Joint Action Health Workforce Planning and Forecasting

From:

Joint Action on Health Worforce Planning & Forecasting
Programme Management - Michel Van Hoegaerden
On behalf of the Joint Action Team

To:

HRH FORUM
RANIA KAWAR (WHO.INT)

Cc.: **G. PARFILIEVA (WHO.INT)**
Executive Board members of the Joint Action

RECIFE (BR), Sunday November 10th, 2013.

Dear Colleague,
Dear Rania,

As per your request, please receive attached a preparation work for the panel activity on.

Yours faithfully,

Eng. Michel Van Hoegaerden
Programme Manager on behalf of Belgium
Joint Action on Health Workforce Planning & Forecasting

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the Health Programme
of the European Union

D. Proposed dimensions and leading questions asked to Mr Michel Van Hoegaerden

• Dimension 1: What have we learned about health workforce planning and forecasting in the last decade?

Leading Question: From your experience what are the differences between "planning" and "forecasting"? Is it feasible to draw on the evidence from the last 10 years to plan/forecast for the concept of UHC across all countries, irrespective of economic status?

Proposal/

EU has the privilege to work in an healthcare environment where most of the basic needs for care are covered, and where emergency care systems are in place to insure that all EU citizens receive a relatively immediate response to vital threats. Social security all through EU together with a historical production of healthcare workers allows most population (beside some local / specific situations) to benefit from the healthcare systems at a basic but sufficient level. Together with this, the **expectations** of the population on the **sustainability** of the healthcare systems, on their quality, and on their cost are very high, and somehow higher than what we can deliver. Parameters like ageing, chronical desease, pressure on cost, new working expectations from health workers and so on, come on top of the easy Inflow <-> Outflow modelisation, which I would call « warehouse management » type of forecasting, and gives new broad dimensions to forecasting exercices.

And there comes the **main challenge** … As **basic forecasting is no longer enough for policy making in any EU-country**, the professionnals health workforce analysts should build a number of scenarios, using both data-based evidence and hypotheses difficult to translate in numbers.

These scenarios should then be presented to policy makers. They should be make clear in their aims and methods, assess the match with politcal concensus on the most acceptable and efficient actions, and turned into planning. **Planning means building up a plan of actions to reach a forecast target.**

Today, the **amount of dimensions for forecasts**, the low reliability of the cause to effect liaison and large impacts of the supra-national context, **makes it difficult** for EU policy makers to turn those forecast into plans, but still it is a necessity. **The increase of our capacity** to collect data, create evidence, join data at EU level and build up aligned scenarios is what we plan to do **to help policy making to take place**.

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• Dimension 2: How can countries improve data collection and quality to meet the requirements for effective planning processes?

Leading Question: Does the same apply to European/OECD countries? Who stands out for developing and implementing 'good practice'?

Please note that this question follows one intended for Charles Godue (PAHO) - PAHO has recently agreed a new Resolution on Increasing Access to Qualified Health Workers in Primary Health Care-based Health Systems, which includes an emphasis on improving data collection and quality. What are some of the key issues in the region of the Americas?

Proposal/

Some EU countries, like UK countries, The Nederlands, Finland and Belgium **have an history of investing** quite a lot of money **in data collection processes, forecasting models**, and in evaluating planning decisions from the recent past. On what I would call « basic warehouse type forecasting » of Health Workforce we have several models with each quality and weaknesses that we currently review within our Joint Action to make a sound summary model available for all EU countries at no cost. Italy is leading this piece of work. Both NL & BE **have proved though their legal instrument and central coordination** of competent authority that **collecting those data**, almost on-line, **is possible.** Though, we have also proven that the international data collection and benchmarking is usefull and helps the things moving in some countries, but we also know that the **current international data collection remains non sense as we are all talking about different definitions in different contexts**. EU is taking action there together with OCDE & WHO to analyse the terminology gap on our side – this work being led by the Hungarian team.

Back to the core message: lessons show us that **major decisions are expected in Europe**, which such gross forecasting cannot support.

We all know that our EU Healthcare system is at **risk for no longer matching the high historical expectations** of the population in terms of availability, quality, affordability. Furthermore health care professionnals themselves request a decent perspective of living, regarding quality of the work environment and personnal potential within a carreer.

