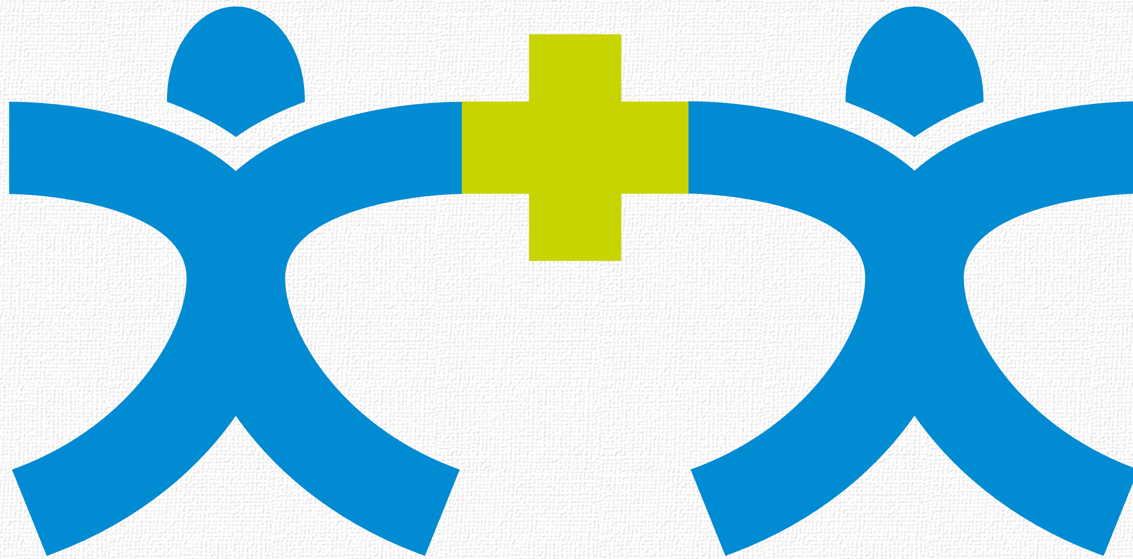

Joint Action Health Workforce Planning and Forecasting

Mobility of Physicians

-

opportunities and threats

Ljubljana – May 9th, 2014 – ECTS-MA Network

Joint Action Health Workforce Planning and Forecasting

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GOOD MORNING

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Former General Manager at the Federal Public Service of Health (Belgium), in charge of Primary Health Care, Emergency Care, Crisis Management & Health Professionals.

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MOBILITY … VARIOUS CONCEPTS

- Permanent mobility to EU
- Permanent mobility intra EU
  - To another country than nationality / training country
  - Back home when trained abroad
- Permanent mobility from EU
- Circular mobility in the context of training
- Circular mobility in the context of a career
- (Semi-)permanent or Circular mobility in the context of a bi-lateral agreement
- Temporary work
- Cross-border work

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MOBILITY – RIGHTS & FEARS

Mobility could be looked at and defined very different ways.

- (easy) Mobility of individuals is an achievement !
- Open EU Market (services, goods & workers) is a EU fundamental
- **Mobility is a tool to fight unbalances of HC provision to patients**
- Quality improvement of the training & research through foreign experience/collaboration is generally agreed
- Inter-university collaboration offers scale effect oppotunities
- …

- Planning can become out of political control (we do not know anymore who we have in the future)
- Snowball effect
- Greater unbalances with impact
- Countries becoming dependant on foreign workforce
- Protectionist behaviours & fear of lower quality
- …

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MOBILITY & GOVERNANCE

Abstract of "*Health professional mobility in a changing Europe. New dynamics, mobile individuals and diverse responses*"

Health professional mobility in Europe has become a fast-moving target for policy-makers. It is evolving rapidly in direction and magnitude as a consequence of fundamental change caused by European Union (EU) enlargement and the financial and economic crisis.

Health professional mobility changes the numbers of health professionals in countries and the skill-mix of the workforce, with consequences for health-system performance. Countries must factor in mobility if they are forecasting and planning their workforce requirements. To this end they need clarity on mobility trends and the mobile workforce, and effective interventions for retaining domestic and integrating foreign-trained health workers. Health professional mobility remains an unfinished agenda in Europe, at a time when the repercussions of the financial crisis continue to have an impact on the European health workforce and its patterns of mobility.

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THIS SESSION

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LET'S ILLUSTRATE DIFFERENT REALITIES THROUGH DIFFERENT NUMBERS FROM COUNTRY EXAMPLES

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TANGIBLE CASES – BELGIUM (1)

Number of health professionals authorized to practice -31/12/2012.

	All	Residing in Belgium
Physicians	56.127	**48.706**
Dentists	9.763	**8.866**
Physiotherapists	34.972	29.007
Health care assistants	86.411	84.142
Nurses	174.849	**166.659**
Midwives	9.542	9.004
Pharmacists	18.350	17.524
Paramedicals	21.580	21.290
TOTAL	**411.594**	**385.198**

.be

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TANGIBLE CASES – BELGIUM (2)

Basis Physician – recognition of qualifications according to the diploma's nationality

Diploma	Code	2007	2008	2009	2010	2011	Total
Autriche	AT	3	3	2	2	1	11
Bulgarie	BG	4	10	10	7	12	43
Suisse	CH	9	3	1	0	5	18
Rép. Tchèque	CZ	2	4	3	3	3	15
Allemagne	DE	22	37	20	25	38	142
Danemark	DK	2	0	0	0	0	2
Espagne	ES	8	4	4	11	17	44
Finlande	FI	1	0	0	0	0	1
France	FR	80	61	38	68	98	345
Grande Bretagne	GB	6	6	2	4	2	20
Grece	GR	20	27	26	21	28	122
Hongrie	HU	3	4	2	4	2	15
Irlande	IE	0	1	1	1	1	4
Italie	IT	31	24	37	38	61	191
Lituanie	LT	2	2	3	3	5	15
Luxembourg	LU	0	0	0	3	0	3
Lettonie	LV	1	1	2	2	3	9
Malte	MT	0	0	0	1	2	3
Pays Bas	NL	67	70	42	35	58	272
Pologne	PL	6	7	6	6	6	31
Portugal	PT	0	2	3	6	3	14
Roumanie	RO	134	133	153	163	178	761
Suede	SE	0	1	0	2	1	4
Slovénie	SI	0	0	0	1	0	1
Slovaquie	SK	2	0	0	0	5	7
Total		403	400	355	406	529	2093

