Meeting minutes

Work Package 4 Utrecht Workshop – Data in Action
Joint Action on European Health Workforce Planning
Date: 6-7 March 2014
Location: NIVEL Headquarters
Otterstraat 118-124, 3513 CR Utrecht, the Netherlands

Note: Presentations of the workshop are all available online on the following website: http://euhwforce.weebly.com/140306-wp4-utrecht.html

The Objectives of the WP4 Utrecht Workshop

The work carried out in the Work Package 4 of the Joint Action is intended to provide key building blocks for health workforce planning and forecasting systems, in order to provide a better understanding of available data at Member State and European levels.

The objective of the workshop organised by WP4 in Utrecht was to support the Terminology Gap Analysis and Mobility Data Mapping activities of Work Package 4, with the high level involvement of the 48 participants, representing national Ministries of Health and research institutes as well as the EU Commission, EU level organisations and OECD.

6 March, Thursday

9.00. **Registration**

9.15. **Presentation**: **Greetings by and introduction to the Netherlands Institute for Health Services Research** (NIVEL) - Prof. dr. Peter Groenewegen, director, NIVEL

TERMINOLOGY Section of the Workshop

9.25. **Workshop Opening**: Goals of the Terminology Section of the Utrecht Workshop - Zoltan Aszalos, WP4 Leader

The focus of the Terminology Activity is on the gap between the HWF data requested by the Joint Questionnaire on the five sectoral professions in the three status categories (Licensed to Practice, Practicing, Professionally Active) - and the data actually supplied by Members States. The full definition of this activity is to be found on www.euhfworce.eu.

9.35. Introductory presentations with a question round

- **Presentation**:**The OECD-Eurostat-WHO Joint Questionnaire data categories** – Gaetan Lafortune, Senior Economist, Health Division, OECD
- **Presentation**:**The ECHIM analysis on JQ categories** - Silla, Sigurlaug Hauksdottir, Health Information Unit, DG Sanco, Commission
- **Presentation**:**Eurostat activities on non-monetary health statistics and the Task Force** - Hartmut D. Buchow, European Commission – Eurostat, Public Health Statistics

10.20 **Presentation**: **The preliminary results of the WP4 Survey - "Behind the data"** – Data source gap analysis of the JQ - Eszter Kovacs, WP4

Questions & answers session - selected special comments:

- Based on the Survey analysis on the data supply by Member States in the different JQ data categories, the *Practising* category can be considered as the most complete for the dentist and pharmacist professions. For medical doctors, it is the *Licensed to Practise* and the *Practising* categories, and for the nurses and midwives the *Professionally active* category has proven to be the most complete JQ data collection.
- Member States have high responsibility over the quality of data provided to the JQ: Focal Points do not always produce HWF data on their own, while they play a crucial role as central data-flow coordinators between other data owner organisations at national level. In practice, the responsibility over the quality of data produced for the JQ at national level is usually spread between various organisations that produce the data and the authorities that shape the network of these data producing organisations. The responsibility of reporting to the JQ belongs to the NFPs, however, the quality of the data relies on those bodies sending the data for the NFPs.
- In relation to the practical application of JQ data, the following data categories are meant to be used as a starting point to benchmark national level data with international JQ data:
    - ratio per capita for doctors and nurses in each country
    - national regulations on HWF categories
    - HWF categories - ratio analysis e.g. doctors/nurses ratio
- The objective of the JQ is rather modest as it currently cannot help to measure and benchmark efficiency and productivity between countries. For this long term purpose, the measurement of inputs and outputs would be equally necessary.
- Data collection in new categories needs careful analysis of cost effectiveness and feasibility. Still, there is already data available which can be made useful. For this purpose, new ways of collecting and aggregating the same or similar data is to be explored. These new solutions are to be justified by real life situations and by actual HWF monitoring requirements at national level.
- The European Core Health Indicators (ECHI) have been developed to have comparable indicators that cover all aspects of health. The ECHI shortlist of 88 indicators are the products of many years of cooperation between the Commission and it's MS. The shortlist should cover all aspects of health and can be used for setting and monitoring of health policy. In relation to HWF issues three indicators

are of the highest importance: 63: Practising physicians, 64. Practising nurses, and 65. Mobility of professionals.

10.40. Coffee break

10.50. **Session on Terminology** – Group sessions

Summary to the session:

Building on the morning presentations, the objective of the morning group sessions was to deepen the understanding of participants on the gap between data requested by the Joint Questionnaire non-monetary health care statistics and data actually supplied by Members States.

These sessions were scheduled to provide inputs for recommendations and proposals developed in the afternoon session.

The discussions in the groups followed the same structure:

- Step 1: Participants outlined the most burning issues and most significant gaps in data collection - each participant outlined 2-3 issues on post-its
- Step 2: Issues were arranged in main thematic groups
- Step 3: The thematic group discussed and identified the main reasons for data gaps and the potential solutions to the failure of the requested data provision.

Group 1. - facilitated by Edit Eke and Eszter Kovács

Key burning issues discussed in this group:

1. Classification/definition problems

- Various forms of deviations from the JQ definitions exist in MSs: professional classifications with the same labels do not indicate the same content in different countries. Qualifications might cover different content, professional status also differs among countries, and definitions may also change.
- Some **functional definitions** (functional equivalents) /proposals for having more comparable categories would be needed, particularly in the nurse category. Updating ISCO classification might help, but harmonisation of definitions and **tasks** are necessary for comparable data.

