SCENARIO:
A NEW NATIONAL PRIMARY HEALTHCARE STRATEGY HAS BEEN AGREED.

HOW CAN WE ENABLE THE WORKFORCE TO DELIVER MORE EFFECTIVE PRIMARY CARE?

Step 1: Understanding the health workforce (please consult *Sheet 2*)

Step 2: Understanding the health workforce policy question and designing a policy response

Education

- **2 – 02** Duration of education and training
- **2 – 04** Ratio of admissions to available places
- **2 – 05** Ratio of students to qualified educators for education and training
- **2 – 06** Exit / drop-out rate from education and training programmes
- **2 – 07** Graduation rate from education and training programmes
- **3 – 01** Standards for the duration and content of education and training
- **3 – 02** Accreditation mechanisms for education and training institutions and their programmes
- **3 – 06** Standards for interprofessional education
- **3 – 08** Continuing professional development
- **3 – 09** In-service training
- **4 – 03** Average tuition fee per student
- **4 – 04** Investment in transformative education and training
- **4 – 05** Expenditure per graduate on health workforce education
- **4 – 07** Cost of qualified educators per graduate
- **4 – 08** Total expenditure on in-service training and continuing professional development

Labour force

- **5 – 01** Graduates starting practice within one year
- **5 – 02** Replenishment rate from domestic efforts
- **5 – 04** Voluntary exit rate from health labour market
- **5 – 05** Involuntary exit rate from health labour market
- **5 – 06** Unemployment rate
- **5 – 07** Vacancy rate
- **6 – 02** Health workers with a part-time contract
- **6 – 06** Health worker status in employment
- **6 – 07** Regulation on dual practice
- **6 – 09** Measures to prevent attacks on health workers
- **6 – 10** Attacks on health-care system
- **7 – 05** Entry-level wages and salaries

Serving population health needs

- **8 – 06** Existence of advanced nursing roles

Relevant qualitative and contextual information

- What do health workers think about the new primary care model?
- What kind of education and training is already available to support the new primary care model and how effective is the approach and content?

Step 3: Mobilizing policy options

- Policies that align education and training of staff, standards and accreditation with new patient pathways defined by the new model of care.
- Policies that prepare, attract and retain a workforce with the required competencies, e.g. funding positions in primary health care, clear identification of key competencies needed and direction to services and training institutions to prioritize in job descriptions and student applications, financial support to promote and reward workforce with identified competencies (fellowships, countrywide award campaigns).
- Policies that support the transition of existing staff into new roles, e.g. continuing professional development, bridging programmes, financial incentives.
- Policies that secure funds to pay for any new equipment and infrastructure that the workforce will need to work in new model of care, e.g. new technologies, equipment, consultation rooms.
- Health workforce governance arrangements that support long-term sustainable planning for appropriate workforce.

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SCENARIO:
UNFILLED MEDICAL VACANCIES IN HOSPITALS ARE IMPACTING ON SERVICE DELIVERY.

WHY ARE OUR DOCTORS LEAVING AND WHAT CAN WE DO TO KEEP THEM?

Step 1: Understanding the health workforce (please consult *Sheet 2*)

Step 2: Understanding the health workforce policy question and designing a policy response

Education

- **2 – 02** Duration of education and training
- **2 – 06** Exit / drop-out rate from education and training programmes
- **2 – 07** Graduation rate from education and training programmes
- **3 – 07** Agreement on accreditation standards
- **3 – 08** Continuing professional development
- **3 – 09** In-service training
- **4 – 03** Average tuition fee per student
- **4 – 04** Investment in transformative education and training
- **4 – 06** Cost per graduate of medical specialist education programmes
- **4 – 08** Total expenditure on in-service training and continuing professional development

Labour force

- **5 – 01** Graduates starting practice within one year
- **5 – 02** Replenishment rate from domestic efforts
- **5 – 03** Entry rate for foreign health workers
- **5 – 04** Voluntary exit rate from health labour market
- **5 – 05** Involuntary exit rate from health labour market
- **5 – 06** Unemployment rate
- **5 – 07** Vacancy rate
- **6 – 01** Standard working hours
- **6 – 03** Regulation on working hours and conditions
- **6 – 05** Regulation on social protection
- **6 – 07** Regulation on dual practice
- **6 – 08** Regulation on compulsory service
- **6 – 09** Measures to prevent attacks on health workers
- **6 – 10** Attacks on health-care system
- **7 – 04** Public expenditure on compensation of health workers
- **7 – 05** Entry-level wages and salaries
- **7 – 06** Policies on public sector wage ceilings
- **7 – 07** Gender wage gap

Relevant qualitative and contextual information

+ Is it only doctors who are leaving or is this part of a wider pattern?
+ What are the characteristics of the doctors who have left?
+ What reasons are doctors giving for leaving?
+ How are services trying to fill the gaps?

