

JA Health Workforce Planning and Forecasting

D.051 – Release 1

MINIMUM PLANNING DATA REQUIREMENTS

WP5
Deliverable
D.051



Joint Action Health Workforce
Planning and Forecasting

Italy Ministry of Health & Agenas

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MINIMUM DATA SET

1. Management summary

The healthcare sector constitutes one of the most significant sectors in the EU economy with an important employment potential due to an ageing population and increasing demand for healthcare.

Despite this, the sector faces major challenges:

- an aging workforce and too few new recruits to replace retirees
- significant employee turnover in some fields due to demanding working conditions and relatively low pay
- the need for new skills to deal with innovative technologies and with the rise in chronic conditions such as diabetes and heart disease among the elderly.

One of the actions pointed out in the action plan for EU health workforce (1) is improving health workforce planning and forecasting also because the degree to which European countries currently face health workforce planning varies considerably (feasibility study). The planning process needs a good set of data in order to produce reliable results. Improving health workforce planning and forecasting goes through the identification of a set of key indicators and a process of measuring through the collection of the related data.

At the moment there is no agreement at the international level on minimum data requirements for health workforce planning (feasibility study).

A **joint action on workforce planning**, funded under the 2012 Health Programme is intended to create a European platform to share good practice and to develop methodologies on forecasting health workforce and skills needs (ref). One of the objectives of the joint action on workforce planning is to identify a Minimum Data Set for Health Workforce Planning. The Joint Action is focused on the five "regulated" type of professionals: P, N, MW, PH DEN (Directive x).

A Minimum Data Set for Health Workforce Planning consists of a core set of standard indicators which are used, generally, at a national level, for the collection and reporting on key aspects of health system delivery, including current workforce/staffing resources and future Health workforce needs. This can enable the comprehensive analysis of supply, requirements and adequacy in professional-based workforce planning (WHO – 2008).

This document contains the results of a shared process involving thirty-seven EU partners of the Joint Action (European member states as well as stake-holder organizations) (see appendix x).

The key planning indicators and the related minimum set of data presented in this document are the necessary tool kit to reach the scope of a basic planning model which is to recognize the major problems of HWF, to analyze these problems and to identify possible solutions.

To draw future scenarios and implement the found solutions (and gather the data to deliver those scenarios to the decision makers who decides on the implementation) will be the scope of an advanced model and, thus, a possible prosecution of the Joint Action.

2. Introduction of the concept of minimum data set (MDS)

In the various European Countries health systems are very different. Even the use of human resources, both on the whole and for single groups of professionals, has a large variability. When comparing the States of Western Europe it is surprising to see the stability over time of the differences between the individual states that depends on traditions and organization of the health system itself. The new Member States (MS) that have entered into the European Union during the last fifteen years also have different traditions and organizations.

The planning of human resources in health must take into account these differences and respect the autonomy of each MS. On the other hand, the free movement of workers within the EU requires to consider, dealing with HWF planning, the EU market as a unique system with common elements in each MS.

The system of planning and forecasting is motivated by the possibility to improve the decision making. It is thus necessary to identify a set of key indicators that are instrumental to health workforce planning by defining a conceptual model (Meta model).

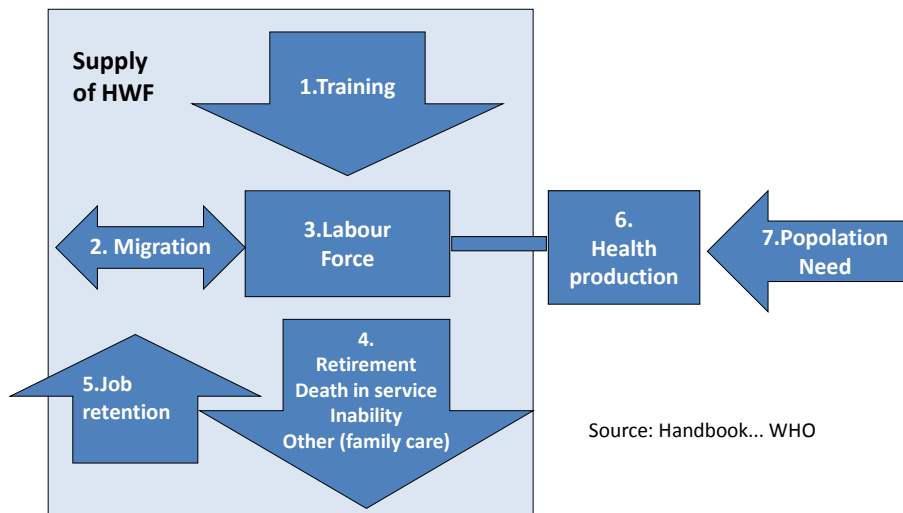
2.1 The conceptual model

The Meta model contains all relevant elements of a planning system and of a planning model that can be used to map the different situations in each country. The model distinguishes between the Planning process that produces a policy proposal and the Forecasting model as part of the planning process that will produce the data necessary for formulating the policy proposal.