2. Usefulness of the JQ data collection (national and/or international level)

- Motivation to use JQ data and to invest in resources (financial, HR) to collect good quality data is lacking, because the OECD/WHO/EU analysis is particularly unclear, the countries who provide data do not see **any added value currently at MS level.** The commitment of the MSs might be facilitated by more transparent and valuable process, financial support (to maintain capacity development) and a paradigm shift is

needed - underlining the added value of JQ at both EU and MS level.
- Lack of transparency also leads to reluctance/missing trust to deliver: the communication on how JQ data is used at EU/OECD/WHO level is unclear.
- **Developments initiated by the JA:** In several countries (Portugal, Bulgaria, Slovakia, Belgium, Hungary) the JA WP4 work initiated national level coordination and cooperation among in-country stakeholders - involved in data collection and reporting, especially due to the WP4 Survey process. That is evaluated as a favorable development by group members.

3. HWF data and information
- At national level, sometimes the inadequate dialogue of the actors may lead to difficulties in information/data flow. This frequently leads to stakeholders using different data sources and in different data holders/providers not crossing their data. Processes matter: only useful processes produce accurate data. Linking the existing databases could contribute to better data. In some MSs it is not clear which organisation is in charge of collecting different HWF data categories. Training of people who collect data would be needed.
- Different data sources have different coverage and use different interpretation of definitions.
- Connection with archives (files) of different countries is an issue, as some archives are outdated, and frequently some variables are missing: age, nationality or gender for example.
- Data is usually not used for policy planning in Member States. In general there is no or limited planning processes in MSs.
- In many EU countries data is aggregated, and individual data cannot be followed, albeit there would be needed for analysis and evaluation at a primary data level.

4. Legislative issues
- There is a legislative gap concerning HWF definitions between EU members on one hand, between EU and some countries on the other hand.
- EU legislation already in operation may not be fulfilled due to the slow reaction time and inability to change the relevant involved national systems and practices.
- While 2005/36 is the MSs' Bible at high level, integration of definitions between EU legislatives is missing.

Group 2. - facilitated by Reka Kovacs and Zoltan Cserhati

Main topics and statements:
- **Usefulness:** data reported for JQ is not used by the countries; therefore they are not interested in their collection. The JQ is not designed for health workforce planning, and it was questioned what extent the JQ can be used for benchmarking or monitoring purposes. Maintaining and securing the policy will to respond to the Questionnaire is of key importance. It should be declared why it is useful and why the comparison is helpful at international level (achieving total practicing coverage is a challenge) considering purpose at national level is not international comparability. Data used for the international report is not the same as the data used by health

ministries for policy purposes.

- **Differences in health care systems limit comparability:** MSs have developed highly different healthcare systems (with different models and skill mixes), and it is problematic to extend those comparisons without understanding the difference in the healthcare systems.
- **Connection with health workforce planning:** JQ is not designed for health workforce planning and JQ data cannot be used for planning at national level, either. A possible use could be the comparison of FTE/population ratios between countries.
- **Data quality and data sources**: what data is going to be reported for JQ is highly **depends on what data is available at country level**. Data available is reported, not necessarily what is asked for. In most of the countries there are multiple data sources with different methodology for data collection. It is a great challenge gathering available data from any sources and **transforming** into answers for the questionnaire. Sometimes there is no sufficient cooperation between different data sources, or data providers are not motivated. Especially professional organizations are not collecting data according to the JQ, and they are very independent by their nature, it is difficult to influence them from policy level.
- **Evolution of data:** introducing a new health profession changes the data structure and affects the comparability in national trends. Similar problems can occur when the way of reporting changes (it can cause "breaks in the series").
- **Licensed to practice category should be based on qualification, while professionally active and practicing categories on occupations**. These are different types of information – both of which has value (regarding planning as well), but they are different. The sources of LTP data are mainly registries (from regulatory bodies or professional organisations) in which **the qualifications** are registered and it is difficult to turn this data into ISCO codes. Countries that have registries based on qualification can produce LTP data, but no data for practicing (IRL). Countries who collects only data on practicing (who delivers the service, "registered to practice" – like UK) cannot produce LTP data. In other countries (ISL) practicing data is based on estimation.
- **Head counts and FTE:** FTE is calculated for the JQ only for hospital activity, but professionals can work in part-time also in primary care. Practicing category of JQ contains all active doctors, including doctors who work once a week, although in some countries these professionals are not reported. (FRA)
- **Private practice:** where there is a lot of private practice, not all inhabitants have equal access to health care services; calculating density like number of professionals/total population ratio can be misleading in comparison.
- **Professionals registered in more countries:** doctors who are registered in more countries parallel are counted twice (Nordic countries, UK-IRL, CEE-UK). It is a possible issue for activity on mobility, too.
- **Nurses: definition** can be problematic, at least three types of definitions exists: ISCO codes, the 36/2005 EU directive (as amended by DIRECTIVE 2013/55/EU) and other national definitions. In some countries, midwives are a category of nurses (POR), or nurses and associate professional nurses are registered, but there is no registration for caring personnel, therefore this information is not provided. Qualified nurses working in social care are not reported in several countries.
- **Doctors:** The definition and interpretation of "GP" category varies across countries.

