



MIGRACIONES PROFESIONALES LA-UE. OPORTUNIDADES PARA EL DESARROLLO COMPARTIDO

WORKFORCE PLANNING FOR DOCTORS AND NURSES IN SELECT EUROPEAN COUNTRIES: FRANCE, GERMANY, SPAIN, SWEDEN AND THE UK





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THE STUDY DESCRIBED in this report was prepared under the EC funded project, Migration of Health Professionals between Latin America and Europe: Analysis and generation of opportunities for shared development, MIGR/2008/152-804(5.2). This project is implemented by a consortium, composed of the Escuela Andaluza de Salud Pública, the Pan American Health Organization and a working group, coordinated by the Ministry of Health of Uruguay.

The goal of the study was to examine and describe how five selected EU countries plan their medical and nursing workforce. A particular attention was given to whether migratory flows of doctors and nurses are taken into consideration in workforce planning in these countries. The selected countries are France, Germany, Spain, Sweden and the United Kingdom. Given the limitations of resources and time available, the study was intended to 'scan of scene', rather than do an in-depth analysis.

The report starts by discussing briefly how the data were collected and what challenges were encountered in the process. Next, workforce planning and related issues are examined for each study country. A few Europe-wide initiatives, of relevance to the theme of the paper, are described at the end of the report before the concluding section.

THE DATA COLLECTION STARTED by searching the web for relevant documents, using multiple search words (i.e. health workforce planning, human resources for health planning, etc.). The data base collected by the Migration of Health Professionals project, which is housed at the EASP server, was also consulted.

Next, an e-mail was sent to a number of informants, soliciting their views regarding a set of questions about workforce planning (see Annex I). These individuals were known to be knowledgeable about the topic or their name had been suggested by another informant. Two of the 20 contacted individuals did not respond to the e-mail. Three particularly knowledgeable individuals were interviewed over the phone, following the initial e-mail contact.

THE FIRST CHALLENGE was the lack of a uniformly accepted definition of “workforce planning”. This meant that the web search produced a varied set of documents, many of limited relevance. The most useful documents were those received directly from the informants.

The second challenge had to do with the language in which the original documents were written, often placing constraints on an in-depth analysis of their contents.

The third major challenge was identifying the key individuals who would be most knowledgeable about health workforce planning in their country. A full identification of this would have required understanding how a particular country undertakes workforce planning, which organisations have key planning roles, who the concerned individuals are in these organisations and/or which researchers have examined the issues. Such an undertaking was beyond the resources available for this study. The individuals contacted are thus a “convenience sample”, rather than a representative one. The data obtained reflects the knowledge base of those contacted, leaving substantial information gaps and inconsistencies in the type of data received from the countries.

The fourth challenge was the definition of foreign doctors or nurses. Those trained in EU/EEC countries and those trained outside have different levels of access to a country and its labour market. The definition of a “foreign” health worker also varies between countries. It can mean a person trained in another country, a citizen of another country or someone born in another country.

FRANCE

Health services in the French health system are delivered through a public/private mix. Ambulatory care is provided mainly through office-based practices; 70% of general practitioners are in private practice. A universal health insurance scheme funds the health care costs, but 90% of the population also holds supplementary insurance.

Health professionals in France have complete freedom to choose where and how they practice. This freedom is combined with tight regulation and highly centralised authority.

PLANNING ORGANISATIONS AND THEIR ROLES

The ONDPS (L'Observatoire national de la démographie des professions de santé) was created by the Ministry of Health in 2003. It has three staff members and works in cooperation with Observatories of Health Professionals in each region. The national ONDPS:

- Collects, analyses and communicates objective information on health professionals and
- Undertakes research on working conditions, needs for health professionals and professional development.

A regional ONDPS has a part-time staff member.

Planning for the workforce of doctors takes place at the national level and covers both public and private sectors. The supply is regulated by the central government through a system of *numerus clausus*. *Numerus clausus* was substantially increased a few years ago due to a projected shortage of medical doctors. Prior to that, it had continually decreased the number of medical students. (Midwifery is also subject to *numerus clausus*.)

The number of training posts for specialist doctors each year is also a central level decision. Each October, the Directorate of Hospitalisation and Organisation of Care (DHOS) asks the Regional Departments of Health and Social Affairs

(DRASS) to solicit views on training needs for the following year. The regional ONDPS brings together local representatives of doctors, state authorities, sickness funds, hospitals and medical schools to make recommendations. They are based on the number of patients, population, planned infrastructure projects and the universities' training capacity. The regional diagnostic is sent to the national ONDPS. Guidelines for the desirable number of specialists are set in a national-level meeting of representatives from Ministries of Health, Education and Defence, universities, practicing professionals, students, citizens, hospitals and researchers. The ONDPS then makes national recommendations by specialty and region for five years, disseminated through an annual decree.

