

White Paper

WHITE PAPER on the Health Care Professions in Catalonia

on the Health Care
Professions
in Catalonia



Generalitat de Catalunya
Departament de Sanitat
i Seguretat Social

WHITE PAPER

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professions
in Catalonia**

Barcelona, 2003



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PRESENTATION

The main objective of this *White Paper on Health Professions in Catalonia* (WPHPC) is the formulation of a series of proposals addressed to medium and long term challenges, which were drawn up after analysing the Catalan health care system.

In order to prepare the *White Paper*, all the agents involved, which include citizens, health care professionals and their organisations and associations, have been prime movers and active participants. This participatory process was supervised by the *White Paper* Steering Committee, which made a variety of instruments and methods available to all interested parties, personally or on the Internet.

The citizenry is the central focus of operational strategy. Their needs and expectations are the framework in which the reflections and proposals of the *White Paper* must be placed. The health care system and its professionals can only be justified by being of service to the people, and to the population groups demanding attention to their health problems.

Influencing the policy of human resources in the health system must be done in an innovative way, and it must be done with an analytical strategy based on two critical factors: flexibility and an intersectoral perspective. On the one hand, flexibility would permit an efficient ongoing adaptation to changing organisational needs and a technological adaptation of the system in order to generate human resources, mainly in the long term. On the other hand, a technical and organisational intersectoral stance would lead to more effective and

integrated health care personnel plans - as long as they take into account the ongoing collaboration of health care professionals who come from different training spheres and who are dependent on different institutions.

The current problems that health care professions face require a positive approach and proposals that provide medium and long-term solutions, notwithstanding the inherent difficulties of analysing future expectations in this sphere. The *White Paper on Health Professions* attempts to provide suitable responses to the needs posed by the objectives, activities, new services and health care professionals that are constantly being incorporated into the health care system.

The *White Paper* is not the end of the line; on the contrary, it is the beginning of a process of reflection aimed at stimulating responsible judgements and generating a new social and professional consensus in the field of human resources, which has service to the citizenry as its goal.

Xavier Pomés i Abella

Minister of Health and Social Security

Barcelona, January 2003

PREFACE

In the framework of the Act on Planning and Development of Health Care in Catalonia (LOSC), health care policies have developed through the establishment of health priorities and services that respond to the needs of the population. Starting with an analysis of the current situation, the problems related to the health professions must be approached in such a way as to improve quality, and to satisfy the needs and expectations of the citizenry, rather than to propose changes aimed exclusively at health care professionals.

The Minister of Health and Social Security created the Steering Committee to prepare the WPHPC in May 2000. Its aim was to stimulate, plan, and co-ordinate the WPHPC and to guarantee and provide its considerations and proposals to all the elements involved in this sphere.

The WPHPC is a strategic instrument that shall guide decision-making in the future development of the health care professions by planning, training, and managing the workforce in this field. The WPHPC must facilitate and promote initiatives and actions aimed at ensuring the coherence of social needs and professional competence, by providing health care professionals who are able to respond to the needs of the citizenry with effectiveness, efficiency, and excellence, from both a qualitative and quantitative standpoint.

The Steering Committee has designed the WPHPC and driven its development within the complex and dynamic framework of the set of health professions. A large measure of uncertainty is apparent as a result of demographic, epidemiological and technical changes; changes in the social and family model; changes

in the health care system and health expectations; and changes in organisations, structures and procedures.

Indeed, the WPHPC marks a turning point in the way of approaching the complex field of the health care professions and professionals, and a starting point for a new more human and social vision of the health care world.

Albert Oriol i Bosch

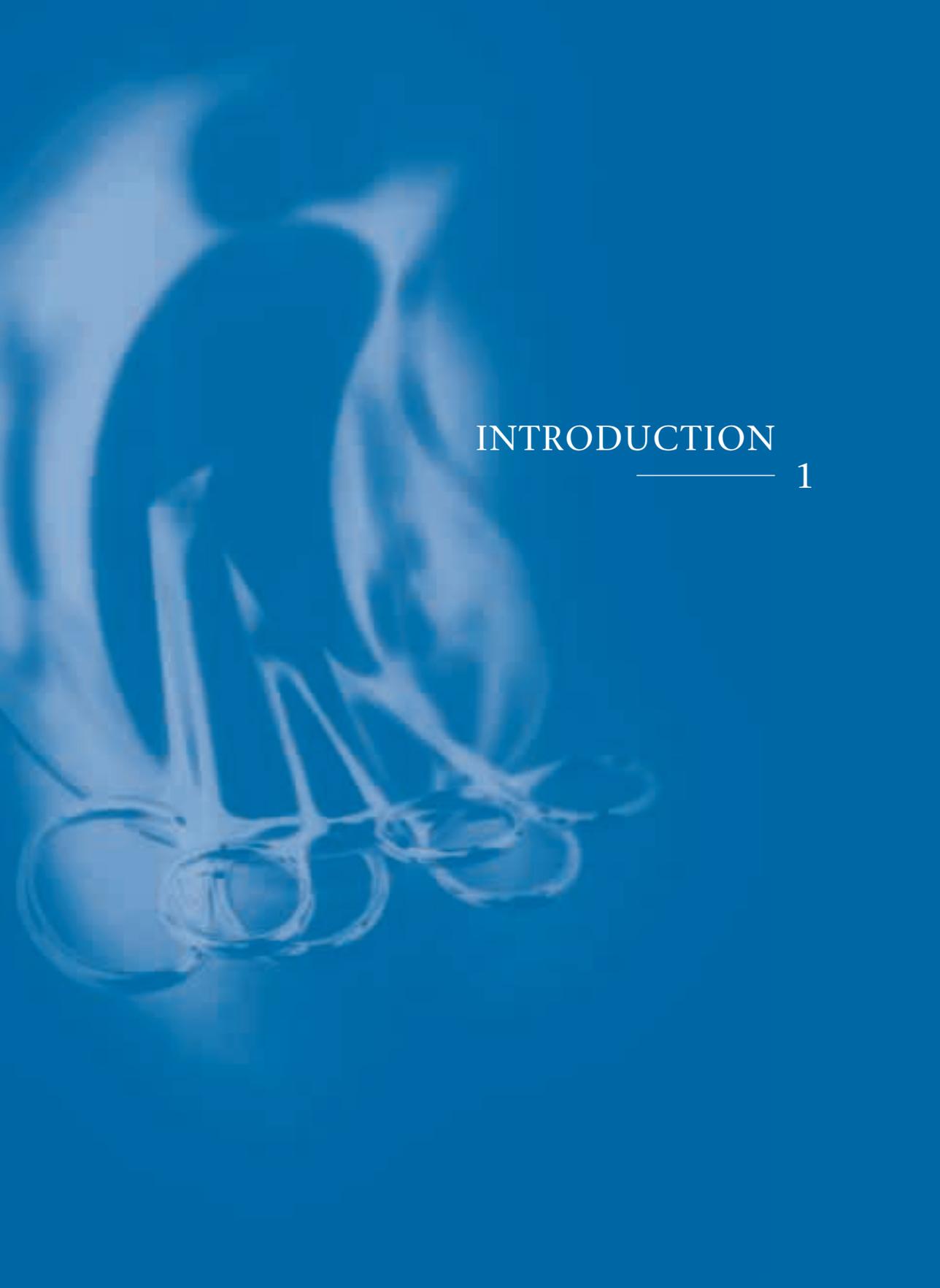
WPHPC Project Director

Barcelona, January 2003

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INTRODUCTION

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Almost thirty years ago the World Health Assembly of WHO pleaded for the need to intensify efforts for the integral development of health care staff and services in order to promote systems that responded to the health needs of each country.

The integral development of the health care personnel had to include the following fundamental principles:

- Hierarchy of objectives (attending to the health needs of the population, developing services, and developing human resources).
- Capacitation and competence in health care professionals working in health care services.
- Harmonious integration of planning, training and development, and management, which are the three components of health care staff policy.

When developing health care services and human resources, the planning subsystem must consider the quantitative and qualitative requirements by taking into account the needs as well as the available resources. The training subsystem must consider the contributions of the educational system as well as the health care system. The subsystem of developing and managing staff must anticipate effectiveness and quality with the co-operation of the people in charge of provider organisations and professional associations; in other words, the distribution of the workload in health organisations. The integral development of staff and health care services must be addressed to the needs of the citizens they serve.

Illustration 1. The development of human resources addressed to the needs of the population



In Catalonia, the situation of professionals in the health care system is similar to that in other industrialised countries of Europe. Health care services are well developed and, on the whole, their resources are sufficient and their capacity is high; however, there are problems of quantitative and qualitative adaptation to new needs. Hence, we can say that the functions of developing and managing human resources is crucial, and that the management of personnel must be improved in all aspects: professional development, training opportunities, as well as internal and social recognition.

The health care professions have been characterised by their commitment and their spirit to serve. The workplace is often experienced as an area where the degree of control limits professional discretionality, and where bureaucracy interferes with taking responsibility, the routine interferes with innovation, and all this causes stress and a lack of satisfaction. Health care staff perceive that their professional status is eroding, and that they do not have the authority to

make decisions. They also believe that their professional ethics are damaged by economic principles that force them to make decisions far beyond their professional capacities, and that the increase in costs, which they have to control, is the result of social conduct fostered by politicians.

The citizens expect the health care system to deal with any illness, to resolve most of the problems with no limitations of any kind, whether of knowledge or resources. This means that there is a certain lack of satisfaction in both society and the health care professions. The health professional-patient relationship is weakened by the citizens' loss of confidence in health care staff. Citizens want to be better informed; they demand more accountability, more transparency, and more guarantees of quality. The lack of agreement between the citizens' value system and that of the health care staff must be overcome. All things considered, the values of specialised knowledge and the comprehensive humanistic values of the person must be reconciled.

In organisations, interactions are complex and reciprocal; thus a change in one component of the system is likely to have consequences in the others. The development of health care professionals is not possible without a harmonious development of the entire organisation. In order to develop the system fully, the organisation's management culture must adapt and become compatible with social and professional values. The necessary professionals must be available, as well as suitable technology and resources, and any internal or external resistance to change must be overcome. In this regard, all the health care professionals must undertake an engagement with the people in charge of the organisations and the system in order to adapt to policies, organisational structures, programmes, and planning methods.

In this document, the Catalan health care setting and the basic features of the process of planning, training, development, and management of health care professionals in Catalonia is described. The results of qualitative research on the citizens' perception of health care professionals are highlighted as well as the conclusions of the conference on the WPHPC (IES, October 2001). The crucial points and the possible ways of approaching them are identified. Proposals that were the result of an analysis of the setting are presented, as well as the contributions made by citizens, health care professionals, and people and institutions of recognised prestige. These were carried out following the four central issues that must guide the undertaking (citizens, health care pro-

professionals, health organisations, and the health care model). The last part contains the final considerations, where the following key elements appear: the definition of a new social contract between the citizenry and the professional; the values of professionalism; continuing professional development; certification and re-certification of professional competence; the reorientation of the educational training process and its transverse character; the organisational innovations and the redesign of structures and procedures in institutions; interdisciplinary and multidisciplinary teamwork; the need to establish a dynamic and permanently up-to-date information system for health care professionals and workplaces in the system; and the need to have instruments and mechanisms for research, and permanent sociological evaluation.

THE WHITE PAPER
ON HEALTH PROFESSIONS
IN CATALONIA:
A TRANSPARENT AND
PARTICIPATORY PROCESS

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The Steering Committee designed a process to prepare the WPHPC that was open to the contributions of the citizenry, health care professionals, organisations and institutions, in keeping with the principles of orienting the citizenry, intersectoral commitment, transparency, and participation.

