



# Improving the Skills Mix for Chronic Care in Europe

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# Different skill-mix models in dentistry



Dentist  
Implantologist  
Owner

Dentist

Office  
management

Prevention

Dentist  
Implantologist  
Owner

Office management

Prevention

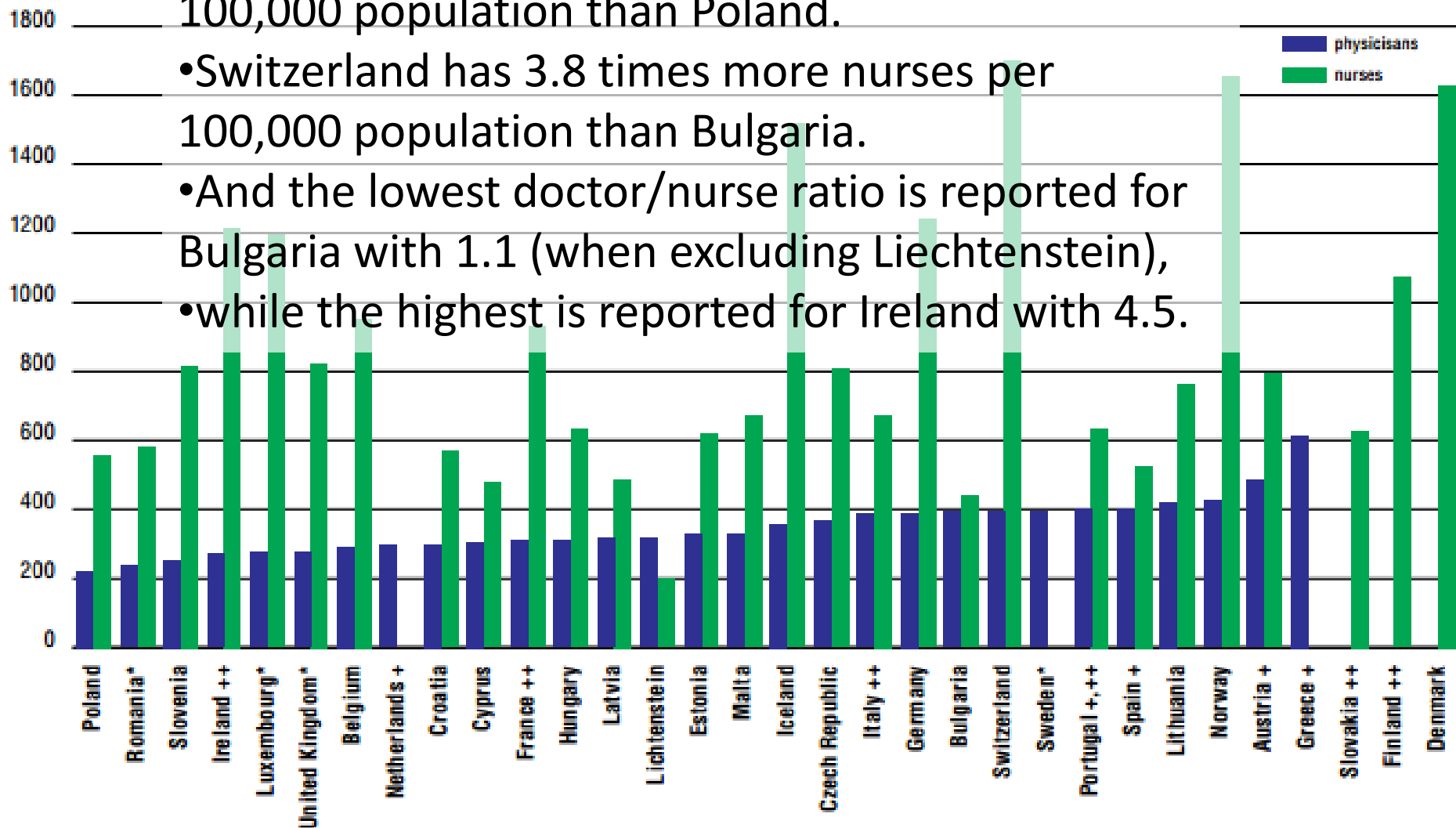
Assistance  
Apprentice  
Dental technicians





