McMaster University | HEALTH FORUM

Living Evidence Brief

Addressing the Politics of the Health Human Resources Crisis in Canada (Version 4)

15 & 16 May 2023

Context for the brief

The health human resources (HHR) crisis has garnered significant attention across Canadian provincial and territorial (PT) health systems in the last year, rising to the top of most federal, provincial and territorial (FPT) governments' policy agendas in the latter half of 2022. Of the resulting decisions made by health-system decision-makers, most have been jurisdiction- or region-specific, and address particular aspects of the crisis. Examples of such decisions include Ontario's introduction of 'As of Right' rules in early 2023, which aimed to attract healthcare workers from other provinces and territories by recognizing licensure from those jurisdictions, and the introduction of a new physicians and surgeons registry in Atlantic provinces to support cross-jurisdictional practice in the region. Most PT governments also introduced targeted efforts to bolster recruitment and retention (often with financial incentives underpinning them) and invested in the supply of health workers by increasing the number of admissions to professional-education programs (see Appendix 2 for more details). Additionally, new FPT agreements have provided for enhanced funding commitments to PT health systems, which can also help to pay for these HHR initiatives.

These PT HHR decisions address some of the factors contributing to the current HHR crisis, and incorporate some of the policy solutions that have been proposed by long-standing initiatives (e.g., the FPT Committee on the Health Workforce) as well as recent initiatives (e.g., the Canadian Academy of Health Sciences' Assessment on Health Human Resources). The decisions may also create additional policy challenges that will need to be addressed in the future (e.g., growing competition for health workers across PT health systems, both at the level of individual jurisdictions and at the level of regional 'blocs').

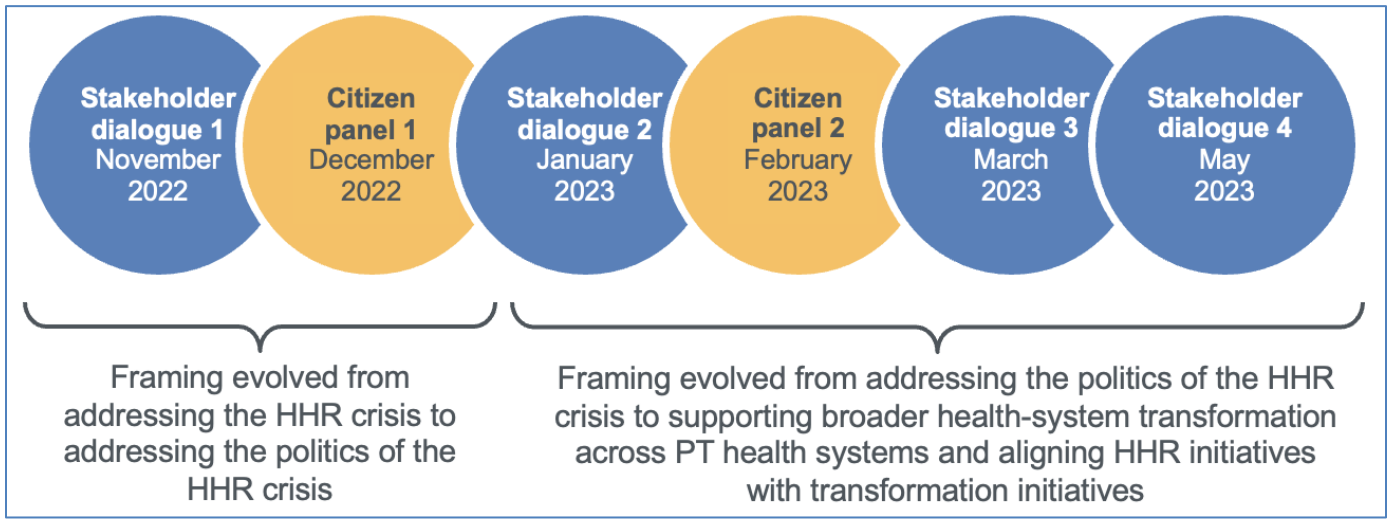
Box 1: Approach and supporting materials

This document is the fourth and final version of a 'living' evidence brief, and it was prepared to inform a fourth and final meeting of a 'living' stakeholder dialogue. A separate document contains nine appendices:

