Policy dialogue
Brussels, 4-5 May 2017

Health workforce planning and professional mobility:
how to steer inflows of medical doctors and students?

Meeting report

Aims and objectives

This policy dialogue, which was hosted by the Belgian Federal Public Service on Health, Food Chain Safety and Environment, focused on approaches to effectively implement a national planning policy for health professions (especially medical doctors) within the context of EU free movement of healthcare providers.

It was organized to inform policy makers in Belgium about policy options with regards to steering the inflow of foreign doctors and medical students. The meeting built on the experiences of other EU and EEA Member States (Austria, France, Switzerland, Germany, Netherlands) that are confronted with similar challenges and that have adopted policies or have relevant experience in these fields.

Participants included representatives of the Minister’s Cabinet, the Federal Public Service on Health, Food Chain Safety and Environment, the National Institute of Health and Disability Insurance as well as academia. The meeting was held under Chatham House rule¹.

The policy dialogue specifically discussed planning policies and regulation of access into medical education and the medical profession around three main levels:

1) entry into basic under-graduate medical training;
2) access to specialist post-graduate medical training;
3) access to medical practice;

The context

The issue

Over the years countries have established planning mechanisms in order to steer and control the production and supply of health care workers within their territory. These mechanisms were often meant to limit the number of mainly doctors with a view to containing health expenditure (supply-induced demand) and ensuring quality of medical training and health care.

However, this national planning is confounded by cross-border mobility of both health care students and professionals. Especially in the context of EU citizens’ fundamental rights of free movement and residence, Member States are restricted in the actions they can take to manage these flows. Based on the Professional Qualifications Directive they are required to automatically recognize the qualifications of doctors and dentists trained in another Member State. Even if the regulation of the medical profession is a national prerogative, any condition to which the authorisation to practice is made subject, needs to respect the principles of non-discrimination and proportionality. This is also

¹ When a meeting, or part thereof, is held under the Chatham House Rule, participants are free to use the information received, but neither the identity nor the affiliation of the speaker(s), nor that of any other participant, may be revealed. (See more at: http://www.chathamhouse.org/about/chatham-house-rule#sthash.6A6iU8I3.dpuf)
the case when countries take measures to reduce reliance on foreign health care workers and ensure self-sufficiency.

**Trends in the medical workforce in Europe: numbers, skill-mix, distribution and migration**

According to OECD data the number of doctors per capita has increased in nearly all European countries between 2000 and 2014, except in Belgium and France. While the number of doctors has proportionally grown more rapidly in the UK and the Netherlands, Belgium and France have a relatively higher share of ageing doctors. The share of GPs has in the same period declined in most countries, while it remains highest in France and Netherlands. There are also significant variations in doctors-nurses ratio.

The share of foreign-trained doctors has increased in most countries, with the UK and Switzerland as prominent outliers (see Fig. 1). In Belgium, the share of foreign-trained doctors in the total stock of doctors has increased from 5.3% in 2006 to 11.9% in 2016. At the same time the source countries have diversified beyond the traditional neighbouring countries, and now also include countries such as Romania, Italy, Greece and Spain. The “outflow” of doctors trained in Belgium seems to be lower than the “inflow” of doctors trained in other countries.

**Figure 1: Share of foreign-trained doctors in selected OECD countries (2000-2015)**

Health workforce forecasting is complex, especially since not only changes in population needs have to be factored in but also changes within the medical profession (e.g. age to retirement, activity levels) as well as the interaction with other health professions. Also international mobility is a complicating factor, with flows that can change rapidly. Particularly outflows are difficult to trace.

Any provider stocks and flows model needs to be put into broader context of demand and supply of health services. With respect to doctors’ supply OECD countries pursue a variety of different priorities: extending working time, immigration policy, task shifting to other health professionals, encouraging general practices or specialities with shortages, addressing geographical shortage, increasing training capacity. The demand for doctors (both GPs and specialists) can be reduced through expanding the scope of practice of other “mid-level” providers (nurses, pharmacists, ...).

**Regulating the medical profession and steering professional mobility under the EU legal framework: possibilities and limitations**

Under the framework of mutual recognition of professional qualifications (Directive 2005/36/EC), doctors, general care nurses, dental practitioners, and pharmacists can obtain permanent establishment in another Member State based on the automatic recognition of their medical degree, without any additional condition. This automatic recognition is based on harmonised minimum training requirements as specified in the Directive. While minimum harmonisation under the Directive is focused on requirements towards training and length of training, it provides room for further specifying the portfolio of acquired competences, which has only been done for nurses so far.
There is no intention under the Directive to create complete similarity between training programmes in different Member States.

According to the Directive, professionals are required to have the necessary language skills. For professions with patient safety implications Member States are allowed to organise a systematic language control, but no systematic language test (cf. CJEU Case C-317/14). The health professional must be able to demonstrate his language knowledge in different ways. Besides, language knowledge can only be checked for one official or administrative language of the host Member State, and only after this Member State has recognised the qualification. Any checks need to be proportional and open to appeal. It is up to the Member States to decide whether these checks are performed by one central body or delegated to the employers, but it can only be checked once.