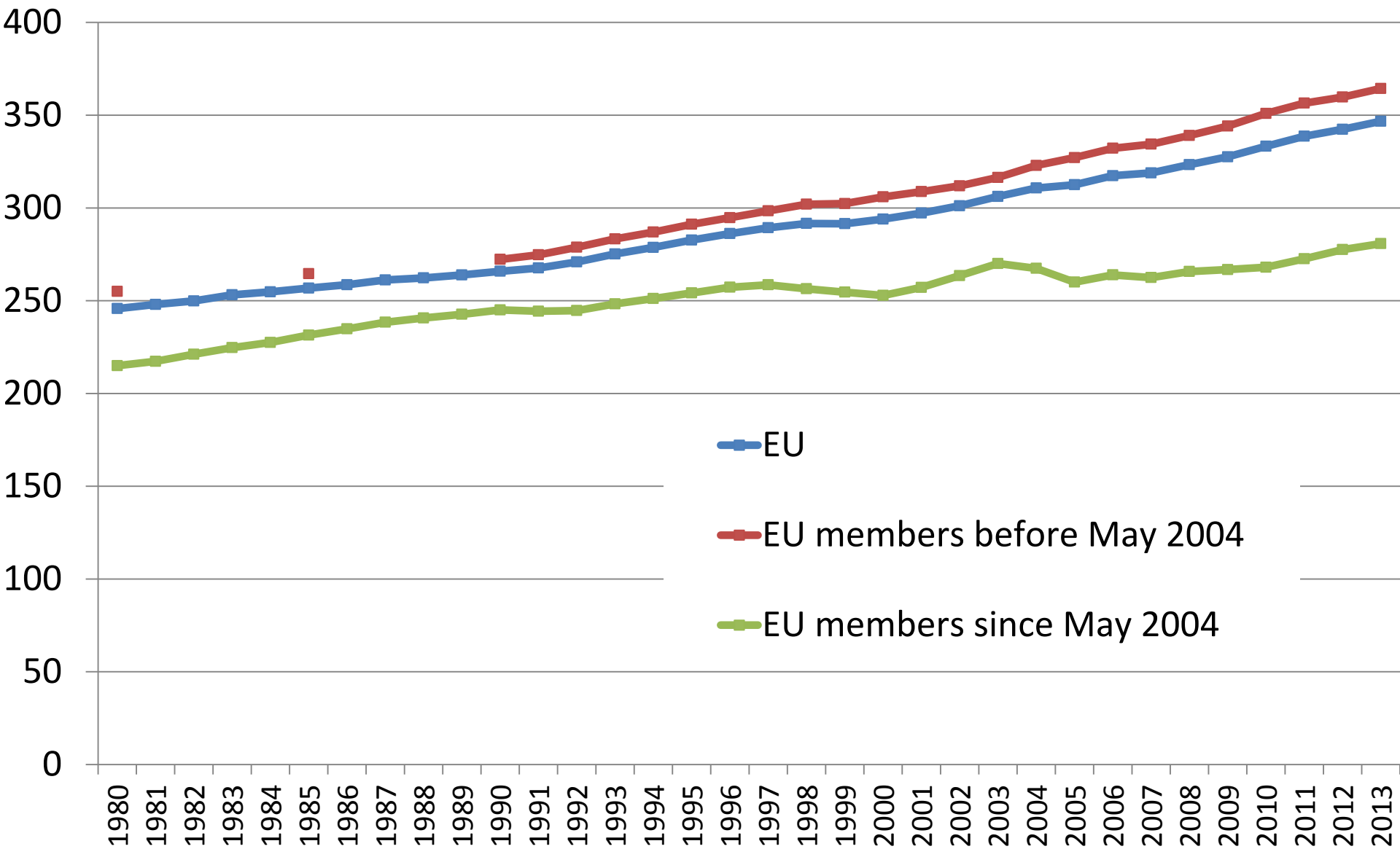
# Skill-mix: medical doctors and Nurses pp 100,000, free-mobility zone 2012\*

- Greece has 2.8 times more medical doctors per 100,000 population than Poland.
- Switzerland has 3.8 times more nurses per 100,000 population than Bulgaria.
- And the lowest doctor/nurse ratio is reported for Bulgaria with 1.1 (when excluding Liechtenstein),
- while the highest is reported for Ireland with 4.5.