Workforce planning for nurses is more regionalised. Each region negotiates the numbers to be trained with public and private training schools in their region. Financing the training is also a regional level decision. The central level reviews and approves the number of training places.

The ONDPS is responsible for monitoring the implementation of workforce plans.

DATA SOURCES FOR WORKFORCE PLANNING

The data on the stock of medical doctors comes from two main sources: government and the Medical College. Government data base includes only those who graduate from university or work in the public sector. The Medical College also registers foreign medical graduates and thus maintains a more complete data base.

All nurses are registered by the government. Thus, the government data on nursing stock is more accurate, particularly since the Nursing College was created only a year ago. Recognition of qualifications is done at the regional level and the data then sent to the national level. National level data on qualifications is always somewhat out-of-date, e.g. only 2008 data were available in May 2010.

Data are available on annual number of graduates from national medical schools. However, data on the exit of doctors from the workforce due to retirement,

migration, etc. are poor or non-existent. The Medical College has data on foreign graduates entering the workforce, but not on those leaving employment. No data are available on either national or foreign doctors moving out of the country.

Data on nurses' entry and exit from the workforce are available, but with a delay. No data are available on nurses moving out of France.

WORKFORCE PLANNING METHODOLOGIES, PLANNING HORIZON AND COSTING

Methods for projecting the numbers of health professionals are said to have remained simplistic up to 2006. In more recent projection models, the trend of the total stock of doctors is linked mainly to the trend of the *numerus clausus*. Current projections (by specialty and region) go to 2030. The projections up to 2020 are considered relatively reliable. They are annually updated for the subsequent five years. No particular assumptions are made regarding migration. The workforce plans are not costed.

ROLE OF MIGRATION IN THE WORKFORCE

International recruitment does not play a major role in France. Most foreign doctors come from EU countries and are employed in hospitals. In 2006, 3% of foreign-trained doctors were estimated to come from outside the EU. The government does not expect a massive influx of foreign doctors to France in the near future. Migration is not yet taken into account in workforce projections because of the small numbers.

Few French doctors train outside France or seek employment abroad. A significant number of nurses have, however, been trained abroad.

The boxed text below presents the views of the French National Council, regarding doctors who come from outside the European Union.

The Position Expressed by the National Council on Foreign Doctors
In the OECD Working Paper no. 36:

Foreign health professionals have contributed to easing the deficit of doctors in French hospitals, a situation that stems partially from inadequate recruitment policies but is also influenced by the inability of institutions and hospitals to attract and retain professionals.

Foreign doctors have made it possible to meet the population's demand for care in centers close to their places of residence. In fact, in the year 2000 there were 3,330 candidates for 2,485 slots during the first competitive exam for hospital staff. Of the 1,974 professionals who joined the ranks, 872 were praticiens adjoints contractuels (PAC).

The fact that French citizens form a significant cohort of practicing doctors (either through adoption or naturalization) should not be overlooked; they represent 44% of the PAC and 27% of fully licensed doctors. Nonetheless, many practicing doctors have managed to avoid having to comply with key admissions criteria (*numeros clausus*), including, occasionally, a qualifying exam known as the PCEMI (*première année du premier cycle des études de médecine*).

Medical professionals reject continuing such recruitment policies in the future for the following reasons:

- It is difficult to evaluate foreigners' capacities; it is not always possible to compare their curricular contents and diplomas within the context of European universities. The overriding goal should be not to lower the quality of care.
- A coherent recruitment policy of doctors who are going to practice in France is indispensable. From an ethical perspective it doesn't seem justifiable for our country to contribute to depriving other states of their elite professionals, taking doctors from their hospitals and communities. On the economic level, the French university system cannot survive at the expense of foreign medical schools. Only professionally competent doctors who have been granted political asylum should be allowed to benefit from a special authorization to practice.

- Recruited on a temporary basis, these doctors can continue to practice for extended periods of time, as regulations permit, eventually becoming eligible to collect a retirement pension. In effect, such policies create a parallel route through which foreign workers can become permanent members of the workforce. Given the circumstances, it would seem reasonable that such parallel access routes be eliminated and that a professional's incorporation into the workforce should be based on his or her ability to pass a competitive medical exam, following completion of the PCMI.

Germany is a federal country in which states (länder) are responsible for health services, medical education and supervision of professional associations. Multiple regional physicians' associations (23 in 2006) negotiate collective contracts with sickness funds (300 in 2006). Health insurance through the sickness funds is statutory. Access to a profession of one's choice is considered a right.

PLANNING ORGANISATIONS AND THEIR ROLES

There is no national system of health workforce planning. Undergraduate medical education is regulated at the federal level, while medical colleges have virtual autonomy in regulating training of specialist doctors. States register health professionals and regulate and finance education. A law regulates the number of doctors that the health insurance system contracts with. This is intended to prevent an oversupply in urban areas.

No workforce planning or monitoring system exists for nursing professionals. There is no Nursing College or equivalent to register, monitor and supervise the nursing workforce.