The elements of the planning process are:

- the objectives of the planning system (set of outcome indicators)
- the measure of benefits of planning (outcome indicators)
- any national and regional legislation;
- actors and organization of the planning;
- the organizational resources for planning;
- the model of forecasting / simulation;
- a set reference values (targets for the planning process);
- the decision on key forecasting elements (time horizon, frequency);
- the actions for reaching the reference values;

The forecasting model contains seven categories belonging to two areas (supply of HWF and demand of HWF):



1

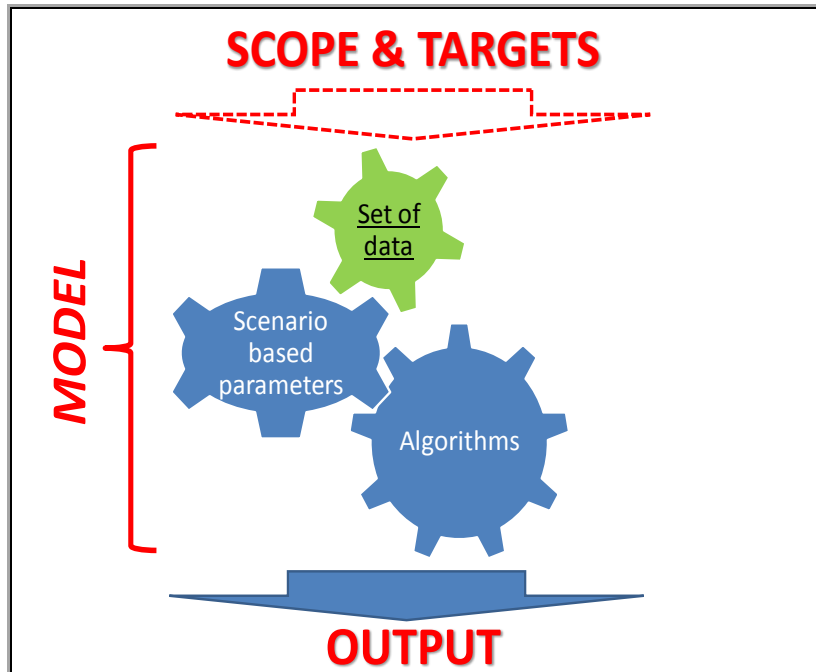
As you can see, the conceptual model contains explicit reference to coverage, objectives of the planning and the decisions to be taken, path of activation, type of planning model (supply/demand based), technical results (output), decision making process in which the output is used, specific indicators used to monitoring the process and planning results (outcome indicators). This meta model is important as it stresses the need to focus on the Decisions that will be taken (by policy makers) as a result of the programming. It also put the data collection and the forecasting methods in a setting composed of Planners, Stake Holders and Experts.

Based on this conceptual model it is possible to identify a "HWF minimum purpose of planning" and to define a related forecasting "basic model".

2.2 A forecasting basic model

The forecasting model necessary to offer decisions makers a shared opinion of a probable situation in the future can be described by the following figure.

Forecasting model



The figure evidences the need of precise targets for the forecasting model. The model is composed by a set of data as input, a certain number of scenario based parameters and algorithms. The output is expressed (measured) by the indicators defined by the planning process. The necessary set of data (in green in the figure) depends on the targets and on the indicators.

The Work Package 5, as part of the Joint Action on workforce planning, has defined the set of data that is “necessary and sufficient” for a basic forecasting model, thought of as a starting point for the countries that are to develop a planning process of Health Work Force.

Thus the forecasting model, based on the *necessary and sufficient*, i.e. *minimum*, set of data, will be simple and repeatable, as OECD pointed out:

"Health workforce planning is not an exact science and needs regular updating: Assessing the future supply and demand for doctors, nurses or other health professionals 10 or 15 years down the road is a very complicated task, fraught with uncertainties on the supply side and even more so on the demand side. Projections are inevitably based on a set of assumptions about the future; these assumptions need to be regularly re-assessed in light of changing circumstances, new data, and the effect of new policies and programs."

