Joint Action Health Workforce Planning and Forecasting

How can countries learn from each other in Health Workforce Planning?

Towards a context-sensitive and goal-based health workforce planning in Europe

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Health workforce planning in Europe: Creating learning country clusters

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Starting question and perspective

- How can countries learn from each other?
  - Through good or best practices
  - Through benchmarking
  - **Through 'blended' learning: a mix of best practices and benchmarking**
- Cross-country learning should be based on:
  - Clear goals about <u>what</u> to learn from each other
  - Reliable and valid data, that enables 'transparent' comparisons/benches
  - **Take into account the context sensitivity of countries:**
    - Their starting position (what is in place?)
    - Their resources (financial, demographic)
    - Their health care system (institutional and cultural condition)
    - Their geographical location

Basic data and measurements for the paper and this presentation

- The (?) first systematic 'measurement' of health workforce planning in Europe:
  - The Matrix Insight Feasibility Study on EU level Collaboration on Forecasting Health Workforce Needs, Workforce Planning and Health Workforce Trends
    - Data collected through statistical sources and country experts in 34 EU-countries
    - Latest available year 2012
    - Not a ranking but an explorative/mapping study
    - Multiple indicators on how health workforce planning is executed
- More data available by the OECD study (Ono et al. 2014)

The Matrix study provides indicators for a countries' HWF data-infrastructure

The number of **institutions** that collect and provide necessary data for health labor market monitoring and planning:

1. Ministry of Health,
2. Ministry of Education,
3. Other public institutions,
4. Universities,
5. Professional associations,
6. Health/social security insurers,
7. Service providers

The number of medical **occupations** covered by health workforce data available:

1. physicians,
2. nurses,
3. midwives,
4. dentists,
5. pharmacists,
6. Physiotherapists

The number of **variables** available to determine and specific the human resources in stock:

1. headcount,
2. age,
3. gender,
4. geographical distribution,
5. active workforce,
6. working fulltime/part-time,
7. education/qualifications,
8. specialization,
9. inflow,
10. outflow

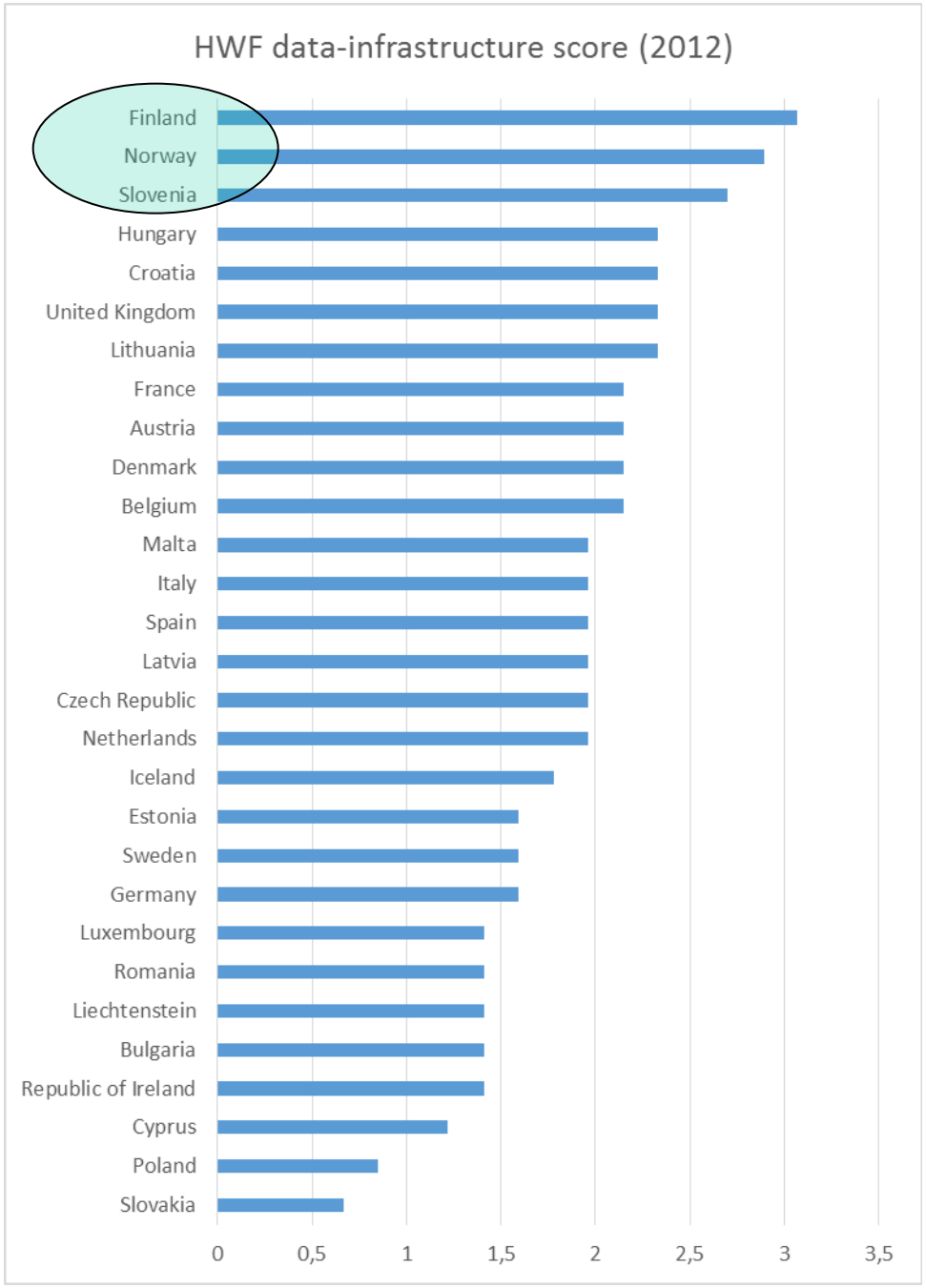
The Matrix study provides indicators for a countries' HWF institutionalization

