Living Evidence Brief

Addressing the Politics of the Health Human Resource Crisis in Canada

22 & 23 November 2022

Version 1

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McMaster Health Forum

The McMaster Health Forum's goal is to generate action on the pressing health and social issues of our time. We do this based on the best-available research evidence, as well as experiences and insights from citizens, professionals, organizational leaders, and government policymakers. We undertake some of our work under the Forum banner, and other work in our role as secretariat for Rapid-Improvement Support and Exchange, COVID-19 Evidence Network to support Decision-making (COVID-END), and Global Commission on Evidence to Address Societal Challenges.

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Conflict of interest

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Merit review

The evidence brief was reviewed by a small number of policymakers, stakeholders and researchers in order to ensure its scientific rigour and system relevance.

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KEY MESSAGES

What's the problem?

A long-standing problem that we face with health human resources (HHR) in Canada is the *politics* of transformative change, rather than fundamental disagreements about the policy framework underpinning the required changes. Governmental policymakers, system and organizational leaders, professional leaders and researchers have over many decades discussed the broad policy framework – including the components of planning and development, deployment and service delivery, and support and retention – albeit with some variation in language and approaches to categorization. What we have not seen is transformative change based on this framework, which may be attributed to three factors:

- managing the 'HHR commons' (i.e., the HHR that groups of people such as government policymakers and system and organizational leaders 'manage' for individual and collective benefit) represents a collective action problem shaped by politics
- while the policy framework is well established, little attention is paid to matching a compelling problem and viable policy options with conducive politics
- the available evidence continues to advance in some dimensions of the policy framework, but not in others (i.e., there is an imbalance in the HHR topics covered by the best-available evidence syntheses).

A 'window of opportunity' has now emerged in Canada, with decision-makers faced with a compelling problem (an HHR crisis) and viable policy options (based on an established policy framework). The big challenge is finding or creating the 'conducive politics.'

What do we know (from evidence syntheses) about three elements of a potentially comprehensive approach to addressing the problem?

- Element 1 – Develop the norms and values that need to underpin collective action to manage the 'HHR commons'
  - No evidence syntheses relevant to developing norms and values in the context of HHR policy were found, but two low-quality syntheses identified utility and efficiency, justice and equity, autonomy, solidarity, participation, sustainability, transparency and accountability, as important values in various decision-making contexts. Three medium-quality syntheses found factors that support collaborative decision-making, particularly when these are formalized (e.g., communication, trust, respect, shared goals and consensus), and noted the importance of governance structures, a unified strategy, and political skill.
  - While we have started a list of candidate norms and values, we encourage dialogue participants to add to the list, particularly with norms and values that have been explicitly highlighted in past Canadian efforts.
- Element 2 – Identify the policy levers available to provincial/territorial government policymakers and system/organizational leaders that would incentivize adherence to these norms and values regardless of the role of the federal government
  - No evidence syntheses were identified that addressed this element.
  - While we have started a list of candidate policy levers, we encourage dialogue participants to add to the list, particularly with policy levers likely to be viable in the current political context.
- Element 3 – Identify the policy levers available to federal government policymakers that would incentivize adherence to these norms and values
  - No evidence syntheses were identified that addressed this element.
  - Again, while we have started a list of candidate policy levers, we encourage dialogue participants to add to the list.

What implementation considerations need to be kept in mind?

Governments at the federal and provincial/territorial levels have taken action to address HHR challenges and sent clear signals about the importance of this issue, which are two facilitators of pan-Canadian efforts to address the current crisis. However, efforts and messages are not always congruent with shared norms and values to manage the 'HHR commons', which is a barrier that needs to be overcome.

REPORT

As the COVID-19 pandemic continues to shape the key policy issues being considered in health systems around the world, perhaps none have been more attention grabbing for decision-makers than the impact the pandemic has had on the health workforce. While the approach to addressing the COVID-19 pandemic continues to shift in many parts of the world, governmental policymakers and system/organizational leaders in almost all countries are now tasked with finding the best ways to manage a health human resources (HHR) crisis characterized by high rates of burnout, attrition, and turnover among many types of health workers.(1) However, despite the current framing of the HHR crisis in Canada in relation to COVID-19, this issue is one that is longstanding, and there have been many critical junctures in the past where HHR has emerged on governments' and stakeholders' agendas.