As showed in the previous figure, at the beginning of the planning process there are the scope and the targets of planning. So, to identify the key planning indicators of a basic forecasting model we need first of all, to define the scope and, subsequently, setting the targets (HWF minimum purposes).

The Work Package 5 partners and experts, introducing a priority scheme with the objectives and targets that are necessary to include in a basic model, decided that **the scope** of this basic forecasting model is to recognize the major problems of HWF, to analyze these problems and to identify possible solutions. This scope was split into two stages:

1. the first, named 1.a., is to assess the current situation
2. and the second, named 1.b., is to identify the solutions.

Theoretically, the scope of a HWF planning process is also to draw future scenarios and implement the found solutions (and gather the data to deliver those scenarios to the decision makers who decides on the implementation). But that was considered the scope of an advanced model and, thus, not included in the Minimum Data Set.

As for the scopes, and connected to them, the targets of the forecasting model were listed.

For stage 1a the identified target is:

- to identify high level shortage vs. overall evaluation demand of healthcare.

For stage 1b the identified targets are:

- to identify major costs aspects of HWF
- to make a first evaluation on impact of shortages on quality;
- to monitor overall coverage;
- to identify detailed shortage;
- to identify if in land production meets the needs;
- to monitor geographical variances of coverage.

On the base of the information that could be included in a forecasting model, a set of key planning indicators has been defined in order to monitor each of the above mentioned targets (both stage 1a and stage 1b). Consequently, a list of data, that were *necessary and sufficient* (minimum), was selected in order to create those indicators.

3. MDS definitions and requirements

3.1 Some basic principles

The Minimum Data Set presents in this document are founded on some basic planning requirements.

1. Universal coverage.
2. Affordability.
3. Effectiveness.
4. Shortages are no options as it is a threat to the coverage and quality.
5. Education and not immigration to meet Healthcare needs.

3.2 What is a minimum data set?

An Health Workforce Planning System consists of a core set of key indicators which are used, generally, at a national level, for the collection and reporting on key aspects of health system delivery, including current workforce/staffing resources and future Health workforce needs. This can enable the comprehensive analysis of supply, requirements and adequacy in professional-based workforce planning (WHO – 2008). The data are for planning as well as to promote coordination and collaboration between stakeholders at the national and European level.

A minimum data set is a minimum number of data items that has to be present as an input to a decision making process in order to be able to reach a certain goal. The decision making process in this case is the planning for the future need of health work force.

The process of collecting data is very costly in terms of time, of use of scarce resources, of quality control, of the necessary reiteration process etc. Thus it is necessary to contemplate the need of each data item before starting the process, balancing the cost of the information and the value of the decision to be made on the bases of that information.

The Health Workforce MDS for planning is focused on physicians, pharmacists, dentists, nurses and midwives.

Main elements of the key planning indicators:

- target (i.e. why we plan),
- title of the indicator,
- numerator and denominator,
- formulas that consist of algorithms, scenario based parameters and **set of data**.
- rationale for why.

The set of data used in the formulas for the key planning indicators, necessary for the Minimum Purpose of Planning, is the Minimum Data Set (MDS).

Main elements of MDS are:

- area (supply or demand),
- category (for example stock, immigration, etc)
- characterization (for example type of profession, specialty, age, etc).

3.3 Consensus and Limitations

The key planning indicators and the minimum data set presented in the next sessions (4 & 5) reflects the priorities agreed on by the Work Package 5 Partners within the EUHWF Joint Action framework and the feedback from the MDS workshop held in Milan, the 19th and 20th of September (see Minutes in Appendix n°X).

In particular, the Minimum Data Set represents the minimum indicators that WP5 partners agree are required to be collected in order to meet workforce planning objectives.

The Minimum Data Sret is not intended to provide (or replace) a country-level workforce planning system. Suggestions for supplementary information are also given so that the MDS can be adapted or developed, if required, to support in-country workforce planning.

4. Key planning indicators

{the draft 2 of this document will present at this point a short description of the below listed indicators. The draft 2 will also contain, for each of the key planning indicators, a description that will explain why the indicator is important / rationale}

Below the key planning indicators are overall presented. To have the details of formula see Appendix 7.1.

