

- EXECUTIVE SUMMARY

The Handbook on Health Workforce Planning Methodologies (hereinafter “Handbook”) has the aim of furnishing an useful contribution to all those people engaged in the development and improvement of HWF planning systems in EU Countries.

Starting from the importance of workforce planning in healthcare and the specificity that this subject meets in the European Union (free movement of professionals and patients in the EU, the principle of universal coverage of the NHS, the economic crisis are some of the elements characterizing the demand and supply of health professionals in the EU) the Handbook describes and analyzes the **planning practices developed in some EU countries.**

The **focus** is on the planning experiences concretely realized and currently working. In light of the aforementioned scope, practices considered as most significant and interesting to be reproduced in other European contexts were selected and described. So, planning systems developed in **BELGIUM, DENMARK, ENGLAND, FINLAND, NORWAY, SPAIN** and **THE NETHERLANDS** have been analyzed through a grid of five elements, here defined as **the 5 key elements of a planning system.**

1. *The setting of the **goals** of the planning system is itself a planning activity. The seven systems have provided different answers on this issue based on their assumptions (current equilibrium between supply and demand or not) and on their desired future health care levels, context of their health systems and structure of future health workforce*
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2. *A lot of forecasting activities on both supply and demand side ask for a solid and appropriate mathematical forecasting model; to project, to develop, to improve and to maintain the **forecasting model** are themselves planning activities. The seven systems have developed their own forecasting mathematical model, more or less sophisticated and using quantitative and qualitative information in different ways. In particular, the Handbook describes in depth the quantitative forecasting approaches.⁽¹⁾*
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3. *To produce all this knowledge about the future and to run the forecasting model **data** are needed. Based on the requirements of the forecasting model each planning system defined its own data set and developed a data collection process with great attention to have*

(1) For a description on the qualitative forecasting methods, see D061 - User guidelines on qualitative methods in health workforce planning and forecasting available at <http://euhwforce.weebly.com/results.html>



updated and reliable data. The two options for data collection are to collect aggregated data or individual data, but the use of register with individual data is the prevailing choice.

4. *To translate the planning into actions is a key feature of all the planning systems; very important are the instruments and the levers that the policy makers and the planners can implement to realize the project and to check whether the goals are going to be reached. Of course all the seven systems manage the link to the policy actions considering it as a strategic part of all the planning activities. The regulation of student intakes in medical schools or universities is the main lever adopted by the seven planning systems. Other levers used are managing attrition and developing the existing workforce.*

5. *All these planning activities require an **organisation** in order to guarantee a permanent process. The seven systems organise in different ways the activities required to achieve the desired goals, with different quantities of resources invested and different ways of involvement but, in every case, with great efforts spend to engage the various stakeholders in order to give commitment to the forecasting results and communicate them with the right efficacy to the policy makers.*

The comparison of these key aspects among the seven planning systems highlighted the **diversity** of approaches to the issue of workforce planning in healthcare but also allowed to detect some **constants**.

In particular there are various reasons that led to the implementation of the planning system as well as different institutional systems led to focus on **different goals** with different attention to specific professions compared to others. So, there are systems that take into account the full range of health professions forecasting and analyzing the interactions between different professions and others who plan only a single profession (medical doctors in particular) or certain professions (doctors, dentists, nurses) but with different approaches and not related to each other, with obvious limitations in imagining a structure of the future labor force different from the present one.

Consequently, the **organisation** of the planning system is **different** between the seven systems. The systems that plan the overall health workforce involve a large number of people with different skills to manage the planning activities. In these cases there are specific organisations dedicated to this purpose. Conversely, in systems planning for one or few professions the number of people dedicated to this purpose is lower and they



usually work within public organisations that do not have planning as main activity.

The comparison allowed to highlight also the **constants** between the different planning systems. All seven systems pose great attention to the information and data collection (even if the main **data collection** purpose is not for planning), the **involvement and dialogue with stakeholders**, in organised forms, to the sharing of the various parameters of the models of forecasting (which before being technically sound is important that they are shared and agreed). Common to the seven systems is also **the interaction with the local levels** (regions). Another constant is regulation or limitation of student intakes in universities and schools as main output of the planning process of the medical professions.

The comparison of experiences puts in evidence the **strengths** of the seven planning systems, both among the constants and the diversities (different useful ways to address common problems). Definitely we consider strengths:

- *how to involve stakeholders in both the construction and feeding of the forecasting model and in the discussion of its results;*
- *how the forecasting models has been developed, albeit in their diversity (supply-side, demand-side, needs based and combinations of all these approaches)*
- *as are strengths various ways of collecting data (individual register, date estimation, etc.).*

The strengths have been turned and described as “**good practices**” concerning 15 specific aspects developed among the seven planning systems. Those “good practices” are conceived as useful to policy makers and planners to improve their own planning system or to implement a new one from the scratch.

The comparison among the seven systems also allowed to highlight some **weaknesses**:

- *the goals are often conceived as a mission statement and rarely translate into operational objectives broken down based on the desired future health care level or on the desired structure of the future health workforce;*
- *forecasting models generally assume the current balance between supply and demand and do not take into account any current imbalances;*
- *data collection shows in general failings in the mobility data, particularly on health professionals going abroad; consequently, the future dependency on foreign labor force is rather taken into account in the forecasting; for the same reason an important variable as “wages” that can vastly affect the future supply of health workforce usually is not considered;*
- *the policy actions implemented to achieve the objectives of the planning system are rarely different from regulation of the student intakes;*



- *moreover, the evaluation of the planning process and of the forecasting exercise is not always done.*

In order to provide elements useful to approach these weaknesses, specific insights and recommendations are presented.

On the base of the potential different users of the Handbook, it's possible to browse its contents by three reading paths.

1. **IMPLEMENTATION PATH:** *for those who need guidelines and suggestions on how to implement a new planning system starting from scratch.*
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2. **FROM THEORY TO PRACTICE PATH:** *for those who wants to know the essential theoretical elements for planning the HWF and deepen them through some practical applications.*
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3. **IMPROVING PATH:** *for those looking for suggestions and ideas to improve their own planning system taking a cue from solutions implemented in other EU Countries.*
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Anyhow, the hyper textual structure of the Handbook allows the reader to browse freely all the contents, even if their **future web version** will further improve their readability.

Finally, the **modular approach** used to organise the contents will enable the updating of individual parts without necessarily having to change the entire structure of the Handbook.