Chart 1. Phases of the process of preparing the WPHPC

Phase I	Design of the project Revision of documents Analysis of the setting Creation of the Web site http://www.fdps.org WPHPC Conference Qualitative research on the citizenry's perception
Phase II	Identification of crucial points and ways to advance Consultations with people and institutions of recognised prestige Drawing up of proposals
Phase III	Drawing up, approval, and dissemination of the <i>White Paper on the Health Care Professions</i>

In September 2000, the preliminary document with basic guidance criteria, methodology, and the proposed schedule to carry out the project was presented to the Minister of Health and Social Security.

In January 2001, it was presented publicly on the Web site as an instrument to simplify and promote the participation of institutions and to increase the transparency of the process. Initially, it was planned as a Web site with open access

to consult information, as well as having a Web page with restricted access for the people participating in forums. Five participatory forums were created: the first one was addressed to professional organisations; the second, to the citizenry; the third, to trade unions; the fourth, to educational institutions; and the fifth, to people and institutions of recognised prestige in the field of health. Twenty-three professional associations, the four main health care management associations, fifteen advisory boards and commissions, seven trade unions, fifty-one associations of patients and health care users, eighteen schools and universities, and eleven institutions in the health care field participated.

The Web site has enabled, and enables, the transmission of information about documents, national and international initiatives that are carried out in the field of health care, as well as the dissemination of the work and the contributions of the Steering Committee during the process.

In February 2001, the Steering Committee set up a citizens' working group, which initiated a qualitative study of the perception of health care professionals by the user population. More than seventy citizens participated in the discussion groups and in the interviews carried out. The results have been included in the WPHPC.

In March 2001, the Steering Committee began the work of gathering and analysing the available data on the human resources of the health care system in diverse institutions and organisations, with the aim of also including them in the WPHPC.

In June 2001, members of the Steering Committee and external experts set up an organising committee for a conference whose aim was to gather and analyse information on the perception of the health care system by health care professionals. This conference took place at the Institute of Health Studies on 17 October 2001. More than sixty health care professionals participated, and four working groups were set up to analyse and debate the training of health care professionals; improvement and guarantees of competence; interaction; the limits of responsibilities; and the motivational strategies of health care professionals.

In February 2002, the editorial team, made up of members of the Steering Committee, drew up the working document, *White Paper on Health Professions in Catalonia*. This document set out crucial points and ways to advance, but it did not include either conclusions or recommendations, since it had to be submitted to

representatives of the sector and the citizenry so the final document would include their contributions.

During the months of June and July in 2002, the Secretary General of the Health Department presided over sessions in which people of recognised prestige and/or representing health care institutions and organisations analysed the working document and gave their points of view as well as contributing to the contents.

In October 2002, the editorial staff of the Steering Committee prepared the WPHPC proposals and submitted them to be considered and approved by the Minister of Health and Social Security.

THE SETTING

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3.1 Population and the State of Health

According to data from the Institute of Statistics of Catalonia (Idescat), on 31 December 1999, the population of Catalonia had 6,150,494 inhabitants, of which 3,147,648 were women (51.2%) and 3,002,846 were men (48.8%). The demographic estimates of Idescat put the population figure at about 6.5 million by the end of the first decade of the twenty-first century, about 6.7 millions in 2020, and about 7 million around 2030. In regard to the evolution of the age structure in the Catalan population, the emphasis on demographic ageing is one of most consistent results provided by the Idescat estimates. The migratory phenomenon that is being experienced today in Catalonia has introduced new elements into the demographic picture by making the extent of change uncertain, although it will undoubtedly cause a strong impact on the health care services.

The state of health of the Catalan population is similar to that of developed Western countries. In recent decades, there have been major changes in the health of the population. The improved socio-economic situation, scientific and technological advances, and the development of preventive health care services have contributed to an increase of life expectancy (83.4 years for women and 76.5 years for men by 2000), as well as a better quality of life.

In keeping with estimates for Europe as a whole, the main challenges facing the future will be health problems, the needs derived from the progressive ageing of the population, problems related to cardiovascular and respiratory illnesses, cancer, mental disorders (depression and dementia), injuries and dis-

abilities due to accidents, life style, the social context (migrations, changes in the social and family structure), and the environment.

Furthermore, the constant appearance of new technologies and the increasing costs of health care are factors that will force continual decisions to be made on where to put resources in order to provide an adequate response to the health needs and demands of the population.

3.2 The Catalan Health Care System

The Health Care Model

The health care model that is defined in the 1990 Act on Planning and Development of Health Care in Catalonia (LOSC) is the result of programmes that the government of the Generalitat has carried out since 1981, when it took over the Social Security health care services from the central government.

The Catalonia Health Care Map and its development in the following years (1980-1983) were the autonomous government's first attempts at planning. It basically included the territorial divisions for health care, a review of existing resources, and a proposal for new resources. In 1983, the Catalan Institute of Health (ICS) was created as the managing body for providing the health care services included in the Social Security system.

In 1985, two major action plans were initiated in Catalonia to transform the services. In the sphere of hospital care, the Public Hospital Network was set up (XHUP), and the Hospital Reorganisation Plan (PRH) was established. In the field of primary health care, a process of reform (RAP) was begun in the field of primary health care.

In 1986, the General Health Care Act declared that health care was universal – for the entire citizenry – and it stated that every autonomous community would set up its own health service, within the framework of a national health system.

In 1990, the approval of the Act on Planning and Development of Health Care in Catalonia (LOSC) was the turning point for formalising the basis of the current health care model in Catalonia. The features that define the system are

universal coverage, public financing, the system as the sole public insurer, and the provision of a public network of services through accredited centres. It is a mixed model, integrating all the health care resources of primary and specialised care through private or public providers in one network for public use.

The health care system separates the functions of planning, financing, purchasing and evaluation of health care services from the functions of providing services and the management of services.

The Catalan Health Care Service (CatSalut) is the mainstay of the health care system, and the Health Care Plan of Catalonia is the main instrument of the government of the Generalitat's health care policy.

The Catalan health care model places citizens at the centre of the system; they have priority in all the activities of the health care system. The citizen should perceive the defining traits of the health care system as a body that provides friendly personal treatment, individualised medical treatment, proper information, and all in all, respect for people's dignity, individual freedom, as well as the idea that health care is an individual and collective right and responsibility.

The Department of Health and Social Security (DSSS) takes on the role of financing, as well as being responsible for establishing a framework for all public activity in the health care sphere. It defines health policy and sets the objectives for health care, the coefficients and the basic levels of the aspects that are included in the Health Care Plan of Catalonia, and must be fulfilled.

Chart 2. The Catalan health care model. Chronology of legislative framework

Year	Legislative Framework
1978	The Spanish Constitution is approved. The territorial organisation of the state in autonomous communities is set up with legislative and executive responsibilities.
1979	The Statute of Autonomy of Catalonia is approved. Catalonia assumes exclusive responsibility in matters of hygiene, professional associations and the exercise of qualified professions, as well as the responsibility to deploy the basic central government regulations in matters of public health.
1981	The process of transferring functions begins. Public resources are insufficient and there are territorial inequalities. Diverse ownership of health care infrastructure exists.
1981-1983	The Health Care Map is used to make the most of resources.
1983	The Catalan Institute of Health is created to manage the Social Security health care services and benefits.
1985	The Public Hospital Network of Catalonia (XHUP) is created and the reform of primary health care is begun.
1986	The General Health Act, which stated that health care was universal, meant the establishment of health care services in the autonomous communities.
1990	The Health Care Act of Catalonia, which consolidated the mixed health care system and differentiated between financing and the supply of services, is approved. The Catalan Health Service is created.
1991	The Pharmaceutical Act of Catalonia is approved.
1995	The Health Care Act of Catalonia, which regulates the creation of professional associations, is modified.
1997	The Public Hospital Network of Catalonia is enlarged.
1999	Public networks of centres, services, health care and mental health care establishments are created.
2000	The structures of the Department of Health Care and Social Security (in charge of establishing the framework for all public activities in the sphere of health) and CatSalut (insures and guarantees the services of the public health care system) are reorganised and put into practice.

The Cost of Health Care

From the 1960s, the increment in health care expenditure has been a common feature in developed countries. Since then, the majority of European countries devote between 6.5% and 10% of the gross domestic product (GDP) to financing their health care service, and the tendency is that expenditure for health care will increase more quickly as the GDP of a country increases.

The increasing gap between public resources and demand involves the establishment of priorities and the acceptance of limitations when developing and improving the network of services. Financing and the real expenditure must be adjusted to avoid conditioning future resources.

Public health care finds itself facing the challenge of adapting the increase of costs to the growth of the economy, but historical budgetary failure, on the one hand, and the difficulty of assuming a policy of restricting services, on the other, slow down the process of reforms already initiated in the sector.

3.3 Human Resources in the Catalan Health Care System

The quantitative and qualitative analysis of professional health care communities in Catalonia comes up against the problem of not having reliable data available, like most countries in the region. The existing data is mainly limited to the data that professional groups provide, and as far as the workplaces in most centres and services of the health care system are concerned, almost nothing is known. Moreover, it is not possible to make a comparative assessment of the significance of the demographic density of different professional groups, because that would require knowing about the organisation of the services and the real situation of supply and demand in the labour market for each professional group or subgroup.

This situation shows the need to articulate mechanisms to obtain reliable and continuous data, starting with the creation of a dynamic information system that is permanently updated, and the need for health professionals and their workplaces to have instruments and mechanisms for research and permanent sociological evaluation.

The available data indicates that there is a clear tendency towards the feminisation of health care professions, which is more marked in younger generations. In reference to the age of health care professionals, the distribution shows the majority is in the group under 50 years old.

Table 1. Registered health care professionals in Catalonia per 1,000 inhabitants

Registered Professionals	Percentage (per 1,000 inhab.)
Physicians	4,63
Chemists (*)	1,16
Dental Surgeons	0,48
Clinical Psychologists	—
Biologists (health specialists)	0,08
Nurses (**)	5,09
Midwives	1,62
Dieticians and Nutritionists	0,03
Physical Therapists	0,53
Opticians and Optometrists	0,21
Podiatrists	0,12
Dental Technicians	0,15
Nursing Aids	2,14

(*) Does not include data from Tarragona and Girona.

(**) Does not include data from Lleida.

Source: Professional associations. 2001.

Table 2. Distribution by age groups of health care professionals registered in Catalonia

Professionals	Under 40 yrs. (%)	40 to 50 yrs. (%)	Over 50 yrs. (%)
Physicians	38	43	19
Dental Surgeons and Stomatologists	52	31	17
Chemists (*)	51	24	25
Biologists	63	32	5
Nurses (**)	53	30	17
Midwives	10	48	42
Opticians	63	19	18
Podiatrists	42	29	29
Physical therapists	81	12	7
Dental Technicians	53	25	22

(*) Does not include data from Tarragona and Girona.

(**) Does not include data from Lleida.

Source: Professional associations. 2001.

In Catalonia, the ratio of professionals per 1,000 inhabitants is similar to that of Italy and France, although other aspects must be considered, such as the functions and tasks performed by different health care collectives in their respective countries, in order to make assessments. Nevertheless, in quantitative terms, an industrialised country with an average of fewer than two physicians per thousand inhabitants is considered to have a shortage of medical personnel, and a country with more than 3.5 doctors per thousand inhabitants has a surplus.

In the health care field, professional migration from European Union countries to our country has not been significant up to now. However, this situation might change with the enlargement of the European Union to include countries in Eastern Europe, which is planned for 2004-2005. The regulations that simplify the free movement of professionals in the health care field in the European Union are made up of sectoral directives approved by professionals in medicine, pharmacy,

dentistry, veterinary medicine, nursing, obstetrical nursing, and gynaecology, which are included in our internal laws by royal decrees, or if there is no sectoral directive, by the general directives that recognise diplomas, degrees and other qualifications.

