European Observatory on Health Systems and Policies

Investing in Europe's health workforce of tomorrow: Scope for innovation and collaboration

Summary report of the three Policy Dialogues

Leuven, Belgium, 26-30 April 2010

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1. Background to Policy Dialogues

In April 2010, the European Observatory on Health Systems and Policies organised three Policy Dialogues on health workforce issues in the European Union and beyond, in response to a request from the European Commission. The meetings took place in Leuven, Belgium, from 26 to 30 April 2010 and aimed at sharing evidence and stimulating discussion among EU Member States, candidate and EFTA countries, academia and stakeholder groups. Discussions centred on several topics ranging from workforce forecasting and life-long learning to working conditions and feed-back mechanisms to health professionals

This meeting report summarises the contents and main outcomes of the presentations and country examples and provides key conclusions drawn from the participants' comments[1].

The Policy Dialogues were organized in follow up to the 2008 Green Paper on the European Workforce for Health and to prepare for a Ministerial Conference in September 2010 during the forthcoming Belgian EU Council Presidency.

The following two sections elaborate the context in which the three Policy Dialogues took place.

1.1. Follow-up to the Green paper

The European Union today is made up of 27 countries and 493 million citizens. Total expenditure on health across the EU Member States has been estimated to account for 8,2% of GDP (OECD 2006). Roughly 10% of the active EU workforce is engaged in the health sector in its widest sense, including physicians, nurses, pharmacists, administrative and supportive staff, researchers, teachers and trainees.

With government debt and deficits rising, there will be strong pressures on social expenditure. At the same time, health systems are facing major new challenges such as ageing populations, new health threats, rapid development of new technologies, raising expectations of citizens, which have implications for spending on healthcare. An efficient and effective health workforce is necessary to respond adequately to these challenges.

The WHO in its annual report in 2006 (The World Health Report 2006) turned the issue of the health workforce into a global debate, describing the challenges for the developing world. To raise the profile of the health workforce debate in Europe, the EU took the initiative by launching a consultation document, the **"Green paper on the European Workforce for Health"** in December 2008. The Green Paper focused on 9 topics: demography and the promotion of a sustainable health workforce, public health capacity, training, managing mobility of health workers within the EU, global migration of health workers, data to support decision-making, impact of new technology on

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[1] Further information about the policy dialogues, the detailed programme and presentations, background material, pictures and summary of the evaluation results are available at www.healthworkforce4Europe.eu

efficiency and effectiveness of health workforce, the role of health professional entrepreneurs in the workforce and lastly cohesion policy.

From December 2008 to April 2009, DG SANCO held an open consultation on the Green Paper. 197 different responses were received from various stakeholders: health professionals and carers, national and regional governments, academia, regulators, trade unions, individuals, service providers, patients, industry, insurers, EU bodies and international organisations. The Commission is committed to reflect on the outcomes and results from this consultation and to consider possible concrete actions in line with this.

In December 2009 the report of the consultation was published. The main conclusions of the report are that:

- An overwhelming majority of respondents recognise a that the health workforce 'crisis' has a European dimension. It must be further clarified however, which role it is exactly that the EU can play.
- The majority agrees that EU action would add value to the work being done by Member States
- Action needs to be cross-cutting: taking into account the development of human resources, education and training strategies, EU employment, social affairs, internal market and cohesion policies; policy initiatives relevant to health care should be allied with both the European and the national level (e.g. Social Agenda, Qualifications Directive, Working Time Directive, Roadmap for equality between women and men)

In the report of the consultation on the Green Paper four areas of action were defined:

1. Mapping the health needs of the future and assisting Member States in workforce planning

2. Mapping the skills and competences for the future and assisting Member States in training the workforce accordingly

3. Raising the attractiveness of health professions by improving working conditions

4. Addressing the challenges of global migration and mobility within the EU

Overview of follow-up activities to the 2008 EC Green paper on the European Health Workforce:

2008

- Adoption of the EC Green Paper

    - Public consultation of the EC Green Paper (Dec 2008-Apr 2009)

2009

- Three Policy Dialogues in 2009 on nurses and social care workers

    - Migration of nurses (February in Prague)

    - Planning for a well-skilled nursing workforce (May in Venice)

    - Changing roles of nurses and social care workers (November in Stockholm

- Publication of the report summarising input from the public consultation (Dec 2009)

2010

- Policy Dialogues on the health workforce in Europe, in Leuven, Belgium; (26-30 April 2010)

- Ministerial conference on health workforce under the Belgian EU Council Presidency (9-10 September 2010), adoption of council conclusions foreseen

2011

- Impact assessment

These actions fit into the ***EUROPE 2020 strategy for smart, sustainable and inclusive growth*** (http://ec.europa.eu). This post-Lisbon strategy is setting the political scene for the next years, building the foundations for future prosperity and well-being. There are several flagship initiatives in this strategy, of which two are of particular relevance for the health workforce debate:

- Flagship initiative 'An agenda for new skills and new jobs'

- Better matching supply and demand
- Creating attractive working conditions in the health area in order to improve attraction and retention of health workers
- Equipping the health workforce for the challenges of the future through acquisition and development of new skills throughout the life cycle and preparing the health workforce for potential new roles

- Flagship initiative 'Youth on the move'

- Improving the employability and mobility of young workers
- Creating mobility programmes for specialised young health professionals

The EC presented several policy options to the participants of the Policy Dialogue for further discussion and consideration:

1. Strengthened cooperation with Member States and stakeholders
    a. policy dialogues on the European health workforce with Member States and main stakeholders
    b. joint action under the Health Programme on workforce planning and exchange of good practice, to pilot the concept of a common workforce planning and provide evidence of its usefulness
2. Council Conclusions on workforce by one of the incoming Presidencies to explore the common ground for action at EU level and to invite the Commission to take action in specific areas
3. Commission Communication or action plan in 2012, providing a cross-cutting framework of relevant policies and key actions to be implemented by the European Union.
4. Setting up of a European 'Observatory function' on workforce trends in order to monitor workforce trends, forecast health needs, assist the Member States in workforce planning, map skills and competences or inform about training possibilities under the EU programmes.

1.2. Preparing for the Belgian EU Presidency

Belgium has taken over the EU Council Presidency from Spain in the second half of 2010, preceding Hungary, which will be at the helm of the EU during the first six months of 2011 (Trio Presidency). With the EU Council Presidency comes the opportunity to play a key role in organizing and stimulating European activities. Belgium has signalled its intention to include health workforce issues among their key political priorities.

The Belgian EU Presidency is planning a Ministerial conference on health workforce (La Hulpe, 9-10 September 2010). The theme of this conference will be *"Investing in Europe's health workforce of tomorrow: scope for innovation and collaboration"*. The conference will explore the scope for innovative and collaborative approaches. Priorities have been identified:

- How can we improve forecasting future health workforce needs?
- How to create the best conditions for adapting skills to new needs and for life-long learning?
- How to create an attractive and supportive working environment for health professionals?
- How can audit of and feedback mechanisms for health professionals improve the quality and safety of health care?

The conference is expected to lead to Council conclusions in these fields, initiating or supporting action at EU level.

To prepare for this conference, the Belgian Ministry of Health commissioned the European Observatory on Health systems and Policies to produce a series of policy summaries and briefs that

will gather evidence on specific aspects and raise policy options in this field. The following products have been commissioned:

- A policy summary on forecasting future health workforce needs
  "Assessing future health workforce needs.",

- A policy brief on adapting skills and redistribution of tasks through education and training
  "How to create the best conditions for adapting skills to new needs and for life-long learning?",

- A policy brief on attractive and supportive working environments
  "How to create an attractive and supportive working environment for health professionals?",

- A policy brief on audit and feedback mechanisms for monitoring and managing health professionals' quality and safety performance
  "How can audit of and feedback mechanisms for health professionals improve the quality and safety of health care?"

The policy summary is broader in scope than the briefs; it provides a more generic overview, while the policy briefs focus on more specific questions.

The Policy Dialogues were organized by the European Commission's Directorate General of Health and Consumers together with the Observatory in order to follow up the consultation on the Green Paper on the European Workforce for Health and to prepare the ministerial conference.

1.3. Objectives of the Policy Dialogues

The Policy Dialogues' objectives were twofold. First, to share country experiences and evidence on the health workforce situation at national, regional and European levels. They aimed to identify good practice in the four key topics of the workshops, forecasting mechanisms, life-long learning, working environments and feed-back mechanisms to health professionals. Second, they served as an informal platform for discussion on possible EU action in the field which could feed into the Belgian EU Presidency's work.

The draft policy summary and briefs mentioned above were tabled in these policy dialogues in order to initiate reflections and pave the way for the Ministerial Conference, which in its turn should create the momentum and produce specific policy options which can be translated into Council conclusions.