DATA SOURCES FOR WORKFORCE PLANNING

No integrated data base exists for the health workforce. For example, there is no national register of nurses and thus no data on geographic distribution or specialisation within nursing. Such data that are available on the workforce differ significantly according to source.

WORKFORCE PLANNING METHODOLOGIES, PLANNING HORIZON AND COSTING

The number of places available at medical schools determines the medical school intake. The numbers are negotiated between health policy makers and educators. This has led to an over-supply of physicians. More recently, the government

has started to regulate the number of posts for doctors, but not the number of medical students.

The need for doctors is reportedly calculated on the basis of their regional distribution in the mandatory health insurance system in 1990. The country is divided into 10 geographic categories. New practices not allowed to open in areas where the supply exceeds 110% of the number of doctors per population, who worked in that geographic category in 1990.

The 1993 Health Care Structure Law regulated the number of nurses based on standard nursing times. This regulation was applied between 1993 and 1996, but led to unexpected increases in staffing levels. It has since been discontinued.

A report on the development of long-term care insurance pointed out that qualified nurses will be in short supply in the future without appropriate action. Various specific planning initiatives are said to have followed from this report.

ROLE OF MIGRANTS IN THE WORKFORCE

Increasing numbers of doctors have migrated to Germany. Emigration was not considered significant in 2006, but subsequently Germany has exported doctors to neighbouring countries and England.

About a thousand trained nurses are from Asia and the former Yugoslavia. The Asian nurses, mainly from Korea and the Philippines were recruited in the 1960s and 1970s and those from former Yugoslavia in the 1980s. Some hospital trusts have privately recruited nurses from other countries, but this is not a large group. There is a grey market of non-trained individuals from Eastern countries, who are employed by families to care for dependent patients. The government's 2005 Green Card program for 10,000 foreign nurses was intended to solve the problem of illegal employment, but was reportedly a totally insufficient measure. Only a few German nurses work abroad; this trend has remained stable.

Spain devolved the responsibility for health care to 17 autonomous communities in January 2002. Funding is collected centrally and allocated to the autonomous communities on a per capita basis. Health workers are employees of the regional health services of these communities.

PLANNING ORGANISATIONS AND THEIR ROLES

The Ministry of Health and Social Policy (Ministerio de Sanidad y Política Social or MSPS) and the Ministry of Education regulate undergraduate and postgraduate training of medical professionals. Guidance on training is provided by the National Commission on Human Resources under the Law on the Cohesion and Quality of the Spanish Health Service. The National University Commission, which is accountable to the Ministry of Education, determines the number of university places. Medical school places were drastically reduced after 1979 because of rapidly rising numbers of doctors. In the last decade, however, Spain moved from a surplus to a shortage of doctors.

The MSPS, regional governments and the National Council for Specialists make a joint decision on the number of annual training slots for specialists. There are more openings than graduating medical students, because of the demand by hospitals of cheap labour. There is a single national entrance exam for specialist training.

Autonomous communities are responsible for planning the number and type of staff they require to run services and can afford to employ.

DATA SOURCES FOR WORKFORCE PLANNING

There are no national registries of doctors or nurses. Professional associations do hold information on members, but membership has not been obligatory since 2000. Accurate data on number of specialists is thus lacking. The MSPS and Ministry of Education have a register of awarded degrees, but inactive or deceased health professionals are not removed from the data base. It is now

recognised that such a registry of health professionals is needed in Spain and the MSPS intends to establish one in the coming years.

WORKFORCE PLANNING METHODOLOGIES, PLANNING HORIZON AND COSTING

Coordinated health workforce planning is lacking in Spain. In 2006, the MSPS commissioned a study on current and future needs of physicians by specialty to serve as a basis for planning. The study, recently updated, was the first one in Spain that included complete and detailed information of doctors who work in the public sector. The data included their specialty, age, sex and the Autonomous Community where they work. A simulation model for planning the stock of medical specialists, based on Systems Dynamics software, was used.

The simulation model follows a doctor's professional life cycle from entry into the medical school until retirement. Variables used to assess the needs per specialty included existing numerus clausus, number of training positions in each specialty, retirement age, attrition and mortality rates (by age-sex), emigration and immigration rates; population demographic profile, growth forecasts and normative standard of need (medical specialists per population) for each specialty. "Need" was estimated on the basis of market data. The future evolution of these needs was estimated using a Delphi technique with independent experts and staff of the Autonomous Communities. A second study into the need for doctors, recently conducted by a university in Madrid, emphasised the need to adjust workforce planning models to the changing health care context.

The MSPS is currently planning to:

- (1) update the study on current and future needs for doctors.
- (2) undertake a study on need for nurses, nurse specialists and nursing assistants.
- (3) establish a common system for health workforce planning. This system will include criteria for determining the need for and distribution of doctors, nurses and other professionals.