Key planning indicators to monitor the HWF targets of stage 1a

Target	Indicator	Stratify by
-Identify high level shortage vs. overall evaluation demand of Healthcare	1. Coverage of future demand (high level) Numerator: Future supply "inland" + Future supply from abroad Denominator: Future demand	Type of profession

Key planning indicators to monitor the HWF targets of stage 1b

Target	Indicator	Stratify by
-Identify major cost aspects of HWF; -First evaluation on impact of shortages on quality	2. Relative future cost Numerator: Future health cost Denominator: Current health cost	Depends on the responsibility for the health costs. If it is the country, the indicator will not be articulated further.
-Monitor overall coverage -Identify detailed shortage -Identify if in land production meets the needs -First evaluation on impact of shortages on quality	3. Coverage of future demand, detailed Numerator: Future supply inland + Future potential supply from abroad Denominator: Future demand 4. Coverage of needs by foreign professionals Numerator: N° of professionals with foreign first qualification. Denominator: Total n° of professionals.	Type of profession. Single specialty within the type of profession.

Target	Indicator	Stratify by
-Monitor geographical variances of coverage	<p>5. N° of professionals per inhabitant Numerator: N° of professionals Denominator: population</p> <p>6. N° of professionals per weighed inhabitant Numerator: N° of professionals Denominator: population weighed by the cost per age group (basic index: average of EU countries)</p>	region within the country articulated by macro-area in order to separate the greater municipal areas (for example Province in Italy, Department in France ecc..).

5. Minimum data set

{the draft 2 of this document will present at this point a short description of the below listed data}

Here are listed the data necessary and sufficient (minimum) to create the indicators in figure 2 and 3.

Information needed for measuring the indicators - Minimum Data Set 1a

Areas	Supply					Demand
Category	Stock	From training	Retired	Emigration	Immigration	Population
type	x	x	x	x	x	
age	x	x	x	x	x	x
Head count	x	x	x	x	x	x

Information needed for measuring the indicators - Minimum Data Set 1b

Areas	Supply					Demand
Category	Stock	From training	Retired	Emigration	Immigration	Population
Type	x	x	x	x	x	
Age	x	x	x	x	x	x
Head count	x	x	x	x	x	x
FTE	x					
Geographical area	x	x	x	x	x	x
Specialization (where applied)	x	x	x	x	x	
Country of first qualification	x	x	x	x	x	



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{the draft 2 of this document will contain a discussion based on the WP5 partners feedbacks, on the MDS / is it necessary and sufficient? Are there any differences between the following three groups: Physicians and dentists, Nurses and Midwives, Pharmacists?

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6. Appendices

6.1 Appendix n.1 - Definition of each indicator

6.1.1 Coverage of future demand, high level

<p>Numerator: Future supply inland + Future supply abroad Denominator: Future demand Articulated by: Type of profession</p>
<p>Numerator: Future supply Future supply inland= current stock + from education - retired Future supply abroad = + immigration - emigration Current stock: Current number of professionals (headcount) that are currently producing health care stratified by type (5 types) and age. From education: Forecast of number of professionals (headcount) that will be produced by the education system during the period. The first years will be using the students in training and subsequently will be used the actual training capacity. Retired: Forecast of number of professionals (headcount) that will retire each year using the actual probability according to the existing laws. Immigration: Forecast of number of professionals (headcount) that may arrive calculated using the average of the last years. Emigration: Forecast of number of professionals (headcount) that may leave calculated using the average of the last years.</p>
<p>Denominator: Future demand Future demand = $HWF_{px} = k_p \cdot HCT_x$ where $HCT_x = (HC1_0 \cdot Pop1_x + HC2_0 \cdot Pop2_x + HC3_0 \cdot Pop3_x)$ HWF_{px} : The demand of a specific profession "p" (headcounts) in the year x. k_p: The constant that connect the total health production with the demand for a specific profession. HCT_x : The total health consumption in year x.(1) $HC1_0$: The pro capita consumption of age group 1 in year 0 (basic year) $HC2_0$: The pro capita consumption of age group 2 in year 0 (basic year) $HC3_0$: The pro capita consumption of age group 3 in year 0 (basic year) $Pop1_x$: The population of age group 1 in year x. $Pop2_x$: The population of age group 2 in year x. $Pop3_x$: The population of age group 3 in year x. (1) Note: it is important to check the sustainability of the total health consumption in year x compared with the current consumption.</p>

6.1.2 Relative future cost

Numerator: Future health cost

Denominator: Current health cost

Articulated by: Depends on the responsibility for the health costs. If it is the country, the indicator will not be articulated further, otherwise it has to be further detailed.