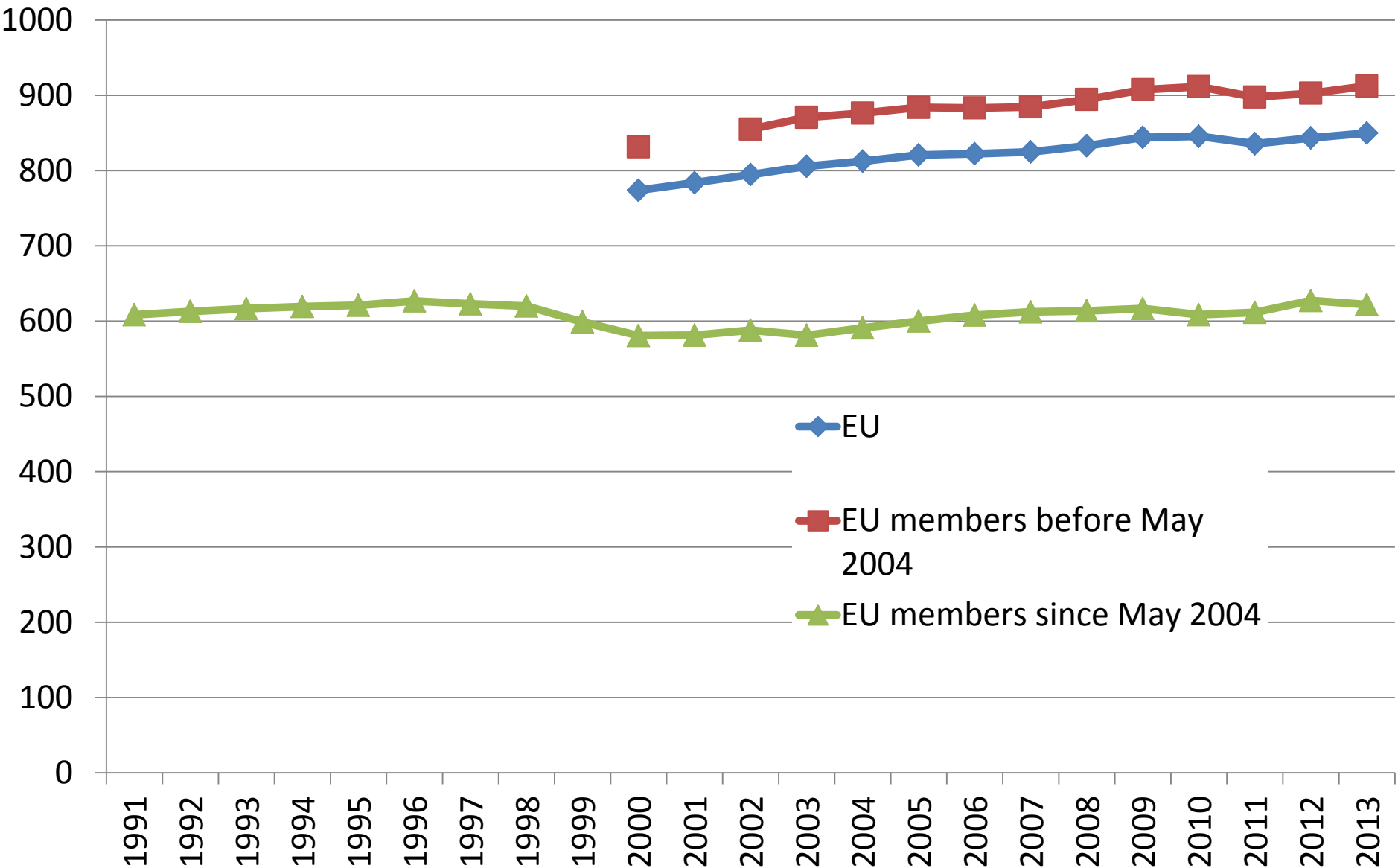


# Workforce growth: Physicians per 100,000 population 1980-2013



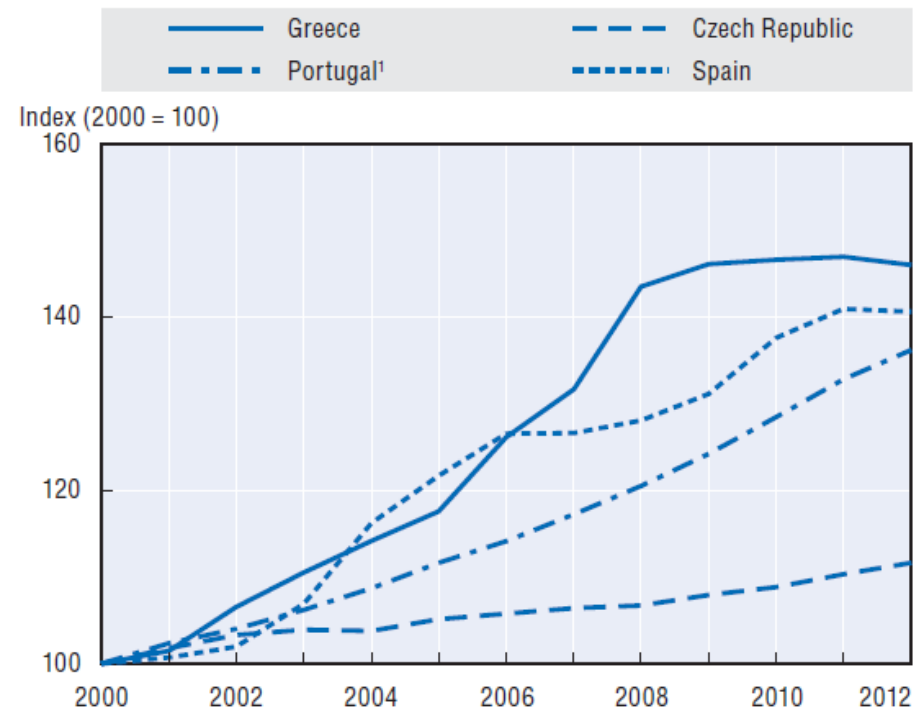
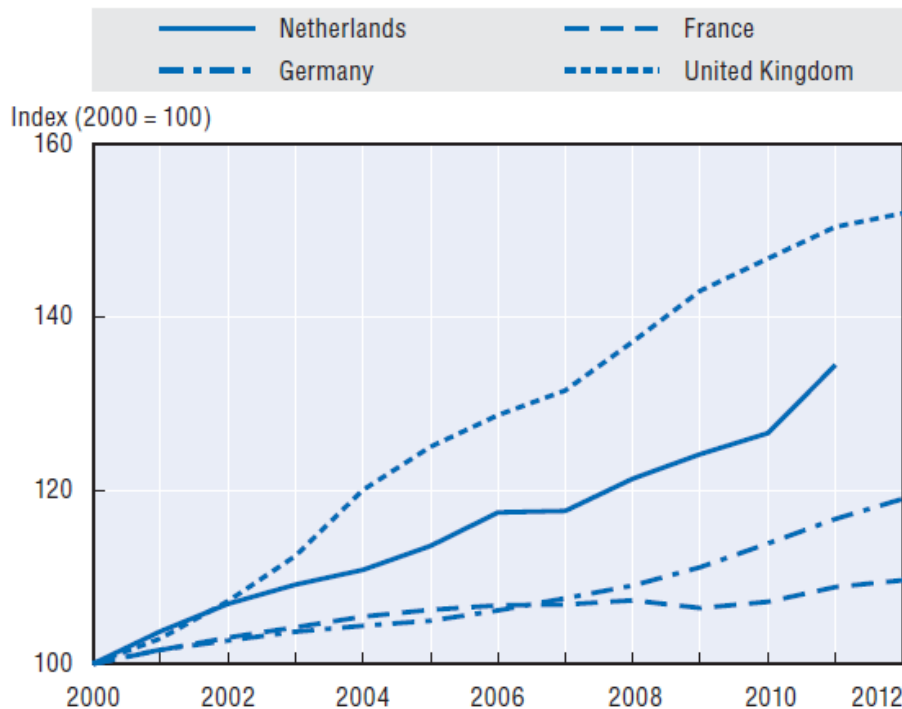


# Workforce growth: Nurses per 100,000 population 1991-2013





# Evolution in the number of doctors, selected EU countries, 2000 to 2012 (or nearest year)





# Aim and objectives

- Improving the performance on chronic care in primary health care settings by
  - Identifying major skill-gaps
  - Assessing major reform strategies for close these gap
  - Analyzing the barriers and facilitators
    - regulatory context
    - and the governance (and politics) it takes to change it