ROLE OF MIGRANTS IN THE WORKFORCE

Migration of doctors to Spain has increased in recent years. In the last five years, an average of 3,280 medical qualifications were homologised, mainly for doctors from Latin American countries.

Spanish specialist doctors are emigrating to nearby countries, though their migration was traditionally limited. The exact extent of migration from Spain is unknown. There is little emigration of nurses. In 2000, Spain and the UK signed an agreement to facilitate employment of Spanish doctors in the UK, but this agreement has not been continued.

The Swedish health system is decentralised to the county level. It is funded from national taxation.

PLANNING ORGANISATIONS AND THEIR ROLES

Responsibility for planning the Swedish health workforce lies with the counties. They are also indirectly responsible for planning the private workforce, because they arrange contracts with private health care companies for health delivery.

The Ministry of Health cannot instruct counties to increase or decrease their staff numbers. It can, however, influence staff numbers indirectly by funding training slots.

DATA SOURCES FOR WORKFORCE PLANNING

Various data sources are available:

1. National register of health professionals (HQSP): Data base of licenses and specialty certifications, not of individuals. Holds a complete record of all licenses/certificates of health and dental professionals. (Note that a person can have multiple licenses, e.g. a midwife can be licensed both as a nurse and as a midwife.)
2. Longitudinal Integration System for Medical Insurance and Labour Studies (LISA) is an individual-based database that integrates existing data files from the social, education and employment sectors.
3. Data on doctors trained outside EU/EEA and Switzerland who work under the Board's upgrading program are available from the National Board of Health and Welfare.
4. National Planning Support have data on immigration and emigration for both Swedish and foreign personnel by country of training. Immigration of both categories is available by the country of training, except for the specific country that a foreign nurse comes from outside the EU/EEA. Emigration for Swedish and foreign personnel is not specified by specific country of destination.

Data are based on all individuals registered in Sweden as having been trained or licensed as a health care worker. There is an interactive data base for data on age, sex, region, etc. for all employed personnel. In this data base, "employment" is defined as a minimum of one hour of employment in the month of November. Thus, the data base has no data on part-time workers.

Most individuals in the HOSP without a Swedish ID number are foreign-trained. Without an ID number, it is not possible to tell whether they are resident in Sweden or even alive. The Board intends to ensure in 2010 that the missing ID numbers of foreign doctors, who were employed by county councils in 2008, are entered into HOSP. This is to be done through a single connection between the HOSP code and the employee records of county councils and municipalities. The latter are included in the data base of the Swedish Association of Local Authorities and Regions. These changes are expected to lead to much better information on the working status of foreign doctors.

WORKFORCE PLANNING METHODOLOGIES, PLANNING HORIZON AND COSTING

The "National Planning Support" project prepares a projection of the supply of health care workers every three years. The data collected do not make it clear what methodology is used to prepare the projection. The projection includes international migration for doctors, but not for nurses. The next one will be published in autumn 2010.

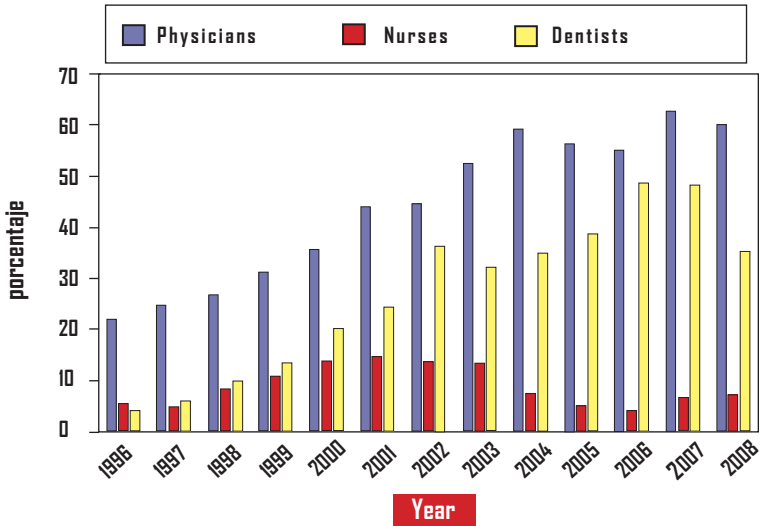
ROLE OF MIGRANTS IN THE WORKFORCE

Net immigration of doctors has increased in recent years. The first year when more foreign-trained than Swedish-trained doctors were licensed was 2003. Foreign trained staff are mainly trained in EU/EEA. Net migration of nurses is very limited. Altogether, 18% of doctors and 2.6% of both nurses and midwives, who work in the public sector, were foreign-trained in 2007.

Diagram 1 below shows the growth in the percentage of foreign-trained doctors, nurses and dentist between 1996 and 2006.

Diagram 1:

Overseas trained as a proportion of those licensed to practice per year for the period of 1996-2008



Fuente: Statistik över hälso- och sjukvårdspersonal 2008. Socialstyrelsen. Sweden. August 2009.