1. **no** workforce planning institution in place,
2. a national **or** regional organization is in place, and the main institution has an **advisory** mandate,
3. both a national **and** regional organization is in place, and the main institution has an **advisory** mandate,
4. a national **or** regional organization is in place, and the main institution has an **prescriptive** mandate,
5. both a national **and** regional organization is in place, and the main institution has an **prescriptive** mandate.

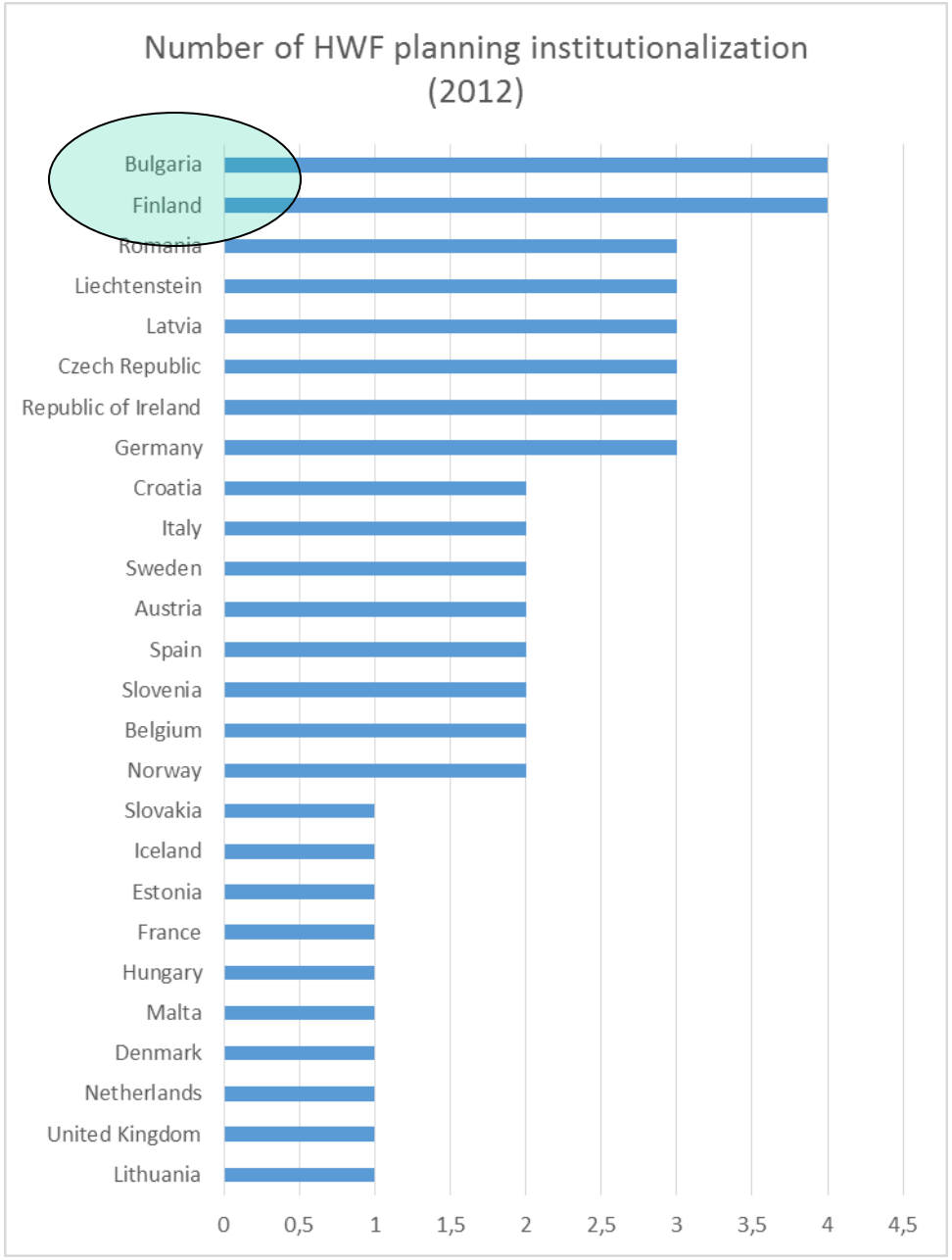
The Matrix study provides indicators for a countries' HWF planning model