Table 3. Professionals and workplaces in the health care sector per 1,000 inhabitants in several countries of our area. 1999

Country	Population (millions)	Physicians	Nurses	Dentists	Workplaces
Germany	82,0	3,5	9,6	0,8	29
United Kingdom	59,4	1,7	5,0	0,4	30
France	58,2	3,3	6,0	0,7	—
Italy	57,7	5,9	4,6	0,5	15
Spain	39,4	4,4	5,6	0,4	16
Sweden	8,9	—	—	0,9	35
Denmark	5,3	—	7,2	0,9	—
Finland	5,2	—	13,9	0,9	46
Norway	4,5	—	9,7	0,8	—
Netherlands	15,8	—	12,5	0,5	24
Belgium	10,2	—	—	0,7	—
Austria	8,1	—	8,4	0,5	—
Switzerland	7,2	—	—	0,5	—
United States	272,5	—	8,2	0,6	33
Canada	30,6	—	7,4	0,5	24
Catalonia	6,1	4,6	5,4	0,5	11(*)

(*) Public sector data from CatSalut. 1995.

Source: Bui Dang Ha Doan. Human Resources in Health Care Systems: Situation and Evolution in Industrialised Countries. February 2002.

3.4 Users of the Catalan Health Care System

The provisions of the General Health Act concerning the right of people to receive information and to give free and informed consent to interventions, and the provisions of the Health Care Act of Catalonia to make the health care services more humane, more respectful of people's dignity and individual freedom were concretised in Catalonia with Act 21/2000 of 29th December on the right to receive information related to health, the patient's right to autonomy and clinical documents, which jointly assumes all the indications of the European Convention on Human Rights and Biomedicine that the Council of Europe established in 1997, and which Spain ratified in 2000. Two of the most innovative aspects of this Convention is the inclusion, with respect to patients' autonomy, of the regulation of the possibility of establishing documents of prior wishes.

In July 2001, the Executive Council of the Generalitat of Catalonia approved the Charter of Citizens Rights and Responsibilities in relation to health and health care. It should be pointed out that this document sets out the rights and duties that are applicable to all health care services, independently of their level of care and their legal ownership, on the one hand; and on the other hand, it advocates respect for dignity, for the person and for the autonomy of the patient, as a core of rights that lend meaning to all the others. Lastly, it considers citizens as active subjects, who are responsible for their own health, and who have to comply with a series of duties of which both they and the health care professionals must be aware.

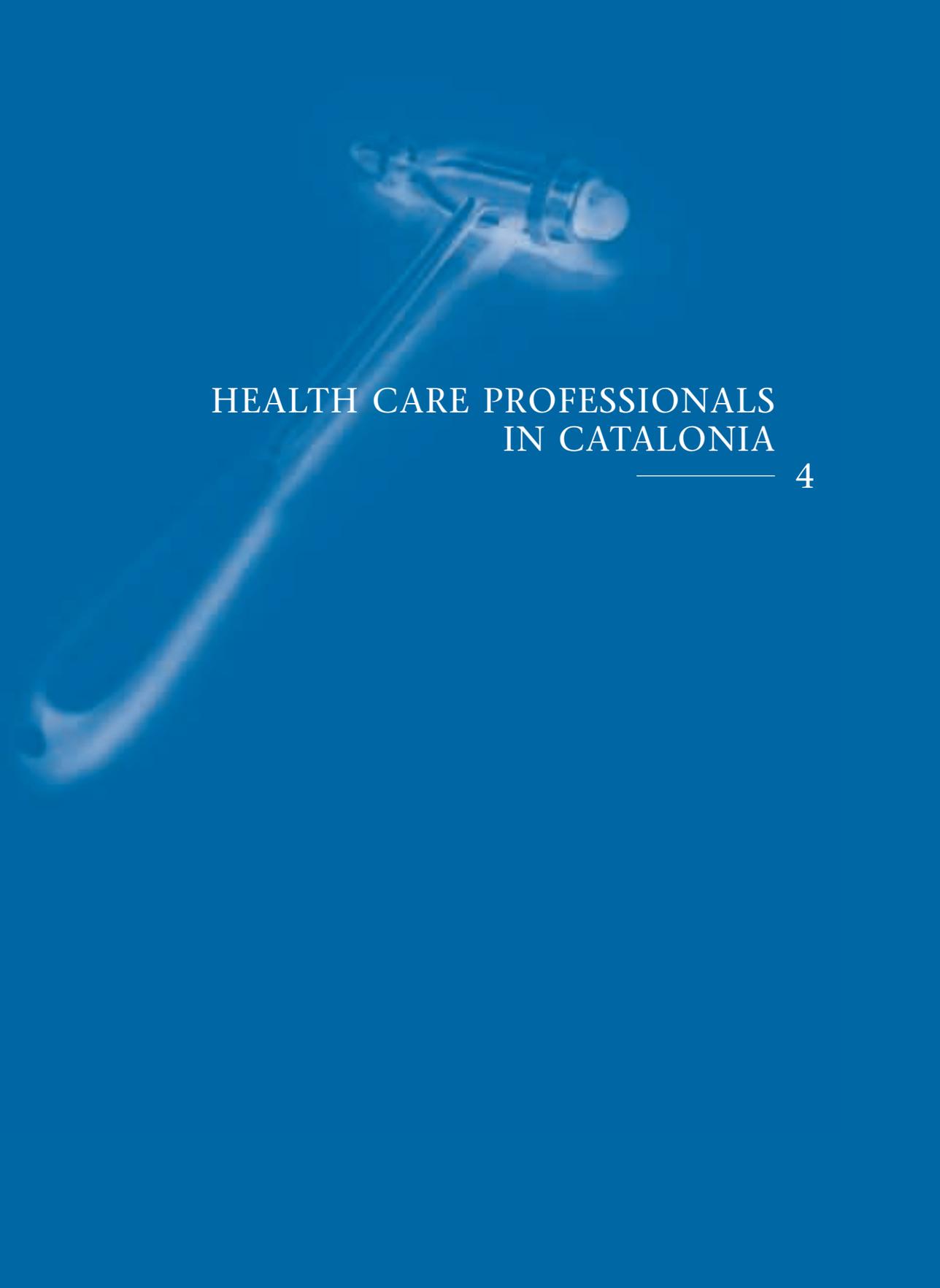
3.5 Information and Communication Technology (ICTs)

The ICTs will increasingly have more influence on the health care sector and in a variety of fields related to health care professions:

- To plan the needs of different types of professionals as health care organisational models are transformed and clinical, educational and research activities are modified, quantitatively and qualitatively, in a new context that favours the vertical and horizontal integration of the health care process.

- To train professionals, which would mainly have an impact on teaching and learning methods, as well as on the periodical process of certification and re-certification of professionals.
- To generate new specialities related to the creation and handling of the ITCs.
- To provide communications between health care professionals and the citizenry, and citizens' access to information on subjects related to health.
- To increase transparency of the processes of change in the health care system, arising from the necessary participation of all the sectors involved.

In the context of the information society, planning social and educational policies that make new technology available to most of the population compensate for unequal access to knowledge. On the whole, all the institutions must rethink their organisational models and must assess the contributions that information technology and communication can make in regard to new forms of relating to other organisations, to health care professionals and to customers.



HEALTH CARE PROFESSIONALS
IN CATALONIA

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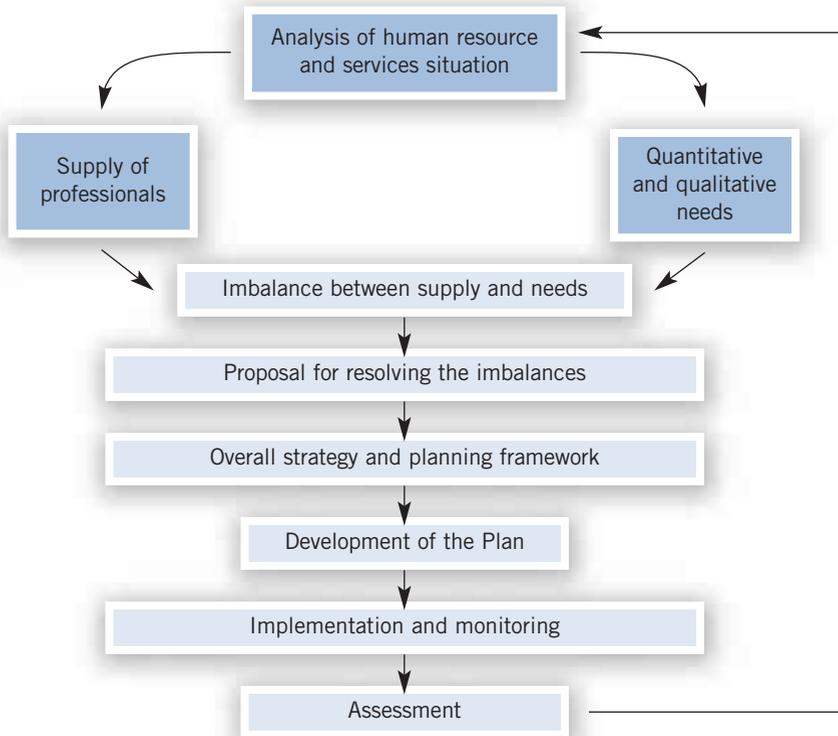
4.1 Planning

The objective of personnel planning is to determine the number and make-up of the teams necessary to provide responses to the population's health care expectations. Planning includes qualitative elements (the capacity to carry out the tasks assigned), in addition to quantitative elements (the number of required professionals). It is a dynamic and cyclical process that should assure that the required professionals with the proper skills are available to be effectively deployed, as well as to include evaluation mechanisms to record reactions.

Planning essentially consists of being able to determine future availability, to seek solutions for disruptions in service, and to develop operative plans to implement them. Continuing with this line of thought, one should be aware of what changes are taking place in staffs' internal and external movements, and their causes and effects. To achieve this, it is essential to have information systems of a permanent nature so as to be aware of the current situation, and to detect phenomena that may arise.

In order to establish a plan of human resources in the area of health, the coordination required between the educational and the health care systems must be established. Motivation and the role of training opportunities, as well as structuring professional studies, are key elements that determine whether or not the planning process will succeed in achieving visible improvements in the operation of health care services.

Illustration 2. The Human Resources Planning Process



4.2 Training

Traditionally, the training process in health sciences is divided into three major cycles: Undergraduate studies, postgraduate professional training (FPP), and continuing professional education (FC). Undergraduate studies currently lead to graduate diploma degrees and licentiate degrees. FPP is the cycle that leads to officially recognised specialist degrees. FC is made up of all the learning activities that professionals undertake throughout their careers from the perspective of continuing professional development (DPC). The generation of a health care workforce should be the result of medium and long term planning of quantitative and qualitative needs. Because of the many factors and variables to take into account, the prospects of undertaking this task is by no means easy. On the one hand, the administrations and the professional organisations do not

have methodologically correct mechanisms of ongoing analysis to forecast the development of problems; on the other hand, it would be necessary to reorient the current educational system – which is focussed on the process – to concentrate on results, in order to provide a proper response to present needs and demands, while bearing in mind both the new and the traditional resources of the educational system, such as the medical resources of the health system. At the same time, we must make use of more diversified settings than the present ones (hospitals, primary care centres and other centres with health care resources) and begin a debate on the need and advisability of establishing simulation training and laboratories of clinical skills.