1) background and methods for preparing this document
2) recent provincial and territorial decisions for addressing the HHR crisis (which was the original impetus for the living stakeholder dialogue and the focus of approach element 3)
3) examples of provincial and territorial efforts to advance health-system transformation in Canada (which pertains to approach element 1)
4) examples of structures and processes that enable a diverse array of Canadians to play a role in designing, executing and ensuring accountability for health-system transformation (which pertains to approach element 2)
5) evidence syntheses relevant to element 2 (with evidence syntheses relevant to elements 1 and 3 having been covered in previous versions of the evidence brief)
6) overview of frameworks related to spread and scale-up of innovations as part of health-system transformation initiatives (which pertains to element 2)
7) overview of organizations and approaches used to spread and scale health-system innovations in Canada and internationally (which pertains to element 2)
8) key features of an evidence-support system, compared to a research system and innovation system
9) approaches to health workforce planning (which pertains to element 3).

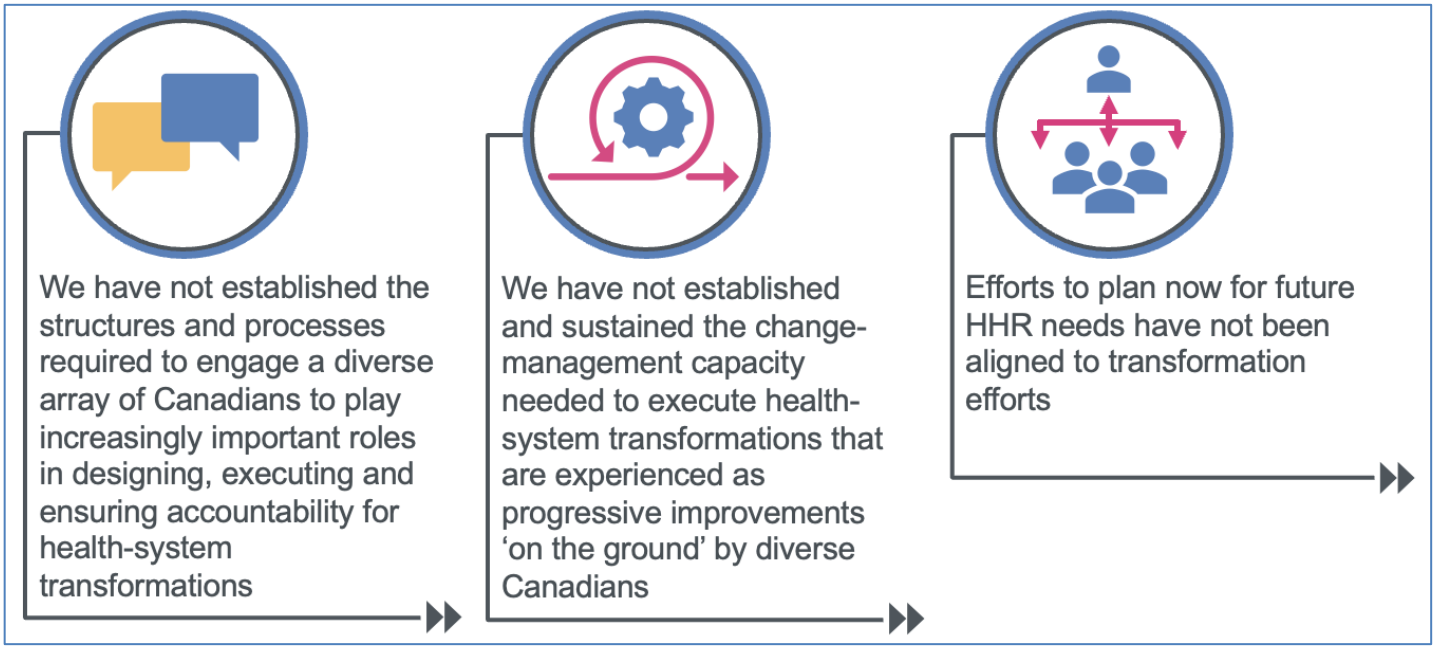
All documents related to this suite of work will be made publicly available and can be accessed here.

The focus of this fourth and final version of a 'living' evidence brief reflects a significant evolution in the framing of the problem and ways forward, which was spurred by three earlier stakeholder dialogues and two citizen panels.



The problem

Efforts to address the HHR crisis, as well as other health-system developments, have started broader conversations about the need for fundamental changes across health systems in Canada.(1). While some health-system transformations have been initiated (see Appendix 3), three features of the problem have dominated dialogues 2 and 3, and we consider each in turn below.