Numerator: Future health cost

HCT_x: The total health consumption in year x.

$$HCT_x = (HC1_0 * Pop1_x + HC2_0 * Pop2_x + HC3_0 * Pop3_x)$$

HCT_x: The total health consumption in year x.

HC1₀: The pro capita consumption of age group 1 in year 0 (basic year)

HC2₀: The pro capita consumption of age group 2 in year 0 (basic year)

HC3₀: The pro capita consumption of age group 3 in year 0 (basic year)

Pop1_x: The population of age group 1 in year x.

Pop2_x: The population of age group 2 in year x.

Pop3_x: The population of age group 3 in year x.

Denominator: Current health cost:

HCT₀: The total current health consumption.

$$HCT_0 = (HC1_0 * Pop1_0 + HC2_0 * Pop2_0 + HC3_0 * Pop3_0)$$

HC1₀: The current pro capita consumption of age group 1

HC2₀: The current pro capita consumption of age group 2

HC3₀: The current pro capita consumption of age group 3

Pop1_x: The current population of age group 1.

Pop2_x: The current population of age group 2.

Pop3_x: The current population of age group 3.

6.1.3 Coverage of future demand, detailed

Numerator: Future supply inland + Future potential supply from abroad

Denominator: Future demand

Articulated by: Type of profession, specialty within the profession, geographical area

Numerator: Future supply

Future supply inland= current stock + from education - retired

Future potential supply from abroad = + immigration - emigration

Current stock: Current number of professionals (headcount) that are currently producing health care stratified by type (5 types) and age.

From education: Forecast of number of professionals (headcount) that will be produced by the education system during the period. The first years will be using the scholars in training and subsequently will be used the actual training capacity.

Retired: Forecast of number of professionals (headcount) that will retire each year using the actual probability according to the existing laws of the country.

Immigration: Forecast of number of professionals (headcount) that may arrive calculated using the average of the last years.

Emigration: Forecast of number of professionals (headcount) that may leave calculated using the average of the last years.

Denominator: Future demand

Future demand = $HWF_{px} = k_p \cdot HCT_x$ where

$$HCT_x = (HC1_0 \cdot Pop1_x + HC2_0 \cdot Pop2_x + HC3_0 \cdot Pop3_x)$$

HWF_{px} : The demand of a specific profession "p" (headcounts) in the year x.

k_p : The constant that connect the total health production with the demand for a specific profession.

HCT_x : The total health consumption in year x.(1)

$HC1_0$: The pro capita consumption of age group 1 in year 0 (basic year)

$HC2_0$: The pro capita consumption of age group 2 in year 0 (basic year)

$HC3_0$: The pro capita consumption of age group 3 in year 0 (basic year)

$Pop1_x$: The population of age group 1 in year x.

$Pop2_x$: The population of age group 2 in year x.

$Pop3_x$: The population of age group 3 in year x.

(1) **Note:** it is important to check the sustainability of the total health consumption in year x compared with the current consumption.

6.1.4 Coverage of needs by foreign professionals today and in the future

<p>Numerator: N° of professionals with foreign first qualification.</p> <p>Denominator: Total n° of professionals.</p> <p>Articulated by: Type of profession, specialty within the profession, geographical area</p>
<p>Numerator: N° of professionals with foreign first qualification.</p> <p>Current stock of professionals with foreign qualification: The part of the current stock with with country of first qualification <> current country of activity.</p> <p>Future stock of professionals with foreign qualification: The part of the future stock with country of first qualification <> current country of activity..</p>
<p>Denominator: Total n° of professionals.</p> <p>Total current stock: Current number from indicator 3.</p> <p>Total future stock: Numerator of indicator 3</p>

6.1.5 N° of professionals per inhabitant

<p>Numerator: N° of professionals</p> <p>Denominator: population</p> <p>Articulated by: Type of profession, specialty within the profession, geographical area</p>
<p>Numerator: Actual number of professionals</p> <p>Actual number of professionals: From indicator 3</p> <p>Future number of professionals: From indicator 3</p>
<p>Denominator: population</p> <p>Actual population: Number of population (without weighting)</p> <p>Future population: Number of population (without weighting) from a reliable institute of forecasting.</p>

