COMITÉ PERMANENT DES MÉDECINS EUROPÉENS
STANDING COMMITTEE OF EUROPEAN DOCTORS

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At the CPME Board Meeting in Prague on 14 March 2009, CPME adopted the following document "**GREEN PAPER on the European Workforce for Health" (CPME 2009/034 final EN/Fr)"** (referring to CPME 2009/034 EN/Fr)

GREEN PAPER on the European Workforce for Health

CPME comments to the Commission consultation

CPME welcomes this Green paper and the opportunity to comment the issues it addresses. **The European doctors consider a well-educated, motivated and sufficient health workforce as a necessity to guarantee high quality of care and safety of patients in all European countries. It is therefore important to link health workforce issues to the ongoing work of the European Union in the field of patient safety.**

Community action is intended to complement national policies notably by networking and sharing good practice without impeding article 152 of the EC Treaty. CPME realises that with this Green Paper the Commission had to walk a very thin line to satisfy both of these basic principles and that other legislation such as the Working Time Directive (to be amended), Recognition of Professional Qualification (2005/36/EC) and the proposed Directive on Patient Rights in Cross Border Care have a direct influence on these topics.

The Green Paper does address most of the concerns of CPME, but we would like to highlight some of the comments and put them on a higher priority ranking. As part of the internal procedure CPME has forwarded the Green Paper to all its internal committees as the subject is relevant to all of them.

On the scope of the Workforce for Health: the Green Paper does not define the terms related to the health workforce. However, in graph 1 (page 4), under the category "health management workforce" there are four groups of personnel identified. Clinical workforce is one and doctors of course belong to this group. Attached to it there are two other groups: social care workforce and informal carers. Their scope is presented as overlapping with the clinical workforce. While the CPME agrees that there are areas where co-operation between these groups takes place and is indeed useful for the patients, this interface would need some clarification in future documents. The fourth group included in the category is "complementary and alternative". The CPME does not support references in this document to types of care that are not evidence-based and

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groups of personnel that do not have a professional education based on science. These groups do not (and should not) form a part of the officially recognized health management workforce.

On an ageing population: the combination of achieving more healthy life years and the collapse of traditional so called informal care structures (large families) are putting a strain on the medical workforce but the increased access to diagnosis and yet untreated disease patterns are the real strain for our health care systems. Diagnosis and treatment for an ever larger range of diseases and afflictions have to be addressed by an ever larger medical workforce and this has to be paid for. Increased health literacy and improved access to diagnosis and treatment, be it via new technologies or other means, also increases the proportion of the population which is treated for its ailments. To which extent this can be offset by a better prevention, health education and health literacy has to be proven.

On sustainability of health systems: financing this very labour intensive and dynamic economic sector is of course the key issue. Without engaging in a useless system discussion it is clear that through its particular aspects (equal access, universality, quality amongst others), this sector cannot be controlled or stimulated in the same way as other classical economic sectors. It is in this context that CPME would like to suggest to submitting the question of "attractiveness" of the sector to the new generation, the unequal mobility and the migration in and out of the EU by health care professionals, to a deeper analysis. Also crucial to sustainability of health care is to assure adequate balance between primary and secondary care.

On 4.1 Demography and the promotion of a sustainable health workforce
The number of doctors in the EU has increased by 300% since the beginning of the 1970's. Still, there is a prevailing shortage of doctors and other healthcare workers and retirements among doctors that have to be solved.
Therefore, the competence of each profession has to be utilised efficiently in order for the health care resources to be used in the best way.
It is also important to create working conditions suitable for both women and men throughout the whole working career, which includes the possibility to combine family and work.

Furthermore, the doctors must have sufficient time for his/her patients. Time is also required for acquiring knowledge and for collaboration with others within and outside the profession. There must be time for continuous professional development, opportunities to carry on research, as well as for instructing and teaching.

Although there are large differences in the different Member States, the common problem is the "attractiveness" of the profession. For CPME,

attractiveness is a mix of remuneration, working conditions, public recognition and social status. All these variables are deficient in varying degrees and combinations in the different EU Member States but CPME would like to put a detailed analysis of these variables (and possible ways to address them) on top of the list of actions to be taken. It also urges to focus on attractiveness amongst all different medical specialities including general practice/family medicine.