In some countries family specialists are not reported as GPs (because they are specialists) in other countries reported GPs are doctors who work in **primary care**. Comparing specialties of doctors is difficult because of country differences.

- **Dentist and stomatologists:** although these two professions have similar skills, in some countries stomatologist registered as specialists (in different registry)
- **Pharmacists:** many pharmacists do not provide direct care - hospital pharmacists are known as practicing but there is no information on others (e.g. working in research). **LTP data could be most appropriate** regarding pharmacists for international comparison.
- **Role of skill mix:** we cannot look one single discipline in isolation we have to look the interdependencies between them, as it generates particular efficiencies.

Group 3. - facilitated by Zoltan Aszalos and Edmond Girasek

The key categories of burning issues identified by participants of this group were the following:

- **Use and objectives of JQ:** There is a need for a better understanding of what JQ is for - both at national and international level. Countries that supply data to the JQ should understand clearly what their benefit from this data collection is. Expectations of countries should be also managed, they should have a clear message on this, and understand what the expected JQ functions such as HWF monitoring or benchmarking mean in practice. Some countries request data only on "peer countries", i.e. countries with a similar socio-economic background.
- **Classification:** Definitions and classification in occupations are interpreted differently in different Member States. ISCO is too rigid and outdated, and there is a need for clearer definitions. There is especially a need for further breakdown and more clarity in nurses categories for further planning purposes.
- **Resources and motivation:** Resource allocation on national level as well as the motivation of individuals involved in the data collection have an important impact on the quality of data supplied. In various MSs multiple organisations are involved, which makes data collection more complex. JQ currently is voluntarily completed, and there is no regulatory framework in place that would put pressure on countries for better data supply.
- **Mobility:** Mobility is key in HWF monitoring. Due to the significant volume of international migration, this data category should be also collected. Currently there is a significant data gap on international mobility which is especially apparent for doctors and nurses.
- **Measurement of FTE:** The difference between FTE and headcount data vs. actual working time completed (e.g. holiday issues) still needs methodological concept in many countries. Data as currently collected by the JQ includes FTE data for hospital workers - this may be the feasible scope but this may be challenged in the future.

12.30. Lunch Break

13.45. **Preparation of recommendations based on the data source gap analysis**. Facilitated discussion in group sessions, following the initial outcomes of the morning sessions.

The objective of the afternoon sessions were to provide input for practical and policy level recommendations with a primary focus on the JQ. Both national and international level were to be addressed with these recommendations.

Group 1: Information flow/JQ purpose/utilization timeliness

Facilitated by Zoltan Aszalos and Edmond Girasek

- **JQ purpose:** The purposes of the JQ data collection may be discussed from the national and the OECD-Eurostat-WHO perspective. From the national perspective, the questions are the following: why should a country invest in data collection for the JQ? How can a country use the data? Timeliness is also an issue as when JQ presents data it is already two years old.
- **JQ as a data collection for monitoring purposes**: The contents of *monitoring* has to be defined. What are the expectations about the JQ? It is a basic set of data on health care, an overview on areas covered (technical, resource, activities particularly in hospital, and HWF activity). JQ allows countries to compare their own indicators and to have an understanding on their own positions.
- **Expectations of countries towards the JQ**: What are the expectations of countries? Member states may not have too many expectations *per se*, but JQ can be used as operational tool, for widening the scope of interpretation of national indicators. Some countries are skeptical about comparison/benchmarking in general, on whether it would be useful to compare occupation numbers based on JQ, and national data series over an extended timeline is preferred. An expectation is the reduction of the administrative burden of regular reporting. WHO and OECD, Eurostat collected similar dataset and due to the JQ now the response rate is higher.
- **Potential utilisation of the JQ**: JQ provides a general insight to the HWF of a country, the international comparison is an additional feature. JQ provides primarily an overall picture about the efficiency of health system, as it builds on information from different sources. To interpret all the data categories independently is not the best option due to the strong interdependency between professions.
- **The JQ extension with mobility questions:** How valuable is data on reasons behind graduates leaving the country? The survey should provide an answer on this issue. There is motivation (qualitative data) to stay and motivation to leave, therefore the information is the most useful if data can be interlinked from source and host countries.
- **The "ideal" international dataset**: What would be the ideal international dataset that countries genuinely need? The features of different health systems may be highly different and the ideal dataset should include information on these differences. An ideal dataset would also include categories on cross border activity of HWF: information on doctors moving abroad and those who treat foreign patients.

Group 2: JQ categories/Qualification vs. Occupation-based data/Headcount vs. FTE

Facilitated by Edit Eke and Eszter Kovacs

How can countries help each other and benefit from each other's knowledge/ experiences? How member states could be supported at international and EU level?