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TANGIBLE CASES – BELGIUM (3)

Specialist physician – recognition of qualifications according to the diploma's nationality							
Diploma	Code	2007	2008	2009	2010	2011	Total
Autriche	AT	2	0	0	1	1	4
Bulgarie	BG	1	4	3	1	4	13
Suisse	CH	1	1	1	3	4	10
Rep. Tchèque	CZ	0	0	1	0	2	3
Allemagne	DE	21	12	14	18	28	93
Danemark	DK	1	0	0	0	0	1
Espagne	ES	2	1	1	1	2	7
France	FR	20	27	24	31	50	152
Grande Bretagne	GB	5	3	6	0	3	17
Grece	GR	5	4	3	5	10	27
Hongrie	HU	0	1	2	0	3	6
Irlande	IE	0	0	0	1	1	2
Italie	IT	10	10	5	6	11	42
Lituanie	LT	1	0	0	4	2	7
Lettonie	LV	1	2	1	0	0	4
Pays Bas	NL	16	16	29	15	34	110
Norvege	NO	1	0	0	0	0	1
Pologne	PL	2	1	3	2	2	10
Portugal	PT	1	0	0	1	1	3
Roumanie	RO	13	25	28	41	70	177
Suède	SE	1	1	0	0	1	3
Slovaquie	SK	0	0	0	0	3	3
Total		104	108	121	130	232	695

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TANGIBLE CASES – BELGIUM (4)

Conformity certificate	2008	2009	2010	2011
Total	2.015	1.290	1.364	1.496
General practitioner	34	35	29	34
Specialist physicians	281	224	184	254
Basis physicians	217	211	178	196

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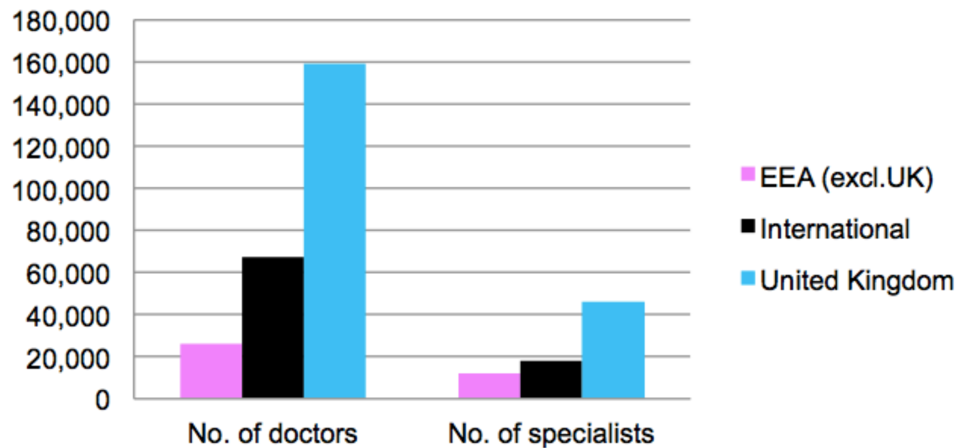
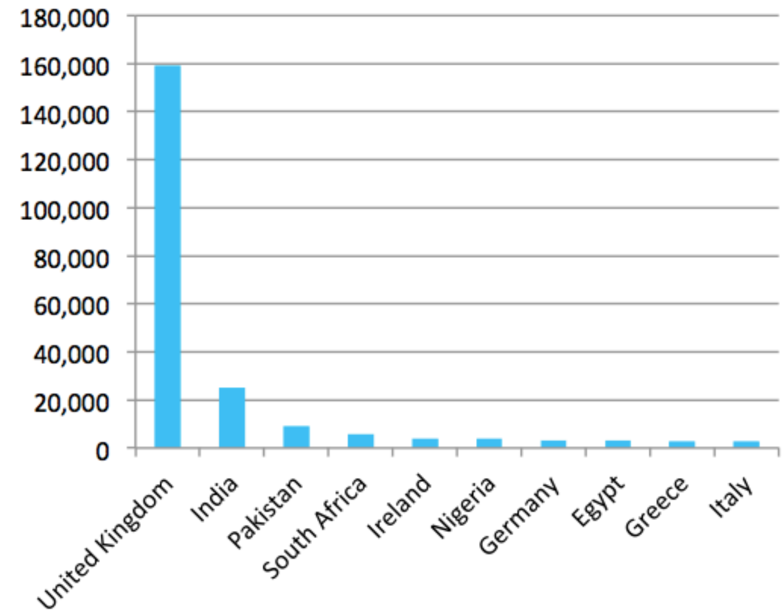
TANGIBLE CASES – UK (source GMC 2013)





TANGIBLE CASES – CA - (source OECD 2008)

Table 5. Main 25 countries of birth of doctors and nurses, by place of training, 2006

