgeons are the specialities more directly affected.

Source: OECD, 2007.

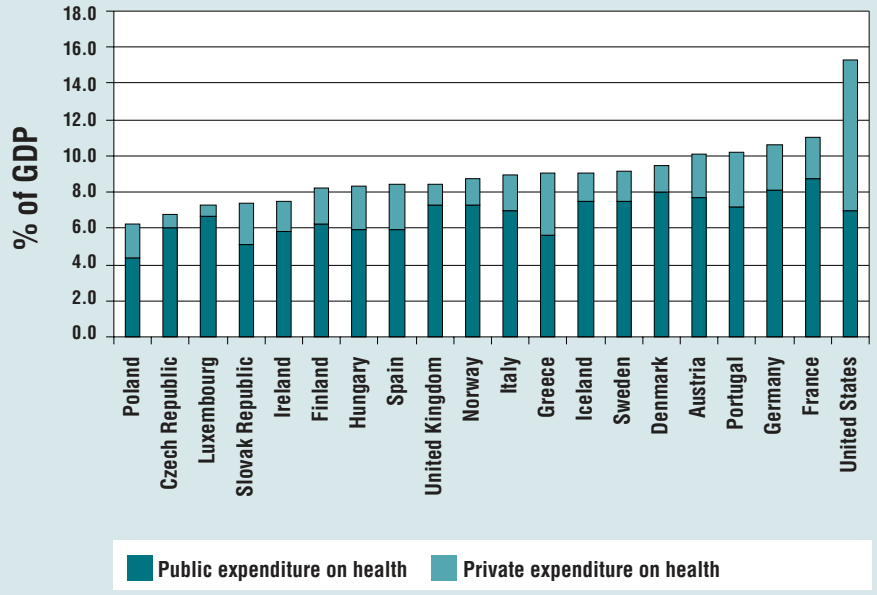
GOVERNANCE AND FINANCE

Workshop participants agreed that, 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, as in Denmark and Norway. The shift in administrative responsibilities often had an impact in the way healthcare and hospitals were financed and controlled by governments. In the Netherlands, the objective of reform was to privatise healthcare insurance and to introduce competition in healthcare provision and financing. Similar plans exist in the Czech Republic and have been discussed in Croatia, although both countries have already undertaken reforms in the past decade.

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

The upcoming EU Directive on application of patients' rights in crossborder healthcare and the increase in patient mobility could also lead to structural changes in healthcare organisation and delivery.

Total expenditure on health as percentage of GDP, 2006



Source: OECD, 2008.

PRIVATE SECTOR GROWTH

In most countries discussed, the number of private healthcare providers is growing, for instance in aesthetic surgery or for specific treatments like hip operations. In some cases there is response to demands for care which cannot be adequately met by public providers. Croatia has seen an increase in private providers of care for the elderly. Public hospitals and providers in some countries, especially in central and eastern Europe, are in debt, making it more difficult for public healthcare systems to offer all the care needed.

It is still difficult to assess the exact effects these developments will have on the organisation of healthcare in general, and specifically on training and qualifications for health professionals. It seems most private providers focus on just a few specialist diagnostic or treatment services.

