



**EVIDENCE >> INSIGHT >> ACTION**

## McMaster Health Forum

For concerned citizens and influential thinkers and doers, the McMaster Health Forum strives to be a leading hub for improving health outcomes through collective problem solving. Operating at regional/provincial levels and at national levels, the Forum harnesses information, convenes stakeholders and prepares action-oriented leaders to meet pressing health issues creatively. The Forum acts as an agent of change by empowering stakeholders to set agendas, take well-considered actions and communicate the rationale for actions effectively.

## About citizen panels

A citizen panel is an innovative way to seek public input on high-priority issues. Each panel brings together 10-16 citizens from all walks of life. Panel members share their ideas and experiences on an issue, and learn from research evidence and from the views of others. The discussions of a citizen panel can reveal new understandings about an issue and spark insights about how it should be addressed.

## About this summary

On 18 August, 10 September and 17 September 2016, the McMaster Health Forum convened three citizen panels on planning for the future health workforce of Ontario. The purpose of the panel was to guide the planning for the future health needs of Ontarians and the necessary workforce to provide this care. This summary highlights the views and experiences of participants from panels in Sudbury, Ottawa and Hamilton about:

- the underlying problem;
- three possible options to address the problem; and
- potential barriers and facilitators to implement these options.

The citizen panel did not aim for consensus. However, the summary describes areas of common ground and differences of opinions among participants and (where possible) identifies the values underlying different positions.

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## Summary of the panel

Panel participants identified eight challenges related to planning for the future health workforce of Ontario. The first three of these challenges related specifically to health workforce planning, while the other five focused on health-system challenges more broadly. These challenges included: 1) poor management of the supply, mix and distribution of health workers in Ontario and lack of clarity about health workers' responsibilities; 2) failure to adequately support caregivers and patients as partners in care delivery; 3) little patient engagement and poor integration of patient and caregiver preferences in decision-making about who provides care, and what types of services are provided; 4) lack of accountability and transparency across all levels of the health system; 5) differential access, availability and quality of services across Ontario; 6) no financial accountability and lack of clarity around resource stewardship; 7) sluggish adoption and integration of innovative technology to improve care; and 8) inadequate consideration of the impact of past policies.

Participants supported developing a data-driven approach for determining population health needs (element 1), but stressed that any approach should be transparent, well communicated and engage patients and citizens in the process of defining needs. In discussing element 2 (determining how to organize care and the health workforce while taking into account economic realities), there was a general consensus that team-based models of care should continue to be pursued in the province. However, some participants stated that moving in this direction would require greater clarity and communication around professional roles and responsibilities. Participants also called for greater care in allocating health-system resources to the models that provide the greatest value for money. Finally, in discussing element 3 (choosing policy levers to meet health workforce planning objectives), participants echoed the call from element 1 to have a greater role in the process of planning the future health workforce in Ontario. Participants also showed support for the use of a number of policy levers, including changes in accreditation and licensing of international physicians, changes to the medical curriculum to reflect changing population health needs, and new methods of remunerating physicians particularly in rural and remote communities.

When turning to implementation considerations, participants focused on three key barriers that they felt needed to be overcome to ensure successful implementation: 1) difficulty in gaining consensus across health-system stakeholders; 2) objections from professionals who may feel their autonomy is threatened; and 3) limited financial resources to support health workforce planning.



“I’ve had  
general  
practitioners  
I have never  
seen”

## **Discussing the problem:** What are the biggest challenges in planning for the future health workforce?

Panel participants at each of the three panels began by reviewing the findings from the pre-circulated citizen brief, which highlighted what is known from research evidence about health workforce planning in Ontario. They focused on three challenges related to planning for the future health workforce:

1. poor management of the supply, mix and distribution of health workers in Ontario and a lack of clarity in defining their responsibilities;
2. failure to adequately support caregivers as partners in care delivery; and
3. little patient engagement and poor integration of patient and caregiver preferences in decision-making about who provides care, and what types of services are provided.

Participants also focused on five issues that related to Ontario’s health system more broadly when discussing the problem:

1. the lack of accountability and transparency across all levels;
2. differential access, availability and quality of services across Ontario;

3. no financial accountability and lack of clarity around resource stewardship;
4. sluggish adoption and integration of innovative technology to improve care; and
5. inadequate consideration of the impact of past policies.

We review each of these challenges in turn below.

