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The Joint Action on Health Workforce Planning and Forecasting: Results of a European programme to improve health workforce policies

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ABSTRACT

Health workforce (HWF) planning and forecasting is faced with a number of challenges, most notably a lack of consistent terminology, a lack of data, limited model-, demand-based- and future-based planning, and limited inter-country collaboration. The Joint Action on Health Workforce Planning and Forecasting (JAHWF, 2013–2016) aimed to move forward on the HWF planning process and support countries in tackling the key challenges facing the HWF and HWF planning. This paper synthesizes and discusses the results of the JAHWF. It is shown that the JAHWF has provided important steps towards improved HWF planning and forecasting across Europe, among others through the creation of a minimum data set for HWF planning and the 'Handbook on Health Workforce Planning Methodologies across EU countries'. At the same time, the context-sensitivity of HWF planning was repeatedly noticeable in the application of the tools through pilot- and feasibility studies. Further investments should be made by all actors involved to support and stimulate countries in their HWF efforts, among others by implementing the tools developed by the JAHWF in diverse national and regional contexts. Simultaneously, investments should be made in evaluation to build a more robust evidence base for HWF planning methods.

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1. Introduction

Health workforces are crucial for the sustainability of health systems as there can be no health without a workforce [1]. Yet many European countries are faced with health workforce shortages. It is estimated that by 2020 there will be a shortfall of one million health workers in Europe [2,3], although it should be noted that this number is somewhat out-dated and the underlying calculations are subject to debate [4]. Expected shortages are particularly critical for certain health professions and specialisations, including nursing, elderly care and general practice. In addition, almost all European countries are faced with geographical maldistributions of health professionals, mostly expressed by an undersupply in rural and sparsely populated areas and oversupply in some urban areas [2,5,6]. The shortage of health workers is compounded by the fact that their skills, competencies and expectations are often

not optimally suited to meet changing population health needs [7,8]. Moreover, health reforms, taking place in many countries, also change the legal and institutional context of health professions. Given these challenges, human resource planning in the health sector, or health workforce planning, emerges as a key tool to address them [9].

1.1. Health workforce planning

Health workforce planning is concerned with ensuring that the right number of people, with the right skills, are at the right place at the right time to deliver the right services to those in need of them [10]. The main aim of planning is to achieve an optimal balance of demand and supply of health workers in both the short and long term [11]. To achieve this aim, forecasting is an important part of the planning process. Yet despite its importance, there is no agreed definition or single accepted approach to forecasting health workforce requirements [12]. In this paper, we understand forecasting as a scientific based and policy driven methodology. Forecasting workforces requires multiple steps: to predict several alternative futures, decide which is most probable or desirable, and

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then plan for that selected future by factoring in particular forces, such as political climate and resources [13]. It is important to stress that forecasts are not projections. A projection takes current conditions, develops scenarios by ‘educated guesses’ about possible future changes, and looks at the implications of those changes. In contrast, forecasting explicitly aims to define what the future will hold and requires theory and hypothesis about the mechanisms behind these potential futures [14].

1.2. Aim of this paper

The aim of this paper is to synthesize and discuss the results of an EU initiative – the Joint Action on Health Workforce Planning & Forecasting – set up to support and stimulate country efforts in health workforce development. The paper in particular focuses on five key findings of the JAHWF, related to the most severe current challenges in HWF planning, i.e. planning terminology, data availability, model-based planning, future-based planning and collaboration.