CPME would also like to propose its collaboration on the proposed action: "providing for a more effective deployment of the available health workforce".

On 4.2 Public Health Capacity

For CPME, the shortage of specialised occupational health physicians and the resulting public health capacity problems should be considered in the larger context of specific shortages of several medical specialties. A specific concern must be considered to promote European recognition of the general practice/family medicine specialisation.

Health promotion and disease prevention are also part of the primary care sector's profile (amongst others) and CPME would prefer that one of the actions undertaken would comprise a detailed analysis on the numeric needs for the different specialities.

CPME does recognise the need for specific action on the Public Health Capacity and the need for European coordination, including on data collection

On 4.3 Training and 4.4 Managing mobility

CPME proposes that a European policy should be developed in order to assist and to help Member States to plan sufficient local training capacity to face their needs. By establishing common standards towards educating, funding and supporting their respective national healthcare needs, the "financially motivated" migrations within the European Union should be kept to the level where free movement (a fundamental right) is the only factor driving migration. Relying unduly on external recruitment should be thus eliminated. CPME thinks that the best way to prevent these "brain drain" situations within the EU is to establish common standards on high quality training and CPD for health professionals on one side and to invest in proper working conditions and remuneration on the other side.

CPME wishes to distance itself from the cooperation in the management of numerus clausus for health workers and would rather promote the idea of an Observatory on the health workforce which then could assist Member States in their planification.

CPME would also encourage the use of ESF (European Structural Funds) in order to improve working conditions in the health care sector in order to eliminate disparities.

Nevertheless, CPME would like to reiterate that mobility for studying and training purposes is essential for the harmonisation of the quality of provided

Health Care. Hence, mobility of medical students and young doctors should be facilitated and encouraged.

On 4.5 Global migration of health workers
CPME wishes to strongly support the proposed actions on ethical recruitment. The code of conduct would be a first step in the right direction which should also include incentives to stimulate circular migration, which would create a bilateral win-win situation.

On 5. Impact of new technology
Ensuring better distribution of new technology throughout the EU as well as taking action to encourage the use of new information technology must be subject to three main principles

Firstly, ICT should only be implemented under the condition that it supports and benefits medical work and is adjusted to the needs of patients and health professionals. Patients on one hand and physicians and other health professionals on the other hand must be the main beneficiaries of any type of e-health applications. This means that the implementation of new technology in health care must not be driven by market forces and the economic interest of the ICT industry.

Secondly, before new technology is implemented, acceptance of the health workforce to use this new technology must be ensured. To achieve acceptance among health professionals and especially doctors, they must be involved in the development of e-health technology, to make sure that the ICT tools are easy and safe to use in daily practice. Suitable training of doctors and other health professionals in order to make the best use of new technology is also vital in the process of implementation of these technologies.

Thirdly, confidentiality of patient data is crucial for physicians and other health care providers in order to conduct their work in accordance with the requirements of professional responsibility and diligent care (CPME 2008/181). If patients do not trust that a high and appropriate level of confidentiality will be maintained, they might withhold medically essential information.
CPME does not see new technologies as a way to reduce the workload of health care workers. There will be a need for new skills and specific training to handle the technology but by making healthcare more accessible the need for diagnosis and treatment shall increase. The shift from hospital care (technical and high cost) towards primary care (not necessarily less technical but lower cost) should also be analysed in more detail as to the consequences on the global workforce.

On 6. The role of health professional entrepreneurs

When encouraging more entrepreneurs to enter the health care sector, it must be clear, that health services, due to their specific nature, have a particular position within professional services.
In all European countries, health services are subject to specific provisions, as they cover a highly sensitive area and they are provided by experts subject to strict regulations on training and authorisation. They cannot be made subject to principles of the free market, as they have to be equally available to every patient, regardless of his/her economic situation.

Market forces and promotional activities, which play a major role in other areas, are of minor importance in the field of health care, as the provision of medical services cannot be compared to ordinary consumer goods.

Each and every doctor is personally responsible to his patients and his acts, although primarily based on medical criteria, should take into account the economic and regulatory framework.

On top of these considerations CPME wants to steer clear from any system discussion and particularly on their respective advantages or disadvantages. In the case of entrepreneurial stimulation the above mentioned arguments show that a strict equality between public and private sectors would be needed in order to achieve the proposed actions.