- Recommendation: The identification of smaller gaps, and international experience could support countries and countries' national Focal Points. Awareness raising about the JQ is an important factor. While data collection should be optimised, countries failing on this should be helped out. Data sources are available at international level, however, the registrations and databases have to be interconnected, merged and integrated to reach adequate outcome.
- Countries, possibly in regional/cultural clusters, could exchange their experiences, best practices, and common data-problems.
- **JQ issues.** Finding the right data sources for reporting frequently raises problems. JQ could serve monitoring purposes. Better information flow at EU level and support awareness raising also towards national decision makers could help. Recommendations could be provided to MS level in order to strengthen the efforts to improve national data sources and to meet the definitions --- clustering countries together having similar problems in data reporting?! Some new, intended data collections could be tested on pilot countries.
- **Motivation:** Revision of NFPs could support the reporting process as well, namely, competent organisation should be elected to this position, extra awareness raising and encouraging of NFPs is needed. No Focal Point (often one person) but Focal Groups should promote and merge existing national level data. Obligatory data reporting might ensure pressure for reporting?!
- **Process optimisation:** Different organisations (stakeholders in data collection and data flow) do not know each other, do not sit and work together. JA can raise awareness on that (there are already some good examples, initiatives).
- **Being aware of and using already existing data sources:** Better information flow at national level can be based on an proper connection of national databases: registries, tax, survey, etc data sources should be linked together, BEFORE creating new databases. Use what you have the very best first.

Group 3: Professions/skills & competences/nurses

Facilitated by Reka Kovacs and Zoltan Cserhati

Member States were asked to focus on possible recommendation based on the key issues covered by the morning discussion. The key messages of the debate are the followings:

- **Comparability** is wished to be reached, however definitions are not clear enough. *EU level definitions should be built on Directive 2005/36/EC*, which would have a clear added value. At the same time occupation *(ISCO) is also important* for comparability, as comparison of tasks is important even if it is very difficult to do it at European level. The question is, whether these *two aspects could be brought together.* Clear difference has to be ensured at the same time between *qualification and occupation based data.* Comparison is hindered by the differences of health systems.
- **Definitions** from 2005/36/EC and its Annexes could serve as the fundament; the countries themselves could go further in a deeper analysis on the basis of data collected at EU-level. *Reporting could be made according to the comparison made by the Directive's Annexes, which should be improved and nurses could be added.*
- DG EMPL's work on ***ESCO*** has also to be taken into account as a *common European basis*, which is inevitable for the good functioning of EU labour market. This project has three pillars, one of them is examining **skills and competencies.** As sometimes e.g. lower qualified nurses do the job of "2005/36/EC-nurses", data gaps are caused in reporting, so such kind of **mapping exercise of** what professionals really do has a real added value.
- ***Eurostat*** data collection should also *build on the European dimension.*
- **Nurses definitions** have been reported as the most problematic, as national level definitions vary to a great extent, and matching them with international data collections' requirements is challenging. It can be assumed that less, but better categories are necessary in order to have a common basic level of understanding and facilitate easier and better reporting. *Nurse under 36/2005/EC and a limited number of other nurse categories should be defined*.
- **Involvement** *of professionals* on national and EU level into data collection, making them responsible *is inevitable* in order to benefit from better data quality.
- **Trends** behind the data are relevant for **policy makers**, and not absolute data. When talking about possible improvement of data collection, this always has to be considered. For planners information on mobility could be useful, which is not yet the content of JQ.
- ***Practising*** *and* ***professionally active*** *categories could also have an EU level understanding,* EU-level definition. Definition for „active" could take into account e.g. patient contacts/year, or nurses could be considered as active for example on the basis of minimum hours worked/week. Common estimation methods could support the process.
- Considering **elderly care nurses** would most probably be useful and needed as overlaps might distort our picture of nursing staff otherwise.

15.15. **Plenary feedback** - Lessons learnt from the afternoon sessions.

Each of the three groups presented the main findings of their discussion in plenary. In addition to statements already summarised above, participants underlined that while JQ data is not a set of indicators, they may serve as a basis for evidence based HWF monitoring. For international comparison, countries should be aware of the features of health systems of other countries, their cross border activities, as well as mobility data

concerning HWF working abroad and HWF working in their home countries but treating foreign patients. Countries should have an agreement on what *monitoring* as an activity should include and focus on, how it is to be carried out.

15.45. Coffee break

16.00. **A special meeting of the Advisory Committee on Medical Manpower Planning of the Netherlands**. Plenary session- stakeholder debate. Key topics for the discussion:

- Measuring the *practicing* category for GPs in the Netherlands
- Interpreting and applying international mobility data in HWF planning

Both discussions are based on **presentations** also available online

18.00. Participants meet for **Dinner & Social evening** Address: Stadskasteel Ouaden, Oudegracht 99, 3511 AE Utrecht.

7 March, Friday

9.00 **Feedback and summary of the 1st day - Closure of activity on terminology**
Facilitated by Zoltan Aszalos

Participants, based on an interview sheet, asked the following questions from each other:

- Question 1. What have you learnt from the Terminology Activity you can apply in your work? (Workshops, Survey, Discussion, Pre-reading materials)
- Question 2. Where do you see the opportunity for the fastest progress in improving HWF data supply for the JQ? What recommendation do you have? (national or international level)

Following this exercise, groups of 3 were formed and each group formulated one sentence as a reflection on the Terminology activity. These final statements concentrated around the following themes:

- Member States see the JQ as an opportunity to compare national data at an international level.
- Member States expect that organisations running the JQ data collection provide transparency concerning its purposes.
- Data collection at national level should be also optimised, registrations and databases have to be interconnected, merged and integrated to reach the objective of the JQ data collection.
- Policymakers should be supplied with the most relevant data to be able to look at causes behind the data.

