Planning of health workforce is a complex issue even in times of stable socio-economic circumstances. Due to the multiple influences affecting it and due to the high costs of health workforce education and training, health workforce represents an important asset in any country. In contrast, as the demand for health services keeps growing, so does the demand for the different health professionals. Countries decide to opt for different answers to the challenges of the financial crisis within health care. In the first place, they try to reduce costs. Being the key expense in health care, health workforce raises temptations to restrict it in its growth or even achieving its contraction as that can bring about significant savings. Of course, such approaches are rather shortlived. But sometimes, as it has been the case of Sweden since the 1990s, restructuring of health care can lead to less need and consequently to a drop in the number of health professionals. It remains questionable whether it is true that subsectors in the public sector need to bear ‘equal’ shares in carrying the burden of the crisis.

The following considerations are important in view of health workforce planning in a period of crisis. Firstly, restricting admission to studies for health professions has multiple effects—it may be overly restricting the future availability of health professionals; it may lead to excessive demands of the shortnumbered health workforce; it ‘resolves’ the domestic surplus of health professionals only in the long run; and it may be indiscriminately selective due to inappropriate criteria. Secondly, pressures on salaries for health professionals, both in terms of their restricted growth or, even, explicit reductions (as it has been the case in several European countries over the last 2 years) can have multiple detrimental effects. As health professions are among those with the most demanding working hour arrangements, these careers are increasingly becoming less attractive to young people. Downgrading health professions also with respect to incomes can lead to them becoming handicapped in competing with other university studies. Thirdly, countries with an already existing shortage of health professionals, which opt for further restrictions on salaries, may become less attractive to foreign health professionals who have or would otherwise relieve the situation without the need for additional own investment. Fourthly, difficulties in accessing medical and other health services are common to several European countries. That means that restricting the number of health care providers may seriously affect accessibility of some of the services through lengthened access times, including waiting lists. This may, unfortunately, become a reality not due to the shortages of health professionals but simply due to the lack of finance. Fifthly and finally, health professionals can get attracted by the private sector, not only in health care but elsewhere, too, the pharmaceutical industry being just one of these examples. Weakening the public and the publicly directly financed health sector in Europe could result in health professionals becoming more interested in pursuing other careers. Such examples are best known in the health workforce fluctuations in Germany.2

On the other hand, countries less affected by the crisis may opt for additional shopping for health professionals thus further weakening the situation of the less developed or less well staffed countries. European Union’s position on this situation is that there should be ethical and fair judgements in approaches to solving the situation in the Member States. European Union (EU) should steer these processes with a view of securing the development of health care systems within its member states. Scarcely workforce is facing another challenge and that lies in the relatively significant benefits, the most important being the Working hours Directive of the EU.4 Regulating working hours regulates workloads, but it does not define the necessary competencies. Crisis will make an impact beyond its immediate duration and beyond its overall magnitude. It will instead cause health care to have to struggle for keeping health professionals on board and motivated throughout a period where they will have relatively limited benefits. In the same way, as health workforce planning yields slow and limited results in the times of prosperity, it is also in crisis when many effects will be noticed only after the passing of a certain period of time. Mistakes or rash decisions in health workforce planning in this period will have serious consequences for many years to come, especially following the standard cycle of education and training of these professionals. Europe is already today, with some rather limited exceptions, short of health professionals. Estimates vary from a few hundred thousand up to 1 million (by the year 2020). As the final point of these projections is not that far away, it is unlikely that EU itself is capable of overcoming these deficits purely with domestic productions. Still, it should not resort into aggressive headhunting within or beyond its borders.

References


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