The UK consists of four countries, namely England, Scotland, Wales and Northern Ireland. Powers were devolved to them in 1998. Each of these countries has a legislative responsibility for health policy. There is a single, over-arching regulatory framework and a single National Health Service (NHS)-wide pay and career structure. England is the largest of the four countries and has the most developed planning systems, followed by Scotland.

PLANNING ORGANISATIONS AND THEIR ROLES

Workforce planning in the National Health Service (NHS) in England has been in a state of flux over the last ten years. Regional 'workforce development confederations' were superseded when workforce planning functions were given to the strategic health authorities (SHAs). The SHAs were later reduced from 28 to 10.

The programme for Modernising Medical Careers (MMC) started in 2002. Five years later, planned reforms were introduced. The revised recruitment processes and procedures, especially a national computerized matching system (Medical Training Application Service or MTAS), and the introduction of a new 'run-through' specialty training were very controversial. However, foreign-trained medical doctors, who could enter the UK with relative ease under the 'permit free training' scheme or the 'Highly Skilled Migrant Programme', found the new 'run-through' specialist training programme particularly appealing. They applied in much larger numbers than anticipated, overwhelming the system in 2007. In that year, some 10,000 foreign-trained graduates applied for the 23,247 training posts. Such large numbers greatly increased competition for national graduates.

About the same time, the House of Commons Health Committee had become concerned about substantial increases in NHS staff numbers, which were followed by funding deficits in many trusts. In 2006 it decided to undertake an inquiry into health workforce planning. The Committee found significant

failings in this area. Quoting its 2007 report, "There has been a disastrous failure of workforce planning. Little if any thought has been given to long term or strategic planning. There were, and are, too few people with the ability and skills to do the task. The situation has been exacerbated by constant reorganization including the establishment and abolition of Workforce Development Confederations within 3 years. The planning system remains poorly integrated and there is an appalling lack of coordination between workforce and financial planning. The health service, including the Department of Health, Strategic Health Authorities (SHAs), acute trusts and Primary Care Trusts (PCTs) has not made workforce planning a priority."

The Committee set out four significant challenges for NHS workforce planning in England:

- Increase workforce planning capacity at national, regional and local levels.
- Better integrate workforce planning across the workforce (medical and non- medical), across the NHS (financial and service) and across health care (NHS and non-NHS organisations).
- Deliver a more productive workforce.
- Deliver a more flexible workforce.

An independent review led by Professor Sir John Tooke in 2008 examined the framework and processes that underlay Modernising Medical Careers. His report (2008) also identified several workforce planning problems, such as limited and under-resourced workforce planning capacity; tensions and overlaps between local, SHA-level and national planning processes; and a lack of effective national oversight of SHA-level plans.

The UK government set out to reform the workforce planning system in response to the criticisms. The 2008 NHS Next Stage Review, led by Lord Darzi, focused on improving quality and clinical engagement in the NHS. A specific review of workforce and workforce planning was undertaken as part of this review. The broad vision of this High Quality Workforce: NHS next stage review included the following:

- Planning must be based on a clear, clinical vision built around patient pathways.
- PCTs, providers and SHAs must work together to ensure that workforce plans reflect future health requirements, and that workforce, activity and financial plans are aligned.
- Regional and national professional advisory bodies will offer coherent evidence-based clinical input, particularly on long-term developments and the effect on future workforce requirements.
- A Centre of Excellence (since renamed the Centre for Workforce Intelligence [CWI]) will be established as a major objective resource for the health and social care system.

The Darzi report states that “in a devolved NHS, to be successful, workforce planning must be devolved locally and assured nationally.” A bottom-up approach to NHS workforce planning and commissioning was set out. Responsibility at local level (NHS, foundation trust, independent sector provider and PCTs) was increased and these entities are now expected to ‘plan needs for workforce based on patients’ needs by pathway and model of care’. Health innovation and education clusters (HIECs) were established to facilitate greater workforce and service innovation. The SHAs remain responsible for workforce planning and education commissioning in their regions.

The CWI was expected to be operational by October 2009 but the contract was not signed until March 2010. The functions of the centre are to:

- Align the whole system around a shared endeavour to improve and use high-quality data, analysis and modelling,
- Undertake horizon-scanning for innovation and future service, workforce and labour market issues,
- Provide leadership for capability building in workforce planning, and
- Set standards for resources and tools.

The role for the Department of Health is to:

- Commission medical and dental undergraduate training,
- Secure and allocate funding for workforce development, education and training,
- Identify national risks through a strengthened, well informed bilateral process with SHAs, and
- Undertake long-term strategic workforce planning and policy development.

The NHS Next Stage Review workforce report set out a new structure for NHS workforce planning and gave key roles at SHA and national levels. Annex 2 outlines the key organizations and their roles and responsibilities in England currently. One of the key changes was re-establishing a national advisory mechanism on medical workforce education and training. It is called Medical Education England (MEE). (Scotland already had an equivalent body).