	Doctors			Nurses
Country of birth	**Foreign-Born**	**Share of foreign-born doctors who were trained abroad**	**Country of birth**	**Foreign-Born**
United Kingdom	3905	49.3	Philippines	10040
India	2515	51.9	United Kingdom	6755
South Africa	2070	80.7	Jamaica	4085
United States	1605	31.1	United States	3180
Hong Kong, China	1355	14.7	India	2930
China	1110	51.6	Haiti	2140
Egypt	910	52.2	Poland	1990
Poland	805	48.4	China	1665
Pakistan	655	67.4	Hong Kong, China	1580
Vietnam	625	16.8	Germany	1430
Iran	620	54.1	Trinidad and Tobago	1255
France	535	52.3	Netherlands	1135
Germany	480	30.2	Guyana	1080
Ireland	455	76.9	France	680
Philippines	455	72.7	Iran	655
Korea	415	36.1	Roumania	640
Saudi Arabia	410	72.0	Korea	615
Taiwan	410	40.2	Vietnam	595
Lebanon	395	25.3	Ukraine	515
Roumania	395	59.5	Ghana	510
Sri Lanka	340	55.9	Russia	495
Kenya	325	41.3	Ireland	455
Italy	320	42.2	Italy	455
Malaysia	250	22.9	Barbados	445
Israel	245	46.9	Nigeria	440
Nigeria	245	61.2	South Africa	435
OECD	10645	45.6	**OECD**	19690
All foreign-born	29790	50.1	**All foreign-born**	58365
Canadian-born	49185	3.3	**Canadian-born**	240655

Note : Data on doctors include specialists and general practitionners; Data on nurses include registered nurses and head nurses and supervisors. Data refer to landed immigrants and non permanent residents.

Source: Statistics Canada 2006 Census, Citizenship and Immigration Canada custom tabulations.

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TANGIBLE CASES – HU (source MoH)

Year	Foreign born	Foreign trained	Foreign nationality
2012	69	75	33
2011	43	52	25
2010	23	32	17

Discussion : outflow

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FRANCE & NORTHERN AFRICA

Active Doctors with a foreign diploma practising in France

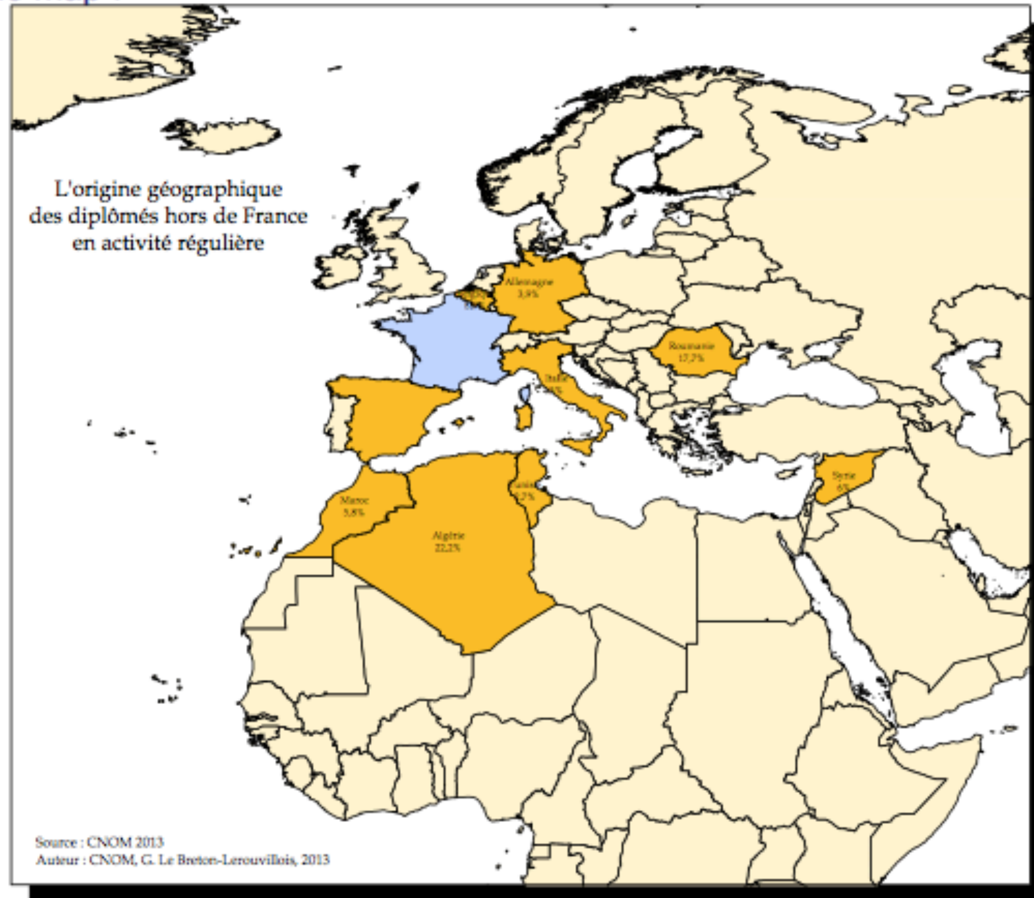
76,4% of these Doctors graduated in one of these 10 countries in the map :

They are 17 835 in total.

-7958 hold a European degree

-9877 hold a non EU degree

-62% of them are men



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IN FACT WE KNOW A LOT ABOUT INFLOWS

Important studies to read :

- Prometheus study (books I & II)
- MohProf (Mobility of Health Professionals) study
- RN4cast (this one on nurses)

But also : **European Observatory on Medical Demography**

Note / show a bit of this

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AND YET WE FEEL HELPLESS …

We have very poor data on outflow

We are not able to produce ECHIM indicator “mobility”

We have no qualitative date

“hit’ topic for parliamentary discussions

We do not have a EU data strategy

We do not know the price tag

We all know ecellent specialists who left

We all know good trainees who left

We have no grip on the outflow

In some countries, immigrants took a specific place in HC system

Some countries face terrible consequences

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Others

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INTENTIONS

Table 2.1 *Yearly outflows/outflow intentions of medical doctors from selected 2004 and 2007 EU Member States*