We have not established the structures and processes required to engage a diverse array of Canadians to play increasingly important roles in designing, executing and ensuring accountability for health-system transformations

In recent months there have been many calls for widespread, people-centred health-system transformation across Canada.(1; 2). There have also been calls for renewed efforts to engage Canadians in crafting a vision for health-

system transformation,(3; 4) which was repeatedly reinforced by participants in the two citizen panels convened in December 2022 and February 2023.(5-7) The idea of seeking input from Canadians about health- and social-system reform is not a new one, with efforts like the Citizens' Forum on Canada's Future – colloquially known as the Spicer Commission – having taken place more than three decades ago.(8) Since then, many initiatives to engage citizens and patients in various aspects of health-system decision-making have been established (see Appendix 4). These initiatives vary widely in terms of:

- **who leads them** (e.g., governments versu organizations that provide strategic direction and/or oversight in health systems versus healthcare delivery organizations versus organizations focused on regulating or representing specific types of health workers versus organizations representing citizens and patient groups versus research groups)
- **what level of decision-making they aim to inform** (e.g., some are focused on particular PT health systems and others are focusd on several jurisdictions or at the pan-Canadian level, and many are focused on specific programs and services within health systems rather than on policies about transforming health systems)
- **which sectors, conditions and populations they aim to benefit** (e.g., many are focused on transforming health systems for particular sectors like primary care, conditions such as mental health and addictions, and populations such as older adults)
- **which roles citizens and patients play in the decision-making process** (e.g., most are focused on eliciting patient, family and caregiver preferences for reform, which can help to inform designing part of a vision, while fewer are focused on executing the vision and still fewer on ensuring accountability).

Vevy few of these initiatives have focused on co-designing with citizens the structures and processes necessary to ensure a diverse array of Canadians (including equity-deserving groups) are embedded in ongoing cycles of health-system transformation decisions, and more specifically enabled to aid with designing 'the vision,' executing it, and holding decision-makers accountable for achieving it. Publicly available information suggests that one initiative signalling its intention to take steps in this direction is Saskatchewan's Patient and Family Advisor Program, which has the goal of engaging patients and families in the development, implementation and evaluation of health-system policies and programs.

We have not established and sustained the change-management capacity needed to execute health-system transformations that are experienced as progressive improvements 'on the ground' by diverse Canadians

Canada has long been dubbed the 'land of pilot projects.'(9) The Primary Health Care Transformation Fund, which included an $800 million investment but no requirement that PT goverments would sustain and expand successful pilots to transform systems, is an illustration of this situation.(10) Examples of widespread reform resulting in sustained transformative change 'on the ground' are sparse in Canadian health systems, and those that do exist, such as the Hospital Sector Restructuring Commission from 1996 to 2000 and the integration of cancer services from 2002-2004 in Ontario, often credit leaders with a strong mandate, long-standing relationships with key health-system stakeholders, and the willingness to broker the necessary tradeoffs among these stakeholders – that is leaders using their accumulated political and social capital – as key facilitators of success.(11; 12)

While these examples indicate that moving beyond pilot projects to system transformation is not impossible, they also suggest that health-system transformation is possible only when the right constellation of factors – many out of the hands of health-system decision-makers – align. However, the rarity of transformatiative change in health systems can also be linked to failures among PT governments to invest in sustainable and effective change-management infrastructure that can help to steward the process of health-system transformation.(10)

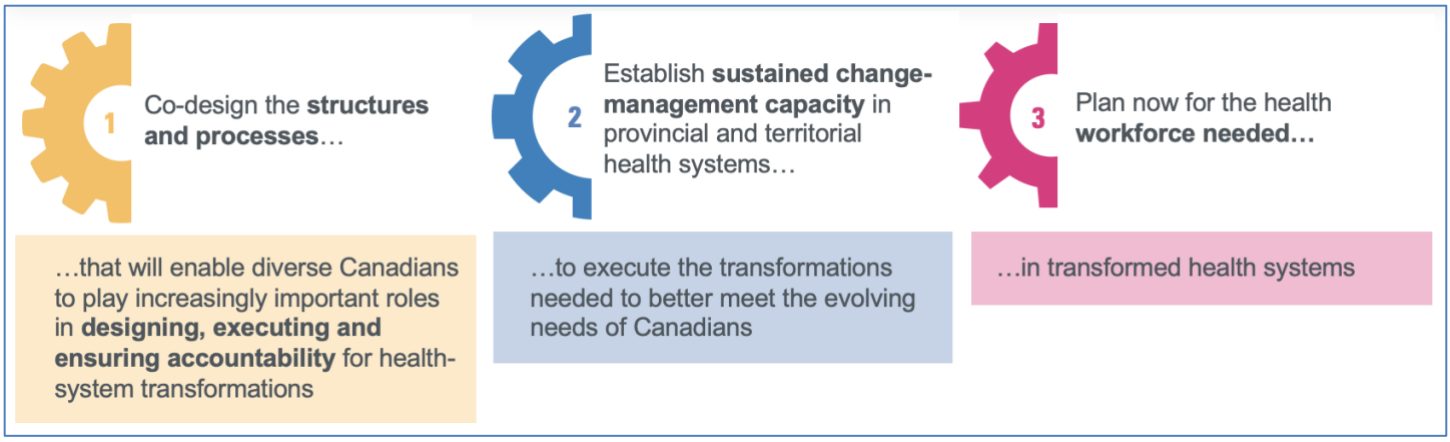
Across PT health systems today, very few examples of such investments exist. The assets that do exist are useful examples to learn from, but likely don't go far enough to provide the change-management infrastructure necessary to support the type of health-system transformation needed across PT health systems. For example, some are only