6.1.6 N° of professionals per weighted inhabitant

<p>Numerator: N° of professionals</p> <p>Denominator: weighted population</p> <p>Articulated by: Type of profession, specialty within the profession, geographical area</p>
<p>Numerator: Actual number of professionals</p> <p>Current number of professionals: From indicator 3</p> <p>Future number of professionals: From indicator 3</p>
<p>Denominator: population</p> <p>Current population: Number of inhabitants weighted by the health consumption for each age group (average current EU countries).</p> <p>Future population: Number of population from a reliable institute of forecasting weighted by the health consumption for each age group (average actual EU countries).</p>

6.2 Appendix n.2 - Minority opinions [TO BE DEFINED]

appendix with the minority opinions and why they were not taken into account.

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6.3 Appendix n.3 – Glossary

ITEM	DEFINITION
Population size	Number of inhabitants in the Country or Region considered at the reference date (Source: National Institute of Statistics)
Gender	Male/Female
Age	Population by age groups (ie: 0-4; 5-9; 10-14;... 60-64;65+)
Full time equivalent (FTE)	<p>Unit to measure employed persons in a way that makes them comparable although they may work a different number of hours per week.</p> <p>The unit is obtained by comparing an employee's average number of hours worked to the average number of hours of a full-time worker. A full-time person is therefore counted as one FTE, while a part-time worker gets a score in proportion to the hours he or she works or studies. For example, a part-time worker employed for 20 hours a week where full-time work consists of 40 hours, is counted as 0.5 FTE</p>
Group of professionals	Physicians, nurses, midwives, pharmacists, dentists
Stock of professionals	Current number of professionals practicing (providing services directly to patients) in the Country/Region
Primary care	Family doctor-type services delivered to individual patients
Specialized care	Specialist medical or nursing services not included in primary care
New professionals from education	Annual number of professionals who complete education (basic or specialist) and licensed to practice
Immigration	Annual number of licensed and recognized professionals entering in the Country
Number of professionals retired	Annual number of professionals retiring from labour market
Emigration	Annual number of practicing professionals exiting from the Country
Short term	1- 3 years
Medium term	4- 9 years
Shortage	Negative gap between supply and demand

6.4 Appendix n. 4 - Table of references

N#	Title	Author	Year
01	Commission feasibility study on EU level collaboration on forecasting health workforce needs, workforce planning and health workforce trend	Matrix Insight Ltd, in collaboration with the Centre for Workforce Intelligence (CfWI) - for EC	2012
	http://ec.europa.eu/health/workforce/key_documents/study_2012/index_en.htm		
02	Health Workforce Planning in OECD Countries: A Review of 26 Projection Models from 18 Countries	Tomoko Ono, Gaetan Lafortune, Michael Schoenstein. <i>OECD Health Working Papers</i> , No. 62, OECD Publishing.	June 2013
	http://www.oecd-ilibrary.org/social-issues-migration-health/health-workforce-planning-in-oecd-countries_5k44t787zcbw-en		
03	WHO human resources for health minimum data set.	WHO Library Cataloguing (in Publication Data)	2008
	http://www.who.int/hrh/documents/hrh_minimum_data_set.pdf		
04	Draft guidelines on monitoring the implementation of the WHO Global Code on the International Recruitment of Health Personnel. <i>Part II</i> – Regular national reporting instrument – Section 2: Quantitative information – Minimum Data Sets	OECD-WHO	
	http://www.who.int/hrh/migration/section_2_quantitative.pdf		
05			
06			
07			

6.5 Appendix n. 5 – WP5 general description

6.5.1 WP5 scope

Work Package 5 (WP5) scope is to promote and support the use of quantitative model-based planning methodologies (both supply-side and demand-side) based on what is in use today or shortcomings in EU countries and a “good practices” evaluation.

Health professions in focus are doctors, nurses, pharmacists, dentists and midwives (the five health professions covered by the Recognition of Professional Qualifications Directive).

6.5.2 WP5 actions

The WP5 specific Objective is to „define guidelines on quantitative HWF planning methodology and increased quantitative planning capacity”.

