SUPPORT FOR THE HEALTH
WORKFORCE PLANNING AND
FORECASTING EXPERT NETWORK

WORKSHOP 2 - SUMMARY REPORT
'DIALOGUE ON KEY HEALTH WORKFORCE PLANNING DATA DEFINITIONS'

29-30 October 2018
Budapest, Hungary

INTRODUCTION

The "Support for the health workforce planning and forecasting expert network" (SEPEN) Joint Tender organized its second workshop in the series of five SEPEN workshops held in the frame of the service contract (No. 20167301) with the Consumers, Health, Agriculture and Food Executive Agency (Chafea) acting under the mandate of the European Commission.

Experts were invited to foster the exchange of knowledge that leads to national level support for EU Member States in health workforce (HWF) planning data management, and to deepen the common understanding of health workforce planning data definitions.

European level discussions on health workforce planning data have been ongoing in the last few decades. Several papers discussed the core data required for health workforce planning, among which the Minimum Planning Data Requirements was published by the Joint Action on European Health Workforce Planning (JAHWF). The event focused on exploring key health workforce planning data, among the Minimum Planning Data Requirements in relation with the implementation of the WHO National Health Workforce Accounts (NHWA).

LEARNING OBJECTIVE AND THE DISCUSSION QUESTIONS OF THE WORKSHOP

The workshop addressed selected data and discussed indicators that are highly useful for EU health workforce planning and NHWA reporting. The learning objectives focused on the following areas:
1. Understanding of the key indicators that support and go beyond the minimum data requirements for basic health workforce planning.
2. System thinking through experts' analysis of the interactions between national/sub-national planning, as well as facilities.
3. Improving health workforce planning skills by discussing relations and similarities with labour market dynamics and analytics.
4. Enriching theoretical knowledge with practical cases, testimonials and expert discussions on data collections, data management and process optimization.

Additionally, the two key questions of the workshop were:
1. Health workforce distribution: How to tackle health workforce data asymmetry stemming from different levels of vertical and horizontal planning?
2. Health workforce domestic planning data: How to contribute to the sustainability of health workforce with the support of data on education and replenishment?

SUMMARY OF DISCUSSIONS, THE KEYNOTE SPEECHES, AND KEY LEARNING ELEMENTS

Two keynote presentations provided an overview of the related initiatives and findings on health workforce planning data.

The first keynote speech was delivered by Dr. Mathieu Boniol. He presented the latest achievements of the WHO National Health Workforce Accounts. Dr. Boniol called for strengthening health workforce data collection to monitor equitable access to health workers as indication of universal health coverage within the 2030 Agenda for Sustainable Development. The WHO also urges Member states to implement the consolidation of a core set of human resources for health data with annual reporting to the Global Health Observatory, and in the national health workforce accounts (NHWA) framework. Dr. Boniol introduced the purpose of NHWA as to standardize health workforce information, to provide interoperability and to track HRH policy performance towards universal health coverage. He favored the use of the NHWA selected indicators for health workforce planning objectives.

The second keynote speech was given by the representatives of the Joint Action on European Health Workforce Planning and Forecasting (JAHWF) Programme. Michel Van Hoegaerden - Programme Manager - introduced its outcomes and main findings and underlined the ways they could be utilized at Member State level. Paolo Michelutti presented the Minimum Planning Data Requirements. Dr. Eszter Kovacs provided an overview on the practical Toolkit on Health Workforce Planning.

MAIN MESSAGES OF THE WORKSHOP

The workshop discussions enriched theoretical knowledge with practical cases, testimonials and expert discussions on data collections, data management and process optimization especially by introducing country case studies from Belgium, Italy, the Netherlands and Hungary.

Discussions on the interaction between national/sub-national planning
Governance plays a key role in stakeholder-engagement. Different levels have to continuously feed each other. Context-specific forms of coordination and flexibility need to ensure a balance between top-down and bottom-up governance advantages. There is no universal form of interaction - it is important to keep patient outcomes as the priority.
Participants stressed that a bottom-up approach should receive priority when determining the ideal coverage of health professionals based on patient needs. The service area per type of service was found to be the ideal granularity for assessing and monitoring the evolution of the matching between needs and supply. However, the service areas must preferably be aligned with the sub-national administrative level for simplifying the adoption of policies.

Discussions on health worker distribution according to facility ownership and type:
Density can be compared between countries, however - because of different health care pathways, demographic and epidemiological trends - **member states should not use these experiences as a benchmark or as a gold standard**. Still, **comparison helps a lot in the learning process.** Common interpretation for distribution according to facility types is challenging - despite the accepted classification systems for facilities - as structures of health systems may vary from member state to member state.
Private sector employment data are to be collected and pooled into central registries. Though this is challenging to do. Incentives (eg. governmental) for data providers of the private sector may be considered.