We have to **investigate scenarios on a broader perspective** taking into account an evolving society, and gather the data needed for that. Several methods are to be used, but

the most important lesson is to take into account that **most of the determinant on health care systems are to be found outside of a pure healthcare context**. Employement numbers, Social figures, Education, Budget, Consumation, Insurance sector, Innovation & Research… **all those departments collect data in numbers that should be turned into variables for healthcare workforce forecasting**. The challenge is to turn such external data into **measurable data for our purpose**.

Within the Joint Action funded by the EU Executve Agency for Health & Consumers, we will provide a review of the major trends that might have a long term impact and apply the most qualitative methodologies **to put numbers on those trends**. Conducting **pilot projects will allow us to step from theory to practice and evaluate the interpretation of the hypotheses and findings all over our countries**. Our UK partners are leading this piece of work, with participation of Belgium for the pilot project.

• Dimension 3: Do current planning and forecasting models integrate well enough variables linked to equity in geographical distribution?

Leading Question: Your work with the European Union has a major component of the 'Geography of HRH', considering flows and mobility of health professionals. Are the models able to tease this out, and can they be applied to consider distribution, and especially equitable distribution, within a country? How can we better measure the availability of and accessibility to health workers?

Proposal/

You are right to say that **Geography is a key issue in an equity context**. EU principles allows **free mobility of persons, goods and services**. **From a patient perspective**, we know that the expectations of people is to benefit from health care with equity wherever they are living, whether in rich cities or in remote areas. Though, with some cultural and technical variation, there are distances that population consider as being to far. **From a healthcare worker perspective though**, the tendency of willing to working in an urban area with up to standard facilities is dominant.

Based on the Belgian examples at least, I can tell you that we have an evaluation of the regional distribution of Health Workforce activities that is clear enough to inform the policy maker. Our Federal public service have sponsored **various studies on mobility optimisation of patients** for, by example, emergency care, cardiologic intervention, after hours general practionners activities, nursing home service, planning of hospital facilities and so one. We have the data and I'm pretty sur many other EU countries or

regions do the same.

Havine the data does not mean that we can solve the problems !

Nevertheless, based on those data, several policies have been implemented to evaluate the needs, and find a balance between needs and offer all through the country.

Belgium, Finland, Nederlands, UK, Italy, others, are conducting actions to build up scenarios to address those imbalances and the observed negative trends.

With the Joint Action, we aim at bringing this debate at a EU level based on a network providing local evidence. Both Hugarian and Bulgarian teams are leading elements of this topic.

Though, I wish to strongly insist on a major concern ! **More people and more money is not the only solution** ! Healthcare systems need innovation and improvement. Many trends will change drastically the ways of providing care, at least in our EU countries.

Belgium does not need more General Practionners in rural areas if the inefficient, labour intesive, after hours activity is not upgraded to a new system first. As an example, we installed a dispatching center joined with emergency care dispatching, we provided patient transportation facilities to secured rural medical after hours units.

The same applies to cardiologic monitoring and intervention. In our EU countries, and taking into account the new monitoring technologies, there is no need for a full capacity every 50 kilometers (BE standards) but some think there is a need for a strong monitoring organization with upscaling to reference centers of high activity.

Health Workforce planning is not only planning people, but planning a healthcare system essentially runned by skilled individuals and groups.

- What is your key message on this topic (2 minutes)

Lot of knowledge has been developed all through the years and some countries build further on horizon scanning and impact assessment of bigger adaptation of their healthcare systems. **Some countries have proved that data collection is possible, and courageous policies are based on forecast.**

We know we can. Today there is need to **share this knowledge and increase the capacity of forecasting and planning** all through the countries of this world. At least a basic data gathering and scenario building is possible in the coming year, as strongly recommended by the WHO code.

We, EU countries and the many partners joining us, applied to do that in our

region, and to share or findings with everyone.

Though, Forecasting and Planning imply taking decision with respect for the major principles that EU promotes as freedom of movement, patient safety, equity for all citizens and many more. Many scenarios can be promoted.

My key message is to be ambitious and think of HWF planning as a major component of Healthcare system planning. A muldimensionnal analysis and decision making is necessary to continuously upgrade our systems, **with full respect for their human component, where both patient and heathcare professionnals are Kings'.**
Increase our planning capacities is recognized a major deliverable as a way to build sustainable healthcare systems.