## Poor management of the supply, mix and distribution of health workers in Ontario and lack of clarity in defining their responsibilities

Across all three panels, participants expressed frustration with a number of problems related to the supply, mix and distribution of health workers, including:

- unequal distribution of health workers across Ontario;
- narrowly defined roles and responsibilities in professional practice;
- lack of proper training for, and ongoing assessments of non-regulated professionals, both in their clinical competencies and broader approach to care; and
- limited coordination across professions.

### **Box 1: Key features of the citizen panel**

The citizen panel about planning for the future health workforce of Ontario had the following 11 features:

- 1) it addressed a high-priority issue in Ontario;
- 2) it provided an opportunity to discuss different features of the problem;
- 3) it provided an opportunity to discuss three elements for addressing the problem;
- 4) it provided an opportunity to discuss key implementation considerations (e.g., barriers);
- 5) it provided an opportunity to talk about who might do what differently;
- 6) it was informed by a pre-circulated, plain language brief;
- 7) it involved a facilitator to assist with the discussions;
- 8) it brought together citizens affected by the problem or by future decisions related to the problem;
- 9) it aimed for fair representation among the diversity of citizens involved in or affected by the problem;
- 10) it aimed for open and frank discussions that will preserve the anonymity of participants; and
- 11) it aimed to find both common ground and differences of opinion.

Many participants discussed the unequal distribution of health workers across Ontario in relation to their ease of access to primary care, with one participant stating: “I have had general practitioners I have never seen.” This participant explained that due to challenges getting same- or next-day appointments, they often use walk-in and after-hours clinics, despite being registered with a family physician in their area. The point was further elaborated upon by the participant, who stated that they believed the challenge in seeing providers was not the fault of the professionals, but rather a symptom of not having enough providers in rural communities. Another participant had a similar experience when moving into a new city where it took her family five years to find a family practice that was accepting patients.

Participants at all three panels also expressed their feeling that the health system is not maximizing the skills and education of professionals in a way that would help to compensate for the challenges in distribution considered. A number of participants suggested that this is particularly challenging in rural and remote communities.

### **Box 2: Profile of panel participants**

The citizen panel aimed for fair representation among the diversity of citizens likely to be affected by the problem. We provide below a brief profile of panel participants:

- **How many participants?**  
16 (Sudbury); 14 (Ottawa); 13 (Hamilton)
- **Where were they from?**  
Regions covered by Mississauga Halton, Hamilton Niagara Halidmand Brant, Ottawa Champlain, Sudbury North East
- **How old were they?**  
18-24 (1), 25-34 (5), 35-49 (11), 50-64 (17) 65 and older (9)
- **Were they men or women?**  
Men (23) and women (20)
- **Were they living in urban or suburban settings?**  
Urban (20), suburban (16) and rural (7)
- **How many identify as Indigenous?**  
Yes (3) No (40)
- **How many identify as Francophone?**  
Yes (8) No (35)
- **What was the income level of participants?** 16% earned less than \$20,000, 19% between \$20,000 and \$34,999, 14% between \$35,000 and \$49,999, 25% between \$50,000 and \$79,999, 21% earned more than \$80,000, and 5% preferred not to answer.
- **How were they recruited?** Selected based on explicit criteria from the AskingCanadians™ panel

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Several participants also expressed that they understood current regulations as defining health-worker roles within relatively narrow scopes of practice, which seemed to further complicate the problem. However, participants at each of the panels framed this issue in very different ways. One participant shared his experience of waiting for a doctor to put a bandage on his hand noting that, “I didn’t need a doctor to do it, I could have been seen by someone else and the doctor could have spent the 10 minutes with someone who actually needed those resources.” Other participants suggested that they felt current policy was too “doctor centric,” focusing on the roles of physicians in the system rather than taking the possible roles of other health workers into consideration. A third participant discussed this issue in terms of public expectations, stating that while physicians should have an overarching view of a patient’s health, “it is unreasonable for us to think that a physician is always the point of contact for each visit.”

Additionally, many participants highlighted that they believed there were inconsistencies in the skills and in the training that health workers have, particularly among non-regulated professionals. To illustrate this point further, one participant expressed that “[personal-support workers] are sometimes unprepared for the situations they walk into,” and that it is important for the safety of both the patient and the health worker that they be regulated and monitored as are other health professionals.