MOBILITY Section of the Workshop

9.50. **Presentation**: **Critical identified items on mobility** - Edit Eke, Edmond Girasek WP4

10.30. **Mobility Session Introduction**

Discussion - questions & focuses
1.**WHY?** Follow up mobility - What is it for? Why to collect mobility data?
2.**WHAT?** HWF Mobility – terminology issues- what are the definitions/ interpretations/ indicators? Do we have a consensus?
3.**HOW?** What data are available, what data/info can be considered „minimal" to offer a view on mobility (meet the minimum mobility information requirement) at national & international level? How data can/ should be collected? What are the main challenges, and obstacles? How international flow of mobility data should be supported?

10:35 **Mobility Session Part 1.** Facilitated discussion in plenary session based on predefined topics and questions. *Objective: Exploration and exchange of information.*

WHY? The most important question is to clarify WHY mobility should be monitored. The objective underlines the answer hence ~~-~~it serves as an important tool in HWF planning, and in light of this forecast inputs about mobility, are still comprise of great need. Mobility trend data are of equal importance, along with stock and flow of foreign HWF at ~~a~~ given time points.

Since, it is a macroeconomic issue on international level, inter-country agreements should be facilitated such as Bilateral Agreements (BLAs), and international statistics reports taking into consideration border-effects, and education~~.~~ and the fact that mobility factors may be increased by dynamic recruiting. In terms of implementation, the structure is more feasible in Commission Feasibility Study, rather than a linear report format.

Burning issues, crucial points discussed

- FTE and its relation to planning process, since a mobile health worker ~~can~~ may still work part-time (or even full-time) at his/her home country. How it can be monitored and linked to HWF planning?
- Periods spent in another country in course of graduate and postgraduate training.
- WP4 and WP5 work connection - Minimum Mobility Information Requirements in the Minimum Planning Data Requirements (MPDR, WP5 D051) - foreign trained/ foreign born/ foreign nationality - which one and what else should be considered?
- The main issues on the approaches to "WHY" vary according to different levels
    - Policy level/ top level:
        - When used for planning purposes, the aim is to see the trends,

and intentions (to work abroad), and obtain time series analysis. It is important to provide information to health professionals as well.
    - How to manage education budget if after graduation part of the graduated HWF is being employed in another country?
- Key issue: the "WHY"s at national, regional and at EU-level.
- At macroeconomic level it is crucial to be able to forecast not just see the trends.

WHAT?
Different types of mobility exist, and it is very important to be aware of the types of mobility. Registration of the applications for recognition, and following foreign HWF professional activities could serve as the basis to identify the types of mobility, however. However, these are not sufficient enough to provide even partial information on all different types of mobility. It should be noted that the answer to "WHAT" (what type of mobility is considered as important) influences the "WHY" and "HOW".

Different definitions/ indicators
OECD, UEMS (European Union of Medical Specialists), other international organisations may use different definitions/ categories.
The role of professional categories
Professional HWF category and connecting "status", power at national and international level matters and links to the "WHY".

HOW? Existing surveys, data collections, researches, projects should be listed to include within the mobility data.

Existing databases, tools: Regarding the recognition of qualifications, **IMI** at present is not a good mobility information source, hence it has no special interest in collection of data. In future the planned **EU professional card** system could be of use if it was mandatory. **WHO** uses a–nationality based approach (related risk: if trained abroad and going back home is not counted as mobility).

10.50. **Coffee Break**

11.10. **Plenary discussion and consensus** on six different perspectives for the group discussions, according to which each group discusses HWF mobility issues following the line of the predefined questions and focuses. Participants are free to choose their group, each is led by a voluntary facilitator. WP4 team is represented by one member in each group.

Level	identified perspective, crucial point	group number & facilitator	identified perspective, crucial point	group number & facilitator
"Top"	Comparable EU data on HWF mobility	G1 - Zoltán Aszalós	EU & the world	G2 - Caroline Hager
Macro	Massive HWF emigration - Education for other countries , viewpoint of the "source countries"	G3 - Heinz Rothgang	Significant HWF immigration Rely on other countries, viewpoint of "target countries"	G4 - Giovanni Leonardi
Micro	Role of regulator and competent authorities, registries	G5 - Michel Van Hoegaerden	Health professional organisations	G6 - Zoltán Cserháti

11.20 **Mobility Session Part 2.** Group sessions in 6 groups. Objective: Explore and discuss HWF mobility issues from the identified perspective of the group, proceeding towards input and initial suggestions regarding potential policy recommendations as, and if apply - what EU level policy steps could be considered with what goals and reasoning?

1. Top-level; Comparable EU data on HWF mobility (The group focused on JQ options.)
Zoltán Aszalós, Pilar Carbajo Arias, Reijo Ailasmaa, Matt Edwards, Vera Beleza, Silla-Sigurlaug Hauksdottir, Radeva Nikolina

- Aim of the JQ mobility data collection: comparable EU data to monitor and facilitate the implementation of the WHO Code of Practice.
- Focus on the registered HWF and those currently in education.
  - Primarily data on the country of education of the HWF, and on the nationality of foreign professionals.
  - The number of international students and the ratio of international students to the number of national/ all students are also useful.
- Actual (real) mobility could be monitored by defining a methodology for the collection and dissemination of these data among EU countries such as 1) Focus on the data of the destination country can facilitate and enhance the efficiency of the collection of HWF data as the HWF inflow data of one country mean HWF outflow data to another (source) country. It would ensure separation of actual (real)mobility data from the proxy outflow data on intention to leave (can be collected in the source country).