N#	Title		WHEN
3.1	Minimum data set (MDS)		
	MILESTONES 5.1	Agreement on the minimum data set	October 2013
	DELIVERABLE D.051	Minimum planning data requirements	November 2013
3.2	Exchange of good practices		
	MILESTONES 5.2	Experts group conference on HWF planning methodologies	January 2014
	DELIVERABLE D.052	Report of good practices in planning methodologies	September 2014
	DELIVERABLE D.053	Web portal on HWF planning methodologies, with WP2	January 2015
3.3	Defining and experimenting guide lines on HWF planning (cookbook)		
	MILESTONES 5.3	Validation of the cookbook	March 2015
	MILESTONES 5.4	Startup of the Pilot studies	June 2015
	MILESTONES 5.5	Finalization of the cookbook	September 2015
	DELIVERABLE D.054	Report on WP5 pilot study experiences	March 2016

6.5.3 WP5 team members

WP5 is managed by Italy. The WP5 Team Leader is Giovanni Leonardi, General Director Health Professions and Human Resources at Ministry of Health.

There are two Italian organizations covering the competencies of WP5: the Ministry of Health (MoH) and the National Agency for Regional Healthcare (AGENAS), their roles, within the project, were divided accordingly. Their primary responsibilities are:

MoH
- Results of WP5
- Represent the Italian knowledge broker
- Relationships with international contacts
- Dissemination to Italian stakeholders
- Pilot study project

AGENAS
- Project management
- Methodology of research
- Budget and reporting management
- Logistics and organization of meeting
- Operational secretariat

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WP5 Italy Ministry of Health / Agenas

Italy is supported by WP5 Partners, divided in Associated and Collaborative, which together make up the team. They are:

Associated partners			Collaborating partners		
Country	Acronym	Name	Country	Acronym	Name
Belgium	BE_FPS	Pieter-Jan Miermans	Belgium	BE_FP	Peter Willemé
Bulgaria	BG_NCPHA	Nastashka Danova	Denmark	DK_DHMA	Anders Haahr
Bulgaria	BG_NCPHA	Milena Vladimirova	Germany	DE_KBV	Filip J. Lassahn
Bulgaria	BG_NCPHA	Plamen Dimitrov	Ireland	IE_DoH	Gabrielle Jacob
Bulgaria	BG_MUV	Nikolina Radeva	Italy	IT_AIC	John Williams
Finland	FI_MOH	Reijo Ailasmaa	Moldova	MD_MoH	Eugenia Berzan
Germany	DE_UNI-HB	Melanie Boeckmann	Moldova	MD_MoH	Nicolae Jelamschi
Germany	DE_UNI-HB	Heinz Rothgang	Serbia	RS_MoH	Milena Vasic
Greece	EL_NSHPJ	Despena Andrioti	Serbia	RS_UNI-BG	Milena Santric Milicevic
Hungary	HU_SU	Eszter Kovacs	Europe	STAK_ENMCA	Tanja Schubert
Hungary	HU_SU	Edit Eke	Europe	STAK_ENMCA	Marie Colegrave-Juge
Hungary	HU_SU	Edmond Girasek	Europe	STAK_ENMCA	Generic Mail
Iceland	IS_MOH	Valgerdur Gunnarsdottir	Europe	STAK_UEMO	Marie-Christine Bonnamour
Netherlands	NL_CAPORG	Victor Slenter	Europe	STAK_IOM	Benedict Roumyana
Netherlands	NL_MOH	Leon Van Berkel	Europe	STAK_IOM	Giuliana Urso
Poland	PL_MOH	Aleksandra Kotowicz	Europe	STAK_OECD	Michael Schoenstein
Poland	PL_MOH	Bartosz Baran	Europe	STAK_OECD	Tomoko Ono
Portugal	PT_ACSS	Ivo Rui Santos	Europe	STAK_WHO	Galina Perfilieva
Portugal	PT_ACSS	Filomena Parra da Silva			
Portugal	PT_ACSS	Ana Paula Gouveia			
Portugal	PT_ACSS	Gustavo Ferreira			
Slovenia	SI_IVZ	Rade Pribakovic			
Spain	ES_MOH	Pilar Carbajo			
Spain	ES_MOH	Mercedes De Jorge			
Spain	ES_MOH	Sebas Martin			
Europe	STAK_AMREF	Giulia De Ponte			
Europe	STAK_EFN	Silvia Gomez			
Europe	STAK_EFN	Cecilia Sironi			
Europe	STAK_EFN	Paul de Raeve			
Europe	STAK_HOPE	Isabella Notarangelo			
Europe	STAK_PGEU	Patricia Munoz			
Europe	STAK_PGEU	John Chave			