CHAPTER 7

LINK TO POLICY ACTIONS

To reach the goals of the planning system (see chapter "Goals" in the second part), and so turn what has been planned into outputs, it is important to use the right levers and put into practice the right actions.

From an organisational point of view, it is also important to define the **responsibilities** relating to these levers and actions.

Finally, it is crucial **monitoring** and **checking** that those actions and levers provide the desired results and that the objectives have been achieved.

The reference methodology in this regard is the continuous improvement process as defined by Edward Deming in its cycle: **Plan-Do-Check-Act** (PDCA).

The "Do" step is represented by policy initiatives which, for example, a ministry takes to face emerging problems (e.g. an expected shortage of the number of health care professionals). In Belgium, for example, in 2008 the Ministry of Public Health and Social Affairs started an attractiveness plan for the profession of nurses. It was designed to meet the needs of all nurses, their patients and the quality of care. Several actions were undertaken: diminishing the workload and stress of nurses; functional differentiation (increasing the number of titles and qualifications); annual payment for the holders of a particular professional title or qualification. All these initiatives aim to increase (or at least maintain) the number of nurses in the health sector (hospitals, nursing homes and home care).

The "Check" step is represented by all the tools and process set to assess and check the policy decision-making and its accuracy in helping to achieve their main objective of ensuring a proper balance over time between the supply and demand of different categories of health professionals. The evaluation of a planning strategy and system can take place at different stages of the process of health workforce planning.

- *Ex-ante:*
  - *Alignment of HRH objectives on service and health objectives;*

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- *Soundness of the underlying conceptual framework;*
- *Validity of assessment of baseline situation;*
- *Assessment of the various dimensions of feasibility, which all have an impact on the success/failure of planning (economic, legal, technical/organisational, political, social).*

- *In itinere:*
  - *Comparing the observed changes to the expected ones.*
  - *Looking for the explanation of the differences? Are these intrinsic to the planning process (wrong assumptions, technical failures, poor management) or to external factors (unexpected economic or political change)?*
  - *Deciding whether a change of course is needed?*
- *Ex post:*
  - *an analysis of results can be conducted to assess the dimensions of effectiveness, efficiency, satisfaction of health professionals and of users of services. Research can help explain what worked, what did not work, which lessons can be learned, which practices proved good and may be recommended.*

FINDINGS

How the planning process is connected with the actions that will achieve what has been planned?

In the analyzed methodologies, the objectives finalized to modify the number of profession in the labour market are prevailing, in particular through the definition of the numerous clausus in university or fixing limits to the number of posts in prost graduating schools or even limits to the entrance to the labour market. In some case aspects connected to the professional mix, skills needed, future working conditions are taken into account to define the right objective of "**quantity of professionals**". In this case the Dutch case has to be mentioned.

The Finnish and the English model are different. In these systems, the objectives have

as a focus the future skills needed and the future professional mix.

Goals defined by the HWF planning system are achieved through different instruments. Most of them appertain to the category **"barriers to entry"**: depending on the circumstances, their purpose is to regulate the access to the university, to postgraduate schools or labour market. There are also other instruments utilized to regulate HWF labour market.

Barriers to the entrance are a measure present in all the observed planning systems, in particular the regulation of the access to education and training programs. But in many cases these initiatives flank **other type of actions** which directly intervene on actual HWF. That' the case, for example, of Belgium, which has started different incentive and promotion initiatives aimed at HWF. Different is the case of England where, compared with the goal defined in "Mandate", specific instruments and actions of realization have been identified.

Which are the processes that lead to the realization of planned plans and goals and which are the responsibilities within those processes?

Concerning the process of realization of the target set, there seems to be two aspects common to the different experiences:

1. *A solid technical analysis supported by a certain amount of data and, in most cases, by a quantitative, and sometimes also qualitative, method;*

2. *A sharing of scenarios, context, interpretative lectures through the involvement of a series of stakeholders, to reach social "commitment" to the technical proposal.*

This double decisional support allow the **decision maker** (policy maker) to take decisions with a higher degree of assurance and with a lower degree of conflict.