2. Top-level; EU & the World

Réka Kovács, **Caroline Hager**, Linda Mans, Melanie Böckmann, Gabrielle Jacob, Aleksandra Kotowicz

Inward migration: from non-EU to EU countries

WHY: Information is needed

- immediately for healthcare provision,
- in medium term for investment into education and training.

Ethical recruitment is also an important issue. Information is necessary

- to see the impact on source countries, and
- for destination countries to support the integration of the foreign workforce.

WHAT: The group has agreed in that more discussion is needed on the "WHAT".

HOW: It is very important to know the driving factors–in the ministries responsible for immigration–as they are in the possession of the necessary data sources. The links between employment, immigration and health policies are very important, useful information ~~is~~ can be obtained from employment permits, and residence permits. Bilateral agreements in force may also serve as a very important source of information. There is also a general need for a greater extent of awareness-raising. According to the group consensus it should be part of the health ministries' responsibility to take the lead over other ministries (labour ministries or internal affairs ministries)

Outward migration: from EU to non-EU countries

The outward migration is a greater challenge for the Anglophone world, France, Spain, Portugal.

HOW: Through improving cooperation between destination and source countries, which can also result in extra burdens. Cooperation with destination countries to get these statistics could work by mutual reciprocity agreements between registries for example – which is yet unclear whether it is taking place or not, that would need further research. The work of WHO on the Code, and the OECD to improve the data available to monitor the WHO Code has to be emphasized, and the group also discussed the–statistical work that the International Organisation on Migration (IOM) can offer in this regard (collaborating partner of JA).

3. Macro-level; Massive HWF emigration - Education for other countries , viewpoint of the "source countries"

Edit Eke, Margrét Björk, Elitsa Ilieva, Miloslava Kovacova, Kristina Mickeviciute, **Heinz**

Rothgang, Pascale Steinberg

Key statements, issues to consider:

- HWF flows should be monitored, and the type of compensation scheme considered and evaluated (e.g. in training). Policy makers (EU level) should be convinced in case of unsustainable HWF emigration that some countries face.
    - How can this issue be tackled?
        - Individual level: students' fee/fine (e.g. repayment of training cost if leaving country of training)
        - EU level - society level: decision should be made whether to compensate the education system of the source countries. - ~~i~~t has to be explored/ researched further, as it can lead to support emigration if joining measures are not introduced next to it.
- What can data justify? Different types of data collection are needed for different purposes (it matters, if resource reallocation is considered such as in training or in another field). Data are key factors, therefore consensus should be reached on what data is necessary to be collected for monitoring regarding compensations scheme, and decisions to be made on what—incentives could result in—the obtainment of such data?
    - What kind of data and indicators should be used?
        - Data on students in training who leave to work in another country: number of all students, number of foreign students as compared to all students, time of training, cost of training, etc.
        - what happens next (after training)- what indicators could be used for follow-up?
- Experiences and lessons can help other countries, kind of education for them.

4. Macro-level; Significant HWF immigration Rely on other countries, viewpoint of "target countries"

Eszter Kovács, **Giovanni Leonardi**, Leon van Berkel, Gretel Dumont, Lieve Jorens.

WHY: In order to improve HWF planning and forecasting, destination countries need information on foreign health professionals working in their HWF and coming into their HWF.

What: It is important to distinguish short and long-term stay – short-term mobility cannot be tracked. ~~-~~The focus should be on regular entries~~,~~ ~~–~~effective contribution to HWF in health systems abroad, when professionals regularly practice abroad.

HOW: Long-term outflow can be tracked via the applications at the competent authorities and registration data, (and its comparison). This also provides data on medium term, intra EU level migration, Bilateral Agreements, and trainings abroad (student mobility).

Key issues to consider: Facilitate information flow of competent authorities, Bilateral Agreements

5. Micro-level, Role of regulator and competent authorities, registries

Michel van Hoegaerden, Edmond Girasek, Despana Andrioti, Mariane Cimino.

The perspective of the regulatory authorities on the collection of mobility data was discussed in this group

WHY? Regulatory authorities have the mission to ensure quality of care and patient safety. Therefore they require the following information from immigrant HWF:

- Competencies
  - Certified education/trainings – for the 5 sectoral professions automatic recognition may apply – and uncertified education
  - Previous experience – for the 5 sectoral professions, general system may apply if divergent from local curricula
  - Language skills (linked to the licensed to practice).
- Sanctions (+time) linked to professional activities

Competent authorities have even more data on nationally trained HWF. Their data should have the highest quality for usage into planning systems and international data collection. Major statement is that only the data used locally and frequently have a good quality.

An EU level registry or a data warehousing would facilitate the work of the national level regulatory authorities and enable easy EU reporting.

- Combined data on workload and employment (multi employers)
- Temporary mobility data (The group also stated that temporary work allowance process is not working properly , so nobody knows about this small percentage of the workforce used.)
- Various patient-right legislations & info on health professionals

Supported by EU, Competent national authorities should provide this registry with data, which would ensure that mobile HWF is monitored, from the perspective of ethical behavior, trainings undertaken, workload taken in various countries.

JA could support more interactions to help this international EU level data collection and sharing, taking into account that privacy legislation may need to be harmonized.

