TO SET TARGET OF HWF PLANNING – GENERAL PRINCIPLES AND DUTCH EXPERIENCE

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In the Health Workforce planning there are basically two dimensions to consider:

1. *The targeted quantities for any health profession;*
2. *The year in which these set quantities are to be accomplished.*

The **first dimension** could be expressed in working full time equivalents or in headcount. The expression in full time equivalent is important because in most countries there appears to be a gender difference in average working FTE between males and females that changes very slow. Females tend to work less fte on average than man. In combination with an expected feminisation of the health workforce this will augment the number of students required to enter educational programmes.

The **second dimension** is the biggest challenge in most cases. Most health professions require a prolonged education period, and in case government wants to implement new policies there is also a lead time due to all the legislative hurdles that have to be passed before any change can be started. Therefore, any Country commencing with health workforce planning has to dampen the expectations on the short term, e.g. the first 6 to 10 years. The implementation of a new policy will take at least one year. If a new policy implies creating additional educational and training facilities is can even take more time before this policy can be implemented.

After implementation, the duration of the training is the major contributing parameter. There is a vast range of education years for the different professions, from 4 years for a nursing profession to 12 years for a fully trained clinical specialist. Under normal circumstances it is therefore for the latter advised to create a certain stock of medical graduates to enable earlier responses to shifts in the need for medical specialists. In The Netherlands, this stock of medical graduates is sufficient to fill all training places for one year. By this means the response time to changes in need for medical professions can be relieved from 12 to 6 years.

If a period of 6 to 7 years is considered realistic for any policy to result in more newly registered health professionals entering the work force, what would be a feasible time

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to expect noticeable changes in the workforce? In The Netherlands it is considered realistic to use a short term of 5 additional years and a long term of 12 years for changes to be accomplished. The total time frame is therefore usually 12 to 18 years from the present time, where the 12 year timeframe is considered an intermediate one. This may seem very far away, but by starting HWF planning now countries will gain insight in the effects of changes in parameters or strategies besides training more professionals. This gives them the opportunity to adjust their training policies timely.

Member states that expect or endure substantial differences between the need and the supply of health workforce should consider other (temporary) means of increasing the health workforce on a shorter time span. There are a number of options on the time dimension and a number of options on the quantity dimension. For the time dimension, there is an annual flow into the stock of health care professionals and an annual flow out of the stock. The inflow into the stock can be augmented instantaneously by lowering the attrition e.g. improving the quality of the training. An even more radical approach is by reducing the total duration of the education, e.g. to the European standard. This will cause a substantial single extra flow of medical specialists into the stock.

Besides the inflow in the stock government can develop policies to postpone outflow out of the stock. These policies will also have an instantaneous effect on the total number of FTE available for the health workforce. Policies that might be considered are an increase of the actual retirement age for the health workforce and/ or relieving work stress in order to prevent professionals from leaving the health workforce early, be it into another profession or into another country.

Setting differences between goals for different professions

It is common to set different goals for different professions on both the dimension time and the dimension quantity.

It is possible that there are differences between professions on the **dimension "quantity"**, considering the need and the supply of the population. In circumstances where there is a chronic shortage of supply in a specific profession there evolves a tendency of other, adjacent professions to fulfil those needs as best as they can. A shortage of gastroenterologists can be partially resolved by enrolling more general

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internal medicine physicians, a shortage of radiotherapists can be partially resolved by hiring more radiologists, a shortage of surgeons can partially be resolved by having general practitioners doing minor surgery procedures. This type of work/ time shifts between two academic professions is called horizontal substitution. This may cause differences in goals set for the different professions. In The Netherlands, emphasis is placed on a shift of work towards outpatient care, performed by the general practitioner. The corresponding quantitative goal is adjusted downwards for the workforce of clinical professionals and upwards for the workforce of general practitioners.

The same mode is practised in vertical substitution, from an academic profession to an applied sciences profession. Nurse practitioners and physician assistants are able to relieve the medical doctors partially from time-consuming protocoled work. Because the training to become a nurse practitioner takes only 5 years whereas the training to become a medical specialist in total may take up to 12 years it is advantageous to implement a strategy that stimulates the deployment of nurse practitioners. This will lead to a higher target for the nursing workforce and a more modest target for the medical workforce. This strategy is the final (and most discussed) one in possibilities to shorten the time elapsing between implementing a strategy and observing results in the work force.

