ORGANISATION

A planning system should be organised in order to guarantee a constant process. The literature defines planning (also called forethought) as the process of thinking about and organising the activities required to achieve a desired goal. Planning is deciding in advance what to do, how to do it, when to do it, and who should do it. In a complex system it is critical to engage the stakeholders in the planning process.

The organisation of the planning system inevitably reflects the institutional assess of the Country and is strongly affected by the current regulations on the subject, that often defines the centralism/ decentralism of the process, the involved actors, and the approach to be followed (top-down / bottom-up).

Countries are different in terms of the structure of government, in particular whether the country has a centralized or federal structure, and the role played by nongovernmental organisations.

Also, the involvement of the stakeholders, when it's considered useful to the decision making process, is different depending on the institutional context and the role assigned by the law or by the national regulation to the different stakeholders.

FINDINGS

HWF planning process requires an **organisation** of all its phases which may be more or less articulated and detailed, also on the strength of the number of profession to be planned. Possible solutions may vary, depending on whether you want to import the process for vertical kind of specialization (system dedicated to the single profession) or for horizontal specialization (phases common to different professions analyzed).

Thus, we may have:

1. *A different workflow for each profession managed by different planning institutions.*

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2. *The same workflow with some specific articulation for the different professions managed by the same planning institutions.*

3. *A unique workflow with no specific procedures for the different professions managed by the planning institutions.*

All the analyzed methodologies have an articulated workflow, which is strongly coordinated by Councils or Central Commission, which are the core of the process. Also, in those cases in which the system takes into account more professions, these Central Bodies are unique, and so the process is unique (except from the case of nurses in The Netherlands).

Inside those Councils or Commissions, the work is often granted through working Groups or Committees for the single profession - such as in Belgium, England, The Netherlands and Spain. There aren't mechanisms or processes of verification and reciprocal control on the results achieved by each Committee or working group. However, when working group exists (as it is in Belgium), the results of the working group are submitted to a process of feedback and validation by the Commission.

Health workforce planning may be managed at a **central level** by one or more institutions for the whole country or may be decentralized at a **local level**. In the later case it is important to understand which role is performed by the central level and which by the local one. From this derives the organisation of the decisional process.

Almost all the systems, except for the Dutch one, provide the involvement of local stakeholders to the planning process. Mostly, the role of local stakeholders involved is mainly advisory and in the definition of the required estimates. The decisional role remains at the central level, where the organisations involved are often multiple, with a main role for the Ministry of Health and the Ministry of Education.

