DATA & TRENDS – SIDEBAR

Creating a Workforce for Health: Next Steps for North Carolina

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Years of health workforce research, policy, and funding have focused on the question: Do we have enough health care workers? This singular focus stems from a belief that an inadequate supply of health care workers limits patients' access to health care services. Yet, the COVID-19 pandemic, in conjunction with new payment and care delivery models, is putting increased pressure on the health care system to adopt a more patient-centered approach to workforce planning aimed at improving access to health services for individuals, populations, and communities. This approach requires redesigning our health workforce around the conditions that are plaguing our state and causing significant health disparities in maternal mortality, chronic disease, and opioid misuse and addiction. At the same time, we must also focus on prioritizing the health and well-being of health workers themselves.

To build a workforce for health, health systems, employers, professional organizations, educators, and policymakers will need to move toward designing models of care and developing teams of providers that are specifically trained, deployed, and paid to address the physical, behavioral, and social needs of North Carolina's citizens [1–2]. This is not an easy undertaking. We propose a roadmap that illuminates the complex and interdependent factors affecting access to care and the workforce considerations embedded within each of these factors.

In 1981, Penchansky and Thomas developed a framework for examining access to health services [3]. They posited that access to health care results from a fit between the patient and health service delivery system. The framework described availability—that is, demand compared to supply—as only one component of understanding who accesses care and why. Four additional dimensions—accessibility of services, acceptability of programs, accommodation or ease of navigating these health systems, and affordability—all influence access to health care services in our communities. The interplay of these five factors (5 As) is dynamic and cumulative, impacting the likelihood that those who need care will receive it.

Understanding the workforce challenges in each of these components can shape our thinking about planning for a workforce for health. In Table 1 we present the 5 As alongside workforce questions that challenge traditional approaches to workforce planning and design. For example, acceptability of services—that is, the individual's

TABLE 1.
The '5 As' Approach to Health Workforce Research and Planning

Dimension of Access	Approach to Health Workforce Research and Planning
Availability	Do we have the right number and skill mix of clinicians needed to meet the physical, behavioral, and social needs of North Carolina's citizens?
Accessibility	How can teams of providers address health needs in areas with fewer clinics, like rural areas in North Carolina?
Acceptability	Are health care teams designed to meet the health care needs of the populations served and do they represent the diversity of North Carolina citizens?
Accommodation	How can the health workforce provide care across health, community, and home-based settings?
Affordability	Which health care workers are needed to deploy the public health and preventive interventions required to reduce costs and improve the health of communities?

belief that the health service will support them—requires that we prioritize increasing the diversity of the workforce and addressing the stigma and bias that get in the way of patients accessing behavioral health care services. Instead of simply pointing to a maldistribution of health workers, we'd consider how teams of health providers that include community health workers and peer counselors could help increase access to services for vulnerable and underserved populations.

By assessing the health needs of communities, we can design a health workforce system that addresses the specific problems patients regularly face. With this understanding, we'd focus less on whether we have enough health workers and ask what types of health providers we require to meet the needs of North Carolina communities. For instance, to address maternal mortality, we'd focus on how different health workers, such as doulas with shared lived experience and cultural perspective, to change birth experiences for Black women, making them healthier and safer [4]. We'd invest in training more health workers to deliver preventive health services, reducing risks of chronic health conditions that shorten lives.

COVID-19 underscored that our usual approach to health workforce planning and policy is not fit to withstand external shocks like a pandemic or other future public health crisis. North Carolina's health care workforce has lurched from oversupply to shortage because we have taken a piecemeal, fragmented approach to planning, policy, and funding [5]. Although it is unclear how the pandemic will affect the health workforce in the long run, we see that many of the challenges facing the workforce even before the pandemic have been exacerbated, including burnout, workplace violence, and rising workloads. These forces are likely to increase attrition from the workforce.

To ensure we have the workforce needed to address patient and population health in North Carolina, we must invest in a workforce planning infrastructure that combines good data with the expertise needed to interpret what these data suggest about the state's health workforce needs, and the best practices to address them. We must also leverage on-the-ground perspectives from North Carolina's educators, employers, regulators, and policymakers to understand what policy action and funding is needed to bolster the state's health workforce and improve availability, accessibility, acceptability, accommodation, and affordability of health care services. NCMJ

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Acknowledgments

Disclosure of interests. The authors report no conflicts of interest.

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Electronically published November 1, 2022.

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N C Med J. 2022;83(6):405-406. 0029-2559/2022/83607