Undergraduate Education

Health science subjects are classified – according to university cycles and/or level of training – by licentiate degrees (medicine, pharmacy, dentistry, veterinary medicine), graduate diploma degrees (nursing, physiotherapy, speech therapy, podiatry, occupational therapy, human nutrition, dietetics, optics and optometry) and professional training qualifications (first-aid treatment, pharmacy, pathological anatomy and cytology, dietetics, health documentation, dental hygiene, diagnostic images, diagnosis laboratory, orthopaedic prostheses, dentures, radiotherapy, and environmental health).

Licentiate degrees in psychology, chemistry, biology, and physics are not specifically health science studies, but they are qualifications that can be used to find employment in some health specialities and specialisations. The Generalitat, through the Department of Universities, Research and the Information Society, regulates the titles for the first and second cycles of university education; while the Department of Education regulates the titles of professional training; and the Department of Labour, Industry, Commerce and Tourism regulates those of occupational training.

One of the basic problems posed by undergraduate education in the health professions is its fragmentation since the passive conveyance of knowledge on which it is based, instead of an active learning process, leads to an exclusive vision of what is represented by each title. Our university faculties and schools still have many difficulties when they attempt to place among their priorities the need to be accountable to the society that they theoretically serve.

Learning based on problem-solving, the early continuous tutoring of students, group work, Best Evidence Medical Education (BEME), a firm introduction of

both theoretical and practical primary health care, and the curricular integration of basic and clinical subjects are the elements of conceptual and technical progress that is still pending. A determined political and legislative stimulus should be generated in order to initiate this new educational pathway.

Postgraduate Professional Training

Licentiates in health sciences have varied prospects for postgraduate training. Some professionals have the need or the chance to continue their education in paid postgraduate programmes, which are announced publicly and regulated at the state level. These programmes are focussed on supervised practice, providing a gradual taking on of responsibility in accredited programmes and learning centres. These programmes have undoubtedly signified an important element of progress.

For university degrees in health sciences with recognised health care specialities, the following educational continuum is considered: (1) undergraduate, which takes place in a university setting; (2) postgraduate or specialised health care training, which takes place in a health care setting; (3) continuing training in the health care and university settings, in professional associations, scientific societies and other educational centres.

Although this is an educational continuum, there is no joint planning for the needs of different types of health care professionals and specialists by the responsible institutions or by institutions that have an effect on the three traditional cycles of training (Department of Universities, Research and the Information Society; Department of Health and Social Security, professional associations, etc.).

The specialities of higher degree programmes that are taught through the system of internship (forty-three medical specialities from the first and second groups and some pharmaceutical specialisations) last from three to five years, except for radiopharmacy, which lasts two years. Some qualifications (biology, chemistry) provide entry to medical and pharmaceutical specialities.

Chart 3. Classification of recognised health care specialities and the licentiate degrees and graduate diploma degrees to access them

Licentiate degree/ Graduate diploma degree	Legal Norms	Classification of Specialities
Medicine	Royal decree 127/1984, of 11 January	Specialities that basically require hospital training (41) ¹ Specialities that basically do not require hospital training (2) ² Specialities that do not require hospital training (6) ³
Pharmacy	Royal decree 2708/1982, of 15 October	Specialities that basically require hospital training (4) ⁴ Specialities that basically do not require hospital training (8) ⁵
Nursing	Royal decree 992/1987, of 3 July	Obstetrical and gynaecological nursing, paediatric nursing, mental health nursing, community health nursing, special-treatment nursing, geriatric nursing, nursing management and administration
Physics	Royal decree 220/1997, of 14 February	Creates and regulates the obtaining of the official specialist title in hospital radio-physics
Psychology	Royal decree 2490/1998, of 20 November	Creates and regulates the official specialist title in clinical psychology
Chemistry, Biology and Biochemistry	Royal decree 1163/2002, of 8 November	Create and regulates health care specialities for chemists, biologists, and biochemists

Source: Ministry of Education, Culture, and Sports. <http://www.mec.es>.

¹ Allergology, clinical analysis, pathological anatomy, anaesthesiology and resuscitation, angiology and vascular surgery, digestive system, clinical biochemistry, cardiology, cardiovascular surgery, general and digestive system surgery, maxillofacial surgery, paediatric surgery, plastic and repair surgery, thoracic surgery, medicosurgical dermatology and venereology, endocrinology and nutrition, clinical pharmacology, geriatrics, haematology and haemotherapy, immunology, intensive medicine, internal medicine, nuclear medicine, microbiology and parasitology, nephrology, neurosurgery, clinical neurophysiology, neurology, obstetrics and gynaecology, ophthalmology, medical oncology, radiotherapeutic oncology, otorhinolaryngology, paediatrics and specific areas, respiratory medicine, radiodiagnosis, radiopharmacy, hospital radiophysics, rehabilitation, rheumatology, traumatology, orthopaedic surgery, and urology.

² Family and community medicine, preventive medicine, and public health.

³ Stomatology, hydrology, space medicine, physical education and sports medicine, legal medicine and forensic medicine, and occupational medicine.

⁴ Clinical analysis, clinical biochemistry, hospital pharmacy, microbiology and parasitology.

⁵ Analysis and control of medicines and drugs, industrial and galenic pharmacy, experimental pharmacology, industrial microbiology, nutrition and dietetics, radiopharmacy, environmental health and public health, and experimental and analytical toxicology.

The organisation and planning of specialised health care training is carried out on a state level, and it is the central government that annually establishes criteria to determine the number of specialists and the available posts. There is no available data about the number of Catalan graduates who take the competitive examination to enter health specialist programmes, nor about the number of those who pass the examination and obtain a post, nor where those posts are located. Up to the present, there has not been any study of the tendencies governing the hiring of those who have finished their internship, which makes it difficult to know the number of specialists trained in Catalonia who find permanent employment in the Catalan health care system.

As for the examination to access the postgraduate training programme (MIR), the excessive centralism must be seriously reconsidered since it does not allow enough room for the health authorities of the autonomous communities in Spain to make decisions. Furthermore, the model, judging from appearances, encourages hyper-specialisation in detriment to a balance between a general education and a specialised one. Finally, it must be pointed out that the evaluation procedures for specialists in training must improve. A new comprehensive model must be designed in which specialisation comes after a wide-ranging initial training, providing a much-needed multipurpose system to eliminate the rigidity that reigns in the labour market, where each post is linked to one qualification. Lastly, the evaluation procedure for specialists in training must be improved.

Continuing Training or Continuing Professional Development

The skills of health care professionals must be updated in relation to organisational and functional changes and in regard to scientific and technical progress, in keeping with the strategies of continuous professional development. It is advisable to reach a joint agreement for accreditation of activities and provider centres, as well as to promote teaching methodology directed at the improvement of skills and attitudes, prioritising active comprehensive training methods. Modern strategies of continuing professional development must permit the personalised design of careers, depending on the organisation in which the professional works, and the gradual substitution of identical professional studies for all those belonging to the same professional group.

The initial certification and periodic re-certification of professional skills is the chief element for socially guaranteeing the quality of performance. The administration and professional organisations have to be endowed with these types of

instruments to generate a progressive cultural change by adopting the correlative political and legislative decisions. The creation of an evaluating agency of health professionals in Catalonia would be an initiative that has positive effects on this process.

4.3 Development and Management

Human resource policies must be oriented towards the development of professionals in health care organisations, and any normative framework should not make individual contributions more difficult for professionals in the exercise of their functions. The management of developing professions must at least take into account the following elements:

- Leadership, to involve the professionals.
- A process of selecting professionals that guarantees the suitability of the person for the post through a process that is more individualised and is able to make an estimate of their capacity.
- Professional development to improve the functioning of organisations. The most relevant elements for professional development would be the existence of a framework for personnel policies, the development of professional careers, the evaluation of professional performance, counselling, and continuous training.
- The relationship between managers and professionals, understood as maintaining a balance between concern for people and the productivity of the organisation.

The management of human resources is strongly influenced by the culture of the social environment; it is not possible to co-ordinate the performance of professionals without understanding their values and beliefs.

To achieve an organisational design in which professionals and health organisations perform in an integrated manner, the health care organisations must be able to establish a principle of authority while recognising the individuality of their professionals; to adjust the number of professionals to their needs; to make the aims of the procedures explicit; to be able to adapt, to show leadership, to orient themselves towards the users, to be committed, to have control and autonomy; to comply with the objectives set out, to act with integrity, and a capacity to innovate.



THE CITIZENRY'S PERCEPTION

5



The citizenry in general and the users of the service are often asked to give their opinion through opinion polls and other types of research. With the purpose of delving deeper into their perception and opinions on the health care professions, qualitative research* was carried out that identified emerging and significant aspects that must be taken into account in order to redefine the relationship of the agents involved in maintaining and improving health (institutions, professionals, the citizenry, and politicians). These aspects are grouped together in the following points:

- The social debate on health, illness, and the health care environment.
- Health care: the actors and their relationships.
- The dilemma: the professional, between the organisation and the citizen.
- The relationship between the professional and the patient.
- The balance between what users receive and their needs and expectations.
- The responsibilities of the health care professional in future.

* *The citizenry and the health care professions. Towards a new social contract.* Research carried out for the project to prepare the WPHPC. Barcelona, July 2002.

The social debate on health, illness and the health care environment

Socio-economic and cultural values condition the conception of health, illness, and the way society is organised to care for health needs. Predominant values are set in the context of a hedonist environment where pain, illness, and death are difficult to accept. In the welfare state, health care is considered one of the fundamental pillars; citizens expect the health system to have the capacity to confront and resolve most of their health problems with no limitations of any kind, whether of knowledge or of resources. It is essential for political authorities to promote a broad social debate on health and the limits of the health care system in which the citizenry have a relevant role. If no progress is made along these lines, it is difficult to know what can be expected from the health care system, the health care professions, and the citizens as agents responsible for their own health. Discussing health means discussing value systems that may or may not be accepted in the different health care spheres.

One of the keys to changes in future relations points to the fact that the citizenry, especially the new generations, will be better informed. The citizenry will be more co-responsible for looking after their own health, and will therefore have more realistic expectations, but they will also be more demanding and critical, and will complain if professionals do not respond quickly to their demands. The use of new technology cannot be a substitute for what is essential in their relationship with physicians: direct personal contact.

Health care: the actors and their relationships

A triangle made up of professionals, institutions, and the citizenry may be observed and the roles and spheres of their responsibilities are identifiable in their organisations: physicians heal, managers manage efficiently, and citizens want their demands and expectations satisfied. The opinion of the citizenry is that these different perspectives often do not merge into a shared definition on what the health care process should be.

Users see themselves more as consumers of health care services than as passive receptors of clinical decisions, and they are redefining their position as citizens of a welfare state. They increasingly show themselves to be active, informed, and demanding members, willing to assume their share of responsibility.

The citizenry recognises the teamwork and the relationships of power that exist among the different professionals, which they valued positively. However, they

have a negative perception of teamwork when responsibilities become diluted and the members of the team do not confront situations that come under their responsibility.

Doctors are granted the central role in the health care process, because they make the diagnosis and establish the treatment, activities that are highly valued by patients. On the other hand, nursing professionals are granted the role of carers and doctor's aides. Furthermore, as these professionals are considered to be more accessible, the patients' demands are often channelled through them, particularly in the hospital setting.

In the future, citizens should be more aware of their rights and responsibilities, and they should assume their share of responsibility as consumers of health services. The professionals should become more aware of the economic importance of clinical decisions, and the managers should be more mindful of values that cannot only be measured in terms of efficiency.

The dilemma: the health care professional between the organisation and the citizenry.