1. **no** model in place or use,
2. no specific model in place or use but some (local) projects, programs or **local** for monitoring and policy support are in place,
3. a specific health workforce model is in place, that monitors and **projects** the supply side of the workforce only,
4. a specific health workforce model is in place, that monitors and projects the supply side of the workforce and **demand** on demographic factors (demand-based planning),
5. a specific health workforce model is in place, that monitors and projects the supply side of the workforce and demand on demographic and **non-demographic** factors (needs-based planning model).

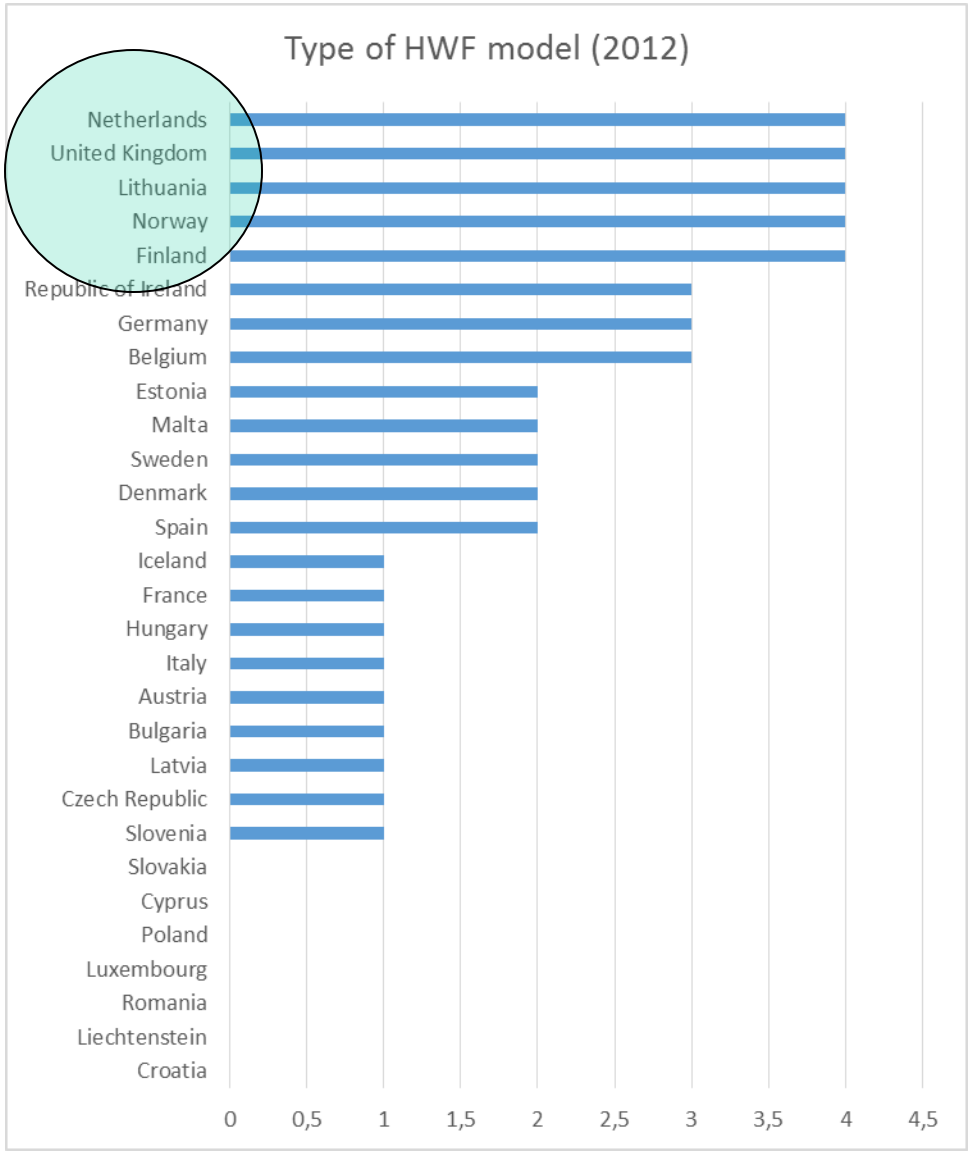
What variation do we see in HWF data infrastructure?



