The Dutch approach to health manpower planning:

Lessons for Norway?

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Outline of the presentation

• General aspects of the Dutch approach to health manpower planning (2 slides)
• Introduction of the Dutch Advisory Committee on Medical Manpower Planning (3 slides)
• Overview of the main parameters of the Dutch Model for Manpower Planning (5 slides)
• Impact of planning (2 slides)
• Lessons for Norway? (1 slide)
• Some references (1 slide)
General aspects of the Dutch approach to manpower planning (1 of 2)

- A demand-led, stock-and-flow-model was developed in 1999
- Data from the past play a big role, but educated guesses also
- Manpower planning is considered not to be just a technical exercise, but also a political exercise
- Therefore, both researchers and stakeholders should be involved
General aspects of the Dutch approach to manpower planning (2 of 2)

• The model is mainly used for national planning
  ➢ But some regional planning has been done
• The model is a “one size fits all”-model
  ➢ It is used for pharmaceutical, dental, medical, para-medical and mental health professions
• The model is “lean and mean”
  ➢ It encompasses a set of 18 input parameters and 7 output parameters, with 4 different scenarios
• For some input parameters, submodels are developed
  ➢ For instance for the expected outflow, submodels are used, which vary between professions
The Dutch Advisory Committee on Medical Manpower Planning (ACMMP) (1 of 3)

- Founded in 1999 on request of the MoH, and governed by three groups of stakeholders:
  - Insurance companies
  - Professional organizations
  - Educators (mainly universities/teaching hospitals)

- Gives independent advice on intake in training to:
  - Ministry of Health (finances post-master training for almost all medical specialties)
  - Ministry of Education (finances medical and dental master training)
  - Others (for non-governmental medical and mental health training)
The ACMMP (2 of 3): Structure

• Chambers:
  - Currently: (1) General practitioners, (2) Nursing home physicians, (3) Medical specialists, (4) Public health specialists, (5) Mental health professionals
  - Tasks: Assess available data; Initiate and supervise new research; Discuss possible scenario’s
  - Composition: ± 4 experts per stakeholder group (± 12 experts) in each chamber
  - Meetings: ± 4 per year

• Plenary board:
  - Task: Discuss the final advice on student intake
  - Composition: ± 6 experts per stakeholder group (± 18 experts)
  - Meetings: ± 3 per year
The ACMMP (3 of 3): Structure

• Bureau:
  ➢ Tasks: Prepares documents, commissions research and supervises and evaluates all of that research. The Bureau itself is not responsible for any research, thus guaranteeing the independence of its staff under all circumstances
  ➢ Composition: ± 6 policy advisors, 1 director, 1 secretary

• Involvement of research institutes:
  ➢ Tasks: Collect and/or deliver data; Governance of the model development; Perform the modeling; Give independent advice
  ➢ Preferred providers: NIVEL (± 1FTE), Kiwa Carity (± 1FTE), Statistics Netherlands (<< 1FTE), Registration bodies (<< 1FTE)
The model: Supply side
The model: Demand side

1. Number in stock (male/female)
2. FTE per person (male/female)
3. Available supply (total FTE)
4. Outflow (male/female & projection year)
5. Inflow from abroad (male/female)
6. Number in training (m/f & duration of training)
7. Return on training
8. Labour market return
9. Labour market return
10. Number in stock (male/female)
11. FTE per person (male/female)
12. Available supply (total FTE)
13. Unfulfilled demand for care
14. Required supply (total FTE)
15. Demographic developments
16. Required supply (total FTE)

Scenario 0

Demographic change in demand

Current demand

Required supply in year T

Development required supply until T+X

Future demand

Required supply in year T+X
The model: Balance?

Balance between future supply and demand?

Scenario 0

Future supply

Future demand
The model: Balance!

Available supply in year T

1. Number in stock (male/female)
2. FTE per person (male/female)
3. Available supply (total FTE)

4. Outflow (male/female & projection year)
5. Inflow from abroad (male/female)
6. Number in training (m/f & duration of training)

7. Return on training
8. Labour market return
9. Labour market return
10. Number in stock (male/female)
11. FTE per person (male/female)
12. Available supply (total FTE)

13. Unfulfilled demand for care
14. Required supply (total FTE)
15. Demographic developments

17. Difference between available and required supply

Balance between future supply and demand!

Scenario 0

Available supply in year T+X
16. Required supply (total FTE)

Required supply in year T

Development required supply until T+X

Required supply in year T+X
The Dutch Model for Manpower Planning: Conceptual image of the Excel spreadsheet

The model: Scenarios

- **Scenario 0**: Demographic developments
- **Scenario 1**: Epidemiological developments, Socio-cultural developments
- **Scenario 2**: Technical developments regarding the profession, Developments regarding horizontal substitution
- **Scenario 3**: Developments regarding vertical substitution

Required supply in year T

Development required supply until T+X

Required supply in year T+X

Available supply in year T

Development available supply until T+X

Available supply in year T+X

1. Number in stock (male/female)
2. FTE per person (male/female)
3. Available supply (total FTE)
4. Outflow (male/female & projection year)
5. Inflow from abroad (male/female)
6. Number in training (m/f & duration of training)
7. Return on training
8. Labour market return
9. Labour market return
10. Number in stock (male/female)
11. FTE per person (male/female)
12. Available supply (total FTE)
13. Unfulfilled demand for care
14. Required supply (total FTE)
15. Demographic developments
16. Required supply (total FTE)
17. Difference between available and required supply
18. Required number in training for scenario 0 - 3
19. Epidemiological developments
20. Socio-cultural developments
21. Technical developments regarding the profession
22. Developments regarding horizontal substitution
23. Developments regarding efficiency
24. Developments in working hours per FTE
25. Developments regarding vertical substitution
Impact of planning (1 of 2)

• The advices of the ACMMP are followed-up by stakeholders and the government
  ➢ For most specialties, inflow has followed the advice in the past 15 years

• Consensus and involvement of the three stakeholder groups has been important for the acceptance of the advices

• The Dutch approach is internationally considered as “good practice”
Impact of planning (2 of 2)

- Most of the times, there are enough candidates to fill all vacancies, but sometimes there are too few to fill all training positions, e.g.:
  - For nursing home physicians and some public health specialties, the intake in training has been lower than the advice for some years

- ACMMP advices are sometimes ‘neglected’ too, e.g.:
  - For ophthalmologists, the intake in training has been lower than the advice for most years
  - Lately, the MoH has maintained a high inflow for GP’s, despite an advice to lower the inflow
Lessons for Norway?

- Organize consensus among and involvement of all stakeholders in manpower planning
- Retain simplicity of the model at the front-end, but keep improving the back-end and data quality
- Define and document parameters for transparency
- Make a flexible model, to cope with fast changing conditions and health policy changes
- Learn from other countries with similar systems
Some references

Advisory Committee on Medical Manpower Planning: *The 2013 Recommendations for Medical Specialist Training*. Utrecht; 2013.