In the past when HHR challenges have risen to the top of agendas, there have been consensus statements issued about how to address these challenges (e.g., the 2004 Health Accord, the 2007 Framework for Collaborative Pan-Canadian Health Human Resource Planning). Such statements have never been followed by widespread changes on the ground across provincial and territorial (PT) health systems.(2) Instead, we have tended to see incremental adjustments to the status quo within specific jurisdictions, with just one notable exception, namely the 1992 PT health ministers' agreement to take collective action to address a perceived surplus of physicians, which was only one of the 53 recommendations put forward for their consideration. Pan-Canadian collaboration has rarely figured as a stand-alone agenda item in federal/provincial/territorial (FPT) ministers' meetings since this time.(3)

While the history of FPT discussions offers little reason for optimism, there are a remarkable number of ad hoc initiatives underway now to respond to the current HHR crisis across PT health systems. Some of the most recent examples include:

- the Health Canada-funded and KPMG-led roundtables (convened between 4 and 8 April 2022) and symposium (convened on 10 and 11 May 2022)
- the Canadian Academy of Health Sciences' (CAHS) assessment (begun in March 2022 and set to conclude in January 2023)

Box 1: Background to the living evidence brief

This first version of the living evidence brief mobilizes both global and local research evidence about a problem, three approach elements for addressing the problem, and key implementation considerations. It also draws on the experiences from federal, provincial and territorial jurisdictions to inform our understanding of the issue, which were gathered through reviews of government documents and websites, as well as through key informant interviews. Whenever possible, the evidence brief summarizes research evidence drawn from evidence syntheses and occasionally from single research studies. An evidence synthesis is a summary of studies addressing a clearly formulated question that uses systematic and explicit methods to identify, select and appraise research studies and to synthesize data from the included studies. The evidence brief does not contain recommendations, which would have required the authors of the brief to make judgements based on their personal values and preferences, and which could pre-empt important deliberations about whose values and preferences matter in making such judgments.

The preparation of the evidence brief involved five steps:

1) convening a Steering Committee comprised of representatives from the partner organization, key stakeholder groups, and the McMaster Health Forum
2) developing and refining the terms of reference for an evidence brief, particularly the framing of the problem and three approach elements for addressing it, in consultation with the Steering Committee and a number of key informants and with the aid of several conceptual frameworks that organize thinking about ways to approach the issue
3) identifying, selecting, appraising and synthesizing relevant research evidence and undertaking a jurisdictional scan about the problem, approach elements, and implementation considerations
4) drafting the evidence brief in such a way as to present concisely and in accessible language the global and local research evidence, and insights from the jurisdictional scan
5) finalizing the evidence brief based on the input of several merit reviewers.

The three approach elements for addressing the problem were not designed to be mutually exclusive. They could be pursued simultaneously or in a sequenced way, and each approach element could be given greater or lesser attention relative to the others. The evidence brief was prepared to inform a living stakeholder dialogue consisting of four interactions spanning several months, and it will be iteratively revised after each interaction to reflect key insights from the discussion. At each dialogue interaction, research evidence is one of many considerations alongside participants' views and experiences and their tacit knowledge. The goal of the dialogue is to spark insights and generate action by participants and by those who review the dialogue summary.

- the Coalition for Action for Health Workers (reporting to the federal Deputy Minister of Health), which held its first meeting on 1 November 2022.

These ad hoc initiatives are being overlaid on a number of long-standing initiatives, such as the FPT Committee on Health Workforce (CHW), which was established in 2002 as the Advisory Committee on Health Delivery and Human Resources by the FPT Conference of Deputy Ministers of Health (CDM).

These many initiatives – both ad hoc current (and past) ones and long-standing ones – are largely consistent in how they outline the core components of a needed HHR policy framework. What has been missing has been efforts to understand the politics of HHR planning, and to shape them so that they are more conducive to supporting collective action. This living evidence brief and the living stakeholder dialogue it was prepared to inform seek to add politics to the mix in supporting informed deliberations about the problem, elements of an approach to address it, and key implementation considerations.

Aim of this 'living' evidence brief

This is the first version of a living evidence brief that will inform a living stakeholder dialogue about how to address the HHR crisis in Canada. The living stakeholder dialogue will consist of four separate interactions among government policymakers, system and organizational leaders, health professional leaders, patient and community leaders, and researchers – all of whom are directly involved in or likely to be affected by future decisions about the issue – that will take place from November 2022 to May 2023. This evidence brief will be iteratively updated before each successive dialogue to capture changes to the political context, issues, and actions being taken to respond to the evolving context and issues. A living citizen panel that consists of two separate interactions focused on the same issue will also yield insights from an ethnoculturally and socio-demographically diverse group of individuals with lived experience with HHR challenges. These insights from the living citizen panels – and the values underpinning them – will also be used to iteratively revise this living evidence brief.

The aim of this evidence brief is to mobilize the best-available evidence, insights from a documentary and website review of all Canadian FPT jurisdictions, and the views and experiences of key informants in order to:

1) frame the problem underpinning the challenges with addressing the HHR crisis in Canada
2) identify elements of a potentially comprehensive approach for addressing the problem
3) identify key implementation considerations that can inform next steps

As explained in Box 1, the evidence brief does not contain recommendations. Moving from evidence and insights to recommendations would have required the authors to introduce their own values and preferences. Instead, the intent is for the evidence brief to inform deliberations where participants in the living stakeholder dialogue will themselves decide what actions are needed based on the available evidence, their own knowledge and experiences, and insights arising through deliberations.