focused on supporting change related to a specific model of care (e.g., the Team Primary Care initiative co-led by the College of Family Physicians of Canada and the Candian Health Workforce Network) or for prioritized clinical areas (e.g., Transformationl Roadmaps for Alberta's Strategic Clinical Networks, and the support infrastructure created to underpin Nova Scotia's Clinical and Service Networks). Other assets such as Healthcare Excellence Canada, a pan-Canadian health organization with a mandate and capacity to support the identification, implementation and scale-up of promising health-system innovations across PT health systems, don't have change-management infrascture to 'plug into' within each PT jurisdiction to support widespread and sustained transformation.

Efforts to plan now for future health human resources (HHR) needs have not been aligned to transformation efforts

As noted above (and with additional details provided in Appendix 2), the targeted decisions made by PT governments to address the acute dimensions of the HHR crisis only address aspects of the challenge, and don't achieve the comprehensive solutions needed to align future HHR needs with transformation efforts (many of which have been outlined in detail in the aforementioned Assessment on Health Human Resources released by the Canadian Academy of Health Sciences). Unfortunately, there is a risk that with these decisions taken, less effort will be invested by decision-makers involved with HHR planning to move beyond traditional approaches, and meet the moment by revitalizing the approach to support an ongoing process that anticipates future requirements to meet population needs, demand and utilization.(13)

Elements of a potentially comprehensive approach for addressing the problem



Co-design the structures and processes that will enable diverse Canadians to play increasingly important roles in designing, executing and ensuring accountability for health-system transformations

This element builds on insights from previous dialogues interactions and citizen panels as well as the insights about key initiatives underway across the country presesnted in Appendix 4 and mentioned in the previous section. Specifically, it would build on existing strengths and work to fill gaps by:

1) leveraging existing initiatiaves in place across the country that could play a role in enabling Canadians to play important roles in designing, executing and ensuring accountability for health-system transformation
2) expanding existing structures and processes (or creating new ones) to ensure:
   i. the focus of engagement goes beyond specific programs and services, to focus on broader health-system transformation

ii. engagement goes beyond designing a vision to include a focus on execution of and accountability for health-system transformation

3) ensuring the voices of equity-deserving groups are amplified in citizen-engagement structures and processes.

The organizations and initiatives included in Appendix 4 could provide a starting point for the sub-elements, and could be informed by insights from the best available evidence about citizen engagement. A variation of this element was included in the previous version of this evidence brief, which provides a summary of what is known from several evidence syntheses about the different types of citizen engagement, promising models of citizen engagement, and its importance as part of health-system governance (particularly as a way to support greater accountability). These syntheses generally found a lack of evidence about what citizen-engagement methods are most effective in what context, due to the limited number of robust evaluations,(14-17) but they revealed potential instrumental benefits of citizen engagement (for example, integrating citizen values and preferences in policies and decisions) and developmental benefits (for example, raising public awareness and improving citizen understanding of complex policy issues).(14-16; 18-21) For those who are interested additional details are also included in the citizen briefs prepared to inform the two citizen panels we convened on the topic in the technical appendices available here.