Step 3: Mobilizing policy options

- Policies focused on retention of existing staff, e.g. continuing professional development opportunities, career pathways, flexible working and retirement options, professional recognition systems, family friendly policies, and stress and workload reduction strategies.
- Policies for optimizing or extending scopes of practice, e.g. introducing advanced practice for nurses, physician assistants, therapists.
- Policies focused on increasing recruitment of new staff, e.g. compensation, flexible working hours.
- Policies to mitigate negative impacts of migration, e.g. bilateral agreements with destination countries that support circular migration.

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SCENARIO:
VACANT POSITIONS ARE HAMPERING EFFECTIVE SERVICE DELIVERY ACROSS PRIMARY CARE AND HOSPITAL SERVICES.

HOW CAN WE MITIGATE OUR URGENT HEALTH WORKFORCE GAPS?

Step 1: Understanding the health workforce (please consult *Sheet 2*)

Step 2: Understanding the health workforce policy question and designing a policy response

Education

2 – 06 Exit / drop-out rate from education and training programmes
2 – 07 Graduation rate from education and training programmes
3 – 08 Continuing professional development
3 – 09 In-service training

Labour force

5 – 01 Graduates starting practice within one year
5 – 04 Voluntary exit rate from health labour market
6 – 02 Health workers with a part-time contract
6 – 03 Regulation on working hours and conditions
6 – 05 Regulation on social protection
6 – 06 Health worker status in employment
6 – 07 Regulation on dual practice
6 – 08 Regulation on compulsory service
7 – 04 Public expenditure on compensation of health workers
7 – 05 Entry-level wages and salaries
7 – 06 Policies on public sector wage ceilings
7 – 07 Gender wage gap

Serving population health needs

8 – 06 Existence of advanced nursing roles

Relevant qualitative and contextual information

+ What workforce gaps are services reporting?
+ What reasons do health workers and new graduates give for not taking up these vacancies?
+ Is there a temporal pattern to these vacancies?
+ Why are people voluntarily exiting the labour market in the health sector?
+ Are staff enabled to use their competencies and work at their full scope?

Step 3: Mobilizing policy options

- Policies that make it attractive to opt for full-time rather than part time contracts.
- Policies to enhance labour market uptake of graduates, e.g. improving entry-level wages, social protection measures, enhancing working conditions and mentorships.
- Policies aimed at reducing voluntary exit rates e.g. improving working conditions, increased compensation, continuing professional development and social protection measures.
- Policies to attract back health workers who have exited the health system, e.g. in-service training, re-instating previous pay grade.
- Policies to upgrade the health workforce with needed qualifications, e.g. in-service training and strategic investment in continous professional development.
- Policies to improve the retention of students e.g. scholarships, additional training, focus on topics relevant to vacant positions.

SCENARIO:
A NEW NATIONAL PRIMARY HEALTHCARE STRATEGY IS BEING IMPLEMENTED.

ARE WE PRODUCING ENOUGH HEALTH WORKERS TO DELIVER EFFECTIVE PRIMARY HEALTHCARE? IF NOT, WHAT CAN WE DO?

Step 1: Understanding the health workforce (please consult *Sheet 2*)

Step 2: Understanding the health workforce policy question and designing a policy response

Education

- **2 – 01** Master list of accredited health workforce education and training institutions
- **2 – 02** Duration of education and training
- **2 – 04** Ratio of admissions to available places
- **2 – 05** Ratio of students to qualified educators for education and training
- **2 – 06** Exit / drop-out rate from education and training programmes
- **2 – 07** Graduation rate from education and training programmes
- **3 – 01** Standards for the duration and content of education and training
- **3 – 05** Standards for social determinants of health
- **3 – 06** Standards for interprofessional education
- **3 – 08** Continuing professional development
- **3 – 09** In-service training
- **4 – 04** Investment in transformative education and training
- **4 – 05** Expenditure per graduate on health workforce education
- **4 – 07** Cost of qualified educators per graduate
- **4 – 08** Total expenditure on in-service training and continuing professional development

Labour force

- **5 – 01** Graduates starting practice within one year
- **5 – 02** Replenishment rate from domestic efforts
- **5 – 03** Entry rate for foreign health workers
- **5 – 04** Voluntary exit rate from health labour market
- **5 – 05** Involuntary exit rate from health labour market
- **5 – 06** Unemployment rate
- **5 – 07** Vacancy rate
- **6 – 02** Health workers with a part-time contract
- **7 – 05** Entry-level wages and salaries

Relevant qualitative and contextual information

- What are the competencies needed in primary health care?
- Are we already producing any health workers with the required competencies?
- Are education and training institutions equipped to provide the required education, training and/or continuing professional development?
- How equipped do our health workers feel to work in this new model?

