Comité économique et social européen
European Economic and Social Committee

Fédération Européenne des Médecins Salariés
European Federation of Salaried Doctors

Conference on inequalities in doctors' working conditions in the EU

21 September 2018

Venue: Room JDE 62, Rue Belliard 99, 1040 Brussels, Belgium

Conference Report

FEMS research conducted over the past several months, with the support of our member delegations has shown that the migrations patterns are quite complex especially on the emigration side, seeing many countries where working conditions are not considered as bad, to be net exporters of doctors. However, the major impact on the national healthcare systems can be seen on the immigration side: countries which are not able to attract foreign doctors are usually quite unfavorable for their own doctors, too, and they have many healthcare concerns as well.

The conference was meant as a joint action of governmental and non-governmental organizations, (EU institutions – EESC, European Commission - OECD, European medical organizations and EPSU), aimed at identifying potential solutions to improving working conditions of doctors across the EU as well as of healthcare systems as a whole. \

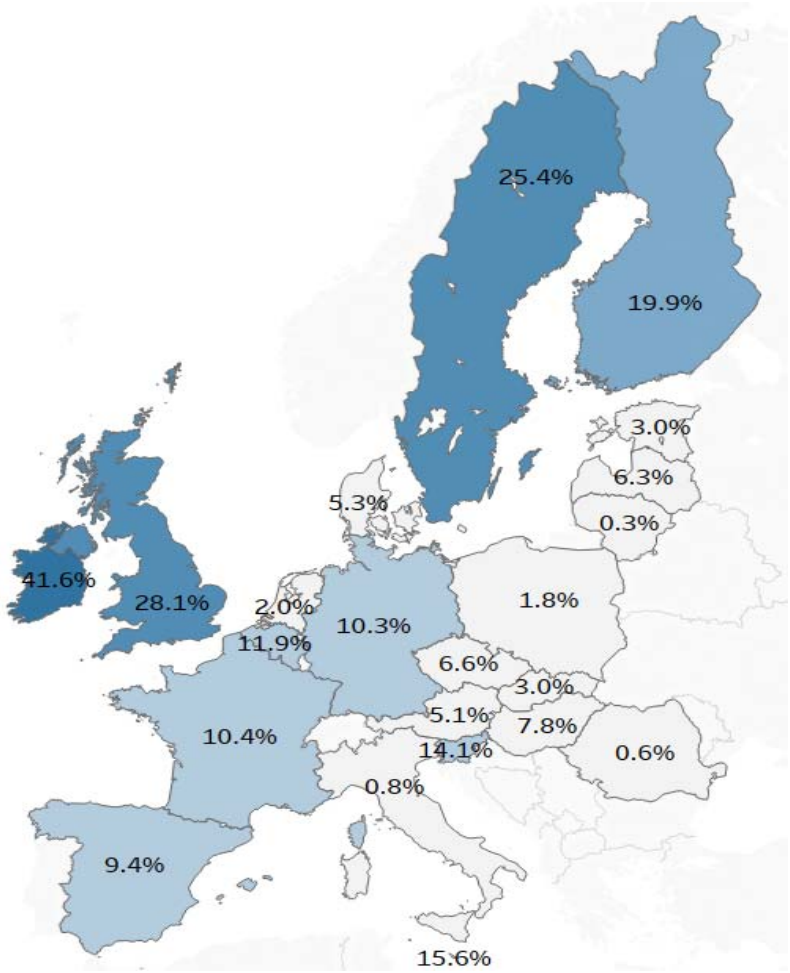
Dr Janos Weltner, member of the EESC, opened the conference and introduced the activity of the EESC to the participants. He pointed out the issue of the brain drain from Eastern to Western Europe and specifically referred to the situation of Hungary, where half of the medical students plan to go abroad with the support of the recipient country. This situation creates uncompensated costs for the community/university that contributed to their education.

OECD research

Ms Caroline Berchet (OECD) presented data showing significant improvement in the quality of life reported in 11 OECD countries (based on 11 indicators, as follows: life expectancy, educational attainment, safety feeling, homicide, air quality, working hours, water quality, voter turnout, perceived health, life satisfaction and social support), while 6 others reported few improvements (i.e. Norway, Iceland, Ireland, Greece, Luxembourg

and France). According to OECD research, the quality of care is improving over the past decade and there have been substantial gains in life expectancy over time. Health spending account for 9.6% (EU28 average) of the GDP remains largely unchanged in recent years. Higher national income and health spending are indeed associated with higher life expectancy at birth (according to the OECD Health Statistics 2017).