Establish sustained change-management capacity in PT health systems to execute the transformations needed to better meet the evolving needs of Canadians

This element would addresss some of the shortcomings in change-management capacity within PT health systems in Canada by focusing efforts in three areas:

1) establish the **general change-management capacity** to set the strategic direction and develop guidance for implementing the vision across the health system (e.g., establishing leadership, structures and processes and technical supports required), and for holding system leaders to account
2) establish **context-specific change-management capacity** for implementing the vision (e.g., establishing technical supports that help drive local adoption of the key components of health-system transformation through targeted implementation supports and, when required, behaviour-change supports)
3) creating new or leveraging existing assets in the **evidence-support system** (which would underpin efforts related to general change management and context-specific change management by ensuring decision-makers can access, on demand, the best-available evidence for the full range of decisions they are involved with).

We identified eight evidence syntheses that addressed this element (see Appendix 5). In summary, these syntheses did not directly address any of the sub-elements listed above, although they provided general insights about overarching enablers and characteristics of innovations that facilitate transformational change. These insights could be considered in the design of efforts to establish either general change-management capacity, or context-specific change-mangement capacity and include:

- a clear understanding of the innovation or change (e.g., evidence on its effectiveness and cost-effectiveness, feasibility, perceived value, historical efforts, and ability to address a service or policy challenge)
- partnership and community engagement (e.g., leadership buy-in, alignment of values and goals, partnerships among experts, decision-makers, organizations and networks, structured governance and engagement)
- workflow analysis and integration (e.g., system readiness, organizational capacity, path dependency considerations, change-management models, awareness of resistance to change, integration in existing strategies or priorities and/or policies)
- fit within local context (e.g., tailored innovations to meet the needs of the local context, flexibility and adaptability to relevant contexts)
- monitoring and evaluation (e.g., short and long-term outcomes, implementation success, and iterative feedback).

Eight frameworks relating to the spread and/or scale-up of health-system innovations were also identified (see Appendix 6), which prioritized many of the same enabling factors outlined above, but also raised the importance of:

- working with and through credible change agents, with clearly defined roles and responsibilities
- ensuring sufficient investment of resources (both financial and human) to support innovation-specific and general capacity for implementing change.

Organizations and approaches used to spread and scale health-system innovations in Canada and internationally (see Appendix 7), all of which could be drawn upon in establishing sustained change-management capacity in provincial and territorial health systems.

A jurisdictional scan identified a number of useful examples of technical supports that could be learned from when considering the first and second sub-elements, with examples such as NHS Transformation Directorate and Future NHS Platform from the United Kingdom providing examples of general change-management capacities, and the others providing insights about how supports for context-specific change-management could be designed. Related to the last sub-element, Appendix 8 presents a figure that lays out the key features of an evidence-support system, which can be used to inform planning on this front.

Plan now for the health workforce needed in transformed health systems

This element needs to be considered as one that can be pursued once a 'vision' has been established (element 1), so that workforce planning is oriented towards what is established as the future of PT health systems. Specific sub-elements could include:

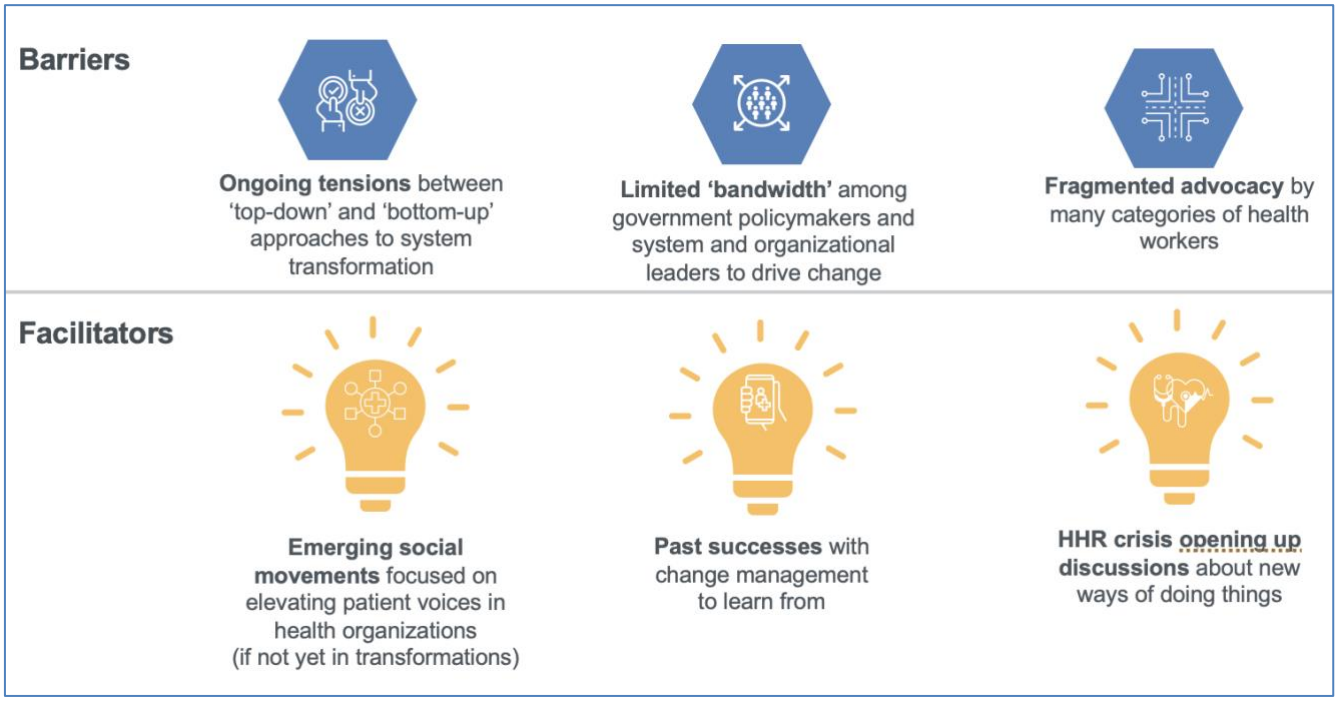
1) adopting models of workforce planning that can account for planned health-system transformations across PTs (i.e., moving away from stock-flow or utilization-based planning to effective-demand based planning)
2) ensuring the right enablers are in place to support the approach, including:
    - developing detailed, interoperable and standardized health workforce data to support planning across professional groups and jurisdictions
    - engaging diverse partners, including citizens and patients, in the development and implementation of health workforce planning to support decisions that achieve equity-centred quadruple-aim metrics (i.e., improving health outcomes, improving care experiences, improving provider well-being, and keeping per capita costs manageable)
    - linking health workforce planning with supply-side considerations (e.g., education programs, career pathways and receptor capacity).

Regarding sub-element 1, the McMaster Health Forum has previously prepared contextualized evidence syntheses that present an overview of heatlh-workforce planning models more generally,(22) as well as the approaches that can be adopted when planning for the workforce while accounting for planned health-system transformations specifically.(23) While these syntheses did not identify evidence that offered definitive answers about the 'best' approach for workforce planning, they document characteristics of different approaches, which suggest that effective-demand based planning is the most appropropriate approach in the context of health-system transformation (see Appendix 9 for an overview of different approaches to workforce planning typically considered in the literature).

With respect to the second sub-element, the Canadian Academy of Health Sciences assessment – which draws on an extensive review of the most recent evidence syntheses focused on specific aspects of health workforce planning and development (e.g., assessing population needs, ensuring diversity of the health workforce, establishing data requirements and infrastructure, understanding workforce supply, addressing shortages, developing education and training pipelines and integrating and licensing internationally trained workers) – has recommended these and other similar enablers as a way to address the HHR crisis in Canada.(13) Previous versions of this evidence brief also provide a collection of 'best' evidence syntheses about these domains (of which four recent high-quality and 15 recent medium-quality syntheses were identified) which can be accessed via their appendices here. This collection

suggests that the balance of 'best' evidence about workforce-planning enablers tends to focus on ways to strengthen education and training pipelines.

Implementation considerations



Some examples of the key barriers and facilitators to pursuing each of approach elements 1, 2 and 3 are listed below.

The following questions could help to guide next steps:

1) What existing initiatives (including those outlined in Appendix 4) should be leveraged now, and what new initiatives are needed, to put Canadians in the 'driver's seat' for health-system transformations?
2) Who needs to do what to support building the change-management capacity in PT health systems?
3) Who needs to plan now for the health workforce needed in transformed health systems?

References – see Appendix

Moat KA, Gauvin FP, Lavis JN. Living evidence brief v4: Addressing the politics of the HHR crisis in Canada. Hamilton: McMaster Health Forum, 15 & 16 May 2023.

The evidence brief and the stakeholder dialogue it was prepared to inform were funded with support received through a gift provided by the CMA Foundation. The McMaster Health Forum receives both financial and in-kind support from McMaster University. The views expressed in the evidence brief are the views of the authors and should not be taken to represent the views of the CMA Foundation or McMaster University

ISSN 2817-1888 (online)