In later versions of the evidence brief we will include two equity sub-sections, with one addressing how the problem disproportionately affects some groups in society, and the other addressing how the benefits, harms and costs of the approach elements to address the problem (and implementation considerations) may vary across groups. Dialogue participants are encouraged to identify potential candidates for such equity-deserving groups. One way to identify groups warranting particular attention is to use the PROGRESS-Plus framework, which captures: 1) place of residence (e.g., rural and remote populations); 2) race/ethnicity/culture (e.g., First Nations and Inuit populations, immigrant populations and linguistic minority populations); 3) occupation or labour-market experiences more generally (e.g., those in "precarious work" arrangements); 4) gender; 5) religion; 6) educational level (e.g., health literacy); 7) socio-economic status (e.g., economically disadvantaged populations); 8) social capital/social exclusion; 9) personal characteristics associated with discrimination (e.g., age, disability); 10) features of relationships (e.g., smoking parents, excluded from school; and 11) time-dependent relationships (e.g., leaving the hospital, respite care, other instances where a person may be temporarily at a disadvantage).

THE PROBLEM: IT'S THE POLITICS, NOT THE POLICY FRAMEWORK

A long-standing problem that we face with HHR in Canada is the *politics* of transformative change, rather than fundamental disagreements about the policy framework underpinning the required changes. Governmental policymakers, system and organizational leaders, professional leaders and researchers have over many decades discussed the broad policy framework – including the components of planning and development, deployment and service delivery, and support and retention – albeit with some variation in language and approaches to categorization. We summarize the components of one version of this policy framework in Table 1 and note 'what's new' for each component, where applicable. We then turn to the politics of transformative change based on such a framework. The methods we used to prepare this description of the problem are provided in Box 2.

Box 2: Mobilizing experiences from Canadian jurisdictions and the best-available research evidence about the problem

The available research evidence about the problem was sought from a range of published and 'grey' research literature sources. Published literature that provided a comparative dimension to an understanding of the problem was sought using three health services research 'hedges' in MedLine, namely those for appropriateness, processes and outcomes of care (which increase the chances of us identifying administrative database studies and community surveys). Published literature that provided insights into alternative ways of framing the problem was sought using a fourth hedge in MedLine, namely the one for qualitative research. Grey literature was sought by reviewing the websites of a number of domestic and international organizations, such as Health Quality Ontario, Canadian Institute for Health Information, and Organisation for Economic Co-operation and Development.

Priority was given to research evidence that was published more recently, that was locally applicable (in the sense of having been conducted in Canada), and that took equity considerations into account.

Table 1: A version of Canada's long-standing HHR policy framework and what's new

Long-standing policy framework components*	**Key aspects of how the components have been framed**, *with select illustrations of current framing*	**What's new**

Planning and development	• Population trends
	• Diversity of the health workforce
	• Data requirements and infrastructure
	• Current health workforce supply, including its intersection with demand-related issues such as changing volumes/needs for health workers
	  ○ *e.g., temporary reductions in work, such as when palliative-care patients die or high-needs children are admitted to hospital (and health workers are awaiting re-assignment), temporary redeployment to other units, organizations or sectors, and temporary pivoting from in-person to virtual care*
	  ○ *e.g., demographic shifts re-focusing services on those with chronic conditions and older adults*
	  ○ *e.g., increasing need to acknowledge and respond to socio-economic, ethnocultural and geographic diversity*
	• Shortages (by profession/geography/care setting)
	• Education and training pipelines
	• Integration and licensure of internationally educated health workers
		• Growing recognition that there are many needed forms of evidence (such as evidence synthesis) not just data analytics and modelling

Deployment and service delivery	• Efficient deployment (scope of practice; interprofessional participation)
	  ○ *e.g., introduction of new types of health workers (e.g., physician assistants) and expansion of the roles of others (e.g., personal support workers)*
	• Team-based models of care
	  ○ *e.g., increasing emphasis on interprofessional teams, and transitioning out of hospitals and into home- and community-care settings*
		• Extraordinary transition to virtual care during COVID-19 means that a much greater emphasis needs to be placed here than in the past

	• Fee models and wage structures
	  ○ *e.g., cross-sectoral pay differentials*
	  ○ *e.g., temporary and/or sector-specific wage increases (and the potential challenges associated with sectors where there are no wage increases, or the increase comes to an end)*
	• Private care delivery
	• Virtual care
	• Culturally safe and unbiased care
	• Workforce mobility
	• Rural/remote
	• Licensure and regulation
		• Once-in-a-generation system transformations in some PT jurisdictions (e.g., introduction of Ontario Health Teams) have brought the need to rethink HHR planning to the fore

Support and retention	• Systemic issues (workplace, violence, racism)
	• Supportive policies and regulations
	• Training, education and support
	• Sustainable and safe health workforce staffing
	• Staff retention
	• State of mental health and resiliency of the health workforce
	  ○ *e.g., absenteeism (includes being off for COVID or for other reasons, and having to return to work early after having COVID, and including topics like test-to-stay)*
	  ○ *e.g., burnout (and mental health more generally, and trauma more specifically)*
	  ○ *e.g., premature exit (e.g., early retirement and/or leaving the profession), which can result in unanticipated shortages in the workforce*
		• Focus on systemic racism and racialized communities means that much more attention is being given to these issues than in the past

