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Better health workforce governance in Europe:

how to make it happen?

Ellen Kuhlmann

Contact
kuhlmann.ellen@mh-hannover.de

Background

Creating an integrated, sustainable and people-centred health workforce is a widely shared goal across countries to respond effectively to changing population needs and shortage and maldistribution of health human resources.

The importance of governance is increasingly recognised.

However: health systems respond differently to the challenges of and little is known on the governance models and policy levers for successfully implementing innovative actions.

Aims

- Introduce a multi-level and intersectoral governance approach to research health workforce development,

- Explore different strategies and the importance of coordination in health workforce governance,

Methods

- Material from various cross-country comparative studies and a research approach developed in the context of EUPHA Health Workforce Research section.

Integrated health workforce governance: a comprehensive model

based on:

- Kuhlmann, Batenburg, Groenewegen, Larsen (Health Policy, 2013)

- Statement on behalf of the European Public Health Association section Health Workforce Research, Consultation on the next EU Research Programme (2018, Kuhlmann, Groenewegen, Batenburg); **https://eupha.org/health-workforce-research**

Hierarchical levels of workforce governance	Content-based dimensions of workforce governance			
	System integration	Sector integration	Occupational integration	Socio-cultural integration and gender equality
Transnational (global/EU level)			Harmonisation of professional requirements	International migration, brain drain
Macro-level (state/regional)	Educational system, labour market, health labour market	Primary care; secondary care; mental health, public health; social sector	Relationships between different professions;	Regional imbalances, remote/rural areas, deprived areas
Meso-level (organizations/ professions)	Match of education, workforce, and population needs	People-centred organization of care	Task delegation and substitution; power differences in organizations; gender equality	Integration of diverse (gender, ethnicity, international, etc.) professionals
Micro-level (actors)	Competences for people-centred care	Cooperation, skill mix in teams	Interprofessional education and practice	Motivation, intercultural relations

The challenges

Creating an integrated health workforce needs complex changes on different levels and areas of governance (as the model shows).

However, health systems are rarely driven by population needs, thus aiming for 'quick fixes', which avoid conflicts with powerful actors and produce short-term results.

Major strategies of health workforce development:

- ➢ organisational change,

- ➢ professional development,

- ➢ competence development.

Organisational change:

Seem to be prioritised in health systems with doctors as insiders in the governance settings and policy process and resistance against new roles/professional development, examples:

➢ Germany: various pilot projects to strengthen integrated care organisation, yet slow/ little change in the skill mix and new roles.

Professional development:

Seem to be prioritised in NHS/ systems with doctors as outsiders in the governance settings and policy process; examples:

➢ UK: task-shifting/ new roles for nurses in primary care, also for pharmacists, some change in the organisation;

➢ Portugal and Spain: professional development of nurses, but little change in the organisation.

Competence development:

Seem to be overall weak and primarily focused on micro-level changes and education (e.g. communication skills), yet poorly connected to complex governance changes:

➢ Interprofessional education in several countries, but poorly connected to professional development;

➢ skill mix policies and performance assessment still based on 'professional silos' (e.g. new roles of nurses) rather than on team competences.

Nordic countries and The Netherlands with more integrated governance of doctors and nurses/other health professions) seem to do better than other health systems.

Conclusions

➢ Innovation in the health workforce must be assessed in context, as strategies are shaped by the different governance arrangements.

➢ Health workforce governance must become a policy priority and needs a system approach.

Conclusions

➢ Stronger coordination of organisational, professional and competences development and improved participation of diverse professional groups may contribute to better health workforce governance – but the policy levers and strategies towards better governance may vary.

Questions

How to create knowledge on better governance and leadership for an integrated people-centred health workforce, if capacity depends on health systems and the role of stakeholders in governance?

How to use global/ European networks effectively to transform health workforce governance, if the policy levers and conditions are defined nationally?