More specifically, these Policy Dialogues aimed at

- Addressing the main outcomes of the public consultation;
- Presenting the focus and objectives of the ministerial conference;
- Testing the validity of the evidence gathered and policy options suggested in the policy summary and briefs and identifying possible gaps in the analysis;

- Promoting best practice examples of any innovative and collaborative approaches and analyzing them in terms of their potential for replication;
- Exploring the scope for EU action in these fields

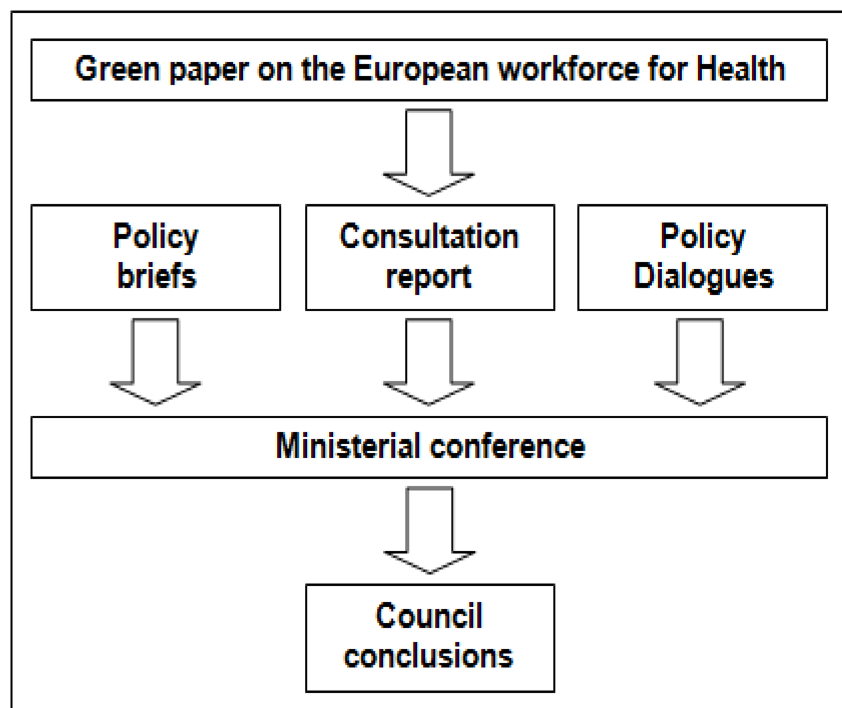
The structure of the Policy Dialogues followed the structure of the four Belgian priorities. Each strand was introduced by the draft policy summary and briefs.

Best practice examples of innovative and collaborative approaches were discussed. The EU scope of action was explored. Participants received the draft of the policy summary and briefs that had been prepared for the Belgian EU Presidency Ministerial Conference one week in advance of the Policy Dialogues. The detailed programme of Policy Dialogues is enclosed in appendix 1.

Three policy dialogues were organized using the same format, but each one composed of a different mix of countries and stakeholder groups. In order to create an atmosphere for lively debate, the number of participants in each policy dialogue was restricted to around 40 people. In total 126 participants attended the Policy Dialogues.

The policy dialogues gathered delegates from Member States, selected candidate countries and European Economic Area countries as well as European stakeholder organizations. Overall, three representatives from each EU Member State were invited including a representative from the Ministry of Health, a stakeholder representative (e.g. a professional organization or a provider association) and a leading academic in the area of health workforce or health system research.

The mix of countries for each policy dialogue reflected the diversity of health systems in Europe characterized by differences in country size, accession date and type of health system. This ensured a rich perspective on the issue from all angles and countries. Participants came from 25 countries including 19 EU Member States: Austria, Belgium, Croatia, Czech Republic, Estonia, Finland, Former Yugoslav Republic of Macedonia, France, Germany, Hungary, Iceland, Ireland, Italy, Latvia, Lithuania, Malta, Norway, Poland, Slovenia, Spain Sweden, Switzerland, The Netherlands, Turkey, UK.



Country coverage per Policy Dialogue:

- Policy Dialogue, Group 1: Belgium, Croatia, Latvia, Poland, Slovenia, Switzerland, United Kingdom
- Policy Dialogue, Group 2: Belgium, Czech Republic, Finland, Germany, Iceland, Italy, Lithuania, Malta, Sweden, The Netherlands, Turkey
- Policy Dialogue, Group 3: Austria, Belgium, Estonia, Former Yugoslav Republic of Macedonia, France, Hungary, Ireland, Norway, Spain

Moreover, participants from 14 international organizations participated in the meetings: European Hospital and Healthcare Federation (HOPE), Association International de Mutualité (AIM), Standing Committee of European Doctors (CPME), European Federation of Nurses Associations (EFN), WHO - Regional Office for Europe (WHO-EURO), European Health Management Association (EHMA), European Union of General Practitioners/ Family Physicians (UEMO), European Council for Classical Homeopathy (ECCH), European Council of Nursing Regulators (FEPI), European Hospital and Health care Employers' Association (HOSPEEM), European Federation of Nurse Educators (FINE), European Social Insurance Partners (ESIP), Health Professionals Crossing Borders (HCPB), Pharmaceutical Group of European Union (PGEU).

All three health policy dialogues were attended by the representatives of the Belgian Ministry of Health, DG SANCO and DG INFSO, European Commission, European Observatory on Health Systems and Policies, experts, facilitators, authors and presenters of the policy briefs.

The participants' lists are enclosed in appendix 2.

The Policy Dialogues took place during the week of 26-30 April 2010 and were hosted by the Belgian Ministry of Health and the University of Leuven in the nice setting of the University's Grand Béguinage. Each of the Policy Dialogues took one and a half days. Chatham House Rules have been used for discussion and reporting. Throughout the Policy Dialogues, discussions were organised in three rounds: first, the draft policy briefs and summary were presented to the participants who then were invited to provide feed-back. Second, participants were invited to share country experiences and third, to discuss potential action and added value of EU activities in the respective area.

2. Key findings and conclusions of the three Policy Dialogues

2.1. Assessing future health workforce needs

The European Commission, DG SANCO, presented the contents and objectives of the Green Paper, the policy process to date and the results from the public consultation. Among other issues, DG SANCO presented a figure (table 1) for what they called a *shortage* of health professionals, in particular specialist doctors and nurses, now and in the future. The Commission estimates the gap in supply of human resources in health by 2020 to be approximately 1,000,000 health workers. This means that almost 15% of the care for the EU population will not be covered. There are of course several possible scenarios to come to these figures. Other scenarios could slightly increase or decrease the presented figures.

Table 1: Estimate of the shortage of health professionals in 2020 (based on DG SANCO own calculations)

Health professionals or other health workers	Estimated shortage by 2020	Estimated percentage of care not covered
Physicians	230.000	13.5%
Dentists, pharmacists and physiotherapists	150.000	13.5%
Nurses	590.000	14.0%
Total	970.000	13.8%

Source: DG SANCO, 2010

2.2. Policy summary on forecasting future health workforce needs

Gilles Dussault, James Buchan, Walter Sermeus and Zilvinas Padaiga

This policy summary supports a definitive requirement for needs assessment for future health workers as a foundation on which broader health workforce planning should be based. It is considered to be a very complex and challenging task. Health workforce planners are experiencing fundamental methodological issues: lack of sound, up-to-date and accessible data, uncertainty on definitions of health professions as well as on health labour market indicators terminology, and a lack of comprehensive integrated approaches towards health workforce planning. Apart from these methodological issues remain many other questions that health workforce planners must address: (1) Estimating future needs and demand (e.g. How will technology and organizational changes influence demand?) (2) How will the supply and labour market evolve? (e.g. What will be the preferences and behaviours of providers, in terms of type and intensity of activity) (3) Policy/political: vision, stakeholders, continuity. It is important to get started: What are your service objectives? What is the present situation of the health workforce? What are trends which will affect health workforce (HW) needs? What do stakeholders say?

To address these challenges, there is a need for agreement on certain premises. First, human and other resources needs should be aligned to service needs and objectives, which themselves are derived from health needs and objectives. Forecasting in terms of expectations of the future health workforce thus starts by defining what sort of health services are needed. These needs depend on what is expected from a performing workforce. A performing workforce could be defined as one which covers all health needs, meeting all quality standards, at a high productivity level, for all subgroups of the population and to all geographical regions of a country. This is a straightforward translation of the ideal for a country's health workforce, which is to have the right number of health workers, with the right skills, in the right place, with the right attitudes and commitment, doing the right work effectively and efficiently, at the right cost, with the right productivity. A last premise is that a sound understanding of the dynamics of the health labour market (e.g. migration within or between sectors, retention, and attraction) is a prerequisite to achieving accurate forecasts of future needs.

