Aspects related with planning and development of human resources

The progressive transfer of responsibilities for health services to the autonomous communities and the adaptation of legislation at this level in the wake of this transfer was not consolidated until the years 2004-2005.

There has been constant concern from 2004 to 2007 over the shortage of specialists in the health system. In the 2004 edition of this report, this problem was only visible in the annexes to the information provided by the autonomous communities, while in 2007, the discussion on the lack of qualified personnel is far more intense (tables 40-42).

There is *more demand than supply*[35], a situation which has worsened in recent years in most communities. The deficit in human resources also affects other health professions such as nursing and clinical auxiliaries.

Both the growth and the *aging* of the population have an inevitable effect on the demography of the health profession and the demand for health services. This, has increased demand and the degree of dependency of the over 65 age group in Spain not only leads to greater expenditure on health but also a higher demand for health professionals.

The aging of the medical workforce continues, influenced by the rigidity of supply from both higher education and the labour market.

As regards the study of Medicine, the level required for access is still high, and depends on student numbers decided in the faculties. Training is a long-term process, and the impact of changes in training policies can only be detected after a lengthy period.

The *labour market* in 2007 reveals that 41.6 % of physicians and paediatricians in primary care are over 50 years old, as are 36.9 % of registered nurses in the same area. In specialised care, the proportion of physicians (20.9 %) and nurses (14.6 %) is lower[36].

35 See the data for vacancies or the growing demand for foreign health professionals in Internet or public bodies of the autonomous communities.

36 From the data provided.

TABLE 40. Evolution of the total number of workers* in the Spanish health system , 2004-2007

	2004	2005	2006	2007	Increase between 2004 and 2007**
Andalusia	80,917	78,387	93,808	90,537	11.89
Aragon	15,267	13,269	15,233	15,780	3.36
Asturies	12,885	12,370	13,932	13,497	4.75
Balearic Islands	10,766	10,879	11,432	12,151	12.86
Canary Islands	18,789	20,128	21,098	21,927	16.70
Cantabria		6,433		6,539	1.65
Castile and Leon	33,356	30,713	33,989	32,406	-2.85
Castile-La Mancha	18,577	20,013	22,015	23,586	26.96
Catalonia***	78,913	82,257	86,433	95,985	21.63
Valencian Community		40,608	36,571	48,514	19.47
Extremadura	13,256	13,347	18,479		39.40
Galicia	30,927	39,007	32,699	36,565	18.23
Madrid	52,171		65,261		25.09
Murcia	12,841	12,948	14,758	17,702	37.86
Navarre	6,298	6,843	7,261	7,640	21.31
The Basque Country	22,404	22,416	20,860	21,117	-5.74
La Rioja		3,190	3,107		-2.60
Ceuta and Melilla		756	765		1.19

*Statutory employees, workers and civil servants. **Except Cantabria (2005-2007), Madrid (2004-2006), Extremadura, La Rioja and Ceuta and Melilla (2005-2006). ***Data referring to the staff of equivalent personnel. 2007: Provisional data.

TABLE 41. Evolution of the total number of workers* in primary care in the Spanish health system, 2004-2007

	Medicine				Paediatrics				Nursing			
	2004	2005	2006	2007	2004	2005	2006	2007	2004	2005	2006	2007
Andalusia	4,949	5,209	6,547	6,824	969	1,020	1,072	946	4,533	4,940	9,560	6,625
Aragon	940	941	941	951	141	141	141	141	1,003	1,010	1,010	
Asturies	704	704	1004	830	121	121	128	119	744	744	903	870
Balearic Islands	474	486	528	711	117	125	127	128	512	528	533	726
Canary Islands	941	897		1,729	222	216		310	1,198	1,200		2,058
Cantabria	493			367	65			74	489			379
Castile and Leon		2,541	2,667	2,988		254	289	301		2,246	2,393	2,957

Castile-La Mancha	1,734		1,857		186		212	0	1,789		1,994	
Catalonia	3,536	3,208	3,208	4,486	995	664	664	692	3,937	3,612	3,612	6,074
Valencian Community		3,281	3,197	1,276		666	737	0		2,998	3,313	
Extremadura	1,339	1,143	1,250		135	126	131	131	1,462	1,288	1,344	1,497
Galicia	2,369	2,599	2,659	3,901	297	339	339	320	1,910	2,581	2,609	2,615
Madrid	2,039	3,084	3,403		800	811	817	840	3,427	3,777	3,787	4,024
Murcia	672		1,033	1,074	173		187	201	655		1,083	1,172
Navarre	334	336	375	404	80	80	87	90	395	420	450	598
The Basque Country	1,236	1,287	1,290	1,311	254	256	253	254	1,520	1,565	1,573	1,578
La Rioja	213	209	208		33	31	29		217	225	215	
Ceuta and Melilla		33	33	99		11	11	22		55	48	102

Blank spaces correspond to data not yet received.
*Including statutory employees, workers and civil servants.