Proportion of foreign-trained doctors*



*% of foreign-trained **doctors** (OECD-Eurostat Health workforce migration)*

** Figures are for 2016, except for DE, EE, FR, HU, PL, SI (2015); DK, NL, RO, SE (2014); FI (2012) and SK, ES (2011). Data is not available for BG, EL, PT, HR, CY.*

FEMS research

Dan Perețianu (CFSMR) further presented the results of the FEMS research aimed to provide more accurate information on the process of doctors' migration across Europe. 12 FEMS member organizations from 10 European countries provided information for this research. One first interesting finding of the study is that there is a huge gap between doctors' intention to leave a country in order to settle abroad and the actual action to do so.
The research was constructed around providing answers to the following questions:

1. Which are the main problems in healthcare in your country ?
2. How many doctors have left your country in the last 10 years, i.e. between 2007-2016?
3. How many doctors per gender have left your country in the last 10 years (2007-2016) ?
4. Which are the countries where the doctors from your country migrated ?
5. Which are the main medical specializations of the doctors who leave for other countries?
6. Which are the doctors' reasons to leave and work in other countries?
7. Which is the doctors' income in your country without shifts per month?
8. Which is the age structure of the doctors' exodus in your country? (figures and/or %)
9. Which is the number of foreign doctors that have come to work in your country in the last 10 years (2007-2016) ?
10. Which are the countries of origin of the foreign doctors working in your country?
11. Which are the main reasons of dissatisfaction for hospital doctors ?
12. What is good about working as a doctor in your country (e.g. good education, lower cost of living, lower cost of property, less crowded areas, good career opportunities, good opportunities for your family, less legal claims against doctors, opportunities to earn extra money etc.)
13. How many jobs for doctors are available at the moment?
14. How fast can a foreign doctor learn to speak your official language?
15. How long does it take on average to get your EU diploma recognized?
16. What is the feeling of local doctors and medical chamber towards the doctors from the rest of EU: they are welcome, indifferent, better they don't come.
17. If you wanted to convince a doctor from another EU country to come to work to your department, what would you tell him/her?

Some of the recurrent problems in the countries where the study was performed were the lack of doctors (and of overall healthcare professionals) and the underfunding of the public healthcare systems. The reported lack of doctors clashed most of the times with the official data which show that there are enough doctors over OECD average.

While the commonly accepted perspective is that Western Europe is the target of immigration while Eastern Europe is that of emigration of doctors, the study shows that actual data do not support this belief. In absolute numbers, for instance, there are four countries that are the main source of emigration, i.e. Italy, Poland, Romania and France, therefore 2 countries from Eastern Europe and two from Western Europe.

The main reasons pushing doctors to emigrate are the low wages, the poor working conditions as well as the lack of career perspectives.

The study draws the attention on the fact that the migration of physicians in Europe is a complex phenomenon that cannot be ignored because it influences the labor market both in emigration source and the target countries. Thus, in the source countries, the process can aggravate the population's access to services qualified medical professionals, and in the target countries, it affects the structure and fluctuations of the labor market in the healthcare sector.

The migration process of doctors cannot be stopped, but it can be better monitored to facilitate a fair projection and distribution of labor across the EU.

Christian Keijzer (LAD) presented a cross national analysis of doctors' working conditions. 20 associations from 15 countries participated in this study, whose main topics were working hours and compensatory rest, salaries and migration.

The conclusions of this study showed that in point of:

- Working hours and compensatory rest: most doctors are fairly satisfied with their (formal!) working hours, although they work more than other employees. FEMS is concerned about the hours doctors work in practice and the rest doctors can get after working a shift. Finally, doctors want to have more influence on adjusting their working hours to their personal needs;
- Salaries: there are big differences in salaries between the European countries. Although there seems not to be a direct relationship between the ratios and migration, salary shall influence the choice of a doctor in which country he would like to work;
- Migration: Migration is a serious issue of which it seems that no country is really satisfied about. This asks for an European approach and a more profound research on the most important underlying factors causing this migration.

