European Journal of Public Health, Vol. 30, No. Supplement 4, iv1–iv2
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doi:10.1093/eurpub/ckaa122

Editorial

Health labour markets and the 'human face' of the health workforce: resilience beyond the COVID-19 pandemic

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Here is to you, with deep thanks! For all healthcare workers fighting COVID-19 at the frontlines of healthcare systems in Europe and across the globe, putting their own health and safety at risk, and for the numerous healthcare workers who have lost their lives during the pandemic.

At the time of the planning of this supplement in January 2020, only few people in Europe were concerned about the outbreak of a new corona virus SARS-CoV-2 and aware of its global consequences. A few months later, when COVID-19 had spread across the globe and caused the most serious pandemic of the last century, the world has changed: protecting health and saving lives temporarily dominated politics and disrupted everyday-life and routines. The pandemic shock triggered policy developments that public health professionals had been advocating for many years: the health workforce was moving from cost factors and 'faceless numbers or units of health producers to the heart and soul of health systems'.[1] When the pandemic was peaking in Europe, people were applauding health workers every evening, banners in public places were expressing appreciation of frontline personnel, and business companies, sports and film stars and many others were standing together and donating for health workers and better personal protective equipment.

Countries under lockdown discovered healthcare workers as their new heroes. This is a welcomed sign of appreciation of frontline healthcare staff, but it is neither sufficient nor sustainable. We do not need heroes, who pay with their health and wellbeing, even with their life. What is needed the most are healthcare systems that take care of the health and wellbeing of their staff, and societies willing to pay them in a fair and gender-equitable manner.

There is a lot to learn for health systems and the health workforce from country responses to the COVID-19 crisis. Some of the major issues include: (i) health workforce surge capacity through mobilizing health workers, (ii) introducing rapid up-skilling and skill-mix changes according to local needs, (iii) protecting the physical and mental health of frontline health workers, (iv) compensating income loss of health workers and (v) protecting nursing homes and health workers in nursing homes.[2] For most of these issues, we can only hope that the lessons learned will be retained after the pandemic. We also need stronger political commitment to, and support for, European health workforce governance that ensures solidarity between countries. To this end, this Supplement could hardly be more timely and needed.

The scope of the supplement

This Supplement is an initiative by the EUPHA section 'Health Workforce Research' (HWR) and builds on its proposed research agenda.[3] It seeks to bring a 'human face' to health labour market analysis, and to strengthen a public health approach in the health workforce debate. Inspired by EUPHA's strategy of 'analysis, advocacy and action', we present new empirical results on health labour markets, advocating for the health workforce as 'heart and soul' of healthcare systems, and providing policy recommendations towards a resilient future health workforce more sensitive to the individual behind every healthcare worker.

Comprehensive research and reliable data are the key conditions to create and retain a healthy and resilient health workforce, and to help healthcare systems to recover from the COVID-19 pandemic. However, the virus not only is a test bed for healthcare systems and health labour markets in Europe, but even more for the capacity to improve governance based on solidarity and participation. This includes the development of health workforce governance models capable of moving beyond countries' self-interest and mere economic aspects of health labour markets. Action is needed to reduce health labour market mismatches and inequalities within and between European countries and globally. This collection of articles offers empirical data and policy recommendations to take first steps in this direction.

The Supplement builds bridges between macro-level health labour markets and the perceptions of the individual healthcare workers at the micro-level of the healthcare system. It demonstrates how qualitative and quantitative methods and data sources may be aligned to draw a more comprehensive and in-depth picture of the health workforce. The research presented relates to ethical, cultural and social aspects of the health labour market with a human face and shows the connections between working conditions, staff turn-over, job satisfaction and quality of care. It acknowledges that there is a European labour market for health workers, but that there are very few common policies developing a European health workforce, let alone improving its human face.

From a public health perspective, two interconnected policy areas are emerging, where action towards a resilient healthcare workforce is most needed:

- the integration of the 'human face'—the needs and expectations of health workers and their individual and collective agency—in research, policy and planning;

- the development of a transnational European framework for health workforce governance to mitigate growing nationalism and inequality caused by workforce shortage and maldistribution. Successful policy interventions in other areas (e.g. the tobacco control frameworks) might provide some guidance on how to establish this approach.

