

Health Council of Canada



Conseil canadien de la santé

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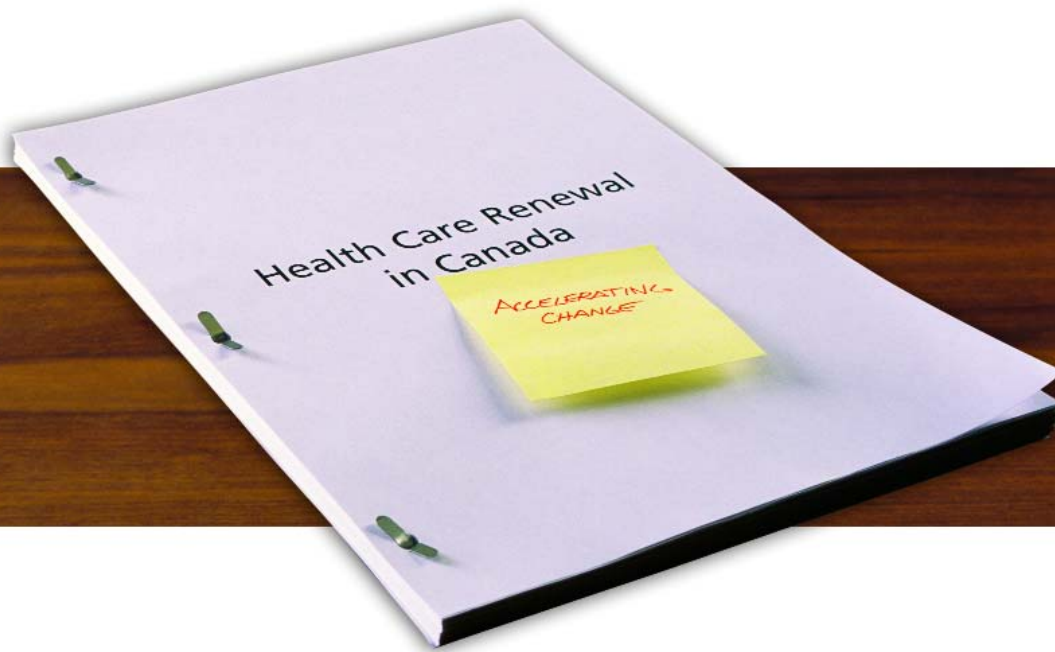
MODERNIZING THE MANAGEMENT OF HEALTH HUMAN RESOURCES IN CANADA:

Identifying Areas for Accelerated Change

EXECUTIVE SUMMARY

Report from a National Summit

June 23, 2005



ABOUT THE HEALTH COUNCIL OF CANADA

The Health Council of Canada was created as a result of the 2003 First Ministers' Accord on Health Care Renewal to report publicly on the progress of health care renewal in Canada, particularly in areas outlined in the 2003 Accord and the 2004 10-Year Plan to Strengthen Health Care. Our goal is to provide a system-wide perspective on health care reform for the Canadian public, with particular attention to accountability and transparency.

The participating jurisdictions have named Councillors representing each of their governments and also Councillors with expertise and broad experience in areas such as community care, Aboriginal health, nursing, health education and administration, finance, medicine and pharmacy. Participating jurisdictions include British Columbia, Saskatchewan, Manitoba, Ontario, Prince Edward Island, Nova Scotia, New Brunswick, Newfoundland and Labrador, Yukon, the Northwest Territories, Nunavut and the federal government. Funded by Health Canada, the Health Council operates as an independent non-profit agency, with members of the corporation being the ministers of health of the participating jurisdictions.

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*as of October 2005

EXECUTIVE SUMMARY

On June 23, 2005, the Health Council of Canada brought together over 120 key players in health care to address what the Council believes is the most pressing challenge facing our health care system – health human resources. More than one million people work in our health care system, providing care to Canadians on a daily basis. They are the backbone of the system – the provision of high quality, accessible health care services depends on having the right people, with the right skills, in the right settings.

First Ministers recognized the importance of health human resources (HHR) in their health care renewal accords of 2003 and 2004. As part of strategies to reduce wait times and improve access to health care, Canada's federal, provincial and territorial governments made significant commitments to reform the workforce aspects of our health care system.