Four main approaches have been used in the past to estimate future needs: (1) Health worker to population ratio approach, (2) Service-target approach, (3) Utilization and demand approach, (4) Health and service needs approach. Most countries use the simplest approach as a ratio of the number of healthcare workers to population. The most valuable, but very challenging approach that requires more information is the health and service needs approach.

Some important lessons were derived from the literature search on the topic of assessing future needs such as the needs for data on numbers, skill-mix, competences, working conditions, standards for quality of care to move the debate away from opinions and professional interest. A need for quantitative models and tools is identified, but this is no substitute for judgment. There is no agreement on planning horizon lengths, or than the longer the horizon, the higher the risks of imprecise forecasting. A ten-year planning horizon seems reasonable. Forecasting future needs is difficult when decentralized, since needs vary however at the local level. A good strategy is to have a mix of bottom-up and top-down forecasting, engaging stakeholders at both the national and the EU level. An integrative approach valuing the interactions between health workers is required.

2.3. Country experiences

Most countries want to improve their health workforce planning. Different strategies are in place, from very sophisticated to basic demographic planning. There are some examples of good practice that may inspire other countries. Country experiences on political or technical aspects of health workforce planning are illustrated here.

2.3.1. Croatia

Croatia has 76,932 workers in the healthcare system of which 58,682 healthcare professionals (and associates) (51,000 full-time and 7,682 part-time) and 18,250 administration and technical staff. There are 12,669 medical doctors (284 / 100000 inhabitants), 3,455 dentists (76 / 100000 inhabitants), 2,760 pharmacists (62 / 100000 inhabitants), and 32,838 nurses/technicians (538 / 100000 inhabitants). The workforce per population ratio is well-below the EU-level average, except

for dentists. Therefore, three main priorities in the planning of healthcare professionals for Croatia were defined:

- assessment of current situation
- optimum distribution of healthcare professionals according to movements in total number of population, epidemiological profile and healthcare services
- development of skills: qualifications upgrade, higher university quotas, specialist training based on competencies, quality of the healthcare service

2.3.2. Czech Republic

In 2009 the Czech Republic had to solve the increasing shortage of nurses. A range of measures were taken to stabilize the situation such as re-grading nurses for salary purposes, subsidizing the education for nurse specialists, shortening educational programs, providing places for practical training, better reimbursement of nurses, support for nurses returning after maternity leave, providing workplace nurseries, better statistical monitoring of the nursing workforce and the number of nursing students, and support of continuous professional development by a system of credits/points.

The positive effect of these stabilization measures is that the nursing shortage reduced from a shortage of 1090 nurses in 2008 to one of 570 in 2009. This positive effect was certainly boosted by the overall unemployment and the return of nurses from other industries. On the other hand, not surprisingly the introduction of benefits for nurses was followed by similar demands from other professional groups. The effect of the stabilization measures was smaller in private facilities (lower salaries, CPD – time off for studies) than in public facilities.

2.3.3. Belgium

According to OECD-figures, Belgium has 2 GPs per 1000 inhabitants which is much higher than the OECD-average of 0,9 GPs per 1000 inhabitants. However, the number of *practicing* GPs in Belgium is 1,2 GPs per 1000 inhabitants. By looking at the number of full-time equivalents instead of head counts, the number further decreases to less than 0,9 GPs per 1000 inhabitants. The case has been made that definitions are key in benchmarking international data.

2.3.4. Turkey

Strategic planning of human resources for health (HRH) is ongoing in Turkey. The objective is to determine HRH needs for the next 15 years and to forecast the distribution of health professional and new health jobs according to health care demands tendency and demographic changes. Current HRH production was therefore scaled up and workshops with stakeholders were organized. This was followed by several initiatives on workforce planning, e.g. the translation of WHO simulation models into Turkish and the training of a taskforce on how to use these models, the collection of the required data, and the identification of a technical working group. The plan is based on a comprehensive amount of assumptions such as major morbidity and mortality patterns, growth rate

in public and private health expenditure, expenditure to personnel vs. non-personnel costs, preventive vs. curative care, primary care vs. secondary care, urban population vs. rural population, required competency levels.

This led to clear objectives and policy proposals not only for the required number of health professionals, but also for training and recruitment needs and skills required to manage this workforce. Implementation achievement and progress of the plan is closely monitored.

2.3.5. Ireland

Ireland has an Expert Group on Future Skills Needs (EGFSN) which was established to assess the balance in demand and supply in many sectors. A Skills and Labour Market Research Unit (FAS) was set up for that purpose in charge of guiding the National Skills Database where data is collected at occupational level on demand and supply of skills. The Irish Ministry for Health and Children approached this expert group and asked their expertise to assess the demand and supply of health workers. A report was produced on this in 2009 by Behan et.al. (2009).

The assignment was to develop a quantitative tool which would assess the balance between the demand and supply of health care workers in Ireland under various scenarios. A selected number of healthcare occupations were therefore covered, of both higher and lower skill-levels (e.g. general practitioner, nurses, health care assistants, social care workers). The first step was to assess the situation i.e. the size and composition of the workforce. Next, it was questioned what happens if the population in Ireland grows and sourcing is limited to domestic supply and the healthcare model remains unchanged. Against this baseline projection, the result of changing certain parameters underpinning the model were examined. The forecasting methodology captured expansion demand (2008-2020), replacement demand and supply. Main lessons from Ireland were in addressing the data gap, adopting an integrated approach in setting level and type of service provision and addressing workforce planning as an ongoing process.

2.3.6. Spain

The Spanish case is an excellent example of a country that has moved debate from opinions to facts. In Spain, the responsibility for health services is decentralized to the 17 Autonomous Communities. The case presented concerned the assessment of the need for physician specialists. Over the last decade, Spain went from a surplus to a shortage of physicians, with some specialties more affected than others. In 2006, a team was commissioned by the Ministry of Health to conduct a study on current and future needs of physicians, by specialty, to serve as a basis for planning, which had by then become recognized as needed. It was a three-step analysis. In a first phase, 12 countries were analyzed regarding their demographic and social data, the healthcare system, contractual relationship, medical specialties, nursing competencies and specialties, the health care professional planning process and structure, standards identification by specialty. In a second phase, an expert group (Members from Scientific Societies, National Boards, Medical Council, Medical providers, Health Technology Corporations) performed the analysis on data that came up from the country analyses, also evaluating and comparing them with the Spanish care system. This expert group

reported and proposed key messages for action such as defining competencies of different healthcare specialities, changes in skill mix, update of healthcare professionals register, evaluation of new models of healthcare services (ambulatory surgery, primary attention, home care, regional or local allocation of specific process….), scientific and technological innovation, changes in social services needs and citizens change health-behaviours (self-care, information accessibility, non formal care providers, implication in decision making), trends in demography and epidemiology.

2.4. Summary of participants' comments

The current shortcomings in health workforce planning in some countries led to the formulation of pressing policy questions. Should there be EU standardized definitions of health occupational categories and of health labour market indicators? Should the EU propose or even require the utilization of standardized data collection tools and reporting formats? What role can the EU play in this respect, relative to that of technical agencies like the WHO, and what are the responsibilities of these organizations? Would it be opportune to create a "EU Observatory function" to (1) support countries in developing their HW database, in analyzing data, in developing HW policies (2) consolidate country information and produce regional analysis (3) monitor, analyze and disseminate country experiences. Finally, should the EU encourage and technically support inter-country health workers development, for instance between countries which already experience important cross-border movements?

Participants' opinions on the policy summary were very positive. In particular, participants recognised the challenges towards accurate forecasting described in the summary, which served well as initial input for discussion. Participants appreciated the methods for forecasting that were summed up in the summary, yet many questions remain on the technical aspects of forecasting. Challenges similar to those described in the Policy Brief and those that came up in the country presentations were echoed by participants.

Data issues remained the biggest preoccupation throughout the Policy Dialogues. Researchers and policy-makers indicate they are often limited in their forecasting efforts because they are confronted with invalid, unreliable, old or inaccessible data that is not comparable between countries. There are examples of countries (e.g. Belgium, Ireland) and current European projects on health workforce that have generated survey data as a solid way to fill in missing or lagging data. Databases that allow for up-to-date benchmarking of health data between and within countries are nevertheless vital to assure continuity in health workforce planning. Survey data indeed often only reflect a well-defined moment in time of short duration. There is agreement among the participants that efforts should be made on improving existing databases like EUROSTAT, WHO, OECD although the creation of a so called minimum HRH database would also be likely to help researchers and policy-makers to overcome these data issues. The first questions to be answered before making these efforts are what do we want this data to be used for, which results in many other questions: at what level do we want this data to be aggregated? By what should forecasting efforts be driven/what is the desired outcome? What data are essential for estimating which variables in planning models? Does our model rely on both quantitative and qualitative data? Can we predict over 10 years?