Since January 2016, the European Commission has launched an alert mechanism on professionals exercising a health- or child-related profession, with the aim to protect patients and consumers. It introduces an obligation for competent authorities of a Member State to inform the competent authorities of all other Member States about a professional who has been prohibited, even temporarily, from exercising his professional activity or who made use of falsified documents. More than 10,000 alerts were sent in the first year, mainly for nurses and doctors. This exchange of information is based on the use of the Internal Market Information system (IMI). The database works under strict data protection rules and can only be consulted by the competent authorities.

In January 2017, the Commission as part of its Single Market Strategy issued a package of measures to improve access to regulated professions. In this context a draft directive was issued that introduces a general obligation for Member States to conduct an ex-ante proportionality assessment of any new and any amendments to existing provisions that are likely to restrict access to or the pursuit of regulated professions (42% of which are to be situated in the health and social services sector). The proportionality test is based on criteria established by the European Court of Justice. In essence, Member States are required to justify any restriction to the free movement, demonstrating that the measure is necessary to ensure a general interest (e.g. public health, patient safety) and that it cannot be achieved with a less restrictive measure. This assessment can be challenged by individual citizens or the European Commission. The proposal in principle does not distinguish between different professions. It applies in the same way to medical and other professions. However, in the individual appreciation criteria can be weighted differently according to the specificity of each sector. Even if in Belgium a national quota system applies to nationally trained graduate doctors (see next section), on the basis of which they can be denied a NIHDI number, required to practice under the statutory health insurance, foreign-trained doctors could not be refused access to the market (and the NIHDI number) as a result of a “full quota”. Indeed, under European law reverse discrimination - meaning that a Member State’s national law provides for worse treatment of its own citizens than other EU citizens - is not prohibited. Also any limitations imposed on foreign health professionals to work within the statutory health insurance system would have to go through proportionality test (justification of the measure as necessary to protect a public interest) and meet the requirement of non-discrimination on the basis of nationality or establishment.

The Belgian situation

Federal planning system

Belgium is said to have one of the most advanced health workforce forecasting systems in Europe. It includes a federal database containing information on the more than 40,000 health professionals who are entitled to provide health services (identity, certification, permit, etc.). This register is matched with other databases (e.g. health insurance, social security) to obtain an overview of the professional’s activity in Belgium (PlanCad). Based on a comprehensive health workforce mathematical model, the future evolution of the health workforce is projected in different scenarios. These projections serve as a basis for the Federal Planning Committee to define quotas on the number of doctors trained in Belgian universities who will have access to a work placement in order to obtain a specific professional qualification (specialisation).
In 1997 Belgium decided to introduce a mechanism for limiting the number of health practitioners in the health system. This mechanism became effective as of 2004. Based on an estimation of inflows and outflows as well as other factors that may influence the future needs in terms of health workforce, annually a maximum number is set of medical graduates who will be allowed to start residency training in family medicine or any other specialization. In practice, this is operated by limiting the number of registrations with the National Institute of Health and Disability Insurance (NIHDI), required to work under the statutory health insurance system during specialization. Recently, the Federal Planning Committee proposed to set the number of graduating doctors needed for 2023 at 1,445 (a separate mechanism applies for dentists). Next to the general maximum threshold, also minimum thresholds are set for certain specialties (GP, acute and emergency medicine, child psychiatry, geriatrics). The competence to set these minimum thresholds has recently been transferred to the Communities.

The actual implementation of this federal planning mechanism is left to the Communities, which are competent for education. Since 1997 the Flemish Community applies an entrance exam for starting medical studies at Flemish universities\(^2\). The French Community attempted several times to introduce its own selection process but this was each time successfully challenged in court. This has led to a relative overproduction of doctors who graduated from medical schools of the French-speaking Community. Still they could all be registered with the NIHDI, by basically anticipating registration quota for future years (‘système de lissage’). However, this practice will stop in 2018 and according to a recent government agreement, the surplus number will be compensated by a reduction of the quota for the French Community from 2024 onwards.\(^3\)

Currently, the federal quotas only apply to doctors and dentists who successfully finished their basic medical training in Belgium, regardless of their nationality. Medical students coming from a country that doesn’t organise a full curriculum (i.e. Luxembourg, Malta and Liechtenstein) are exempted.

**Foreign flows**

There are an increasing number of non-resident students (i.e. students coming from abroad) pursuing their medical studies in Belgium, especially in the French Community (26% in 2013-14 compared to 8.5% in Flanders)\(^4\). In addition, medical graduates from abroad come to do their medical specialization (11.4% in 2015) and foreign-trained doctors establish their medical practice in Belgium. Foreign trained doctors represented 9.4% of the stock in 2012, but only 3.7% practice within the context of the statutory health insurance. Their activity level in terms of average FTE is also 3 times lower than that of domestically trained doctors. There are about 6500 foreign medical doctors who enter the Belgian labour market with only basic training and no enrolment in any recognized plan for specialized/GP training. They represent up to 30% of the stock of foreign doctors. In principle they are registered at the NIHDI with a number starting with the code “000”.

In recent years more than 25% of new licenses to practices were attributed to foreign-trained doctors. For dentists, these shares are even a bit higher, but - more importantly - have increased significantly since 2011. The inflows are relatively higher in the French Community than in Flanders. For foreign-trained doctors this amounted in 2016 to 35.9% of all new licenses in the French Community compared to 11.1% in Flanders (Fig. 2). The number of foreign nationals arriving on the Belgian labour market is taken into account in future workforce forecasts in order to determine forthcoming quotas.

