PLANNING OF HEALTH WORKFORCE

Introductory Remarks by Tsung-Mei Cheng
Princeton University
Chair of Session I

9th Annual Symposium of the Bertelsmann Stiftung
International Network Health Policy & Reform

Session I: Planning and Implementing Change in Health Care

Odense, Denmark
July 4-7, 2010
By way of introduction to this session, I would like to make two points:

I. The link between a given population morbidity and a particular type of health professional is much looser than seems often to be assumed.

II. A brief listing of policy issues in health-workforce planning.
Traditional health-workforce forecasting models have used fixed, “ideal” ratios of a particular type of health professional-to-population – e.g., ideal physician-population ratios.

These models are flawed, because they overlook the considerable flexibility countries have to address a given disease burden with different mixes of health workers and supporting equipment.
Population health to be managed

Health Care

Public Health

Environment

Education
Nutrition

Ambulatory Care

Hospital Inpatient Care

Nursing Homes

Home-Care (w. telemedicine)

Primary Care MDs
Specialist Physicians
Physician Assistants

Technicians

Clerks
ACTIVE PHYSICIAN PER 1,000 POPULATION, OECD 2006-7

SOURCE: OECD DATA 2009
Figure 1. Active Physicians by Degree Type Per 100,000 Population

2006 Data

IN SUM:

Beware of alarmist health workforce forecasts based on fixed, normative ratios of particular types of health professionals to population.
II. ISSUES IN HEALTH WORKFORCE POLICY

One can structure a discussion on the planning of health workforce of the future around 5 subtopics:

1. A global shortage of working-age population in general, driven mainly by a rising old-age dependency ratio.
1. A GROWING GLOBAL SHORTAGE OF WORKING AGE PEOPLE

Total dependency ratios -- loosely defined as the number of people too young or too old to work divided by the working age population – are rising in many countries, driven mainly by:

1. Longer life expectancy, coupled with
2. Falling fertility rates

These trends are especially pronounced in the European OECD countries, Singapore, China and, worst of all, Japan.

Health care, a highly labor-intensive economic sector, will have to compete with other sectors for labor in a shrinking pool of workers.
OLD-AGE DEPENDENCY RATIO 2007 AND 2050, BY CONTINENT

Figure 1.6. The “old age dependency ratio” set to double by 2050
Population aged 65 and over relative to the population of 15-64 in 2000 and 2050

Source: OECD (2006), Society at a Glance.

The problem in Singapore: This chap is not doing his patriotic duty. He’s always on the road somewhere.
One can order a discussion on planning the health workforce of the future around 5 subtopics (Continued):

1. A global shortage of working-age population in general, driven mainly by a rising old-age dependency ratio.

2. An inefficient assignment of tasks across health workers with different levels of education and training.

3. A clinically and economically inefficient mix of physicians (in the US, too many specialists, not enough primary care physicians).

4. A geographically inequitable allocation of the health workforce (rural areas tend to be understaffed).

5. An inequitable allocation of the health workforce among socio-economic classes within countries.
So, let us now turn to this session’s presentations to hear about how some countries address these issues:

**Presentation 1**: Toni Ashton, University of Auckland:  
“*Strategies to overcome workforce shortages in New Zealand and Australia*”

**Presentation 2**: Ryozo Matsuda, Ritsumeikan University, Japan:  
“*Tackling physician shortages for certain specialties and regions*”

**Presentation 3**: Zeynep Or, IRDES:  
“*Skill mix in France: Chances and challenges*”