Further, looking at the **dimension "time"** there may be differences for the different professions. The present balance between need and demand could be different for nurses, midwives, pharmacists, dentists, and medical doctors. Anyway, this does not have influence on the long term goal of reaching balance between need and supply for each profession, but it may have an impact on the pace in which the goal has to be reached. In case of slight (<3%) differences between need and supply a long term time frame of 18 years may be perfectly suitable. In cases of major differences between need and supply the time frame of 12 years will be the absolute maximum for measures to be taken in order to accommodate need and supply. For nurses and midwives an even more comprehensive time frame of 10 years might be considered. The average training duration is four years, so a 10 year time frame plus a one year introduction will allow for 5 years attaining balance between need and supply.

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Goals have to be Specific, Measurable, Acceptable, Realistic and Timed (SMART)

- *The goal has to be specific in at least the two named dimensions;*
- *The degree of acceptance of a set goal is crucial;*
- *The goal has to be realistic from the perspective of the health field stakeholders and from the perspective of the government.*

"By the year 2025, in The Netherlands there will be 12.000 FTE working general practitioners". We will attain this goal by permitting 720 medical graduates as of 2015 to enter vocational training to become a general practitioner each year. This is an example of **specific, measurable**, and **timed** goal. In most cases however, these are not the problematic letters in the word. The missing letters are the "a" for acceptable and the "r" for realistic.

The degree of **acceptance** of a set goal is crucial for the chances of reaching it. In most health professions, part of the education and training is done in the actual health settings. Broad acceptance of the goals by health (teaching) institutes and (teaching) health professionals is vital to obtain cooperation in case of changing numbers of students that have to be trained or otherwise facilitated. The institutes are academic or applied sciences universities and academic or general hospitals that have their own research facilities. If they do not accept the set goals they will hamper the planned efforts by not enabling the set number of students to start (or continue) with their training programmes. The health professionals, especially in the case of medical doctors, are crucial in teaching and coaching medical graduates during their training to become a medical specialist, as it is a hands-on training. If their scientific associations disagree on e.g. the used vocational parameters they will disagree on the set goal.

Basically, the government and the health field have the same objectives. Both parties want an adequate health care system that takes care of the needs of the population. Both parties realize that an adequate health care system can only thrive when the health workforce is adequately staffed. There can be differences in opinion on the operationalization of "adequately staffed" in terms of FTE. It is helpful to create room for this discussion to be held by using a number of different scenarios in the planning. By choosing the two most likely scenario's, consequently, the "numbers needed to train" will be within a certain range. This will facilitate the discussion and the acceptance because is visualizes the "safe" margins irrespective of the underlying scenario's.

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The "r" for **realistic** is more of a challenge. The goal has to be realistic from the perspective of the health field stakeholders and from the perspective of the government. For the latter the financial dimensions of the set goal are in most cases the limitation. For the stakeholders in the field it is the number of practical solutions they experience for the problems that encompass changes in the number of students to be trained. The problems range from the training and hiring of additional professors up to the founding of an additional university. In most cases, training institutes opt for gradual changes, giving them more time to adapt to the new circumstances.

Goals shared or agreed with stakeholders

- *The goals will have to be agreed upon by the stakeholders;*
- *To reach agreement on the set goals, different methods can be used;*
- *Participation of the stakeholders in the process of setting the goals is advisable.*

Stakeholders may differ between member states but generally this will include the training institutes (universities, both academic and of applied sciences, academic, general and specific hospitals, nursing homes, revalidation institutes etc.), the professionals themselves in their function as teacher, researcher, and potential colleagues, the health insurance companies and the general public. The general public can be represented either by government or by patient organisations.

As long as the goals are still global, sharing the goals does not create any problem. Every organisation and professional wants that the needs of the population are met by an adequate supply of professionals in the future. The problems arise when the goals become smarter. In this stage there will be comparisons made with the historical numbers entering training. In practice, the goals will have to be agreed upon by the stakeholders.

For the education and training institutes there are two major derivative questions: will there be changes in the number of needed training institutes and will there be changes made in the distribution of the trainees between the different institutes? This will influence the discussion. For the professionals themselves the discussion will be more vocational oriented. Is the number needed to train different form the present number? Are there enough professionals willing and able to train the student/ graduates?

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The issue of having enough training institutes and enough teachers is mainly depending on the cooperation of the training institutes. They are the ones that can estimate how realistic the set goals are in terms of changing the capacity. Of course, the government has to facilitate these changes. Government cannot force the institutes and professionals to cooperate. This leads to the conclusion that agreeing upon the set goals by the stakeholders is fundamental for swift changes to be made.

For the medical specialists, the first step to be taken is to assess the number of medical graduates that are going to be needed. This number can be based on the overall number of medical specialists that are going to be needed in 12 to 18 years. In the first years, a breakdown into individual specialisms is not even necessary to accomplish the number of medical graduates needed. There is ample time to make or improve this breakdown in the period during which the medical students do their training. An agreed set goal on the (extra) number of medical students can ease the way for agreeing upon set goals for the different medical specialists.

