Kommission
for **robusthed i**
**sundhedsvæsenet**

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# Recommendations by the Danish Resilience Commission

September 2023

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# The Commission's recommendations

## STRONGER PRIORITISING AND WISER TASK SOLUTION

**Recommendation 1: National Priority Council should free up resources for the core task**

**Recommendation 2: Improper treatment to be reduced through stronger prioritising rooted in professional expertise**

**Recommendation 3: Prioritising should be strengthened through common decision-making, differentiated offers and increased self-care**

**Recommendation 4: Improper documentation must be reduced**

**Recommendation 5: Competences should be used across geography and sectors**

**Recommendation 6: Introduce a common principle of "digital and technological first"**

**Recommendation 7: Ensure a better framework for the rapid deployment of proven, labour-saving technologies**

**Recommendation 8: Digital competences and technological understanding must be strengthened**

## ATTRACTIVE WORKPLACES AND TIME FOR THE CORE TASK

**Recommendation 9: Management must be prioritised, and management quality must be strengthened**

**Recommendation 10: Get more to work more hours**

**Recommendation 11: Out of hours work must be thinned out and distributed among more persons**

**Recommendation 12: Jobs and career paths should be rooted in patient- and citizen-centred work**

**Recommendation 13: Realise the potential arising from late retirement**

**Recommendation 14: Competences from abroad must be utilised more efficiently through strengthened attachment**

**Recommendation 15: More and better introductions for new graduates**

## RIGHT COMPETENCES AND PROFESSIONAL FLEXIBILITY

**Recommendation 16: Ensure increased coherence and more flexibility across healthcare training programmes**

**Recommendation 17: Reform retraining and further training to target career paths towards practice**

**Recommendation 18: Remove professional silos, more should contribute**

**Recommendation 19: The connection between training and job must be strengthened to avoid a practice and responsibility shock**

**Recommendation 20: Ensure more strategic and long-term management of the offer of healthcare training programmes**

A resilient healthcare system needs time for each patient and citizen. It requires sufficient and competent staff to match the extent and number of tasks. The Commission uses that basis to focus on a number of initiatives to increase jobs on offer and to support better utilisation of competences while ensuring a reduction of unnecessary activities and smarter task solving through, i.a., better use of technology.

The broadness of the Commission's recommendations reflects both the seriousness of the challenges faced by healthcare and elder care and the complexity of the necessary initiatives. The Commission finds that initiatives are necessary in all areas and that the initiatives are able to supplement and strengthen each other. One initiative will not be the decisive factor on its own. It takes more.

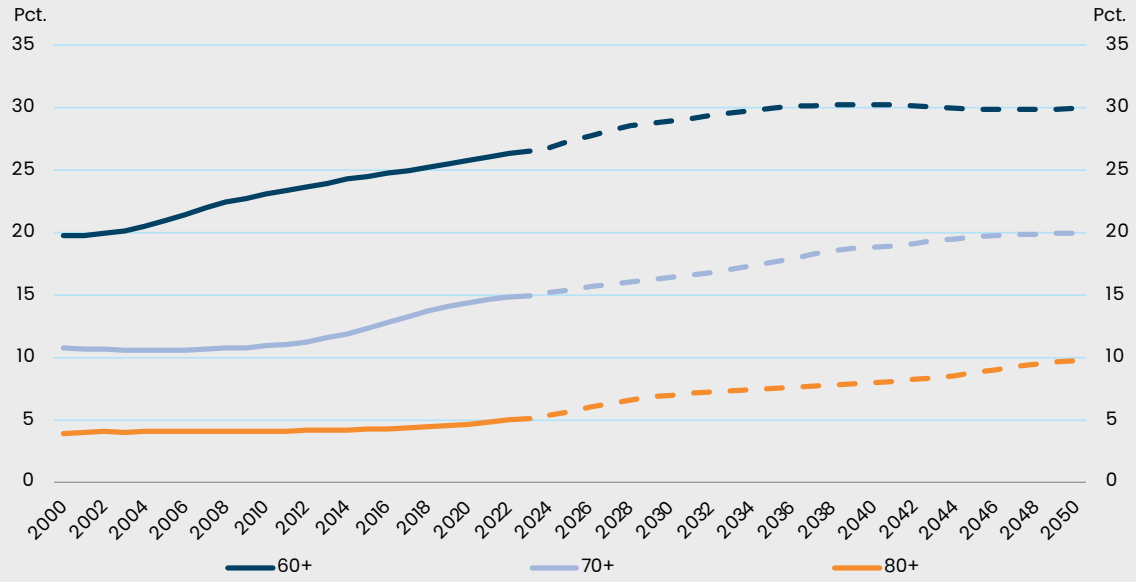
The Commission for resilience in the healthcare system was established by the then government in August 2022 in continuation of the political agreement of 20 May 2022 on a healthcare reform. The Commission was charged with the task of providing recommendations for ways to ensure more staff with more time for the core task and recommendations for smarter task solving through systems and technologies to reduce bureaucracy and give more time and space to perform the core task.

# STATUS

## THE NEED FOR HEALTHCARE SERVICES WILL INCREASE IN THE FUTURE

Healthcare and elder care face significant challenges, especially in the municipal area. The proportion of elderly people will increase, there will be more patients with chronic diseases and multiple diseases, the need for treatment and care will increase, and the complexity of the tasks will grow. Up until 2050, the number of citizens over the age of 80 is expected to increase by 310,000. That proportion is twice as big as today, *see figure 1*. This age group takes up many resources for treatment and care in their own homes, at rest homes and in the healthcare system.

**Figure 1 - Development in older age groups, 2000-2050**




Note: The dashed lines indicate Statistics Denmark's population projection. Stated in the main report as figure 1.
Source: Statistics Denmark, StatBank Denmark, tables BEFOLK1 and FRDK123.

Quality development in the healthcare system the past decades has meant that more diseases can be treated more effectively while a healthier lifestyle, improved working environment, accident prevention etc. mean that we live healthier and longer. The demographic challenge is therefore partially the result of success in the healthcare system.

## HEALTHCARE AND ELDER CARE ABSORB AN INCREASING SHARE OF SOCIETY'S RESOURCES

For the past decades, healthcare and elder care have spent an increasing share of society's resources, *see figure 2.a*, and healthcare and elder care currently make up a larger proportion of total employment than previously. Approx. 9 per cent of all people in employment are employed in the healthcare system, at a rest home or at institutions for persons with mental illnesses, disabilities etc. In 1980, that number was a little less than 7 per cent, *see figure 2.b*. That corresponds to an increase of approx. 30 per cent. The development is the result of both the demographic development and the fact that quality in the healthcare system has increased for a number of years and that the areas have been highly prioritised politically.

**Figure 2.a - Healthcare and elder care as a proportion of the gross value added (GVA)**

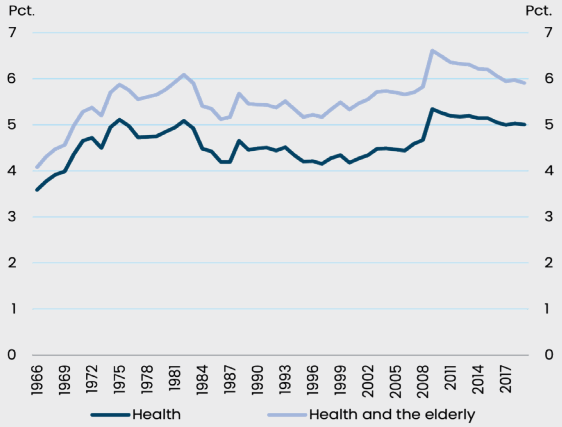
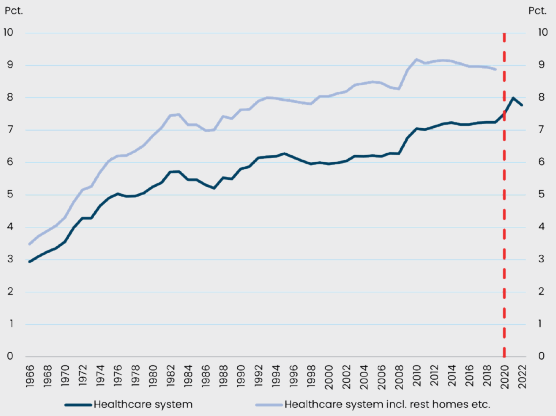



**Figure 2.b - The proportion of total employment in the public healthcare system and in rest homes etc., 1966-2022**




Note: Figure 2.a: The figure is based on the national accounts divided into 117 trades where healthcare and elder care have been delimited to 860,010 Hospitals, 860,020 Doctors, dentists etc. and 870,000 Rest homes etc. The category "rest homes" covers stays at institutions with nursing care, stays at institutions for people with mental disabilities, mentally ill persons and drug addicts as well as stays at institutions for the elderly and people with disabilities. In the statement, parts of the elder care that concern care in private homes (not assisted living facilities with integrated home help schemes) have not been separated from expenditure for institutions for children and have therefore been left out. Stated in the main report as figure 11.a.

Figure 2.b: The red, dashed line indicates the beginning of COVID-19. Healthcare system including rest homes etc. can only be calculated until 2019 as table NABB117 only contains data until 2019. Stated in the main report as figure 13.

Source: Figure 2.a: Statistics Denmark, StatBank Denmark, NABP117, own calculations.

Figure 2.b: Statistics Denmark, StatBank Denmark tables NABB69 and NABB117, own calculations.

At the same time, digitalisation and use of technology have increased, and work procedures have become more efficient. In recent years, the average inpatient stay has decreased by 12 per cent. This may be an indication of a healthcare system that has become more efficient in the period and has transitioned to outpatient treatment. At the same time, the annual number of contacts per full-time employee at public hospitals has increased by 21 per cent from 2009 to 2018. In light of the increases in production value, this may indicate that each employee has become more productive in that period. However, the transition to outpatient treatment has also meant a changed content in the tasks performed by the staff.

Recent years have indicated a drop in productivity in the specialised healthcare system with fewer operations, outpatient contacts and number of admissions. Recent years' development should be seen in the light of changed tasks and activities during COVID-19 and the dispute in the nurse field.

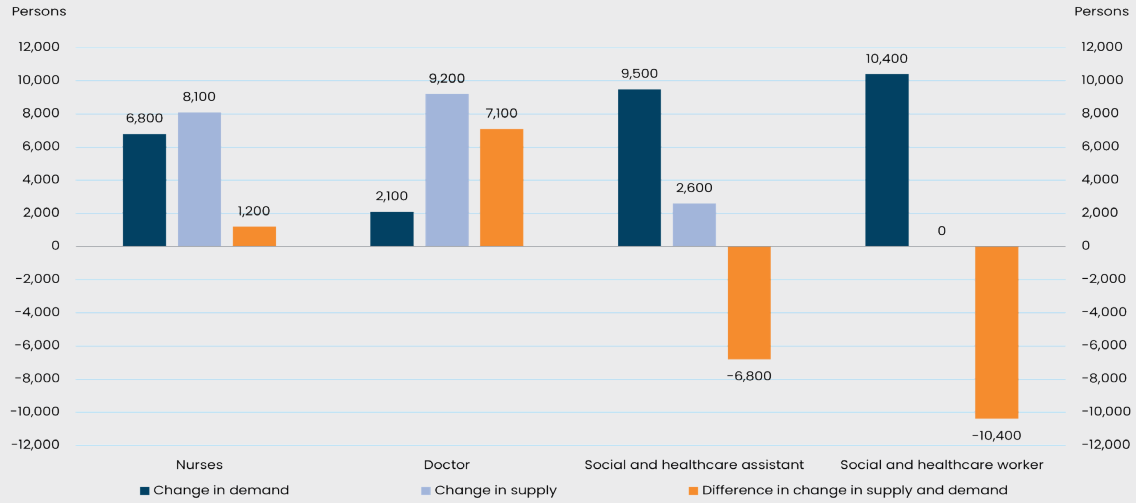
## THE FUTURE EMPLOYMENT CATCHMENT AREA DOES NOT KEEP UP WITH THE NEED

Challenges within recruitment have increased the past couple of years but seem to diminish a little for the largest staff groups in 2023. It may become difficult in the future to increase recruitment to healthcare and elder care to the same extent as previously as the part of the population engaged in active employment does not increase in line with the oldest age group. The gradual increase in the state pension age may be a partial counteraction, but the need for staff resources for citizen- and patient-centred tasks is anticipated to grow even faster.

The challenges are unequally distributed across the country, and there are significant social and demographic differences in the burden of disease. Social and geographical differences in care and treatment options are therefore at risk of increasing.