The MEE is expected to:

- Establish consensus on the future postgraduate training structure,
- Examine and advise on workforce plans at the national level,
- Scrutinise the education and training commissioning, which SHAs undertake at regional level, and
- Advise on curriculum development.

Medical workforce planning has always been done at the national level and some account has been taken of international flows. The MEE is the core of the planning process. It, together with the Royal Colleges and Department of Health, determines intakes to medical school, while government funds the training places.

The Nursing and Midwifery Council (NMC) maintains a single over-arching regulatory framework, but workforce of nurses is planned mostly at the regional level. International flows are much more difficult to take into account at this level. There has never been UK-wide nurse workforce planning or monitoring.

DATA SOURCES FOR WORKFORCE PLANNING

All NHS health professionals are registered at the UK level, and virtually all are employed by the NHS. Nearly all NHS trusts provide planning data through a new national Electronic Staff Record (ESR) system. The increasing number of non-NHS service providers and independent contractors, however, do not do so. Foundation trusts are also not obliged to provide workforce data to the national systems.

Royal Colleges have data on inflows and outflows of national doctors and on non-UK trained doctors in the workforce. Data on flows between the four UK countries are said to be poorer than data on inflows and outflows from the UK, e.g. Scottish data show that an individual left Scotland but not where s/he moved to.

The single UK-wide nursing council has reasonably good data on inflows and outflows. However, 25-30% of nurses work outside the NHS, resulting in more fragmented data bases.

WORKFORCE PLANNING METHODOLOGIES, PLANNING HORIZON AND COSTING

NHS workforce planning has generally focused on modelling future supply of a single profession. Nationally, the medical workforce and particularly the supply side, has received most attention. Modelling future workforce numbers has used the current workforce 'stock' numbers, adjusted by estimates of 'flows' from retirement (based on age) and new entrants (based on training numbers).

Projections made by individual professional groups have been the main source of estimates of future demand. The main emphasis has been of commissioning undergraduate training places, or securing sufficient postgraduate training posts. Such decisions have often been taken at the regional or national level.

The NHS Next Stage Review sets out an annual cycle of planning. It begins with PCTs and local councils commissioning services from service providers to meet the health needs of their local populations. These providers must demonstrate that they have integrated service and workforce plans, including proposals for training and development. PCTs produce combined service and workforce plans and send them to the SHAs. SHAs combine PCT plans into a single regional plan, and develop integrated service and workforce plans for their region. The SHA regional plans, covering all staff groups, are supposed to be sent via the Centre for Workforce Intelligence to the 'relevant national and regional professional advisory boards for their scrutiny and advice'.

In Scotland, the Government has changed its process of long-term projections for doctors in 2009. The new process replaced the five and ten year projections of previous planning cycles. It reflects different requirements due to the Reshaping of Medical Workforce project. In 2009, the Scottish NHS Boards were required to estimate clinical workforce requirements for each specialty area at a departmental level. These estimations were then used to model changes over the subsequent five years.

ROLE OF MIGRANTS IN THE WORKFORCE

Foreign-trained health workers form a substantial portion of the British health workforce. A third of doctors, for example, are foreign graduates. The UK has traditionally undertrained doctors and relied on the gap being filled by foreign-trained staff. Recruitment efforts of foreign doctors in the early 2000s focused on countries with a surplus, such as Spain at the time. They, however, also attracted doctors from other countries, e.g. South Africa. The Department of Health in England supported international recruitment of nurses as a way of achieving staffing growth. This resulted in a steep growth in the recruitment of nurses. Initially, the recruitment was portrayed as a short-term stopgap, but it soon became an integral part of recruitment to NHS in England. A Code of Practice on recruitment was eventually enacted but private sector was not bound by it.

Migration policy changed 2-3 years ago to a point based system. Points are given for age, financial position, skills and qualifications. Certain professional categories are classified as being in shortage and the list is reviewed every six months. Most health professional categories are not on the shortage list. There is now virtually no active international recruitment.

THE WHO EUROPEAN OBSERVATORY on Health Systems and Policies leads a consortium implementing the PROMeTHEUS project, which is funded with a grant from the EC. The project aims to answer the following six questions:

- What is the scale of health professional mobility in Europe?
- Which elements in countries, health systems and individuals encourage health professional mobility?
- What implications does mobility have for health systems, professionals and patients?
- Which policy responses have proved the most effective, and in what way?
- What are the future challenges with regards to health professional mobility?
- What can decision makers do to develop appropriate human resource policies, and to steer, stop, boost or facilitate health professional mobility?

The focus of the PROMeTHEUS project is mainly on doctors, nurses and dentists. The findings will be published as a book in summer 2010.