A well-discussed topic was the issue of definitions. First, demand is distinct from need. *Demand* was defined as an economic concept, relating to the purchase and consumption of goods and services, depending among other things, on the availability of necessary resources to afford it. A shortage of health workers refers to the situation where the demand for health workers is greater than the supply of health workers. *Need* in the context of health workforce planning was defined as the level of health services which good medical opinion deems necessary to meet particular health targets. Individuals demanding health care when they do not need it, will thus waste resources. Individuals not demanding health care (e.g. because they cannot afford it) while they actually need it, put at risk their own health (and sometimes that of others). When resources are not able to meet the needs, it will be called a *deficit* rather than a shortage.

More challenging, although many efforts have been already made both at the national and EU level, are the definitions and scopes of practice of different health professions across, and sometimes even within countries. What is a nurse? What is a generalist? What is a specialist? Differences in scope of practice of health professionals are very hard to assess and define. As the Belgian example made clear, it should also be defined whether data are based on full-time equivalents or head counts when discussing health personnel needs.

Health workforce planning should be an integrated action. It should involve the various disciplines such as medical doctors, nurses, other health professionals as they work in interdisciplinary teams and their work and roles are highly interrelated. It should be geographically integrated as health workforce issues in Europe are connected to issues in other continents giving the international mobility of health professionals. It should be integrated in terms of responsibilities not only being limited to healthcare but broadened to including financing and economic departments, labour market, foreign affairs and internal markets. For the EU, collaboration among DG SANCO, DG MARKT and DG EMPL was recommended.

Health workforce planning is an emerging science. It requires inter-disciplinary teamwork, multi-country cooperation, and deep stakeholder involvement. As new participants contributed to the Policy Dialogue, new lessons, new challenges, and new questions came up. Continued dialogue could sharpen the methodologies and desired objectives of health workforce planning. The concept of "performing workforce" was used, not limiting workforce planning to numbers and qualifications, but opening to quality, quality standards and coverage of services as well.

Future forecasting should be flexible enough to reflect changing realities within a broader economy, to account for trends not only within the healthcare sector, but also in other sectors. The impact of the current financial and economic crisis was more than once used as an example of how difficult forecasting is. Indeed, having to cut health expenditures by 30% due to an economic downturn, as was imposed by the Latvian government, is very hard to foresee ten years in advance. This again raised the question within which timescale planning should take place. For tackling challenges in 2020, one needs to start now. Doing nothing is not a realistic option and will lead to more expensive, short-term reactions in the future. Although shortages in the health care workforce are a common threat for countries worldwide, country situations remain unique and require unique approaches. Most importantly, researchers and policy makers, when taking this decision, should bear in mind that change takes time. They must try to maintain responsiveness to legitimate expectations of

populations. Health workforce planning should be valued as a tool for helping policy-makers to reflect on policy options and scenarios and for stimulating dialogue.

2.5. Conclusions for potential action at EU level on assessing future needs

A variety of issues for possible EU action in the area of human resources for health, were discussed during the Policy Dialogues based on which the following recommendations emerged:

Several participants suggested that the EU should support Member States in raising the need for integrated HRH planning. The country examples revealed some good practice with regard to sharing experiences across borders. There was mutual understanding between participants and the EU that establishing a network of health workforce planners would be a beneficial way of learning from other countries' successes and mistakes.

Although some participants expressed an appetite for EU intervention in this regard, there was no definite conclusion on the structure and set-up of any such EU intervention. It was proposed to set up a permanent platform or network for health workforce planners either as a EU responsibility or a shared responsibility/joint action between different countries, research centres or stakeholder organisations. The network itself could also for example have some responsibility for monitoring health data (e.g. data on mobility of health workers). Further thought needs to be given to deciding whether this network would be a new structure or whether more intelligent use should be made of already existing networks. Either way, this network could also be helpful in addressing one of the other challenges mentioned before; it could facilitate in bridging inter-professional and inter-sectoral gaps in health workforce planning.

Models that could be used to build a European network of health workforce planners were mentioned: the European Network for Health Technology Assessment (EUnetHTA) or the European Union Network for Patient Safety (EUNetPas).

More specifically, it was recommended that the EU could support Member States in looking across the health professions, by:

- Raising the overall need for integrated HRH planning
- Mapping/reviewing skills and competence profiles needed for the future
- Developing integrated planning methodologies
- Sharing good practice of innovative HRH forecasting tools including future needs assessment

Several participants supported EU suggestions for improving qualitative and comparable data by:

- setting out basic requirements for building HRH information systems,
- proposing a minimum HRH information database and
- investigating the relevance of cross-border collaboration in this field.

The link with the European Qualification Framework was mentioned as one measure to enhance comparability of qualifications among Europe.

3. Adapting skills and redistribution of tasks to meet future healthcare needs

3.1. Policy brief on creating conditions for adapting skills to new needs & lifelong learning

Tanja Horsley, Jeremy Grimshaw and Craig Campbell

The Policy Brief focussed on the issue that the knowledge and skills acquired at the end of formal undergraduate and postgraduate professional education may not be sufficient to sustain competence and performance over a career. Either through participating in organized continuing education programs or through individual learning activities, healthcare professionals are expected to remain current in their practice through efficient knowledge management practices (evidence-informed practice) and self-directed learning strategies (lifelong learning). The Policy Brief focussed mainly on medical education and the discussion was broadened later to other health professionals.

Healthcare professionals are expected to effectively engage in lifelong learning strategies in a rapidly changing healthcare system that is increasingly strained due to under-funding, insufficient number of health care workers and limited access to data on performance or current health outcomes. Further compounding these challenges is the increasing scrutiny of professional and public concerns related to the variability in the quality of care provided, the safety of the health system, and the frequency of adverse events. Collectively these concerns have fostered a growing emphasis on the need for accountability within the health professions for the continued privilege of self-regulation.

The healthcare landscape is diverse and complex. Within Europe there is currently no commonly accepted approach to lifelong learning; however, there is broad agreement that patients are best served when those who care for them maintain their competence by engaging in continuous learning and assessment strategies. Optimally, these strategies would be highly self-directed, with content, learning methods, and learning resources selected specifically for the purpose of improving the knowledge, skill, and attitudes that physicians require in their daily professional lives that lead to improved patient outcomes.

Academics and educators in the continuing professional development (CPD) community have increasingly promulgated the belief that CPD should be a shared responsibility between the individual learner (e.g. healthcare professional), organizations (e.g. accredited providers, education and training institutions), and healthcare systems (e.g. access to point-of-care information). This is a relatively novel way of describing a CPD model; however, if the goal is to improve delivery of patient care and thus improve patient outcomes, the environment (e.g. hospital, clinic) in which physicians practice should be both supportive and constructed in a way that promotes and enhances learning. Physician learning is not static and should be approached with an appreciation for the unique contextual and environmental challenges and opportunities for learning within a complex healthcare system. It is important to recognize that physicians, organizations, and health systems should be adaptable, this is to say, at any given time physician learning could be individualized or as part of a learning community, unplanned (e.g. resultant from an error) or strategic (e.g. pursuing a question), focused on personal or organization accountability, and assessed from a learner perspective (e.g. learner-centred) or as part of a team (e.g. 360° assessment). Any CPD models or approaches to

learning will need to consider social, cultural, financial, and contextual issues as part of their planning and assessment strategies

The principle that physicians and other health professionals should engage in continuous learning as members of a knowledge intensive profession is generally accepted. However there is no consistent strategy or agreement regarding how to organize, structure, deliver, document and regulate continuous learning in practice. The specific needs and issues that require reconsideration of lifelong learning concepts are specifically outlined below:

Standard approaches should be considered for:

1. Ensuring participation in lifelong learning activities is compulsory versus voluntary.

2. Defining the need for time limited certification and the requirements for recertification

3. Management of lifelong learning systems or activities (e.g. National or regional)

4. Although participation in CME is currently compulsory in some countries, defining the sanctions or implications for non-participation remains to be defined.

5. Developing incentive structures for effective participation in CME / CPD activities (e.g. credit systems, pay for performance options)

6. Developing classifications or taxonomies of CME activities across national systems

7. Defining the principles, values, and metrics of CPD accreditation systems focused on either CPD providers, activities or programs or both

8. Determining the degree to which physicians can choose to select learning activities that meet their practice specific learning needs.

9. Accreditation ex ante for providers

10. Defining industry involvement and sponsorship of CPD activities or events.

3.2. Country experiences

3.2.1. Slovenia

The internet has become an essential part of life. The Slovenian case is on how useful the World Wide Web can be as a teaching tool suitable for students for self-testing. The web provides a knowledge infrastructure, also in the field of health. It provides day and night access to medical information, from literature search engines to medical images databases. It also facilitates collaboration between health care workers.