Mechanical projections of the need for staff seem to indicate that there will be a future need for a lot more social and healthcare assistants and workers compared to today, the recruitment situation will slightly improve for nurses compared to today while recruiting doctors will be easier, *see figure 3*. The projections are subject to some insecurity as they are, i.a., based on a number of prerequisites including a sustained influx to training programmes, and the current recruitment situation has not been considered, nor the fact that demand for treatment and care can change in the future.

**Figure 3 - Mechanical projections of a change in the supply of and demand for selected welfare employees in 2030, measured compared to 2019**



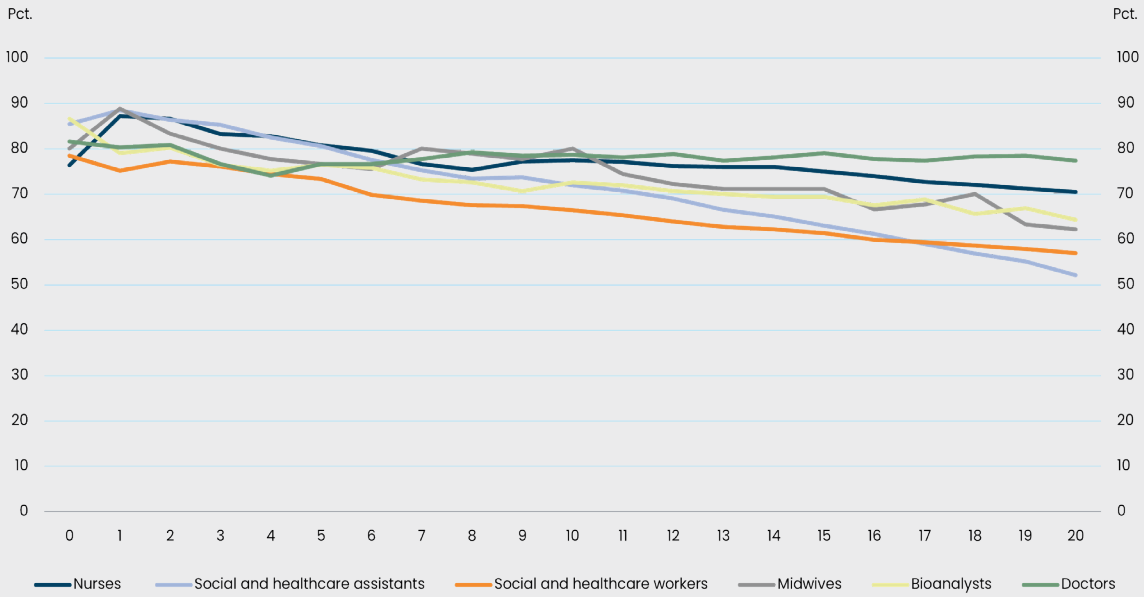

Note: The projections cannot be interpreted as forecasts but merely mechanical projections that are based on current behaviour, service level, staff composition and a number of assumptions. The future development involves a large degree of insecurity and will depend on a number of factors which have not necessarily been included. The results are stated in number of persons, not full-time equivalents, and there is an assumption of a constant allocation of working hours in the projection years. Stated in the main report as figure 35.

Source: "Økonomisk Analyse: Mekaniske fremskrivninger af udbud og efterspørgsel efter velfærdsmedarbejdere, 2022" (Economic Analysis: Mechanical projections of supply and demand according to welfare employees, 2022) by the Danish Ministry of Finance.

## EMPLOYEES LEAVE HEALTHCARE AND ELDER CARE DURING THEIR WORK LIFE

Employee attachment in healthcare and elder care is challenged. In 2020, a little less than 47,000 persons with a health degree worked outside healthcare and elder care. Many employees who start their work life in healthcare and elder care stop in the years following their degree, *see figure 4.* Wastage is not something new but seems to be growing, particularly in areas with many shifts, acute functions, medical departments and in psychiatry.

**Figure 4 - Proportion of persons with a health degree within healthcare and elder care 20 years after completed training programme**




Note: The figure shows the proportion of persons who completed their training in 2000 and who were either employed in healthcare or elder care or obtain a new health degree each year after their completed training programme. "Healthcare and elder care" covers public and private healthcare and elder care initiatives in regions, municipalities, in the practice sector and in the private sector, *see box A.1 in the appendix.* Stated in the main report as figure 37.

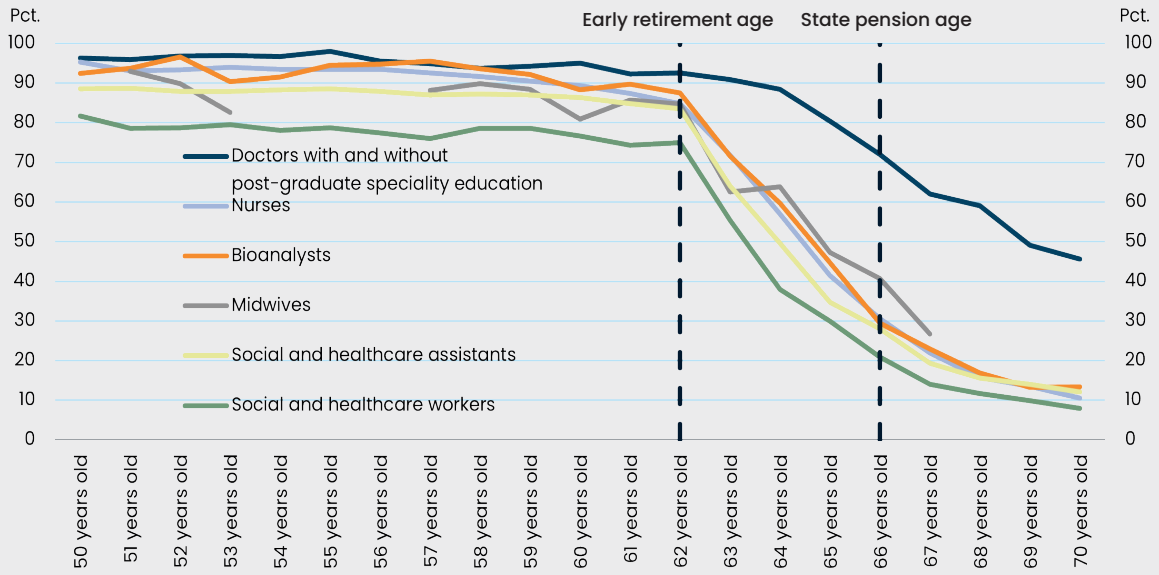
Source: Own calculations based on data from the Danish Mobility Register.

In 2020, 12 per cent of social and healthcare assistants and nurses in employment and 21 per cent of social and healthcare workers in employment were employed outside healthcare and elder care.

## MANY RETIRE EARLY

The extent and length of a clinical work life are unevenly distributed among staff groups. While, e.g., midwives, nurses and social and healthcare workers and assistants seem to retire around the early retirement age, doctors stay at the labour market longer. Nearly half of 70-year old doctors are in employment while that only applies to 8-12 per cent of nurses and social and healthcare workers and assistants at the age of 70, *see figure 5.*

**Figure 5 - Proportion of persons with a health degree in employment by age, 2020**

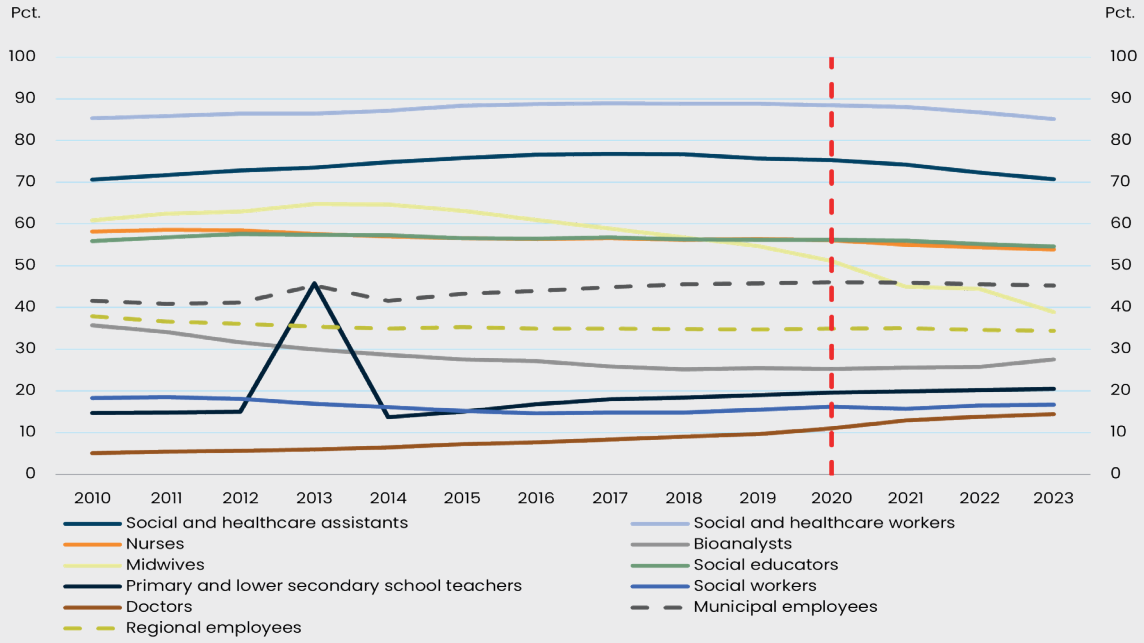



Note: Due to too few observations, the graph for midwives cannot be shown for the ages 53-57 and 67-70. Stated in the main report as figure 41.
Source: The Danish Mobility Register, own calculations.

## MANY WORK PART-TIME, AND OUT OF HOURS WORK IS UNEVENLY DISTRIBUTED

Many employees in healthcare and elder care work part-time, also in comparison with other welfare areas. 85 per cent of social and healthcare workers work part-time while 71 per cent of social and healthcare assistants and 54 per cent of nurses work part-time, *see figure 6.*

**Figure 6 - Proportion of part-time employees among selected regional and municipal employees**

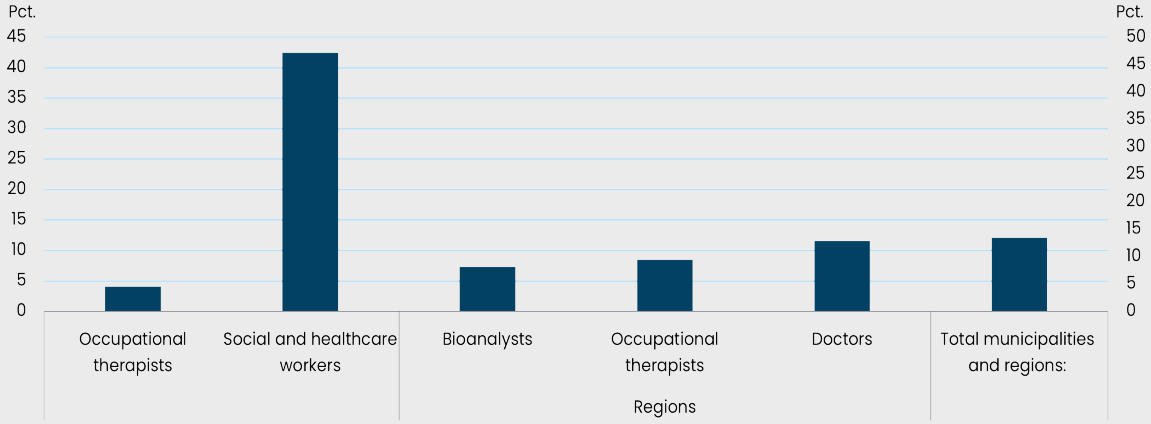



Note: The red, dashed line indicates the beginning of COVID-19. The figure shows the proportion of regional and municipal employees who had average, agreed working hours of less than 37 hours a week divided into selected staff groups in the years 2010 until 2023 and may also include, e.g., persons with flex-jobs and seniors. The statement does not include extra shifts or temporary work. Thus, there may be persons who are included as part-time employees although they may have had average working hours of more than 37 hours a week because of extra shifts or multiple part-time employments. The statement does not include managers. However, that does not apply to doctors where chief physicians, medical chiefs and foundation doctors are included in the statement. The variation in the proportion of part-time primary and lower secondary school teachers in 2013 may be because many teachers were locked out in April due to the dispute between KL - Local Government Denmark and the Danish Union of Teachers. Stated in the main report as figure 42.

Source: Own calculations based on data from Sirka 2023, KRL (the office for regional and municipal wage data). Data were retrieved on 18 July 2023.