Finally, participants discussed how challenges related to the supply, mix and distribution of providers are exacerbated by the fragmentation that exists both when it comes to referrals to specialists as well as with a lack of coordination of information between professionals. Several participants discussed their experience with being referred to a new provider, and shared that they felt they often spent much of the appointment time re-telling their ‘patient-story’ rather than working through their concerns. Another participant expressed that he felt this challenge was also a detriment to providers, stating that some of the patient volume could be shifted to other health workers. This same participant suggested that this would be more feasible if patients felt that information could be easily shared with their primary-care practitioner.

## Failure to adequately support caregivers as partners in care delivery

The aging population and the anticipated growth in need for health services among this population was an important source of concern that many participants indicated motivated them to participate in the citizen panel. Many panel participants were either acting or expecting to act as caregivers for family or friends and felt that the health system was not doing an adequate job of supporting them. One participant suggested that “the health system was there to help you in emergency circumstances, but otherwise you are left to your own devices and it is expected that the family will figure it out.” Other participants discussed how they did not feel that health workers and system decision-makers acknowledged how much “heavy lifting” caregivers were doing.

## Little patient engagement and poor integration of patient and caregiver preferences in decision-making about who provides care and what types of services are provided

Many participants mentioned that they were initially surprised when asked to be part of the panel to discuss planning for the future of the health workforce in Ontario. Participants indicated that they did not feel that patients and citizens were regularly consulted on planning decisions. One participant stated that, “as a citizen I am not used to my opinion being asked or even listened to.”

Despite being initially hesitant, as the discussion continued, participants were increasingly convinced that members of the public should be regularly consulted on decisions about who provides care and what types of services are being provided. One participant expressed this by saying, “negotiations and decisions happen between the [Ontario Medical Association] and the government, but they aren’t the ones using the system.” Other participants discussed how this lack of involvement stemmed from insufficient knowledge and education regarding how these decisions are made and what avenues exist for public involvement.

In addition, participants felt that the following issues were particularly pressing with respect to patient and caregiver engagement in decision-making:

- insufficient acknowledgment of patient preferences among care provider(s);

- lack of consideration of the types of programs and services (and drugs when considering brand versus generic options) patients want to receive from their preferred provider; and
- increasing expectations that patients and their caregivers need to advocate for themselves if they want to ensure they receive appropriate high-quality care.

In discussing the problem, five additional challenges that relate to the health system more broadly were reiterated by participants at each of the panels. We now turn to discussing these issues.

## A lack of accountability across all levels

Across the three panels, participants discussed how a lack of accountability across all levels of the health system contributed to challenges in planning the future health workforce. Participants felt that the following challenges existed with regards to accountability at the levels of providers and the health system:

- health workers are not held accountable for the quality of care being delivered;
- non-regulated professionals (specifically home-care and personal-support workers) are not held accountable for the services (or lack of services) they provide;
- the health system has evolved more around the ways in which care is paid for rather than the needs of the patient;
- the lack of patient education and insufficient emphasis on public communication contributes to erode patients' trust towards provider and government decisions; and
- the social contract between the public, providers and government has been compromised (particularly with respect to an increasing misalignment between the societal goals viewed as important by each of these groups).

Participants also expressed frustration with lack of accountability at the political level, specifically with regards to:

- political decision-making about what services to fund;
- negotiations of health workers' contracts; and
- the use of public funds more generally.

## Differential access, availability and quality of services across Ontario

Differential access, availability and quality of services was consistently brought up by several participants throughout each of the three panels. Participants acknowledged that Ontario was a large province and understood that the same resources would not be available in all communities, but felt there should be more consistency in levels of access and in the quality of care being provided. Many participants from northern communities expressed this concern particularly as it related to primary care. They further emphasized that the arrangements currently in place to help ensure equity of access were insufficient. For example, one participant mentioned how current travel allowances for acute care do not go far enough in covering the cost of a trip, particularly when patients are asked to stay overnight in urban centres such as Toronto. This same participant also stated that these arrangements fail to consider many of the other barriers that may restrict access, including limited transportation or inability to take time off work.

Another common challenge in access to care that was frequently reiterated by participants was a feeling that different levels of access were granted to different populations. Participants expressed that affluence, connection to the health system and proximity to an urban area were larger determinants of access to and availability of care than actual health needs.

In addition to these two challenges, participants raised a number of other issues relating to access, availability and quality of services in Ontario, which included:

- long wait times and lack of physical resources to meet patient demands (e.g., hospital beds);
- acute conditions being overly emphasized in delivering care, with less acute and preventive concerns routinely overlooked; and
- variations in quality across the system and a lack of consistent quality-control mechanisms.

