THE EUROPEAN HEALTH WORKFORCE: BUILDING A TRUE LABOUR MARKET FOR HEALTH WORKERS

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Summary: Strengthening the health workforce is a critical priority to improve the resilience of health systems. In this article we consider how a European Health Union can help support health workforce development. It shows that greater cooperation between the European Union (EU) and Member States within a European Health Union can help to: promote voluntary collaboration on training and life-long learning; support retention strategies; and improve health workforce planning, forecasting and monitoring. It remains important that the EU takes stock of the positive and negative effects of inter-and intra-regional health worker mobility to safeguard health workers and the performance of health systems.

Keywords: Health Workforce, Labour Market, Human Resource For Health Data, Professional Mobility, European Health Union

Introduction

The COVID-19 pandemic has demonstrated the value of the health workforce, but also shown that it is vulnerable. Health workers were often put under extreme pressure, quickly changing working hours, deployment and skill-sets. They have been hailed as heroes. But at the same time, they were often exposed to physical and mental health risks and violence. Research suggests that 43% of frontline workers have experienced significant levels of anxiety during COVID-19, while 40% of clinical staff meet the threshold for post-traumatic stress disorder. Meanwhile, violence, hostility and anger against health workers has risen, often due to fear of infection transmission or by those protesting COVID-19 restrictions and reduced access to care.

The additional pressures of the pandemic, combined with long-standing challenges such as poor working conditions, insufficient pay, lack of flexibility in working hours, limited career opportunities and growing work pressures, are contributing to growing disaffection. In some countries, this has already translated into health workers resorting to industrial action, while evidence is emerging that increasing numbers are contemplating leaving the public sector or their profession entirely.
Clearly, the pandemic has aggravated existing shortcomings in the European health workforce including shortages, skill-gaps, mal-distribution (medical deserts), insufficient support for physical and mental health and social protection, and the failure to implement effective retention strategies. If we are to improve the resilience of our health systems, strengthening the health workforce will be a central priority. In this article, we focus on how a European Health Union could support the strengthening of the health workforce, including by improving the EU-labour market and fostering research on health workforce innovation and implementation. We first start by considering what the creation of the European Union (EU) has already contributed to health workforce development.

**What has been achieved?**

**The EU has created a dynamic and vibrant labour market for health workers**

Inter-regional health worker mobility has played a critical role in shaping the health and care workforce in the EU. This mobility has been facilitated by a regulatory regime based in the Treaties, guaranteeing the free mobility of workers and the right to reside and establish themselves. For the so-called regulated professions, which include medical doctors, nurses, midwives and pharmacists, an automatic procedure is in place that guarantees acknowledgement of qualifications obtained in another EU-country within a three-month period. The recognition is based on a common set of minimal training hours or training standards depending on the profession. Health worker qualifications are therefore highly mobile in the EU.

This EU wide labour market has created lots of opportunities for health workers, resulting in highly diverse forms of cross-border mobility. This ranges from commuting in border regions or covering weekend shifts or seasonal work, for example during the flu season, to moving to another country permanently or seeking training abroad. Some smaller countries now rely to a great extent on foreign-trained health professionals, while some of the bigger countries with large domestic labour markets attract large numbers of foreign-trained health professionals (see Figure 1). The dynamic and growth of mobility has increased in the past two decades, though directions and hot-spots have changed due to geopolitical changes, like the EU accession process, or external shocks such as the economic and financial crisis, the COVID-19 pandemic and war and conflict in Ukraine, as well as domestic reforms. Overall, trends over the past two decades have seen a major outflow of health workers from EU countries in the South and East of the region to other Member States, with some countries such as Belgium, Germany and Ireland both source and destination countries.

**EU wide labour market has created lots of opportunities for health workers**

The EU labour market for health workers is constantly growing, which, in theory, seems like a positive development. If we are to ask more systematically who is actually benefiting from it, the answer is less straightforward. Mobility is a complex phenomenon because it is neither wholly positive nor negative for source and destination countries; its effects change over time and are equivocal, overlapping, hard to pin down, and depend on the context and governance of mobility. Countries are faced with balancing the free mobility of health professionals in the European labour market on one hand, and the planning requirements of health systems ensuring universal health coverage on the other.