Out of hours work is a necessary part of the execution of tasks within the healthcare system and elder care. However, there are significant differences in the volume of out of hours work in various employee groups in the healthcare system. Social and healthcare assistants constitute the staff group within healthcare and elder care that uses the largest share of their working hours on out of hours work as more than one third of their working hours is out of hours work, *see figure 7.*

**Figure 7 - Proportion of working hours in the evening, at night or at weekends divided into selected staff groups, 2021**




Note: The proportion of shifts is shown as the number of hours outside of normal working hours (evening, night and weekend) measured in relation to the total number of actual working hours. This proportion of shifts has been calculated on a monthly basis for each month in the calendar year of 2021. A person who is in employment all year is therefore included with 12 "monthly observations" and therefore weights 12 times more than a person who is only in employment for one month. Stated in the main report as figure 43.

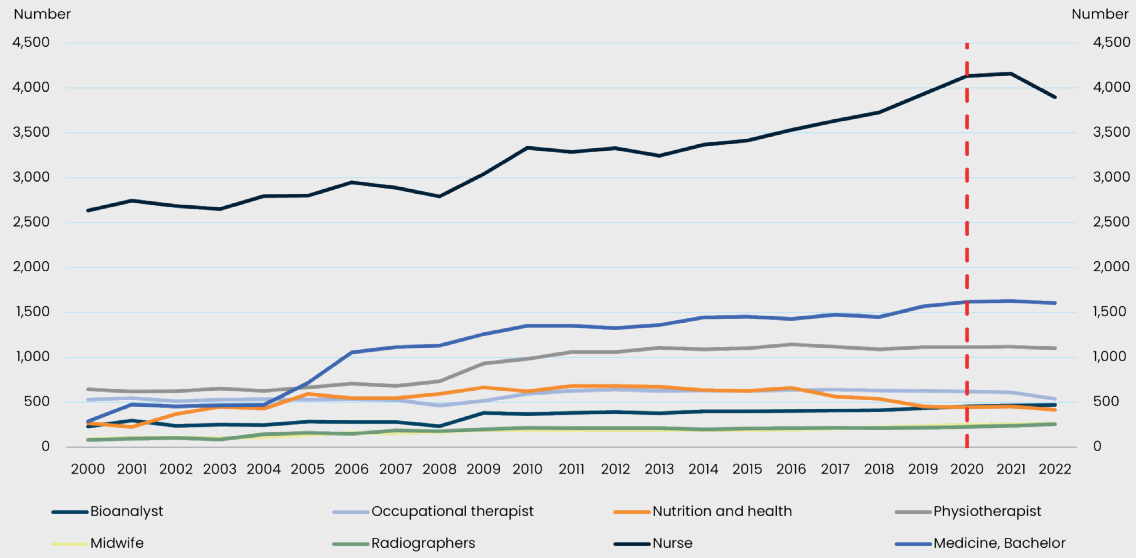
Source: Own calculations based on special extracts from KRL (the office for regional and municipal wage data).

## MORE GRADUATE, BUT THE INFLUX TO MANY TRAINING PROGRAMMES IS DECREASING

For most healthcare training programmes, the number of persons who started the programme was stable up until 2022. Exceptions are the number of students who started a BA in medicine, nursing and physiotherapy, respectively. In 2021, 20 per cent more students started a BA in medicine compared to 2013, and 28 per cent more started the nursing programme.

2022 saw a decline in the influx to the nursing programme and a few other healthcare training programmes, *see figure 8*. At the same time, it seems that fewer people apply for healthcare training programmes as their first priority when choosing their education. The total number of applications still exceeds the number of student places.

**Figure 8 - Influx of healthcare students from 2000 until 2022**




Note: The red, dashed line indicates the beginning of COVID-19. "Influx" is based on the Register of Students by Statistics Denmark and shows the influx of persons to the training programme in the period 1 October the year before until 30 September that year, meaning those who actually enrol in the programme. Stated in the main report as figure 49.

Source: Own presentation based on data from the data warehouse of the Danish Ministry of Higher Education and Science (KOTBasis and ElevBasis).

# KNOWLEDGE

To ensure a sufficient knowledge base, the Commission included three forms of knowledge in its work:

- Thorough knowledge such as Danish and international peer-reviewed research. This type of knowledge is systematic and builds on research based on the overall literature within a field.
- Broad experience and context-oriented knowledge such as reports and analyses. Involving this type of knowledge was necessary as it is directly linked to the healthcare system and elder care.
- Descriptions of cases, existing initiatives, inputs and practice within healthcare and elder care. This type has been included to ensure practical applicability and emphasise good experience.

Thus, knowledge review is not a systematic review of research literature.

The Commission has also initiated a number of external analyses in a number of key areas. The main conclusions from the analyses are summed up below.

### Main conclusions from analyses prepared for the Danish Resilience Commission

#### Main conclusions from an analysis of lack of competences in the healthcare system

Nursing sees the biggest lack of competences. Anticipations are that those competences will also be missing in the future healthcare system. The analysis identifies five development perspectives that can contribute to a resilient healthcare system: 1) Improved and more flexible organisation of the task solution, 2) improved utilisation of technological possibilities, 3) right tasks at the right specialisation level, 4) overtreatment, treatment level and prioritisation and 5) local organisation and incentives.

Source: Implement. 2023. Analysis of lack of competences in the healthcare system.

#### Main conclusions from a literature survey of knowledge on working environment, recruitment and retention

An attractive working environment promotes job satisfaction, makes employees want to stay in their jobs and is attractive for new employees. Important working environment factors that can be strengthened are, e.g., motivation, influence, management quality, constructive team co-operation and a balanced workload.

Source: Implement. 2023. Literature survey – Knowledge on working environment, recruitment and retention of trained and competent staff in the healthcare system.

#### Main conclusions from an analysis of possibilities for retraining and further training in the healthcare system

The retraining and further training supply is comprehensive and extensive, making it difficult for each employee to tell apart each training programme and to form a view of career paths. The analysis indicates a need for more well-arranged, uniform and clear retraining and further training, flexibility in the execution of retraining and further training and an educational system that supports the development of the healthcare system.

Source: VIVE. 2023. Retraining/further training in the healthcare system.

#### Main conclusions from an analysis of improper documentation and treatment in the healthcare system

There is a significant potential in countering improper documentation and treatment, and the analysis describes the various types of improper documentation and treatment. It also describes the primary motives behind improper documentation and treatment being implemented in various ways

and requiring various initiatives in municipalities, general practice and at hospitals, respectively. The analysis concludes that the complexity of the motives means that there is a need for multi-pronged initiatives which require both a local focus and long-term, structural initiatives. The analysis points to a number of focus areas and particularly emphasises the following initiatives. 1) Integration of bodies of laws and a break with the organisation of sections in acts in the municipal nursing care and elder care, 2) improved possibilities of gate-keeping in general practice and 3) support of a systematic "pause culture" at hospitals.

Source: VIVE. 2023. Improper documentation and treatment in the healthcare system – Analysis of concepts, motives and possible focus areas.

**Main conclusions from workshop on the implementation of technology and digital solutions in the healthcare system**

There are a number of barriers preventing the implementation and scaling of labour-saving technological solutions and the fulfilment of the full potential. More mutual decisions, reuse of good solutions and a clearer division of labour defining which tasks to solve a national level and which tasks to solve at local level, for example, are necessary. Implementation of labour-saving technologies and digital solutions are crucial but difficult and must be supported to a higher degree. At the same time, a number of factors hinder implementation and dissemination. These are, e.g., restricting regulatory frameworks and ambiguity in legislation. At the same time, uncertainty may arise concerning the consequences that new digital and technological solutions will have on the responsibility that is placed on health professionals under the Danish Health Act (sundhedsloven).

Source: PWC. 2023. Recap of workshop arranged by the Danish Resilience Commission on 24 April 2023.

The review indicates that focusing on the core task and prioritising what healthcare and elder care should be able to deliver in the future are crucial, for example by cutting overtreatment and improper documentation away. Time for the core task is also of importance to employees' motivation and attachment. If employees face tasks for which they do not have the time or competences to perform, job satisfaction may be affected. Part of the drop-out rate at some healthcare training programmes is because students cannot see themselves in the subsequent job. All in all, the analyses indicate that it is necessary to implement various types of instruments to make healthcare and elder care resilient.

# CHALLENGES AND POSSIBILITIES

## A PARADOX

The pressure within the healthcare system and elder care threatens our welfare society. The number of the elderly in Denmark is increasing as is the number of people with chronic diseases, multiple diseases and loss of functioning which increases the future need for services within healthcare and elder care. That further increases the pressure and the need for staff, particularly within nursing.

Although retirement reforms may result in a certain balance, the supply of labour will not increase to the same extent as the need for staff resources will grow. Unless we do something.

Staff shortage and recruitment challenges in the particularly challenged parts of healthcare and elder care will increase unless new initiatives are implemented. Geographical and social inequality in offers and services will worsen, and a vicious circle will be created with failing trust to public services within healthcare and elder care, both among citizens and employees.

Paradoxically, the challenges are connected with the success of the healthcare system. Political priorities for the last couple of decades, investments and professional development within healthcare have resulted in a significant quality boost which has resulted in improved survival rates, improved quality of life in the treatment of major, common diseases such as cancer, diabetes, cardiovascular diseases etc. Together with some improvement in public health, this means that the Danish population can expect to live longer.

We will see a larger share of elderly in the population, and that larger share will have diseases and loss of functioning which will increase the pressure on the healthcare system and elder care. At the same time, the technological and professional development within healthcare and elder care and increasing wealth will increase expectations to welfare offers among the population, employees and decision-makers.

However, quality development and increased demand come at a price. Healthcare and elder care absorb a growing share of society's resources and an increasing share of the total workforce.

Hence the paradox. It is obviously both a success and a gain for society as well as for the average citizen who has been given more good years to live. A rising life expectancy increases the need for treatment, nursing and care despite partially healthy ageing. At the same time, new treatment options are constantly being developed which means that more people can be offered treatment - often highly specialised. When we also have strong, statutory rights allowing the population quick diagnosing and treatment, citizens will have high expectations for quality and service in the healthcare system.

With a view to the future, expectations will become more difficult to fulfil, and challenges will grow. Simple growth in recruitment and resource consumption are not sustainable. It takes other, more extensive and structural initiatives to ensure resilience within healthcare and elder care.

## LOW ATTACHMENT AND HIGH PRESSURE OF WORK INTENSIFY EACH OTHER

In the future, the biggest challenges will be in connection with the citizen- and patient-centred nursing tasks. The challenge is divided into two parts as it is not merely a matter of the difficulty of attracting health and nursing staff. It is also a matter of many employees leaving the most stressful tasks or leaving the public sector altogether, either by working reduced hours, retiring early from the job market or by entering other industries and sectors.

Although we increased the intake at most healthcare training programmes, we apparently cannot keep up. There is some indication that several of the health professions are no longer very attractive among young generations.

This may be connected with a high work pressure in some parts of healthcare and elder care, especially in the patient- and citizen-centred parts where staff leaves functions that cover all shifts. This causes a negative spiral where poor attachment and a high degree of work pressure intensify each other.

These challenges are far from unique to Denmark, and the challenges in many of our neighbouring countries are far bigger.

## MORE OF THE SAME IS NOT SUSTAINABLE

Overall, increasing expectations to what healthcare and elder care can deliver, a demographic development with more elderly and more people with multiple diseases and the consequences to the working environment in parts of healthcare and elder care constitute challenges so extensive that it may be described as a crisis. If we do not do something, we risk a future scenario where the public healthcare system and elder care, being the foundation of a strong welfare sector, are at risk of breaking.

Growing social and geographic inequality in services will further worsen the situation, making trust and support to public offers within healthcare and elder care fall apart.

Geographic inequality in health may increase if healthcare professionals are even more concentrated in and around the big cities. Social inequality in health increases because resource-rich citizens and patients who know how to navigate in rules and rights are prioritised before citizens and patients who are less resource-rich but may have bigger needs.

However, merely aiming at spending more resources, including a bigger part of the workforce, attempting to satisfy the need for healthcare services and elder care is not sustainable. Other sectors also need labour, and it will be at the expense of, i.a., other welfare areas, the green transition, global agendas and companies.

Healthcare and elder care should not be given lower priority. However, we do need to ensure a keener, professionally founded prioritisation of the offers that provide the most value for the money in terms of health. We need to perform the tasks in a smarter way so that employees across professions have the most possible time for citizen- and patient-centred tasks, and we need to fulfil the labour-saving potential of new technologies to a higher degree. We need to create more attractive jobs with a higher degree of interdisciplinarity in the task solution, making employees want to work fully and for a long time with citizen- and patient-centred tasks. And we need more quality and flexibility in training programmes at all levels so that employees can have a long and good work life with attractive career paths in the citizen- and patient-centred tasks.

Significant initiatives make it possible to ensure sustainable healthcare and elder care. However, it takes bold decisions and the will to change among citizens, politicians and professionals. A resilient healthcare system requires other decisions and initiatives than previously.