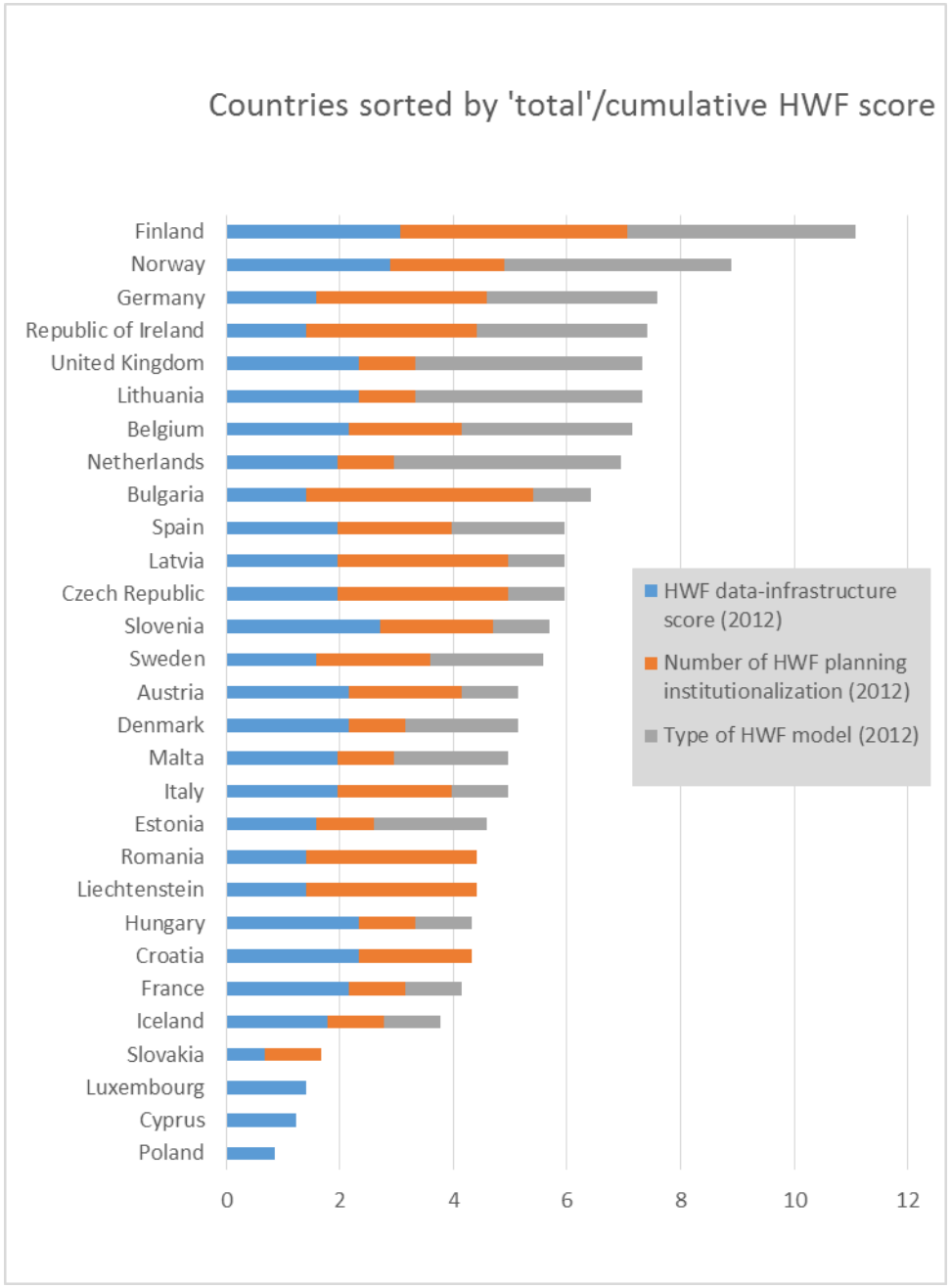
What variation do we see in HWF institutions?