Obviously, the federal quota system does not apply to foreign-trained doctors and dentists who register in Belgium. Those who qualified within the European Economic Area (EEA) and Switzerland...
can based on the Professional Qualifications Directive\(^5\) start their specialisation in Belgium (provided they can find a training place) or establish their practice. Those coming from outside the EEA have to submit an individual request for academic equivalence of their diploma.

There is a growing concern that by limiting the national production of doctors without controlling inflows of foreign-trained doctors, shortages in certain fields might occur which then can only be overcome by relying even more on foreign doctors. At the same time, Belgian students as a way to bypass the federal quota system are looking to start their basic training in other EU Member States.

**Figure 2: Belgium: Flows of medical students and doctors (figures 2016)**

In 2006, the Wallonia-Brussels Federation adopted a Decree limiting the enrolment of non-resident students (legally residing in Belgium for less than 15 months) in paramedical courses to 30% of the available places. This decree has been extended to students in medicine since 2012. After the European Court of Justice in 2010 (C-73/08, Bressol case) already clarified the limited grounds on which such a restriction could be justified, the Commission prolonged its freeze on infringement proceedings, allowing Belgium to improve the evidence base for its decision and to explore alternative policy options for avoiding any possible shortages of qualified personnel in Belgium. Whereas the total number of enrollees in the first year of French-speaking medical schools has more than doubled since 2004, the share of Belgian students decreased from 80% to 70% prior to the entry into force of the Decree. Since 2012, the share of students with residence in France has slightly decreased from 16% to 14%. The share from other countries has remained stable at 14% and the percentage of Belgian students rose slightly.

The large majority of foreign nationals who followed basic medical training in Belgium also apply for an internship in Belgium (e.g. 91% of French graduates, 55% of Dutch graduates). They are also taken into account in the quota system.

**Entry into basic medical education**

*Planning and selection*

In the Netherlands, a numerus clausus applies for entry into basic medical education. Based on nationally set quota, the number of training places is then distributed among the different medical faculties. These quotas are decided by the ministers of health and education, based on an advice of the Advisory Committee on Medical Manpower that explores scenarios and validates forecasting assumptions, involving all relevant stakeholders (health professions, health insurers, medical faculties, patient organisations). The projection model also takes into account inflows from abroad,

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which remain however limited (9.3% of new licenses). Quota are first defined for each specialisation, and based on this, quota are defined for both basic and post-graduate training places. While places for basic training are financed by the Ministry of Education, the training places for specialisation are financed by the Ministry of Health. Candidates for basic medical training are since two years selected on the basis of an interview that is carried out by the medical faculties and tries to assess motivation, basic knowledge and skills.

**Figure 3: Doctor flows’ capacity plan 2013 in the Netherlands**

In **Switzerland**, entry into basic medical training is defined by the capacity of the universities. All universities apply a numerus clausus since 2004, either at the start of the medical education (German-speaking universities) or before entering the second year (French-speaking medical schools). The test is mainly cognitive. The numerus clausus is motivated by the limited number of clinical training places. The authorities asked the deans of the different universities to increase the number of basic training places from 900 to 1,300, not with the intention to ultimately increase the number of doctors but to decrease the reliance on foreign-trained professionals (representing more than 2/3 of the new licenses). Only 15% of candidate students participating in the Swiss entry exam can start basic training. This is ethically and politically sensitive considering the high inflows of foreign-trained post-graduate students and doctors. The unregulated inflow of foreign-trained health professionals undermines any attempt to plan the national production of doctors.

In **Germany**, the federated States (Länder), who are responsible for financing education, define the number of places for medical students in consultation with the universities. An historical agreement between the Länder applies to ensure 10,000 undergraduate training slots per annum, even if this was never codified. If there is an agreement on quota between involved stakeholders at regional level (insurers, doctors, authorities), then the federal level can take this into account. Admission to the studies is decided centrally and is dependent upon the candidates’ secondary school leaving grade and waiting time. Special quotas for specific target groups apply. A limited number (15%) of medical students are accepted by means of interviews at university level. The policy debate focuses mainly on criteria for admission rather than the annual number of students to be admitted, with some stakeholders highlighting the possibility of placing more weight on aptitude and commitment.
to (future) practice in primary care among students applying to medical school. Some initiatives are taken to ensure more emphasis on basic and primary care and adapt the selection process. Incentives also aim to attract more students from rural areas.

In Austria, access to basic medical education in public universities is organised based on a standardized EMS test. Following the massive inflow of German students bypassing the numerus clausus in Germany (35%), Austria in 2006 introduced a quota system by which 75% of the 1,500 available training places available are reserved to students with Austrian high-school diplomas. As this constitutes an indirect discrimination against EU citizens from other Member States, the European Commission started infringement proceedings. In May 2017, the Commission finally closed the infringement case against Austria, classifying the quota system for medical studies as a justified and proportional measure to protect the Austrian public health system. On the other hand, it concluded that the restrictions in place for dental studies were not justified as no shortage of dentists is likely in Austria.

In France, the first year of studies is common for medicine, midwifery, dentistry and pharmacy. At the end of this first year an entrance examination is organised for candidate medical students. The option of abandoning the national numerus clausus (Fig. 4) and regionalizing the human resources needs assessment and planning, is being discussed. In order to solve the problem of “medical deserts” and attract more students who would be willing to set up their practice in rural areas, it is suggested to also organise examination and training in rural areas. Candidate students who contractually accept to work for a specified period in an underserved region can receive a study grant. This also allows students with a less favourable socio-economic background to enter the studies and helps to ensure that the health workforce is more reflecting society. Ambulatory residency posts should also improve attractiveness of primary care. Furthermore, reorientations in the training programs to encourage working in team are under discussion.