## STRONGER PRIORITISING AND WISER TASK SOLUTION

There is a need for a stronger and broader approach to prioritisation where treatment methods, diagnostic examinations and initiatives are to be compared with the absorption of staff resources and a goal of making most value for the money in terms of health.

For that to succeed, identifying the right balance between universal rights and differentiated initiatives is key where more citizens and patients are to be supported in self-care while less resource-rich citizens and patients will be able to have close contact with the healthcare system.

Labour-saving technology may contribute to relieve healthcare professionals, partly because technology can take over certain tasks, e.g., monitoring tasks, and partly by functioning as a tool for some patients and citizens to be supported in self-care and by contributing to treat-

ment in their own home. In that way, technology can also be a facilitator for more differentiated initiatives based on each citizen's and patient's needs and resources.

This could, for example, mean that some patients can live an ordinary life with a chronic disease without many contacts, especially to the specialised healthcare system. This would also mean that time and capacity are freed up for patients and citizens who need close and continuous follow-up by the healthcare system. In that way, resources in the healthcare system can easier by distributed as needed.

### ATTRACTIVE WORKPLACES AND TIME FOR THE CORE TASK

The Commission has identified initiatives which, in the shorter term, support an improved working environment and improved working conditions. The attachment of staff working in healthcare and elder care can and must be increased so that more people will want to work more hours and retire from the labour market at a later point in time. The healthcare system is an attractive workplace with many development opportunities, but new generations of employees have new requirements and requests for flexibility which the healthcare system traditionally does not meet. Seniors also need working conditions that are adapted to each individual person to a higher degree.

The career paths within healthcare and elder care need more width and diversity so that not only the ones with the longest training programmes will be given more training and promotions. Competence development must also be possible for more groups of employees to motivate and strengthen a sense of attachment to the challenging tasks in the citizen- and patient-centred work.

Through better management, more flexibility in the work organisation and task solution and demarcations that are less locked, we can achieve a lot in making healthcare and elder care resilient. We need to improve workplaces so that work is organised in a more flexible way and based on the individual person's requests and needs while the staff has time for their patients and citizens when patients and citizens need it.

### RIGHT COMPETENCES AND PROFESSIONAL FLEXIBILITY

Improved utilisation of competences starts already at the recruitment for and organisation of healthcare training programmes. The Commission's analyses show that it is crucial for career paths in the healthcare system to be clear and attractive to young persons making decisions concerning their training. The Commission finds that career paths must be rooted in the patient- and citizen-centred work, and it must be ensured that career paths such as management, teaching and research do not take each healthcare professional away from that.

The educational paths must also be flexible so that it is, for example, possible to switch directions between the training programmes without having to start over in a programme, and there must be an improved link between teaching and practice as well as job training. In the medium term, this will also contribute to increase recruitment and reduce drop-out rates while ensuring better utilisation of competences and enabling healthcare professionals to work more flexibly and stand in for each other. Therefore there is a need for creating a more flexible training system across healthcare training programmes.

# RECOMMENDATIONS

The Commission has set out 20 recommendations that are based on six premises. The recommendations have been divided into three overall approaches to ensure that the future healthcare and elder care are resilient and can offer citizens and patients necessary and sufficient treatment and care.

- We must use increased prioritising and more efficient task solutions to ensure that we solve the correct tasks and that we do so in new ways to reduce the need for labour.
- We must strengthen attachment and make workplaces more attractive to ensure that more employees want a long and full work life working with patient- and citizen-centred work.
- We must make the educational system much more flexible and strengthen the link between training and work to make sure that we have the right competences that correspond to the needs of the healthcare system.

The three approaches complement and strengthen each other and work together to ensure a resilient healthcare system that allows time for each patient and citizen and has sufficient and competent staff, corresponding to the extent and number of tasks.

## PREMISES FOR THE COMMISSION'S RECOMMENDATIONS RECOMMENDATIONS

Overall, the Commission is of the opinion that a thorough, systematic and structural change of the framework and administration of specialist initiatives must occur within healthcare and elder care to make those areas resilient and sustainable in the long term. More of the same is not a lasting solution. A new direction is necessary. The number of tasks must be reduced, and the performance of the tasks must be smarter and more flexible. The staff must continue to find a long and full work life with the citizen- and patient-centred core task that exist within healthcare and elder care in Denmark attractive while we ensure the proper competences for future needs.

A successful turn of development requires fundamental changes in the performance of inter-sectoral tasks. Transitioning into a more centred healthcare system with increased focus on prevention, using initiatives that reduce geographic and social inequality, is necessary to obtain a resilient healthcare system.

The Danish Resilience Commission has identified six fundamental premises for the 20 recommendations to ensure resilience and sustainability within healthcare and elder care in Denmark:

- **We should not occupy a disproportionate share of the workforce.** Put together, healthcare and elder care, public as well as private, should not occupy a disproportionate share of society's resources, including of the total workforce. Doing so would weaken the sustainability of the welfare society. A transformation of the healthcare and elder care is therefore necessary through stronger prioritising that is rooted in professional expertise and through a smarter task solution, less unnecessary activity and better use of technology to free up time for citizen- and patient-centred core tasks.
- **Prioritisation must be keener.** Public services within healthcare and elder care must be adapted and differentiated, or they will not be sustainable in the long term. The quality of the healthcare system must be satisfactory and compare with the use of resources. However, it is not necessary for all services to be provided by specialists.

And not everyone needs the same. Many resource-rich persons can manage with less resource-demanding solutions and are supported in self-care by means of technology to free up resources to those who need more. Prioritisation and a transition of the healthcare system should be based on a broad social debate with transparent principles and a strong, professional basis. This requires clear expectations to what the public healthcare system should offer and how services should be provided.

- **We must ensure attractive workplaces, and tasks should be flexibly solved with the right competences.** There should be more time for the citizen- and patient-centred core task for which the staff is passionate. If the working environment is challenged, there must be a much higher level of ambition for initiatives that strengthen attachment to the workplace and the working environment. More people should be part of out of hours work, professional silos must be removed, and the tasks must be solved in a flexible manner. Training programmes must be made more flexible with better possibilities to switch directions and solve tasks across the programmes and with more and better career paths, making a long and full work life with citizen- and patient-centred work attractive. Healthcare and elder care must be attractive for young people, and they must be introduced to it early on, for example through after-school jobs and internships.
- **We need to give greater priority to growth, innovation and quality in the primary healthcare system.** A bigger share of the tasks in the overall work, particularly for the elderly and for people with multiple diseases, must be handled in the primary healthcare system in the future, involving more professional groups and better utilising welfare technology and digital solutions. The medical practice sector, municipal initiatives and new, cross-sectorial co-operation close to the citizens must handle treatment to a higher degree so that the specialised healthcare system, particularly hospitals, can focus on taking care of people with more critical illnesses and the most complicated cases.
- **We need higher ambitions for the structural prevention.** We see that particularly the occurrence of chronic diseases, multiple diseases and functional limitations, particularly among the elderly, will add pressure on future healthcare and elder care. We know that a major part of the disease burden can be prevented. Sustainability in healthcare and elder care is therefore also about becoming more ambitious within structural precautionary measures that we know work, including preventing children and young persons from taking up smoking, breaking the unhealthy alcohol culture in Denmark, countering physical inactivity and unhealthy dietary habits and increasing mental health. Cost-effective precautionary measures and early initiatives must be prioritised to a much higher degree than today.
- **We need focus on preventing social and geographic inequality from increasing.** There is a growing geographic imbalance across the country in relation to where the elderly and people with multiple diseases live and where the healthcare system is the strongest. Among other things, there is a need to ensure an adequate number of doctors across the entire country, to aim career paths towards citizen- and patient-centred work so that healthcare competences are used where the need is the greatest and to bring, to a higher degree, specialised competences into play across geography, including by means of digital solutions and the development of treatment options closer to home.

# STRONGER PRIORITISATION AND WISER TASK SOLUTION

## Recommendation 1: National Priority Council should free up resources for the core task

Demographic development and development and implementation of new treatment options mean a significantly increased pressure on the healthcare system. At the same time, we have thorough knowledge on the motives that contribute to improper treatment being initiated. These are, i.a., higher expectations and an increased demand. Prioritisation may counter the pressure by identifying tasks which either are not to be solved or which must be solved in a different way, thus freeing up resources for the core task and investments in a resilient healthcare system. Norway, for example, has a strong tradition for professional prioritisation based on politically laid down criteria. In Denmark, the Danish Health Technology Council and the Danish Medicines Council are examples of priority bodies.

In its government platform, the government announced that it will establish a priority council. The Commission is of the opinion that a priority council with the right framework and ambitions can be the cornerstone for a sustainable and resilient healthcare system.

The Commission therefore recommends:

**Recommendation 1: National Priority Council should free up resources for the core task**

**The national priority council should promote cross-disciplinary, transparent and fair prioritisation.** The council should promote systematic priorities for what the healthcare system should offer within and across the healthcare system sectors, thus support using the healthcare system's resources where they benefit society the most. That is particularly the case in relation to staff resources.

Among other things, this means that the priority council:

1. should focus on the healthcare system's task solution across sectors
2. should involve patients' perspectives in its work, e.g., through patients associations
3. should be mandated to assess both new and existing treatment options with great potential for resource freeing
4. should express recommendations for, e.g., enhanced pre-admission assessments, a reduction of the treatment level, increased self-payment or contributions rather than free treatment
5. may express recommendations on investments in specific technologies or initiatives to contribute to making healthcare and elder care resilient.

**The council must work with a set objective to free up resources to make the healthcare system more resilient, e.g., through investing in new, labour-saving technology or prevention.** This may be, for example, by identifying unnecessary, expensive forms of treatment, recommending a changed handling of jobs or rationalising the use of outpatient check-ups at hospitals. If 1 per cent of the public expenditure for health can be freed up, it will correspond to approx. DKK 2.2b which can be used in other parts of healthcare and elder care. If the current activity in healthcare and elder care can be reduced by 1 per cent, there is potential to free up 3,200 full-time equivalents.

**The council must base its work on politically adopted basic principles for prioritisation.** The basic principles must state the criteria according to which healthcare initiatives must be given greater or lower priority. The principles must ensure political mandate to the general prioritisation and management while ensuring an arm's length to the specific recommendations based on professional opinions.

**The council must contribute to ensuring that the use of staff and resources is systematically incorporated into guidelines.** The preparation of, i.a., clinical guidelines must follow the same politically adopted principles concerning priorities and must assess cost effectiveness, use of staff and resources and organisational and derived consequences.

The Commission is of the opinion that a future priority council with a purpose and an ambition as described below will have a significant impact on a resilient healthcare system in the long term. Implementation means that new legislation must be adopted. Thus, implementation and the effect have a longer time frame.

## Recommendation 2: Improper treatment to be reduced through stronger prioritising rooted in professional expertise

The assessment is that up to one fifth of healthcare expenditure could be used better because of, e.g., overdiagnosis, treatment with a low effect or at a specialisation level too high. At the same time, OECD estimated in 2017 that one out of ten patients suffers harm during treatment because of mistakes that could have been prevented and that more than 10 per cent of hospital expenditure in OECD countries is used on handling mistakes.

We have thorough knowledge that motives behind improper treatment exist at various levels. The demand for healthcare services is driven by, i.a., which treatment options and diagnostic examinations are available. Furthermore, there are regulatory frameworks such as professional guidelines, treatment guidelines and instructions setting a high standard for the level of treatment without adequately considering the use of resources and inexpedient organisation across sectors among the motives that are a factor in improper treatment. Experience also shows that professional guidelines for pre-admission assessments emphasising that people with the biggest need may receive treatment and that initiatives which strengthen work outside of hospitals may contribute to reducing improper treatment and that tasks are solved at a lower specialisation level.

The Commission therefore recommends:

**Recommendation 2: Improper treatment to be reduced through stronger prioritising rooted in professional expertise**

**General medicine offers outside of hospitals must manage more treatment.** Treatment tasks in a wide sense, including diagnosing and follow-up, must be managed or co-ordinated by general medicine offers outside of hospitals to a higher degree so to avoid any specialised and resource-demanding treatment from being unnecessarily initiated. Regular and known doctors near the patient will continue to be the central point for this initiative, but the general practitioner's role should be rethought. This may be done, i.a., by strengthening the regular doctor's responsibility for the patient's combined course of treatment and making it more accessible throughout the country and by involving more professional groups in the work. The centred general medicine services should be supported in being able to solve more treatment tasks such as diagnostic ultrasound or follow-up after cancer treatment to avoid referrals from medical specialists or hospitals. The possibility of getting specialist advice from a medical specialist or from the hospital should be strengthened so that the patient will avoid further referrals. For fragile citizens at, e.g., rest homes or in municipal acute functions, good access to help from doctors or nurses should be ensured to avoid admissions.

