

REPORT OF CECDO WORKSHOP ON ORAL HEALTH CARE WORKFORCE PLANNING IN EUROPE

Held at the Cultural Centre, Ermoupoli, Greece on Saturday, 24 May 2003

1. Introduction

Prior to the meeting CDOs had received the following background papers :-

- Over-view on techniques for health and oral health care workforce planning and data on oral health care personnel in the European Economic Area in 1998. Chapter 5 from Dr K.A.Eaton's PhD thesis 2002.
- The oral health care workforce plan for Northern Ireland (2002), from Dr D.Wilson.
- Factors shaping the Medical Workforce – a Report from an Ad Hoc Group on the OECD Health Project (April 2003) from Dr. J van den Heuvel.
- Notification of the issues to be considered during the workshop.

2. Issues Considered

After a brief introduction by Dr K.A. Eaton, who acted as facilitator for the workshop, those present split into two groups.

Group 1 (Quality Issues)

Was chaired by Dr J. van den Heuvel. Dr Doreen Wilson was the rapporteur for the group. The following issues were considered :-

1. Is there a need for oral health care workforce planning on either a country or Pan-European basis?
2. Is yes why? If no why?
3. How could oral health care workforce training be planned and integrated on a Pan-European basis in the future?
4. What barriers exist to planning the oral health care workforce and its training on a Pan-European basis?

Group 2 (Quantity Issues)

Was chaired by Dr P.Langmaid. Dr. H. Augustsdottir was the rapporteur for the group. The following issues were considered :-

1. Is there a need for oral health care workforce planning on either a country or Pan-European basis?

2. Does this happen in any countries and if so how?
3. Has it been effective in the past and if so why?
4. Are there any relevant key indicators to assist oral health care workforce planning?

Both groups were asked to consider the following points when discussing the issues:-

- Is it possible to plan a workforce in health care?
- If yes, what are the most important elements to be included in any plans?
- If no, why do we attempt to plan?
- Who is responsible for the most effective and efficient “use” of health care personnel?

3.Additional “Inputs”

Dr.H. Michelet was unable to attend the workshop. However, he had produced a short paper which gave answers to the questions considered by both groups and information about oral health care workforce planning in France. This paper was circulated to all those who attended the workshop.

Immediately after the coffee break Dr. H. Galea presented a short paper on the development of oral health care work force planning in Malta since 1970.

4. Report from Group 1 (Quality Issues)

A wide ranging discussion took place during which the following points were made :-

- In terms of quality, an ideal oral health work force would be appropriately trained to deliver the most effective care and treatment for the whole population and would be paid to match the work carried out.
- History and culture were often factors which had limited effective work force planning and dentists (through Dental Associations) had often taken a short-term view to protect their earnings rather than the long-term future. In some countries this had meant that oral health care planning was “led by money” and was not patient focussed.
- Dental education should be matched to future oral health needs.
- There was a role for team dentistry. However, at present it appears that but clinical auxiliaries are trained to different levels of competency in different countries.
- In some countries , dental teams and practices were often very small and not well managed. They should be managed to commercial standards.

- Each country needed a strategy for planning its oral health work force in the medium and long-term.
- At present, workforce planning is specific to each country and may be governed by systems of regulation, payment and registration.
- At present, the Czech Republic has the problem that many of those training in its dental schools are not Czech nationals and will not work in the Czech Republic once they have completed training thus causing a fall in the number of dentists in the country.
- The stakeholders (those with an interest and influence) in the oral health care work force are :- Patients, Dentists, Governments, the Dental Industry, Dental Educators and Other Health Workers.
- Decision making over oral health care planning varies from country to country, depending on the extent to which it is funded by governments (publicly). The dental profession and dental educators are always involved as were Government Departments of Education. Regulatory bodies, insurance companies and patient groups had varying degrees of influence depending on the country concerned.
- As the European Directives permit freedom of movement throughout the EU and the right to work in a profession/trade anywhere in the Union, without Pan-European agreement over numbers of oral health care workers in training, there is a great risk of unemployed or underemployed dentists and dental team members in the future.
- At present , there is no Pan-European oral health care workforce planning and some member states within the EU appear to have no plans for their own states.
- A Pan-European over-view of the Oral health Care Workforce is needed and recommendations from European bodies such as the CECDO may help to improve the current situation and to alert decision makers in individual countries to the consequences of a lack of planning.

5. Report from Group 2 (Quantity Issues)

Each member of the group was invited to describe the oral health workforce in their countries, in terms of numbers and roles, and whether or not any planning took place. If there was oral health work force planning, they were asked to describe how it took place. The following points of particular interest emerged :-

In general, there are government controlled quotas for the number of students entering dental schools (numerus clauses) in member states from the north

and centre of the EU but not in those from the south. In countries where there was a quota system, the Government Department of Education (and sometimes Health) made agreements with Universities over how many dentists were to be trained per year and provided funds accordingly. In some countries the Regulatory bodies and Dental Associations discussed quotas and in all countries the Dental Associations expressed their views on the matter.