## No financial accountability and lack of clarity around resource stewardship

Financial accountability and clarity around resource stewardship were also associated with a number of challenges highlighted by participants. Many participants discussed their

knowledge of current financial pressures in the province and the threats to affordability that these pose in the future. These participants prioritized the need to consider efficiency and cost-effectiveness in the system.

Despite being optimistic that efficiencies could be found, participants expressed frustration at patterns of current public spending. Select participants at each of the panels felt that public spending has not appropriately prioritized allocations, and that instead of funds being primarily directed to patient care or to front-line workers, in many cases they have been spent on administrative and executive costs.

## Sluggish adoption and integration of innovative technology to improve care

Participants indicated that they believed the adoption of innovative technology has been slow in the province, with the failure to integrate electronic health records serving as a particularly problematic example of a missed opportunity for significantly improving care. While the majority of participants discussed this with regards to the delivery of care, some participants made an optimistic link to planning for the future health workforce, noting how innovative technology could improve the ability to collect data and inform decision-making.

Participants also expressed that they felt Ontario had not done enough to learn from other jurisdictions across the country and internationally about how to best adopt innovative practices and models of care.

## Inadequate consideration of the impact of past policies

Finally, participants shared their views on the impact of past policies and the ways in which these have contributed to inequities in health and limited access to services among Indigenous groups, expressing that there is a need to consider universal access to health services as being inclusive of traditional medicines and providers.



“Our minds are set right now... and I think we need to accept that things are changing and we don't always need to see a doctor”

## Discussing the elements of an approach to address the problem

After discussing their views and experiences related to the problem, participants were asked to reflect on these three elements of a potentially comprehensive approach for planning for the future health workforce of Ontario:

- 1) determine the current and future needs of Ontarians and describe the types of care that can best meet those needs;
- 2) establish the best ways to organize care and the health workforce required to meet Ontarians' health needs, while taking into account the economic realities in the province; and
- 3) select the appropriate policy levers to meet health-workforce needs.

Several values-related themes emerged during the discussion about these elements, with two emerging across three elements with some consistency:

- patient engagement (in their own care and in policy decision-making); and
- transparency (in roles and responsibilities of the health workforce and in health-system decision-making processes).

We describe below these values as they relate to the three elements, along with other values that emerged during the deliberations.

## **Element 1** – Determine the current and future needs of Ontarians and describe the types of care that can best meet those needs

Element 1 can be considered the first step in building a new process for health workforce planning, understanding that planning requires clearly defining the health needs of Ontarians, which will require good data about population health. The element included the following sub-elements:

- 1) using population health and health-system data to determine health needs (and unmet health needs) for Ontarians now and in the future;
- 2) engaging experts to provide insights about the most cost-effective and feasible types of care available for addressing population health needs; and
- 3) establishing deliberative processes that engage champions from health professional groups and health-system stakeholders to collectively agree on which types of care could be more appropriately adopted by whom, in order to meet population health needs.

Four values-related themes emerged during the discussion about element 1:

- 1) decision-making informed by high-quality data on the needs and preferences of Ontarians;
- 2) transparency in data collection and use;
- 3) citizen engagement in decision-making; and
- 4) equity of access to high-quality services (between rural and urban communities, and between English- and French-speaking communities).

### **Box 3: Key messages about determining the current and future health needs of Ontarians and describing the types of care that can best meet those needs**

- Account for current health priorities in caring for older adults and those with chronic conditions, but recognize that health needs will change with the end of the baby-boomer generation
- Ensure the health system is reoriented to better accommodate the needs of older adults and those with chronic conditions through a greater focus on community services and integrated clinics
- Focus on collecting data that considers both what the current health trends are and how demographics will change in the province
- Develop a transparent process of determining population health needs
- Engage patients and members of the public in the process of determining health needs through public consultations and surveys

Participants generally agreed with the approach outlined in element 1, affirming the importance of using a data-driven method for collecting reliable information on today's health trends to forecast future needs, which was the first values-related theme to emerge during discussions. One participant stated that “while it is difficult to change what is happening right now, we need to do research today to figure out what the trends are and to determine if these will still be true five and 10 years from now.” Participants indicated that it is important to look not only at collecting reliable data, but also at how demographics will change in the province in coming years, including through the increase in new Canadians, such as immigrants and refugees. Participants highlighted that these and many other communities have different needs that will need to be reflected in the providers available. Participants also discussed that this data and reflection on future needs will likely spur a discussion on what services should be available and insured by the Ontario Health Insurance Plan. In particular, one participant felt that “the things that are not currently covered but help to keep us healthy are going to be of greater and greater importance,” while another mentioned the need to think of services, models and provider roles “that we have not yet imagined.”