**More systematic, professional prioritisation of resource-demanding treatments with limited health professional effect or potential adverse effects.** It may be, e.g., by selecting areas where professional diagnosing guidelines are introduced based on health professional opinions of benefits and harm and assessments of the use of resources in terms of finances and staff for the given treatment compared to other treatments. Research in professional prioritisation must be strengthened, and managerial responsibility for prioritisation and diagnosing must be made clear. Enhanced pre-admission assessment should free up financial and staff resources to manage treatments with an improved health effect in relation to costs.

**Improved preventive and early initiatives and pre-admission assessment in the primary healthcare system.** Admissions and illnesses requiring treatment must, to a higher degree, be prevented through initiatives in the primary healthcare system. In combination with keener pre-admission assessments, this should reduce the number of unnecessary inquiries, admissions and visits to the doctor. This could be, e.g., in case of an acute worsening of the disease or functional level of citizens at rest homes where the municipal emergency function of the municipality can attend to the citizen before referring to the specialised healthcare system. It could also be by distributing and using pre-hospital assessment units or emergency vehicles with a health professional that can be sent out to citizens in cases where the operation control centre needs further qualification of whether the patient should be admitted or can be treated at the site of the injury or in his or her own home. This may result in changed tasks where resources are freed up in the ambulance services and at hospitals, the citizen will avoid necessary admissions, and overall treatment is managed at a more efficient care and cost level.

The Commission is of the opinion that a stronger, professional prioritisation in the long term will be important to a sustainable and resilient healthcare system. The effect depends on, e.g., the extent of areas where guidelines for pre-admission assessments are introduced. The selection of areas can be managed by a future priority council. The development of guidelines for pre-admission assessments involves thorough, professional work, and the implementation therefore has a long time frame. The Commission notes that the Danish Commission on the Structure of the Healthcare System should assess specific solutions to relieve hospitals, including organising and managing general practice.

## Recommendation 3: Prioritising should be strengthened through common decision-making, differentiated offers and increased self-care

Improper treatment may occur at several levels, including in the encounter between the health professional and the individual patient and citizen. Thorough knowledge shows that, i.a., defensive behaviour among health professionals and the fear of missing illnesses are some of the forces that drive improper treatment. Initiatives to counter improper treatment are, i.a., common decision-making, more continuity in the relation between the practitioner and the patient and more focus on patient preferences and involvement. A high proportion of the total health expenditure is used on patients at the end of life. At the same time, patient treatment is often standardised and regulated based on knowledge about the best treatment of various diseases with no differentiation according to individual needs and resources. Initiatives for people in their last year of their life make up approx. 11 per cent of the overall health expenditure. At the same time, there is thorough knowledge indicating that the proper level of treatment is important to the patient's quality of life and that, e.g., an expedited palliative effort rather than continued treatment may increase the quality of life and treatment and that it is linked to reduced costs.

There is much experience establishing that the patient should be recognised as a resource and that initiatives should be differentiated so that they are adjusted to the individual person's needs. The approach means that patients' and citizens' own resources are brought into play, and it will be of fundamental importance to the organisation and task solution in the healthcare system. The Commission is of the opinion that if more citizens and patients are supported in self-care and can manage part of their illness on their own, it will free up resources for citizens who need closer contact with the healthcare system. Thus, differentiated initiatives contribute to more equality in health.

The Commission therefore recommends:

**Recommendation 3: Prioritising should be strengthened through common decision-making, differentiated offers and increased self-care**

**The patient and the citizen should systematically be involved in decisions concerning their treatment.** This will ensure that more patients and citizens will, to a higher degree, receive the treatment they want and will benefit from, that resources and distributed more appropriately and that the treatment intensity will be reduced so that less intrusive

treatments will be selected more often. The approach is already used in several areas within healthcare and elder care but should be spread and systematised.

**Healthcare professionals need better competences and tools to support common decision-making with the patient.** This should reduce the risk of over- and undertreatment as patients often want less intense and intrusive treatment when being involved in decisions. That applies to, i.a., difficult conversations about treatment at the end of life.

**Therapeutic treatment must be ended, and palliative work must be started in due time at the end of life.** In addition to the involvement of patients and relatives, this also means that professional guidelines etc. must, to a higher degree, hold an individual approach to treatment, including stopping treatment and medication. This should ensure that patients will not continue to receive improper medicine and treatment, and it should, e.g., reduce the number of medicine-related readmissions and ensure that any palliative initiative is started on time.

**More people should be supported in self-care, and the initiatives should be differentiated and controlled by demand.** To a far higher degree, citizens who are capable should be supported in taking care of their health and disease to free up resources for those who need more support. This means more differentiation in treatment initiatives and finding the right balance between individualised and standardised courses of treatment. This could be through adapted solutions and the use of digital solutions so that citizens can, e.g., monitor and manage their disease on their own and through open and digital access to health professionals at the right specialisation level. This will replace, e.g., regular check-ups at outpatient clinics.

**Initiatives that support the citizen in self-care should formally be viewed as the lowest effective cost and care level.** This will not only relieve the healthcare system but will also make it easier for many citizens to live a normal with, for example, a chronic disease where admissions and more serious courses are prevented to a higher degree. This will free up resources, e.g., for citizens who need closer and more frequent contact with the healthcare system to receive services adapted to their needs.

The Commission is of the opinion that common decision-making, differentiated offers and increased self-care have great potential in the medium term in relation to reducing both over- and undertreatment if the approach is distributed systematically. That particularly applies in relation to treatment at the end of the patient's life. Implementation requires professional rooting and may be on an ongoing basis.

## Recommendation 4: Improper documentation must be reduced

Improper documentation takes resources in healthcare and elder care and demotivates the staff. Thorough knowledge indicates that the motives behind improper documentation are complex and arise at many levels, both in the clinical meeting, in relation to the health professional's interests and competences, due to the work organisation within healthcare and elder care and in the political and regulatory framework conditions. Multi-pronged and long-term initiatives at a structural, organisational and individual level are necessary to counter improper documentation.

The Commission therefore recommends:

**Recommendation 4: Improper documentation must be reduced**

**A requirement for all documentation that does not add value, thus not being defensible, to be removed.** Current information and documentation requirements and documentation practice should be reviewed for the purpose of reducing documentation with no value. This means a thorough removal of and prioritisation in guidelines, directions and data recording and focus on ending quality measuring, directions, checklists etc. which do not make a difference in day-to-day work. The removal and prioritisation should be across levels: Municipal, regional and national. At the national level, it could be, i.a., through legislation. In the regions, municipalities and at each institution, the reason for documentation

should be established and made clear. Citizens' possibilities to document their own data should be incorporated in the work.

**The dialogue on documentation requirements should be strengthened among professionals, management, supervision and citizens.** A more uniform understanding of documentation requirements among professionals, management, supervision and citizens across all sectors, professional groups and functions must be made based on mutual task solutions in relation to patients and citizens. The purpose must be to minimise defensive medicine and behaviour among health professions, including doctors, resulting in needless and unnecessary diagnostics and treatment. Training and a possibility for support for employees should therefore be ensured in relation to the use of digital solutions and knowledge on documentation requirements. Citizens should be involved a lot more in relation to including their own information and critically assess the extent of documentation.

**Supervision should be made simpler, particularly in the municipal area.** The outcome should be no unnecessary bureaucracy with various and partially overlapping supervision which is, e.g., the case in municipalities. The simplification could be, e.g. by reducing the number of supervisory authorities and by ensuring increased co-ordination between supervisory authorities, e.g., in relation to the frequency of supervision. This should reduce double documentation where professionals are required to document several places or defensively document how they meet separate or partially overlapping requirements and directions.

The Commission is of the opinion that a reduction of improper documentation has great potential to free up resources for the core task in the medium term. Implementation may be on an ongoing basis but will require a change in legislation in terms of changes to the current supervision scheme. Full implementation and effect require professional rooting across and in regions and municipalities, thus a longer time frame.

## Recommendation 5: Competences should be used across geography and sectors

Challenges in recruiting sufficient employees in healthcare and elder care vary across professional groups and geography. There also is an imbalance in the medical profession in parts of the country and in certain specialities. Conversely, there is a large influx of applicants to highly specialised functions and university hospitals. This does not match the future need for increased focus on the elderly and patients with multiple diseases, mental health disorders etc.

As there will also be a growing share of the elderly in the rural and remote municipalities in the future, some parts of the country will see a growing double challenge with recruitment difficulties and a population with a relatively high pressure on the healthcare system. There are a number of good examples to illustrate how staff resources can be utilised better across geography. The Commission is of the opinion that initiatives that spread and distribute competences in the healthcare system, geographically and across sectors, should be expanded to make sure that scarce competences and staff resources do not accumulate in the big cities to an undesirable extent.

The Commission therefore recommends:

**Recommendation 5: Competences should be used across geography and sectors**

**Attractive combination jobs must be developed where each employee can have more places of employment.** Combination jobs can be horizontally between units, e.g., a medical specialist or other specialised competences that work in two regions as per agreement. That could be across sectors, e.g., from a hospital to a municipal service, and it could be across clinical and non-clinical tasks, e.g., between hospitals and training or research institutions. Making sure that the jobs are attractive to employees is key, for example in the form of good development opportunities, attachment to both workplaces, clear reference to managers etc.

**There must be binding co-operation on the combined staff resources in cases where the work does not require physical presence.** In recent years, work has been done within radiology to make competences available across geography and organisational units using digital solutions. Experience with staffing or task solutions with no permanent address, for example telemedical monitoring centres, must be expanded to other areas across sectors and possibly across national borders. Units can, e.g., be part of binding co-operation agreements, and common emergency lines can be established.

**New technology and the digital infrastructure must support diagnostics.** Co-operation across units and geography on analyses of test results, image reading etc. requires modern, digital infrastructure and distribution of digital solutions making it possible for relevant staff to access analyses and images irrespective of their place of employment or geographical location. At the same time, there is a need for increased distribution of AI technologies (artificial intelligence) for decision support within diagnostics.

**Medical competences should be more evenly distributed across specialities and geography.** The follow-up and implementation of the Danish Health Authority's review of the medical further education must ensure increased focus on medical competences and career paths to ensure broader focus on generalist competences, multiple diseases, mental health disorders etc. and increased focus on career paths that do not lead away from the clinical work.

The Commission is of the opinion that combination jobs and binding co-operation on staff resources with digital support have long-term potential in relation to making sure that the competences will reach all parts of the country and will benefit patients and citizens. The effect of the initiatives depend on the distribution and willingness in the sector to share staff resources and the willingness among healthcare professionals to be part of combination jobs. The terms for being part of combination jobs must be made specific by the social partners. Implementation must be in regions and municipalities and can be on an ongoing basis.

## Recommendation 6: Introduce a common principle of "digital and technological first"

Broad experience shows that distributing and implementing technology to free up time for the core task is too slow although there is much innovation in the Danish healthcare system. Among other things, this is because of uncertainty concerning which areas to boost at national and local levels, respectively, and a missing framework for implementation of digital solutions across the healthcare system. That constitutes structural barriers for the implementation of technology that frees up time for the core task. Among other things, this means that common, national solutions are given lower priority, and resources are wasted on developing the same solutions across regions and municipalities. To fulfil the labour-saving potential of technology, there is a need for mutual prioritisation and direction for the development of the digital and resource-saving transformation. The Commission is of the opinion that there is a need for a clear, common direction for the use of technology.

The Commission therefore recommends:

**Recommendation 6: Introduce a common principle of "digital and technological first"**

**A basic principle for "digital and technological first" should be adopted politically.** Digital solutions and new technology, including welfare technology, with a proven effect in relation to being able to free up time and resources should be the first choice in solving tasks in the healthcare system. The dissemination of the principle should especially be in relation to tasks that are labour-intensive, can be standardised and where there is no need for physical patient contact. Thus, "digital and technological first" supports the LEON principle.

**Common public agreements must establish national requirements concerning which tasks to be included in a "digital and technological first" principle.** National requirements

should ensure a common direction for which tasks to be solved throughout the healthcare system using digital solutions and new technology. The requirements must give regions and municipalities a binding implementation responsibility with the possibility of local decisions concerning, e.g., the specific choice of product. National requirements must be based on task areas with the biggest volume and most maturity. They could be, e.g., digital video consultations and digital home monitoring.

**Common, intersectorial goals must be agreed for the digital and technological development within the healthcare system and elder care.** All actors, including state, regions, municipalities and general practice must work in a common direction towards a digital transition to free up more time among the staff for the core task. This could be, e.g., goals for one third of all outpatient activity to be converted to digital contact.

**Technology and digital solutions should be an integral part of guidelines and directions, locally and nationally.** It must support implementation of the principle on "digital and technological first" and contribute to the weighting of assessments made by, e.g., AI, being equal to assessments made by the staff. This should contribute to healthcare professions seeing the use of technology and digital solutions as recommended in terms of healthcare and professionally legitimate.

