- DATA COLLECTION AND FTE ESTIMATION IN THE DUTCH PLANNING SYSTEM

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Main aspects:

- *Data collected on current stock of HWF allow to know: number of active professionals; number of full-time equivalent; types of providers; where they work; their skills; the services they provide; workloads, including also gender and age;*
- *Workloads are not collected as this is multi-interpretable in The Netherlands;*
- *The FTE is partly measured by asking the specialists themselves;*
- *The strength of this solution is good. The employed clinical specialists already account for 58% of the total population and the information retrieved is reliable. They are able to do comparisons between the earlier surveys amongst all clinical specialists and the data in this database;*
- *The remaining weakness is the lag time of two years for the data to become available. Another weakness is that the relation between reported fte and actual hours worked is not determined.*

Description of the activities (including challenges):

The supply of care is measured by multiplying the number of professionals actually offering services to patients by the average fte (fulltime equivalent) they are working. This sounds fairly simple, but it is not. Regarding the number of professionals actually treating patients, The Netherlands has the advantage that a medical specialist is only allowed to treat a patient as long as he/ she is registered in the only national register of medical specialists. The registration is valid for a maximum of five years, after which it has to be renewed. The number of medical specialists actually treating patients therefore is a subsample of the registered medical specialists. By doing a survey amongst the registered medical specialists and asking them whether they (still) treat patients one can get a good estimate on the supply of medical specialists.

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To get reliable data on the fte is more difficult. In this good practice, we focus on clinical specialists. To start out, almost half of the clinical specialists are self-employed. They are not bound to keep track of the number of hours they work. When asked, most self-employed clinical specialists work between 50 and 60 hours in a week. However, self-reports on hours worked are not very reliable. The other half of the clinical specialists are employed by academic or general hospitals, but the labour union's definition of full time differs between "40 to 48 hours" for academic specialists to "40 to 45 hours" for non-academic specialists.

The ACMMP has used surveys amongst clinical specialists from 2000 up to 2010. Because of the burden this places on the clinical specialists, in 2013 the ACMMP switched to a different mode of retrieving fte data. For all employed clinical specialists, all kinds of tax and income data are available through a combined (confidential) database, including the fte worked in the tax year and the employer. These data are handled by Statistics Netherlands. The drawbacks are that it takes two years for tax and income data to become final, so the dataset lags two years behind, and that there are no data on self-employed clinical specialists in the database regarding the fte numbers. The advantages are that no survey amongst a sample of the clinical specialists is necessary any more because there is a census data collection on all employed clinical specialists and that it was possible to retrieve the data up to 2001.

Results:

The average fte of the employed clinical specialists has been 0,92 as of 2006 and has not changed until 2010. There is a clear difference between men and women, although the difference has diminished substantially between 2001 and 2006 and still diminished but in a much slower pace in more recent years.

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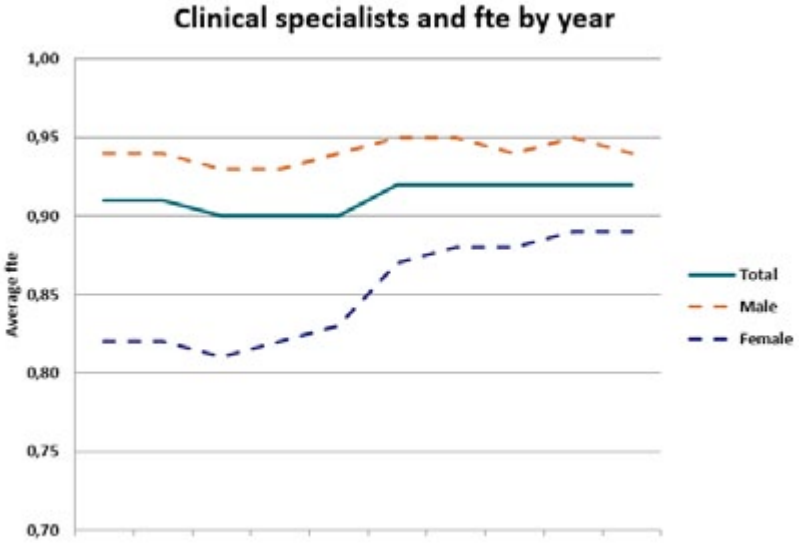

Developments FTE for employed clinical specialists by gender

The remaining gap in fte between the male and female clinical specialists (0,05 fte) in combination with the feminization in the clinical specialisms accounts for part of the growth in the number of needed clinical specialists in the future.

Helpful tips:

There are a number of possible improvements. In the first place, we can consider combining both methods to improve the actuality and the completeness (for the self-employed) of the data. We will start out by comparing the available data on the subject.

In the second place, there still is the missing link between self-reported fte and actual worked patient related hours. The relation between these two items is poor. Some promising research has been done in 2013 regarding actual hours worked and self-reported fte amongst general physicians. The results imply that self-employed general physicians work more patient-related hours per fte than employed general physicians.

Suggestions for a quick / easy implementation:

The quickest way to implement this parameter is to do a survey per clinical specialism and to have a subset of the specialists report on specialism, age, gender, and percentage of fte they are working. This will produce fairly reliable and timely data. You do not need to bother on employed or self- employed, unless you expect distinct and sudden changes in the ratio between employed and self-employed professionals. This is usually policy-driven, so you should be aware of it.

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Further information:

The next recommendation for clinical specialists will provide in 2016

The 2010 Recommendations for Medical Specialist Training http://www.capaciteitsorgaan.nl/Portals/0/capaciteitsorgaan/publicaties/capaciteitsplan2010/0%20Capaciteitsplan%20Hoofdrapport%20Engels.pdf

The 2013 Recommendations for Medical Specialist Training http://www.capaciteitsorgaan.nl/Portals/0/capaciteitsorgaan/publicaties/Capaciteitsplan%202013/DEFINITIEF%20hoofdrapport%20engels%20compl.pdf

Capaciteitsplan 2010: deelrapport 1 http://www.capaciteitsorgaan.nl/Portals/0/capaciteitsorgaan/publicaties/capaciteitsplan2010/Deelrapport%201%20%20Medisch%20Specialisten.pdf

Capaciteitsplan 2013: deelrapport1 http://www.capaciteitsorgaan.nl/Portals/0/capaciteitsorgaan/publicaties/Capaciteitsplan%202013/Deelrapport%201.pdf

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