TABLE 42. Evolution of the total number of workers* in specialised care in the Spanish health system, 2004-2007

	Medicine				Nursing			
	2004	2005	2006	2007	2004	2005	2006	2007
Andalusia	7,390	9,046	10,246	8,506	14,808	15,978	18,313	16,370
Aragon			1,964	2,032		3,348	3,348	
Asturies	1,488	1,488	1,866	1,736	2,987	2,987	3,400	2,947
Balearic Islands	1,560	1,570	1,343	1,573	2,292	2,310	2,497	2,525
Canary Islands	1,228	1,554		3,019	3,252	2,553		5,142
Cantabria	807			872	1,784			1,545
Castile and Leon		3,792	3,812	4,304		6,357	7,337	7,749
Castile-La Mancha	2,269		2,778	3,129	3,578		4,296	4,516
Catalonia*	11,174	11,797	12,547	29,537	17,390	18,246	19,126	36,124
Valencian Community		5,418	5,925			9,048	11,024	
Extremadura	1,742	1,632	1,690	1,791	2,737	2,548	2,678	2,800
Galicia	4,445	4,494	4,692	4,569	6,254	7,380	7,675	7,795
Madrid	6,136	6,912	8,359	8,610	11,236	11,658	13,827	14,962
Murcia	1,778		2,017	2,133	2,977		3,244	3,989
Navarre	793	800	804	785	1,406	1,468	1,507	1,579
The Basque Country	2,939	2,886	2,914	3,030	5,020	4,835	4,912	4,954
La Rioja	505	430	137		804	710	736	
Ceuta and Melilla		83	84	176		173	179	387

Blank spaces correspond to data not yet received. *Including statutory employees, workers and civil servants. ***Data referring to the staff of equivalent personnel. 2007: Provisional data.

This *imbalance in the labour market,* in the view of experts, is due to segmentation, acute specialization and limited flexibility in the face of change, but also to salaries which are regulated/fixed by the expectations of the personnel, the difficulty experienced by professionals in adapting to the constant and rapid changes brought about by technological innovation and the barriers to entry (MIR places) and a "sudden expansion of the size and scope of the network of health service providers".

The *mass retirements* which have been undertaken in several autonomous communities using forced retirement is another key component in the current debate over the effects of this lack of health professionals. In general terms, forced retirement has enabled a rejuvenation of the workforce and the incorporation of more permanent staff.

Another measure adopted in autonomous communities from July 2004 to avoid this shortage is the postponement of retirement. Castile-La Mancha, for example, has enabled the voluntary postponement of retirement of over 65s in 2004, while Galicia and Catalonia have extended working life to 70 years in certain specializations[37], based on the results of studies on the availability of qualified staff in the coming decade.

The Balearic Islands, as part of its Plan for the Organization of Human Resources, is introducing mechanisms to permit personnel to choose *partial retirement.* In Catalonia, many retirements are still forced.

The large cities are generally perceived as being more attractive than rural areas, both in the peninsula and the islands, for professional development and self-realisation, with greater *incentives.*

Some communities are improving working conditions to make them more attractive for health professionals. All of the autonomous communities[38] have increased the number of offers of public employment (OPE) for their plans and health services throughout the 2004-2007 period with the aim of consolidating their workforce, and have set up extraordinary OPEs in some cases.

They have also adopted measures to improve working conditions, *loyalty and stability* in accordance with their requirements and each context, based on the prior analysis of studies into the needs of health professionals. Galicia created its analysis in 2004, while Aragon[39] made its first quantitative approach to the issue of personnel shortage in 2005. This year also saw

37 These specializations include: allergist-immunologist, cardiology, oral and maxillofacial surgery, paediatric surgery, general surgery, intensive-care medicine, microbiology, nephrology, neurology, obstetrics and gynaecology, paediatrics, clinical neurophysiology and urology.

38 From the data available, which does not include 100 % of the autonomous communities.

39 Study of the needs of specialist physicians.

Catalonia carry out its study and publish its *White paper on health professions,* a continuous analysis on the trends in recent years in the requirements of health personnel, created by the Observatory on the Health Professions. Andalusia created a Report on the Need for Professional Personnel in 2006 and approved its offer of public employment in 2007[40].

The hiring of a greater number of foreign doctors, the incorporation of measures to transfer and consolidate employees from temporary to permanent positions in some specializations, or plans for handling substitutions and exchanges have all been carried out in different communities to alleviate the lack of professionals in certain specializations.

Availability of professionals

The exploration and analysis of the causes of the shortage of professionals in some fields will enable the preparation of actions specifically aimed at improving this situation.