The Commission is of the opinion that the fulfilment of the labour-saving potential of technology is crucial to a sustainable healthcare system in the short and long term. Implementation requires an obligation across state, regions and municipalities as well as professional rooting in regions and municipalities. Implementation can be on an ongoing basis. Full implementation has a long time frame. The Commission notes that the Danish Commission on the Structure of the Healthcare System should assess the organisation of digital solutions and IT infrastructure in the healthcare system to support the dissemination of common solutions and smooth exchange of digital information across sectors, including a weighing of benefits and disadvantages from strengthening national co-ordination and co-operation within the area.

## Recommendation 7: Ensure a better framework for the rapid deployment of proven, labour-saving technologies

Labour-saving technologies with a proven effect already exist but have not been implemented. Experience shows that there are a number of structural and organisational barriers for the implementation and dissemination of technologies that free up time for the core task. They are, i.a., missing financial incentives, "reaping-sowing issues", legal barriers and a lack of managerial prioritisation.

The Commission therefore recommends:

**Recommendation 7: Ensure a better framework for the rapid deployment of proven, labour-saving technologies**

**New models for financial structures across sectors must be examined.** Work must be initiated to identify new management models to create balanced incentives across "reaping-sowing barriers" and to promote the development and dissemination of digital solutions and other technologies to make more time for the core task. This may require fundamental innovative thinking in terms of management and co-operation on, i.a., common digital solutions across sectors. There also is a need for including a multi-year investment perspective for the financing of specific initiatives as the gain of new technology typically cannot be redeemed in the short term.

**Legislation should be modernised to support development, application and implementation of data-driven technology throughout the healthcare system.** Modernisation work across state, regions and municipalities must be implemented to consider current EU rules, citizens' privacy protection etc.

**The legal framework for sharing data and knowledge must be strengthened.** When possible, legislation must be updated so that there are no legal barriers for sharing data across the healthcare system, making it possible to share more information across the healthcare system and elder care when professionally relevant. The work must consider current EU rules and the privacy protection of citizens' data. Knowledge about the legal framework laying down which data about patients can already be shared must also be disseminated to prevent insecurity concerning the interpretation and lack of knowledge of the rules from constituting a barrier for data sharing.

The Commission is of the opinion that breaking down structural barriers for the implementation of technologies that can free up time for the core task is key to ensure a sustainable healthcare system in the short and long term. The Commission notes that the Danish Commission on the Structure of the Healthcare System should examine and assess the financing and incentive structures that support a transition of the centred healthcare system and better utilisation of resources and capacity within and across sectors.

## Recommendation 8: Digital competences and technological understanding must be strengthened

A lack of digital competences and technological understanding among both managers and employees in healthcare and elder care could be a barrier for the implementation of new technology. Experience also shows that the staff is not sufficiently involved in implementation and development projects. Employees' digital competences are a requirement for being able to assess citizens' digital competences and support citizens in the use of digital tools. They are organisational and cultural barriers for the implementation of technology. The Commission is of the opinion that it is crucial that the barriers are broken down.

The Commission therefore recommends:

**Recommendation 8: Digital competences and technological understanding must be strengthened**

**More technological understanding is necessary in health professional basic training programmes.** Focus must remain on technological understanding in teaching at health professional basic training programmes, retraining and further training, and there must be a continuous assessment of whether the teaching provides the students with the competences in demand. Furthermore, more electives can be made at university colleges which students can take together at the health professional and technical training programmes where focus is on health innovation, the use of technologies and interdisciplinary technological understanding in a health professional context. Technological understanding at the social and health professional training programmes can be promoted with inspiration from the DigiTech assistant programme currently offered at some social and healthcare schools. DigiTech is a social and healthcare assistant training programme aimed at digitalisation and welfare technologies in the healthcare and elder care sector.

**Positions must be developed that combine clinical work, research and development of technology.** It is meant to bridge clinical work and the need for new technological solutions and research and development of technology to match the need. At the same time, combination jobs will mean that healthcare professionals' digital competences and technological understanding are developed so that healthcare professionals are involved in the development and implementation of new technology and digital, professional beacons are developed.

**Managers' technological understanding and their understanding of digital change management must be strengthened.** Managers should take courses providing insight in the implementation and change tasks brought about by new technology. This should ensure that decisions on strategic directions for the use of technological solutions are made based on thorough, professional knowledge on the potentials of health technologies and restrictions in hospital services and municipal health services.

**Healthcare professionals should be safeguarded in their practitioner professional liability when using digital solutions and technology when diagnosing and treating patients.** Guiding and advising healthcare professionals in the use of technology and digital solutions in patient treatment should be strengthened. When existing guidelines are updated, the practitioner professional liability when using technology and digital solutions should be described so that it is clear to healthcare professionals.

The Commission is of the opinion that increased, digital competences and technological understanding are key elements in being able to fulfil the potential of technology to free up time for the core task in the short and long term. Implementation must be in municipalities and regions in co-operation with the educational institutions. Implementation can be on an ongoing basis, but full implementation has a longer time frame.

# ATTRACTIVE WORKPLACES AND TIME FOR THE CORE TASK

## Recommendation 9: Management must be prioritised, and management quality must be strengthened

The majority of persons with a health degree start their work life in healthcare and elder care, but over time, many of them switch to other sectors. There is a thorough knowledge base indicating that employees' perception of management is decisive to their attachment to work and is important to their motivation. There also is much experience indicating that employees' perception of affiliation and cohesion in their job have a positive significance to their motivation, thus attachment. At the same time, inadequate management may challenge the working environment. Research also shows that the right management span is important to public management and to employees' job satisfaction.

The Commission therefore recommends:

**Recommendation 9: Management must be prioritised, and management quality must be strengthened**

**Management competences must be strengthened, and management must be attentive to employees.** Healthcare managers should, to a higher degree, be recruited based on their managerial skills, values and identity. Professional insight and knowledge are key, and the ability to lead is crucial. Managers, should, e.g., be able to lead several professional groups and not only employees with the same professional background as their own. At the same time, managers should have knowledge on working environment conditions that can strengthen the mental as well as the physical working environment. More interdisciplinary management should support flexible demarcations and flexible task solution in the healthcare system and in elder care. The preparation of a general description of competence profiles for managers in the healthcare system should contribute to promoting management development focusing on key competences. Competence profiles for managers should be translated in each municipality and region and should be used actively for each individual to define a development and educational course, for evaluation of managers and for a common focus on management development within each organisation and across sectors.

**More management power and managers should have the correct management span.** Management power in the healthcare system and in elder care should be increased through more practice-oriented management. This should be reflected in local decisions on organisation, e.g., through systematic assessment of managers' conditions, employees and task type, including with focus the right management span. This is a condition for exercising attentive and compassionate management. The right management span can, e.g., be supported by hiring more equal-ranking managers in large units.

**Employees should be organised in small teams with more influence on tasks and work organisation.** At hospitals, the trend is towards more employees per manager and larger units. This trend has had positive effects but may cause a number of challenges in relation to employees' perception of attentive and compassionate management and the sense of affiliation at the workplace. Organisations and managers should, to a higher degree, use distributed management where various management functions are managed by employees on the manager's behalf.

The Commission is of the assessment that there is a short-term and long-term potential linked to strengthened management within healthcare and elder care as it is key to the attachment of healthcare professionals. Implementation requires a discussion between employers and trade organisations on specific organisation and dissemination. Regions and municipalities can use competence profiles for managers in the healthcare system as a tool to recruit managers, development and educational courses and focus on the organisational management development. Implementation can be on an ongoing basis.

## Recommendation 10: Get more to work more hours

A large share of employees in the healthcare system and in elder care work part-time compared to other welfare areas. At the same time, there is a big difference in the prevalence of part time across professional groups and sectors. We know that more working hours per employee may have more potential derived gains, e.g., higher quality in the task performance, strengthened working environment and stronger continuity in the encounter between professionals and citizens and patients. On the other hand, the possibility of working less than full time in some situations, e.g., in certain phases of life, may contribute to increasing employees' attachment.

The Commission finds that there is a significant potential to make healthcare and elder care resilient if more employees contribute with more hours so that full time will be the basis in the same way as within many other professions. However, the Commission also finds that a condition for that to happen is that the workplaces in general are made more attractive as emphasised in a number of the Commission's other recommendations, including keener prioritisation of tasks, improvement of the working environment, better distribution of out of hours work, more flexibility in the work organisation and attractive career paths.

The Commission therefore recommends:

**Recommendation 10: Get more to work more hours**

**Full time for all employees who want to.** This should contribute to promoting a full-time culture in the healthcare system and in elder care rather than a part-time culture. And it should support a working environment where you know your colleagues and work together as a team while reducing the need for temporary workers and crate more continuity. Employers should examine the possibilities of having employees who currently do not work full time work more hours. That applies to all staff groups.

**Unbalanced incentives should be removed.** Financial benefits of working fewer hours or taking on extra shifts under special schemes or in other contexts should be removed. The use of external temporary employment agencies that distort incentives should be minimised. Frameworks to increase employees' incentives to work more hours should also be made, i.a., through increased possibility of flexibility.

**More flexibility should make working more hours attractive.** Considering patients' and citizens' needs, employees should have more influence in the organisation of work. That specifically applies to out of hours work. It may also be through schemes where the employee has a say and flexibility in the placing of a number of working hours in the standard time period. And it may be through the possibility of fewer but longer shifts.

**Employee participation in duty rosters for increased engagement.** The requests of each employee should, to a higher degree, be considered in a flexible organisation of shifts where the employee group takes on responsibility for the overall work organisation. Increased flexibility should motivate more people to work more hours.

The Commission is of the opinion that in relation to ensuring a resilient healthcare system, there is great short-term and long-term potential linked to a bigger share of healthcare professionals wanting to work more hours. The effect depends on how many employees will find it attractive in the future. Implementation requires a discussion between employers and trade organisations on specific organisation and dissemination of the recommendation. Implementation can be on an ongoing basis.

## Recommendation 11: Out of hours work must be thinned out and distributed among more persons

A major part of out of hours work in the healthcare system are concentrated on a relatively small group of employees and few professional groups. There therefore is a big difference in each individual person's shift intensity, and the shift intensity is often unbalanced so that newly qualified persons, young parents, specific departments and professional groups carry a disproportionately large shift burden. At the same time, there is thorough knowledge that initiatives that increase employees' influence on their own hours have a positive effect on the balance between work life and private life, the psychosocial working environment and, thus, employees' attachment to work. Thorough knowledge indicates that motivation, opinions, affiliation and a sense of being competent in the job promote attachment.

The Commission therefore recommends:

**Recommendation 11: Out of hours work must be thinned out and distributed among more persons**

**Tasks should, to a higher degree, be prioritised for day shifts and weekdays.** Through, i.a., enhanced professional prioritisation, clear management responsibility, strengthened initiatives in the primary healthcare system and improved use of digital solutions and other technologies, the pressure in out of hours work should be reduced.

**Out of hours work should be more evenly distributed among employees.** It is important that out of hours work is more evenly distributed among all clinical employees in units with functions having the responsibility for the shift. When everyone contributes across generations, the pressure on each individual is reduced. The distribution of out of hours work should consider professional, working environment and health considerations.

**Everyone who can, should contribute to shift functions.** All relevant positions in the healthcare system should generally be positions that also contribute to shift functions. This means that, e.g., an employee who is employed in an outpatient clinic with daytime work should also contribute to shifts outside of daytime hours at an in-patient or operation ward when professionally prudent. The positions should be made attractive through, i.a., an improved working environment, professional development, clear management reference, more continuity in patient care etc.

**More professional groups should be included in out of hours work.** Positions with out of hours work should be made possible and attractive for professional groups that traditionally do not participate in out of hours work, i.a., through flexible on-duty scheduling ensuring relevant competences, scheduling in teams, possibilities for professional development etc. At the same time, employees should be ensured proper training to participate in shifts. These could be, e.g., occupational therapists, clinical dieticians, pharmacists and service assistants and others.

**Increased professionalisation of on-duty scheduling.** The distribution of shifts should, to a higher degree, focus on the overall staff capacity, thus contribute to a more flexible use of professional groups in the performance of tasks. This may be supported by data-driven on-duty scheduling, systematic overview of competences and tasks, including more organisational focus on the scheduling.

The Commission is of the opinion that shift thinning has great short-term and long-term potential in relation to ensuring attachment to functions that cover all shifts, thus relieving the

lack of competences in the healthcare system. The effect depends on the extent of the shift thinning and whether it is possible to improve the balance in incentives making out of hours work attractive. Furthermore, the right balance must be found between flexibility for employees, the right support to employees and security that shifts will be covered. Broad involvement in the implementation process may support the rooting. Implementation must be in regions and municipalities and involves discussions between employers and trade organisations concerning dissemination. Implementation can be on an ongoing basis.