The perception exists that health professionals (doctors, in particular) find themselves trapped between providing the health care services expected by society and the high standards of clinical practice and efficiency that health care organisations demand. This situation creates anxiety and frustration. The limitation of resources and organisation means that professionals have to prioritise the most important and/or urgent cases. In this regard, professionals often feel that the organisation is not sufficiently sensitive to the needs that they raise.

The people in charge of organisations cannot abandon the professionals who face this dilemma, since this will only generate an inadequate working climate, and would end up trapping the system in strict economism. Therefore, it is necessary that both the public Administration and the managers of the organisation incorporate the preoccupations of professionals in their thinking.

The relationship between the professional and the patient

The users think that technical quality and human relations are key ingredients for satisfactory health care relationships. The relationships between the citizen and professional have to be based on trust and the standards of good practice. The lack of personalised attention and information, often replaced by the in-

discriminate use of high technology, improper familiarity, lack of respect for their privacy, lack of time, follow-up procedures, and feelings of deception are seen by the citizens as elements that distort relationships.

Health care relationships are accepted as unequal relationships when one of the parties possesses specific knowledge. However, recognising the fact that patients are experts as well is the key to a satisfactory doctor/patient relationship; doctors have – or should have – knowledge about diagnosis techniques, treatment, and prevention, and the patients have knowledge about their own experiences in facing illness, their social circumstances, behaviour, attitudes, and preferences. What is being proposed and debated is a change in the doctor/patient relationship in terms of mutual participation. It is desirable for the relationship to be more symmetrical; patients have to learn from doctors and doctors have to learn from patients. In this way, doctors distance themselves from the pyramidal position that they have traditionally occupied.

Involving the patients, maintaining them informed, improving communication, giving advice and support, obtaining consent for procedures and processes, respecting their points of view, and accepting that adverse situations can arise, are objectives that should characterize the relationship between professionals and patients.

The balance between what users receive and their needs and expectations.

The citizenry is especially critical of how the organisations operate; they are considered ungainly and bureaucratic, especially in regard to several aspects of accessibility, such as information, attending to telephone calls, opening hours, and the quality of accommodations and meals when in hospital.

From the patient's point of view, waiting time, and overcrowding are obstacles to a satisfactory health care relationship; these are perceived as barriers to accessibility, as elements that hinder good communication. To have access to services, patients use means that they think solve their problems more rapidly. Lack of alternatives is the argument they use to justify this way of behaving; they are aware that sometimes this is a wrong, or improper, use of health care resources. In this regard, the use of hospital emergency services and informal procedures are exemplary.

Time is a constant preoccupation, whether it is the time waiting to access services, or the time that the professional spends with the patient; in both cases,

preoccupation is associated more with the public health system than the private. The patients' uncertainty is related to how much time a visit will take, since it interferes with their daily life and generates a feeling of disorientation and impotence. Furthermore, the short time available for each visit may deteriorate the patients' trust in the professional's skill by making them feel that detecting serious illnesses cannot be done properly, and this leads to the breakdown of communication. More time for visits is essential to provide quality clinical care. Patients want to be heard, and they want time to listen and assimilate what the professional tells them.

As for the social and family repercussions that arise from certain illnesses, the citizenry has identified the lack of support in people's daily lives as an unresolved necessity.

The professionals' health care skills in future.

In addition to a high standard of technical skill, the qualities that citizens expect to find in health care professionals – especially in doctors and nurses – are associated with relationships and attitudes. They especially emphasize a series of qualities directly related to a receptive attitude, a pleasant manner, and a good communicative ability. A certain degree of dehumanisation in the health care relationship is perceived; the professionals' values are oriented towards technical effectiveness to solve the organic problems of patients. Depersonalised practice makes empathy difficult for the citizen, who demands to be heard and informed. The lack of understanding between the citizenry's values and the professionals' must be overcome.

On the whole, the technical capacity of health care professionals is not questioned in our environment; they are considered to have achieved a high standard and they are valued positively, although the citizenry demands that professionals be up to date in their fields. It is generally accepted that medical errors are human, and are an inherent contingency in professional health care practice. What is considered unacceptable is not to recognise making mistakes or attempting to conceal or evade them. The training process is considered to be essential in order to adapt professionals to needs, and it is thought that there is a separation between the training of professionals and what is really required of them. A solid scientific and technical training would have to be combined with the development of communication and relationship skills, along with an attitude that generates trust and a feeling of security in patients.

The future will require professionals to be flexible and adaptable in a changing environment with changing demands. Throughout a long career, the professionals will have to be prepared to modify their way of working and the sphere they work in by incorporating the notion of the economic significance of their decisions, by realising they are the managers of patients' needs, and by continuing to help patients to face illness, pain and death.

THE PROFESSIONALS' PERCEPTION

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To draw up the *White Paper on the Health Care Professions*, it was necessary to have a set of elements to be considered, which were provided by the professional groups themselves. A conference was organised with the participation of professionals* to this end, and its conclusions are summarised below:

Planning needs

As a result of the excessive number of physicians who graduated during the 1970s and the first half of 1980s, Spain, along with Italy, is the European Union country with the most physicians per inhabitant. As for the nursing professionals, it seems that few are trained at present and a decrease in the demand for places in nursing schools has been verified, which is something that should make us reflect on the suitability of the competencial model and the fields of specialisation available to these professionals.

There are some specialities where we show a moderate surplus, and there are others with a shortage of staff. In spite of this situation, the Spanish health care system does not suffer from a serious imbalance, except for the existence of a long-standing group of underemployed physicians. Because of the average age of working physicians, a change in needs may arise from 2010 on.

* Conference on the *White Paper on the Health Care Professions in Catalonia*. October 2001.

Permanent sociological research instruments must be designed to have available data in order to estimate the quantitative and qualitative needs for professionals in our territory. They should be adapted to the expectations of the population and the sustainability of the system.

From the perspective of developing the three main components of the social and health care systems (primary care, specialised care, and social welfare support for the dependent ailing or ageing population), the importance of strengthening short-term strategies that put more emphasis on primary care, the pluri-potentiality of health care professionals, and resources for social-health care support appear obvious. Training for the majority of health care professionals in the field of care for the elderly and mental health problems must also be strengthened. Moreover, the need for human resources in acute-patient hospitals will gradually be concentrated in specialities that use highly complex technology, diagnosis, and therapeutic applications. In these types of hospitals, the core medical specialities will essentially have a co-ordinating and consulting role. These health care professionals will gradually be transferred to medium or long-stay institutions where their highly specialised skills will be needed.

Changes in today's family models, with a clear reduction of prolonged aid resources, will make it essential to rethink the role of family support for social and health care problems. A new strategic equilibrium between the family subsystem and the social-health care systems must be found. This will undoubtedly involve a very important increase in the number and the qualifications of health care professionals who are totally or partially devoted to these support functions.

Training

The following chart indicates a series of changes that must be introduced into undergraduate studies.

Chart 4. Proposal for changes in undergraduate studies

To orient studies towards learning instead of teaching
To redefine curricula in accordance with the skills that must be acquired
To design and organise evaluation that is based on acquiring these skills
To promote attitudes of self-criticism and social accountability in teaching staff
To make teamwork, ethics, and epistemology relevant

As for postgraduate professional training, some of the aspects that must be reformed to maintain the effectiveness of the system include decentralised training, the firm establishment of core medical studies and areas of expertise; the modification of evaluation systems for admission, during training and at the end of training; and the improvement of accreditation systems of teaching centres and teaching staff. Demonstrated expertise in a particular field must be recognised, but that should not involve new official qualifications that generate competencial monopolies.

Continuing training is in a phase of organisational configuration, and it is still not an instrument that sufficiently guarantees quality health care to the population. Among other aspects, the role of scientific societies in continuous training must be defined. Furthermore, a system of certifying and re-certifying health care professionals does not exist, and the activities involved in continuing training have diverse sources of financing, with the pharmaceutical industry playing a significantly leading role.

Management

From the perspective of health care professionals, the definition and management of their competences is an important element which must be linked to the responsibilities that the health-care, teaching or research actions must have before the citizenry: in brief, competence is held by the persons who are to be accountable for their actions.

Teamwork is an organisational model that is firmly established in health care systems. The teams cannot be a factor in diluting responsibilities. The sphere of responsibility of each member must be defined, and must be linked to their competences.

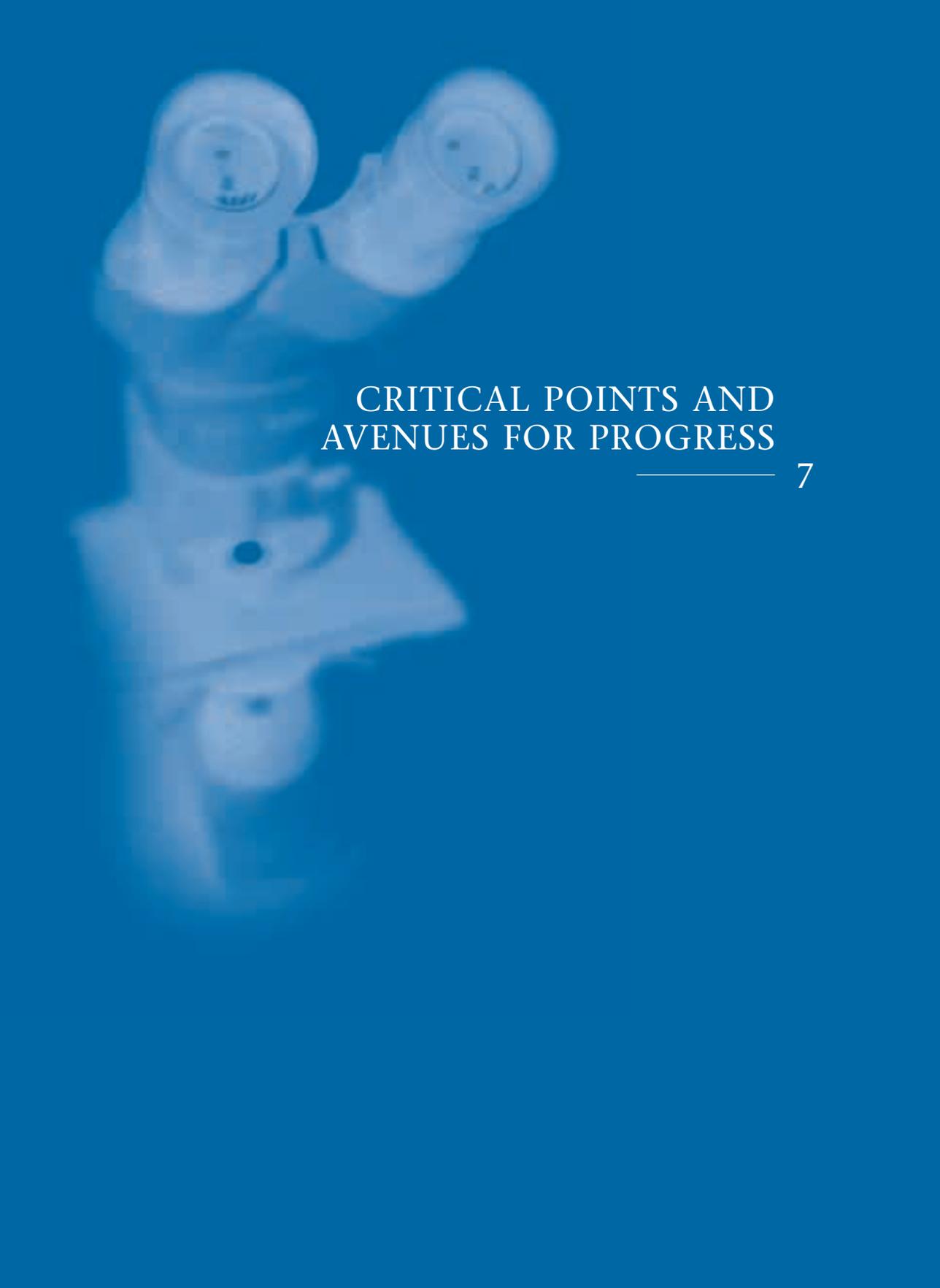
The balance between general training and specialised training is another point of great interest, since important directives may arise in relation to the training and needs of different types of health care professionals, and the distribution of work in organisations. In order to confront the situation of “burn-out”, which seriously affects professionals, strategies to promote professional autonomy must be put into operation. Clinical management (of the clinical process) must again become the responsibility of health care professionals.