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MAIN LEVERS AND RESPONSABILITIES	MAIN LEVERS	RESPONSABILITIES
BELGIUM	SETTING MAXIMUM NUMBER OF NEW PROFESSIONALS IN HEALTH INSURANCE SYSTEM PER YEAR; SETTING NUMBERS OF ACCESSES TO SPECIALTY (ONLY FOR PHYSICIANS AND DENTISTS); SETTING NUMBERS OF ACCESSES TO PRIVATE PRACTICE (ONLY FOR PHYSIOTHERAPISTS). CONTROLLING INFLOW WITH ENTRANCE EXAMS FOR MEDICAL STUDIES (AT COMMUNITIES LEVEL).	MINISTRY OF HEALTH WITH THE SUPPORT OF THE PLANNING COMMISSION. MINISTRY OF HEALTH WITH THE SUPPORT OF THE PLANNING COMMISSION. MINISTRY OF HEALTH WITH THE SUPPORT OF THE PLANNING COMMISSION. COMMUNITIES.
DENMARK	REGULATION OF THE NUMBER OF POSTGRADUATE TRAINING POSTS ON A YEARLY BASIS IN A FIVE YEAR PERIOD. REGULATION OF THE STUDENT INTAKES.	THE DANISH HEALTH AND MEDICINES AUTHORITY. THE MINISTER FOR HIGHER EDUCATION AND SCIENCE.
ENGLAND	SETTING NUMBERS OF STUDENT INTAKES AT THE LOCAL LEVEL ENSURING THAT OVERALL TRAINING NUMBERS IN THE PLANS REFLECT THE NATIONAL DEMAND FOR HEALTH PROFESSIONS SHAPING THE TRAINING CONTENTS AND LENGTH OF TRAINING IN ORDER TO PRODUCE HEALTH PROFESSIONALS WITH THE REQUIRED COMPETENCIES TO PRACTISE IN THE NEW NHS.	NUMEROUS PLANS AND STAKEHOLDERS INVOLVED WITH DIFFERENT RESPONSABILITIES. MAINLY: HEALTH EDUCATION ENGLAND; LETBS; DEPARTMENT OF HEALTH.
FINLAND	SETTING ENTRANT TARGETS AND OUTPUT OF QUALIFICATIONS FOR EVERY FIELD AND LEVEL OF PROFESSIONAL AND VOCATIONAL EDUCATION AND TRAINING. MEASURES TO ENSURE THE SUFFICIENCY AND SKILLS OF THE PERSONNEL, RETENTION POLICY ISSUES, REDISTRIBUTION OF PROFESSIONAL RESPONSIBILITIES AND WELL-BEING AT WORK IN SOCIAL AND HEALTH CARE.	THE NATIONAL GOVERNMENT WITH THE INVOLVMENT OF THE MINISTRY OF EDUCATION AND CULTURE, MINISTRY OF ECONOMICS AND THE MINISTRY OF SOCIAL AFFAIRS AND HEALTH.
NORWAY	RESTRICTED INTAKE OF STUDENTS TO SOME OF THE HELATH EDUCATIONS, SUCH AS MEDICINE, DENTISTRY, PHARMACOLOGY, PSYCOLOGY AND OTHERS. THIS NATIONAL QUOTA SYSTEM WAS DISCONTINUED IN 2012. NATIONAL QUOTA SYSTEM FOR NEW POSITIONS AS PHYSICIAN IN HOSPITALS.	MINISTRY OF EDUCATION AND RESEARCH THE DIRECTORATE OF HEALTH THROUGH THE MINISTRY OF HEALTH AND CARE SERVICES
SPAIN	REGULATION OF THE NUMBER OF AVAILABLE SPECIALIST TRAINING VACANCIES.	MINISTRY OF HEALTH, SOCIAL SERVICES AND EQUALITY, SUPPORTED BY THE HUMAN RESOURCES COMMISSION

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THE NETHERLANDS	SETTING THE NUMBER OF ADMISSIONS TO THE 8 MEDICAL SCHOOLS (SO-CALLED "NUMERUS FIXUS").	MINISTRY OF EDUCATION AND SCIENCE ADVICED BY ACMMP.
	SETTING THE NUMBER OF ADMISSIONS TO THE VOCATIONAL (SPECIALIST) TRAINING PROGRAMS FOR MEDICAL GRADUATES.	MINISTRY OF HEALTH, WELFARE AND SPORTS ADVICED BY ACMMP.

Controlling and monitoring of the progress of the process to join the goal is a basic aspect of any system of goals. It helps to understand if the actions taken are bringing in the desired direction and if it is necessary to intervene to correct those actions taken or define new ones. If starting condition have changed, monitoring and control stage may be also useful to re-define the goal. Is there in the analyzed experiences this control stage.

Exception made from Norway and Denmark, the other methodologies have built some control systems. In most cases the control is done by the same subject responsible of the planning system. In this sense the case of The Netherlands is interesting for the set of evaluation parameters arranged with stakeholders. Usually a series of reports containing data and monitoring evaluation are published.

On the other hand, in the case of Belgium the control is done by a third body, the Belgian health care knowledge center (https://kce.fgov.be/).

FOR FURTHER DETAILS:

- *Focus on --> Details of the seven planning systems --> Link to policy actions.*

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