# Editors (in alphabetical order), timeline and focus

- Jim Buchan
  - Irene A Glinos
  - Martin McKee
  - Matthias Wismar
  - Thematic chapters
  - Country case studies
  - July 2015 preparatory workshop
  - Dec 2015 Commissioning of country case studies and thematic chapters
  - Feb 2017 pdf goes online, followed by the hardcopy
- Focus on chronic care  
in primary health care settings**





# Skill-mix study: conceptual framework

## *Skill-gaps in*

### *Primary and chronic care*

- Patients and peers
- Community
- Fragmentation/coordination
- PC medical capacity
- Multi-disciplinarity

### *Professionals, patients and peers*

- Knowledge
- Practical skills
- Attitude
- Motivation

### *Enablers and barriers*

- Regulation of practice
- Payment mechanisms
- Health Profession's education
- Employment and working conditions
- Governance

### **Tasks**

- medical expertise
- com **Innovate**
- coll **enhancement**
- management
- hea **delegate**
- sch **substitute**
- professionalis



## *Patients and Peers*

- Improving the skill-mix through empowerment of patients and peers including self-management, health literacy, care counseling for relatives .



## Community

- shifting mental health care into the community (experiences from most European countries)
- shifting end-of life care into the community/hospices; Belgium, France, Germany.
- dove-tailing health services with social care in places of residence and rest homes
- supplying domestic services like cleaning and meals on wheels to allow patients with chronic conditions to stay as long as they wish in their own house.



## Coordination

- coordination and communications in settings: the French/Belgium/Canadian 'maison communale'; but also healthcare centers in Sweden and Finland or the (re)establish multidisciplinary ambulatory medical treatment centres in Germany.
- the use of ICT: clinical medical records, national health registers or messaging systems between providers employed in Denmark, Norway the Netherlands, Croatia and Slovenia.
- the use of 'navigators', case managers performed by GPs, nurses, practice managers or sickness fund personnel. Examples from Belgium, Sweden, France and Germany.
- regional provider coordination platforms like in the Netherlands but also at the municipal level in some of the Nordic countries.



## *PHC medical capacity:*

- Freeing GP capacity through expanding the stock of nurses. Examples are from Slovenia, introducing 'model practices' in general/ family medicine in 2011 to strengthen PHC through employing each practice employs an additional 0,5 FTE qualified nurse. Similar strategy was pursued by Latvia.
- Adding medical capacity through task shifting, there are 10 countries now in Europe that have legislated or are in the process of legislating nurse practitioners. There are also smaller approaches like e.g. Germany authorizes autonomous home visits of health care assistants.
- Retraining or re-licensing doctors of internal medicine or other specialties for general practice. Examples come from Germany, Estonia and Slovenia.



# *PHC multidisciplinary*

- scaling up the allied health professions like physiotherapists, long-term carer, as in Belgium, Germany and many other countries.
- developing interdisciplinary training in primary health settings as in the Netherlands (foundation model).
- joint basic education between different professions, like in France. Or joint practical training episodes as in many countries.
- performance-based payment scheme for multi-professional primary care group practices as in France.
- physicians networks including new contracts and payment mechanisms and new curricular development for health care assistants. Examples come from Germany with Kinzingtal-network the best publisized and the Southwest network the largest covering more than 5 mio people.
- reregulating health professions as happening in Spain through the work of the Human Resources Commission. This includes new career pathways and the development of regional registries that feed into a national registry.
- national actions plans strengthening of primary care, psychiatric care and care for older people accompanied with investment. Example comes from Sweden.

POLICY BRIEF 18

# How can countries address the efficiency and equity implications of health professional mobility in Europe?

Adapting policies in the context of the WHO Code of Practice and EU freedom of movement

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## Contents

	page
Key messages	3
Executive summary	5
Policy brief	5
1. Introducing the Efficiency-Equity Conundrum	6
2. Trends in Mobility: A New Map of Europe?	9
3. Unpacking the Efficiency-Equity Conundrum: A Matrix	11
4. Policy Options: How to make mobility work better	15
5. Implementation Considerations	18
6. Conclusions	20
Acknowledgements	20
References	20

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