Governments agreed to:

- ensure that the right information is available to support HHR planning on a national basis;
- create opportunities for health care providers to learn and work in interprofessional teams;
- ensure that all parts of Canada have an adequate supply of health professionals;
- report to the public on their action plans by December 31, 2005, including targets for training, recruitment and retention of health professionals.

Modernizing the way health care professionals are educated and engaged in their vital work requires a collaborative and coordinated approach among many players – universities, colleges, regulatory bodies, employers, unions, professional associations, and governments. The Health Council convened the summit on health human resources to focus on practical, short-term solutions. This report attempts to capture the lively discussion and encouraging examples of innovation brought forward at that forum, organized into four theme areas. The recommendations were developed by the Council following the meeting. While we asked participants for feedback on an earlier draft of this report – and were rewarded with a vigorous response – we did not seek the endorsement of any individual or organization. The synthesis of discussion and the recommendations are the Health Council's responsibility alone.

Along with a substantial appetite for progress evident at the summit, there was also a good dose of frustration concerning the slow pace of change. While many of the strategies highlighted here are not new, the day's dialogue clearly spoke to a collective interest in moving forward to address the critical issues: burnout, shortages and inequitable distribution of care providers, structural barriers to reforming care delivery, and disconnected planning efforts across the country, among others.

Throughout the summit, participants called for better mechanisms to share knowledge from experience across Canada and internationally. There was a strong sense that a great deal of innovation is occurring, but planners, educators and health care providers are frustrated in not having easy access to that information. Hand-in-hand with this problem is the need for more rigorous evaluation research, to understand why innovations succeed or fail and how

they affect patient outcomes in the long term. Such research requires better data collection, timely analysis, and common definitions so that outcomes from activities in different jurisdictions can be more easily compared. We need such research to understand what works in large systems and what doesn't. But we cannot simply wait for those answers. There are a number of promising models that we encourage the country to consider now.

Recommendations

Based on current commitments on funding and reform, we have set a number of specific targets which we believe are achievable within two to five years. The Health Council acknowledges that substantial efforts are underway toward many of these objectives – yet we challenge governments, professional associations, regulatory bodies, employers, unions, and educators to go further, to work together and to work with us in reporting back to Canadians on their progress. Action on each of these recommendations requires collaboration among key stakeholders, but active leadership is essential.

1) Expand opportunities for interprofessional education and post-graduate collaborative practice.

Lead responsibilities:

- Universities and colleges to design new programs;
- Governments to fund programs;
- Employers and unions to create workplaces supportive of teamwork.

By 2008:

- a. Each of Canada's university health sciences programs should offer an interprofessional educational program through collaboration among appropriate disciplines.
- b. Incentives such as tuition subsidies should be available to encourage students and post-graduate trainees to enter interprofessional education programs.
- c. A collaborative practice workplace fund should be created to enable primary health care settings to provide high-quality interprofessional care and education (for example, to fund mentorships and logistical support for such costs as transportation in rural areas and information technology).
- d. All health professionals – both new graduates and the existing workforce – should be able to access an interprofessional clinical learning experience.

2) Create more interim training and certification steps along pathways to health careers.

Lead responsibilities:

- Universities and colleges to design and implement programs;
- Governments to fund programs;
- Regulatory boards to work in partnership with educational institutions and professional associations to design and accept new credentials;
- Employers and unions to embrace new roles for providers.

By 2010:

Existing health science programs in each jurisdiction, in partnership with college-level training institutions, should offer tiered pathways in the health professions.

3) Increase the numbers of First Nations, Inuit and Métis professionals in the health workforce.

Lead responsibilities:

- Universities and colleges to implement, in partnership with governments as well as with Aboriginal leadership, national organizations, and communities;
- Employers to develop recruitment and retention programs for Aboriginal graduates.

By 2008:

- a. Colleges and universities should complete an assessment of their internal capacity to support Aboriginal students (e.g. financial support for education and living expenses, and psycho-social supports such as mentoring and peer counseling) and take action to improve insufficient supports.

