THE EUROPEAN HEALTH WORKFORCE: CLOSING THE GAPS

By: Martin McKee

Summary: Europe may be united politically, but it is divided by health. 30 years after the physical borders between East and West came down, the health of those in central Europe still lags far behind that of their western neighbours yet their health services continue to suffer from underinvestment. The gap is particularly large for the health workforce. The COVID pandemic has shone a light on these long-standing inequalities, but as Europe moves forward into a post-pandemic period, it has an opportunity to address them. This pandemic will not be the last. If Europe is to be prepared for future threats, it must begin the process of creating a European Health Union, in which a strong, resilient, and equitable health workforce will play a major role.

Keywords: Inequalities, Health Workforce, Preparedness, European Health Union

A divided Europe

Over 30 years after the fall of the Berlin Wall, Europe remains divided. Not by walls and fences, but by health (see Figure 1). The Global Burden of Disease (GBD) project reports a death rate, in 2019, of 1,201 per 100,000 people in the countries of central Europe (which includes those in the Balkans) that is 22% higher than the figure of 979 in western Europe (the European Economic Area plus the United Kingdom). Measured in Disability Adjusted Life Years, the difference is similar, at 35,488 compared to 29,075 per 100,000. Yet, in a clear demonstration of the Inverse Care Law, it is in central Europe that health services are weakest. The Health Access and Quality Index, developed within the GBD project, captures deaths that should not occur in the presence of timely and effective care. With Iceland, Norway, the Netherlands, and Luxembourg topping the list worldwide, it is clear that western Europe is performing well. Slovenia comes in at 21st and the Czech Republic comes in at 28th, but their neighbours fare considerably worse, with Poland in 39th position and Hungary in 40th.

There are many reasons for this, and among the most important is the underinvestment in health workers. The opening of borders within Europe has brought many benefits for health services, opening up the market for modern equipment and pharmaceuticals, promoting the exchange of knowledge on evidence-based practice, and providing structural funds for health facilities. However, it also created the conditions for large-scale migration of health workers, seeking better working conditions in western European countries. This was exacerbated by the historical underinvestment in training in some
Western countries, for example the United Kingdom, which had long depended on recruitment from its former colonies.

This European health divide was the subject of a panel at the 2020 European Health Forum Gastein chaired by Alex Soros, Deputy Chair of the Open Society Foundations and Vytenis Andriukaitis, former European Union Health Commissioner and Special Envoy for the European Region of the World Health Organization. The other participants were Corinne Hinlopen, Global Health Policy Researcher at Wemos, Salija Ljatifi-Petrushovska, Director of the Specialized Hospital for Geriatric and Palliative Medicine in Skopje, and Martin McKee, from the London School of Hygiene & Tropical Medicine and European Observatory on Health Systems and Policies.

**COVID shines a light on longstanding problems**

The panel discussed how the COVID pandemic had shone a light on these problems, as health systems across Europe struggled in the face of rising rates of infection. Even those countries that are, in relative terms, well supplied with health workers, health providers struggled in the face of rapidly rising need for care, including many of their own staff who faced daily risks on the front line of the response. As Alex Soros said, “The epidemic affected not only Europe’s most vulnerable patients, but also its most vulnerable workers – including health workers on the front lines, many of them migrants who had left behind failing health systems in their home countries”. Vytenis Andriukaitis added “Europe had witnessed market and state failures to regulate labour markets in the health sector. It’s doable to find win-win solutions for countries donors and countries recipients of health professionals”.

In the initial months of the pandemic, the countries of central Europe were relatively spared. Unlike in some of their western neighbours, they implemented measures to reduce the spread of transmission early. Yet this initial success may have given rise to a degree of complacency and as summer approached, they looked at how they might return to a semblance of normality. While some remained cautious, others moved quickly. The Czech Republic held a ‘Goodbye to Coronavirus’ celebration in early July, with tragic consequences as cases began to rise, to reach some of the highest rates in Europe by October.

The pandemic also shed light on another weakness. In the initial panic, Europe’s governments pursued their own interests, competing on global markets for personal protective equipment, tests, and other supplies but also for health and care workers. The pan-European mechanisms that had been created in response to earlier disease threats, such as joint procurement, took far too long to begin. There was some collaboration. Some countries, such as Germany, accepted patients from their struggling neighbours. But in almost all respects, they pursued their own policies, closing borders that had been open since the Schengen Agreement, and creating confusion along increasingly integrated border communities, with different rules on either side of the frontiers. It was only after several months that the European Union developed a concerted roadmap to exit the initial restrictions.

Of course, these differences created an opportunity for researchers. By setting up what were, essentially, natural experiments in which different policies were adopted at different times, it created a situation which might help to determine what policies work in what circumstances. Early in the pandemic differences in mandates on wearing of face coverings in German cities had provided valuable evidence on their effectiveness in reducing transmission. Yet these opportunities were difficult to exploit as the data collected in different jurisdictions varied and, in many cases, simply did not exist. There were substantial differences in definitions, such as of a COVID-related death, and in data collection, such as the intensity of testing. It soon became clear that excess all-cause mortality was one of the best measures of the effectiveness of responses and these data were available in the EuroMoMo project, but for only about two-thirds of Member States.

![Figure 1: Life expectancy at birth (2018 or nearest year)](image-url)
Resilient systems

What can be done?

Returning to the main theme of the session, what can be done to address the imbalance of health workers in Europe? First, it is essential to improve the working conditions of health workers, and not just their incomes. Improvements should come in their working conditions as well as opportunities for developing their skills and responsibilities. Salija Ljatifi-Petrushovska described graphically the challenges faced by those working in a country like North Macedonia.

In some countries, promotion depends on nepotism rather than expertise, creating a major disincentive for professional development and driving ambitious young health workers to look abroad. A particular challenge is the difference among countries in the status of nurses.

In many European countries it is necessary to ensure that the health workers that do exist are doing what they should, and not doing what they should not. A recent report from the European Commission’s Expert Panel on Investing in Health explored the scope for task shifting. Often seen as a way of delegating tasks to lower skilled and lower paid workers, the report painted a much more complex picture. Tasks should be distributed among and between different types of health workers, patients and their carers, and increasingly, machines. However, for this to happen, ingrained and restrictive practices must be challenged. In many parts of central Europe, the challenge is exacerbated by the persistence of informal payments that create serious barriers to change. Why should a senior doctor ask someone else to do something if they lose income as a result? The pandemic has already brought about changes that would until recently have been thought impossible, such as the massive growth of online consultations although, as Corinne Hinlopen noted, this needs to be managed carefully to avoid a “digital divide”. Yet the direction of travel is clear. We will see a much greater role for digital health. The panelists were emphatic. Countries in western Europe are facing enormous shortages of health workers, especially nurses, in the coming years and change cannot be delayed.

Taken together, the weaknesses in many health systems in Europe and the failure to work together to address them, have led to calls to “build back better”, offering many practical suggestions for the European Union. These included creating mechanisms to support health professionals to exchange ideas on innovations in models of care, strengthening the voice of civil society and particularly those speaking out for vulnerable communities, and living up to the commitment to pursue Health in All Policies. But the panelists were unanimous that more was needed, supporting the idea of a European Health Union as set out by Commission President Ursula von der Leyen when she told the European Parliament that now is the time to “build a stronger European Health Union” and in a recently launched Manifesto for a European Health Union.

As Corinne Hinlopen said, “now is our moment”. In this she echoed the words of an earlier citizen of Europe, Primo Levi, who had first hand experience of divisions in Europe and asked, “if not now, when”. [1]

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