To support these changes, participants valued the development of a transparent process for collecting and using data – the second values-related theme to emerge during discussions. Participants specified what they believed to be the elements of a transparent process, which included: 1) determining what data are being used; 2) establishing a process for how data are being collected; 3) defining who is analyzing the results; and 4) clearly communicating all of these aspects of the process to the public, alongside regular reports and publications. Across all panels, participants also agreed that this level of transparency in data collection should be reflected in decisions about the type and number of services that should be funded.

While participants agreed that there was a need to engage experts and health-system stakeholders in providing insights about how best to address population health needs, they overwhelmingly supported the increased engagement of patients and members of the public, which was the third values-related theme to emerge in the panels. Participants felt that this would ensure that any information presented to decision-makers reflected changes that citizens believed to be important. One participant also felt that the inclusion of the citizens' voice would provide some confidence that designed processes and protocols for prioritizing needs were being followed.

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While participants felt confident in the ability of transparent data combined with citizen and stakeholder opinion to make adequate decisions on the types of care that could meet the defined population health needs, they articulated the need for greater consideration of equity of access to available services (reflecting the fourth values-related theme to emerge in relation to element 1). At each panel, participants mentioned that they felt the current level of services did not provide sufficient access to services for those living in rural and remote communities as well as in Franco-Ontarian communities. To support a focus on providing an equitable level of care, some participants suggested that in collecting citizen input on services and data on health needs, a greater weight should be placed on the opinions of these populations. Another participant suggested that rather than shifting the weight of opinions that inform decisions, perhaps service planning to meet population health needs could begin at the local level and inform a broader province-wide plan.

## Element 2 – Establish the best ways to organize care and the health workforce required to meet Ontarians’ health needs, while taking into account the economic realities in the province

Element 2 focused on addressing short-term objectives for health workforce planning that would require building on existing models of care and adjusting an established health workforce planning process that reflects the current realities of the health system. This element included four sub-elements:

- 1) establishing the models of care that will likely be pursued in the short and medium term in Ontario to meet the health needs of Ontarians;
- 2) defining the mix of health workers involved in these models;
- 3) adjusting existing approaches to health workforce planning in Ontario to account for the mix of health workers involved in delivering care in new models; and
- 4) incorporating the full range of budgetary factors that may influence health workforce planning decisions, such as projected economic development and the price of various healthcare inputs (e.g., equipment, facilities, provider remuneration) to establish the parameters for incorporating effective demand principles.

### **Box 4: Key messages about establishing the best ways to organize care and the health workforce required to meet Ontarians’ health needs, while taking into account the economic realities in the province**

- Improve the continuity of and access to care through coordinated services
- Increase adoption of technology to facilitate easier access to care
- Broaden professional roles and responsibilities to improve the efficiency of care
- Empower communities with a greater role in planning for the health workforce and ensure these plans are integrated with efforts at both the regional and the provincial levels
- Engage patients and citizens in determining the best ways to organize care and the health workforce to meet patient needs
- Encourage the careful allocation of resources, prioritizing cost-effective services and models of delivery

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Six values-related themes emerged during the discussion on element 2:

- 1) coordination of services to ensure continuity of and better access to care;
- 2) access to care facilitated by the adoption of technology;
- 3) efficiency through broadening professional roles and responsibilities;
- 4) recognition of diversity in communities across the province;
- 5) patient engagement in decision-making; and
- 6) cost-effectiveness of services.

In discussing how to organize care and the health workforce to meet patients' needs, participants overwhelmingly supported the continued development of models of care that emphasize coordination across professionals, which was the first values-related theme that participants focused on in discussing element 2. At least one participant at each of the panels supported the expansion of Ontario's Family Health Teams for this reason, believing that while it may not be the best model, the coordination it provides between health workers is valuable. In addition, participants felt that emphasizing team-based models, particularly in areas with insufficient numbers of professionals, may enable better access to community care. One participant in particular noted that "instead of placing the burden and pressure of caring for patients on one provider, they should work together as a team to balance more people with a larger range of skills."