Country	Indicator	2004[h]	2005	2006	2007	2008	2009
Estonia	Intention to leave[a]	283	79	87	75	79	106
	(% among active workforce)	(6.5%)	(1.8%)	(2.0%)	(1.7%)	(1.8%)	(2.4%)
Hungary	Intention to leave[b]	906	889	721	695	803	887
	(% among active workforce)	(2.7%)	(2.7%)	(2.2%)	(2.1%)	(2.4%)	(na)
Lithuania	Intention to leave[c]	357	186	–	–	–	132
	(% among active workforce)	(2.7%)	(1.4%)				(0.9%)
Poland	Intention to leave[d]	na	3579[i]	1535[i]	1123[i]	901[j]	na
Slovakia	Intention to leave[e]	442	594	376	267	250	217
Romania	Intention to leave[f]	–	–	–	4990	2683[k]	na
	(% among active workforce)				(10.2%)		
	Emigration study[g]	–	–	–	1421	na	na
	(% among active workforce)				(3%)		

Sources: [a] Certificates of recognition of diplomas issued (Health Care Board); [b] applications for certification – all applicants, whether residing in Hungary or elsewhere (Office of Health Authorisation and Administrative Procedures); [c] issued to medical doctors (Lithuanian Ministry of Health); [d] certificates issued in Poland (Central Statistical Office 2009); [e] certificates issued (Ministry of Health of Slovakia); [f] applications for diploma verifications (Ministry of Health of Romania); [g] study on emigration among all practising medical doctors (Dragomiristeanu et al. 2008).

Notes: [h] May–December only; [i] as of 30 June (numbers for 2005 may be cumulative); [j] as of 31 December; [k] Covers 2008 and January to May 2009; na: Not available..

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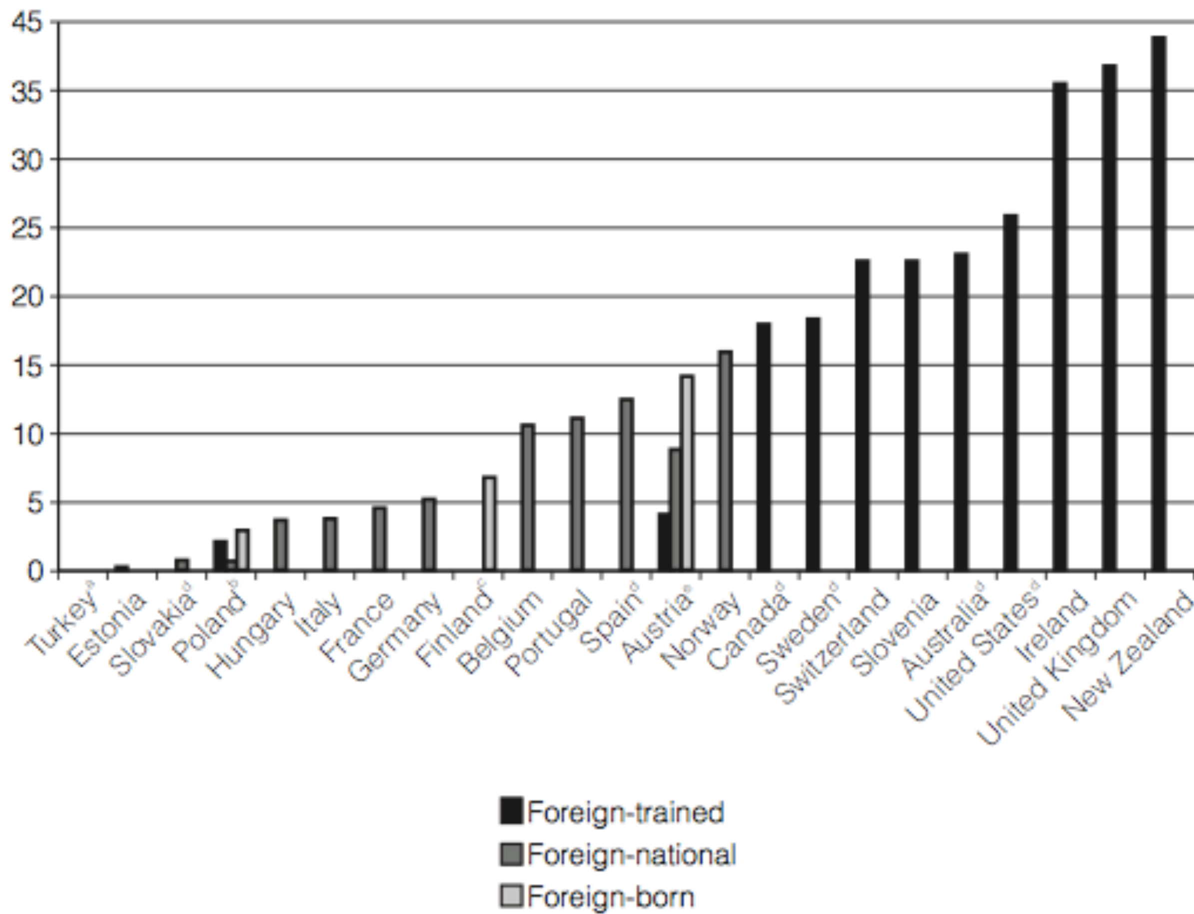
RELIANCE ON FOREIGN WORKFORCE

Fig. 2.1 *Reliance on foreign medical doctors in selected European and non-European OECD countries, 2008 or latest year available*



