RESEARCH PAPER

Mind the Gap: Governance Mechanisms and Health Workforce Outcomes

Attention à la marche : mécanismes de gouvernance et résultats de la main-d'œuvre en santé

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Abstract

Attempts at health system reform have not been as successful as governments and health authorities had hoped. Working from the premise that health system governance and changes to the workforce are at the heart of health system performance, we conducted a systematic review examining how they are linked. Key messages from the report are that: (1) leadership, communication and engagement are crucial to workforce change; (2) workforce outcomes need to be considered in conjunction with patient outcomes; and (3) decision-makers and researchers need to work together to develop an evidence base to inform future reform planning.

Résumé

Les tentatives de réforme des systèmes de santé n'ont pas connu un succès aussi retentissant que ne l'espéraient les gouvernements et les autorités sanitaires. À partir de la prémisse voulant que la gouvernance et les changements apportés à la main-d'œuvre sont au cœur du rendement des systèmes de santé, nous avons procédé à une revue systématique pour examiner le lien existant entre ces deux éléments. Les messages clés qui se dégagent du rapport sont : (1) le leadership, la communication et l'engagement sont des aspects cruciaux pour les changements à la main-d'œuvre; (2) il faut tenir compte des résultats de la main-d'œuvre de pair avec les résultats pour les patients; et (3) les décideurs et les chercheurs doivent travailler ensemble au développement d'un fonds de données pour éclairer d'éventuels plans de réforme.

In its final report, the Health Council of Canada opens with the sobering statement that "A decade of reform under the health accords led to only modest improvements in health and healthcare. The transformation we hoped for did not occur" (Health Council of Canada 2013: 1). Actions under the two federal/provincial/territorial health accords focused on quality, accessibility and sustainability, but led to only limited improvements in measures of patient care and health outcomes.

As part of international efforts to address health system pressures, the literature on governance and health system transformation has been expanding in recent years. While there are differences in the definition and operationalization (Barbazza and Tello 2014) of governance, it is generally understood to mean the tasks and functions established to drive the direction, accountability and performance of health services (World Health Organization n.d.). Hence, governance is increasingly regarded as key to transforming the health system. At the same time, successful health system change is premised on availability of an educated and skilled workforce (Health Council of Canada 2005), an appropriate skill mix and efficient and effective use of existing human resources. Unfortunately, the relationship between governance structures and processes and workforce outcomes is not well-understood. There is a gap in knowledge about how particular "tools" or mechanisms of governance work in practice (Barbazza and Tello 2014) and their impact on the health workforce. We developed a systematic review to address this knowledge gap and pull together diverse evidence on governance

mechanisms and health workforce outcomes. We used standard synthesis methods to manage the review, quality appraisal and evidence synthesis phases.[1] Our conceptualization of governance was broad and inclusive to allow us to identify a wide range of governance mechanisms in the early searches. It encompassed strategic policy frameworks, mechanisms, effective oversight, coalition building, accountability, legislation, information, regulations and incentives related to health system design. We defined workforce changes as more effective utilization of the workforce and a change in the way healthcare providers work together to deliver care and looked for a range of workforce outcomes.

A total of 149 articles (77 empirical, 34 non-empirical, 38 grey literature) met relevancy and quality criteria for inclusion. After initial appraisal and extraction, we identified the following governance mechanisms: provider engagement (shared governance, Magnet accreditation, professional development and education), quality focus, organizing structures (organization of healthcare delivery, funding), healthcare reform and strategic planning and informal governance (physician leadership, communication).

The workforce outcomes we identified included absenteeism, adoption of care protocols, collaborative practice, learning, professional behaviour, recruitment, retention, role clarity, skill or staff mix, work attitudes and workload.

A full discussion of our methods and findings can be found elsewhere (Hastings et al. 2013). This paper reflects on some key issues that the research team found challenging during the review, and that are important considerations for future research on this topic. Namely, we are concerned with drawing out the "invisible" mechanisms (Pawson 2008) of change (related to people and processes) that were absent in the findings of many studies we reviewed but were highlighted as key to success in those reporting positive outcomes. We suggest that the unbalanced reporting and discussion of workforce outcomes in the existing literature has three elements and it is these elements that we highlight below.

Leadership Matters (... and So Does Communication and Engagement)

Overall, the evidence on the workforce impact of governance mechanisms is mixed, and it is difficult to claim that one type of initiative is better at changing health workforce behaviours than another. Mechanisms focused on improving staff engagement, such as shared governance, Magnet accreditation and professional development programs are successful in improving some key outcomes such as retention, job satisfaction and collaborative practice. Evaluations of clinical governance and quality improvement initiatives suggest some positive impacts on uptake of evidence-based practice when providers are given appropriate training. Our findings on pay-for-performance and other funding initiatives report mixed impacts on workforce behaviours. Importantly, contextual factors (e.g., design of performance indicators, size of rewards and distribution of rewards) seem to have an important impact on local successes and failures, but they are not consistently reported.

The key message for policy makers is that some of these projects work some of the time. There is no simple fix to the challenge of changing the health workforce. Having said that,

we have identified some characteristics across projects reporting successful workforce outcomes, regardless of the context, scale and design of the initiative, that appear to lead to better outcomes. These success factors pertain to the quality and consistency of the leadership, communication and engagement underpinning the change processes being implemented.