The content

The present Supplement opens with a Commentary that makes the case for the importance of public health policy in health workforce development and research. Azzopardi-Muscat illustrates the need for, and the benefits of this approach by referring to the lessons we may learn from the COVID-19 pandemic. A public health policy approach may help understand the political dimension of our work, combine 'art and science' and bring together knowledge from several disciplines to improve health workforce research and policy. She argues for a participatory approach with the voices of health workers and patients being as important as epidemiology and planning and forecasting.

COVID-19 has also led to closed borders in the European Union and has reinforced the tensions between national health systems and a European approach to healthcare and workforce governance. However, health workforce migration and mobility flows are revealing weaknesses in European and international health labour market governance far beyond the pandemic. Williams *et al*. analyze data from the joint EUROSTAT/OECD/WHO Europe questionnaire to determine trends in the proportion of foreign-trained doctors and nurses working in selected destination countries. Their results show increased mobility driven by rising East-West and South-North intra-European migration, especially within the European Union. Regarding migration from developing countries, the trends are more heterogeneous. The authors not only found, in general, signs of compliance with the WHO Global Code, but also call for improved data and monitoring, especially in source countries.

Mobility flows and geographical mismatches also matter in relation to rural and urban health workforce conditions. Groenewegen *et al*. provide important information on the primary care workforce in Europe and other selected OECD countries. The authors highlight a need for policy action to counteract decreasing attractiveness of rural areas. They suggest dedicated human resource for health policies for rural areas with a view to an ageing GP population and to the individual preferences and needs of the GPs.

The following two articles set the focus on intra-EU mobility and further illustrate the interconnectedness of individual perceptions at the micro-level and health systems and policy factors. Leone *et al.* explore the effects of individual migratory experiences, organizational settings and health policy by investigating the situation of Portuguese nurses in the English National Health Service (NHS). This research reveals that retention policies, in order to be effective, must understand the constant interaction between institutions and individual actors at different levels.

Kuhlmann *et al*. direct our attention to the mobile carers in long-term care (LTC) in times of the COVID-19 pandemic. LTC carers have largely been neglected in health workforce research. However, COVID-19 has unmasked system deficits and fragile labour market arrangements, which may cause health risks for the individual carer and the population. The authors suggest to include LTC migrant carers more systematically in public health and health workforce research and to develop European health workforce governance, which connects health system needs, health labour markets and the individual migrant carers.

The development of a geriatric care workforce in a poorly resourced healthcare system in an Eastern EU Member State empirically demonstrates the need for a public health approach, including better data, more effective management and transnational health workforce regulations in Europe. Ungureanu *et al*. explore the situation of geriatricians in Romania, who are challenged by significant shortage nation-wide, by an unequal distribution at sub-national level, and by out-flows of staff because of poor work conditions. The authors highlight the risk of burnout for the individual doctor, caused in part by higher workload of few remaining geriatricians. This case also echoes the previous plea by Williams *et a*l. for improved data and monitoring especially in source countries, in order to bring the problems on the policy agenda, both nationally and in the EU.

The remaining two articles shift the focus further towards the individual health professional and their expectations and needs. Humphries *et al*. show that poor work-life balance is a widespread experience of hospital doctors in Ireland. Negative effects stretch far beyond the individual perceptions of stress and poor work conditions, but might threaten retention strategies and the wider Irish healthcare system. Galleta *et al.* suggest that stress and burn-out in the health workforce might be reduced through improvement in teamwork, using England and the primary care workforce as an empirical example. Both studies remind us on the importance of the 'human face' in health workforce research and illustrate, how greater attention to the individual healthcare worker and to the organization of work can improve capacity for innovation to create a more resilient health workforce.

This collection of articles deepens our understanding of the connectedness of health labour markets and health systems at the macro-level and of the individual healthcare worker and their expectations, work conditions and health needs at the micro-level. The Supplement stimulates a much needed debate on the human face of the health workforce and offers policy recommendations on how to create a more resilient health workforce.

Acknowledgements

We wish to thank EUPHA and its Governing Board for dedicating this Supplement to health workforce research and Maaike Droogers and colleagues in the EUPHA Office for valuable support and technical assistance. Our authors and the anonymous reviewers made time to contribute to this Supplement during the COVID-19 lock-down and restrictions. Thank you for your support, collaboration and friendship in difficult times!

Funding

This open access Supplement received co-funding under an operating grant from the European Union's Health Programme (2014–2020).

Disclaimer

M.W. is a staff member of the World Health Organization. The author alone is responsible for the views expressed in this article and they do not necessarily represent the decisions, policy or views of the World Health Organization.

Conflicts of interest: None declared.

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