An accurate count of the number of professionals is a basic and vital step in the planning of human resources in the health services in the short, medium and long term. It is no easy task if one considers that there are many instruments and conceptual criteria for this calculation among the autonomous communities, impeding the mutual exchange of information and experience in the development of measures aimed at reducing this deficit (good practices).

There is an added difficulty in obtaining accumulated figures at the national level which reflect this situation. The most common instrument (according to the National Statistics Institute or INE) is to count the registered doctors in Spain. However, there are autonomous communities, such as Andalusia, Asturies, the Canary Islands and Extremadura, where registration with the corresponding college or professional body is not a requirement in order to practice. Even where such registration is required, the number of registered specialists cannot be extrapolated to the number of positions existing. In those health professions where registration is not a requirement, the accounting problem with this criteria is greater.

Another instrument used is that which takes the number of professionals hired by each health service as its source of data, although the criteria chosen for collecting this data can lead to significant bias. In Catalonia, for example,

40 Decree 162/2007, of the 5th of June, approving the Offer of Public Employment for 2007 in the Health Centres of the Health Service of Andalusia, and modifies Decree 97/2004, of the 9th of March, which approved the Offer of Public Employment for 2004 of the Health Centres of the Health Service of Andalusia.

the health system is characterised by having a mixture of private and public assets and management, with public finance and contracts specifically drawn up for each organization. Counting the number of doctors available and comparing their position is therefore far more complex. Given the enormous variety of companies operating in the sector, the data is collected and compiled from a number of sources.

Some autonomous communities, such as Andalusia, the Canary Islands and Murcia, began to apply –or are in the process of applying– specific tools make it easier and faster to create a mutually compatible and accumulable calculation of medical personnel. They detected this need in 2004 and, aware of the limitations of quantitative data, agreed to create a single continuous Register of Health (and Statutory) Personnel. Catalonia raised the first recommendation for such a register in 2005 in coordination with all the health authorities based on their own research into health professionals[41] in order to obtain data sufficiently standardised to create an analysis of the requirements of professional personnel. The creation and operation of the Councils of the Medical Profession and of the Nursing Profession in Catalonia and the Supply Plan of Galicia in 2007 should be noted.

Most of the autonomous communities take their data on public employment from their own health services. As was mentioned previously, the result is different from that obtained by counting registration data and also differs from the human resources which are really available.

Instruments for planning and interventions

Incentive system

During the period from 2004 to 2007 most of the autonomous communities updated and increased the remuneration in their agreements on incentive schemes in an effort to stem the drain of valuable human resources towards other regions or countries where the working conditions are more attractive. Table 43 shows the agreements in force from 2004 until 2007 in this area and table 44 details the initiatives undertaken by the different communities in their organization of their human resources.

41 The Regional Government of Catalonia published the *White paper on the health professions* in 2003, although there was no pilot scheme of an objective register of professionals until 2008, and a regulatory decree is not being prepared.

TABLE 43. Initiatives from the autonomous communities on incentives (financial and in kind), 2004-2007

2004	2005	2006	2007
Andalusia			
Agreement of the Governing Council on the unification of leave, permits and holidays. Professional Performance Bonus (CRP) dependent upon the evaluation of shared objectives (2003)		Agreement on the reorganization of urgent treatment in specialized care, bonus for continuous service through the prolongation of the working day to the afternoon	Resolution of the Board of Directors of the Andalusian Health Service (SAS) on the variable productivity bonus for professional performance in reaching targets in order to unify the concepts for remuneration
Aragon			
	Agreement for health personnel		
Balearic Islands			
New ordinance on incentives, unspecified		Agreement on measures to reconcile home life with work for personnel of the health service, of the 3rd of March 2006 (improvement in the increase in substitution days)	Remuneration in accordance with professional career
Canary Islands			
	New incentive programme based on objectives of quality care to reduce deficit and standardise remunerations		Agreement of the Sectorial Committee Improvement of remunerative incentives for primary care groups and non-hospital emergency services Three-yearly increment for temporary personnel
Cantabria			
Agreement, of the 24th of June 2004, on holidays and permits for personnel of the health facilities of the Health Service of Cantabria			Agreement with unions/ Various agreements on remuneration (BOC 2007)
Castile and Leon			
Agreement 38/2004, of the 25th of March, increasing the number of holidays, permits and leave. Increase of compensation for travel in primary care New remuneration model for variable productivity	Increase of the specific allowance for shift work, with general application Decree 61/2005, regulating and standardizing timetable and working hours	New regulation for variable productivity Agreement on travel for primary care and specialised care Modification of the value of duty hours for doctors and nurses	Law 2/ 2007 of the legal status of Statutory Personnel/Agreement of the Sectorial Committee
Castile-La Mancha			
Support for disabled children (studies and education) and financial assistance for prosthesis and orthodoncy	Increase of the bonus for continuous attendance, in line with the new regulations of the legal status of the professionals		Sectorial Committee of Health Institutions. Agreement on the specific allowance