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DECENTRALIZATION OF THE PLANNING SYSTEM	LOCAL STAKEHOLDERS WITH A KEY ROLE IN THE PLANNING SYSTEMS	THEIR ROLE
BELGIUM	FLEMISH COMMUNITY, FRENCH COMMUNITY AND GERMAN-SPEAKING COMMUNITY. 4 UNIVERSITIES OF FLEMISH COMMUNITY, 3 UNIVERSITIES OF FRENCH COMMUNITY.	COMMUNITIES ARE RESPONSIBLE FOR MANAGING EDUCATION AND TRAINING (CONTENT OF COURSES, STANDARDS FOR SELECTIONS, NUMERUS CLAUSUS POLICIES). COMMUNITIES AND THEIR UNIVERSITIES ARE MEMBERS OF THE PLANNING COMMISSION.
DENMARK	REGIONS. REGIONAL COUNCILS.	REGIONS ARE IN CHARGE OF ASSIGNING PROVIDER NUMBERS TO GENERAL PRACTITIONERS (NECESSARY TO BE REIMBURSED BY THE PUBLIC TAX BASED HEALTH SYSTEM). THREE REGIONAL COUNCILS FOR POSTGRADUATE EDUCATION ARE RESPONSIBLE FOR - ANNOUNCING POSTGRADUATE TRAINING POSTS ON THE BASIS OF THE PLAN OUTLINED BY THE DANISH HEALTH AND MEDICINES AUTHORITY; - TO DISTRIBUTE TRAINING POSTS WITHIN THE REGION; - COMPOSING THE POSTGRADUATE TRAINING POSTS AND THEIR EDUCATIONAL PROGRAMS. - THE REGIONS, AS THE MAIN EMPLOYER, PLAY A CRUCIAL ROLE IN SECURING THE QUALITY OF EDUCATION IN THE POST GRADUATE EDUCATION.
ENGLAND	LOCAL EDUCATION AND TRAINING BOARD (LETB). NHS PROVIDERS.	EACH LOCAL EDUCATION AND TRAINING BOARD (LETB) PLACES CONTRACTS WITH LOCAL EDUCATION PROVIDERS FOR THAT ACADEMIC YEAR ON THE BASE OF WORKFORCE PLAN FOR ENGLAND SET OUT BY HEE ANNUALLY. NHS PROVIDERS (E.G. NHS FOUNDATION TRUST) GIVE TO LETBS THEIR FIVE YEAR PROJECTIONS.
FINLAND	REGIONAL COUNCILS. HOSPITALS DISTRICTS. LOCAL GOVERNMENT EMPLOYERS TRADE UNIONS. ASSOCIATION OF FINNISH LOCAL AND REGIONAL AUTHORITIES.	REGIONAL COUNCILS, ON THE BASE OF HEALTH CARE ORGANISATIONS, MAKE ANALYSIS AND FORECAST OF WORKFORCE DEMAND AND EDUCATIONAL NEEDS. HOSPITALS DISTRICTS, LOCAL GOVERNMENT EMPLOYERS TRADE UNIONS AND ASSOCIATION OF FINNISH LOCAL AND REGIONAL AUTHORITIES PARTICIPATE IN THE REGIONAL FORECASTING PROCESS IN ORDER TO PROVIDE HEALTH CARE EXPERTISE.
NORWAY	NORWEGIAN ASSOCIATION OF LOCAL AND REGIONAL AUTHORITIES (KS). REGIONAL HEALTH AUTHORITIES (RHF). MUNICIPALITIES.	THE NORWEGIAN ASSOCIATION OF LOCAL AND REGIONAL AUTHORITIES (KS) OPERATE THEIR OWN PERSONNEL REGISTER (PAI) BASED ON REPORTS FROM THE MUNICIPALITIES EVERY YEAR. THIS COVERS ALL SECTORS. REGIONAL HEALTH AUTHORITIES PLAN ON REGIONAL LEVEL FOR HOSPITALS AND MUNICIPALITIES ON A LOCAL LEVEL.

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SPAIN	17 AUTONOMOUS COMMUNITIES.	AUTONOMOUS COMMUNITIES ARE INVOLVED AS PERMANENT MEMBERS IN THE HUMAN RESOURCES COMMISSION (PROPOSING NUMBER OF SPECIALISED MEDICAL TRAINING POST) AND IN THE COUNCIL OF UNIVERSITY POLICY (SETTING THE NUMBER OF STUDENTS ADMITTED IN THE BASIC EDUCATION).
THE NETHERLANDS	STAKEHOLDERS INVOLVED ARE MAINLY NATIONAL REPRESENTATIVES.	THERE AREN'T STAKEHOLDERS WITH LOCAL OR REGIONAL RESPONSABILITIES

Inside HWF planning system, the **decision making process** is the most important phase and maybe also the most critical one. In fact, if the decision is not coherent with the results and the conclusion arrived at during the process, it means that the efforts of the planning system have been made in vain. To better understand how the decision making process operates, one of the elements to be analyzed concerns the responsibility of the decisions to be taken. Who are these responsibilities? To one or more subjects (shared responsibility)?

In most cases, planning process advisory decisions are taken by a single body (Minister or, in the case of Denmark concerning posts of specialists in medicine, by the Danish Health and Medicines Authority) as sole responsible. In any case, this decision follows and is taken on the basis of a long decisional process, in which different subjects (stakeholders) share a proposal. In the examined cases, the proposal shared by stakeholders has such a strength and a commitment to be always confirmed by the final decision of the Minister (this is the case, for example, of The Netherlands, Spain, Belgium and Finland).

Stakeholders' involvement is one of the fundamental and most critical points of the whole planning system. The importance of their involvement is due both to the necessity of acquire information and points of view and to find the consensus on some solution. It is thus necessary to define objectives for the problems highlighted and, once the objectives are established, arrive to the target with the least opposition.