## Recommendation 12: Jobs and career paths should be rooted in patient- and citizen-centred work

Projections indicate that the future will have a particular lack of staff to manage patient- and citizen-centred care. The reason is that there will be more elderly people requiring care in the future while the workforce grows only a little. The lack of competences is currently the biggest within functions with a high shift obligation, e.g., in emergency departments and at in-patient wards. Much experience indicates that the possibility of development in the job and clear career paths may be important to employees' attachment. The Commission believes that there is potential in ensuring that career paths are aimed at the patient- and citizen-centred tasks to strengthen employees' attachment to the patient- and citizen-centred work.

The Commission therefore recommends:

**Recommendation 12: Jobs and career paths should be rooted in patient- and citizen-centred work**

**All jobs in healthcare and elder care should be rooted in patient- and citizen-centred work.** Career paths should be aimed at patient- and citizen-centred work and not away from it. Employees in, e.g., research or quality development functions should therefore also take part in patient- and citizen-centred work. Therefore, attractive jobs should be developed combining, e.g., quality work, administration and research with patient- and citizen-centred functions. The development and implementation of jobs should focus on employees' job satisfaction, clear management reference and motivation.

**Clear career paths must ensure motivation and attachment within care and treatment tasks.** It must be ensured that career paths are clear and aimed at patient- and citizen-centred work. Basis must be that professional development and upgrading of qualifications within a profession is a key career opportunity. Professional development as a career path will contribute to creating professional beacons that can be role models and that colleagues can rely on in their performance of the work. Just like career paths, management, quality development and research should be patient- and citizen-centred.

**Career paths should not just point upwards and be for those with the longest training.** Career paths in healthcare and elder care must have more width and diversity so that not only those with the longest training will be given more training and promotions. It must be possible for several groups of employees to get competence development to provide motivation and strengthen attachment to the challenging tasks in the citizen- and patient-centred work.

The Commission is of the opinion that jobs that combine patient- and citizen-centred work and non-patient- and non-citizen-centred work and career paths within patient- and citizen-centred work have a certain short-term and long-term potential in relation to contributing to shift thinning and healthcare professionals' attachment to those functions. Implementation requires discussion between employers and trade organisations. Implementation can be on an ongoing basis.

## Recommendation 13: Realise the potential arising from late retirement

A major part of, e.g., midwives, nurses and social healthcare employees retire from the job market around the early retirement age. There is thorough knowledge indicating that poor

health and a request for more spare time are reasons that healthcare professionals expect to leave the labour market. We know that the decision for retirement depends, among other things, on financial, job-, health- and family-related factors. We also know that a better balance between work life and private life and less strenuous work are reasons for expecting to work at an advanced age and that flexibility and individual agreements have an effect in relation to later retirement. It is also key that physical and mental attrition is prevented.

The Commission therefore recommends:

**Recommendation 13: Realise the potential from late retirement**

**Senior citizens should have better possibilities for gradual retirement.** It should be attractive for seniors who work in healthcare and elder care to postpone retirement, e.g., through more flexible working methods that ensure balance between work life and private life and more focus on competence development. It is important that the conditions meet each individual person's and the workplace's possibilities and needs. At the same time, employee competences are acknowledged and applied in the patient- and citizen-centred work. Seniors contribute with important experience, and it is key that there is a transfer of knowledge to younger colleagues. Strengthened initiatives should also be made to prevent physical and mental attrition and so that more people can stay in the citizen- and patient-centred work longer.

**Employees who take early retirement and pensioners should have better incentives to contribute.** The Commission notes that the agreement on an emergency plan for hospital services that was concluded between the government and the Regions of Denmark in February 2023 laid down that the government would phase out the early retirement set-off in 2023 and 2024 for employees in the healthcare system, including the nursing sector. In the future, work should be done with models encouraging employees who take early retirement to have the incentive to contribute to the work in the healthcare system and in elder care but without increasing the influx to the early retirement scheme. Models should also be prepared encouraging healthcare professionals to contribute to the work in the healthcare system and in elder care after the state pension age. Models can be based on local experience with incentives.

The Commission is of the opinion that initiatives that strengthen seniors' and pensioners' attachment have a great potential in relation to making healthcare and elder care resilient in the short and long term. The effect depends on the distribution, ambition level and implementation of the recommendations. Implementation requires discussion between employers and trade organisations. Implementation can be on an ongoing basis.

## Recommendation 14: Competences from abroad must be utilised more efficiently through strengthened attachment

Denmark is below the OECD average for the share of doctors and nurses who have a degree from Denmark, and there are indications that attachment by foreign employees is not strong enough. Around 20 per cent of foreign doctors and nurses who were licensed in the period 2016-2021 had left the country again after five years. Experience indicates that initiatives focusing on each employee and their family's well-being may be decisive for the employee to feel an attachment, wanting to continue in the job. At the same time, there may also be a need for strengthening the possibilities for young people wanting to go to Denmark, particularly from EU/EEA countries, to find it attractive to apply for a training programme and employment within healthcare and elder care. The Commission is of the opinion that there is a need for a broader focus on competences from abroad, including removing barriers to mobility and attachment, and the Commission finds that there must be particular focus on ensuring strengthened attachment by those foreigners who are already in the country.

The Commission therefore recommends:

**Recommendation 14: Competences from abroad must be utilised more efficiently through strengthened attachment**

**The catchment area within healthcare and elder care should be developed by removing barriers to mobility and attachment with particular focus on young people from EU/EEA countries.** The group may both include trained healthcare professionals and young persons who have not started or completed a healthcare training programme. This could be, e.g., young people from EU/EEA countries, particularly neighbouring areas, who want to go to Denmark for various reasons and who may be motivated to enrol in a training programme within healthcare and elder care in Denmark. Currently, that group is not sufficiently taken into consideration by employers as a potential resource.

**Attachment by foreign employees should be strengthened.** Already now, regions and municipalities work with strategies for both recruitment of and attachment by foreign employees. Attachment initiatives are, i.a., help to find housing, a job for the partner, school and daycare institutions and language programmes. There are a number of existing initiatives that support employers in their search for and attachment by foreign employees, including the possibility to co-operate with Work in Denmark. Employers are encouraged to increase their use of the initiatives.

**Initiatives that promote foreign healthcare professionals' participation in the performance of tasks.** Licensing of foreign healthcare professionals must be organised to allow prioritisation of applicants with competences that are specifically in demand while ensuring a smooth transition from authorisation to the labour market. As part of the Agreement on an emergency plan for the healthcare system, the government, Regions of Denmark and Local Government Denmark established a task force which should, i.a., give recommendations for language requirements and possibilities for a faster licensing process for healthcare professionals with a specific job offer. The initiatives can enable regions and municipalities to further target their recruitment work.

The Commission is of the opinion that potential is linked with a broader look at the catchment area of persons from EU/EEA countries who are motivated to take a healthcare degree and work in Denmark. Effect and implementation have a longer time frame.

## Recommendation 15: More and better introductions for new graduates

A relatively high share of new graduates in the healthcare system and in elder care switch jobs within the first years of their work life, and many new graduates within the healthcare system experienced the transition from training to work as difficult. For example, 59 per cent of the graduates from the nursing training programme stated that they completely agree or agree that the transition from training to the labour market was difficult. There is thorough knowledge that the introduction of new graduates has a positive effect on the working environment and is beneficial to attachment. We also know that initiatives such as mentoring schemes, rooms for reflection, feedback and organised dialogue may improve the induction of new employees and new graduates.

The Commission therefore recommends:

**Recommendation 15: More and better introductions for new graduates**

**Induction programmes with, e.g., supervision, mentors and ongoing dialogues must be utilised better.** Sufficient use of induction programmes should be ensured when there is a need in the healthcare system and in elder care. This should be seen as supplementing the consideration of giving new graduates suitable responsibility. The specific content of the programmes should be adapted to the local conditions of the workplace, the specific professional group and each new graduate.

**Insight should be given into the initiatives that effectively reduce wastage and practice and responsibility shocks.** There are many examples of induction programmes and on-boarding concepts of various durations and with various initiatives. Insight must be

given into which initiatives that most effectively reduce wastage and practice and responsibility shocks, thus strengthening attachment by new graduates.

**Educational institutions must contribute to better transitioning from training to job.** Educational institutions must prepare students for work within healthcare and elder care and, to a higher degree, contribute to a good transitioning from training to job.

The Commission is of the opinion that increased focus on the induction of new graduates has potential in relation to facilitating the transition from training to job and increasing the attachment of newly qualified employees in the short and long term. Implementation requires a dialogue between employers and trade organisations and any educational institutions. Implementation can be on an ongoing basis.

# RIGHT COMPETENCES AND PROFESSIONAL FLEXIBILITY

## Recommendation 16: Ensure increased coherence and more flexibility across healthcare training programmes

Recent years have witnessed a decline in the influx to several healthcare training programmes, and a large share of students drop out of the training programmes during the time of their training. There is a need for competences targeted patient- and citizen-centred work, and that need is anticipated to grow. Ensuring better utilisation of competences in the healthcare system and a more flexible workforce are therefore necessary. There is broad experience indicating that clear and flexible career paths are important when young persons choose a training programme. Potential may therefore be connected with more flexibility and better possibilities within healthcare training programmes. This may be through more ways into the training programmes, better possibilities for changing training programmes without any unnecessary delay and in general better utilisation of the possibilities to shorten training programmes for students who have already gained experience, e.g., through work experience, other practice experience in healthcare and elder care or through previous, relevant educational activities, for example from relevant vocational training.

The Commission therefore recommends:

**Recommendation 16: Ensure increased coherence and more flexibility across healthcare training programmes**

**There must be a better coherence and more flexibility across healthcare training programmes.** We can retain more people in the healthcare training programmes and support improved professional flexibility in practice by creating better possibilities to change directions, building on existing programmes and utilising the possibilities of flexibility in the training course. Training programmes should also be clearly aimed at patient- and citizen-centred work. The adjustment specifically consists of:

**It must be easier to build on the healthcare degree already obtained or switch directions in the training course.** It must be possible for, i.a., occupational therapist students to switch to the physiotherapist programme without having to start over, for fully trained nurses to build on their competences and study further to become bioanalysts or for social and healthcare workers to study further to become social and healthcare assistants. This should be through more common educational elements and a more uniform, flexible and widespread use of credit, e.g., through common guidelines.

**There should be more ways to gain admission to healthcare training programmes.** Both vocational training programmes and university colleges should – where not already possible – develop brief courses aimed at applicants with relevant work experience or training, including passed training elements. Furthermore, it should be clarified whether better

possibilities for admission to healthcare training programmes could be established based on individual assessments of the applicant's competences so that relevant, informal competences obtained through work experience or training will provide admittance to a higher degree.

**The training programmes must be flexible.** More people can be recruited and retained by offering flexible educational paths. Existing possibilities for planning the training programmes in a flexible way and on part-time should be used more. Possibilities for developing trials with new training models for selected target groups should be examined, i.a., inspired by social educators based on previous credits. Rule barriers for practical training during retraining and further training should also be removed. Trials with more flexible, modular training should be initiated for students at the social and healthcare worker training programme. The trial should contribute to upskill more unskilled persons into trained social and healthcare workers.

**Informal competences should be brought into play to a higher degree in the patient- and citizen-centred work.** Persons who drop out of a healthcare training programme should be able to use the competences gained through training elements passed to perform specific job functions to earn credit. Healthcare training programmes may, e.g., issue a diploma or certificate to verify courses passed. A basis must also be formed for using the diploma to apply for jobs at a higher level than unskilled functions.

The Commission is of the opinion that a more flexible structure for healthcare training programmes has a long-term potential in relation to making the healthcare system resilient. Implementation requires a government decision, and in some cases involvement of the social partners as the recommendation involves, among other things, changes in the structure of healthcare training programmes. The Commission notes that partnerships have already been established between relevant actors in the area.

## Recommendation 17: Reform retraining and further training to target career paths towards practice

There is an extensive supply of retraining and further training programmes within healthcare and elder care, and employees in general assess the possibility for skill development within their trade as good. Thorough knowledge also shows that the supply is seen as confusing and difficult to see through. Among other things, one reason is that professional groups, regions and municipalities often request each their training supply. In some cases, this means that competences required from retraining and further training cannot be used as part of a coherent career path for each individual and cannot be transferred between workplaces. When the supply is not sufficiently managed and co-ordinated, there is a risk that it does not match the demand in healthcare and elder care.