**Organized using key components and sub-components of the Canadian Academy of Health Sciences framework underpinning their ongoing HHR: https://cahs-acss.ca/assessment-on-health-human-resources-hhr/, which are also covered in a recent analysis undertaken by KPMG on behalf of Health Canada*

What we have not seen is transformative change based on this framework, which may be attributed to:

- managing the 'HHR commons' (i.e., the HHR that groups of people such as government policymakers and system and organizational leaders 'manage' for individual and collective benefit) represents a collective-action problem shaped by politics
- while the policy framework is well established, little attention is paid to matching a compelling problem and viable policy options with conducive politics
- the available evidence continues to advance in some dimensions of the policy framework, but not in others (e.g., there is an imbalance in the HHR topics covered by the best-available evidence syntheses).

Managing the 'HHR commons' represents a collective-action problem

The politics of HHR reflects a 'health commons' dilemma. Here the health commons is the HHR that groups of people such as government policymakers and system and organizational leaders 'manage' for individual and collective benefit. Characteristically, this involves governing a resource not by state or market, but by a community of policymakers and leaders who self-govern the resource by the institutions that they create.

Managing the 'health (HHR) commons' represents a collective action problem – a situation in which all individuals would be better off cooperating, but fail to do so because of conflicting interests between individuals that discourage joint action. Problems arise when too many group members choose to pursue individual gain and immediate benefit rather than behave in the group's best long-term interests. Some of the defining characteristics of the politics of health-system decision-making in Canada contribute to this problem, including:

- federalism, and in particular the division of power between governments that grant provinces and territories the policy authority over health-system decision-making within their own jurisdictions
- little (if any) integration of health-system decision-making across jurisdictional boundaries at the PT level, and confrontational relationships (often driven by questions surrounding the federal health transfer) between health-system decision-makers at the federal and PT levels
- a complex landscape of influential health-professional stakeholders within and across Canadian provinces and territories, which don't always align on priority policy issues (e.g., many PT and national professional associations and many PT professional regulatory bodies).

Not only is there a collective action problem in addressing HHR, there is even a collective action problem in publicly releasing reports that document HHR problems and possible solutions.

Underpinning the collective action problem is the lack of attention to building up 'wins' in operationalizing the norms and values needed to underpin both efforts to address the current crisis, and efforts to put in place levers oriented to longer-term solutions.

As noted above, the policy framework presented in Table 1 has been established for decades, and while the events of the last several years have introduced important refinements and complementary points, they have not fundamentally changed the policy frameworks or its key components. While the components of the policy framework represent a set of viable policy options to address an ongoing (and continuously compelling) problem, overcoming the collective action problem with managing the 'HHR commons' also requires conducive politics, which has been neglected. In the next section, we outline the factors that need to be considered in determining whether the politics are conducive to action, and use insights from a jurisdictional scan to provide an indication of how those politics are currently playing out in Canada in relation to the HHR crisis.

While the policy framework is well established, little attention is paid to matching a compelling problem and viable policy options with conducive politics

Turning now to the politics that have typically been neglected in HHR debates, the most frequent reasons for shifts in the politics – which can either make the situation more conducive or less conducive to transformative policy change – include:

1) **change in mood** among the public (e.g., public views about the issue change, such as the public starting to realize that what unifies their experience of challenges, such as not being able to find a primary-care provider and having to face very long waits in emergency rooms, are unified by our inability to 'manage' the HHR commons)
2) **events within government** (e.g., recent elections which have led to majorities and willingness for politicians to act)
3) **change in the balance of organized forces** (e.g., alignment among key stakeholder groups)(4)

With respect to the first reason for a shift in politics – change in mood – it is very difficult for the general public to appreciate the interconnectedness of HHR issues that span all of the components of the policy framework outlined in Table 1, particularly given the emphasis among politicians and in the media is often on supply challenges. This leaves events within government and change in the balance of organized forces the likely drivers of a change in politics towards something that is conducive to transformational change that can draw on all necessary components of the policy framework (i.e., not just addressing the supply issue).

For the second set of factors – **events within government** – there is an ongoing 'wax and wane' of events across FPT jurisdictions – elections, cabinet shuffles, speeches from the throne, etc. – which can either increase or decrease the likelihood of the issue being addressed, particularly in the context of pan-Canadian solutions. In Table 2 below, we summarize findings from a jurisdictional scan of events within government at the federal level, as well as at the level of provinces and territories. Overall, the insights from the jurisdictional scan suggest there may be events within government that currently contribute to establishing conducive politics for moving forward with transformative pan-Canadian HHR change:

- most PT jurisdictions have a majority government, many of them right-leaning, with more than two years before the next election (although PT governments would have to align on the need to pursue pan-Canadian initiatives to address the current HHR challenges)
- FPT jurisdictions have all recently shown a willingness to embrace transformative change.