Effective leadership that promotes a shared vision and rationale for change is characteristic of projects reporting good workforce outcomes. It seems that health system workers, like most of us, appreciate transparency and consistency of strategic vision delivered through all leadership levels in an organization. Where the organizational culture is shaped by strong leadership, the outcomes are likely to be better. Related to clarity of vision and strong leadership is the need for a communication strategy that allows the timely delivery of information on the rationale for change (why it is being done), the change process (how it is being done) and the locus of change (with whom and where it is being done). Furthermore, a communication process that facilitates information flow across the whole system (including mechanisms for feedback from staff to leaders) is highly valued and linked to positive workforce outcomes. It is perhaps not surprising that communication has to be multi-directional, not just top-down, to promote workforce engagement in new initiatives.

Leadership and communication are strengthened by early stakeholder engagement. Enabling the intellectual and emotional investment of the workforce in both the design and ongoing development of a program is more likely to produce the desired results. For example, engaging healthcare providers in identifying the metrics for assessing performance, in devising performance targets and rewards and agreeing on their distribution appears to give better results than imposed reward systems. Early engagement may help governance boards avoid potential roadblocks further down an implementation process.

The Missing Link

A surprising finding from our review was that the literature very rarely includes workforce and patient or system outcomes simultaneously. Of 77 empirical studies we reviewed, just one considered patient outcomes alongside workforce variables, and we would hazard a guess that the vast majority of patient outcomes literature does not include workforce outcomes. We view this as a major gap and an important step for future research, as every governance mechanism we reviewed was ultimately aimed at improving patient care via influencing the workforce in some way.

Healthcare providers are the instrument through which governance mechanisms are operationalized and outcomes are achieved. Without enabling changes in providers' motivation, knowledge, skill, behaviours or work processes, the desired improvements in patient or financial outcomes cannot be realized. Too often, governance initiatives are designed and implemented without consideration of how the workforce will be affected by the required changes. A funding model that does not properly incentivize physicians may not improve patient care, and a quality improvement project that does not adequately teach providers how to find, interpret and use evidence is unlikely to substantially improve quality. Workforce

outcomes should also be included in evaluations, to identify areas of success and areas for improvement. For example, providers' job satisfaction may decrease as a result of altering the way healthcare is delivered. This outcome may in turn affect absenteeism, turnover or performance and thus undermine efforts to improve patient care or reduce costs. Identifying these issues in an evaluation allows an organization to tweak the initiative to alleviate the problem.

Many of the unsuccessful initiatives we see in the literature and in Canadian healthcare systems are due, at least in part, to a lack of consideration on the part of planners of what the workforce needs to increase engagement. Providers who do not have or do not believe they have the support or resources to carry out an initiative cannot and will not be the "tool" that improves system-level outcomes. A new governance mechanism likely will not successfully move beyond its planning phases without enthusiastic uptake on the part of the workforce and may not be sustainable long-term if providers are unwilling or unable to do what is asked of them. For an initiative to move to its next phase, there should be explicit consideration of what the initiative means for the workforce, whether they have the means to carry it out and how issues that do crop up can be identified and improved to drive the system or patient care quality changes at the heart of the matter.

Learning from Each Other for Success

Our ability to draw firm conclusions about the governance mechanisms we found was hindered by the quality of the articles under review. We rejected almost 30% of our selected full-text articles for quality reasons, and even those we retained were often on the low side of the acceptable quality range. This discovery hints at a larger issue in health systems research: a lack of impartial, well-written, high-quality studies of governance mechanisms and outcomes.

While we acknowledge the challenges of designing and executing evaluations of "real world" program implementation in complex settings, it is important to pursue excellence. Many of the studies we reviewed seemed to have been designed after the fact, rather than planned a priori, leaving the researchers to choose perhaps sub-optimal outcomes to study and less-than-ideal research designs. We encourage decision-makers to partner with researchers early in governance planning efforts, to allow time for proper study design and comparisons across units or sites when possible. This would encourage a focus on expected outcomes from the outset and the generation and dissemination of useful knowledge.

Decision-makers and researchers need to make a concerted effort not only to use evidence in their planning, implementation and evaluation of new initiatives, but to produce evidence and make it available to others. Accounts of successes and failures in systems across Canada and the rest of the world can be found, but evidence is not being reported, collated, reviewed or published for the benefit of others. Health systems leaders potentially stand to learn volumes from others' experiences with governance initiatives if evidence and appropriate knowledge exchange develop. Without the ability and desire to learn from each others' mistakes, decision-makers will repeat mistakes in new settings, with predictable consequences (see the proliferation of pay-for-performance systems for proof of this).

A more intentional focus on research and evaluation would allow us to better understand the markers and mechanisms of successful change. The vast majority of research we reviewed used work attitudes outcomes (e.g., job satisfaction, engagement) to measure the results of governance initiatives. A smaller, but still sizable, proportion examined professional behaviour outcomes (e.g., job performance, care quality). Are these the best indicators of success, or were they merely convenient to measure? Related to this query, the design and implementation of governance structures would be aided by a fuller understanding of how changes in governance influence the workforce, and in turn how the workforce influences patient and system outcomes.

Conclusion

Changes to governance processes and structures are inevitable in today's healthcare environment, where patient acuity is rising and some healthcare providers are becoming scarce. Our synthesis showed that such changes can be effective if leaders consider the context, take responsibility for driving the change, understand the needs of the workforce and take advantage of others' experiences before making irrevocable decisions with huge consequences. We are not the first to say this (see, e.g., Lewis 2009; Wilson et al. 2012), but we hope a continued focus on pushing leaders to recognize the difficulties inherent in such changes will improve the chances of success for future initiatives.

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Note

1. A detailed discussion of the search terms, eligibility criteria, databases searched and screening process is available in the report, "Exploring the relationship between governance models in healthcare and health workforce transformation: A systematic review" (Hastings et al. 2013).

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