The first step in getting the stakeholders to share and agree should be the joint building and agreeing upon the model that will be used by the health workforce planners. To reach agreement on the set goals, different methods can be used. We advocate participation of the stakeholders in the process of setting the goals. They are unmistakably involved in getting all the supply parameters and most of the parameters concerning the working process. They also have expertise on the needs, as far as demographic changes, epidemiology, and cultural changes may be involved. Their expertise is valuable in approximating the parameters as close as possible.

Transparency and communication of the goals and of the reached results

- *Regular communication on the topics under revision and on monitor results of the progress made is essential to keep stakeholders involvement guaranteed;*
- *The planning instrument has to be at the disposal of all stakeholders in order to create a level playing field.*

In most cases there is only a limited attention span in public for matters concerning health workforce planning. It is best to widen these attention spans by being as transparent as possible. This means that evaluations and contra-expertise of the model and the results should be organised and communicated. Once the model is approved by an independent

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auditor, the results of the model become important. Most people are not interested in the modelling itself or the calculations that have to be done, but merely in the results and the corresponding goals.

Communication on the set goals should not be to frequent. There really is not that much of a change in the workforce to be expected in 3 months when training programmes last 4 to 6 years. For the stakeholders however, regular communication on the topics under revision and on monitor results of the progress made is essential to keep their involvement guaranteed. The monitoring should include the core numbers of the supply side: number, gender and FTE of professionals working, number leaving the workforce, number entering the workforce, number entering training, dropouts from training, numbers entering and leaving the country. These data will be the monitors of the reached results for each of the incidental and structural policy measures that are taken. They should be accessible by a website. Besides the supply side, data on policies having impact on the set goals should be included in the communication.

The planning instrument should also be used as an instrument to aid policy makers in assessing the financial and workforce consequences of newly developed policies. This means that the instrument has to be at the disposal of all stakeholders in order to create a level playing field. As a matter a fact, the planning instrument does not always has to be the only input for the set goal. If the results from the planning instrument are not realistic there have to be adaptations made to conclude with a realistic goal. If the planning instrument is constructed correctly, it will take into account the decisions made earlier and adapt correspondingly for the next period.

The reached results should be communicated to the government, the public, and the shareholders. There are many processes operating in the health field, so one should not be too eager to claim any positive changes to be due to the planning process. It can be advantageous to monitor a few trends that can tell something about the effects of additional supply, e.g. changes in trends in waiting times or job vacancies. Previously reached results should always be mentioned in new health workforce planning goals.

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Decision making process: goals set by one or many ministries

- *Usually there are at least 3 ministries involved in setting of the goals;*
- *The health workforce planning team should provide an advice to the Ministries;*
- *In the unlikely event that ministries do not reach consensus on the goals, it's important that the other stakeholders intervene in order to reach an equilibrium between needs and supply.*

The setting of the goals for the health workforce planning by government is never accomplished by one ministry. At least, there will be 3 ministries involved: the ministry of Health, the ministry of Education, and the Ministry of Economic Affairs. Depending upon the importance of changes being made the Ministry of Labour can also be a stakeholder. Usually, the ministry of Health will be in the lead but there may be financial or logistical constraints placed by the other ministries. However, this may differ between member states

This leads to the following statement regarding the unravelling of the goal. The health workforce planning team should agree on an advice to the ministries. This advice should be smart and authentic, without taking into consideration any financial or quality constraints. The ministry of Health then has its own responsibility to translate the advice in a set goal, together with other ministries. This goal may differ from the given advice. The ministry can use its own discretion to decide on promoting certain strategies by training more students than advised by the planning team. By splitting the advice and the set goal, the advice can keep its imago of being independent, professional, and scientifically correct. Otherwise, the planning process will lose its basis of trust amongst the stakeholders. The process of formulating the advice, based on the planning data and the agreement of the stakeholders, should be kept apart from the process of setting the goals, which is usually done by the ministries.

In some cases there could be **contrasted goals by different ministries**. This is a very worrisome scenario. However, the phenomena of contrasting goals will only very rarely occur. In the unlikely event that ministries do not reach consensus on the goals, the other stakeholders will try to intervene because the final goal to reach an equilibrium between needs and supply is jeopardized. In case these interventions are not successful, the stakeholders will have to adapt a strategy of their own. The chances that they will base their strategy at least partly on the given advice -or do not change training numbers at all- are more than likely. In both cases the advice still can bear its original function.

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