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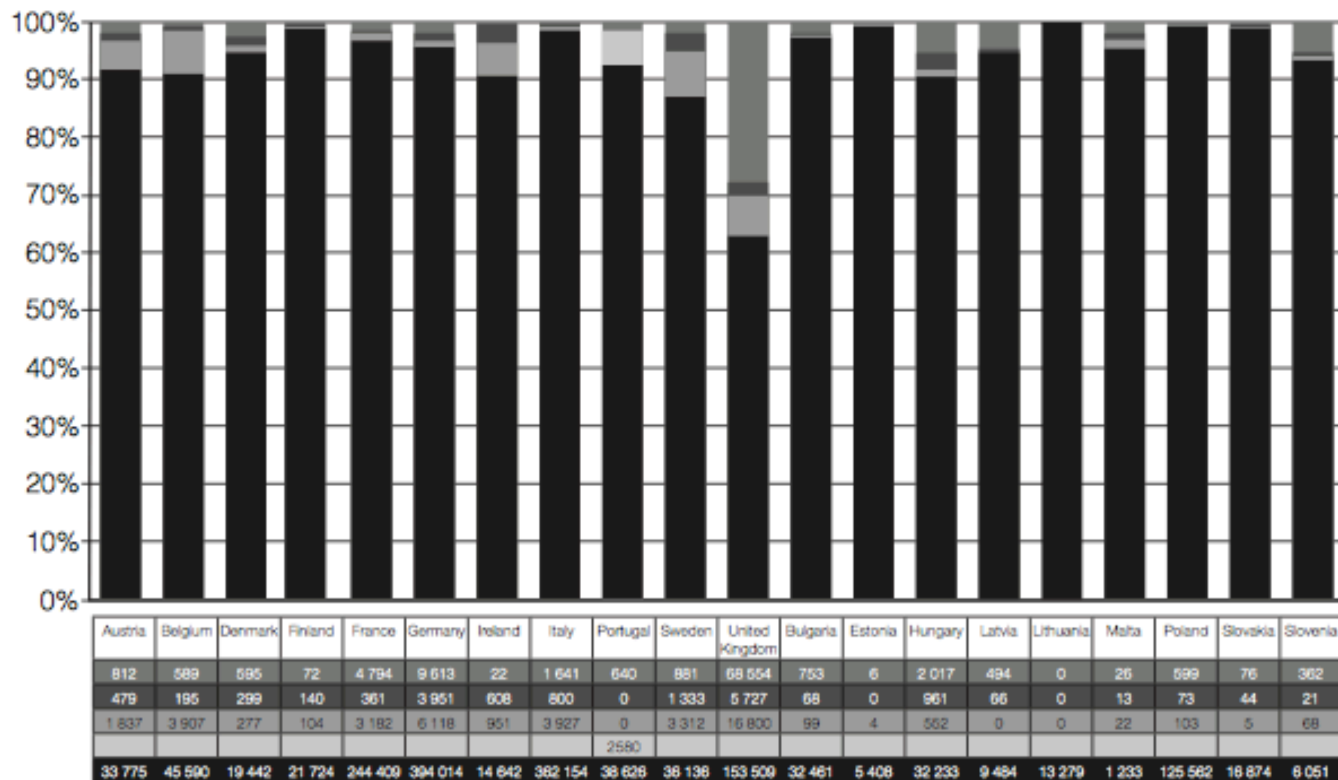
FOREIGN STUDENTS & SELF-SUFFIENCE

Fig. 12.1 *Percentage of foreign (national/trained/born) medical doctors among all medical doctors in selected EU countries, 2007*



Austria	Belgium	Denmark	Finland	France	Germany	Ireland	Italy	Portugal	Sweden	United Kingdom	Bulgaria	Estonia	Hungary	Latvia	Lithuania	Malta	Poland	Slovakia	Slovenia
812	589	595	72	4 794	9 613	22	1 641	640	881	68 554	753	6	2 017	494	0	26	599	76	362
479	195	299	140	361	3 951	608	800	0	1 333	5 727	68	0	961	66	0	13	73	44	21
1 837	3 907	277	104	3 182	6 118	951	3 927	0	3 312	16 800	99	4	552	0	0	22	103	5	68
								2580											
33 775	45 590	19 442	21 724	244 409	394 014	14 642	382 154	38 626	38 138	153 509	32 461	5 408	32 233	9 484	13 279	1 233	125 582	16 874	6 051

- Foreign medical doctors from non-EU countries
- Foreign medical doctors from new EU Member States (EU12)
- Foreign medical doctors from old EU Member States (EU15)
- Foreign medical doctors from all EU Member States
- Domestic doctors

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IS THERE A CHANGE DUE TO THE ECONOMICAL CRISIS ?

- Yes & No, … there is an increased willingness to seek better living conditions & stability, but active recruitment is stopped.
- The pressure on cost in the healthcare sector turned some official shortages into official plethora, cuts in salaries increases the drivers to move – but also reverses the movement between countries.
- Limitation on the budget for healthcare is considered for setting targets within the planning process than calculated population needs, which often leads to a fear of plethora and limitation of home production, but could also create a "shock" helping the (fast) transformation of Health Systems. (see BG country example – Prometheus book II – p46)
- Still … there are no Cost <-> benefits figures on the work of a doctor, making policy making on HWF an ideological debate.
- Des-investment in HC systems together with lack of vision / incoherent response kills the faith in a country and creates exodus

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OUTFLOW

Most drivers are **NOT** specific to health care workers

- Better living conditions for the migrant and his family
- Better training & carrier opportunities
- Better infrastructures and greater hope for performing at high quality level
- Better wages
- Better work conditions
- Language / Relations / Ethnicity / …

These are valid for 99% of the migrants.

The image of a country has a major effect and a depreciation leads to a snowball effect.

We have to recognize that during the long medical training, the conditions will changes. Some small size studies show that the creation of a local family & the social integration plays crucial roles for cancelling intentions to return home.