Role of the EU institutions and the problem of the members states' autonomy in healthcare organization

Martin Seychell (European Commission, DG SANTE) pointed out that, according to the conclusions of the *State of Health in the EU*[1], Member States face significant health workforce challenges. Nevertheless, the migration of doctors in itself is not a problem in itself for the national healthcare systems, but rather the combination between severe health workforce shortages and financial cutbacks. 23 Member States face challenges in retaining health workforce, especially countries in Eastern Europe.

To counteract this, planning and forecasting are crucial tools, together with common longterm political commitment. Despite the fact that resources differ within the various Member States (i.e. in point of GDP allocation and organisation of the national healthcare systems), the challenges remain the same. EU helps and supports the reform processes, the same as it attempts to complement Member States in point of cooperation, collaboration, exchanges and mutual learning initiatives (i.e. SEPEN - Support for the health workforce planning and forecasting expert network (2017 – 2018 as well as other initiatives financed through the Third Health Programme 2014 - 2020).

Marie Lagarrigue (European Commission, DG EMPL) presented the Working Time Directive and its relevance to healthcare workforce. Furthermore she referred to a 2015 study on possible changes to the Directive and impact of the healthcare sector which pointed to little inclination for alternative approaches to count 'inactive on-call', underlined different aspects if opt-out would be to be subject to stricter conditions (health and safety of workers / work-life balance / patient safety versus recruitment needs). Furthermore, it highlighted the need to take account of patient safety when timing of compensatory rest is at stake. It also showed that stricter rules on concurrent contracts would entail staffing needs and it confirmed extrinsic factors (i.e. staffing, financing, organisation of care).

She further informed on a proposal for a Directive on Transparent and Predictable Working Conditions (December 2017) whose general objective would be to promote more secure and predictable employment to **all workers (wider and more homogeneous scope)** while ensuring labour market adaptability and improving living and working conditions. Among its specific objectives, one can count: improving workers' access to information concerning their working conditions, improving working conditions for all workers, while preserving scope for adaptability and for labour market innovation; improving compliance with working conditions standards through enhanced enforcement and improving transparency on the labour market while avoiding excessive burdens.

[1] The *State of Health in the EU* is a two-year initiative undertaken by the European Commission that provides policy makers, interest groups, and health practitioners with factual, comparative data and insights into health and health systems in EU countries. The cycle is developed in cooperation with the Organisation for Economic Co-operation and Development (OECD) and the European Observatory on Health Systems and Policies.

Position of non-governmental organizations and research groups

Mathias Maucher (EPSU) pointed out that most probably trade unions contribute to (more) inequalities between different countries or health professions, as supporting principles of free movement of workers and the freedom of establishment.

Trade unions aim at addressing inequalities, in particular by promoting a regulation of working and pay conditions as well as supportive frameworks to defend decent working conditions also for migrant workers in the health sector by means of

1) EPSU-HOSPEEM Code of Conduct (2008),

2) WHO Code of Practice (2010),

3) (EU & national) anti-discrimination laws and principles.

They try to reduce inequalities by:

1) advocating for public investments, sustainable funding and mechanisms of solidarity-based financing, to the benefit of the workforce (pay and working conditions; healthy and safe workplaces; access to CPD; save and effective staffing levels),

2) negotiating collective agreements,

3) defending or improving individual or collective labour rights

4) building up cross-country solidarity (legal advice and support; input in media campaigns).

Bernard Maillet (CPME) highlighted the need for a strong commitment to health across the European Commission and a strong leadership by DG Sante. What has been lately noted and has become reason of concern is the loss of health policy expertise and point of view, replaced by economic agendas (i.e. an attempt to move the portfolio of pharmaceuticals and medical devices from DG SANTE to DG GROW in 2014, current trends of applying a logic from industrial and commercial policy to healthcare services, such as, for instance, the standardisation of health services). Furthermore, one may also note the loss of structures for health policy discussions and exclusions of stakeholders from various processes (i.e. closing valuable platforms for exchange of expertise in DG SANTE, such as the Patient Safety and Quality of Care Working Group, EU Expert Group on European Health Workforce, non-renewal of successful policies, such as EU Alcohol Strategy).

