Regulating health professions in a European perspective
Health workforce planning in Belgium: steering national production while managing international flows

Brigitte Velkeniers
Chair Belgian Planning Committee
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• Heath care force planning in Belgium and mobility
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Health workforce projection model

• Stock and Flow Model
EU Joint Action on Health Workforce Planning & Forecasting
What is the Joint Action?

• The Joint Action on Health Workforce Planning and Forecasting, coordinated by Belgium and funded by the third EU Health Programme, brings together knowledge and expertise from all over Europe (main partner of the project, 30 associated and 62 collaborative partners from 28 countries). This group of experts has produced Handbooks and Guidelines, describing the most advanced planning methodologies of 7 countries. These are now being pilot-tested by health workforce planners in Italy and Portugal with a feasibility study running in Germany.

• The Joint Action provides insights to an analysis on future skills and competences in the health sector to feed into the labour market intelligence needed in Member States to define skill needs in their health workforce education and training policies.
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• Planning objectives
  – Ensure the training of qualified professionals in order to provide future care: from self-sufficiency to a system open to mobility
Planning tools in Belgium

REGISTER

Federal database of professionals entitled to provide services

DATA LINKING

PLANCAD
Current workforce (health insurance, social security)

BASELINE SCENARIO
Evolution of the workforce

ALTERNATIVE SCENARIOS
According to hypotheses defined by the members of the Planning Committee

DEFINITION OF QUOTAS
By members of COMPLAN
“Workforce planning” Supply of health workers

**Inflows**
- Graduates from medical education
- Foreign-trained health professionals who immigrate
- People returning to work in the health sector after a temporary exit

**Stock**
- Headcounts or full-time equivalents (FTE).
  - FTE is a better measure of the supply of the stock of health workers: adjusts for working hours and part-time work

**Outflows**
- People who leave the health sector to work in other sectors
- People who leave the workforce
- Health professionals who emigrate
- Retirement
- Mortality
Health workforce projection model

• Development of different workforce scenarios

  ➢ Baseline scenario: evolution of professionals and their activity, consumption of care (INAMI-RIZIV) according to age, gender, community, the ageing population according to the trends observed

  ➢ Alternative scenario: hypotheses proposed concerning the evolution of the profession and consumption needs

    Hypotheses formulated by the members of the Planning Commission (taking into account expected changes in the field, the profession's attractiveness, working hours, funding, the delegation of tasks, etc.)

• in interaction/collaboration with the working group (one for each profession) and the plenary working group (for validation)
<table>
<thead>
<tr>
<th></th>
<th>Inschrijvingen</th>
<th>Slag kans</th>
<th>Gediplom.</th>
<th>Stage graad</th>
<th>AIO dip bel</th>
<th>AIO dip non-bel</th>
<th>Totaal AIO</th>
<th>% specialisme</th>
<th>AIO specialisme</th>
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### RIZIV

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<tbody>
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<td>7.164</td>
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<td>0,95</td>
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Attention: the colour codes only provide an indication of the forecast's trend. It is not an evaluation of the current situation or an expression of the expected evolution.

The baseline scenario was developed based on the 2012 activity (PlanCad Médecins 2004-2012)
• Planning tools in Belgium
  – A dynamic model in constant progress

• Planning and mobility
  – 3 entries, 3 different problems

• Planning objectives
  – Ensure the training of qualified professionals in order to provide future care: from self-sufficiency to a system open to mobility
Training path for MD’s in Belgium

Basic training as physician
6 years

Specialist training
Specialist title obtained
(level 2)
From 3 to 6 years

Access to healthcare at INAMI-RIZIV (National Institute for Health and Disability Insurance)
Entry of foreigners into the training path

3 indicators: nationality, non-resident, country of origin, degree

3 moments

• At the start of medical studies
• At the start of the specialisation (internship in order to obtain a medical specialist title)
• On the labour market, in the context of the health insurance system
Health workforce projection model
Foreign inflows and Health workforce projection model

Consequence of taking into account three foreign inflows:

• The arrival of foreign nationals on the Belgian labour market is taken into account in future workforce forecasts and forthcoming quotas

• Forecasts concerning the inflow of foreign nationals for the coming years reproduce historical trends that have been observed, namely the same number, same profile (age and gender), same level of activity.
ENTRY 1: at the start of medical studies
Entry of foreign nationals at the start of medical studies

• The importance of foreign nationals differs according to community
  ✓ ± 8% in the Flemish Community (mainly Dutch)
  ✓ ± 30% in the French Community (mainly French)

• Intensity of the problem for the French community
  Ø Non-resident decree (infringement proceedings in progress)
ENTRY 2: at the start of training for a specific professional qualification (specialist training)
At the start of the specialisation

• Foreign nationals who follow their basic medical studies and their specialisation in Belgium (< non-residents)
  – 59% of graduates with a Dutch nationality submit an internship plan in the Flemish community
  – 91% of graduates with a French nationality submit an internship plan in the French community
  → taken into account in the quota system