Discussion

Several participants expressed doubts as to the efficacy of the numerus clausus system in their country, apart from increasing the success rate in the first year of training. Often a situation of oversupply can very quickly turn into a situation of shortage (cf. pig cycles), especially for remote areas and general practice. This calls for some pragmatism in workforce planning, especially since it takes at least 11 years to see the effect of any planning measure taken at the level of medical education (Fig. 5).

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6 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5158235/
Another point of debate was whether the applied selection mechanisms for medical training are really effective for getting the students with the right profile. While they are focusing on the necessary intellectual capacities, they often seem to disregard the best social attitudes and the right motivation for clinical work. It was also questioned whether students sufficiently reflect society, with regard to social status, and regional or cultural provenance. These flaws of the selection systems are partially held responsible for shortages of candidates for general practices and for working in rural areas.

A system with a first common year for several medical and paramedical professions was considered not advisable. It would not sufficiently take into account the specific training needs for each of these professions and it creates hierarchy between the students. While selection by interviews would allow taking more into account the motivation of the students, it may be difficult to standardize and uphold impartiality. The experience in the Netherlands also demonstrates that it requires a lot of effort for the medical faculties.

### Figure 5: Medical education cycles in England, France, Germany and the Netherlands

![Diagram showing medical education cycles in England, France, Germany, and the Netherlands.](https://www.rand.org/pubs/research_reports/RR622_readonline.html)

**Access to postgraduate medical training (specialist/GP)**

### Planning and allocation

In the Netherlands, training places are tax funded: both the teaching hospital and the intern are paid by the Ministry of Health, separate from the funding of care provision and independent of the activity level of the intern. The number of training places for each specialty is defined by the Advisory Committee on Medical Manpower simultaneously with the quota for basic training. The allocation to the various teaching hospitals is agreed between the concerned hospital boards. Graduate doctors can apply for an internship with the specialisation and location of their preference. The so-called training reservoir, the number of doctors in search of a specialist training position, has been systematically growing over the years, mainly due to a reduction of the number of postgraduate training places as a result of budget cuts. Often, students after graduation work several years in hospitals as a “doctor without a specialization” (ANIos) before they actually can start their residency. Some do a PhD before entering into specialist training. There is an imbalance between the individual preferences of the graduated doctors and the availability of specialist training positions and locations. Student counselling aims to ensure that candidates have realistic expectations about their prospects to qualify in a certain specialty and to inform them about the features of alternative
options. The mild surplus of graduate doctors and the competition to obtain an internship also seems to work a disincentive to inflows from abroad.

In France, the number of places per specialty and per region is decided by the central government (Ministry of Health) based on a proposal of the National Observatory of Health Professions. To enter specialist training (3rd cycle of medical studies) graduated medical students have to participate in a national competitive exam. Based on the obtained results, they are ranked to choose a training programme and region. While all candidates are eligible for a postgraduate training place, it demotivates those who could not have access to the region or profession they initially aimed for. Hence, many drop out after a short period and pass the exam again or try to change specialty by staying in hospitals (particularly for GP’s who ultimately become geriatrician or emergency doctor and do not establish in primary care). This system does not solve the shortages in certain disciplines (in particular GPs) nor the problem of the “medical deserts” and regions with a lack of medical supply. It is criticised for being more focused on the needs of the teaching hospitals rather than on those of the population. It leads to geographical maldistribution of residence places and the decrease of GP’s working in ambulatory care. Specialist training is also strongly hospital-oriented. The deans of the medical faculties proposed to adapt the number of places more according to population needs.

In Austria, post-graduate training is offered at all public hospitals, subject to some quality criteria (e.g. sufficient number of procedures performed). A soft capacity monitoring and planning is organised by regional health funds in particular with regards to GP training. The distribution of specialties is mainly decided by the regional health funds in cooperation with the hospitals. Training for general practice is shorter (3.5 years). To stimulate general practice a common initial training (9 months) was introduced for both tracks and GP teaching practices were set up (Fig. 6). Postgraduate training places are approved and monitored by the medical chambers. Medical graduates apply for a position. Waiting times for an intern position can vary greatly between regions.

Figure 6: Post-graduate training in Austria

In Germany a national exam is organised at the end of the basic training. Practice-based training at the hospital is traditionally funded by the sickness funds through the DRG-financing. As a result, there is an imbalance in the number training places towards those specialisms that generate more revenue. Teaching hospitals in urban areas choose the best candidates, while rural areas take “the rest”. To encourage more training of GPs, subsidies are now provided for residency training in ambulatory practice. Similarly, training places in more rural areas were created to attract more students from the country side. Also in the design of specialist training, the medical chambers also introduce more commonalities between different specialities. In this way, specialists in internal medicine can be easily re-assigned to become family doctors.

In Switzerland post-graduate training is not regulated. As in Germany hospitals are free to attract and accept candidates for specialist training according to their needs and the specialties that
generate revenue from the DRG financing. A considerable number of the residency places are filled with students who obtained their basic training abroad (see Fig. 7).