Slovenian researchers developed solutions related to the integration and presentation of medical images organised in a World Wide Web database. A prototype of an open access, bilingual (Slovenian and English) database of medical images for the field of dermatology was developed. It includes a graphic interface with four modes of access: (1) browsing, (2) searching, (3) comparison of images,

and (4) self-testing. The quantity and quality of requests to this online database was estimated with log file analysis. There was a steady increase in the number of users and of volume of data transferred from this database. From this experience, the researchers learned that medical online databases are a platform for the development of information and educational tools suitable for life-long learning. They state that the usefulness of a digital library, as an everyday reference tool depends on its size and coverage of the topic it is specialised for. Building and maintaining such databases is very expensive and time-consuming. Co-operative work between EU Member States is the long-term solution to overcome such problems.

3.2.2. Croatia

EUSUHM, the European Union for School and University Health and Medicine is a multi-country organization aiming at (1) fostering and encouraging population-based health care for children and young people in all European countries with the emphasis on the relevant setting related to their stage of life (e.g. day-care centres, kindergartens, schools, universities) (2) fostering and encouraging the development and improvement of health services in these settings (3) keeping member associations and individual members informed regarding the current demands and changing pattern of pre-school, school and student health care in the different countries (4) supporting and harmonizing the development and maintenance of specific medical training in school health, respecting the rights and needs of individual countries to create, continue and develop nationally relevant training programs. In EUSUHM-countries school health services employ a wide range of specifically trained professionals.

There is variability in training programs, ranging from full medical specialisation in school and adolescent medicine (e.g. Croatia), specific 1- or 2-year postgraduate programmes (e.g. Belgium, Netherlands), to short intensive courses. In some countries, no specific programs in adolescent health care are recognised. Many challenges remain, such as lack of interest/motivation of providers regarding training in adolescent/school health, financing of training, lack of awareness of authorities of the importance of adolescent health (and therefore for the need of training).

EUSUHM recognises the following needs regarding training in adolescent/school health:

- Definition of minimal competences for professionals in adolescent/school health is needed, specifically for physicians and nurses.
- A EU standard for professional training in adolescent/school health, with the recognition of a (sub)specialty.
- Criteria to evaluate the competence of providers.
- Further international collaboration between universities and training institutions to maximise the educational quality of the existing programmes in the European Region.

3.2.3. Finland

The Finnish initiative on advanced roles of nurses started at the beginning of the 21st century when the shortage of physicians became clear and task shifting between physicians and nurses emerged as

a possible solution. The Finish ministry of health supported this development with national strategies, state grants, and with legislation.

The baseline for redistribution of health task is the national development plan for social and health care services, the so called KASTE programme 2008-2011. The plan was adopted by the government to define development objectives and main measures for municipal social and health care for 2008-2011:

- Prevention and early intervention
- Ensuring the sufficiency of staff and strengthening skills
- Services functioning as an integral whole, effective models of operation

The Ministry of Social Affairs and Health allocated 2,7M € in state grants for the regional implementation of the action plan. Strengthening skills is highly prioritized by the Finish Parliament and is thus one of the three development objectives in this plan, which includes the advancement of nursing roles. Some examples of advanced roles for nurses in primary health care are nurse consultation for acute health problems and non-communicable diseases (NCDs) and nurse consultation supported by the physician´s e-consultation. Nurse consultations at outpatient clinics and advanced roles for nurses in operation rooms are good examples for advanced nursing roles in specialised medical care.

In evaluating this plan, patients felt that access to care and continuity of care had improved. They had received more counselling, which has improved patient education and self-care. The majority of patients positively perceived task shifting from physicians to nurses. Only 14% of the patients in hospital care had negative attitudes towards task shifting. Implications for education include strengthening clinical competencies in nursing education and establishing post-graduate studies for specialisation.

Physicians also mainly report positive experiences, like having more time for their patients and that flexibility has improved. Both physicians and nurses experienced improved multi-professional collaboration. However, physicians felt they had to deal with more demanding cases and that consultations by nurses increased the physician´s workload in the early stages. When the experience of nurses increased, this feeling decreased.

The redistribution of tasks has also been supported by legislation. The Parliament adopted the legislation on Nurse Prescribing in April 2010. A national list of medicines and nationally defined postgraduate education will be regulated. Requirements for nurse prescribing were formulated such as having 3 years of work experience, having following at least 45 ECTS credits in nurse prescribing and being authorized from the physician-in-charge. Other measures are the National Register for Health Care Professionals, development of evidence based guidelines, structure for monitoring adverse events, requirements for CPD. A national steering group was set up by the Ministry to follow-up this initiative.

3.3. Summary of participants' comments

The following key-questions about continuing professional development across the EU were addressed to the participants:

1. What are the specific needs and issues that require reconsideration of life-long learning concepts and processes in Europe?

2. What are the policy options, conditions and incentives for updating knowledge and skills of physicians?

3. Are there existing models or frameworks for continuing medical education (CME) /continuing professional development (CPD) that could be used as a platform for modifying the existing model(s) or for developing a new model of lifelong learning across the EU?

4. What infrastructure considerations would need to be in place for the pursuit of any policy

option with regards to implementation? Specifically addressing considerations for promoting

cross-national learning/training and new forms of knowledge transmission?

Participants found the Policy Brief excellent in terms of introduction and scene-setting for the dialogue. One major comment was that the focus is highly on physicians, while CPD/LLL activities equally important to other health professionals. The authors acknowledge that other professions, like nursing for example, face similar challenges, and that a global approach is required, albeit it is recognized that a one size fits all approach does not apply here.

The subject of this Policy Brief was more focussed than the Policy Summary. Adapting skills and redistribution of tasks to meet future healthcare needs however remains broadly-scoped. The different views, interests and amount of energy among participants on this resulted in a discussion in which many fundamental questions were raised on how to approach continuous professional development (CPD) and lifelong learning (LLL).

There is rich diversity of Europe on this subject, and there are also some commonalities that allow for establishing a network to exchange good practice between Member States. Several participants requested the EC to support a European competence centre in sharing efforts to avoid every country doing the same exercise by providing expertise in transmitting and enriching knowledge on this. Moreover, the need was expressed for the European Commission to move the European Qualifications Framework beyond into a CPD framework. Although there are many good initiatives being taking in various European programmes such as Leonardo da Vinci and other programmes, a comprehensive overview is missing.

A recurrent subject was the expressed need for an integrated approach, beyond the medical model, also incorporating all other health professions. The integrated aspect also emerges from the evolving health care sector. Health workers need to cope with increasing technological complexity, which requires a broader perspective that goes beyond acquiring knowledge. An example is the need to develop social and communicational skills, as health care demand is characterised by cultural diversity. Currently, an integrative approach is lacking, as if teamwork in the healthcare sector is not

always in place. The redistribution of tasks concerns all health professionals. It leads to new ways of learning such as interdisciplinary team learning initiatives which are closer to interdisciplinary collaboration and practice.

One issue is what kind of skills the health workforce should have in the future. Canada is using the CanMeds competence model having seven roles such as Medical Expert (the central Role), Communicator, Collaborator, Health Advocate, Manager, Scholar and Professional (http://rcpsc.medical.org/canmeds/index.php). CPD should be oriented to problem-based learning and requires that all roles should be assessed to identify training needs. Less traditional roles, such as communicator and manager, are not always popular in CPD for health professionals although the majority of problems and bottlenecks are seen in these domains. The shift to acquiring new skills and new practices is not obvious and requires a real cultural shift.

Other well-discussed issues were whether or not CPD/LLL should be compulsory or mandatory and what role the employer has in CPD/LLL. A Belgian case integrates these two issues. Belgium has a compulsory system for continuing education (15 hours per year) for specialist nurses in oncology and geriatric care. This will be further implemented gradually to other specialist nurses and later to non-specialist nurses. The national nursing associations asked for making this system mandatory, because they feared employers would otherwise not allow nurses to take time off for CPD. Hospitals are required to have, for example in geriatric care, 30% specialised nurses on geriatric wards. This was an incentive for employers to send nurses to CPD-courses organized by nursing associations and university colleges.

Participants from Poland illustrated the case in which employers are not sympathetic towards freeing nurses for CPD: Polish nurses often take classes in the morning after their night shift. There were similar stories from other countries too. There is emerging evidence that CPD/LLL activities stimulated by employers lead to high retention and job satisfaction rates.

An issue is what system of incentives and sanctions should be used for supporting CPD. Examples of sanctions for those who do not comply with CPD/LLL requirements are deletion from the register and not reaccrediting.

Another question is how to integrate CPD/LLL in daily practice. Often CPD, such as reading or coursework is seen as an activity separate from clinical work. A potential opportunity lies in using the hospital information system, which has the capacity to link new knowledge and evidence to patient care. Examples are databases such as Up-to-date and Map of Medicine.