6. Micro-level; Health professional organisations

Zoltán Cserháti, Anna Paula Gouveia, Nina Hahtela, Donatello Testerini, Murtomaa Heikki, Sarada Das, Gabriela Valentová, Lesley Bell.

Representatives of nurses, doctors, dentist, pharmacists and chiropractors participated in the discussion.

WHY mobility data needs to be collected?

- quality of care is the main issue, satisfying health care needs;
- facilitate retention;
- impact on regulations for numerus clausus at education entry and its link with HWF mobility.

WHAT kind of data are of interest to individual health professionals?

- salaries;
- tax records, tax regulations;
- they are not specially interested in "number of mobile and migrant health workers".

Recommendation for data sources:

- competent authorities;
- professional chambers (if membership is mandatory - yearly fees are paid and registered);
- universities (career path monitoring systems);
- professional organisations (they are more motivated than regulatory bodies)

Required data:

- inflow data (recognition) and outflow data linked at EU level;
- emigrant nurses who do not work in the profession (CEE countries);
- difference between graduate and registered professionals (if LTP registry is not automatic);
- LTP-practicing difference (who recently left the practicing category)
- individual data (there is public access for certain data in several countries, exchange of publicly available data should be facilitated between countries);
- number of foreign students in training.

12.40. **Plenary feedback** from the group sessions

12.55. **Summary of the Mobility Sessions**, follow-up, next steps. Final comments, close of the sessions.

The Mobility session and group works bring up many aspects and issues due to high engagement in the discussions by all participants. We managed to address and tackle several issues that influence the realisation of reliable data collection and most importantly the achievement of the defined objectives of the data collection on mobility issues. Several items and directions have been explored that require further discussion, clarification and

research.

In summary,-the output of this session is that WP4 obtained a list of items and conclusions, out of which (after review) the most important priorities and directions will serve as the basis in the process of our further work on Mobility from which the WP4 workshop in October 2014 will be derived.

13.15. Lunch

14.10. **Presentation**:**Latest developments in the Joint Action** - Michel Van Hoegaerden, Programme Manager of the Joint Action

Michel Van Hoegaerden highlighted the main developments in the Joint Action. Briefly summarized the Bratislava Conference and addressed the next workshop in Florence, Italy, which will focus on the pilot projects run by WP5. In June 2014, the Executive Board will have its next meeting while Lisbon will host three workshops, one on the applicability of WHO code of practice organised by WP4, another workshop on the WP5 pilot projects, and a WP7 workshop. The year will close with a Conference in Rome, by when 3 main Joint Action deliverables will be already completed.

Michel called for frequent consultation of our web site where the programme is kept up to date.

14.20.-15.00 **Workshop closing** - closing round and next steps in WP4
Facilitated by Zoltan Aszalos

The Utrecht workshop has drawn a great number of participants, and has contributed to the sharing of ideas and practical insights concerning the Terminology and the Mobility Activity of WP4. The workshop has also contributed to the development of the professional relations between

As a feedback round, partners of Work Package 4., especially the Commission representatives, the NIVEL representatives, leaders of other WPs and WP4 team members shared the greatest challenges and best takeaways gained at the workshop.

The next steps of Work Package 4 are as follows:

- Activity 1. on Terminology/Data source gap analysis: The elaboration of the final deliverable of this activity starts after this workshop. The findings in the deliverable will also include the final recommendations on how to close the current gap in the supply of data to the JQ.
- Activity 2. on Mobility will build on its closing Budapest Workshop on 20-21 October 2014, with final deliverables due in March 2015.
- Activity 3. on HWF data gap analysis will begin with the Budapest Workshop in October 2014.

Proposed conclusions of inputs on TERMINOLOGY

1. The purposes of JQ data collection

Conclusion 1: Member States should be clearly communicated that **the HWF data collection of the Joint Questionnaire aims to be a source of international comparative HWF data for monitoring (and not planning) purposes**. The term "monitoring" is to be defined, as well as the usefulness and **policy relevance** of the JQ data from the perspective of the ultimate HWF data users: policy makers, HWF planners, professional organisations and researchers.

Conclusion 2. While structuring the scope of the international data collection schemes, international organisations should take into account that **the quality of data produced at national level highly depends on the resources and traditions of the national health systems**. Furthermore, new forms of incentives should be offered for Member States to develop data collection for the JQ purposes.

2. The scope and contents of the JQ data collection

Conclusion 3: There should be a **compromise between the quality and the quantity of data collected** by the JQ. While the collection of data of a wider scope may lead to low response rate and low quality data, narrowing the scope to match the data supplying potential of each country would decrease the collected data categories to a data pool of limited value.

While creating the balance in the scope of data to be collected, it should be taken into account that countries are characteristically interested in data from countries with a similar socio-economic situation and similarly developed data profile. **A two-gear data collection** may give an answer to this demand: while the current scope of overall data collection covers data categories that most countries are able to provide, a second gear of data collection would include advanced data categories.

Conclusion 4: With a consideration of the various deviations from the JQ definitions at national level, **a categorisation process considering aspects of the actual work carried out by different groups of HWF** (beyond qualifications) could result in a better approximation of data categories. This option of creating **functional definitions** (functional equivalents) / and proposals for more comparable categories, particularly as regards nurses, should be considered in the future. D.