For the second point, while the most frequent examples are not particularly binding (e.g., release of strategic plans and roadmaps), there are examples of targeted reform efforts in specific areas like digital health, and some PT governments have embarked on dramatic health-system transformation initiatives (e.g., the introduction of Ontario Health Teams).

Despite these events within government which may lead to more conducive politics, openness to pan-Canadian initiatives is much less clearly defined across levels of government. In particular, while the federal government has shown an openness to initiating and supporting pan-Canadian policy initiatives (e.g., through the establishment of seven pan-Canadian health organizations, helping to steward targeted programs such as child care, and commitments to pan-Canadian support for dental care, pharmacare, mental health and addictions, and long-term care), and provinces and territories have engaged in pan-Canadian policy discussions by fielding representatives for working groups (including for HHR), there are very few (if any) illustrations of truly pan-Canadian policy initiatives that are emblematic of a coordinated approach to 'managing the health commons.' There are also longstanding reasons why select provinces may choose not to sign onto a pan-Canadian approach (e.g., Quebec), and recent events that could help explain why other provinces may choose not to sign on at this particular time (e.g., Alberta with the election of a new head of the governing party). Moreover, the 'breakdown' of negotiations among FPT health ministers in early November indicate the challenges involved in obtaining agreement between the federal government and PT governments.

Table 2: Summary of events within government that can shape willingness to act on the HHR crisis

Jurisdiction	Mandate given electoral events	Willingness to embrace transformative change in health	Openness to pan-Canadian (or regional) initiatives as long as they clearly benefit own jurisdiction
Federal	• Minority Liberal government, in a 'confidence-and-supply' agreement with the New Democratic party • Three years until the next election	A number of recent announcements have been made that signal willingness to support provinces and territories with their efforts to pursue transformative health and social change (e.g., child and dental care, health research, virtual care) The Health Minister's mandate letter includes commitments to work with PTs in supporting and recruiting health workers	Federal government has shown openness to initiating and supporting pan-Canadian policy initiatives: • establishment of and support for several pan-Canadian health organizations • support for and participation in a number of targeted FPT committees • creation of targeted initiatives that are negotiated bilaterally, but with the intention of supporting Canada-wide solutions (e.g., home care, mental health, pharmacare, virtual care, child care)
Provinces and territories	Most jurisdictions have a majority government (with many of them right-leaning) with more than two years before the next election • 10 jurisdictions with a majority government in power, of which eight are led by right/centre-right leaning parties, and two are led by	Most jurisdictions have shown a willingness to embrace change within their respective health systems in the last five years: • most jurisdictions have released roadmaps and strategy documents that signal intentions to pursue broad health-system transformation (e.g., recently released plans in Quebec and in Newfoundland and Labrador)	Most jurisdictions show an openness to participating in pan-Canadian policy discussions, which includes participation in fora (e.g., participation in Health Ministers/Deputy Minister (DM) meetings, putting forth a representative for a committee or working group on a priority policy issue), as well as in PT-only tables (e.g., Council of the Federation, PT Ministers and PT DMs meetings) There are also some instances of regional agreements (e.g., Maritime provinces' coordination to ensure access to specialist

	left/centre-left leaning parties • one jurisdiction with a minority government led by a left/centre-left leaning party • two jurisdictions with consensus governments in place • nine jurisdictions have two or more years until the next election, and four have elections within the next year	• many jurisdictions have launched strategies and/or pursued reform initiatives in targeted areas such as digital health and technology (e.g., B.C., Alberta, Saskatchewan, Nova Scotia, P.E.I), investment or procurement (e.g., Saskatchewan, Yukon), or research and innovation (e.g., New Brunswick, Nova Scotia) • some jurisdictions have taken concrete actions towards broad health-system transformation through new legislation, or the creation of new agencies with a broad mandate linked to transformation (e.g., Manitoba, Ontario, Nova Scotia)	services), but there are few examples of pan-Canadian policy initiatives Although there have been instances of joined up action over the years, PT governments generally protect their jurisdiction in healthcare and resist approaches that would make them accountable to the federal government or to each other (and Quebec will typically assert its right to asymmetrical arrangements with fewer strings attached) Recently, Premiers have been reluctant to support engagement on federal proposals for new pan-Canadian initiatives pending resolution of their request to significantly increase federal funding through the Canada Health Transfer

For the third set of factors – **change in the balance of organized forces** – the table below provides a high-level overview of how key stakeholder groups (i.e., organized forces) have recently aligned themselves on the HHR issue. Its important to note that there are also 'politics' within a profession and within other categories of stakeholders as well (e.g., medical schools). Overall, the balance of how groups are positioned on the issue are largely supportive of HHR reform, which also contributes to establishing conducive politics.