What variation do we see in HWF planning models?



What do we see of we rank countries on all three dimensions of HWF planning?



Conclusion 1

- In ranking countries, we should take into account that the HWF planning cannot be measured on one dimension
- 'Best practice' countries clusters differ:

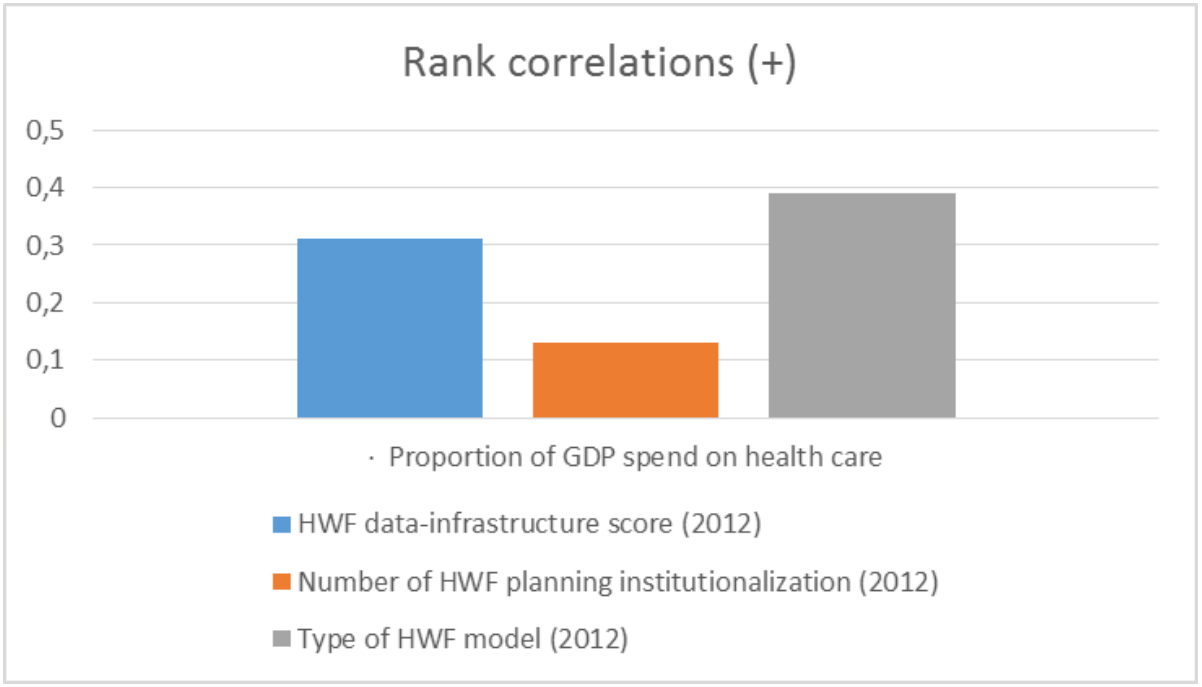
For WHF data infrastucture:
- Finland
- Norway
- Slovenia

For WHF institutionalization:
- Finland
- Bulgaria

For WHF planning model:
- Finland
- Norway
- Lithuania
- United Kingdom
- Netherlands

- Hence: country learning should specify their goals in terms of HWF dimensions

HWF planning dimensions correlates with 'resources'