1.3. Challenges in health workforce planning

In a time of budget restraints, workforce shortages and changing health care needs, health workforce planning is more important than ever, but at the same time it is getting increasingly complicated [10,11]. The main difficulties facing health workforce planning and forecasting are of methodological as well as strategic nature, and are summarized below:

1.3.1. Lack of consistent terminology

To make an accurate calculation of the stock and flow of health workforces, systematic and consistent definitions are required. Definitions enable data and information collected from different sources (e.g. from public and private sector, professional registries, labour force surveys, etc.) to become comparable and to be used consistently in models and calculations. Currently, within and between countries, there is severe inconsistency and heterogeneity in the definitions that are being used for health professions and the general terminology surrounding health labour market indicators [10,15]. For example, there may be differences in health professionals’ status; some numbers may refer to ‘practising professionals’ (i.e. professionals that provide a service directly to the public), while others may refer to the ‘professionally active’ (i.e. professionals that completed an education as a prerequisite for the job). A prerequisite to feed and interpret health workforce models and forecasting is to have uniform definitions of both the units of analysis and the factors or parameters that are included in the models.

1.3.2. Lack of data

Recent data on the number of active health care workers and their distribution in the health system are a key requirement for health workforce planning [11]. Yet these information systems are lacking in numerous countries, representing one of the main obstacles to effective health workforce planning [9,10,16]. For example, in many European countries data on number of health workers and trainees, their specialisation, their geographical spread, age, gender and country of provenance are not or partly available, difficult to gather or not registered. A specific challenge for health workforce planning is the lack of data on cross-border and cross-sectoral mobility of health professionals; to quantify where health workers go, how long they stay away and whether they come back or not [17,18]. Accurate data about the migration of health workforces is not available in many European countries. A deficit which is compounded by the fact that there is no single definition of health professional mobility in place [10].

One way to cope with the lack of data on health workforces, as a first step, is to mobilize data collection and analysis on a limited number of indicators that are available, comparable and measurable using standard data sources. There is, however, no guideline or agreement on what these ‘minimum data requirements’ for health workforce planning should look like [10].

1.3.3. Limited model and demand-based health workforce planning

Currently, there appear to be few countries that engage in model based health workforce planning [19]. In some countries where national health workforce planning institutions are in place, quantitative tools or models are used to develop projections and/or forecasts of the required future workforce [10]. In general, three approaches can be discerned in these types of health workforce planning models [10,11]:

- The supply-based approach, which focuses on balancing health workforce inflow (e.g. graduates, immigrant health workers), outflow (e.g. health workers who emigrate or retire) and the activity rates of the currently active health workers (measured in either headcounts or FTE).
- The demand-based approach, which focuses on the current and future demand for health services (estimated from the population composition, demography, and health service utilization), and therefrom the required capacity of health workers.
- The needs-based approach, which extends the demand-based approach by additionally considering epidemiological and social-cultural factors.

Looking at the evidence that is available, the large majority of European countries that engages in model based workforce planning takes a supply-based approach and does not take into account the actual health needs of the population. Only a minority of countries incorporates a demands-based or needs-based approach in their model [10]. Also, many countries have a partial or ‘silo’ approach of planning separate health professions and ignoring relationships between health professions [20]. This limits the accuracy of planning models and restricts their potential impact. It has been noted that more sophisticated and integrated models of workforce planning that cut across different professional groups and take into account more factors, such as skill mix and working practices, seem to offer a better prospect of contributing to the sustainability of health systems. Finally, it can be concluded that very few health workforce planning models are or have been empirically evaluated, limiting the possibilities for assessment of the quality and impact of the various models on health workforces and health system performance [11].

There are various reasons why so few countries engage in model-based and demand-based health workforce planning. One reason is that it is difficult to incorporate the variables that determine the future supply and demand of workers, mainly due to the earlier mentioned lack of reliable data on these variables [11]. Apart from the methodological challenges, there are also strategic issues that need to be tackled for planning models to be initiated and implemented. This includes ensuring that the required capacity and skills for health workforce planning are sufficiently trained and available within institutions or departments in charge of workforce planning [10].

1.3.4. Limited future-based planning and use of qualitative methods

While planning the required numbers and types of health professionals to sustain the current distribution is a challenge, estimating the required skills and competences of the HWF for the future is an even greater challenge. Comprehensive health

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