Table 3: Summary of changes in how the balance of organized forces has recently shifted on the issue

Health worker categories (organized forces)		**Changes in the balance of how groups are positioned on the issue**	
		Supportive	**Unsupportive**
All health workers		Increasing openness to new virtual models of care	No changes identified
Regulated, mostly publicly remunerated and highly active in HHR political advocacy	Physicians	Increasing support for interprofessional team-based models of care Strong support for pan-Canadian physician licensure	Ongoing resistance to changes with implications for physician remuneration (and in some instances when changes in scopes of practice are discussed)
	Nurses	Ongoing and very visible (to the public) support for enhanced nursing roles and capacity across all sectors in the health system	No changes identified
Regulated, mixed public/private remuneration and less active in HHR political advocacy	E.g., dietitians, physiotherapists, psychologists, psychotherapists, medical laboratory technologists	Certain groups advocating for the ability to provide virtual care across jurisdictions (e.g., dietitians) others emphasizing the need to consider licensing reform (e.g., physiotherapists) and some pushing for broader scopes of practice to alleviate system pressures	No changes identified

Regulated, mostly privately remunerated and less active in HHR political advocacy	E.g., pharmacists, dentists, optometrists, chiropractors, naturopaths	Certain groups increasingly advocating for a larger role in providing publicly funded services to alleviate system pressures (e.g., pharmacists)	No changes identified
Not regulated as a profession per se, mix of remuneration and mix of levels of engagement in HHR political advocacy	E.g., personal-support workers	Some groups have continued to support greater standardization in the profession (e.g., personal-support workers)	No changes identified

Note that in future versions of the evidence brief we will expand this to include groups involved in education and training.

The available evidence continues to advance in some dimensions of the policy framework, but not in others

While the policy framework has long been established, the approach to building out the evidence base for each element of the framework has been very scattershot, with many calls for one-off studies every time the HHR crisis re-emerges, and with very little effort to distill lessons from bodies of evidence and to strategically fill gaps where either evidence syntheses don't exist or the available evidence syntheses point to a lack of primary studies.

The findings from our attempt to identify the 'best' evidence syntheses (summarized in Table 4 below, with an overview of the approach outlined in Box 3 and additional details of the identified syntheses in Appendix tables 1-3) indicate that the majority of 'best' evidence syntheses available focused on the **support and retention** components of the framework (50 total syntheses identified across the various sub-elements, with 10 high quality and 40 medium quality) while the **planning and development** components of the framework had the least evidence syntheses available (19 evidence syntheses were identified, with four high quality and 15 medium quality). The various sub-elements of the policy framework related to **deployment and service delivery** had a total of 39 evidence syntheses (four high quality and 35 medium quality).

The single policy framework sub-component with the most syntheses identified was 'state of mental health and resiliency of the health workforce' in the support and retention component, with 21 identified syntheses (three high quality and 18 medium quality), while there were also a number of sub-components for which no 'best' evidence syntheses were identified ('diversity of the health workforce' and 'data requirements and infrastructure' in the planning and development component of the framework, and 'supportive policies and regulation' in the support and retention component of the framework).

In addition to the high-level observation that the support and retention components of the framework are comparatively better served by evidence syntheses than the other components of the policy framework, the following **trends** were observed across the components of the framework:

- some syntheses address a number of sub-components within the same broad component category (e.g., within the planning and development part of the framework, syntheses often partially addressed aspects of both workforce supply and shortages)
- some syntheses address sub-components across two or more broad component categories, for example, many syntheses focused on supply and shortages within planning and development also address components related to deployment and service delivery (e.g., rural and remote) or retention and support (e.g., staff retention)
- not all syntheses deemed eligible for a particular sub-component (e.g., on education and training) were explicitly framed in the context of HHR (although in most cases there are clear implications for how it

may relate, for example when considering how education and training interventions affect workforce pipelines and development).

Regarding the final point, many of the reviews that were deemed eligible as 'best' were very focused on particular education/training modalities, such as simulation training, or preparing the workforce for particular types of practice (e.g., rural and remote).

The following trends were also observed across specific framework sub-components:

- the majority of 'best' syntheses focused on efficient deployment centre on nursing scope of practice or task-shifting from doctors to nurses, with a wide range of roles and functions addressed by these syntheses (ranging from clinical service delivery to administration)
- there are many syntheses focused on virtual care (and supporting care for chronic conditions more generally), although few 'head-to-head' comparisons between modalities (e.g., telehealth versus videoconferencing)
- several syntheses focused on strategies to prevent or mitigate the impacts of workplace aggression and violence, with none identified on the topic of racism (the 'systemic issues' sub-component)
- the bulk of syntheses about supporting resiliency and wellness among the health workforce focus on physicians and nurses.

Box 3: Approach to identifying 'best' evidence syntheses

To better understand the nature of the available evidence focused on the components of the HHR policy framework outlined in Table 1, we searched Health Systems Evidence for the 'best' evidence syntheses globally. Search strategies were developed and eligibility assessments were conducted at the level of the sub-framework elements, which are also used to organize the results in Table 2 (as well as the more detailed list of included evidence syntheses in Appendix 1). Evidence syntheses were considered eligible for the list of 'best' if the following criteria were met:

- the evidence synthesis was assessed to be of medium quality (i.e., an AMSTAR score of 4-7) or high quality (i.e., an AMSTAR score of 8-11)
- the authors of the evidence synthesis conducted the search for studies no more than five years ago
- the evidence synthesis was 'general' in focus, as in, it did not focus on a specific: disease or condition (i.e., diabetes or dementia); population or patient group (i.e., older adults); or setting (i.e., a country or region such as low- and middle-income countries).