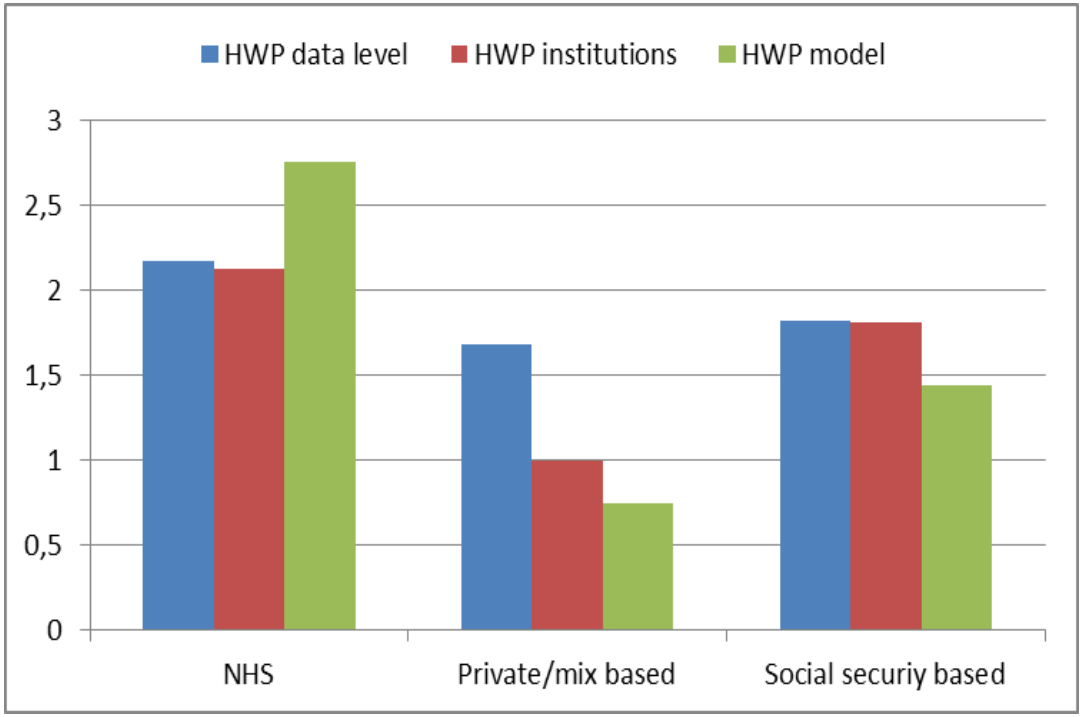
- **This result implies (1) the need for HWF data and planning models is greater if more budget is involved <u>AND</u> (2) more budget enables HWF data and planning models**
- **HWF institutionalization appears non-budget related**

HWF planning dimensions vary by health care system

NHS:
Austria (AT), Finland (FI), Italy (IT), Norway (NO), Sweden (SE), United Kingdom (UK), Spain (ES), Denmark (DK)

Social security based:
Belgium (BE), Bulgaria (BG), Czech Republic (CZ), Estonia (EE), France (FR), Germany (DE), Hungary (HU), Iceland (IS), Republic of Ireland (IE), Romania (RO), Slovakia (SK), Netherlands (NL), Latvia(LV), Lithuania (LT), Luxembourg (LU)

Private/mix based:
Cyprus (CY), Malta (MT), Poland (PL), Slovenia (SI)



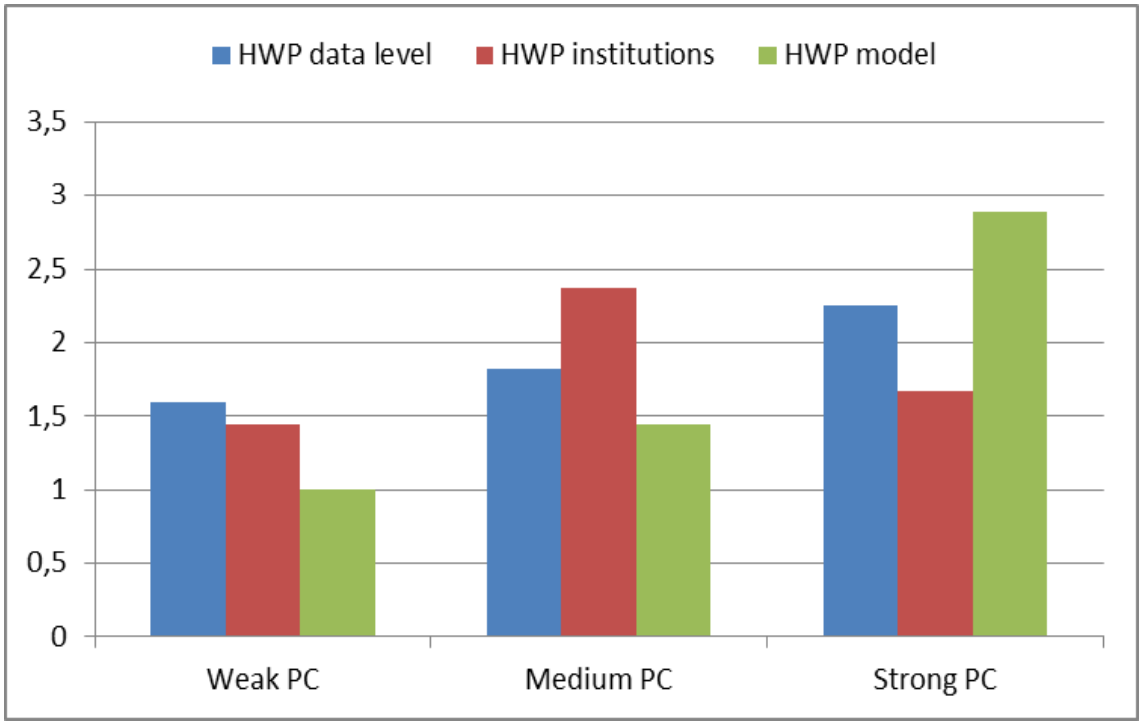
- NHS countries cluster as 'top' HWF planning countries
- Social security countries can cluster to learn from NHS countries (if feasible!)
- Private/mix can cluster to learn from NHS countries (if feasible!)