Belgium, which has the EU Presidency in the second half of 2010, has decided to make the European health workforce one of its priorities. It will organise a ministerial conference on this topic in September 2010. In preparation for the Belgian Presidency, the European Observatory organised three policy dialogues on "Investing in Europe's Health Workforce of Tomorrow: Scope for Innovation and Collaboration." They were held in Leuven, Belgium, in April 2010, and included ministry, academic and other stakeholder groups. One of the outcomes of these policy dialogues was a request by the participants for EC support to set up a European network of health workforce planners.

Registered Nurse Forecasting project (RN4CAST) is a research project, which is funded under the Seventh Framework Programme of the EC. It aims to refine typical workforce planning models with factors that take into account how features of work environment and qualification of the nursing workforce impact on nurse retention, productivity and patient outcomes.

“Carta Europea” is a proposed EC project, which is not yet finalised. It would include issuing EU doctors an ID card with a chip containing relevant personnel data. Officials in any other EU country could consult these data. This would allow accurate data on the number of EU doctors who have left their country to work in another EU country. The system would cover only those third-country-trained doctors, who have been authorised to practice by an EU country.

THIS STUDY CONFIRMS the observations that Dussault et al. made in their recent human resource policy summary. They point out that “the current state of most country databases is generally inadequate to allow a valid and reliable analysis of the baseline situation” and that the “vast majority of countries in the world do not have a structured human resources to health strategy.” Instead, most countries, including those in the EU, “opt for a reactive approach consisting in responding to problems when they become acute and politically sensitive.”

Workforce planning, where it happens, is still focused narrowly on individual categories of staff. Even in the UK, where workforce planning is considerably more advanced than in the other surveyed countries, the recently revised planning processes have not shifted toward integrated planning across professions and disciplines.

The surveyed countries vary considerably in regard to workforce planning methods and their level of sophistication, robustness of available data, participation of relevant actors and the extent to which flows of foreign-trained doctors are taken into account in planning. Most of these countries, however, face similar issues. These include an aging health workforce, increasing feminisation of doctors, reduced attractiveness of health careers, the European Working Time Directive, as well as changing health care needs. Issues, such as these, have raised workforce planning high on the list of priorities of health policy makers and managers both at the European level and in many countries. It is now receiving the necessary attention, but much remains to be done to ensure access to robust data, develop workforce planning skills and design and implement appropriate planning systems.

1. James Buchan, Professor, Faculty of Social Sciences and Health Care, Queen Margaret University, Scotland.
2. Martine Burdillat, Secrétaire Générale, Observatoire National de la Demographie des Professions de Sante, France.
3. Yann Bourgueil, Directeur de l'IRDES (Institut de recherche et documentation en économie de la santé), France.
4. Mario dal Poz, WHO/Geneva.
5. Christophe Debout, Ecole de Hautes Études de Santé Publique, France (no reply).
6. Norbert Dreesch, WHO/Geneva.
7. Josep Figueras, Head, European Observatory on Health Systems and Policies.
8. Alberto Infante, Ministerio de Sanidad y Política Social, Spain.
9. Mireille Kingma, Consultant, Nursing and Health Policy, International Council of Nurses.
10. Leif Lindberg, Senior Administrative Officer, Employer Policy Division, Swedish Association of Local Authorities and Regions, Sweden.
11. Cristina Mattsson Lundberg, International Strategist, Director General's office, Swedish National Institute of Public Health, Sweden.
12. Mario Millan, Deputy Manager, Department of Demography and Training of Health Workforce, Ministry of Health, France.
13. Maria Möllergren, International Affairs, National Board of Health and Welfare, Sweden.
14. Galina Perfliieva, Regional Adviser, Health Sector Human Resources, WHO/Euro (no reply).

15. François Petitjean, Responsable de Formation, Ecole des Hautes Etudes en Santé Publique, France.
16. Jeanine Pommier, Ecole des Hautes Etudes en Santé Publique, France.
17. Paul de Raeve, European Federation of Nursing Organisations.
18. Eva Szutkowska, International Officer, RN, Swedish Association of Health Professionals, Sweden.
19. Peter Tackenberg, Senior consultant, German Nurses Association, Germany.
20. Matthias Wismar, European Observatory on Health Systems and Policies.

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QUESTIONS REGARDING WORKFORCE PLANNING FOR DOCTORS AND NURSES IN SELECT EUROPEAN COUNTRIES (FRANCE, GERMANY, SPAIN, SWEDEN AND THE UK)

1. Who (what entities/organisations) participate in workforce planning for doctors and nurses at local, regional and/or national level?
2. What are the specific workforce planning roles/responsibilities of these entities/organisations?
3. In your opinion, is the workforce planning capacity adequate for the roles/responsibilities at the different planning levels?
4. What workforce planning methodologies (e.g. stock and flow analysis, scenario planning, etc.) are used? Do the methodologies vary by the planning level (local, regional or national)? Is the planning top down or bottom up?
5. What is the workforce-planning horizon at each planning level?
6. Are the workforce plans costed?
7. Do the workforce plans take into account the international migration of doctors and nurses to/from the country? If yes, how? Do they consider or include circular migration?
8. Are local, intermediate and central level workforce planning processes and plans integrated? If yes, how?
9. Who are the workforce planners accountable to at the different planning levels?