Coherent and viable alternative proposals on professional studies must be sought, as well as the generation and development of new professions in the health care sphere.

Professionalism and the interaction of professionals with society

In future, professionalism must be characterized by the capacity to adapt to the increasingly rapid changes of the health care systems in the context of individual and collective empowerment and accountability. This new professionalism will be based on dialogue and pacts made between the different actors who have managerial and clinical responsibilities in the system. The importance of ethical aspects in relation to the fairness and accessibility of resources; clinical decision-making in conflictive situations; and the guarantee of confidentiality in the new and ever stronger transversal information systems, will be central issues in the process of continuous professional training development in the health care system.

The interaction of professionals with society will be characterized by a decrease in the present asymmetry in information and decision-making capacities, by a growing demand for rapid access to resources, and for the efficient resolution of health problems. These interactions will also be marked by the progressive integration of actions at different levels as well as in social welfare and health care centres in the context of information systems that are rapidly growing more powerful. On the whole, more social demands in regard to health care performance should be expected.



CRITICAL POINTS AND
AVENUES FOR PROGRESS

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The citizenry demands more information, participation, and co-responsibility in the decisions that affect its health.

Patients must be informed in order for them to assume co-responsibility regarding their health, self-treatment, and the use of services.

There has been a lack of reflection on the concept of health and illness, the limits of scientific knowledge, and the capacity of the health care system to respond to health care needs.

It is necessary to generate a wide-ranging social debate on the fact that pain, illness, and death are part of life; that medical science has its limits; and that health is an individual and collective right and responsibility. The citizens have to participate in this debate.

The health care system does not adequately tackle family or social problems that are caused by illnesses derived mainly from social and demographic changes, in particular ageing and the migratory phenomena.

Social and health care problems should be oriented towards achieving a new equilibrium between the family, social-health care, and social subsystems.

There has been a rapid growth of the needs for primary care and social-health care resources.

The functions and tasks among the different professional groups (physicians, nursing staff, social workers) must be redistributed to be able to attend to the emerging need for non-professionals (family members and volunteers).

It is difficult to establish balanced relationships of trust between health care professionals and patients.

In order to respond to the expectations of the citizenry, health care professionals should have communication skills and be good at establishing relationships, in addition to maintaining their technical skills.

The safety of users has become a central issue in health care.

The system has to provide the mechanisms necessary in order to avoid and correct undesirable effects, and to generate transparency as regards the citizenry.

The social evaluation of the health care professionals has experienced a transformation in recent years.

The social contract between the agents involved (institutions, professionals, citizens and politicians) must be redefined. This should lead to a request for a more exacting accountability of individual and collective performance.

Information and communication technology is changing the health care process. It is generating the need for new professional skills in order to carry out work properly and to become part of the new information society environment.

Continuous training and professional development, together with the organisational flexibility to learn technology and to learn through technology, are key tools to face this challenge.

The unavailability of enough reliable data on human resources impedes an accurate analysis of future prospects for the health care professions.

Mechanisms to have information available on human resources in the health care system have to be put together, and a register of health care professionals must be created that is reliable, continuous, dynamic, compatible, and permanently updated.

There is an imbalance between the supply and demand for certain professional groups and specialities.

Correcting these imbalances is complex, since it involves making decisions on matters that are related to training and decisions addressed to reducing the rigidity of employment contracts on a state-wide level.

The objectives and contents of the curricula for the health care professions are not appropriate enough for needs, expectations, and current demands.

The establishment of a dynamic process of change in all the phases of the training process, and which is committed to intersectoral co-operation, is essential for the educational system to provide an appropriate response to needs.

In undergraduate education, the objectives, organisation and the curricular contents are not effective enough to achieve the type of professional that is needed.

Undergraduate education must experience an intersectoral transformation that aims at a more practical, interdisciplinary education, which is based on problem solving, and centred on what is learned.

Despite some positive aspects, the postgraduate model of training in the health care needs a profound reform.

The system of postgraduate training must adopt a flexible core teaching structure to allow educational exchanges to take place between specialities. It must have decentralized management and mechanisms for the evaluation of the process and the results that are reliable, feasible, and credible.

At present, we have no clear and reliable mechanisms to accredit continuous training activities or to certify and re-certify health care professionals periodically.

The development of a process of accreditation and reaccreditation of health care professionals and competent organisations to carry it out must be progressive and be based on a professional and social consensus.

As far as the guarantee of professional competence is concerned, institutional responsibilities are not as clearly defined as they should be.

There are international experiences that demonstrate the effectiveness of having professionalised organisations that are dedicated to accrediting professional competence.

There is no clear separation between technical competence and the legal capacity to exercise a health care profession.

The separation of these two conditions requires differentiated and operational procedures and the assignment of responsibilities to the institutions concerned.

The exclusive and shared responsibilities of the different professional groups are not clearly defined.

The delimitation by protocol of the competences and responsibilities of the various professional groups in relation to health-care, teaching and research actions must be a priority of the health care system.

Teamwork must not mean diluting responsibilities.

The team marks the collective responsibilities, and health care professionals assume individual responsibilities derived from their actions.

Health care professionals are immersed in a situation that erodes their self-esteem and motivation.

However, health care professionals, the most important assets of the health care system, are indispensable for an optimum level of effectiveness. The organisations will have to modify their working environments, simplify professional development, and recognise sufficiently the work that is carried out.

Health care professionals are subjected to stress that is related to the workplace and to their profession, which is often a cause of demotivation.

It is necessary to provide more transparency to the establishment of priorities in the allocation of resources and health care services in order to achieve a higher level of acceptance from all the agents involved.

There are not enough clear mechanisms for professional promotion.

The human resources policies of institutions should include operative motivating systems for professional advancement.

The bureaucratic load in the health care system is still excessive, and it is experienced in a negative way by health care professionals and the citizenry.

Health care institutions must introduce organisational changes in order to simplify the citizens' access to services and to reduce the bureaucratic control of the system.

The limited integration of the objectives, the health care procedures, and the personal and institutional communication between the different levels of the health care system, have caused problems that affect health care professionals.

Significant changes in health care objectives have to be introduced, as much from the perspective of the organisations as from the perspective of the health care professionals, to improve the health care continuum and the results of the system.

A serious conflict between clinical and managerial cultures has been detected.

Management and clinicians have to iron out their differences and share objectives in order to guarantee the quality of health care services and the sustainability of the system.

There are new health care professions that are growing little by little, but which do not fit into the system of human resources and institutions in clear way.

The flexibility and diversification of employment in health care institutions are important elements to take into account when approaching this issue.

Organisations link qualifications to jobs in an excessively rigid way.

They should define the skills that are necessary to carry out each job and select the ideal person for it, keeping in mind the person's expertise, and not depending exclusively on a diploma, a degree, or other qualifications.

The selection procedures and the way of incorporating professionals into the public health care system are obsolete.

It is necessary to include more individualized and predictive selection methods by focussing on the real skills of the applicants in relation to the requirements of the position. The organisations must provide mechanisms that ensure that professionals are adequately prepared for their objectives and tasks.

Unconventional treatments are not regulated.

The use of complementary therapies by part of the population makes it necessary to tackle the ethical and professional rules with the aim of guaranteeing the safety of the citizenry.





RESPONSIBILITIES AND
THE SOCIAL CONTRACT:
STRATEGIC ISSUES

8

8.1 The Citizenry

Future scenario

The health care system can justify itself by providing responses that are safe, effective, of high quality, and meet the needs and expectations of the citizenry.

The characteristics of the citizenry of the future are:

- **Capacity to participate** in individual and collective decisions related to the health care system and its performance.
- **Capacity to gather and understand information** related to the possibilities and limitations of the health care system and its health care professionals in such areas as prevention, diagnosis, therapy, rehabilitation, and social reinsertion.
- **Capacity to be responsible for, and committed to**, their own health care and the rational use of health care resources.
- **Capacity to demand safety**, quality, and rapidity in health care services, as well as to demand proper personal treatment, and confidentiality.

Challenge: a new social contract

The fact must be accepted that society is able to organise itself and design its own future. Twenty-first-century society must be built with the participation of citizens. Progress must be made by relying on the concept of mature adult citizens, who assume their responsibilities, and who do not confide in any paternalistic or protective notion. We must progress towards a culture that includes transparency and accountability in individual, collective, and institutional performance.

Socio-economic and cultural values condition views on health, illness, and the way society organises health needs. Citizens increasingly see themselves as consumers of services; they are better informed and more demanding, and they are aware of their rights and duties, both individually and collectively. The evolution of the concept of being a citizen means that future generations may increase their health care demands, and they are likely to exercise pressure to make changes in the health care model.

Access to information and new communication technology have been changing the relationship between health care professionals and patients, which, until now, has been an asymmetrical relationship because of the gap between expert and lay knowledge. It will be necessary to share information in order to come to a decision.

There is a tendency to identify the concept of health with total well-being, and problems in life with health problems, thus neglecting the importance of developing the capacity of adapting oneself to difficulties. The health care system is expected to confront and resolve most of the problems with no limitations of any kind, whether of knowledge or resources. A wide-ranging social debate must be initiated on health and illness, as well as the limits of scientific knowledge and the health care system, in order to redefine the social contract with the participation of institutions, health care professionals, citizens and politicians.

Proposals for action

- To establish transverse information and educational policies for the citizenry.
- To establish ways of working in collaboration with the mass media to maintain the quality of information about health and health care services that is transmitted to the citizenry.
- To design instruments necessary to improve patients' safety and to make more in-depth analyses on the undesirable effects generated in the system.
- To introduce mechanisms that enhance transparency in allocating resources and health care services, and that make society become aware of scientific and technological limitations, and the limits of the health care system.
- To promote the participation of lay associations in policy designs and decisions that are addressed to satisfying the demands of users.
- To broaden the strategies and policies of support for the families of people who are chronically ill or disabled, addressed to achieving a balance between the family, social-health care, and social subsystems so as to design social and educational policies that guarantee the access of users to new communication technology.

Instruments

At the initiative of the Department of Health and Social Security, with the collaboration of the Department of the Presidency, the Department of Education, the Department of Social Welfare and the Family, and the Department of Labour, Industry, Commerce and Tourism, and with the participation of citizens' associations, in order for the health care system to focus on the citizenry, the collaboration of citizens in the existing formal bodies of participation (health councils) has to be strengthened and be actively promoted. Moreover, it is necessary to create a citizen health observatory as a consulting body that gives support to the design, introduction, and evaluation of the health care policies addressed to satisfying the demands of the citizenry, and providing them with the safety they demand.

8.2 Health Care Professionals

Future scenario

Health care professionals will have a more social orientation, since they will focus their service on the interests of the citizenry and will optimise their skills to guarantee safe and high-quality performance.

The profile of future health care professionals must comply with the following requirements:

- To have good working skills and a positive attitude when working in interdisciplinary multiprofessional teams.
- To be committed to continuous learning in order to achieve excellence.
- To show dedication and service, in the interest of patients.
- To be aware of the effects their decisions have as regards the distribution and use of resources.
- To have leadership skills in clinical management.