INCREASED ADMINISTRATION

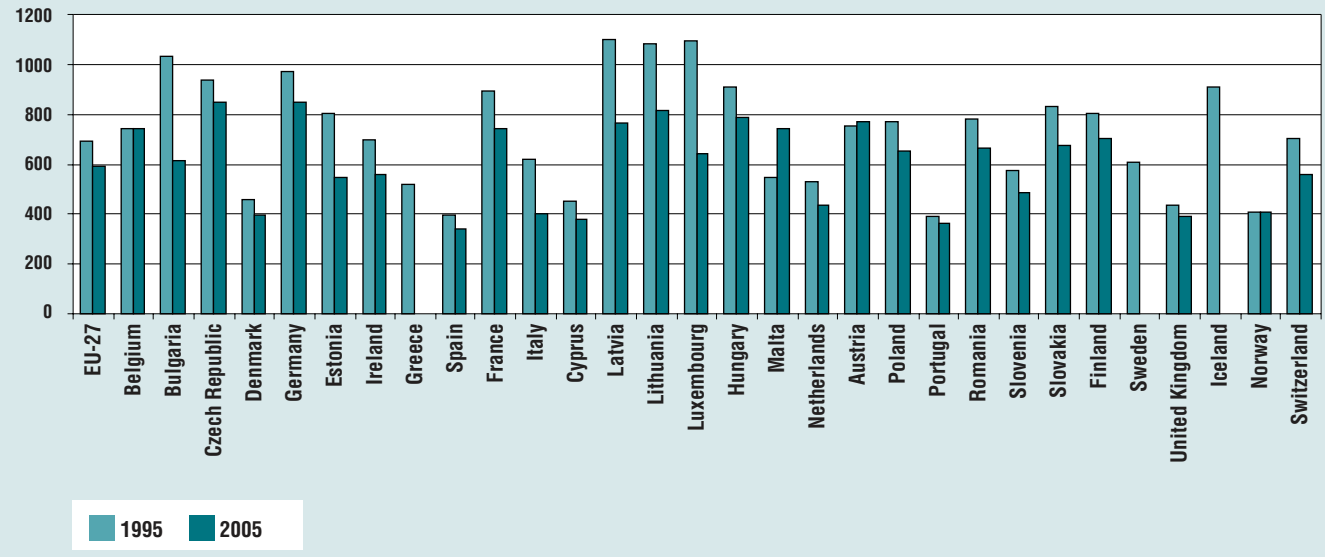
Political demand for accountability and control can require healthcare staff to carry out far more administrative tasks than in the past. Examples of this are: treatments need to be specified and labelled with different codes before they can be invoiced; costs need to be specified according to different accounting structures; referral systems for specialised or follow-up treatment are more formalised and complicated; archiving and filing use different systems and programmes. These tasks are time-consuming and often become a burden. Better organisation should provide a skills mix that frees up medical staff time for patient treatment. Generally, the finance, management and economic aspects of healthcare have grown to a point where medical considerations are not always seen as the main priority.

GROWTH IN OUTPATIENT CARE

Most countries are trying to reduce the duration of hospital stay, shifting focus gradually to out-patient care. The way out-patient care is organised varies from country to country but it is becoming more important in all countries. This is a trend toward individualised treatment using generalised care pathways. Healthcare approaches, not just hospitals, emphasise 'whole patient care' both before and after hospitalisation. This demands more specialised medical skills.

Because of this change, the number of

Hospital beds per 100000 inhabitants in Europe



Source: Eurostat, 2008.

hospital beds per 100 000 inhabitants in Europe decreased from 1995 to 2005 as indicated in the graph.

This raises the question of how to organise a healthcare system which follows the patient, rather than having the patient follow the system. The key is integrated care and integrated management, with consideration of how to train staff to fulfil the tasks associated with such integrated care. As doctors become more specialised, and more than one doctor is needed, patients need guidance through the system to get proper and appropriate care and treatment. Staff at different skill levels need to focus on how to guide 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 '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, leading to significant shortages in staff. Reasons for this vary but usually they are related to working conditions and the long period of training required for many jobs. Ageing health workers (an example mentioned was that of dentists in the Czech Republic) are a problem in several counties. There is the additional problem of operating advanced equipment, requiring governments to increase training opportunities in the health professions, and to develop workforce planning models.

IMPROVEMENTS IN EDUCATION AND TRAINING

Most governments, social partners and professional bodies are working towards improving education and training for healthcare workers.

As healthcare 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 critical for developing high-quality health services. Development of training usually goes hand-in-hand with development of job classification and qualification systems. These specify the tasks and responsibilities of each job as well as 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, on-the-job training and involvement of mentors is a very important part of the curriculum.

Doctors, nurses, dental practitioners, veterinary surgeons, midwives and pharmacists are covered by the general system for recognition of professional qualifications laid down by the Directive 2005/36/EC.

Source: Directive 2005/36/EC.

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HOW TO BECOME A **SKILLS**NET MEMBER?

Cedefop/Skillsnet welcomes all those active in research or policy on early identification of skill needs, to join the network. Skillsnet has around 300 registered members from all over the world. If you are an experienced researcher in skill needs analysis and forecasting, or are actively engaged in the transfer of research results on future skill requirements into policy and practice, you are welcome to submit the online application form on Skillsnet website **(http://www.cedefop.europa.eu/skillsnet)**.

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