Catalonia			
		Pay agreements: II Agreement of the Catalan Health Institute nd the VII Agreement XHUP (Public Hospital Network)	Approval of an analysis of payments for doctors (by the Commission of the Medical Profession)
Valencian Community			
Introduction of a Variable Productivity Bonus	Resolution, of the 21st of February 2005, and Agreement on Improvements in relation with Continuous Attendance and Duty Rosters Agreement of the 27th of May 2005, on the concept of variable productivity		Various agreements and decrees, among which Decree 38/2007 of the Council
Extremadura			
	Agreement on professional career and development		
Galicia			
			Management contracts for the Galician Health Service (Sergas) with management centres
Murcia			
			Remuneration by goals for managers
Navarre			
		Agreement on working conditions	
The Basque Country			
Financial incentives for training and substitution in the fulfilment of objectives (although not individualised)	Decree 57/2005, of the 15th of March, on policies of permits and leave	Agreement on the regulation of working conditions	
La Rioja			
	Unspecified collective and six-monthly incentives and an annual incentive according to institutional objectives, by the Hospital Foundation of Calahorra		
Ceuta and Melilla			
New systems of incentives by remuneration without specific agreement (value of duty hours, continuous attendance, shift work, etc.)		Agreement on specific improvements in personnel pay	Increase of different remunerative commitments

TABLE 44. Initiatives of the different autonomous communities with relation to the organization of human resources, 2004-2007

2004	2005	2006	2007
Andalusia			
Single scale for evaluating personnel for selection of statutory personnel in the Andalusian Health System		Agreement between the Andalusian Service and Unions of the Sectorial Committee for Health on personnel issues for 2006-2008	Reorganization of urgent treatment in primary care and specialised care
Aragon			
Professional Health Agreement, of the 26th of April 2005	Professional Health Agreement, of the 26th of April 2005, on remuneration for statutory personnel and transfer of personnel to statutory conditions		
Asturies			
Voluntary change to statutory conditions			
Balearic Islands			
		Unification and statutory conditions for personnel via the Plan for Organization of Human Resources, of the 4th of May 2006	
Canary Islands			
Register of statutory personnel in the health system of the Canary Islands, in accordance with Decree 217/2001, of the 21st of December	Voluntary change to statutory conditions. Register of Statutory Personnel only		
Cantabria			
Decree 118/2004, modifying the relation of positions within the departments of Health and Social Services and Education		Extraordinary OPE for 2007 Development of the second evaluation of the working environment in offices of the Health Services of Cantabria	
Castile and Leon			
Decree 61/2004, of voluntary incorporation of civil servants and permanent employees in conditions of statutory personnel	Decree 61/2004, regulating the conversion of civil servants and permanent workers to statutory personnel Creation of the figure of Doctor and Nurse in primary care for 2006	Extraordinary OPE for 2006 Decree for the conversion of civil servants to statutory employees in specialised care and the Regional Centre of Medicine for Sport Operational guides for the tribunals acting in selection processes	Creation of a demand and supply unit for jobs in the health sector

Castile-La Mancha			
Agreement 38/2004, of the 25th of March, on improvements in working conditions for health personnel Also, voluntary prolongation of working life for those over 65	Decree 63/2005 of the 24th of May, regulating the conversion of civil servants and permanent workers to statutory personnel Creation of the figure of Doctor and Nurse in primary care for 2006		
Catalonia			
White paper on health professions Demographic study of health professionals, first phase	First recommendation for a single continuous register of health professionals White paper on health professions (second phase). Study of the demographics of the medical profession in Catalonia		Register of Health Professionals (pilot phase)
Galicia			
	Voluntary change to statutory conditions		
Murcia			
Process of implanting a single data programme			
La Rioja			
Voluntary change to statutory conditions Extraordinary offer of public employment (OPE) and statutory personnel	Voluntary change to statutory conditions Use of the Comprehensive System of Personnel and Payroll Management (Sigpyn) Hiring of disabled persons for patient care Extraordinary offer of public employment (OPE) and statutory personnel	Agreement for personnel of the Health Service of La Rioja and appeal for transfers	Approval of the first list of job descriptions (RPT) and appeal for transfers
Ceuta and Melilla			
Law 16/2001 on the extraordinary process for the provision of places for statutory personnel			

These incentives, although diverse in nature, are more closely linked to the attainment of targets than before. Their objective is to improve quality, effectiveness and efficiency in the services provided and stimulate individual professional development through variable productivity bonuses, continuous service bonuses, and specific bonuses linked to hours of duty or shift work.