10. Is the execution of the workforce plans regularly monitored? If yes, by whom?
11. Are the requirements of both public and private health services (in the local area, region or country) taken into account in workforce planning? Or do the plans only cover the doctors and nurses required to run government health services?
12. Who (what entity or entities) collects and maintains data on current stocks of doctors and nurses? Are these data available separately for national and international graduates?
13. What data are available on the future stock (i.e. entry to and exit from the workforce) of national doctors and nurses? Who (what entity or entities) collects and maintains such data?
14. What data are available on future stock (i.e. entry to and exit from the workforce) of international doctors and nurses? Who (what entity or entities) collects and maintains such data?
15. What data are available on entry to and exit from the country by national and international doctors and nurses? Who (what entity or entities) collects and maintains such data?
16. In your opinion, are the above data on stocks and flows of national and international health workers accurate, appropriate and easily available for all who need them? If not, what data are particularly weak or non-existent?

CURRENT WORKFORCE PLANNING LANDSCAPE IN ENGLAND: KEY ORGANISATIONS, ROLES AND RESPONSIBILITIES¹

(a) Workforce Directorate Analysis Team (WDAT) is a small team within the Workforce Directorate at the Department of Health which:

- Provides analytical support on workforce capacity issues, including workforce planning,
- Acts as the technical liaison between the DoH and the NHS Workforce Review team (WRT),
- Helps specify and peer review research and analysis undertaken by the WRT,
- Collaborates in model development with partners, such as the WRT.

(b) WRT is a group of dedicated workforce planners, including information analysts, data modellers and professional advisers (e.g. on medical, nursing, etc.). It:

- Produces reliable data and analysis covering the whole registered workforce of the NHS in England.
- Identifies key workforce priorities for the NHS by developing and maintaining mutually beneficial relationships with Strategic Health Authorities (SHAs), professional bodies, academics, independent and third sector representatives.
- Develops technical models and tools and distributes them widely within NHS.
- Runs an induction course for workforce planners.

(c) Skills for health (SfH) is the Sector Skills Council (SSC) for health care. (There are 25 SSCs, licensed by the Secretary of State for Education and Skills).

- Develops and manages national health workforce competencies.
- Profiles the UK workforce.

¹ Adapted from Appendix A in Imison C, Buchan J and Xavier S. NHS workforce planning: Limitations and possibilities. King's Fund. London. 2009.

- Improves workforce skills.
- Influences education and training supply.
- Works with partners.

SfH is likely to develop into the single most important authority on labour market information and intelligence. It is developing a database of national workforce competences. The SfH includes the Workforce Projects Team (WPT), which offers workforce planning tools, techniques and approaches. It also runs an introduction to workforce planning course, a more advanced postgraduate qualification, workshops and masterclasses.

(d) Skills for Care (SfC) England

- Develops the National Minimum Data Set for Social Care.
- Supplies robust workforce data to employers to help develop new ways of working and delivering social care services.

(e) NHS Institute for Innovation and Improvement (NHS I²) provides a national co-ordinated focus to the biggest challenges of the NHS.

- Prioritises rapid development and dissemination of new technologies and ways of working.
- Offers learning opportunities, e.g. 'transformation leadership'.
- Manages the NHS Graduate Management Training Scheme.

(f) NHS Employers (NHSE)

- Represent trusts on workforce issues, such as pay and negotiations, employment policy and practice, recruitment, etc.
- Give employers a voice in policy-making on national workforce issues through the Social Partnership Forum.
- Support employers with workforce planning through advice and information.
- Provide general career support to NHS employees.

(g) NHS Information Centre for Health and Social Care (ICHSC)

- Acts as the hub of comparative national statistics and data on health and social care workforces.
- Verifies (with trusts) the information recorded in the Electronic Staff Record (ESR).
- Collects data on NHS staff numbers, earnings, turnover, vacancies and absence and prepares an annual workforce census.

(h) Professional bodies/associations

- Excellent sources of data, but roles and responsibilities vary by organisation.
- Majority of Royal Colleges perform some form of workforce data collection or planning function. Some produce their own workforce censuses (Royal College of Pathologists and Royal College of Physicians are particularly active).

The Action "Migration of Health Professionals between Latin America and Europe: Analysis and Generation of Shared Development", financed by the European Commission in the framework of the Thematic Programme of Cooperation with Third Countries in the Areas of Migration and Asylum (Contract Nr. MIGR/2008/152-804), is carried out by the Andalusian School of Public Health (EASP) in partnership with the Pan-American Health Organization (PAHO/WHO) and in collaboration with the Ministry of Public Health of the Oriental Republic of Uruguay, through its Working Group on Professional Migration in the Ibero-american Region whose Secretariat it holds.

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