While the approach adopted to generate the above observations are helpful in identifying and understanding the distribution of the 'best' evidence syntheses globally that focus on each of the sub-framework elements more generally, more syntheses than those referenced in Table 4 (and Appendix tables 1-3) are available that focus on the framework elements in the context of specific diseases or conditions (e.g., planning models for specialists in rheumatology), population/patient groups (e.g., older adults in long-term care) or settings (e.g., retention of health workers in low- and middle-income countries). For those interested in searching for these more specific HHR-related evidence syntheses, the search strategies adopted for each framework sub-component are included in Appendix 1-3. In the next version of the evidence brief, we will replace the hyperlinked titles of relevant evidence syntheses with 'declarative titles' that provide more of a description of the key findings.

In addition to the reviews deemed 'best' outlined above, five syntheses (all found to be of medium quality) directly related to components of the policy framework, but that only focused on identifying studies from Canada, were also identified. These syntheses were not included in the list of 'best' because of the specific focus on one jurisdiction, which risks missing many studies from outside of Canada that may be relevant to the question(s) addressed. This could increase the chance that the results are misleading and not a reflection of the totality of evidence on the topic. However, given the nature of the issues addressed by this brief, and the interest in bringing together the best 'local' evidence alongside the global evidence, they are summarized below:

- one synthesis (it isn't clear how up-to-date it is, given the last year the literature was searched wasn't reported by the authors) was identified that focuses on both the **planning and development** and **support and retention** components of the policy framework, with the aim of identifying the factors that influence recruitment and retention of health workers in rural Canada (5)
- three syntheses were identified that focus on the **deployment and service delivery** component of the policy framework:

  - one relatively recent synthesis (the literature was last searched in 2017) analyzed perspectives on Indigenous cultural competency across Canadian hospital emergency departments (6)
  - an older synthesis (the literature was last searched in 2014) summarized the extent to which current Canadian health-science education and training programs build cultural competency and cultural safety skills among health workers in the context of health gaps between Indigenous and non-Indigenous Canadians (7)
  - a final older synthesis (literature last searched in 2016) explored the evolving role of unregulated health workers in Canada, including their role on interprofessional teams, their impact on quality of care and patient safety, and any insights about education and employment standards (8)
- one relatively recent rapid synthesis (literature last searched in 2017) was identified that focuses on the **support and retention** component of the policy framework, and described what is known about the efficiency and effectiveness of Ontario's health workforce regulatory system.(9)

Table 4: Overview of 'best' evidence syntheses identified across key policy framework components
(*Note: these numbers may change as we undertake additional rounds of assessment and some syntheses were categorized in more than one category)*

Policy framework component	Policy framework sub-components	Total number of 'best' available evidence syntheses*	Number of high quality***	Number of medium quality***
Planning and development	**All components**	**19**	**4**	**15**
	Population trends	1	0	1
	Diversity of health workforce**	N/A	N/A	N/A
	Data requirements and infrastructure**	N/A	N/A	N/A
	Current health workforce supply	3	1	2
	Shortages (by profession/geography/ care setting)	2	0	2
	Education and training pipelines	11	2	9
	Integration and licensure of internationally educated health health workers	2	1	1
Deployment and service delivery	**All components**	**39**	**4**	**35**
	Efficient deployment (scope of practice; interprofessional participation)	8	0	8
	Team-based models of care	4	0	4
	Fee models and wage structures	3	1	2
	Private care delivery	1	1	0
	Virtual care	13	1	12
	Culturally safe and unbiased care	1	0	1
	Workforce mobility	1	1	0
	Rural/remote	7	0	7
	Licensure and regulation	1	0	1
Support and retention	**All components**	**50**	**10**	**40**
	Systemic issues (workplace, violence, racism)	6	3	3
	Supportive policies and regulations**	N/A	N/A	N/A
	Training, education and support	13	2	11
	Sustainable and safe health workforce staffing	1	0	1
	Staff retention	9	2	7
	State of mental health and resiliency of the health workforce	21	3	18

* Literature searched within the last five years, of either high or medium quality, and 'general' in focus (i.e., not focused on a specific disease/condition, patient population, or geographical setting)

**No evidence syntheses that were of high or medium quality, had searches updated within the last five years, and that were not too specific in focus were identified for this component
*** The quality of each review has been assessed using AMSTAR (A MeaSurement Tool to Assess Reviews), which rates overall quality on a scale of 0 to 11, where 11/11 represents a review of the highest quality. Those with a score of 4-7 are deemed to be medium quality, and those with a score of 8-11 are deemed to be high quality

Additional equity-related observations about the problem

As noted above, we will add to the next version of the evidence brief key equity-related observations about the problem.