Discussions on key indicators that support and go beyond the minimum data requirements for basic health workforce planning;

1. Indicators supporting the determination of the ideal coverage

The **time of reaching the facility** and the **available capacity of the area** were identified to have crucial importance.

2. Employment indicators highlighting imbalances

Job vacancies:
The **total number** and the **relative number of vacancies**[1] are considered as the best quantitative indicators of job vacancies. Additional indicators focusing more on the process of filling job vacancies support the interpretation: the **time to fill a vacancy** and the **number of vacancies filled in a certain amount of time**. Descriptive indicators complementing and helping stratify the general indicators are e.g. facility type, salary, part-time/full-time, regional variances.

Unemployment:
The **number of unemployed resources** show a potential source/supply area of workforce. The stock of **licensed to practice workforce not active in the labour market under the age of 40** was considered to be a valuable information for a planning model[2]. **Unemployment rate per sector** and **duration of unemployment** is beneficial in planning the training capacities. Additionally, planning should define areas where additional training would increase the uptake of unemployed health workforce.

Biases:
The raw number of job vacancies reported by employers or intermediaries such as employment and interim offices contain several biases - some of which were identified by the participants, such as the lack of willingness to work or to give over the practice - leading to overestimation or underestimation.

Disaggregation:
The top three disaggregation for medical doctors and dentists would be: specialisation, demographic indicators (age, gender, region (eg. rural/urban distinction)) and facility/employer type.

Discussions on planning data and health system:
The activation of a network of experts skilled in health workforce planning and the development of a platform for data collection and exchange is valuable. Participants mentioned that **a centralised, government-operated, superposing database is,** therefore, **essential**. In the absence of such an institution, the planning process - relying on voluntary based participations - is not easy to coordinate. Incentivising stakeholders with different interests would pose unavoidable inefficiencies.

A **specific data collection is preferred over the general collection** method for health workforce, as any data collection first needs to prove value for the area of collection. Well identified political targets are first required prior to synchronise indicators and methods supported by the right data with limited bias.
Though, generally focusing on education data feeding labour market needs is a helpful strategy.

Discussions indicated that **different professions need a different approach** in measuring the replenishment rate. Typically physicians have to be distinguished from others professions, as more data are available for that category. Tracking of their pathway is more feasible due to data related to specialty training (compulsory in the Member States) and medicine prescriptions.

Intersectoral mobility tracking is needed - **especially for nurses** - however it is the most difficult to track, as there is no sectoral distribution data available. In order to influence sectoral mobility, several methods are available such as: increasing the attractiveness of the job;

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[1] on total Full Time Equivalent

[2] cautious interpretation is needed because of possible bias caused by e.g. dual practice

making the labour force feel more valued (e.g. by shifting/sharing more responsibilities); improving their access to training; and making them feel more supported.

Finally, systems should operate in a framework which allows health professionals to improve their skills and broaden their practice.

PROPOSED FOLLOW-UP ACTION

Beyond the technical discussion on how to collect, standardize, exchange, and store **data** in databases, it is important to bring them to life and **be used in daily practice**.

The workshop revealed that data and standards are strong drivers for policies and change:
1. by setting targets: defining indicators and setting targets to reach (e.g. employment rates, densities, …)
2. by linking to policies: data and standards are used in setting up policies, to monitor and evaluate them.

The examples (NL, IT, HU, BE) showed how health workforce data are used to build policies, create drivers and set targets and, most importantly, how this knowledge can fit into local context, working environment, and disciplines. There is a strong willingness among participants to move further.

The traditional *supply* and *demand* model was challenged:
1. *Demand* is to be broadened from consumption to the needs of the population which will require a new set of standards, data and indicators.
2. There is interest in moving beyond the traditional 5 regulated professions (doctors, nurses, midwives, pharmacists, dentists) to a wider range of other health professions, as well as informal caregivers.
3. There is interest in moving beyond the aggregate numbers for healthcare and looking in detail for different sectors (hospitals, primary care, mental health, care for the elderly/long term care) and study the regional imbalances for certain disciplines.
4. There is interest in moving toward a certain level of international planning. Certainly the case of migration is showing that people are moving across countries. Nowadays the world is getting smaller as all workplaces are reachable.
5. Integrating healthcare planning with other sectors such as education, employment, finance is relevant as they all have noticeable impact on health.
6. Static planning should evolve to dynamic planning. It requires the formulation of scenarios, testing alternatives and their impact and designing related policies

Today's approach (data collection, standards, indicators, planning policies) is still dominantly structural. These proposed shifts would have an impact on traditional definitions, standards, indicators and related policies. Participants suggest to take these as a recommendation for future workshops.