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BACK TO : MOBILITY … VARIOUS CONCEPTS
… and variety of thoughts

- Permanent mobility to EU
  - Most of the time from EAST to WEST
  - Or through language / former colonies attraction (Commonwealth / Africa / Latin America / …)
  - But also from USA / Canada / Countries at war / …

  ✓ EU immigration strategy
  ✓ Application of national law
  ✓ Application of previous bilateral agreement
  ✓ Negotiation on bilateral agreements

- Country of entrance is not to be considered a country of final destination
- Applicability of the WHO Global Code for ethical recruitment of HWF

BACK TO : MOBILITY … VARIOUS CONCEPTS
… and variety of thoughts

- Permanent mobility intra EU
  - To another country than nationality / training country
    - Similar factors as non-EU
    - Special influence of education
      - ✓ Structural education proposals e.g. In Norway, a fund encourage 40% of students in medicine to receive an foreign education
      - ✓ Escape route to numerus clausus and shortage of education possibilities
      - ✓ Renowned universities as magnet
  - ✓ Potential of Circular mobility

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BACK TO : MOBILITY … VARIOUS CONCEPTS
… and variety of thoughts

Permanent mobility from EU

- Importance of the "through" flow:
  - U.K. both attracts medical doctors, and looses medical doctors for US, Canada & Australia
  - Germany attracts from central and eastern Europe, and German doctors are attracted to go west.
- Some U.K. responsible consider unbalances in the US (development of a broader insurance coverage system) to be a real threat to U.K. health workforce.
- Case Ireland – most immigrants took junior positions and are limited after a few years in career opportunities (also due to budget reductions) and would migrated again
- …

BACK TO : MOBILITY … VARIOUS CONCEPTS
… and variety of thoughts

The needs from outside of EU

- Currently Africa / Latin America / Eastern Europe / SE Asia are often considered as "plundered" by High Income Countries… but the real issue is that we need more than 6.000.000 HC Workers

- Country response : Brazil

  Note / See presentation Mais Medicos on http://www.euhwforce.eu/web_documents/JAHWF-CONFERENCE-1-BRATISLAVA/DOCUMENTS/140129_BOSESSION3_BRAZIL.pdf

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PLANNING ?
ABONDANCE OF DATA ⇔ TERRIBLE LACK OF FIGURES

- From 7 to 10 countries in Europe not only collect data on health professionals, but also tend to forecast with a supply and demand based model, leading to potential planning actions on the political level.

- Mobility is an increasing threat for planning because of its growing importance, and unpredictability. Currently, due to lack of data those ‘planning’ countries are struggling, … the other one are helpless.

- When identifying importance of shortages, mobility can provide an answers, but self sustainability is the official message

- Though, long term vision recommend self-sustainability at country (or regional) level.

WHAT ARE WE DOING ABOUT IT ?

Ref. Chapter 12 of Prometheus : The unfinished workforce agenda

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THE LEGAL INSTRUMENTS

Mutual recognition (2005/36/EC and soon 2013/55/EU)

- Is a tool to support mobility of regulated and unregulated professionals
- Provide processes to support quality and takes into account to a certain extend the specificity of health care professions
- Strictly restrict the applicability of compensation measures to relevant gaps in the competence
- Opens the door for uncertified training and professional experience to motivate an appliance to recognition
- Builds in a system of ex-ante control and foresee the exchange of information between Member States

- Still this important tool is the results of a compromise. The discrepancies of the curricula, health care systems (but also habits) & number of specialities remains a major threat for quality of the process

Applies only for the persons that respond to the definition of "(EU) migrant", not the most non-EU citizen, non-EU trained persons

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THE LEGAL INSTRUMENTS

EU Blue Card scheme (Directive 2009/50/EC)

- helps attract highly qualified migrants to Europe, supporting Member States' and EU companies' efforts to fill gaps in their labor markets that cannot be filled by their own nationals, other EU nationals or legally resident non-EU nationals

Belgian case

- BE specific system for applying when the 2005/36/EC is not applicable
  => criticism / difference in treatment

- But also specific system for temporary allowance to practice, to support training for countries that need specific competence
  => Criticism / room for inappropriate usage - creates expectations

EU Blue Card is not really used.

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EU HWF PLAN

- EU The action plan for the EU health workforce seeks to help EU countries work together to tackle these challenges and boost employment by:
  - improving health workforce planning and forecasting
  - anticipating future skills needs
  - improving recruitment and retention of health professionals
  - mitigating the negative effects of migration on health systems.

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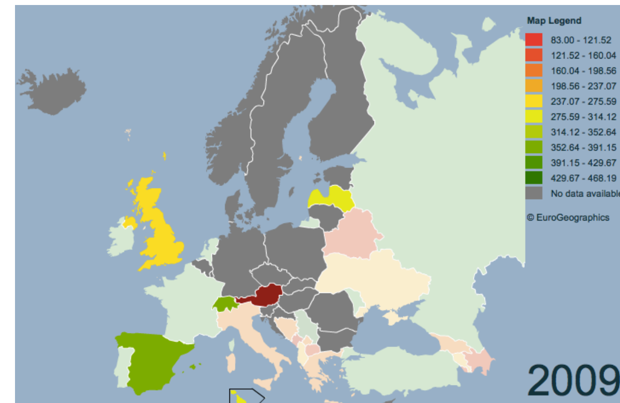
DATA COLLECTION & PLANNING 1

Monitor the trends

European Community Health Indicators (ECHI) is project that was carried out under the Health Monitoring Programme and the Community Public Health Programme 2003-2008. The aim was to advance health monitoring throughout Europe by developing relevant and comparable health indicators and by making them available in the EU and its Member States (MSs). A list of 88 'indicators' (ECHI short list) was developed.



Indicator 63. “Physicians employed” is available (e.g. http://www.statistik.at/web_en/statistics/health/european_community_health_indicators_echi/index.html - page 7 and http://ec.europa.eu/health/indicators/echi/list/index_en.htm)

Indicator 65. “Mobility of professionals” is not available yet.

DATA COLLECTION & PLANNING 2

International data collection and comparability

WHO / OECD / EUROSTAT have agreed on a Joined Questionnaire

- **Discrepancies of the definitions is the major identified issue;**
- **Discrepancies on the accuracy of data delivery (time & quality) is the second major issue**

⇒ WHO / OECD / EUROSTAT have projects to upgrade the process (improvement – no revolution)

MEMBER STATES representatives are concerned about

- **The analysis made by these international bodies on incomparable data**
- **The analysis made by the government on the resulting statements**

There is room for improvement locally & globally

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ETHICAL - CODE

The European Social Dialogue in the hospital and healthcare sector has agreed a Code of Conduct on the Ethical Cross-Border Recruitment and Retention in the Hospital Sector and a Framework of Actions on Recruitment and Retention.