CPD/LLL is still in a transitional phase. There is need for intensive lifelong learning opportunities for all health workers, in an integrative approach. Questions for further discussion include:

- How to prevent CPD/LLL from becoming provider-driven?
- What is the minimum required effort in CPD/LLL?
- How to transfer CPD/LLL achievements (e.g. points, hours) between Member States
- (Re)training of migrant health professionals
- How to ensure that what is being provided is appropriate to improving patient care?
- How can we learn from the patient perspective on CPD/LLL?

- Where should ownership lie in the delivery of courses?
- What is the appropriate time period for recertification?
- How much of the working time can be used for education? What is a good balance?
- How to measure the effect of CPD/LLL?
- At what level should CPD/LLL start (e.g. make undergraduates already familiar with this, thus restructuring undergraduate education)?
- What incentives would be best (e.g. financial incentives, educational opportunities incentives)?
- With the gap between education and practice becoming wider, what should be the impact of CPD/LLL on the length of the basic education?
- What skills are required for the future health workforce.

No one challenged the need for CPD/LLL. It is indeed a responsibility to develop health workers who feel the need of knowledge, skills and competences to embed in the curriculum, make it culturally relevant, and interlink this professional obligation with professional practice.

3.4. Conclusions for potential action at EU level

Participants welcomed the EU suggestion to support Member States in facilitating the exchange of good practice on tasks and competence profiles of different types of health professions.

Several initiatives and roles for the EU would be welcomed by the participants such as targeting programmes and initiatives to help member states equip people with the necessary skills such as the use of structural funds for retraining, new skills for new jobs flagship initiative (EU2020).

Participants suggested that the EU should take a role in promoting and preserving CPD in the context of financial crisis. The participants suggested that the role of employers in life-long learning be addressed in the social dialogue between the representatives of the European trade unions and employers' organisations. As the EU has a role in promoting and facilitating cross-national learning initiatives (educational exchange programmes, e-learning) the participants emphasised the benefit of promoting a system of mutual recognition of credit points in CPD

4. Creating a supportive working environment to attract motivated health professionals

4.1. How to create an attractive and supportive working environment for health professionals

Christiane Wiskow, Tit Albreht, Carlo de Pietro

The Policy Brief stressed that investing in working environments matters. First, the health care sector is a vital part of national economies and an important employment sector. In fact, the health sector in some countries has been one of the few sectors with positive employment trends during the recent economic downturn. Second, the health labour market has become increasingly competitive. There is a major challenge in recruiting and retaining health professionals to meet the increasing demand. Third, working environments influence the quality of care.

Characteristics of the work environment affect organizational performance, individual satisfaction, work-family balance, continuing development and the organizational culture, of which trust is a key element for effectiveness in highly professionalised contexts. The first three issues impact on quality of care via errors, burnout and turnover, as demonstrated by several studies where the quality of care is measured in terms of mortality rates, readmissions, perceived quality by patients, perceived quality by nurses, etc. Positive effects can also been expected from continuing development and, despite weaker evidence, from trust.

There is no agreed definition of working environments or working conditions. Yet both terms encompass a common set of elements that may vary in focus and scope: terms of employment, income, working time, safety and health, professional development and work organisation. Creating a supportive and attractive work environment relates to the quality dimension of work. Two dimensions with different elements, employment quality and work quality, influence job quality. Whereas work quality refers to material aspects (e.g. risk of accidents, health variables), employment quality refers to the relationship between employers and employees (type of contract, working hours, social benefits, training and skill development). This illustrates the complexity of addressing work environment actions.

Attractive and supportive work environments incentivise health professionals to enter and stay, conditions that enable health workers to perform effectively (make best use of their competences), with the ultimate goal of providing high quality care. When looking at policy options, the authors of this Policy Brief looked into what can be done and how it can be achieved or advanced to create such work environments. In view of the complexity of the subject, rather than providing a broad view (which is debatable), two policy options were selected to illustrate what can be done.

A first option is to promote family-friendly workplace policies.

There is a general tendency among the health workforce, and also in other sectors, towards balancing work and non-work life. The increasing feminization in an already highly feminized health workforce makes this very challenging. The general approach is to generate a family-friendly workplace culture where time taken off for family issues, with equal opportunities for men and women, is not seen as a time loss. Actions to achieve this include providing flexible working time

arrangements, a safe workplace, and child care facilities or arrangements. There is also an issue of maternity protection. Some measures to be taken in this respect are providing job protection, maternity leave or financial compensation. There can also be special work measures taken, like the passage from regular to adapted workloads, prioritizing less risk exposure and special leave (e.g. care for sick child).

The second illustration relates to the protection of health workers. Many health workers perceive their health is at risk because of their working conditions, which often leads to premature exits or reduced work ability for example. Although many occupational diseases and accidents are preventable, two categories of risk are important in the health sector: biological risks (e.g. SARS, H1N1, needlestick injuries) and psychological risk (stress, violence, harassment).

Addressing occupational safety and health issues requires an integrated multi-dimensional approach to tackle the complex and interdependent factors influencing health at work. The authors see the policy actions being addressed at different levels.

- International level: standards, codes of practice, directives, guidelines
- National level: legislation, regulation, guidelines, compliance with international/regional legislation, surveillance
- Sector level (health sector): identification and translation of relevant standards/legislation, tailoring guidelines to health sector and health occupations, monitoring application
- Organizational level: implementation in the work setting, compliance with occupational safety and health legislation and requirements, occupational safety health management, measures tailored to health facility and work places, feedback on trends and emerging needs

While standards and legislation provide for minimum standards, these in themselves are not sufficient to address these changes. The European Commission observed shortcomings in the application of Community legislation, especially in sectors at risk and for vulnerable workers. It is the organizational level that faces the challenge of translating policies into practice and adapting interventions in a timely manner to trends and changes in the work realities.

This further leads to the question how work environment can advance on the policy agenda. Working environment/working conditions issues often lie within the mandates of Ministries of Labour and associated authorities, such as labour inspectorates. Therefore inter-sectoral collaboration is indispensible for effective approaches to improving the working environment in the health sector. Also, social dialogue is a major instrument to achieve sustainable improvements in health services, including the work environment, because the key stakeholders can voice their needs and concerns and negotiate feasible solutions, in a constructive way.

Another way to advance work place issues could be to promote the assessment of work place and certification programs (e.g. The Magnet Recognition Program, The Great Place to Work Model).

4.2. Country experiences

4.2.1. Belgium

A multi-annual plan (2008-2011) was developed to make nursing care more attractive in Belgium. The two primary objectives of this plan were to enhance the attractiveness (including retention strategies) of the nursing profession and to ensure professionals are able to meet changing patients' nursing needs. The plan applied to nurses working in hospitals, in nursing and residential homes for older people, and in home care. Four areas for action were identified.

A first area for action is easing workload and stress. Several measures are being taken, such as financing an extra nurse or auxiliary (1 FTE/30 beds) not assigned to a particular nursing unit but to a pool serving more units. Other actions to be taken in the near future include creating extra non-nursing jobs for administrative and logistic assistance to care units, investing in an ergonomic environment, ensuring a better match between funding and nursing needs, and providing funding for the promotion of care.

A second set of actions concerns nurse qualification. The EC Internal market requires more information from Belgium in meeting the requirements of EU-Directive 2005/36/EC. It is seen as an opportunity to review the nursing education model. Other actions include the increase in funding for continuous training, stimulating master degrees in nursing and midwifery, etc.

A third area are actions such as higher pay, measures to extent practice for specialised nurses, supporting and upgrading nursing consulting and supporting inter-professional co-operation and alternatives to hospitalisation.

A fourth area for action concerns social recognition and participation in decision-making.

4.2.2. EU-funded project on nurse forecasting (RN4CAST)

This example uses data from the FP7 Nurse Forecasting (RN4CAST) project. The objective of this project is to refine current forecasting models for planning the nursing workforce using new elements:

- (perception of) various aspects of the nursing work environment
- Impact of nurse deployment on recruitment, retention and productivity of nurses and on patient outcomes

Using data from a sample of 56 Belgian hospitals on job dissatisfaction and intention-to-leave among 3186 nurses, it was shown that the nursing work environment is significantly associated with nursing outcomes. When asked how satisfied they are with their current job, 20% said they were dissatisfied and almost 30% of all nurses said they would leave their current hospital within the next year as a result of job dissatisfaction, and of this sub group a further 30% said they would look for a job outside the nursing profession (8,2% of the total sample). Variations between hospitals on these outcomes were large; job dissatisfaction varied from 3,2% to 68,2%, while intention to leave varied from 13,0% to 55,9%. Multivariate analysis was performed, with the predictors being elements from the nursing work environment (perception of staffing adequacy, nurse manager ability, relations with

physicians, nursing foundations for quality of care, nurse participation in hospital affairs), the patient-to-nurse ratio and the nurse bachelor percentage. Nurse manager ability and the patient-to-nurse ratio were significantly associated with intention-to-leave the hospital. Other relations between institutional, nurse and staffing issues will have to be further explored.