Participants also discussed how in addition to shifting models towards team-based care, careful consideration should be given to the role technology could play in facilitating access to care and easing the burden on health workers, which was the second values-related theme to emerge in discussions of element 2. The use of electronic health records was brought up in each panel by participants who felt they could improve patient-provider communication, enhance coordination of information between providers, and provide more cost-effective services. For example, participants supported the increased use of telehealth services and Skype for individuals who have shorter appointments or fewer acute visits such as for renewing a prescription.

Additionally, participants felt that broadening professional roles and responsibilities was an important change to help meet patients' needs and could assist in relieving some of the burden shouldered by physicians while improving system efficiencies (the third values-related theme to emerge in discussions of element 2). Most participants provided nurse practitioners and pharmacists as examples of professions who could take on additional responsibilities currently under physicians' scope of practice. For example, one participant mentioned how her current physician would email prescription renewals to her pharmacist

without seeing her. While she said she was pleased with how efficient this was, she noted that “I still want to see someone, to know someone is monitoring my reaction to the prescription ... I don’t care if this is a doctor or a pharmacist, but I would like to speak with someone face-to-face.” While participants were largely supportive of redefining provider roles, some participants had concerns about increasing the role of health workers who are not currently regulated, such as physician assistants and personal-support workers.

Interestingly, a number of participants brought up the idea that it is not just professional responsibilities that will need to change, but that people’s expectations and mindset will need to change as well, regarding the public’s willingness to see other health workers who are not physicians. One participant expressed this by stating, “our minds are set right now... and I think we need to change this and accept that things are changing and we don’t always need to see a doctor,” while another attributed not using professionals to their full scope of practice to a lack of public education on what services professionals are able to deliver.

Participants stressed that in thinking about models of care and roles of providers, decision-makers should more explicitly acknowledge the geographic and cultural diversity that exists across communities in the province, which was the fourth values-related theme to be discussed in relation to element 2. As mentioned in element 1, participants suggested that this could include improving the capacity of, and enabling communities to plan for, local health services and the health workforce. In addition, participants reiterated the need for engagement in decision-making around models of care and health workforce planning, supporting the development of public forums and frequently circulated surveys for citizens to express their preferences, which was the fifth values-related theme to emerge in discussions centred on element 2.

Finally, a number of participants expressed concerns over the current provincial health budget and cautioned that resources need to be carefully allocated to prioritize cost-effective services and models of care (the sixth and final values-related theme to emerge in discussions of element 2).

## **Element 3** – Select the appropriate policy levers to meet health workforce planning objectives

Element 3 focused on identifying what citizens think about the levers that would help to ensure the right mix, supply and distribution of health workers is in place. This included six broad policy levers:

- 1) changes to the capacity and mix of practising health workers in the system (e.g., through adjustments to professional school admissions criteria, the size of entering classes or curriculum);
- 2) changes in the information provided to students and practising health workers that may influence, where, what and how they practise (e.g., sharing of information about anticipated community needs, career opportunities, and the context of practice);
- 3) changes in how organizations are funded, and how individual health workers are remunerated to influence where and how they practise (e.g., adjusting fee levels to increase a specific type of provider such as a rural family physician);
- 4) changes in the examination, licensure, certification and regulation processes to make it easier/harder for certain health workers to practise (e.g., removing licensure barriers to enable quicker transitions for foreign-trained professionals to practise in the province);
- 5) changes to professional development and on-the-job training curricula; and
- 6) changes to planning approaches and policies that affect the geographic distribution of health workers (e.g., introducing regional distribution policies that affect the rules dictating provider hospital privileges).

### **Box 5: Key messages about selecting the appropriate policy levels to meet health workforce planning objectives**

- Adjust policy levers that can support changes to the health workforce and improve the health system, including changes to certification requirements, professional licences, education curriculum and professional remuneration, among others
- Ensure that sufficient supports are available for caregivers including tax breaks, paid leave and therapy or support groups
- Engage patients in the process of planning for the future health workforce.

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Unlike the first two elements, discussions around element 3 primarily involved participants' reactions to the element and its sub-elements, while expressing their support for, or aversion to, a number of the policy levers laid out above.

