On 27 November 2021, the CPME Board adopted the 'CPME Policy on Health Workforce (CPME 2021/096 FINAL).

CPME Policy on Health Workforce

The Standing Committee of European Doctors (CPME) represents national medical associations across Europe. We are committed to contributing the medical profession's point of view to EU institutions and European policy-making through pro-active cooperation on a wide range of health and healthcare related issues.[1]

0. Recommendations

- Health workforce planning must aim to achieve conditions for professional practice which improve quality of care and patient safety and ensure the accessibility of services. A lack of adequate numbers of health professionals is not a justified reason to lower qualifications and training standards.
- National medical associations provide valuable real-life qualitative information on imbalances or shortages in the medical workforce, in some cases supported by quantitative data. They must therefore be involved in the health workforce planning process. It is necessary to ensure every national health system is sufficiently robust to educate and train an adequate number of health professionals to meet the future needs.
- Member States must implement ethical recruitment policies in line with the WHO Global Code of Practice on the International Recruitment of Health Personnel. Recruitment of professionals from abroad should not be regarded as a simple tool to mitigate shortages of domestically trained health professionals.
- Planning systems must also take into account changing expectations relating to work-life balance and ensure equality in the future medical workforce.
- The European Commission should support governments by providing benchmarks for minimum workforce capacities.
- The legal framework should continue to facilitate doctors' cross-border mobility as a personal and professional right. However, where that mobility is driven by economic factors or inappropriate working conditions, governments must pro-actively identify and abolish root causes of such 'push' migration. These may include in particular inadequate remuneration, unlawful working hours, a lack of technical equipment, unsafe staffing levels, and lack of meaningful career development and training opportunities.
- Where there are asymmetric mobility flows, efforts should be made to create compensatory mechanisms to work towards win-win exchange.

[1] CPME is registered in the Transparency Register with the ID number 9276943405-41. More information about CPME's activities can be found under www.cpme.eu.

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- To ensure positive collaborative practice across specialities within the medical profession and between health professions, task-shifting policies must be based on the objective of improving patient safety and quality of care, not as a cost cutting measure.

1. Introduction

CPME has continuously underlined that the health workforce is the pillar of a functioning health system and by consequence essential for the achievement of universal health coverage and the right to health. The factors affecting the health workforce, its composition and distribution, are becoming increasingly complex and dynamic, therefore health workforce planning has become more prominent in health policy. CPME considers that health workforce planning must aim to achieve conditions for professional practice which improve quality of care and patient safety. At the same time, it is necessary to ensure capacities to provide high quality training at all levels.
The COVID-19 pandemic sharpened the awareness of existing problems, such as shortages and raised new challenges, e.g. how to build surge capacities. However, it has also raised interest in health professions with some Member States reporting high intake numbers in education and training. This shows the importance of focussed action to leverage the potential of health workforce policy not only in improving health systems' performance but societal and economic wellbeing.

2. Challenges facing health workforce planning

Mobility
CPME underlines the right to migrate, both within the EU and internationally. CPME strongly believes that cross-border mobility should be facilitated for the benefit of the individual doctor and the profession as a whole, as it provides an opportunity for knowledge transfer and mutual learning, to the benefit of patient care and ultimately the entire health system. In the case of migration driven by economic necessity or adverse working conditions, it is vital to aim at determining and eliminating the root causes of such dynamics and to work towards improving the situation of the medical workforce.

Ethical recruitment
Member States should primarily work towards self-sufficient systems which educate an adequate number of health professionals to meet future needs. Where there is pro-active outreach to professionals abroad, Member States and private actors must implement ethical recruitment policies in full alignment with the EU Directive on the conditions of entry and residence of third-country nationals for the purpose of highly qualified employment ('Blue Card Directive') and the WHO Global Code of Practice on the International Recruitment of Health Personnel. In particular, there must be incentives to stimulate circular migration, which create a bilateral win-win situation, such as partnerships at university and clinical level.

→ *'Green Paper' on the European Workforce for Health: CPME comments to the Commission consultation, March 2009*

Working conditions
The importance of working conditions as a factor for professionals' decisions to take up a career in medicine, stay in the profession or migrate shows the importance of coherent policy-making across areas such as education, employment, family life, finance and migration. While many discussions around health workforce planning focus on the remuneration of professionals as the key factor of recruitment and retention, access to training and education, including continuing professional development and ability to maintain skills, practice conditions such as availability of treatments, lawful working hours, safe staffing levels, meaningful career development opportunities, work-life balance, all contribute to a healthy work environment in which medicine is an attractive and sustainable career choice. In the context of

emergencies such as the COVID-19 pandemic, access to decent and safe Personal Protective Equipment and fair working contracts for professionals who formed part of the surge capacity, as well as for all those working in the health system became additional factors which had an impact on professionals' career choices.