**Figure 7: New licensed physicians in Switzerland (2004-2014) according to country of training (basic/specialisation)**

![Graph showing new licensed physicians in Switzerland by country of training (2004-2014)]

**Discussion**

In most countries, the number of available training places per specialty seems to hardly reflect population needs. It is generally tailored according to the needs and/or the financial means of the teaching hospitals. A planning mechanism that is transparent and more based on the assessment of patients’ needs was seen as more appropriate. Also more stakeholder involvement, including patient representatives and hospitals, in the definition of the quota for GPs and specialist doctors as well as in the allocation at regional and hospital level, would help to ensure a broad support.

Funding specialist training directly from the public budget, as in the Netherlands, would help to allocate training places more across regions and hospitals based on assessed needs. Separating financing of training places from the actual funding of care provision could also improve the quality of training by reducing any pressure on interns to increase their activity rate and protect them from exploitation. In Germany, the external funding of trainees in certain GP practices was criticised for creating unfair competition between practices.

The criteria for professional training should take into account any possible future career shifts, for instance from internist to GP. The development of common basic training for all post-graduate interns and a common training for several specialisms was considered a good practice.

A uniform examination of all candidates for specialist/GP training would contribute to transparency and objectivity in allocating the available training places. However, this examination should not only be based on an assessment of theoretical and clinical competencies but also include a practical component to test the right skills and profile for performing clinical work with patients and comply with minimum quality standards.

Foreign-trained graduate doctors should be ensured equal eligibility to training places. Any limitation that would specifically target them would not stand the test of EU law.

**Access to medical practice**

**Licensing and establishment**

In Austria, licensing and registration of GPs and specialists is conditional upon an exam organised by the medical chamber. Foreign-trained doctors’ diplomas are approved by the medical chamber. In ambulatory care, doctors who want to obtain a contract with the social health insurance system for an outpatient practice, are put on a “waiting list” run by the medical chamber. Places are limited and attributed based on criteria which are negotiated between the medical chamber and sickness funds at regional level. The Ministry of Health or the Parliament can define ranking criteria. For services provided by non-contracted doctors, patients are still reimbursed at 80%. Inflows of foreign-trained
doctors (mainly from Hungary, Czech Republic) have slightly increased in recent years (Fig. 8). They have helped to compensate the drop in numbers of doctors trained in Austria.

**Figure 8: Number of physicians firstly registered in Austria (2006-2015)**

In **Germany**, physicians must pass an examination administered by specialists in the targeted qualification. Outpatient practice places are subject to regional planning, which makes it more difficult to establish a new practice in more urban areas. To provide services within the context of statutory health insurance (SHI), doctors have to be accredited by the regional associations of SHI physicians. To cope with the growing problem of shortages of GPs, in particular in rural areas, designated recruitment programs are set up and financial incentives are provided for settlement in underserved areas. Also the retirement age for ambulatory doctors was abolished and retired doctors are recruited again for ensuring night or weekend service. Recruitment of foreign doctors is not an “official” strategy, but undertaken in particular by hospitals, especially by smaller ones that are struggling to find doctors to ensure activity.

In **France**, once accomplished the specialty training doctors are free to establish a practice or start working in a hospital. The medical profession has traditionally opposed to any limitations to the right to freely establish a practice. In order to ensure a better distribution and address the so-called “medical deserts”, rather supportive and incentive measures have been introduced (e.g. “engagements du Pacte Territoire Santé”, promoting group practice, recall of retired doctors). All doctors with a post-graduate training are also entitled to work within the statutory health insurance. This also counts for foreign-trained doctors moving to France (60% of whom are from outside the EU). France has also been faced with problems of foreign doctors working in hospitals in low positions and bad conditions, but their status has been improved and formalised. Occasionally some concerns are raised regarding quality and language proficiency of doctors trained abroad. Doctors with only basic training are not allowed to practice (except for replacements).

In **Switzerland**, GPs or specialists who want to open an independent medical practice need to get an admission. A block of admissions was applied from 2002 till 2011, and temporarily renewed for the period 2013-2019. However, it is up to the cantons to decide whether or not to make use of it (20 cantons do). While the criteria for admission and the type of specialties it applies to are determined at cantonal level, a federal exemption to the block of admission applies for doctors who have worked for at least 3 years in a Swiss hospital. Also since 2009 an exception is made for GPs. The block of admission equally applies to immigrant doctors who want to set up practice in Switzerland, but the federal exemption may be considered an indirect discrimination from an EU perspective. Policy makers currently discuss the option of continuing the block of admission as well as to improve it by introducing quality-based criteria. Admission automatically opens reimbursement of services provided under the statutory health insurance.

In the **Netherlands**, a specialist exam is organised at the end of specialist training. Registration is valid for five years, after which doctors have to obtain recertification based on certain requirements (e.g. minimum activity level, training points, peer review, participation in a visitation programme).
licenced doctors can be contracted by the health insurance system without restrictions. Foreign-trained doctors can also set up their practice. The Dutch Royal Medical Association certifies their language proficiency. The required level of Dutch is decided by a council for each specialty in accordance with the features of each specialism and the need for patient interaction. Next to the language barrier the relative low number of inflow (9.3% of new licenses) is attributed to the severe budget cuts (volumes and prices) in hospital care, but also the specific care culture with a high focus on primary care and care coordination, a growing centralisation of specialised care in fewer hospitals. Also the gatekeeping system, which makes access to a specialist subject to a referral by a GP, could make it more difficult for foreign doctors, with less professional networks, to set up a practice.