Challenge: the values of professionalism

We need health care professionals who are committed to excellence, who prioritise the well-being of patients and the health needs of the population.

Proposals for action

- To incorporate the values of professionalism in health care training.
- To guarantee quality and safety in the performance of health care professionals.
- To promote self-learning in order to adapt to changes.
- To develop intersectoral strategies to integrate the objectives into the health care educational systems.

Instruments

The health care and educational systems, at the request of the former, will establish transverse training policies whose budgetary funds, objectives, resources, and evaluation of the teaching process will be shared.

The transverse policies must prioritise:

- The regulation of a university space for health sciences.
- The reorientation of teaching to focus on relevant skills, and problem-solving that emphasises teamwork, as well as ethical aspects and interpersonal relationships.
- The promotion of innovating teaching methods and evaluation systems, which include instruments of evaluation that are coherent with objectives.

Challenge: changes in early training

Changes in early training for future health care professionals must be introduced, on the basis of teaching that is:

- Focussed on students.
- Organised with a multiprofessional standpoint.
- Orientated towards results.
- Based on evidence.
- Linked to a diversified and friendly self-learning environment.

Proposals for action

- To establish the strategies needed to develop new paradigms, and to adapt health care professionals to them.
- To orient multiprofessional education and active learning that is based in the community and is supplemented by the acquisition of knowledge of skills and proper attitudes.
- To simplify the training pathways of health care graduate diploma studies at university third-cycle level in order to achieve the best development of professionals.
- To design evaluation systems that are coherent as regards educational objectives, and which foster the process of change.

Instruments

The Departments of Education, of Health and Social Security, and of Universities, Research and the Information Society will design the legislative and technical instruments, keeping in mind their corresponding budgetary allocations necessary for the changes to start operating. This will either be carried out in pilot programmes or in a general way.

Challenge: to update postgraduate health care training

To update the model of postgraduate health care training by including flexibility, core knowledge, broadening of base, supplementary training, tutorial reinforcement, and the evaluation of results.

Proposals for action

- To design a core postgraduate training model for health care professionals that favours comprehensive training and flexibility.
- To adapt the objectives, methodology, and procedures of accessing postgraduate training. The access system must be distributive, not selective, so as not to condition or orient training to passing admission examinations.
- To design a framework programme for training that defines the skills to be learnt.
- To put a budgetary allocation into effect for a system of accreditation and re-accreditation of tutors, which includes instruments and mechanisms to identify tutorial performance.
- To define an evaluation system that is an instrument for improving the quality of training.
- To establish a system of accreditation for health care professionals to exercise their professions after their training period is completed.

Instruments

The Department of Health and Social Security will analyse and propose the transfer of training for health science specialists to the autonomous communities.

The current distribution of jurisdiction in the constitutional and statutory framework in the area of education and health, and the need to avoid any dysfunction in the fields of health care and teaching in health centres, make it advisable to give maximum priority to these changes.

Challenge: To prioritise continuous professional development

Health care professionals have to adapt to changes in their responsibilities and in their organisation, which demands permanent learning efforts. In this regard, training in information and communication technology is especially important.

Proposals for action

To design systems of continuous professional development that respond to the following criteria:

- **Accessibility.**
- **Recognition.**
- **Pertinence.**

Instruments

At the request of the Department of Health and Social Security, an agency of health care professions will be created in the Catalan area that will take responsibility for training courses and the evaluation of their impact on professional skills.

Challenge: to avoid imbalances in the availability of health care professionals

To avoid imbalances in the system and to respond to the health needs of the population, it is necessary to have a suitable number of different types of health care professionals and to incorporate mechanisms that would permit feedback. The health care and educational system have to design strategies for planning, training, and managing of human resources in the health sciences.

Proposals for action

- To make advances in the design of research instruments and mechanisms as well as permanent sociological evaluation (demographic and epidemiological changes) that help in making decisions on the quantitative and qualitative needs of health care professionals.
- To situate the process of staff planning in the health care sphere within the national and European context.
- To have an information system on human resources in the health care system that is reliable, ongoing, dynamic, compatible, constantly updated, and helps to make decision-making agile.
- To generate a process to retrain surplus health care professionals to benefit deficient areas.
- To determine the needs of health care professionals by making reliable short and long-term analyses.

Physicians

It appears suitable to restrict the present admission rate of new students to the faculties of medicine during the next ten or twenty years. After that time span expires, an increase in number could arise by a generational renewal of the people who leave through retirement.

Significant changes in the proportion of types of health care professionals must be considered in order to respond to increasing health needs in the ageing population.

The core skills of increased comprehensive training must be preserved in the context of continual advancement towards specialisation.

The temporary imbalances of certain medical-surgical specialities as a result of changes in technology, competences, and organisations must be analysed.

At present, the imbalance that has arisen has mainly been due to a lack of anaesthetists, ophthalmologists, radiologists, psychiatrists, geriatricians, among others; this is a dynamic phenomenon, and therefore, it is subject to important variations in future. Corrective measures must be taken for these imbalances, such as retraining people in surplus specialities, in the short term, to enter those areas where they are lacking; promote procedures that can foster the hiring of health care professionals from other countries; the redistribution of work among groups of health care professionals, as long as they have the necessary skills; make progress towards the core model in specialised training in the medium and long term; educational modules to access basic instruction; and the providing of specialised training places.

Furthermore, the current rigidity that reigns in the labour market, where each post is linked to one job qualification, should be changed.

Chemists

Qualitative shortcomings of chemists have been detected, both in training and for the planning of needs related to their different fields, in pharmacies, in hospital pharmaceutical specialisations, in the pharmaceutical industry, and in the primary care support system.

Dental surgeons

If the present rate of graduates in dental surgery is maintained, or if public health services are not modified, a surplus situation in this sector will take place.

Clinical psychologists

The preparation of clinical psychologists must be adjusted to the growing needs of mental health care in the health system.

Biologists

It is necessary to set the need for biologists in the context of recognised health care specialities with access to training and jobs (clinical analysis, clinical biochemistry, microbiology, parasitology, and immunology).

Nurses

In nursing, a decline in the demand for studies, the advanced age of many nurses in employment, and the new phenomenon of emigration to nearby countries are facts that forecast a lack of these health care professionals, thus affecting, in particular, such spheres as social health care, mental health, care for the chronically ill, home care, and care for vulnerable communities.

Corrective measures that make the practice of this profession and the systems of recruitment and promotion more flexible must be organised, in order to give incentives to nurses to stay in the health care system, as well as to encourage nursing studies.

It is also necessary to design strategies to retrain nurses to work in new spheres of expertise.

Midwives

There is a problem of ageing and a shortage of professionals in this sector. Specialised training strategies must be designed to guarantee a sufficient supply of midwives.

Dieticians and nutritionists

In the field of dietetics and nutrition, it is estimated that there will be an increase in the need for counselling in hospitals, primary care, and public health projects. The definition of the exclusive and shared competences of graduates and professional-training experts must move forward.

Physical therapists

The need for physical therapy professionals must be raised. Among other factors, this is derived from the ageing of the population, and results in the growing demand for rehabilitation.

Opticians and optometrists

The collaboration and co-ordination of graduate opticians and optometrists must be analysed as regards the rest of the health care professions that are related to the prevention and diagnosis of visual problems.

Podiatrists

We have no significant data that allows us to define the need for professional podiatrists. Despite this, the growing demand by the elderly for preventive and therapeutic services must be considered.

Speech therapists

The need for speech therapists must be raised in relation to a likely increase in speech therapy services in both the public and private sectors.

Specialised radiotherapy technicians

The official training of specialised radiotherapy technicians takes place in the higher stage of professional training. A tendency towards an increase in the need for these health care professionals is foreseen in order to respond to the high-quality technological requirements of the future. These technicians must work together with radiotherapy professionals, hence teamwork must be strengthened.

Nursing aids

The official training of nursing aids is carried out in professional training centres, and there is some confusion with occupational training. On the basis of a clear definition of skills, teamwork must be promoted between professional nurses and nursing aids.

The planning for health care professionals has to take into account the appearance of new health care professions in future (health care managers, managers of health care information, etc.) and the re-training and changes of existing staff.

Instruments

The Department of Health and Social Security, with the collaboration of the Department of Universities, Research and the Information Society, and the Department of Education will set up an advisory council for health care professionals as a permanent body with the following objectives: to identify current deficiencies in available professional skills, to analyse the foreseeable tendencies in accordance with the variations in demand (jobs that must be created) and the studies offered in the educational system, and to establish the criteria for recognising the studies of emerging professional groups.

The Department of Health and Security Social, with the co-operation of agents in the sector, will create the health system observatory of human resources.

The utmost priority must be granted to the establishment of the council as a participatory body and the observatory as a necessary instrument for decision-making.

Challenge: changes in the settings where health care professions are practised

The environment where the health care professions are practised is changing rapidly in the following spheres:

- Teamwork.
- Capacity to make decisions and to allocate functions.
- Safety and quality in the performance of duties.
- Progressive feminisation of the health care professions.

Proposals for action

- To favour teamwork that is organisationally flexible, adapts to the needs of the workplace, and is led by medical and nursing professionals.
- To develop the relation of exclusive, shared, and delegated competences when distributing work, bearing in mind the different levels of responsibility of each health care professional.
- To prioritise safety and quality in performing duties, starting with the accreditation of professional competence, a process that must be distinct from relying on academic qualifications.
- To consider the aspects related to having sufficient resources and the organisational conditions that make quality professional practice possible.
- To diversify hiring formulas and the working hours of health care professionals to respond to the progressive feminisation of the health care system.
- To reduce the bureaucratic burden so that health care professionals can focus their attention on the patient.

Instruments

The Department of Health and Social Security must prioritise the following objectives:

- To establish mechanisms that make a more efficient distribution of resources possible for organisation and responsibility in the workplace.
- To simplify resources that make for safe and high-quality professional performance.
- To take the lead in making working conditions more flexible.

Challenge: to promote clinical leadership in health care professionals

The professionals must lead clinical management and actively participate in the planning and evaluation of the use of resources and results.

Proposals for action

- To generate new and potent structures of functional, institutional and territorial governance, which are centred on clinical management (the problems and procedures) and which are the responsibility of the professionals.
- To promote decentralisation in the management of health centres, services, and staff, with a view to acquiring more professional autonomy and accepting responsibility for the results obtained.

Instruments

The Department of Health and Social Security and the bodies that provide services must generate new designs for the command structure in health centres and areas, and new formulas for managing health centres and staff.

8.3 Organisation

Future scenario

Professional organisations are socially responsible for guaranteeing the safety and quality of professionals' performance. Their greatest efforts must be addressed to carrying out this essential objective.

In a decentralised context, the organisations providing health services would increasingly act with a higher degree of managerial autonomy and be more responsible for the results.

In future, the characteristic objectives of professional organisations will be the following:

- To prioritise control mechanisms to gauge the quality of their members' skills and to provide support when necessary.
- To keep records on professional skills.
- To establish ethical codes of professional behaviour, monitor their observance, and intervene to resolve conflicts.

In future, the characteristic objectives of the organisations providing services will be the following:

- To be independent when designing and managing procedures, bearing in mind their social responsibilities and the social contract, in relation to results.

Challenge: to move ahead in guaranteeing the safety of patients and ethical values in their professional practice

It is important that professional organisations assume the responsibility of guaranteeing the safety of patients, ethical behaviour, and the quality of services that their members provide. Scientific societies should assume the responsibility of promoting the advance of theoretic and practical knowledge. These organisations must bear witness to the new social contract of the professionals.