It can be seen that all the communities have made a great effort to prepare incentives related with targets and merits, especially since 2004, although permanence is still rewarded with three-yearly increments.

Professional career paths are also considered part of an incentive policy. They have developed gradually since 2005. These paths, which were designed initially to distinguish between professional progress in the assignation of management responsibilities, which was the only activity with incentives in the past, are at risk, according to some, of degenerating back to the traditional recognition of permanence in a position. The recent debate on the subject of reversibility and career evaluation, which vary between any two communities, is at the heart of this discussion.

In general, incentives, whether financial or in kind, continue to be aimed at statutory/qualified personnel. Only a few of the autonomous communities have begun to extend this type of measure to other personnel. The Valencian Community, for example, has increased the bonus for continuous service payable to nurses in training through the agreement of the 12th of January 2007 of the Council, and Murcia has a compensation system aimed at management staff to improve the running of the service. Professional career paths have also been extended in the Balearic Islands to include personnel with graduate degrees in health studies, and the decision to extend it further to personnel without degrees and non medical personnel is being studied.

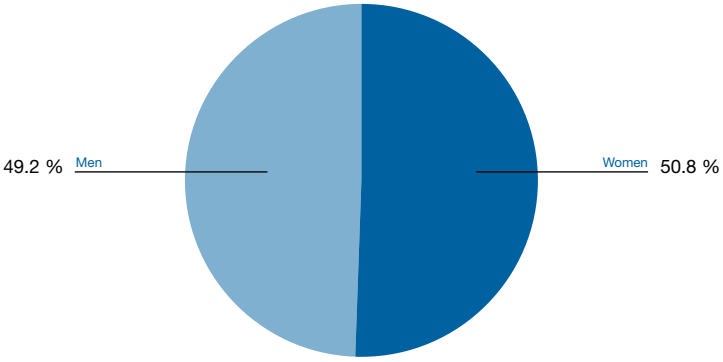
A general trend has been noted among the autonomous communities to apply increases to the bonuses for variable productivity and continuous service.

There has also been a tendency to reward permanence of the health professionals in each region through other non-monetary incentives which are aimed at favouring their individual development.

Permits and leave

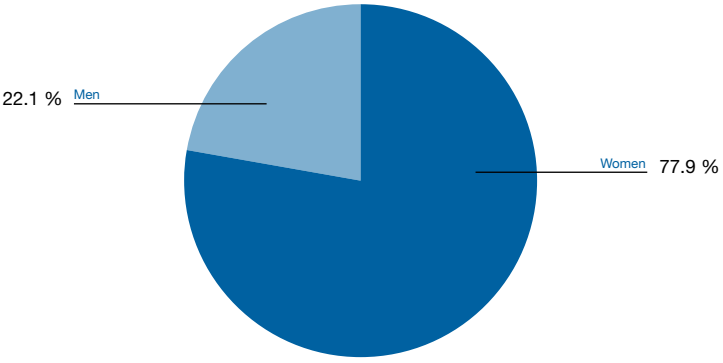
Other means of motivating and promoting the loyalty of health personnel during this period 2004-2007 focus on aspects related with the reconciliation of work with one's private life, both for men and women. All of the autonomous communities have an agreement for 2007 on measures dealing with social issues. From a general perspective, the emphasis has been on improvements in conditions of maternity, paternity and caring for family members. The importance of this subject can be grasped if the continuous tendency toward the feminization of the medical profession is considered, and the consolidation of the number of women working as nurses. In the near future, this phenomenon might lead to a reversal of professional roles. Figures 9 to 13 show the distribution of health professions (qualified physicians, paediatricians and nurses) by sex.

Figure 9. **Medical professionals in primary health care, by sex, 2007**



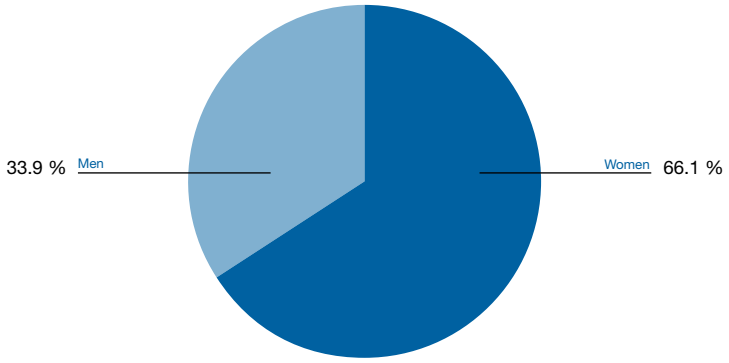
Created with data provided by autonomous communities, 2007