The EU-market in theory can be very efficient. If there are some countries with unemployment, health workers can move to countries where the demand is stronger. Shortages can be fixed in a fast and efficient way by becoming a destination country: instead of waiting until a new generation of health professionals is trained, cross-border recruitment works almost instantly. But source countries can also benefit from collective benefits, for example through the sending of remittances or acquiring new qualifications.

There are, however, many inefficiencies. Brain drain may affect or even undermine domestic workforce planning. If a country loses health professionals in large number, it also loses the investment in them and with it the tax-payer money spent on education, training and development. Moreover, health workers are not necessarily going where the need is the greatest but where the demand is strong. Balancing equity and efficiency to ensure all countries benefit from health worker mobility within the EU environment is therefore enormously challenging in practice.

**The EU has advanced health workforce policymaking**

There is no EU-health system but there is EU health policy, and these policies may sit in different and sometimes surprising places: in the various Directorates-General (DG SANTE, DG MARKET, DG EMPL), the mechanism of the European semester and the social pillar. It is a great achievement to see a growing convergence around primary and integrated care, access and quality, and resilience. This convergence is not perfect, but for an intersectoral policy is arguably more consistent than the all too often implicit health workforce policies in some Member States.

Aside from this convergence, the EU has managed to bring the health workforce into the EU-political agenda. The EU had previously invested in Agenda setting focusing on the health workforce, including under the Belgian (2010), Hungarian (2017) and Maltese (2017) council presidencies. The council conclusions coming from the Belgian presidency, for example, resulted in investment, in particular in research, as well as increased attention on developing
the health workforce. DG SANTE has argued that the health workforce is key to the sustainability and resilience of health systems and focused on it in its monitoring system – the country health profiles.

**The EU has increasingly funded relevant health workforce research**

Research and studies were funded through the programmes of DG RESEARCH and DG SANTE, helping to substantially increase knowledge on the European health workforce. Often, they focused on highly relevant topics such as the impacts of cross-border mobility, mal-distribution of workers and medical deserts, nursing quality, and digital skills (see Box 1). As a side effect, it’s fair to say that the funding has created a health workforce research community, which finds its platform in organisations like the European Public Health Association (EUPHA) and the EU health policy platform.

**How could a European Health Union support further development of the health workforce?**

Despite all the achievements, a fully functioning European Health Union could further help strengthen the health workforce in the EU. We consider how Member States and the EU working more closely together within a strong health union can help improve various aspects of health workforce development, including: planning, forecasting and monitoring; building national and cross-border capacity for education, training and

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**Box 1: Tackling health workforce issues through different EU-instruments**

**EU Research Programme**

- BeWell (Blueprint Alliance for a Future Health Workforce Strategy on Digital and Green Skills).

**EU Health Programme**

- AHEAD (Action for Health and Equity: Addressing medical Deserts)
- METEOR (Mental Health: Focus on Retention of Healthcare Workers)
- OASES (promoting evidence-based reforms on medical deserts)
- TaSHI (Empowering EU health policies on Task SHifting)
- ROUTE-HWF (A Roadmap OUT of Medical deserts into supportive Health Workforce initiatives and policies).

**Joint action**

- HEROES (Health Workforce to meet Health challenges. Planning and forecasting data, tools and capacity).
EU health workforce monitoring needs an overhaul. Figure 2 presents an overview of the ratios of doctors and nurses per 1,000 population. Although it looks very specific, it is at best a vague idea about the numbers of health workers operating in the EU labour market. This is because different indicators are collected in countries and reported to WHO, the OECD and EUROSTAT through the Joint Data Collection (JDC) form.