HWF planning dimensions vary by to primary care strength

Strong:
Finland (FI), United Kingdom (UK), Spain (ES), Denmark (DK), Belgium (BE), Netherlands (NL), Estonia (EE), Lithuania (LT)

Medium:
Italy (IT), Norway (NO), Sweden (SE), Czech Republic (CZ), France (FR), Germany (DE), Romania (RO), Latvia(LV), Slovenia (SI)

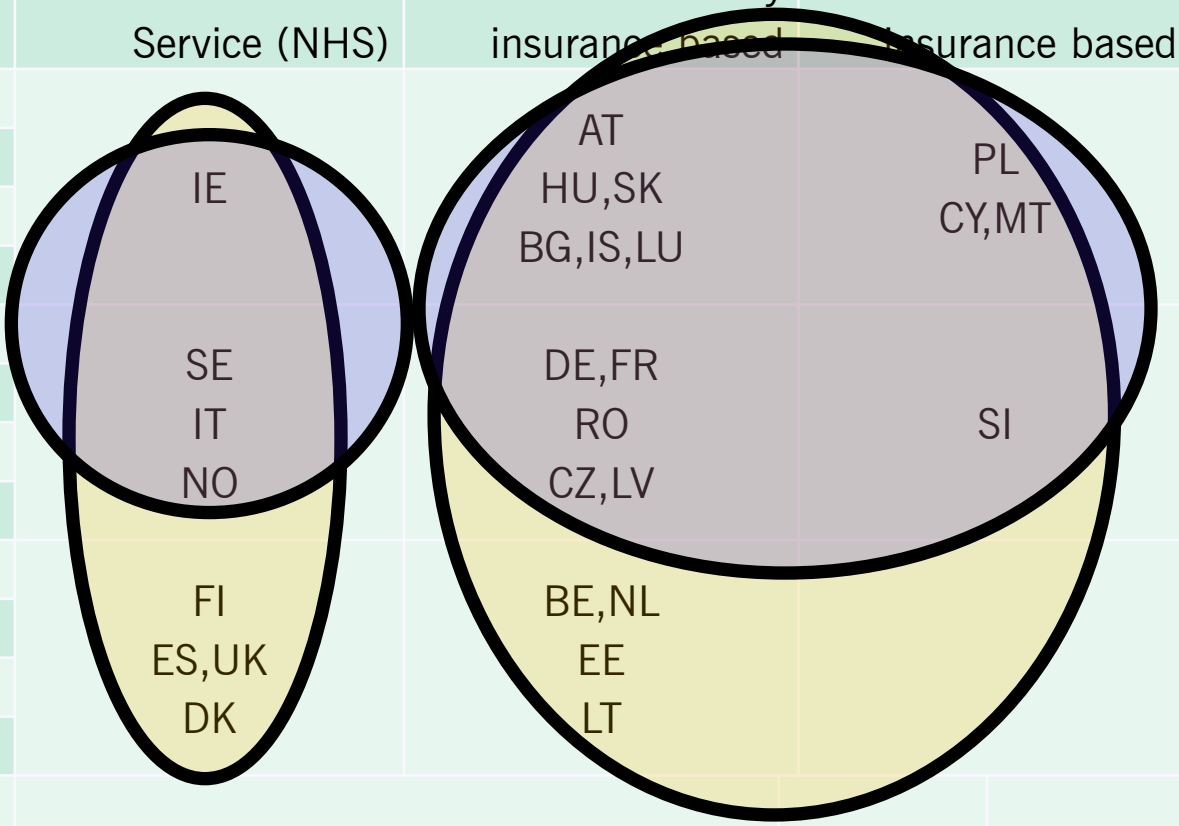
Weak:
Bulgaria (BG), Austria (AT), Cyprus (CY), Malta (MT), Poland (PL), Luxembourg (LU), Slovakia (SK), Hungary (HU), Iceland (IS), Republic of Ireland (IE)