Figure 10. **Nursing professionals in primary health care, by sex, 2007**



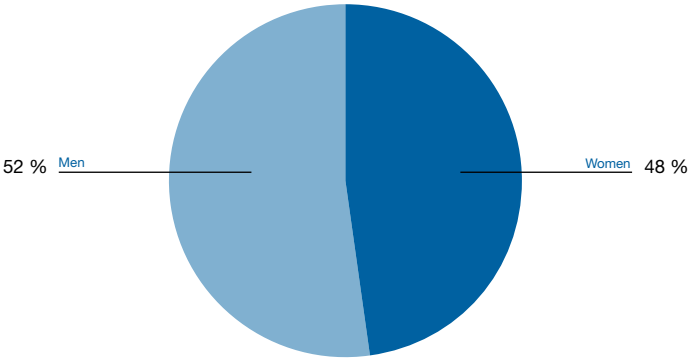
Created with data provided by autonomous communities, 2007.

Figure 11. Paediatric professionals in primary care by sex, 2007



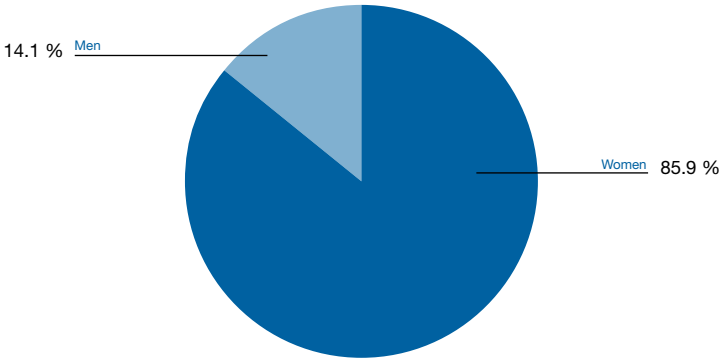
Created with data provided by autonomous communities, 2007.

Figure 12. Medical professionals in specialised health care, by sex, 2007



Created with data provided by autonomous communities, 2007.

Figure 13. Nursing professionals in specialised health care, by sex, 2007



Created with data provided by autonomous communities, 2007.

Working hours

Each autonomous community has approved measures in accordance with its organizational plan to improve the working conditions of its statutory personnel, thereby increasing their loyalty and stability.

The progressive application of changes in the working hours implies the reorganization of human resources by limiting the number of hours worked every week.

Other incentives consist in the prolongation of ordinary working days, by means of a specific financial bonus for every hour of substitution worked in the back up of primary or specialised care or the emergency services. This has been adopted in Andalusia, once the agreements from 2005-2006 on the reorganization of urgent treatments in primary and specialised care had been implemented. The changes in timetable are organized in terms of the needs of each region and, in general, a working week of 35 hours has been established. In some cases, in accordance with European Directive 93/194/CE of the 23rd of November 1993, the maximum working period has been set at 48 hours (ordinary and extraordinary) and the obligatory minimum period of rest is 12 hours without interruption. This has led to an increase in the number of vacancies which in certain specialisations may prove hard to fill, as has been noted previously.

Few autonomous communities began to carry out actions in this area in 2004, although in the following years, until 2007, they have spread and consolidated rapidly in all communities.

Continuous Training

Each of the autonomous communities draws up an annual plan for continuous training in collaboration with other institutions and organizations, health authority bodies and unions. Even so, the final decision always rests with the administration of the community. Table 45 provides a summary of the organizations and institutions which intervene in the plans of the autonomous communities.

Training activities have been set up in most of the regions to meet the priorities set out by the health administrations of each community, in an attempt to respond to the specific requirements detected by the administration and by the participants in the training sessions (table 46).

There is concern over how to improve the quality of this service and its usefulness in the professional development of statutory personnel, which is evaluated annually by means of a survey of satisfaction. In previous years, nearly all the autonomous communities noted the high level of participation and satisfaction in the training activities carried out.

The gradual introduction of new technology has been crucial in enabling access to information. In autonomous communities such as Madrid or Cantabria, training courses have been made available to a greater number of professionals in 2007 through the use of online training platforms. The efforts made by Madrid and Cantabria to include gender perspectives within their training programmes since 2005 is worthy of special mention.

The differences in the process of modernizing and updating the area of continuous training and professional development in different territories has been noted. This leads to the question of whether it would be more appropriate for the level of knowledge to be standardised across the country, or whether it would be better if each training programme was created in response only to the specific needs of each community, or whether continuous training should deal with common basic knowledge.

Galicia, Madrid and the Valencian Community have reported on the incorporation of gender perspective in their training programmes, both in general courses and courses specifically related to the prevention of harassment at work and specific training in healthcare skills for women suffering from gender-based violence during 2007.