However, the rationale for opening or closing dental schools was sometimes not based on likely future need for the provision of oral health care but on other factors such as providing employment for university teachers.

In both Portugal and Spain, there has been a large increase in the number of students studying dentistry at university. In 2002 there were 2000 new entrants to Spanish and 550 to Portuguese dental schools (in 1996 there were 550 new entrants in Spain and about 250 in Portugal). The basis for these numbers is that the universities wish to attract students and that there are applicants for the places. Neither country has an oral health care workforce plan and there are concerns amongst existing dentists that there will be unemployment in the future as patient demand for care and treatment is unlikely to match the greatly expanded supply in the numbers of dentists.

However, the other side of the “lack of workforce planning coin” was that in Belgium, one dental school had attracted no new students in 2002 and only one the previous year.

In the UK and Portugal more than 12% of dentists qualified in other countries. In the UK there are over 4,000 non-UK qualified dentists, over 2000 of whom trained at dental schools in other EU member states. In Portugal, the majority of non-Portuguese qualified dentists come from Brazil.

In many countries the proportion of women in the dental profession is rising and in the majority of the ten countries due to join the EU in 2004, there are more women than men dentists. Many studies have shown that women dentists tend to work (as dentists) for fewer hours per week than men.

Tax regimes in some countries discourage dentists from working more than a certain number of hours.

In general, there appears to be a decline in the prevalence of dental caries in most children in EU member states and fewer and fewer people are edentulous. However, within these overall trends oral health care and treatment needs and patient demands vary widely.

Overall, in the long-term, it may be that there will be a need for increasing numbers of oral health care workers who can provide preventive care and simple treatment and another group who will plan and co-ordinate oral health care and treatment and provide the more complex forms of treatment. The former group are likely to be dental hygienists, nurses and other auxiliaries. The latter dentists who have had excellent training in communication and, team leading, as well as clinical skills.

6. Plenary Session

The Rapporteurs for each group summarised the discussions which had taken place within each group and presented the group's answers to the questions which they had been set.

Group 1 Answers

- 1. All countries should have healthcare including oral healthcare workforce plans. At present, it is difficult to see how Pan-European oral health workforce planning could be co-ordinated.*
- 2. Yes, at country level, oral healthcare workforce planning is necessary to match the oral healthcare needs of the country concerned.*
- 3. There is a need for improved collection and collation of information on the oral health care workforce in Europe to aid planning. All oral health care workers (dentists and others) should be educated to a common baseline of competencies. All oral health care workers (dentist and others) should be registered on a European register.*
- 4. Barriers to planning at a Pan-European level include : different systems for the provision of oral health care in different countries, the "culture and history" of dentists, lack of motivation to change, differing attitudes to the need for continuing professional development and a wide range in the educational standards achieved during training. The latter problem needs to be addressed by agreeing and setting workable Pan-European educational standards and monitoring them,*

Group 2 Answers

- 1. Every country in Europe should have an oral health care workforce plan and there should also be a Pan-European plan. However, it is at present difficult to see how such a Pan-European plan could be initiated and followed.*
- 2. Yes, in some countries but not in others. Where it takes place, planning invariably involves the funders and providers of dental education, others with an interest may or may not be involved.*
- 3. In the past planning has achieved mixed results and been confounded by such factors as migration, life-style changes, tax regimes and the changing balance between numbers of male and female dentists.*
- 4. Key indicators include disease levels (need), patient expectations (demand) and differing payment systems.*

A general discussion then took place during which individuals reiterated and stressed points previously made in the individual group discussions. Three follow up actions were agreed.

7. Follow-Up Actions

A. Production of a Report of the Workshop

Dr Eaton was asked to draft a report of the Workshop and send it to the Secretary of the CECDO for circulation to all those present with a request that they send proposed amendments and comments to Dr Eaton. A final version will then be circulated and included on the CECDO website.

B. Future Workshop on Training Standards for the Oral Health Care Workforce

It was agreed that at a date in the future (possibly at the next CECDO meeting in Belfast) a workshop should be held on this topic. Dr Wilson was asked to discuss this suggestion with the CECDO Executive.

C. Survey of the Current Oral Health Care Workforce in Europe and Systems for Oral Health Care Workforce Planning

Numbers of Oral Health Care workers in each European country are collected regularly by the CECDO and can be found at www.cecdo.org. However, these numbers need constant updating. It was agreed that there should be a CECDO survey to build on the informal reports made during Group 2's discussions which would ascertain details of how oral health care work force planning currently takes place in each country. Dr Augustsdottir was asked to co-ordinate the survey together with Dr Eaton and then produce a report with Drs Eaton and Widström which would serve to inform CDOs and all those involved in oral health care workforce planning.