Strategy for Action on the Crisis in Human Resources for Health in Developing Countries (European Commission, 2005b), and in 2006, the *Programme for Action to Tackle the Shortage of Health Workers in Developing Countries (2007–2013)* (European Commission, 2006)

The WHO Global Code of Practice on the International Recruitment of Health Personnel has been countersigned by adopted by the 193 Member States of the World Health Organization.

Note / See presentation from Dr. Perfilieva

Project Health Workers for All

"We believe everyone should have access to health workers"

http://www.healthworkers4all.eu

The JA EUWHF

General Objective

To collaborate and exchange between Member States to support them in their health workforce planning and to increase Member States' and Europe's capacity to take effective and sustainable measures.

Focus on 5 professions :
- doctors
- nurses
- pharmacists
- dentists
- midwives

Starting date:
April 1st 2013

Duration:
3 years

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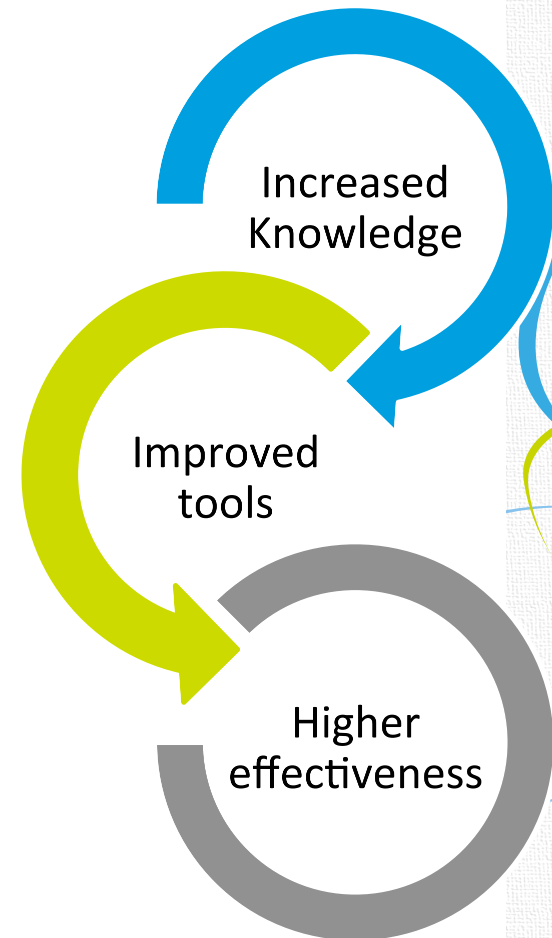
The JA EUHWF: specific objectives

Increased knowledge :
- Better understanding of terminology
- Updated information on mobility trends
- Estimation of future skills and competencies needed for the HWF

Improved tools:
- Guidelines on quantitative and qualitative planning methodologies
- Platform for cooperation to find possible solutions on expected shortages

Higher effectiveness:
- Better monitoring by access to timely data
- Increased quantitative and qualitative planning capacity
- Higher impact of HWF planning and forecasts on policy decision making



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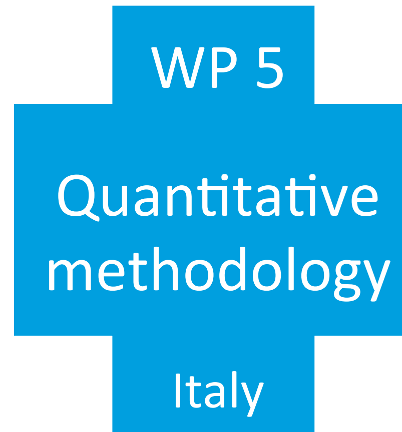
The JA EUHWF : Core work packages



- Terminology mapping
- Mobility data
- WHO Code
- HWF planning data

- Minimal data set
- Quantitative planning methodology
- Pilot project

- Estimation of future needs
- Qualitative planning methodology
- Pilot project

- Network of experts
- Policy advice
- Technical recommen-dations

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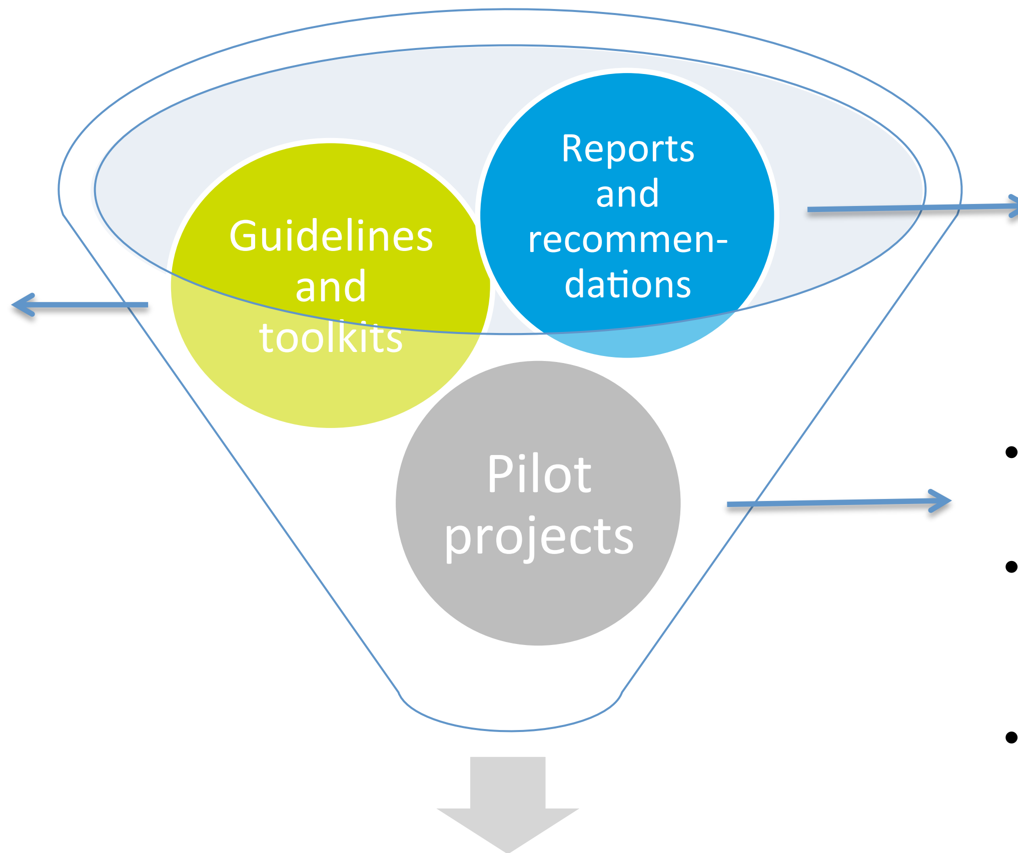
The JA EUHWF : Tangible outcome