The Commission therefore recommends:

**Recommendation 17: Reform retraining and further training to target career paths towards practice**

**The retraining and further training systems for training programmes within healthcare and elder care need to be reformed.** The reform must ensure that retraining and further training for healthcare professionals across sectors are innovated and become much more coherent. The supply of training programmes must be cleaned up, and the overall career paths must be aligned according to the patient- and citizen-centred work and not away from the patient- and citizen-centred work. Specifically, the reform consists of the following initiatives:

**The total retraining and further training systems for training programmes within healthcare and elder care must be innovated and aligned across sectors.** The formal as well as the informal retraining and further training systems must contain both theory and practice and be based on employment in practice. At the same time, all retraining

and further training must be more linked to the basic training to ensure better transfer of knowledge between practice and training. It should be possible to acquire new skills within one's own profession and to switch professions, e.g., from social and healthcare worker to assistant and from nurse to midwife via the retraining and further training systems.

**The supply of retraining and further training must be cleaned up.** There must be stronger management and prioritisation of all types of retraining and further training, including both special training and training programmes offered by university colleges. This should be based on targeting retraining and further training according to the need within healthcare and elder care. At the same time, career paths within healthcare and elder care must be made clearer. This should be done by having regions, municipalities and educational institutions co-operate on the development and supply of the programmes to a higher degree and in a more systematic way.

**Retraining and further training programmes should, to a higher degree, be based on the need in practice.** Retraining and further training are aligned according to areas with the biggest need, e.g., within patient- and citizen-centred work. This should be done by getting regions, municipalities and educational institutions to analyse and monitor the need at a national level and co-operate on the development and supply of the programmes to a higher degree and in a more systematic way.

**Retraining and further training programmes must, to a higher degree, be interdisciplinary.** The structure of retraining and further training should be gradual and interdisciplinary so that the possibility for development and competence development will be across professional groups and will allow a switch in functions. Barriers preventing participation in courses across professional groups should be removed, among other things by looking at the admission requirements. Switches in functions could be, e.g., from nurse at a cancer unit to functions within pregnancy, maternity and childbirth. That allows lifelong development and a lifelong career within healthcare and elder care.

**There must be better possibilities for training via adult educational training.** In the long term, it should be possible to take a full social and healthcare worker degree via a combination of adult educational training courses. Furthermore, the possibility to receive further training from social and healthcare worker to social and healthcare assistant via the adult educational training system should be accommodated, including the requirement to associate students at the social and healthcare assistant programme with several training locations. This requires development work that considers links between adult vocational training courses and social and healthcare training programmes. The work will specifically be in co-operation between vocational committees and further training committees within the social and healthcare area.

**Knowledge of employees' retraining and further training possibilities must be disseminated**. To support each employee in continuous, professional development, managers must have knowledge of, i.a., the possibilities for retraining and further training in the various professional groups. That specifically applies to the possibilities for unskilled workers as well as social and healthcare assistants and workers.

The Commission is of the opinion that a reform of either the retraining and further training system has the potential to support the supply in matching the need within healthcare and elder care in the medium term. A reform and subsequent implementation require extensive, professional work and co-operation between regions, municipalities and training providers and therefore have a long time frame.

## Recommendation 18: Remove professional silos, more should contribute

There is a need for being able to use the competences in the healthcare system in a more flexible way. The healthcare system is characterised by a high degree of specialisation where specific professional groups manage specific tasks. This helps ensure high quality in the performance of tasks but also means that it is difficult for the workforce to stand in for each oth-

er when there is a shortage of specific professional groups or when tasks change. Thorough knowledge shows that strategies with focus on development and flexible use of competences and skills are connected with improved treatment outcomes for patients and more efficient and flexible operations. There is also much experience showing that healthcare professionals at hospitals manage administrative work which could be managed by other competence profiles. It is important that the increased flexibility is professionally meaningful, safe for patients and cost-effective and that a more flexible performance of tasks will not be at the expense of continuity and co-ordination in patient and citizen courses.

The Commission therefore recommends:

**Recommendation 18: Remove professional silos, more should contribute**

**Administrative staff should relieve healthcare professionals of administrative and co-ordinating tasks.** A number of tasks which are currently managed by healthcare professionals should rather be managed by administrative staff such as healthcare administrative co-ordinators and medical secretaries. Thus, staff with patient- and citizen-centred tasks and managers are relieved, time will be freed up for the core task, the pressure on specialised competences can be reduced, and tasks are performed at the right competence level.

**To a higher degree, staffing and distribution of tasks should be across professional groups.** There should be focus on the total staff capacity and on solving tasks at the right competence level when staffing tasks. That includes, i.a., strengthening managers' possibilities to do the on-duty scheduling professionally, and the scheduling should focus on relevant competences being present in relation to the activity to be handled. This could be, e.g., through organisation in interdisciplinary teams organised around the task rather than monodisciplinary teams, e.g., smaller teams where various professional groups are in charge of patient care together. It requires the employees of the team to have knowledge of each other's competences, to receive adequate training etc. In the future, posts should be advertised with more focus on which competences a candidate possesses and not exclusively to which professional group the candidate belongs.

**There must be systematic focus on ways in which more professional groups can contribute to clinical tasks.** Local instructions and guidelines must be updated and allow flexible performance of tasks where it makes sense professionally. The use of framework delegations should be disseminated, and it should be considered whether future development of the task portfolios of the various staff groups means that more professional groups will have tasks with such risks to the patient's safety that they should be licensed social and healthcare workers, pharmaconomist and pharmacists, to mention a few examples.

**Unskilled workers who are not in the process of training and students should manage more practical tasks and basic citizen- and patient-centred tasks.** Employees must be able to build competences to manage specific and demarcated citizen- and patient-centred tasks. An example is unskilled workers who were trained to swab and vaccinate during COVID-19. Other examples are tasks with personal hygiene, help to mobilise patients, sampling such as urinalyses, swabs, measuring of blood pressure, temperature and weight, observation of patients in less complicated cases, help giving food to patients who are not at a nutritional risk and who do not have special challenges and practical tasks such as cleaning up and replenishing. The tasks are performed in interaction with other healthcare colleagues and for the purpose of everyone to obtain a formal, qualifying level in the long term. Unskilled workers who have acquired relevant competences or experience within healthcare and elder care but who do not have actual vocational training or further training may be an important resource which can free up time and reduce the pressure on healthcare professionals. Use of more unskilled workers and students in further education must be under healthcare professional management without impairing patient safety.

**Hiring unskilled workers who are not in the process of training and are not students should be seen as recruitment potential and should bridge training and work life.** Unskilled workers should be offered a training plan and should, where relevant, be supported in enrolling in training within healthcare and elder care with inspiration from regional and municipal experience with having more "unskilled workers become skilled workers". At the

same time, hiring of more students from healthcare training programmes should contribute to building bridges between training and the labour market. This could be with inspiration from those places that currently use medical students as nursing temporary nurses in a systematic way.

The Commission is of the opinion that a more flexible use of the competences of each professional group and increased use of unskilled workers who are not in the process of training, persons with acquired skills and students have great potential in the short and long term in relation to ensuring a resilient healthcare system. The development towards a more flexible use of competences must be on an ongoing basis in regions and municipalities.

Note that the Danish Nurses' Organisation recommends that as many employees as possible who manage patient- and citizen-centred tasks in the healthcare system should have a degree within healthcare. The condition for a resilient healthcare system of a high quality and patient safety is that employees in the healthcare system have the competences to deliver holistic nursing and treatment.

## Recommendation 19: The connection between training and job must be strengthened to avoid a practice and responsibility shock

Several healthcare training programmes have a high drop-out rate, and many new graduates find the transition from training to work difficult. There is thorough knowledge to indicate that good internships and job training are crucial to students' competence development, completion of their training programme, the transition to work life and subsequent work in the profession. Initiatives such as well-functioning internships and job training and the use of simulation training can strengthen the transition from training to work life and reduce the risk of practice and responsibility shock.

The Commission therefore recommends:

**Recommendation 19: The connection between training and job must be strengthened to avoid a practice and responsibility shock**

**Co-operation between educational institutions and job training and internship locations should, to a higher degree, be systematised, made binding and supported at a strategic level.** Specifically, this could be about mutual understanding and ambition for the quality of good internships/job training, exchange of employees, combination jobs, mutual development and/or research co-operation and common places of training such as training wards, training rest homes, simulation facilities etc.

**A stronger link between teaching and practice should counter practice and responsibility shocks.** Students should, to a higher degree, be able to train skills and competences through practice-centred problem definitions in the teaching, i.a., through the use of simulation training. The link between teaching and practice could, e.g., be strengthened through the lecturers' experience from combination jobs based on students' specific experience from training and job training and internships or experience from training wards and simulation facilities. Training wards should be considered when organising new training places and internships for the purpose of centralising, boosting and relieved training tasks in the healthcare system. Furthermore, the last internship at profession-specific training programmes should take place right before the end of the programme so that it will be easier for students to transition from study life to work life.

**Study adviser tasks at vocational training and profession-specific training programmes should be given greater priority.** Study adviser tasks at internship and job training locations should be professionalised and supported structurally and at management level. This could be through an ongoing competence development for advisers, dissemination of good experience with employees dedicated to the adviser task and local work towards a suitable ratio between the number of students per adviser.

**There must be good job training places and internships for healthcare training programmes in the entire healthcare system.** There must be a much bigger share of job training places and internships in the primary healthcare sector and other places in the public sector, e.g., hospices, the Danish Defence, prisons etc. At the same time, the practice sector and the private hospital sector should make a lot more job training places and internships available to students from various healthcare training programmes. The distribution of the training task should contribute to relieving those parts of the healthcare system where the training task has grown over time and to the job training places and internships reflecting the labour market to a higher degree.

The Commission is of the opinion that there is a potential for strengthened internships and job training and co-operation between the educational institution and practice in the short and long term to contribute to making the healthcare system resilient by reducing drop-out rates in the training programmes and increasing attachment of new graduates. Implementation can be on an ongoing basis.

## Recommendation 20: Ensure a more strategic and long-term management of healthcare training programmes

Projections indicate that in the future, there will be a shortage of staff with competences within patient- and citizen-centred work. Today, an overall view of the supply of healthcare training programmes does not exist, and there are no controlling mechanisms to target the number of student places to the need in healthcare and elder care on an analytical foundation.

The Commission therefore recommends:

**Recommendation 20: Ensure a more strategic and long-term management of healthcare training programmes**

**A better overview of the supply of healthcare training programmes must be created.** An overview must be created across geography and educational institutions to illustrate the overall supply of student places at the healthcare profession-specific programmes for the purpose of a long-term and strategic management of the supply of training programmes.

**Dimensioning must be made according to the current and future needs of society.** A strategic and long-term dimensioning of healthcare training programmes should be made with an analytical basis in demand. This should ensure that dimensioning reflects society's future needs for a broad and highly qualified workforce that corresponds to the population and disease development, e.g., competences for the patient- and citizen-centred work.

**Societal challenges that may have an impact on healthcare and elder care must be clarified.** Analyses on the development within healthcare and elder care must form the basis for the dimensioning of the healthcare and profession-specific training programmes and the development of social and healthcare training programmes as well as skill development for social and healthcare professionals determined by the vocational committees and further training committees, respectively. They could be, e.g., projections of the future workforce. How to support that work organisationally should be examined.

The Commission is of the opinion that a dimensioning of healthcare training programmes could contribute to more training for the needs existing in the healthcare system and in elder care in the long term. Effect and implementation have a longer time frame.

# Members of the Commission

**Members of the Commission as of September 2023**

- Søren Brostrøm, former manager, the Danish Health Authority, Chairperson of the Commission
- Annemarie Hellebek, Hospital Administrator, Bornholm Hospital
- Bodil Overgaard Akselsen, Director of Nursing, Medical Department, Gødstrup Regional Hospital
- Christian Bøtcher Jacobsen, professor of health management, Crown Prince Frederik Center for Public Leadership, Aarhus University
- Christian Harsløf, Manager, Local Government Denmark
- Dorthe Boe Danbjørg, second deputy chairperson, Danish Nurses' Organisation
- Helene Rasmussen, Manager of Social and Health, Gentofte Municipality
- Klaus Larsen, IT Manager, North Jutland Region
- Lisbeth Lintz, President, The Danish Confederation of Professional Associations
- Mickael Bech, Professor of Health Economics and Health Management, the Department of Political Science, University of Southern Denmark
- Mona Striib, Union President, FOA
- Nanna Højlund, Deputy Chairperson, Danish Trade Union Confederation
- Per B. Christensen, President, Danske SOSU-skoler
- Randi Brinckmann, Head of Faculty, Faculty of Health, University College Copenhagen
- Ricco Dyhr, Hospital Administrator, Nykøbing Falster Hospital
- Rikke Margrethe Friis, Negotiation Director, Regions of Denmark
- Thomas Kiær, CEO, Acure Private Hospital