Cross-national differences within Europe: what can we learn from them?

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Health workforce planning in Europe: Creating learning country clusters

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Starting question and perspective

• How can countries learn from each other to improve their HWF policy?
  – Not only through good or best practices …
  – Also through comparison with ‘equals’ and reflecting on this
  ➢ This implies ‘blended’ learning: a mix of best practices and benchmarking

• This blended cross-country learning requires:
  – Reliable and valid data, i.e. ’transparent’ comparisons/benches
  – Clear goals: what to learn from each other
  – Clear comparisons: who can learn from who
  ➢ This implies taking contexts into account: a countries’ starting position in particular their current health system
Type of healthcare system: a first relevant context for HWF policies

- National Health Service (‘Beveridge system’)
  - Denmark, Finland, Ireland, Greece, Italy, Norway, Portugal, Spain, Sweden and the United Kingdom

- Social security based (‘Bismarck system’)
  - Austria, Belgium, Bulgaria, Croatia, Czech Republic, Estonia, France, Germany, Hungary, Iceland, Latvia, Lithuania, Luxembourg, Netherlands, Romania and Slovakia

- Private or mixed social security based system
  - Cyprus, Malta, Poland and Slovenia

[Van der Zee J, Kroneman M. Bismarck or Beveridge: a beauty contest between dinosaurs. BMC Health Services Research 2007;7: 94.]
HWF planning resources vary by health care system.
HWF composition varies by health care system
Strength of primary care: a second relevant context for HWF policies

Classification based primary care structure (governance, economic conditions, workforce development) and primary care service-delivery process (accessibility, comprehensiveness, continuity, coordination)

– Weak (IE, AT, HU, SK, BG, IS, LU, PL, CY, MT)
– Medium (SE, IT, NO, DE, FR, RO, CZ, LV, SI)
– Strong (FI, ES, UK, DK, BE, NL, EE, LT)

HWF planning resources vary by primary care strength
HWF composition varies by primary care strength
Conclusions

Health systems clearly matter:
• Compared with countries with (mixed) social security based systems, NHS countries have:
  – more resources for HWF planning in place (in particular HWF planning models)
  – lower densities of health professionals (in particular nurses and healthcare assistants)

Primary care strength partly matters:
• Countries with a strong primary care system have:
  – more resources for HWF planning in place (in particular HWF planning models)
  – But do not differ in densities of health professionals
Recommendations and food for thought …

• NHS countries might form learning clusters to compare and develop policies on their health workforce composition

• Countries with social security based and weak primary care systems, might form learning clusters to compare and develop policies on their health workforce planning
Creating ‘country learning clusters’ by (1) healthcare system and (2) primary care strength

<table>
<thead>
<tr>
<th>Strength of primary care</th>
<th>Type of health care system</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>National Health Service (NHS)</td>
</tr>
<tr>
<td>Weak</td>
<td>IE</td>
</tr>
<tr>
<td>Medium</td>
<td>SE IT NO</td>
</tr>
<tr>
<td>Strong</td>
<td>FI ES,UK DK</td>
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</tbody>
</table>

Austria (AT), Belgium (BE), Bulgaria (BG), Cyprus (CY), Czech Republic (CZ), Denmark (DK), Estonia (EE), Finland (FI), France (FR), Germany (DE), Hungary (HU), Iceland (IS), Italy (IT), Latvia(LV), Lithuania (LT), Luxembourg (LU), Malta (MT), Netherlands (NL), Norway (NO), Poland (PL), Republic of Ireland (IE), Romania (RO), Slovakia (SK), Slovenia (SI), Spain (ES), Sweden (SE), United Kingdom (UK)
Recommendations and food for thought …

• However:
  – ‘More planning’ is not always better planning; it should fit the need for planning
  – Higher densities are not always better: skill mixes should fit the population needs

• Hence:
  – Learning does not imply copying or adapting policies from other systems
  – But using benchmarks for country/context-specific goals
Thank you!

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