TABLE 45. Institutions or organizations specifically offering continuous training, 2007

Autonomous community	Name	Other complementary system
Andalusia	Directorate General of Quality, Research and Management of Knowledge. Accreditation Agency	Andalusian Agency of Health Quality. Evaluation of continuous training activities
Aragon	Health Management Board	Public Administration Institute of Aragon
Asturias	Directorate General of Quality and Innovation in Health Services. Training and Research Service	Adolfo Posada Institute of Public Administration of Asturies
Balearic Islands	Directorate General of Evaluation and Accreditation Continuous Training Commission for the Health Professions. Accreditation Agency	Tripartite Foundation for Training and Employment
Canary Islands	School for Health and Social Services of the Canary Islands (Esscan)/ Directorate General of Human Resources (Canary Islands Health Service)	Management Boards of Specialised Care / Primary Care
Cantabria		Training units in head offices
Castile and Leon	Institute of Health Studies and Centres of Castile and Leon Training Service and Directorate General of Human Resources of the Regional Health Board University School of Emergencies Training Units for primary and specialized care and emergencies of the autonomous community	
Castile-La Mancha		Health Sciences Institute/School of Regional Administration in 2006
Catalonia	Catalan Board for Continuous Training for the Health Professions	Technical Board for Continuous training in Medicine Technical Board for Continuous Training in Pharmacy (belonging to the Catalan Board of the Health Professions)
Valencian Community	EVES (Valencian School of Health Studies)	
Galicia	FEGAS (Galician School of Health Administration)	
Madrid	Laín Entralgo Agency	
Murcia	Directorate General of Quality Training and Research in Healthcare, in coordination with the Directorate General of Human Resources	Foundation for Health Training and Research in the region of Murcia
Navarra	Health Teaching, Research and Development Service	Evaluation and Quality in Primary Care Section/Teaching Commission for Mental Health/Teaching Unit of the Navarre Institute of Occupational Health
La Rioja	Rioja Health Foundation Training Unit	

Created with data provided by autonomous communities, 2007.

TABLE 46. Initiatives of the different autonomous communities in continuous training and professional development, 2004-2007

2004	2005	2006	2007
Andalusia			
Individual development plan		Strategy model of Skills Management. Resolution, defining the Skill Areas for different health professions	
Aragon			
	Training programme for professional skills in the health system (Focuss)		
Asturies			
"gcSalud, a space for knowledge": health knowledge management strategy (2003)			
Balearic Islands			
Coordination of graduate training in medicine, pharmacy and other degree subjects, training for work at high and medium level. Acceptance of foreign qualifications	Creation of a workgroup in accordance with the agreement for the arrangement of negotiations on professional development between the Health Service of the Balearic Islands and social representatives	Approval of the promotion, professional development and career system by the Governing Council of the 22nd of December	
Canary Islands			
	Increase in the number of places for specialists in training First evaluation of the Continuous Training Plan of 2004 Quality Evaluation Questionnaire for the Continuous Training Plan of 2005		Increase in the number of training places
Cantabria			
	Incorporation of the gender perspective in training programmes as a quality criteria Training courses in Health and Gender, of the Directorate General of Public Health		Creation of an online training platform

Castile and Leon			
Pluriannual Continuous Training Plan maintaining the development of decentralised programmes in the head offices of primary and specialised care and emergencies New working strategies towards professional development have been started	Training Activities are encouraged in areas of special interest (quality in pharmaceutical prescription, information systems and patient services, etc.)	Evaluation of the First Training Plan, Training activities in response to management and institutional objectives are encouraged (gender perspective, care for immigrants, etc.) Definition of the model of professional career for all personnel in regional health management and publication of the agreement of the 22nd of December Elaboration, promotion and execution of the General Training Plan 2003-2005 Development of the Teacher Training Plan	Encouragement of training issues such as gender perspective, occupational health etc. Initiate payment of Grade I of the Professional Career
Castile-La Mancha			
Priority training issues, decentralised management and final evaluation A design of a global format for changes in training is under way		Agreement on the professional career of the health service of Castile-La Mancha for graduates in health degrees Agreement of complementary measures for the agreements for professional careers, promotion and development	
Catalonia			
Gender-based violence Child Abuse Community Health and Primary Healthcare Patient Safety. Immigration	Improvement plans for quality coordinators Health and School Objective clinical evaluation of midwives	Objective Structured Clinical Evaluation of paediatricians Social and sanitary areas: neurodegenerative disorders Health in adolescence Publication of Decree 407/2006 of the 24th of October Creation of the Catalan Board of Continuous Training in the Health Professions and Technical Boards for Continuous training in Pharmacy and Medicine	Smoke-free pregnancy Child care in family medicine Rational use of medicine
Valencian Community			
Reorientation of the strategic training plan of EVES (2004-2008). Courses on gender perspective		Development of legislation for approving professional career	Creation of a plan of continuous training for statutory personnel and civil servants