Step 3: Mobilizing policy options

- Policies that define that standards and accreditation for education and training include relevant content on primary healthcare and social determinants of health.
- Policies to address the educational pipeline and expand production, e.g. expansion of education and training places, increasing number of qualified educators.
- Policies to improve the retention of students e.g. funding scholarships for students studying primary health care as a specialization, additional training opportunities in PHC.
- Policies on mandatory continuing professional development and in-service training in primary health care.
- Policies that support transition of existing staff into new roles, e.g. continuing professional development, bridging programmes, financial incentives.

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SCENARIO:
NEW NATIONAL REPORT SHOWS SIGNIFICANT INCREASE IN THE PREVALENCE AND INCIDENCE OF TYPE II DIABETES IN ADULTS.

HOW DO WE CONTINUOUSLY EQUIP OUR NURSES TO RESPOND TO PEOPLE'S CHANGING HEALTH NEEDS?

Step 1: Understanding the health workforce (please consult *Sheet 2*)

Step 2: Understanding the health workforce policy question and designing a policy response

Education

3 – 08 Continuing professional development
3 – 09 In-service training
4 – 04 Investment in transformative education and training
4 – 08 Total expenditure on in-service training and continuing professional development

Labour force

5 – 02 Replenishment rate from domestic efforts
5 – 03 Entry rate for foreign health workers

Serving population health needs

8 – 06 Existence of advanced nursing roles

Relevant qualitative and contextual information

+ What kind of continuing professional development (CPD) is already available and how effective is the approach and content?
+ How are nurses at all levels of care protected and mandated to pursue CPD?
+ What knowledge gaps do nurses identify as necessitating more CPD?
+ Are there barriers for putting this knowledge into action?

Step 3: Mobilizing policy options

- Policies to define content and the amount of CPD to be done in this area, e.g. legislation on number of hours to be completed at what frequency \ and clear guidance on specific topics to be covered, reviewing and updating this on a regular basis.
- Policies that ensure that accreditation and standards are in place for those who are supplying CPD, including associations and education and training institutions.
- Policies on reporting when CPD has been completed, on a regular basis.
- Policies that support the recruitment and retention of nurses, e.g. career pathways linked with delivering CPD, specialties in high priority areas.

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SCENARIO:
NEW PRIMARY CARE MULTI-DISCIPLINARY TEAMS ARE BEING INTRODUCED TO ROLL OUT A NEW PRIMARY HEALTHCARE STRATEGY.

HOW CAN WE ENABLE EFFECTIVE MULTI-DISCIPLINARY TEAMS (MDTS) FOR PRIMARY CARE?

Step 1: Understanding the health workforce (please consult *Sheet 2*)

Step 2: Understanding the health workforce policy question and designing a policy response

Education

- **2 – 01** Master list of accredited health workforce education and training institutions
- **3 – 01** Standards for the duration and content of education and training
- **3 – 02** Accreditation mechanisms for education and training institutions and their programmes
- **3 – 06** Standards for interprofessional education
- **3 – 08** Continuing professional development
- **3 – 09** In-service training
- **4 – 04** Investment in transformative education and training
- **4 – 08** Total expenditure on in-service training and continuing professional development

Labour force

- **5 – 02** Replenishment rate from domestic efforts
- **5 – 03** Entry rate for foreign health workers
- **5 – 07** Vacancy rate
- **7 – 04** Public expenditure on compensation of health workers
- **7 – 05** Entry-level wages and salaries
- **7 – 06** Policies on public sector wage ceilings
- **7 – 07** Gender wage gap

Serving population health needs

- **8 – 06** Existence of advanced nursing roles
- **8 – 07** Availability of human resources to implement the International Health Regulations.

Relevant qualitative and contextual information

+ Are there existing examples of MDTs? If yes, what are the experiences that those health workers have had with MDTs?
+ What kind of education and training is already available to support MDTs and how effective is the approach and content?
+ What are the competencies needed for MDTs? Are we already producing health workers with these competencies?

Step 3: Mobilizing policy options

- Policies to address any gender, sector, professional/occupational and cultural discrepancies between team members that may exist, e.g. compensation, working conditions.
- Policies on financial and/or non-financial incentives to support MDTs.
- Policies to secure special training around any tools introduced for MDTs, e.g. new documentation systems, reporting systems, feedback systems, meeting software.
- Policies to ensure standards and accreditation are in place to enable interprofessional ways of working.

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