3. Practical recommendations to improve data collection

Conclusion 5: **Best practices, working solutions should be presented on how national level data providers should work together to provide a transparent and reliable set of data to the JQ.** These best practices should take into consideration that the quality of the JQ data collection is dependent also on the Focal Points and their resources. These best practices should suggest solutions that enhance national level information flow based on the existing databases, registries, tax data, surveys, etc. before suggesting the setting up of new databases.

Conclusion 6: Those involved at national levels in the data supply to the JQ - the Focal Points as well as the relevant national competent authorities - should be able to receive **regular training on applying the ISCO-08 definitions to the national HWF categories and on any other definitions applied now and in the future by the JQ**. D

Conclusion 7: The Full Time Equivalent (FTE) is considered and accepted by most countries as a better indicator than headcount (HC) to monitor and especially to plan HWF. The large variety in the interpretation and calculation of FTE in the different MSs is to be recognised - with a consideration to legal background, the official working hours, etc. **Continued discussion on a common formula for FTE** at international level will facilitate the understanding of MSs on the contents of FTE-related data supplied by other MSs.

Conclusion 8: **Surveys - as alternatives to overall data collection schemes** - offer various solutions to collect information on HWF. Countries should find a balance between overall data collection and surveys in the light of data collection resources available and national HWF data requirements.

Proposed conclusions of inputs on MOBILITY

Conclusion 1. Identification and clarification of **the objective(s) of HWF mobility data collection (why) are critical, and influence the content of the data (what) and the way/method (how) of data collection.**
These objectives can differ at each level: international, EU and global level (top), national and regional level (macro-level), professional organisations, competent authorities, health

service providers, etc. (micro-level).
Why to collect, **what** to collect and **how** to collect **are mutually interconnected** and dependent questions that have to be addressed and answered BEFORE starting data collection and/or develop capacities for that. **Different purposes should be discussed and harmonised to the extent possible.**

Conclusion 2. There are **many types of HWF mobility**, far beyond the question of the indicators: foreign-born, foreign-trained, foreign-nationality. For instance, permanent/ temporary, commuting, for training, dual/ multiple employment type, etc. **That needs further exploration and evaluation regarding its significance from a defined viewpoint**. The data/indicators that could be used to monitor and follow must be identified and developed accordingly.

Conclusion 3. At international and EU level, **harmonisation of definitions and approaches on HWF mobility types, definitions and indicators is needed**. ECHI 65 indicator (Mobility of professionals) is to be developed further. **Harmonisation and consistency with other European and EU level definitions and indicators that relate to workforce mobility and migration is also needed**.
ECHI indicators:
http://www.healthindicators.eu/healthindicators/object_document/o5956n29063.html
EC European Migration Network, glossary
http://ec.europa.eu/dgs/home-affairs/what-we-do/networks/european_migration_network/docs/emn-glossary-en-version.pdf

Conclusion 4. Currently, besides inflow data that are followed in many countries, albeit by different data and indicators, **no real HWF mobility data are available** at country, regional and EU level.
Proximal data on outflow can be gained in some countries at the best.
International and EU legal and other tools should be developed and used to follow HWF mobility flow and see HWF mobility map at EU level. **For any country actual (real) outflow of national HWF could be verified and followed by getting feedback on their inflow to another country.** This is one of the most important issue for many countries and international professional organisations. **Legal framework and options are to be examined**, including the possible role of already existing ones and/or the ones that are under development currently.

Conclusion 5. Continuous, mutual **cooperation and coordination of all different stakeholders** is needed and crucial both at national and international level. Exploration to support that, and to ensure access to publicly available individual data to follow HWF mobility and activity is needed at EU level.

Conclusion 6. **Data and additional information** that are needed to be able **to evaluate HWF mobility data and indicators in a comprehensive and proper way** must be defined and explored further. For example the availability of practising HWF data, the role (and relating data) on dual/ multiple employment, the use/role of FTE, labour market contexts, etc.

Conclusion 7. As a long-term plan, with the involvement of national authorities, **an EU level registry or Data Warehouse on various information on mobile HWF** should be considered.

This registry would aggregate information such as workload (working hours added from different countries) as well as any records on ethical and professional behaviour. Harmonization of privacy rules on HWF data should therefore be enforced.

Conclusion 8. **Different status and interest advocacy power of the representatives of several HWF categories** must be considered in course of evaluation of any relating data/ information on HWF mobility. At the same time: there are **different patterns behind mobility of the different HWF professions** that must be seen to have proper evaluation of the phenomenon resulting in any measure to address and/or manage it.

Conclusion 9. **Ethical recruitment** of health workforce (WHO Code) must be included and considered in any HWF mobility issue. Practical implications must be considered and evaluated **from different perspectives**:

- country of origin-country of destination, EU-non-EU countries, between EU-member states, etc.
- health care provider organisations/ HC system of a given country - mobile/ migrant HWF to provide care in another country, etc.
- rely on foreign HWF - facing massive loss of HWF, etc.

Best practices should be followed and evaluated considering their use at EU level.

Conclusion 10. **The minimum mobility data/ information requirement in a minimum HWF planning data/ information set is an issue that needs to be discussed and clarified further.**

Conclusion 11. **HWF mobility related information** of previous and ongoing projects, studies, researches, pilots, etc., including the methodology must be evaluated, linked together and **use the results in further work,** both at international level and at national level as well with a consideration for **language barriers** in the latter case.