4.3. Summary of participant's comments

The following key messages from the Brief were:

- The work environment is an important factor in recruitment and retention of health professionals
- The work environment influences the quality of care
- Policy responses need to be multi-dimensional, cross-cutting and inclusive
- Solutions are contextual. Priority is on local /organizational level
- Challenges include: finding the right balance between mobility and retention; creating a work environment suiting older health workers; need to strengthen evidence on links between work environment and quality care

Participants received well the input that the Policy Brief provided on creating an attractive and supportive working environment for health professionals. It was appreciated because of its broad, thorough and systematic content. Some participants would like to see the Policy Brief expanding on working conditions for self-employed health care workers. Also, evidence on economic benefits of investing in the work environment would be appreciated, to further move this discussion from opinions to facts.

It was further emphasized that long-term attraction plans for health professionals are required, targeting all areas of the health sector. As the Policy Brief made clear, there is need to combine different policy-interventions. Organizations must carefully estimate the impact of accreditation programs and always be aware of the efforts and costs involved.

Also the role of emerging technology was mentioned. The Swedish presidency presented a report last summer that shows the impact of eHealth, in which there was an indirect effect on the reduction of the workload for nursing teams (http://www.epractice.eu/).

Emphasis has been put on assuring a good work-life balance, such as flexibility, in providing a family friendly workplace culture, good conditions of return from maternity leave, working from home. Iceland was seen by the participants as a good example where fathers and mothers have equal rights to parental leave. Interesting to note, is that a majority of fathers are taking up that role.

Programmes such as the magnet recognition programme and the good-place-to-work programme are creating competition among hospitals for recruiting large numbers of nurses. The effect of these programmes in attracting new workers to the healthcare sector should be investigated.

4.4. Conclusions for potential action at EU level

Participants were very positive about EU suggestions for supporting Member States in mapping EU action on working environment in health care as taken by European Working Conditions Observatory (EWCO). The participants suggested that the EU can take an active role in launching campaigns for a positive image of healthcare as a career choice.

The participants welcomed the EU initiative to encourage social dialogue on creating a safe working environment in the health and social care sectors. A good example is the recent Council Directive 2010/32/EC (May 11, 2010) in implementing the Framework Agreement on prevention from sharp injuries in the hospital and healthcare sector concluded by HOSPEEM and EPSU.

Some participants suggested that the EU could support the exploration of elements and factors that contribute to a supportive working environment, such as occupational health and safety, working time, better work-life balance, adaptation for older workers, gender differences.

5. Creating a supportive working environment to ensure quality and safety of care

5.1. How can audit and feedback to health professionals improve the quality and safety of health care?

Signe Flottorp, Gro Jamtvedt, Bernhard Gibis, Martin McKee

The Policy Brief focussed on audit and feedback to health professionals. Audit can be defined as "any summary of clinical performance of health care over a specified period of time aimed at providing information to health professionals to allow them to assess and adjust their performance" (Jamtvedt et al, 2006).

The background to the importance of audit and feedback is multifold: (1) there are large variations in practice, in quality care and patient safety between Europeans countries; (2) there are gaps between best evidence and the care that patients receive. Although there is progress in generating and synthesizing of evidence, translating this into routine care is still a challenge; (3) patients express lack of compassionate and patient-centred care, and lack of continuity and coordination of care.

A Cochrane review by Jamtvedt et al. (2010) concludes that providing healthcare professionals with data about their performance (audit and feedback) may help improve their practice. The effects of audit and feedback are generally small to moderate, but may be worthwhile. The relative effectiveness of audit and feedback is likely to be greater when baseline adherence to recommended practice is low and when feedback is delivered more intensively. The results of this review do not support mandatory or unevaluated use of audit and feedback as an intervention to change practice.

The Policy Brief introduced two policy actions: first, to publish performance data to improve the quality of care, (1) by enabling consumers/patients to choose the organizations that provide better care, and (2) on the assumption that professionals who know that information on the care they provide is public will try to improve performance (effectiveness of care, safety, patient-centeredness). Evidence by Fung et al. (2008) suggests that quality improvement activity at hospital level is stimulated by publishing performance data, but that the effect on effectiveness, safety and patient-centeredness remains uncertain.

A second policy action focuses on the use of performance data to inform and underpin pay-for-performance schemes. There are few empirical studies of explicit financial incentives for quality available for review (Petersen et al., 2006). Against a background of increases in the quality of care before the pay-for-performance scheme was introduced in England, the scheme accelerated improvements in quality for two of three chronic conditions (e.g. diabetes) in the short term (Campbell et al., 2009).

Major issues about audit and feedback addressed in the Policy Brief are related to the levels of responsibility and involvement (is it led by professionals or by authorities), mandatory or voluntary (self-regulation), ways of monitoring or auditing practice, sources and formats of the feedback, frequency, duration and content, feedback at individual and/or group level, supplemented with comparisons and/or specific recommendations for change.

5.2. Summary of participants’ comments

The following key questions about audit and feedback were addressed to the participants:

- Should performance and outcome data be made public?
- Should audit and feedback be linked to economic incentives or to reimbursement schemes (e.g. pay-for-performance)?
- Should audit and feedback be a governance or regulatory arrangement, used in accreditation or organisational assessments?

Reactions were mixed on how audit and feedback to health professionals can improve the quality and safety of health care. Participants felt that the linkage of quality and safety issues with regard to assessing the need for health workers should be more comprehensively addressed. Interlinking this Policy Brief to the Policy Summary and other Policy Briefs is one strategy to include this aspect. It was also suggested that the term "audit" can have negative connotations and could be better replaced by "assessment".

With regard to feedback mechanisms, many participants pointed to the need for feedback with a positive tone and incentives rather than punitive measures. Examples of positive incentives are pay for quality initiatives. The experience from the Quality and Outcomes Framework (QOF) in the UK showed that P4P-effects might be limited in time and scope. Moreover, practice nurses, nurse practitioners and others do not receive extra pay because payment is focused on the individual and not on teams. Also, it is important to instal continuous feedback mechanisms (e.g. critical incident analysis), which allows for anonymous feedback if required, stimulating self-reporting, openness and transparency. A no-blame culture is critical. These feedback mechanisms should not only empower health professionals, but also encourage patients to provide feedback. The question came up whether such system should be compulsory or mandatory.

5.3. Conclusions for potential action at EU level

Participants were supportive of the EU suggestion to share good practice, mainly in the use of (blame-free) reporting and learning systems for professionals and patients. These systems were seen as an integral part of the education of health professionals.

6. Conclusion: supporting innovation and collaboration on health workforce policies in Europe

Participants to the health Policy Dialogues gave significant support to the content and key points the Policy Summary and the three Health Policy Briefs. Some general conclusions can be drawn:

Health workforce planning is not an exact science, but good tools are available to help policy-makers to meet the challenge of future needs. The quality of data is variable and often poor and not well designed for comparability among member states. The mobility of patients and health professionals across Europe and even beyond, the shortage of health professionals, the economic crisis and the emphasis on an efficient deployment of health workforce, create a need for more precise health workforce planning. This generates a need for common definitions, comparable data, a knowledge base and a network of professionals in workforce planning. The right terminology used is probably scenario building, rather than deterministic terms such as forecasting, prediction and planning. Because of the difference in the length of education in different professions and disciplines, health workforce planning for 2020 should start now in order to provide the right number of health workers, with the right skills, in the right place, with the right attitudes and commitment, doing the right work effectively and efficiently, at the right cost, with the right productivity at the time we need them. The EU can play an important role in supporting member states in developing health workforce planning skills such as sharing good practice, building a network for health workforce planners, and providing standards for comparability of data.

Health workforce planning requires an integrated approach because of the interdependencies of different disciplines and professionals, shifts in tasks and responsibilities from specialists to generalists, from medical doctors to nurses, and from professionals to patients. It links healthcare to many sectors such as education, finance, employment and foreign affairs. The shortage of healthcare professionals is a complex phenomenon; it might be the result of the image of healthcare, of limited resources in education, of limited budget in health care, of uncompetitive wages and working conditions in comparison with other sectors. Increased patient and professional mobility has moreover led to intra- and inter-country migration leading in imbalances in the demand and supply of health workforce.

The Policy Dialogues emphasized the impact of continuing professional development and life-long learning. Thirty thousand new citations are added to Medline, the online medical journal database, each month, and medical knowledge becomes more and more specific. Main issues are the balance between basic and continuing education, individual and team learning strategies, training for a broader set of competencies such as management and communication, investing in more effective ways of knowledge transfer, monitoring of innovation and of learning capacity. The EU has an important role to play in sharing good practice, and in providing structures and funds for training and retraining.