Licensure and certification were the policy levers that received the most attention among participants in discussions of element 3. Specifically, across the three panels participants agreed that health workers should be required to update their certification on a regular basis, with some panellists suggesting every five to 10 years. Additionally, panellists felt that changes should be made to the licensing of health workers trained outside Canada, making it easier for immigrants and international graduates to begin working within the system. Participants recognized however, that many of the licensure requirements have been put in place to ensure quality and consistency in health professionals' practice in the province, and while no consensus was reached across the panels, several participants felt that the current system posed too many barriers. In response, a number of participants suggested the development of easily accessible government loans to assist health workers who were accredited elsewhere and recently moved to Canada during their re-licensing.

Participants also discussed changes to licensing and regulations for personal-support workers and physician assistants in efforts to ensure greater consistency between training programs. They further suggested that once regulated, the associations that oversee these health workers should implement ongoing monitoring, evaluation and reporting of the services they provide.

In addition to licensure and certification considerations, discussions related to this element also focused on participants' views about levers that could be used to improve the health workforce in rural and remote areas of the province. Participants were pleased to see evidence that training providers from rural communities and in rural communities improved the likelihood that they would practise in these locations. Therefore, participants called for an increase in the number of post-secondary institutions or affiliate campuses in rural communities for training health workers. Recognizing that rural practice requires a broader set of skills, most participants supported the development of a rural speciality or designation specific to rural and remote practice, as well as a change in curricula to include rural and remote area-specific education. To support these changes, participants agreed that adjustments should be made to increase the recruitment of health workers from rural and remote communities, and to support these new recruits with changes in funding for rural locums in order to extend time commitments and encourage them to stay.

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Another area of focus among participants was on the levers available to adjust professional compensation models. Specifically, many participants suggested that there was a need to emphasize and reward the delivery of high-quality care as well as to support the increasing requirements for ongoing education. Additionally, one participant shared that if we are planning for the future of the health workforce we would need to “update the way [professionals] practise to meet the diversity and cultural competency needs of our country.”

In addition to the policy levers focused on health workers, participants also discussed the important role that friends and family caregivers play in the health system, and suggested that there were policy levers that should focus on these individuals as well. Specifically, participants emphasized that if we plan for the future health workforce, it is equally important that we plan the roles and supports for caregivers. Participants suggested a number of approaches that could be considered, including the development of tax breaks, paid leave, and easily accessible therapy and respite services, to increase the recognition and improve the support available to caregivers.

Despite the primary focus of discussions surrounding element 3 on reacting to each policy lever, two values-related themes also emerged during the panel discussions:

- 1) citizen engagement in all levels of decision-making; and
- 2) transparency in decision-making about changes to the system.

Building off the discussion about caregivers, one participant noted that we should consider patients and caregivers to be a part of the health workforce. In line with this statement, a number of participants at each of the panels (in Hamilton, Ottawa and Sudbury) clearly stated that they valued citizen engagement (the first values-related theme) in all levels of the process of planning for the future health workforce. Specific suggestions for improving engagement included:

- establishing forums that enable patients’ opinions to be voiced;
- encouraging the development of a range of mechanisms to support active participation in the planning process;
- introducing accountability mechanisms to ensure patient feedback is being acted on;
- providing increased information and education to patients about their interactions with the health system; and
- developing patient ‘watchdogs’ and other accountability mechanisms.

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Finally, participants clearly expressed that regardless of what policy options are pursued, they valued transparency (the second values-related theme) and disclosure in the decision-making and implementation process. A number of participants expressed a mistrust in political and government decisions, and in response felt that if changes to the health system were being made they should be pursued through a process that is developed in advance, that is clearly communicated to the public, and that requires frequent public reporting on progress.



“We need to get a better bang for our buck and start engaging citizens more in decision-making”

## **Discussing the implementation considerations:** What are the potential barriers and facilitators to implementing these elements?

After discussing the three elements, participants examined potential barriers and facilitators that would be encountered in efforts to improve the planning for the future of the health workforce in Ontario. In particular, while participants were generally optimistic about the changes suggested in each of the three elements, they noted a number of barriers. Chief among these were the difficulty in gaining consensus across health-system stakeholders, objections from professionals, and limited financial resources as the largest barriers to change. Furthermore, participants felt that it would be challenging to find a politician to champion this cause due to potential conflicts with professionals and other stakeholders. Despite this, participants felt there was an opportunity for a bottom-up or grassroots approach to advocate for the development of a comprehensive approach to health workforce planning, which would hinge on better engagement of citizens.

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