Discussion

At the meeting some concerns and reservations were raised about the minimalistic approach towards quality of care and patient safety under the EU Directive on professional qualifications, which does not provide any room for constraining the influx of medical specialists who may not be trained up to the level as would be expected in the country of establishment.

There was support for the idea to make a license to practice, especially in the context of statutory health insurance, more subject to an assessment of the quality of physicians. This would not only have to apply to newly licensed doctors or doctors trained abroad, but should also apply also to doctors with an established practice. In that respect, the idea of periodic recertification of health professionals allows to monitor the quality of the professionals, including foreign-trained doctors. Linking recertification to a minimum activity level not only may desirable for quality reasons, it could also help to obtain a better insight in the outflows of medical doctors or in circular mobility.

The language check was considered an important measure to guarantee the quality of the communication with the patients. It remained unclear as to whether authorities in countries with different official languages in different geographical areas (such as in Belgium) can request the knowledge of the official language of a specific region, and which authority (regional/federal) should do the check in such a case.

Whereas international mobility clearly can help to mitigate imbalances in supply of health professionals, a too high reliance on foreign inflows was considered risky and undesirable as it would make a country’s supply of health professionals too much volatile and dependent on policies and developments in other countries. A mild “overproduction” of doctors nationally may help to guarantee self-sufficiency and mitigate foreign inflows.

The option of restricting access to practice under the statutory health system - while maintaining free access to private practice - as a way to steering inflows was also debated. While this mechanism is used in different manners in Germany, Austria and Switzerland, and to some extent also applies in Belgium for physiotherapists, it raised some concerns about creating a two-speed health system.

Another concern is the group of foreign doctors recruited by hospitals in Belgium with only basic training (cf. the physicians coded “000” by the NHIDI), represent up to 30% of all foreign-trained doctors in Belgium. While in principle they can only provide a limited number of reimbursable health services, it is suspected that many of them do provide a wider range of services than allowed, which are then invoiced to the NHIDI by a Belgian medical doctor with a specialist title. Some may even not be registered at all with the NHIDI. Such practice does not seem to exist in the other countries and should be closely monitored and strictly regulated.

Conclusions

The advantages of free movement and professional mobility are widely acknowledged. The question is more for policy makers how to square the circle, where to put the cursor between self-sufficiency on the one hand and reliance on foreign production of health professionals.

The share of foreign-trained doctors in Belgium is clearly within range of other countries (around 12% of the workforce). However, the inflows are increasingly significant. With nearly 1 in 4 new
licenses being foreign trained, Belgium is similar to France, but still stays far below Switzerland (more than 1 in 2).

This high inflow of doctors is creating the perception that there is a shortage of doctors. The national planning system may not only be considered as the cause of this perceived shortage, it is also seen as discriminating against doctors being trained in Belgium.

The instream of foreign-trained doctors raises some concerns about the quality of care. The Professional Qualifications Directive only provides a minimum harmonisation of training requirements. While it provides room for further specifying the portfolio of acquired competences, this has only been done for nurses so far. These concerns do not only relate to the quality of training abroad but also to the way these foreign-trained doctors are integrated into the Belgian health system. Examples were given of foreign doctors being used specifically to ensure night and weekend shifts or working “under the radar” (i.e. their services being invoiced by a Belgian doctor with NIHDI license).

It was felt that this issue cannot be dealt with in isolation and needs to be addressed in a broader perspective, taking into account both changing patients’ needs and delivery models. Thinking out of the quantitative box, the issue is more about what types of health professionals we need for the future, what skills and competencies we expect from them and how to train them accordingly. This requires regulation and intervention that applies to all doctors alike, both national and foreign-trained.

In addressing some of the problems that have been discussed at the meeting, the EU level could clearly play a supporting role. This would be the case in helping to further monitor mobility flows, including collecting data on outflows and organising surveys on mobile professionals. The EU could also help to push for the need for ensuring quality of all health professionals. At the meeting reference was made to the European Council for Accreditation of Medical Specialist Qualifications (ECAMSQ), which was created in 2010 by the European Union of Medical Specialists (UEMS) as an instrument to assess the competence of individual medical specialists across Europe based on the core curricula developed by the Specialist Sections of the UEMS.

This report was written by

- Willy Palm, Senior Adviser, European Observatory on Health Systems and Policies
- Rita Baeten, Senior Policy Analyst, European Social Observatory
- with support from the Belgian Federal Public Service on Health, Food Chain Safety and Environment

Additional sources consulted:


SPFS, DGGS, Professions de santé et pratique professionnelle, Médecins : mobilités internationales, Note de la cellule Planification de l'Offre des Professions des Soins de Santé, mars 2015, 54 p.;

Disclaimer:
The report is the sole responsibility of the authors and can in no way be taken to reflect the views of the Belgian Federal Public Service on Health, Food Chain Safety and Environment
Key messages from the policy dialogue

- The issue of migration of medical doctors and students cannot be addressed in isolation. Any measures need to be embedded in a broader health workforce policy.
- Foreign inflows can help to address shortages in certain geographical or specialist areas, but they can also add to the existing imbalances between supply and needs. In any case, a too high reliance on foreign inflows is not only undesirable from a planning perspective (as it may undermine any planning efforts and make it subject to volatilities) it also risks to frustrate own residents who want to enter medical education and are faced with barriers nationally.
- The EU should support Member States in squaring the circle and provide for some legal clarity and security as to the measures they can take to address imbalances and ensure the health workforce supply to meet the needs of their population.