The EU should work with Member States on a reporting system that is accurate and timely. There are many challenges that need to be addressed to improve human resource for health (HRH) data. First, not all countries are reporting all professions. For example, nursing data, which is the largest profession by number, is missing from some countries. Secondly, comparability of data is limited. Some countries report all licensed health workers, which includes those unemployed or working in other sectors, while other countries focus only on those health workers that are actively practicing in the health sector. Further, some countries report head counts, while others report full-time equivalents. The latter indicator would be desirable as there are large variations; for instance, in the Netherlands, a large portion of the health workforce is working part time, while in Poland the majority of health workers are working full-time. This can distort comparison. Third, fragmentation of HRH data is high. For example, in many cases it is difficult to get data of health workers working in private health facilities. There are many other data shortcomings which relate to qualifications, settings of work and additional qualifications. One potential solution is for all Member States to strengthen their HRH information systems and introduce electronic health workforce registers that use common definitions of health workers and include health workers from the entire health labour market.

Health workforce planning and forecasting needs to be established and linked to other sectors. The EU needs to develop a link between national and EU planning systems. There is a need to institutionalise an EU-monitoring and forecasting system, that is linked with the forecasting and planning systems in countries. This is ambitious since the planning mechanisms across countries vary widely and some are not very effective. In fact, many countries still don’t have sufficient data, tools and capacities for forecasting and planning. Linking forecasting and planning with other sectors, including education, is another challenge. Health workforce planning should include multiple ministries, such as the Ministry of Education, Ministry of Finance, Ministry of Labour, Ministry of Social Affairs and Ministry of Health among others, to cover the full spectrum of the health labour market. The fact that responsibility for certain key elements of health workforce planning and development lies with other ministries beyond health, often on the regional level, requires sophisticated governance. Undertaking Health Labour Market Analysis is one approach to promote intersectoral workforce planning, investment and policy development, but will require significant efforts to strengthen HRH information systems.

Effective retention efforts are urgently needed to address demographic challenges. The health workforce in Europe is ageing rapidly. At the same time, the ageing of European societies is reducing the pool of young candidates from which to draw future health workers, while the health sector is not proving attractive enough for young students who decide to join professions in other sectors. This is raising serious concerns over replacement efforts in the coming decades. We are already observing shortages of health professionals in EU health systems. They are severe with regards to nurses, long-term and social carers and some medical specialties, such as general practitioners. This underscores the urgent need to invest in improving retention efforts to reduce attrition and early departure from the health workforce. This will require efforts to improve salaries, working conditions and efforts to protect physical and mental health. The manifesto of the European Health Union explicitly highlights the need for the EU to work together with Member States and take

health workforce is key to the sustainability and resilience of health systems

Note: In Greece and Portugal, data refer to all doctors licensed to practice, resulting in an overestimation of the number of practising doctors. In Greece, the number of nurses is underestimated as it only includes those working in hospitals.
action to retain and attract health workers, particularly in underserved areas, and to safeguard the rights of health workers.

Digital skills can help support retention efforts. A new generation of health workers are emerging that value working arrangements that are compatible with having a family and other life goals. Extending working hours is not an option to fix this problem, but rather to consider bringing more flexibility into working arrangements. Digital solutions for remote monitoring and teleconsultation are potential options that may play a role increasing the efficiency (as well as the accessibility and quality) of health care and reduce the bureaucratic burden on health workers. The creation of the European Health Data Space – a central component of a European Health Union – will help create a digital health service infrastructure to support and promote the use of digital health tools. Recovery and Resilience Funds meanwhile offer substantial budgets to support digitalisation, while EU’s the ‘Pact for Skills’ initiative will play a key role in ensuring health workers can develop digital skills for the future.

Closing the skill-gaps through lifelong learning. The EU should support the development of effective life-long learning systems across its Member States. According to OECD many health workers either feel over- or under-qualified. Gaps have been reported with regards to digital skills and green skills, which are indispensable for the health sector’s contribution to sustainability. Curricula adjustment is one way to address skill-gaps. It is, however, a slow and often cumbersome way to get new skills into the system. By the time the adjusted curricular becomes effective, it may already be outdated, given the rapid technological and medical developments. Often, it is not the entire health workforce that requires those skills. Life-long learning, for example in form of continuous medical education or continuous professional development, may provide better ways to strengthen the skills-profile of health workers. To this end, the EU could make life-long learning compulsory and support the establishment of Open Education Resources across the EU.