- Enabling Competent authorities to progress in planning HWF
- Enabling to look further then the current horizon
- Improving dialogue with unified definitions



- EU and Member State level
- Focus on both technical implementation & Policy making
- Feasible

- Start Data collection & Planning : IT & PT
- Already new demands: snowball effect
- Horizon scanning: BE on General Practitioners

Web portal + Network of experts

HWF Planning guide

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STUDENTS SURVEY (in partnership with EMSA)

Currently, we are conducting the pilot phase of a survey among the future generations of Health Care Workers. Within this one, an important question for the "sending" countries is to be answered :

- Do these students already think of leaving the country ?
- For Med. Sdts – their opinion on training & career opportunities

TODAY (pilot study only) :

- BE nurses & midwifes / 0% now thinks to leave
- CZ & SK pharmacists / around 15% think of leaving – 4% will actively try to
- BG doctors & pharmacist / a majority think of leaving

BUILDING AN EU NETWORK OF EXPERTS

To support EU policy making and even more to advise Member States. Experts in planning, HC systems, policy making, labour &, Education

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BILATERAL AGREEMENTS

Bilateral agreements are considered as promising tools for helping states to manage migrations.

- Positive descriptions on training agreements – improving students qualification and fullfilling their expectations – controlled introduction to a world of mobility
- Covering structural shortages
- Common labour market
- Agreement on potential compensation for emmigration
- Creating communication mechanism

A pilot survey made by EU DG SANCO concludes that even though the instrument is growing, there is no homogeneity and few bilateral relations are covered.
MOLDOVA is an initiator on this topic.

Other example : Triple Win approach – see presentation on http://www.euhwforce.eu/web_documents/JAHWF-CONFERENCE-1-BRATISLAVA/DOCUMENTS/140129_BOSESSION3_3WIN.pdf

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RETENTION STRATEGIES

Use lessons learned

Take local responsibilities on work conditions and country image

But even more :

- Work differently !

PROMOTION OF ETHICAL RECRUITMENT

Build awareness of the WHO CODE

Assess applicability to EU

Measurable implementation

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VARIETY OF SYSTEMS – VARIETY OF LESSONS

The current focus is on skill mix (mostly seen as task/responsibility transfer)

Though, sharing experience leads to innovative solution and transposition under pressure of the crisis / the shortages / the technical evolutions

Planning is most of the time either inexistent, or short term (12 years in advance)

HORIZON SCANNING IS A MUST TO IDENTIFY WHAT WILL CHANGE FORTHE MEDICAL PROFESSIONS

(medical issues, but also patient empowerment, IT evolution, other way of practicing, new organisation of medicine, …)

- Important implication on the skills (CURRICULA & CPD) we need now and tomorrow
- Important implication on the redistribution of health professionals

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CONCLUSIONS

- Mobility is a benefit, … but is no (longer?) seen as such by most states

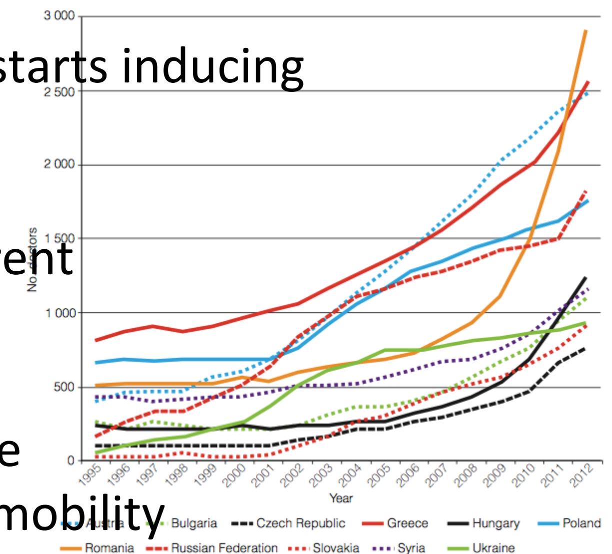

Fig. 9.1 *Medical doctors from selected countries registered in Germany, 1995–2012*

- Shortages and pressure on costs and quality starts inducing a war for talent of today

- Mobility is growing much faster than the current response of our States

- In 40 years of career, a lot can and will change also the career content and the approach of mobility

- High complexity, available data, lack of analysis, need for global and local initiatives

- Are the values of our society high on the agenda ?

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CONCLUSIONS

MESSAGES TO YOUR NETWORK

⇒ Your role of making students “ready for the world”, but still showing the value of own country is even higher during initial training

⇒ Communication with the students and early identification of their expectations is important

⇒ Breaking fears, add human values, help political level, bring your messages – isn’t this a role Universities have always done ?

⇒ Courageous policies, not only from the Government but even more from the medical world are needed

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