Access to basic training

- Considering the length of the medical education cycle, health workforce forecasting and planning needs to be done carefully but also with some pragmatism. We need to think outside the "quantity box" and allow for some flexibility.
- A mild oversupply of nationally trained graduate doctors could seem indicated not only to ensure self-sufficiency and address shortages in certain geographical or specialty areas but also to mitigate foreign inflows.
- Any national restriction on the training of medical doctors should take into account the potential outflow of non-resident students after training. More accurate and reliable outflow data are needed.
- Selection for medical training needs to better reflect society and focus more on social skills and motivation rather than only cognitive capacities. This can actually help to better address shortages in certain areas.

Access to specialist training

- Post-graduate specialisation needs to better reflect population needs and requires the involvement of all stakeholders to ensure consensus and compliance.
- A uniform test before the start of specialist training that would also assess the clinical and social skills, could contribute to a better orientation of students, improve transparency around the allocation of specialist training places and ensure trainee’s compliance with minimum quality standards.
- Separating funding of specialist training from the normal financing of medical activity can help to achieve a better allocation.
- Allowing for more flexibility during the career and creating common trunks between different specialities in post-graduate training can help to better address changing needs and occurring shortages in supply.
- Counselling of post-graduate students to guide them in their future career planning and help them making an informed choice for a specialty, can also be an effective way.

Access to practice

- Access to practice needs to better guarantee the meeting of quality and patient safety standards. This supports the idea of assessing the quality of all health professionals, not only foreign-trained and not only at the start but also during their career through periodical recertification. The option of regulating access to working under statutory health insurance should only be considered in this context.
- Controlling language proficiency is a justified measure to ensure quality health care but needs to be adapted the specific situation and features of each specialty.
- Free movement should not cater for any financial exploitation of foreign-trained doctors or create any patient safety risks. This is why the activities of doctors with only basic training and no enrolment in specialty training should be closely monitored and strictly regulated.
## Health workforce planning and professional mobility: how to control inflows of medical doctors and students?

### Programme

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
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<tbody>
<tr>
<td>13.30-14.00</td>
<td>Registration at Hotel Le Plaza Brussels</td>
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<tr>
<td>14.00-15.30</td>
<td><strong>Session 1: Setting the scene</strong>&lt;br&gt;This opening session will lay out the main issues and questions around organising, planning and regulating the medical profession in the context of free movement, especially from a Belgian perspective.</td>
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<tr>
<td>15.30-16.00</td>
<td>Break</td>
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**Chair:** Jacques Brotchi, Senator, Former President of the Belgian Royal Academy of Medicine  
**Facilitator:** Josep Figueras, Director, European Observatory on Health Systems and Policies

- **Welcome and opening**
  - Welcome statement (Chair)  
  - Structure and objectives of the policy dialogue (Facilitator)  
  - Introduction of the participants and their expectations (Facilitator)

**The Belgian experience: forecasting, planning and regulating the medical profession: achievements and challenges with regards to access, quality and efficiency of care and social acceptability**

Brigitte Velkeniers, President of the Federal Planning Committee Medical Supply, Belgium and Pedro Facon, Director-General Healthcare, Federal Public Service Health, Food Chain Safety and Environment, Belgium

**Trends in the medical workforce in Europe: numbers, skill-mix, distribution and migration**

Gaetan Lafortune, Senior Health Economist, OECD Health Division, Paris, France

**Regulating the medical profession and steering professional mobility under the EU legal framework: possibilities and limitations**

Andras Zsigmond, DG GROW, European Commission

**Q&A**
Session 2: Planning, regulating and organising the health workforce: the international experience

This session will look at how other countries organise, plan and regulate their medical profession in the context of free movement. Experts will present how international mobility of health care professionals, in particular of medical students and doctors, affects both the education and the health care system. More specifically, focus will be on how foreign in- and outflows may obscure the planning and forecasting mechanisms and what is done to anticipate this.

Chair: Jacques Brotchi, Senator, Former President of the Belgian Royal Academy of Medicine

Facilitator: Matthias Wismar, Senior Health Policy Analyst, European Observatory on Health Systems and Policies

Introductory presentation by the international experts followed by facilitated discussion

- **Netherlands**: Ronald Batenburg, Programme Leader health professions, Netherlands institute for health services research (NIVEL), Utrecht
- **France**: Yann Bourgueil, Research Director, Institute for Research and Information in Health Economics (IRDES), Paris
- **Germany**: Bernard Gibis, Head of the Department for service contracts and pharmaceuticals, and Dr Branko Trebar, Head of Unit, Health Care structure, National Association of Statutory Health Insurance physicians (KBV), Berlin
- **Austria**: Herwig Osterman, Executive Director, Austrian Public Health Institute, Wien
- **Switzerland**: Ryan Tandjung, Head Healthcare Professions Division, Swiss Federal Office for Public Health, Bern

Questions

- How do other countries plan and control access to the medical profession? Where and when exactly in the process/pipeline do they intervene? What kind of mechanisms do they use?
- What is the main motivation for countries to apply any restrictions in the supply? What has been the impact of these interventions so far?
- Are these restrictions being contested? Is there any legal leverage against restrictions either nationally or at medical school level?
- How important is cross-border mobility of both health care students and professionals in other countries? Is this mobility raising any concerns? Are there also any advantages/benefits are attached to it for the health system?
- What is done to monitor, steer and/or restrict inflows and outflows? To what extent are these flows taken into account by the national planning mechanisms?
- How are the flows evolving?
- Is cross-border mobility of doctors a matter of public and political debate?
and mid-term exams. A particular focus will be put on decentralized/federalized countries and those with high autonomy of medical schools producing regional diversity in approaches to controlling entry into basic medical education.