• Foreign nationals with a basic medical degree from abroad and follow their specialisation in Belgium
  – 10.2% in the French community (2016)
  – 4.5% in the Flemish community (2016)
  → not taken into account in the quota system
  They are added to the existing stock of medical doctors
ENTRY 3: at the entry to the labour market
In the labour market in the context of health insurance

• New certifications
• Activity of foreign MD’s in Belgium
• MD’s without a speciality
On the labour market in the context of health insurance

New certifications

2016: new certifications for obtaining a professional qualification as a general practitioner or specialist in Belgium

– 35.9% of professionals qualified outside of Belgium in the French community

– 11.1% of professionals qualified outside of Belgium in the Flemish community
On the labour market in the context of health insurance

Activity of foreign doctors in Belgium (based on Plancad 2004-2012)

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<th>In practice</th>
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<td>Non-Belgian nationality</td>
<td>13.0%</td>
<td>5.1%</td>
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<tr>
<td>Non-Belgian degree</td>
<td>9.4%</td>
<td>3.7%</td>
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Average FTE in the context of health and disability insurance for foreigners is much lower than for Belgians (3 X ) (Major disparities by specialty)
Approach for assessing the impact of non-resident students on the labour market

- Measurement of the inactivity of recent **beneficiaries** (<10 years) of a certification as a specialist issued in Belgium
- Analysis conducted by community, based on data from PlanCAD Médecins 2004-2012
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Planning objectives

• Planning: ensure the appropriate number of professionals with adequate training to cover the needs of the future population
  – Need to anticipate in view of the length of training
  – Increasingly precise projection model with the constant addition of data, in particular mobility data
  – But, uncertainties persist concerning the evolution of mobility and the way of implementing it in the context of workforce evolution scenarios
Basic degree from a Belgian university

Basic degree from a non-Belgian university

Secondary school diploma obtained outside of Belgium

Specialisation completed in Belgium

Specialisation completed abroad

SPECIFIC PROFESSIONAL QUALIFICATION (SPQ)

Recognition of the equivalence of the degree and the SPQ obtained abroad

BELGIAN LABOUR MARKET

INAMI-RIZIV activity

Return to country of origin to practice
Emigration of Belgian graduates

V. SYNTHESE DE L’ACTIVITÉ DES MEDECINS EN BELGIQUE

Schéma : Répartition des médecins selon leur activité en Belgique

Actifs
37,626 (73%)

Médecin agréés (Cadastre)
51,420

Non actifs
13,794 (27%)

INAMI + INASTI: 26,693 (71%)

INAMI+ONSS: 4,563 (12%)

ONSS (Hors INAMI): 3,417 (9%)

INASTI (Hors INAMI): 2,953 (8%)

Santé: 4,621 (58%)
Enseignement: 1,027 (13%)
Services: 1,011 (13%)
Public: 835 (10%)
Aide aux personnes: 325 (4%)
Industrie: 160 (2%)
Inconnu: 1 (0%)

Résidence en Belgique: 2,766 (30%)
Non belges 3,709 (59%)
belges 2,613 (41%)

Résidence Hors Belgique: 6,322 (70%)
How to plan the workforce by taking account of mobility?

SELF-SUFFICIENCY

Training of all professionals in Belgium

QUALITY OF CARE

QUALITY OF TRAINING

OPEN SYSTEM

Training of all professionals abroad

QUALITY OF CARE

QUALITY OF TRAINING

Where and HOW should the cursor be placed in accordance with European mobility?

POPULATIONS NEEDS ETC.
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• Europe : Joint Action and Belgium
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Policy dialogue

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

Brussels, 4-5 May 2017
Figure 1: Share of foreign-trained doctors in selected OECD countries (2000-2015)

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;
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. 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.
Belgium: Flows of medical students and doctors (figures 2016)

(*) = 2013-2014

Establishment (practice)

Graduate training (basic)

Post-graduate training (specialisation)

NIHDI registration + authorisation

NIHDI registration + authorisation

EEA

Non-EEA

EEA

Non-EEA

FL = Flemish Community; FR = French-speaking Community; NIHDI = National Institute for Health and Disability Insurance; EEA = European Economic Area

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

NIHDI registration + authorisation

NIHDI registration + authorisation

26% (*)

8.5% (*)

4.5%

10.2%

11.1%

35.9%

(*) = 2013-2014

FL = Flemish Community; FR = French-speaking Community; NIHDI = National Institute for Health and Disability Insurance; EEA = European Economic Area
Belgium: Flows of medical students and doctors (figures 2016)

FL = Flemish Community; FR = French-speaking Community;
NIHDI = National Institute for Health and Disability Insurance; EEA = European Economic Area

(* = 2013-2014)
At EU level

• Quality exam by UEMS?
Thank you for your attention!

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