In any case, this involvement is often critical, both for the number of interested stakeholders and for the strong discrepancy among the represented positions. These criticalities sometimes need a lot of time to be solved or weakened, which is also a criticality.

Stakeholders are involved through the participation, as steering members, in commissions or committees dedicated to the HWF planning (as in The Netherlands, Belgium and

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Spain). In other cases, stakeholders' involvement is a peculiar specificphase inside a multi-phase process, as for example in England, Denmark or Finland.

Stakeholders involved, considering the breadth and importance of the subject (impact of health on population, country socio-economic system, employment, etc.) may vary:

1. *health care providers (public and private);*
2. *health care trainers;*
3. *health care payers;*
4. *health care workforce (professional orders);*
5. *health care users.*

The main evidences regarding stakeholders' involvement is resumed as follows:

- *all seven methodologies give a huge attention to the representation of local entities (municipalities, regions, local providers);*
- *the same attention is given to the involvement of those subjects responsible with of the Education (Universities, Schools, etc.) and professional orders;*
- *there aren't cases of patients' associations involvement;*
- *there is no involvement of representatives of health systems (drug makers, medical devices producers, etc.).*

The **role of the stakeholders** involved can be different. The involvement may be passive, in which ase stakeholders are just informed about decisions taken, or active. In the latter case, such a case their contribution may consist in a series of advices they give to the "process owner" about different subject. The advice may be then utilized by the decision maker to take decisions, or directly contribute to the decision taken, inside a process of collaboration and agreement.

In most of the cases, stakeholders have, inside the process, an advisory role. They give suggestions, make their point, in some case facilitate the process, contributing to the collection of useful data and help in giving their correct interpretation. They never have a decisional role, but, through their advisory role, they try to direct and influence the decision maker toward the most correct choices. We may say that stakeholders'

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involvement gives strength and value to the proposals the policy maker has to decide upon.

Communication is also a strategic element of the organisational process and it is a crucial aspect for the general efficacy of the process and its outcome. In the early stages, in the case of HWF planning, to be able to communicate the objectives of the process, facilitates the involvement of stakeholders and helps in the clarification of their contribution.

In the same way, effectively communicate the results of the planning process it isn't just a reporting operation "due" to citizens, for the impact that this decision will have on future public services, but also un act that makes transparency on the work done and the use that police makers will do on that.

Most planning methodologies foresee the publication of an internet report, accessible to everyone and containing the goals (even if they may not always be considered as such – see the grid concerning the goals) and the output of the process, in a very detailed form (such the case of Netherlands, Spain and England). Even if these report are accessible by all, writing and publishing style have an institutional and typically dedicated to insider character. There aren't examples of communication dedicated to a wide and heterogeneous public.

To be managed effectively HWF planning process requires the use of an adequate number of **staff**. Adequacy number of people involved in the process will depend on different factors as the type of health profession object of the planning (how much and which), the consequent number of stakeholders to be involved, the frequency of planning cycle, the degree of planning "de-localization". Depending on the different stages which characterize HWF planning process and according to the adopted planning model, it is necessary having the right skills: for example, for data collection and forecasting: statistical, computer, epidemiological, sociological skills; for the management of the planning cycle, stakeholder involvement and interaction with the decision makers: management and relations skills.

The number of people involved in the various HWF planning systems, as their modalities of involvement are different from case to case.

In relation to the number, different cases may be synthetized as follows:

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- *everywhere the is a fixed team who works for the HWF planning system, in some case full time, in other part-time;*
- *they range from a minimum of 3 people (Denmark) to more of 50 people (England) who work for the planning system;*
- *number is proportional to the number of planned professions;*
- *to the fixed number of people involved has to be added a variable commitment of people from external organisations, often involved in projects and specific researchers.*

Competence profile of people involved in the HWF planning process corresponds naturally to the skills necessary to manage the different phases: so there are statistical, sociological, epidemiological, computer, administrative, as well as management and leadership skills. In most cases there are people belonging to health professions object of the planning (in particular doctors and dentists). In some cases these people are also managing directors of the section which manage the whole planning process.

In cases of a system that plans more than a profession, prevails, for people of the fixed nucleus, the specialization for health profession.

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