Chair: Jacques Brotchi, Senator, Former President of the Belgian Royal Academy of Medicine

Facilitator: Matthias Wismar, Senior Health Policy Analyst, European Observatory on Health Systems and Policies

Short introductory presentation, followed by interventions by the international experts and facilitated discussion

Questions

- Are countries applying any limitation in the access to medical education? How does it work? Has it been challenged?
- How are targets translated to or imposed on medical schools?
- Are any restrictions applied to non-resident students? How does it work? Has it been challenged?
- Are nationals bypassing the system by starting their medical education abroad?

10.15-10.45 Break

10.45-11.45 Session 3b: Controlling and managing access to specialist training

This session will discuss how countries are trying to steer and fill their specialist training slots. Specialist training slots are in many countries limited and often medical trainees are seeking opportunities to get their preferred specialist training elsewhere. This session will discuss how countries have ensured that their specialist training is not undermining their proposed skill-mix and that students who have passed their basic medical education can proceed smoothly to the next step of their training.

Chair: Jacques Brotchi, Senator, Former President of the Belgian Royal Academy of Medicine

Facilitator: Matthias Wismar, Senior Health Policy Analyst, European Observatory on Health Systems and Policies

Short introductory presentation, followed by interventions by the international experts and facilitated discussion

Questions

- How are residency places allocated in countries?
- Who decides on distribution of different specializations over all residency places?
- Are any restrictions applied to foreign-trained graduates?
- How easy/difficult is it for foreign-trained doctors to find a residency place?
- Are the conditions for doctors trained outside the EEA stricter?

11.45-13.00 Session 3c: Controlling and managing access to medical practice

This session will discuss how to get the planned numbers and skill-mix into the service. It will deal with the question such as attrition, return to the country of origin, inflow from EU and third countries and the reactivation of health professionals that have previously left the service. Among the “knobs” we will discuss are capacity limits at national, regional, or planning area level, incentives for certain specialities
and remote practices, performance based prioritisation, language testing and priority employment for domestically trained medical staff.

Chair: Jacques Brotchi, Senator, Former President of the Belgian Royal Academy of Medicine

Facilitator: Matthias Wismar, Senior Health Policy Analyst, European Observatory on Health Systems and Policies

Short introductory presentation, followed by interventions by the international experts and facilitated discussion

Questions

- Are any conditions applied for registration in countries?
- Are licencing and registration separate processes and what do they imply for providers falling within the remit of the statutory health (insurance) system (publicly funded healthcare)?
- Are any supplementary conditions specifically applied to foreign-trained doctors to assess their skills? Are they automatically enlisted for providing services under the statutory health (insurance) system?
- Is a language test organised for foreign-trained doctors as a condition for registration? How does it work? Who should organise it? What level of knowledge should be required? Should the level depend upon the type of activity/patient contact?
- Are the conditions for doctors trained outside the EEA stricter?
- What qualitative and quantitative measures, as described above, can be imposed on doctors or dentists providing temporary and occasional services?

13.00-14.00 Lunch

14.00-16.00 Session 4: Identifying cornerstones for regulating and planning the medical health workforce

In this final session we will draw together the core elements discussed in the previous sessions. It will lay out the policy options for Belgium to calibrate its system of access to basic medical education, specialist training and to the medical labour market. It will also address the political challenges that healthcare policymakers face in regulating and planning the health workforce in order to meet tomorrow’s needs.

Chair: Jacques Brotchi, Senator, Former President of the Belgian Royal Academy of Medicine

Facilitator: Josep Figueras, Director, European Observatory on Health Systems and Policies

Summary report of the meeting

Rita Baeten, Senior Policy Analyst, European Social Observatory and Willy Palm, Senior Adviser, European Observatory on Health Systems and Policies

Panel discussion with main stakeholders and international experts: How do we make sure that we get health professionals in the right numbers, of the right specialities and with the right competences and skills?

Concluding remarks

- Maggie De Block, Federal Minister of Health, Belgium
- Hans Kluge, Director, WHO Regional Office for EuropeReconciling health workforce planning needs with EU obligations
Questions

- How could the current quota system in Belgium be improved?
- Should foreign-trained doctors (including Belgian nationals who went abroad to obtain their medical degree and then return to practise in Belgium) be included in the quota system? How could this work? In what way should this be aligned with the regional distribution? Could any restriction be applied to the allocation of NIHDI-numbers?
- Could any selection mechanism at the level of medical education (e.g. entrance exam) be replaced by a selection mechanism at the level of registration?
- To what extent are any measures to ensure self-sufficiency and curb influxes from other Member states compatible with European law? What additional measures/actions could be taken at the EU level to support Member States in planning health workforce and safeguarding quality health care in the context of free movement?

16.00 Closure