- Primary care countries cluster as 'top' HWF planning countries for HWF data and planning models, NOT for HWF institutionalization
- Countries with weak/medium primary care systems can cluster to learn from primary care countries (if feasible!)

Creating country learning clusters by (1) healthcare system and (2) primary care strength

		Type of health care system		
Strength of primary care		National Health Service (NHS)	Social security insurance based	Private or mixed insurance based
Weak				
Medium				
Strong				



Austria (AT), Belgium (BE), Bulgaria (BG), Cyprus (CY), Czech Republic (CZ), Denmark (DK), Estonia (EE), Finland (FI), France (FR), Germany (DE), Hungary (HU), Iceland (IS), Italy (IT), Latvia(LV), Lithuania (LT), Luxembourg (LU), Malta (MT), Netherlands (NL), Norway (NO), Poland (PL), Republic of Ireland (IE), Romania (RO), Slovakia (SK), Slovenia (SI), Spain (ES), Sweden (SE), United Kingdom (UK)

Conclusions (1)

- All European countries act on health workforce planning, but the data from the Matrix study shows that:
  - countries particularly differ in the data infrastructures in place and, probably related to this, also differ in the extended planning models they have place
  - countries differ somewhat in the planning institutions in place, but this appears a less distinctive HWF key indicator
  - Only a few countries have consistent lower or higher raking positions
- Hence:
  - it makes sense to define 'European' learning goals, according to the different dimensions and indicators for HWF
  - it makes sense to define 'country cluster' learning goals, according to the position of different groups of countries compared to the good/best practices countries
- But: the (2012) Matrix data and analyses for this paper/presentation need to be updated and validated

Conclusions (2)

- The Matrix data shows that a countries' position on the different HWF dimensions and key indicators are strongly determined by:
  - Healthcare budget (both as a resource and a need for HWF)
  - Healthcare system (the 'given' financial context of all HWF planning)
  - The strength of primary care (the 'given' organizational context of all HWF planning)
- Hence:
  - it makes sense to create country learning clusters by both healthcare system and primary care strength, as these are given conditions ('contingencies') for countries
  - it makes sense to support both learning within and between country clusters
- But: the (2012) Matrix data and analyses for this paper/presentation need to be updated and validated

Recommendations (1)

- Periodically inform all countries about their relative position(s), by mapping and ranking them according to the key HWF indicators, to sustain awareness
- Define and plan learning objectives for all countries, based on the key HWF indicators that:
  - show large country variation (learning potential)
  - are feasible to be improved be mutual learning, taking country conditions into account that work as:
    - common restrictions
    - common opportunities
    - common recognition towards change
- Make country learning clusters to:
  - create a first efficient exchange in smaller and homogeneous groups
  - then create exchange between different cluster to learn by crossing boundaries

Recommendations (2)

1. Cluster similar countries in terms of their healthcare system, and within the cluster:
   1. let them discuss their different positions on the HWF key indicators, understand the differences
   2. let them address common challenges as the learning objectives
   3. let them define the feasibility to achieve learning objectives taking a countries' resources into account
2. Cluster countries that have similar health care systems and primary care strength
   - follow the same A-B-C steps (position, learning objective and feasibility)
3. Cluster countries with a different health care system but a similar primary care strength
   - follow the same A-B-C steps (position, learning objective and feasibility)
4. Compare the results between the three rounds and between the country (sub)clusters, to:
   - define different (focused) agendas for different country learning clusters
   - define a overarching (focused) agenda at the European level

The golden goal of country cluster learning is not maximizing ('the more planning the better') but optimizing, i.e.

a context-sensitive and goal-based health workforce planning in Europe

Thank you!

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