Proposals for action

- **Simplify the mechanisms necessary for maintaining and improving professional skills.**
- **Guarantee the quality of their members' skills.**
- **Maintain up-to-date records of the elements that define their members' skills.**
- **Promote training, and disseminate advances of theoretic and practical knowledge (scientific societies).**

Instruments

Professional organisations and scientific societies must reorient and set priorities for their objectives, and redefine their structure in order to include the citizenry in their governing and controlling bodies.

Challenge: to become more autonomous and responsible

To place the organisations that provide services in a new framework of autonomy as far as structure and procedures are concerned, and to be responsible as regards the results obtained in meeting the health needs and expectations of society.

Proposals for action

- **To progress in the contractual arrangements for providing services in a financial framework of sustainability and exigence in a situation of equity, effectiveness, and efficiency in regard to the distribution of resources, the quality of procedures, and the evaluation of the results obtained.**
- **To prioritise the evaluation of the results, the clinical effectiveness of the organisations and the individual professionals, in a participatory atmosphere for all the actors involved.**

Instruments

The Department of Health and Social Security, through CatSalut, must design and implement new contracting instruments as well as instruments for evaluation.

The bodies that provide services must leave aside the managerial culture to give priority to clinical management.

8.4 The Health Care Model

Future scenario

The principles that inspired the Catalan health model continue to be valid. They are based on guaranteeing the protection of the citizenry's health in accordance with the principles of universal health-care coverage, fairness, effectiveness, and efficiency.

The estimations of the Catalan Institute of Statistics see an accentuated ageing of the Catalan population, a short-term intensification of demographic growth produced by the increase of external migration, and a rise in the birth rate. On the basis of these suppositions, it is estimated that Catalonia will have 6.5 million inhabitants at the end of the first decade of the twenty-first century.

The main health problems that the health care systems will have to face are those derived from ageing, cancer, cardiovascular and respiratory illnesses, mental disorders, and injuries and disabilities caused by accidents, as well as emerging problems related to socio-economic situations, life styles, and the environment. Disabilities and dependence will increase the demand for health and social services.

The impact that new technologies and treatments will have on health costs, and in the organisational models of entities that provide services, must be considered.

The sustainability of the health care system will demand new formulas for citizens to contribute to its financing.

Challenge: to advance towards a more sustainable, transparent, and participatory system

A sustainable system that is more transparent and participatory must be achieved, and it is necessary to carefully consider what improvements have to be introduced into the health profession model to make it viable, as well as suitable, for the new situation and for possible future needs.

Proposals for action

- To promote political and financial strategies in the short and medium term that are aimed at generating a new equilibrium between primary and specialised care, thus favouring a larger allocation of resources to the former in order to develop their potential to the utmost, and respond to the new challenges that arise from the population's health needs.
- To recognise primary health care as a gateway to the system, the role of primary care health agents, the need to establish joint workplaces that contribute to furthering collaboration and co-ordination with other levels of health care and services (especially public health projects and mental health), as well as the need to foster the intermediate care level.
- To make it possible to satisfy needs even though resources are limited, and to establish priorities in the spheres of health care, technology, training, and research.
- To make progress in the awareness of being accountable to society when it comes to the use of resources and the achievement of positive results in health, user satisfaction, and costs.
- To grant the citizenry and professionals more prominence, autonomy, and co-responsibility in regard to health care.
- To develop new management formulas in providing services, such as the ones offered by associative organisations, and to evaluate the results.
- To carry out an effective intersectoral co-ordination between the institutions with responsibilities in the health sphere by seeking out new formulas of interrelation and co-operation among professionals.



FINAL CONSIDERATIONS

9

The social contract

The need for a new social contract between the citizenry and the health care professions has been recognised. Safety, information, education, and the effective participation of citizens regarding health has to be consolidated as a key objective of the health care system in order to reinforce citizens' trust in health care services and health care professionals. If the objective of accountability to society makes progress, progress will also be made in having an increasingly more adult and mature citizenry that is more co-responsible in regard to health and the use of health care services.

The organisations and professionals must be at the service of the citizenry, and they must respond to their demands of accessibility, information, competence, technical quality, and humane treatment.

The real and effective participation of citizens in the formal bodies of participation and the creation of a citizens' health care observatory are two proposals to place citizens at the centre of the health care system.

Professionalism

The values of professionalism demand that health care professionals act in the patients' interest, maintain and improve the standards of competence and integrity, make the knowledge of experts available to society, and to be accountable to patients and society, as well as to the profession itself. The training process and professional practice must foster the acquisition of these values, which are considered crucial for the health care sector to function.

Continuing professional development

Maintaining and improving professional skills as well as continuing professional development are a necessity and an exigency in order to optimise the quality of health care.

Reorientation of medical training

Medical training must be orientated towards obtaining professionals that satisfy the scientific and health care profile, as well as possessing the capacity to develop a critical attitude, good judgement, curiosity, a willingness to devote time to self-learning, the ability to handle uncertainty and change, as well as to be motivated to learn throughout their lives.

Transverse training policies

The establishment of transverse policies which share budgets, the certification and re-certification of professional skills, the evaluation of professional quality oriented towards safety and the satisfaction of patients are three proposals that must contribute to strengthen the values of professionalism in staff planning within the national health care services in Catalonia. This can be carried out through the creation of an agency of health care professions and an interdepartmental commission on health care training.

The quantitative and qualitative adaptation to needs

Adapting to the needs and the availability of human resources in the health care system demands the ability to predict at least five to ten years ahead, to keep up with forecasted needs in distributing work, and the impact of new technologies.

The establishment of a dynamic, compatible information system that is permanently updated with data on human resources in the health care system, as well as the design of instruments and mechanisms for research and permanent sociological evaluation, become essential elements for the quantitative and qualitative planning of health care professionals.

Professional organisations and associations that gather together and represent different types of health care professions must have the authority to guarantee

society the quality and safety of the professional performance of their members, and to maintain permanently updated records of the professionals who are competent to practice their profession.

The creation of an observatory of health care professionals in which all the agents involved participate, and an office of health care professions that correlate the information, co-ordinate departmental performance, and give inter-departmental support, are instruments that must make it possible for the planning of health care professionals to be quantitatively and qualitatively appropriate.

Organisational innovations and redesign of structures and procedures

The organisations that provide health services must balance management objectives and clinical objectives by means of designing structures and procedures that favour teamwork. In this way, they can respond with efficiency and quality to the needs of the population and can provide good results in health care, satisfaction, and costs.

Interdisciplinary and multiprofessional teamwork

Interdisciplinary and multiprofessional teamwork demands the prior distribution of skills that are exclusive, shared, and delegable, and if it is necessary, a consensus for defining the conditions of delegated tasks in order to achieve the effectiveness of health care services, and the involvement and motivation of the health care professionals.

Competences and Responsibilities

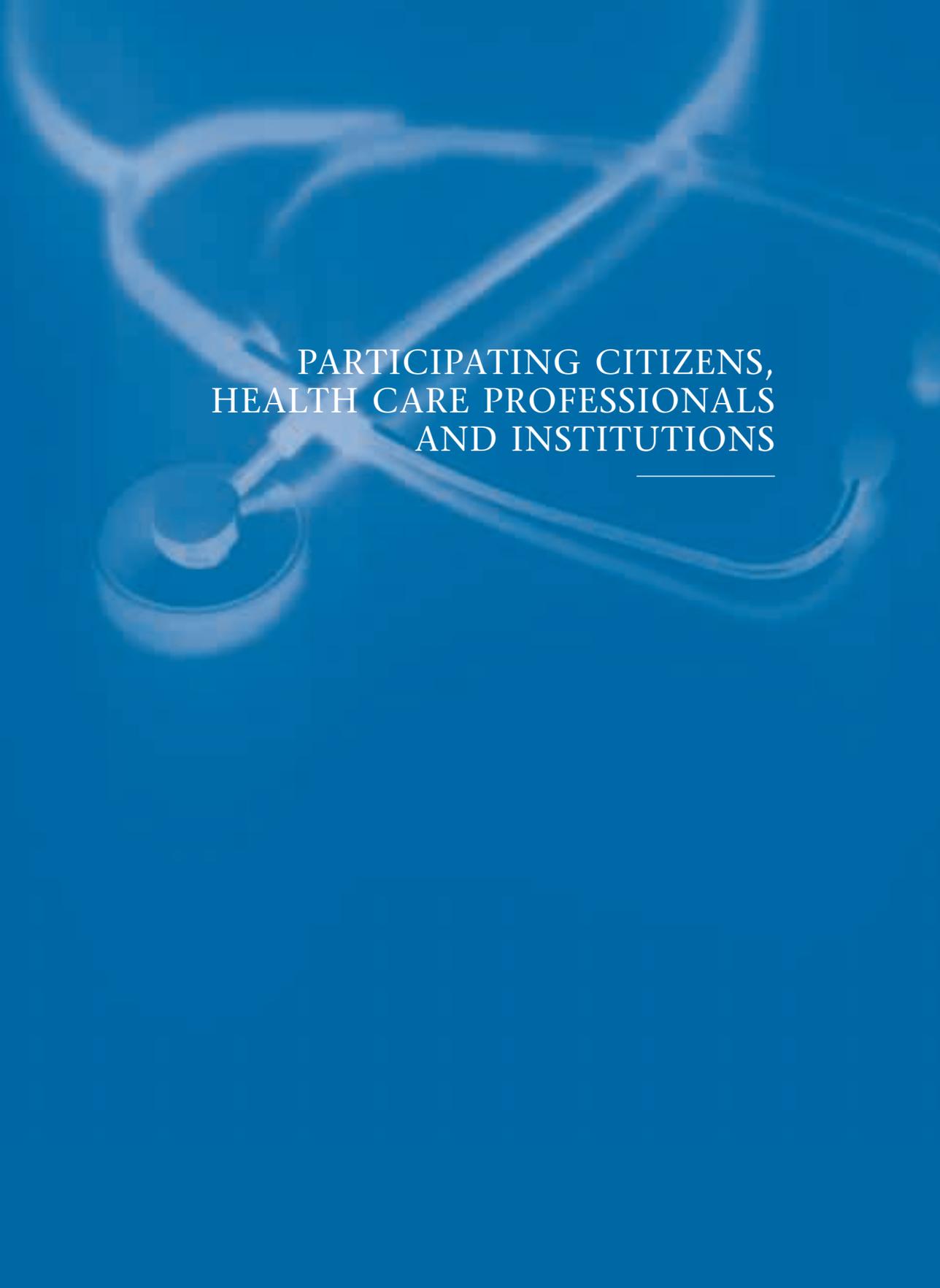
Technical advance in the health care sector, especially in the fields of diagnosis and treatment, accelerate the need to implement innovations regarding the organisation, the allocation of tasks and responsibilities in working groups. These innovations will have to be based on the idea that decision-making capacity is the quality that contributes most to clinical and organisational efficiency.

Training systems and health care organisations must leave aside the current structures for specialities in order to incorporate the training and organisational needs that make interdisciplinary and multiprofessional teamwork possible.

Space for analysis, debate and consensus

The Administration must foster a space for multiprofessional reflection, and it must provide the essential structures to act as the driving force for changes that allow the establishment of transverse policies that take in the complex scope of the health care system.

The creation of a Catalan council of health care professions, as a meeting place to analyse and agree on the spheres of competence and action of the health care professions, is a proposal that will have to be developed by the Administration, with the co-operation of Catalan society.

A stethoscope is shown in a light blue, semi-transparent style against a solid blue background. The stethoscope is positioned diagonally, with the chest piece on the left and the ear pieces on the right. The text is centered over the stethoscope.

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AND INSTITUTIONS

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