Voluntary collaboration on training and specialised care. The EU should support cross-border collaboration in the health workforce. Some EU countries are just too small or do not have the means to train all necessary specialities, though those services are included in their basket of care. Taking training cycles for specialisation in another EU-Member State is possible and common thanks to the mutual recognition of diplomas. Training cycles, however, are often structured in a way that the trainee has incentives to stay in the host country or that the return to the source country is difficult. In order to avoid the unnecessary loss of highly qualified health workers, training cycles abroad should be structured in such a way that it becomes an integral part of the domestic training. Return should be incentivised or made easier. Voluntary collaboration between countries should also be expanded when it comes to patients receiving specialised treatment by doctors coming from abroad or in other countries. Examples are coming from countries like Malta, which has a cross-border collaboration with the United Kingdom giving patients with rare childhood diseases access to specialised care.

Sharing capacity in times of crisis. The EU should facilitate the sending of patients and health workers across borders. COVID-19 has challenged the capacity of health systems in many European countries. One strategy to confront this challenge is by using spare capacities across borders. This was the case for COVID-19 patient requiring intensive care. Examples are from France and Italy sending patients to Germany. Also, Germany has sent health professionals to Portugal, supporting the Portuguese health system in fighting against COVID-19.

It is important that the EU takes stock of the positive and negative effects that the EU-labour market for health workers has on health systems. Shortages of health workers in one country may have consequences for other countries. If the shortage occurs in a higher income country, the vacancies may attract health professionals from other Member States. If the shortage is large, which often happens in larger Member States, cross-border recruitment may affect lower income countries – particularly in the South and East – whose health workers migrate. If large numbers relative to the size of the health workforce leave, the performance of the health system may be undermined. As already noted, intra-regional mobility of health workers presents both positive and negative consequences for health systems; enhancing the benefits and reducing the harms of mobility for all parties is a considerable challenge within the EU regulatory market. The EU should work with Member States to ensure the training pipeline for health workers is transparent, to report on the production of health workers in a timely manner, and to analyse their health labour market to identify possible shortages.

The impact of recruitment efforts on the global health workforce should be addressed. Some EU countries will need to recruit health workers from low- and middle-income countries to fill vacancies in light of demographic challenges. Ensuring Member States adhere to the principles of the WHO Global Code of Practice that aims to promote ethical recruitment practices is therefore fundamental. Any EU global health
strategy must include an honest discussion about health workforce needs and form an important component of multilateral development for health. It should support strengthening of those countries most likely to be left behind and enable clear, fair and ethical recruitment pathways for young people seeking a future as part of the EU health workforce in a way that creates win-win situations.

**Fostering research on health workforce innovation and implementation**

Despite all the progress being made with regard to EU-funded health system research there is still a need to strengthen comparative analysis. Europe is often considered as a natural laboratory for health system research. There are not only many health systems, there are also a lot of differences and countries are implementing innovations to improve universal health coverage and health system performance. To identify what matters most, the EU-funded TO-REACH research project has identified key priority areas where European health systems can learn from each other. These areas can be clustered among four domains:

1. **Person- and population-centredness**
2. **Integration of services across all health sectors and traditional health system boundaries**
3. **Four key sectors of care requiring reform: long-term care, hospital care, primary care and mental health care**
4. **Preconditions for improved functionality of the priority areas above.**

The health workforce is a key component across these four domains. This list of priority areas was compiled before the onset of the pandemic. The pandemic has underscored the importance of research with a focus on innovations and implementation. If we are to draw lessons from COVID-19, we will need to strengthen the health workforce for improved health system resilience and performance. EU-funded research will be a key component in this quest.

**References**

- WHO. Health Labour Market Analysis Guidebook, 2021. Available at: [https://www.who.int/publications/i/item/9789240035546](https://www.who.int/publications/i/item/9789240035546)
- WHO Regional Office for Europe. Human resources for health in small countries: developing and sustaining postgraduate training. *Policy Brief*, 2022. Available at: [https://www.who.int/europe/publications/i/item/9789289057837](https://www.who.int/europe/publications/i/item/9789289057837)