→ *CPME response to public consultation on Social Europe, November 2020*

→ *CPME report on COVID-19 in Europe, November 2020*

Indicators to express impact of working conditions

Successful recruitment and retention are a measure of successful health workforce policies and rates of doctors leaving the profession can give an indication of policy failures. In recent years, reports of doctors reducing professional practice or retiring early due to burnout, depression or other mental health conditions have increased. Others have left the profession to prevent a deterioration of their own health. In health systems in which the private sector offers better working conditions than the public sector, professionals move from the latter to the former, aggravating the situation in the public sector and inducing a vicious circle. At another level, the experience of violence against health professionals or 'moral injury' have been cited as risk factors for low retention. Conversely, positive practice environments have protective effects. In surveys on work satisfaction, doctors regularly cite time spent with patients or an exchange with colleagues as the rewarding aspects of their work which balance out the negative burden professionals associate in particular with non-clinical activities such as documentation. Pro-actively monitoring these factors can support retention and recruitment policies.

3. Objectives for health workforce planning from the medical profession's perspective

Recruitment and retention

Alongside ensuring sufficient education and training capacities, it is necessary to build effective recruitment and retention strategies. This spans from attracting future professionals to take up a career in medicine to ensuring working conditions and career development opportunities which support continued practice. The strategies should provide professionals positive incentives to this end.

National Medical Associations report positive results from the following measures:

- High quality, time and resources allocated for learning
- Adequate time and resources allocated for research
- Promotion of work-life balance (flexibility in terms of full-time/part-time positions)
- New economic and organisational models for free practice settings complementing individual ownership with joint practice and employment options, in particular in family medicine/general practice.
- Workplace visits or internships in family medicine practices in remote areas for medical students, to promote recruitment of future practitioners
- Financial incentives to doctors practising in underserved regions
- Positive practice environments including facilities enabling doctors' well-being at work and ensuring support services are easily accessible and well-publicised
- A fair and transparent selection process for recruitment and promotion free from any form of discrimination

Ratios of health professionals per population unit

As described, CPME emphasises the importance of safe staffing levels not only in the context of lawful working conditions and the attractiveness of medical practice as a long-term career, but for the safety and quality of patient care. Policy discussions so far have focussed on mapping and comparing the ratios of health professionals per capita. Recent experiences in particular the COVID-19 pandemic have shown that

Member States have not made meaningful progress in addressing shortages or imbalances in their health workforce, despite commitments under framework policies such as the WHO Human Resources for Health strategy.

CPME therefore proposes that the European Commission should issue recommendations following the format of the European Semester recommendations as to minimum ratios of resources per population unit for baseline universal health coverage and emergencies, taking into account geographic distribution and age profile including the option of pooling resources at Union level. As a basis for these recommendations, it is important to improve international data collection exercises to harmonise data categories where possible in order to identify differences and avoid misinterpretation of data. It is important to reflect national deviations from the harmonised categories across Europe to be able to put data into context.

→ *CPME position on Commission's Proposal for a Regulation on cross-border threats to health, 20 March 2021*

Collaborative practice & task-shifting

CPME is strongly supportive of collaborative practice across specialities within the medical profession and between health professions. The patient-doctor relationship remains at the heart of this collaboration. Recent initiatives promoting inter-professional education and training including in the area of continuing professional development (CPD), also in implementation of the 'One Health' approach, are facilitating better communication and coordination throughout careers, and can make all health professions more attractive. In the context of health workforce planning however collaborative practice is often conflated with concepts such as task-shifting and misused as a tool to mitigate workforce shortages. CPME reaffirms that task-shifting must always be driven by the objective of improving patient safety and quality of care, and cannot be an organisational stopgap or a cost-cutting measure. Where tasks are redistributed, this must be supported by adequate training, including on aftercare and continuity of care. Furthermore, the implications for quality assurance and liability must be considered and reflected in these frameworks.

→ *CPME Policy on Task Shifting, November 2010*

European level monitoring

Past projects on health workforce planning at EU level have shown the benefits of knowledge exchange on this topic, however there is a lack of continuity in and management of the cooperation. With cross-border mobility providing an additional dimension to workforce planning, the creation of a European monitoring service on the health workforce to assist Member States in setting up and maintaining planning structures as well as coordinating the cross-border aspects of planning would provide a useful long-term infrastructure. It should be integrated with existing WHO programmes such as national health workforce accounts and link up with EU processes in particular the European Semester and the pandemic preparedness planning foreseen under a future EU Regulation on serious cross-border threats to health. The European monitoring service could take the form of a permanent expert working group hosted by the European Commission.

→ *'Green Paper' on the European Workforce for Health: CPME comments to the Commission consultation, March 2009*

→ *CPME position on Commission's Proposal for a Regulation on cross-border threats to health, 20 March 2021*

Other references

- Pandemic preparedness - European doctors' recommendations to the EU (2020)
- European Medical Organisations' Joint Statement on Violence against Doctors and other Health Professionals (2020)

- 'Green Paper' on the European Workforce for Health: CPME comments to the Commission consultation (2009)
- SEPEN mapping of national health workforce planning and policies (2020)
- Support for the health workforce planning and forecasting expert network (SEPEN) (2017-2020)
- Joint Action on Health Workforce Planning and Forecasting (2013-2016)
- WHO-Europe toolkit for a sustainable health workforce in the WHO European Region (2018)
- Health Workforce Policies in OECD Countries - Right Jobs, Right Skills, Right Places (2016)