Extremadura			
Recycling programme for specific sectors of primary care Grants for training abroad	Annual Continuous Training Plan 2005 Increase in the number of training activities Decentralisation of activities in health matters Recycling programme for specific sectors of primary care		
Galicia			
AFCAP Plan, within the Strategic Training Plan. Publication of the free magazine *Galician Review of Health News*	Planning and activities oriented towards the health policy of Galicia 2005-2009	Survey on occupational factors of a psycho-social nature which represent a threat for professional health and well-being	Specific training plan on gender and violence at work
Madrid			
	Training plan (2005) Incorporation of gender perspective	Annual guide for the creation of the continuous training plan Incorporation of gender perspective in courses	Availability of online training Incorporation of gender perspective in courses
Navarre			
		Agreement of the 21st of July 2006 on the commitment to elaborate a proposal for a professional career for all permanent staff	Common strategic programme (availability of a series of strategic lines)
The Basque Country			
	Decree 395/2005, of the 22nd of November, recognising the level of professional development for doctors and technicians	Complete second cycle of measurements of satisfaction among personnel	Creation of a teaching unit for Medicine at Work
La Rioja			
		Order 3/2005, of the 27th of April: regulation of continuous training in the health professions and creation of a Consultative and Advisory Committee Appointment of 6 accreditation committees of the health professions	

Created from data provided by the autonomous communities, 2007. AFCAP, *Acuerdo de Formación Continua en las Administraciones Públicas* (Agreement on continuous training in public administration); EVES, *Escuela Valenciana de Estudios de la Salud* (Valencian School of Health Studies).

Prevention of injuries at work

The rise in the number of aggressions suffered by health personnel has prompted the creation of interventions which follow the guidelines set up under the health system of each autonomous community in its plan for the prevention of injuries in the workplace. They include agreements to provide the employee with legal counsel – in collaboration with other organisms – or programmes for monitoring health and analysis of risk (from a study of the aggressions suffered, their cause and the responses available).

This subject has grown in importance in parallel with the increase in the number of aggressions in recent years. In the past, hardly any of the communities had mentioned their programme for the prevention of injury at work. The Balearic Islands, Castile and Leon, Andalusia and Castile-La Mancha were pioneers in strengthening several measures of social intervention in this area in 2004, consolidating them in the following year. The Autonomous Community of the Balearic Islands created a working group and a plan for the prevention of violence in the centres of ib-salut; Andalusia developed a protocol for intervention in cases of aggression and a single register as part of its Comprehensive Plan of Prevention and Assistance against Aggression. There is also a system of support and legal guidance for personnel who suffer aggression, and specific training courses on the handling of conflictive situations. As regards Castile and Leon, a register of aggressions was proposed and an insurance policy for legal expenses was taken out which did not become valid until the end of 2005. This community is also notable for the many guides that have been prepared for this problem. Finally, Castile-La Mancha created a central commission for occupational health within its General Plan for the Prevention of Injury in the Workplace.

An innovative project was begun in 2007 in the Basque Country[42] which should also be mentioned here. It involves certification of the System for the Prevention of Injury in the Workplace according to the OHSAS standard. In this area, Catalonia has chosen to consolidate the expansion of its occupational health units.

42 OHSAS, Occupational Health and Safety Management System. OHSAS 18001 is a tool which helps companies to identify, assign priority to and control health and occupational hazards as part of their normal business processes.

Gender perspectives

The gradual inclusion of gender perspective among training issues and prevention of injury in the workplace, has been steady in the autonomous communities during the period of the study.

The adoption of this perspective is a sign of modernization and adaptation to current international practice.

The Commission Against Gender Violence, created within the Interterritorial Board of the National Health System in 2004, is an example of good practice and has been presented internationally in this context, both for the subject it addresses and for its procedure of consensus at both technical and institutional level.

Satisfaction

Despite the willingness of the autonomous communities to improve quality in the health system and the working conditions of the statutory personnel, only a few report having carried out research among their staff to reveal the level of their satisfaction. It would be interesting to carry this out on a regular basis to avoid the syndrome of burn-out in cases where the working conditions have deteriorated in recent years, while the level of stress has increased, especially in the current context of insufficient human resources, the shortage of certain specialists, the increasing demand for service and the expectations of the patients combined with the reduction in time available to dedicate to them, among other aspects.

Galicia designed a questionnaire in 2007 on the atmosphere at work for the Galician Health Service (Sergas), which took into consideration factors of psychological and social risk and their repercussions on health, stress and satisfaction. The results suggest that insecurity and self-esteem, difficulties in reconciling family life with work, and control over working hours figured strongly among the elements which determined the health of the personnel, reflecting a worsening of the symptoms of stress and lower satisfaction in over 50 % of workers.