Should we also perceive a loss of the high-level political support for the EU public health policy? The 2017 White Paper on Future of Europe explicitly mentions public health as an area for potentially reducing EU-level action in preferred 'Doing less more efficiently' option for EU agenda setting and there is no mention of health in 2018 'State of the Union' address by Commission President Jean-Claude Juncker.

In May 2018, the Commission released its proposal for the next EU Budget (**MFF 2021-2027**. It does not contain a dedicated Health Programme but allocates health under the **chapter 'investing in people, social cohesion and European values'.** The main funding instrument for health policies will therefore be the European Social Fund + (ESF+) programme, which specifically includes **€ 413 million** for the Health strand (meaning a 8% decrease in comparison with the current Health programme).

What CPME recommends the EC:

- Health policy should remain on the EU agenda under the auspices of DG Sante;
- Continuation of a comprehensive and coherent EU approach to health across all policies relevant to health;
- Need to build on examples of coherent and successful EU approach (i.e. cross-border health threats and antimicrobial resistance, quality and safety of healthcare products, public health policies including vaccination, nutrition, tobacco and alcohol, digital health and health workforce;
- Continuation of a Public Health Programme as a financial instrument in the EU budget post 2020;
- Continuation of political and financial investment in evidence-based policies.

Paul Laffin (BMA) warned on the consequences of BREXIT on the functioning of national healthcare systems. Thus, while 'Brexit' will fundamentally alter both the UK and the EU, it must not be permitted to threaten Europe's health. It is neither right nor necessary to claim that the integrity of the single market, or full membership of the European Union requires the working hours of British hospital doctors to be set in Brussels irrespective of the views of British parliamentarians and practitioners.

Ioanna Psalti presented an example from Finland as to improving effectiveness of the healthcare system to the benefit of patients and doctors.

Thus, Tays Eye Centre, Tampere, Finland is the product of the reformation of the ophthalmology services carried out by professor Anja Tuulonen in Pirkanmaa Hospital District following the 2009 restructuring of municipal services. Tays delivers eye health care services for the region in addition to teaching and research obligations to the medical school of Tampere University. A series of organisational innovations has brought sus-

tainability in service delivery and continues to improve access to care. Timely access to early access to eye health services and accurate early diagnosis is considered the best way to promote patients' well-being through prevention of permanent visual loss caused by the major chronic eye diseases, so-called the 'Big Four': age-related macular degeneration (AMD), glaucoma, retinal diseases and cataract which account for 70% of the number of patients and visits as well as total costs.

The regional eye care strategy has integrated clinical criteria into policy. Capacity building in specialist care and eye care coordination horizontally (across care providers) and vertically (between authorities at local, regional and national level) are based on a 'P5SE' approach: prioritisation of diseases on the basis of causing permanent visual impairment; stratification of patients on the basis of risk for visual disability; standardisation of care pathways; streamlining decision processes; shared care in multidisciplinary teams; sustainability in resource allocation by capping annual health care expenditure. The innovative principles for prioritising permanently blinding eye diseases have been adopted by all public hospitals in Finland.

The approach has improved patients' well-being through targeting those at high risk simultaneously addressing disease inequity created by the narrow focus of national monitoring of access to eye services - currently only on cataract (waiting times for cataract surgery) although cataract being the only disease out of the four not causing permanent visual loss[2].

Sascha Marschang (EPHA) pointed out the establishment of the Health Workers for All Coalition, which advocates access to health workers for all in order to fulfil the right to health and to reach Universal Health Coverage and the Sustainable Development Goals. It further reignites advocacy on health workforce issues at the global, regional and local level.

Kitty Mohan (EJD) highlighted the importance of free movement for junior doctors across Europe. While the reasons for moving look rather complex and should be focus of concern (multifactorial reasons likely including: academic opportunities, financial

[2] https://ec.europa.eu/eip/ageing/sites/eipaha/files/results_attachments/ta_ophthalmologyreforms_tays_b3_eipaha.pdf *Case Report: From Regional Reforms in Specialist Care to National Recommendations.* The P5SE Model of Eye Health Care, Finland, 2016 Report compiled for the European Glaucoma Society Foundation

possibilities, research collaboration, likely to vary depending on where moving from in EU, personal connection/family links), proper consideration should also be granted to what makes doctors remain in their countries.

