Planning the health workforce and skill-mix of the future

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Why the health workforce matters

[A] health workforce with the right number of health workers, with the right skills, in the right place, with the right attitudes and commitment, doing the right work effectively and efficiently, at the right cost, with the right productivity (Dussault et al. 2010)
Overview

• Why the health workforce matters
• Patients and health workers are changing
• Health systems need to adapt to these changes
• Challenges and opportunities while adapting
  – Expanding the health workforce
  – Growth of the health workforce cannot be taken for granted
  – Composition of the health workforce (skill-mix)
  – Governance
  – Mobility
  – European Integration
Patients and health workers are changing

**Chronic disease and multi-morbidity**

- 1 in 6 patients in the UK suffers from more than 1 condition
- 65% of those aged more than 65 years and almost 82% of those aged 85 years or more had two or more chronic conditions.
- prevalence increases substantially with age, in absolute terms multi-morbidity is more prevalent in those aged 65 years or less and is much more common in socioeconomically deprived areas.

(cited after Wallace E et al. 2015)
Health systems need to adapt to these changes

The Chronic Care Model

Community
- Resources and Policies
  - Self-Management Support

Health Systems
- Organization of Health Care
  - Delivery System Design
  - Decision Support
  - Clinical Information Systems

Improved Outcomes
- Informed, Activated Patient
- Prepared, Proactive Practice Team
- Productive Interactions
Expanding the health workforce

- Patients
- Informal carers
- Community
- Coordinators and navigators
- Primary health care medical capacity
- Primary health care multi-disciplinarity
Growth of the health workforce cannot be taken for granted

**Workforce growth: physicians per 100,000 population 1986-2014**

- EU
- EU members before May 2004
- EU members since May 2004

**Workforce growth: nurses per 100,000 population 1986-2014**

- EU
- EU members before May 2004
- EU members since May 2004
Large variations in the composition of the health workforce: Physicians and Nurses per 100,000 head counts 2014 and ratios.
## Composition of the health workforce: skill-mix innovations

<table>
<thead>
<tr>
<th>No.</th>
<th>Model (official name if relevant)</th>
<th>Professional, peer, patient, team</th>
<th>Skill / task innovation</th>
<th>Country</th>
<th>Status</th>
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<tbody>
<tr>
<td></td>
<td><strong>Keeping people healthy: prevention and promotion</strong></td>
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<tr>
<td>1*</td>
<td>Shared care, mental health care in GP practices</td>
<td>Mental health practice nurse</td>
<td>Prevention (screening diagnostics)</td>
<td>The Netherlands</td>
<td>Nationwide, 81% of GP practices employ a mental health PN</td>
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<td>2</td>
<td>GP-nurse team (model practices)</td>
<td>Registered nurse</td>
<td>Prevention and health promotion</td>
<td>Slovenia</td>
<td>Nationwide, 55% of all GP practices employ an additional nurse at 0.5FTE (2016)</td>
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<td><strong>Acute care</strong></td>
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| 3  | Role expansion | Physician assistants  
- Specialised nurses (acute, chronic, intensive, preventive and mental health care)  
- Clinical technicians | Medical tasks (e.g. endoscopies, injections, catheterisation) | The Netherlands | Nationwide experimental phase ongoing (2017) |
| 4  | Role expansion | Oral hygienist | - Treat primary cavities  
- Provide anesthesia  
- Make X-rays for ionizing solo and bitewings | The Netherlands | Nationwide experimental phase ongoing |
Belgium: Flows of medical students and doctors (figures 2015)

FL = Flemish Community; FR = French-speaking Community;
NIHDI = National Institute for Health and Disability Insurance; EEA = European Economic Area

(*) = 2013-2014

Graduate training (basic)
- FL to FR: 8.5% (*)
- FR to FL: 26% (*)
- NIHDI registration + authorisation
  - Quota 60%
  - Quota 40%

Post-graduate training (specialisation)
- FL to FR: 5%
- FR to FL: 17%
- NIHDI registration + authorisation

Establishment (practice)
- FL to FR: 16.1%
- FR to FL: 41.1%
Governance

• Transparency
  – Data and registries

• Accountability
  – With few exceptions competence for training has a different locus than that for health;

• Participation
  – Overrepresentation of physicians

• Capacity
  – Not all countries can plan and train for all professions
SINGLE MARKET, SOCIAL EUROPE AND TAXATION

‘Europe must be a Union of equality and a Union of equals.’

• Equip national authorities with stronger powers to better enforce EU consumer and food quality laws and cut out illegal practices wherever they exist.

Create a common Labour Authority – a European inspection and enforcement body to ensure that all EU rules on labour mobility are enforced in a fair, simple and effective manner.

Address social dumping by agreeing on the European Pillar of Social Rights – setting the basis for a European Social Standards Union (e.g.

‘The single market is the very soul of Europe... But today, Europe does not protect from social dumping; today we have let the European single market develop against the very philosophy of our united labour market. Today, Europe must build a genuine project of fiscal and social convergence.’

• Supports President Juncker’s proposal to put an end to double standards on food, to combat fraud and guarantee food security.

Supports President Juncker’s proposal for a European inspection and enforcement body to ensure that all EU rules on labour mobility are enforced in a fair, simple and effective manner.
Summing up

- What do we mean by planning?
- To what extent can we plan?
- Do we need to approach different professions differently?
- What are the planning instruments?
- What will be the role of stakeholders, Member States and the European Union?