By 2010:

- b. Outreach and support programs to encourage Aboriginal students to consider a health professions career should be established.
- c. The number of Aboriginal students in health professions programs should rise to at least four per cent of total enrolment (to achieve a minimum of proportional representation).
- d. An interprofessional educational cohort program for Aboriginal students in a range of health professions should be established.

4) Strengthen a national approach to managing the role of international graduates in meeting Canada's health human resource needs.

Lead responsibilities:

- Certification agencies and regulatory bodies to develop assessment processes;
- Governments to fund and to reform regulations as required;
- HHR planning authorities to specify the role of international graduates in future HHR planning;
- Federal government, in partnership with provinces and territories, to jointly develop and implement policies on ethical recruitment.

By 2008:

- a. Assessment processes to enable the integration of international graduates in regulated health professions should be standardized across Canada.
- b. The contribution of internationally-educated health care providers should be clearly articulated in HHR plans.
- c. Federal government, in consultation with provincial and territorial governments, should report publicly on progress in collaborating with international health organizations on implementing ways to improve the ethical recruitment of health care professionals.

5) Enhance opportunities for professionals to work to optimal scope of practice to ensure the system's capacity to meet local patient and population health needs.

Lead responsibilities:

- Governments, regional health authorities, employers, unions, professional associations, educators and regulators.

By 2008:

- a. Professional associations and health professions regulators should engage with employers and governments to foster better understanding of the uniqueness and commonalities in key health professions.
- b. Regional health authorities and other employers should review current workforce roles in existing health care settings to assess where people are working to optimal scope of practice and where, with appropriate supports, the workforce could better meet local patient and population health needs.

By 2010:

- c. Changes should be implemented in how work is organized to better match skills and scopes of practice to patient/client needs, and progress on these changes should be publicly reported.

6) Accelerate the shift to provider payment schemes that stimulate interprofessional teamwork.

Lead responsibilities:

- Governments, professional associations, and employers.

By 2008:

Alternate methods of compensation should be promoted so that the proportion of publicly-funded providers paid through flexible alternative schemes has increased by least 20 per cent.

7) Resolve concerns about liability in collaborative practice.

Lead responsibilities:

- Professional liability protection organizations, governments, regulators, and patient safety organizations.

By 2007:

- a. A common understanding of liability issues in collaborative practice and what remains to be done to resolve them should be publicly reported.

By 2008:

- b. An integrated approach to professional liability and accountability consistent with patient safety, risk management, and teamwork should be collaboratively developed.

8) Invest in financial and non-financial incentives to improve recruitment and retention, and report publicly on the progress of healthy workplace initiatives.

Lead responsibilities:

- Health care employers.

By 2008:

- a. Employers – in collaboration with researchers, professional associations and unions – should use comparable indicators on workplace health to publish annual assessments in such areas as employee retention and satisfaction and other aspects of work life quality.
- b. Through public reporting on indicators of workplace health, employers should regularly demonstrate improvements in the quality of work life in health care settings.
- c. Employers should increase by 10 per cent above current levels the time staff spend attending professional development opportunities and providing career mentoring and coaching.

9) Ensure that HHR planning is based on population health needs, fully integrated across jurisdictions, and properly resourced.

Lead responsibilities:

- Federal, provincial and territorial governments in partnership with regional health authorities to improve and report on planning;
- The Canadian College of Health Service Executives to develop competency requirements in interprofessional HHR planning.

By 2008:

- a. Population health needs should be the building blocks of forecasting tools used by governments and others to plan for health human resource requirements.
- b. Federal, provincial, territorial and regional health human resource plans should be mutually integrated.
- c. Governments and others should report publicly on their forecasting tools for HHR planning.
- d. The growth of management skills in planning should be supported by the requirement for competency in HHR planning in an interprofessional care environment.

Next Steps

The recommendations put forward here point to the need for action in specific areas, and the Health Council urges the responsible stakeholders to begin immediately to meet the timelines presented. We plan to report publicly on interim progress towards these goals as part of our mandate to monitor and report on health system renewal. Human resource issues will also form a major part of the Health Council's second annual report to Canadians on health care renewal, coming in January 2006. We look forward to continued dialogue and progress.