The Policy Dialogues supported the aim of creating a supportive working environment which has a direct major impact on burn-out, job-satisfaction and indirectly to the quality of care. The shortage of health professionals in 2020 is estimated by the EC to be around 1,000,000 people or 15% of the

active workforce. Creating a more supportive work environment could have a major effect on retention and intention-to-leave, which are highly correlated for nurses as showed by some current studies. Providing a better work-life balance could extend careers in health care and have a positive impact on recruitment. As some studies showed, this might have a positive impact on the predicted shortage figures. The EU can help to map EU actions on working environments and share best practice among member states.

The Policy Dialogues linked health workforce planning and other workforce initiatives with quality and patient safety. The relationship between instruments of audit and feedback on quality and patient safety to health workforce is not entirely demonstrated, but appears to be important. It relates numbers, qualifications, competences, working environment to its effect on the quality of care. The impact on the quality of care should be the final criterion for health workforce initiatives.

The Policy Dialogues, together with the Policy Summary and the Policy Briefs will serve as input to the Ministerial conference on health workforce *"Investing in Europe's health workforce of tomorrow: scope for innovation and collaboration"* (La Hulpe, 9-10 September 2010).

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Annex I: Integrated programme of the three Policy Dialogues

FINAL PROGRAMME (Group 1-3)

Opening Session: Follow up to the Green Paper on Europe's health workforce

Chair and facilitation:
Prof. Walter Sermeus, Centre for Health Services and Nursing Research, KU Leuven

The European Commission
Ms Katja Neubauer, European Commission, DG SANCO, Health Strategy and Health Systems Unit (Group 1 and 3)
Ms Elisabeth Kidd, European Commission, DG SANCO, Health Strategy and Health Systems Unit (Group 2)

The Belgian Presidency
Ms Riet De Kempeneer, Attaché International and Strategic Coordination, Federal Public Service Public Health, Safety of the Food Chain and Environment, Belgium

Objectives of the policy dialogues
Willy Palm, Dissemination Development Officer, European Observatory on Health Systems and Policies

Workshop 1: Assessing future health workforce needs

Chair and facilitation:
Prof. Zilvinas Padaiga, Kaunas University of Medicine, Lithuania (group 1)
Dr. Matthias Wismar, Health Policy Analyst, European Observatory on Health Systems and Policies (group 2-3)

Policy summary on forecasting future health workforce needs
Prof. Gilles Dussault, Director of the Health Systems Unit at the Institute of Hygiene and Tropical Medicine, Universidade Nova, Lisbon, Portugal

Selected country experience

Planning for health care professionals in Croatia (group 1)
Marija Pederin, Ministry of Health and Social Welfare, Croatia

Nurses shortages in the Czech Republic (group 2)
Alena Šafránková, Ministry of Health of the Czech Republic and Veronika Di Cara, Czech Nurses Association

Practicing general practicioners in Belgium (group 2)
Pascal Meeus, National Institute of Health and Disability Insurance, Belgium

Strategic planning on HRH in Turkey (group 2)
Elif İşlek, Ministry of Health, Turkey

Health workforce planning in Ireland (group 3)
Jasmina Behan, Skills and Labour Market Research Unit, Training and Employment Authority (FÁS), Ireland

Assessing future health workforce needs in Spain (group 3)
Ana Gimenez, Ministry of Health, Spain

Workshop 2: Adapting skills and redistribution of tasks to meet future healthcare needs

Chair and facilitation:
Dr. Matthias Wismar, Health Policy Analyst, European Observatory on Health Systems and Policies (group 1
Prof. James Buchan, Faculty of Health Sciences, Queen Margaret University Edinburgh, Scotland (group 2-3)

Policy brief on how to create the best conditions for adapting skills to new needs and for life-long learning?
Tanya A. Horsley, Research Associate, Centre for Learning in Practice (CLIP), Royal College of Physicians and Surgeons of Canada

Policy brief on how health professionals can be steered towards improving quality and safety of care?
Mrs. Signe Agnes Flottorp, Senior Researcher, Norwegian Knowledge Centre for the Health Services
Mrs. Gro Jamtvedt, Senior Researcher, Norwegian Knowledge Centre for the Health Services

Selected country experience

European Union for School and University Health and Medicine (group 1)
Marina Kuzman, Croatian National Institute of Public Health

The use of web-based multimedia medical databases for lifelong learning (group 1)
Samo Ribarič, University of Ljubljana, Faculty of Medicine, Ljubljana, Slovenia

New roles of nurses and nursing personnel in Finland (group 2)
Marjukka Vallimies-Patomäki, Ministry of Social Affairs and Health, Finland

Workshop 3: Creating a supportive working environment to attract motivated health professionals and to ensure quality and safety of care

Chair and facilitation:
Prof. Walter Sermeus, Centre for Health Services and Nursing Research, KU Leuven (group 1)
Prof. James Buchan, Faculty of Health Sciences, Queen Margaret University Edinburgh, Scotland (group 2-3)

Policy brief on how to create an attractive and supportive working environment for health professionals?
Mrs Christiane Wiskow, independent HRH consultant, Switzerland
Dr Tit Albreht, Head of the Centre for Health System Analyses, Institute of Public Health of the Republic of Slovenia

Selected country experience

Multi-annual plan to make nursing care more attractive in Belgium (group 2)
Miguel Lardennois, Federal Public Service Public Health, Safety of the Food Chain and Environment, Belgium

Job satisfaction among Belgian nursing personnel: first results from the RN4CAST project (group 1 and 3)
Luk Bruyneel, Centre for Health Services and Nursing Research, KU Leuven

Concluding Session: Supporting innovation and collaboration on health workforce policies in Europe

Chair and facilitation:
Prof. Gilles Dussault, Director of the Health Systems Unit at the Institute of Hygiene and Tropical Medicine, Universidade Nova, Lisbon, Portugal

Conclusions and closing

Prof. Walter Sermeus, Centre for Health Services and Nursing Research, KU Leuven
Ms Katja Neubauer, European Commission, DG SANCO, Health Strategy and Health Systems Unit
Dr. Matthias Wismar, Health Policy Analyst, European Observatory on Health Systems and Policies

Annex II: List of participants

Policy Dialogues 26-27 April 2010 (<u>Group 1)</u>
Faculty Club Leuven

	Name	First Name	Country	Function	Affiliation/Organization
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5	PEDERIN	Marija	Croatia	Legal adviser	Ministry of Health and Social Welfare
6	ANDRIOTI	Despena	Greece	National Representative on HRH	Greek Ministry of Health and Social Solidarity

7	KALEJS	Jevgenijs	Latvia	Chairman	Latvian Hospital Association
8	REVALDE	Zane	Latvia	Chairperson	Students' Group of Trade Union of Health and Social Care Employees of Latvia (LVSADA)
9	SMATE	Inga	Latvia	Director Public Health Department	Ministry of Health
10	BARAN	Bartosz	Poland	Representative	Ministry of Health
11	DOBROWOLSKA	Beata	Poland	Representative	Academic society
12	GORZKOWICZ	Bozena	Poland	Representative	Stakeholder
13	RIBARIC	Samo	Slovenia		Faculty of Medicine at the University of Ljubljana
14	TERSEGLAV	Saska	Slovenia	Director	Association of Health Institutions of Slovenia
15	TICAR	Zdenka	Slovenia	Chief Nursing Officer Ministry of Health	Health Care Directorate of the Ministry of Health of the Republic of Slovenia
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17	FACCHINETTI	Nadine	Switzerland	Deputy Head of division health policy	Federal Office of Public Health
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21	HOREMANS	Christian	EU	Head of International Affairs	Association internationale de Mutualité (AIM)
22	LEMYE	Roland	EU	Vice President	Standing Committee of European Doctors (CPME)
23	XYRICHIS	Andreas	EU	Policy Advisor	European Federation of Nurses Associations (EFN)
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26	KIDD	Elizabeth	EC	Seconded National Expert	DG SANCO, European Commssion
27	NEUBAUER	Katja	EC	Head of Section healthcare and quality	DG SANCO, European Commssion
28	BUCHAN	Jim	Expert	Professor	Queen Margaret University Edinburgh/ Scotland
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30	FLOTTORP	Signe Agnes	Expert	Senior Researcher	Norwegian Knowledge Centre for the Health Services
31	PADAIGA	Zilvinas	Expert	Professor	Kaunas University of Medicine/ Lithuania

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Policy Dialogues 28-29 April 2010 (Group 2)
Faculty Club Leuven

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Policy Dialogues 29-30 April 2010 (Group 3)
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13	RAULT	Jean-Francois	France	President	Conseil départemental du Nord/ Ordre national des médecins
14	SICARD	Frédéric	France	Chargé de mission santé Europe communautaire	Ministry for Health and Sport
15	HARMAT	György	Hungary	Representative	Hungarian Hospital Association
16	MEDGYASZAI	Melinda	Hungary	Ministerial Comissioner	Ministry of Health

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