She next informed on a nationwide survey conducted by the BMA in October 2017 of EEA doctors currently working in the UK. There were 1720 responses received. A previous survey in 2017 found that 4 out of 10 EEA doctors working in the UK are planning to leave the country (BMA, 2017) but since this time increasing uncertainty expressed. This survey aimed to identify the scale of potential migration of EEA doctors to other countries, and the key factors affecting their intention to leave the UK. Among the key findings of the study regarding the commitment to working in the UK:

- 56.9% of EEA doctors said they are committed to working in the UK.
- However 44.7% of respondents are currently considering leaving the UK and moving to another country.
- <10% of respondents confident of a positive outcome in Brexit negotiations on EU and UK citizens' rights.
- Most popular countries that the UK EEA doctors are considering moving to Germany (22%) , Spain (8.8%) but **>15% considering to move outside EU.**

She concluded saying that junior doctors are a heterogeneous group and reasons for leaving and remaining in own country are complex. Free movement of doctors across Europe is essential for optimum training, research, and skill-sharing opportunities and to learn about different health systems. The answer does not lie in forcing doctors to remain in country or penalising them if they want to leave. Investments in health systems and in postgraduate training are needed to make junior doctors feel valued and allow doctors to make positive choices to remain in their own countries.

João de Deus (AEMH) emphasized the significant role of the GDP allocation as to national healthcare systems performance. Nevertheless, GDP by itself does not justify all what concerns European health inequalities. Socio-economic inequalities in health are unacceptable and represent one of Europe's greatest challenges for public health.

The main challenge is to develop new and effective policies to address the determinants involved in these inequalities.

This should be possible by addressing several issues, as follows:

- Risk management - involvement of managers, physicians, nurses and other stakeholders is essential to guarantee quality and patients safety; use of

information technology to reduce errors, use of a check control system, create a reporting culture.

- Postgraduate medical training (training programs and periods);
- Continuous professional development (CPD);
- Working conditions of hospital doctors and other hospital staff (i.e. labour conditions of doctors play a crucial role in patients' safety; poorly paid work, non-specialized doctors doing specialized tasks, cheap manpower in health services, quantity instead of quality indicators only leads to an increasing risk for patients' safety);
- Task shifting / shortage of doctors (task shifting occurs both in countries facing shortages of physicians and those not facing shortages. It carries with it significant risks and it should never be a cost saving strategy);
- Hospitals evolving into centres of excellence;
- Patients' rights in cross-border healthcare

The central idea of a healthy healthcare system should be a hospital management based on quality and safety, drawing on a larger doctor's involvement.

João Grenho advised on how can postgraduate training help reducing health inequalities and the work UEMS does in this respect. Thus, it is a fact that there are differences both in pre-graduate and postgraduate medical training as well as differences across European countries and across schools and hospitals within the same country.

Thus, UEMS believes that the problem is related to training duration by itself not being enough to guarantee that specialists competences are equal or even equivalent; furthermore, professional mobility is dependent on it, and, as such, we have to find ways to harmonize PGT that do not jeopardize this mobility. A very important part of UEMS activities are aimed at fighting these inequalities. One of the ways to do it is via the UEMS Exams. UEMS has established, through its 43 sections and boards, exams used to assess the preparation level and asymmetries among candidates and, in some specialties, they are applied to all trainees in a number of countries.

Another way in which UEMS tries to harmonize PGT training is via its European Training Requirements (ETR)'s. UEMS sections, boards, divisions and MJC's developed throughout the years these documents aimed at reflecting modern practices and relevant UpToDate scientific findings. UEMS has no intention on overriding national competences in defining the contents of PGT but rather we aim to complement this training and to ensure high quality PGT across Europe.

UEMS has also established its accreditation system. EACCME is a very robust process, with multiple layers of scientific and deontological verification and which makes it a system that guarantees a CME CPD of a very high scientific value and free of commercial bias.

Possible solutions for the countries of emigration and immigration

- increase to a minimum 6.9% GDP public healthcare spending
- healthcare should be seen as an investment and not a cost
- sustainable patient/staff ratio on EU level
- increase of university production
- other solutions?