Citizens' views about key challenges related to the problem

A broad range of Canadians will be convened through a parallel 'living' citizen panel process. The citizen panel will meet 'between' meetings of the living stakeholder dialogue. In version 2 of this living evidence brief, insights from the first citizen panel will be included here.

THREE ELEMENTS OF A POTENTIALLY COMPREHENSIVE APPROACH FOR ADDRESSING THE PROBLEM

A 'window of opportunity' has now emerged in Canada, with decision-makers faced with a compelling problem (an HHR crisis) and viable policy options (based on an established policy framework). The big challenge is finding or creating the 'conducive politics.'

Many approaches could be selected as a starting point for deliberations about an approach addressing the HHR crisis in Canada. To promote discussion about the pros and cons of potentially viable approaches, we have selected three elements of a larger, more comprehensive approach. The three elements were developed and refined through consultation with the steering committee and key informants who we interviewed during the development of this evidence brief. The elements are:

1) develop the norms and values that need to underpin collective action to manage the 'HHR commons' (e.g., we agree to contribute PT and organizational data to a national HHR database, we don't poach from other Canadian jurisdictions, we agree to acknowledge licensure from other jurisdictions)
2) identify the policy levers available to PT government policymakers and system/organizational leaders that would incentivize adherence to these norms and values regardless of the role of the federal government
3) identify the policy levers available to federal government policymakers that would incentivize adherence to these norms and values.

The elements could be pursued separately or simultaneously, or components could be drawn from each element to create a new (fourth) element. They are presented separately to foster deliberations about their respective components, the relative importance or priority of each, their interconnectedness and potential of or need for sequencing, and their feasibility.

The principal focus in this section is on what is known about these elements based on findings from evidence syntheses. We present the findings from evidence syntheses along with an appraisal of whether their methodological quality (using the AMSTAR tool) is high (scores of 8 or higher out of a possible 11), medium (scores of 4-7) or low (scores less than 4) (see the appendix for more details about the quality-appraisal process). We also highlight whether they were conducted recently, which we define as the search being conducted within the last five years. In the next section, the focus turns to the barriers to adopting and implementing these elements, and to possible implementation strategies to address the barriers.

Box 4: Mobilizing research evidence about approach elements for addressing the problem

The available research evidence about approach elements for addressing the problem was sought primarily from Health Systems Evidence (www.healthsystemsevidence.org), which is a continuously updated database containing more than 9,400 evidence syntheses and more than 2,800 economic evaluations of delivery, financial and governance arrangements within health systems. The syntheses and economic evaluations were identified by searching the database for syntheses addressing features of each of the approach elements.

The authors' conclusions were extracted from the syntheses whenever possible. Some syntheses may have contained no studies despite an exhaustive search (i.e., they were 'empty' reviews), while others may have concluded that there was substantial uncertainty about the approach elements based on the identified studies. Where relevant, caveats were introduced about these authors' conclusions based on assessments of the syntheses' quality, the local applicability of the reviews' findings, equity considerations, and relevance to the issue. (See the appendices for a complete description of these assessments.)

Being aware of what is not known can be as important as being aware of what is known. When faced with an empty synthesis, substantial uncertainty, or concerns about quality and local applicability or lack of attention to equity considerations, primary research could be commissioned, or an approach element could be pursued and a monitoring and evaluation plan designed as part of its implementation. When faced with a synthesis that was published many years ago, an updating of the review could be commissioned if time allows.

No additional research evidence was sought beyond what was included in the evidence syntheses. Those interested in pursuing a particular approach element may want to search for a more detailed description of the approach element or for additional research evidence about the element.

Citizens' values and preferences related to the three approach elements

In the next version of the evidence brief, we will include key insights about each of these approach elements from citizens participating in an upcoming citizen panel.

Element 1 – Develop the norms and values that need to underpin collective action to manage the 'HHR commons'

This element is primarily about developing the norms and values that can underpin efforts to manage the 'HHR commons', and that should be held by every PT government and health authority and every health organization within these jurisdictions. An emerging list of these norms and values that should be considered as a starting point from which to build upon include (but aren't limited to):

- all governments and organizations contribute PT and organizational data to a national HHR database
- all governments and organizations plan now for the future of technology-enabled healthcare work, which includes issues such as the provision of virtual care when physically based in another PT jurisdiction (and which will be addressed more fulsomely in a separate evidence brief and in a stakeholder dialogue being organized for 7 and 8 March 2022)
- all governments and organizations agree to not 'poach' human resources from other Canadian jurisdictions
- all governments and organizations agree to acknowledge licensure from other jurisdictions.

While we have started this list of candidate norms and values, we encourage dialogue participants to add to the list, particularly with norms and values that have been explicitly highlighted in past pan-Canadian efforts.

This element also includes establishing the appropriate processes that will enable the further development (and ultimately a final list contextualized in a way that leads to action) of these norms and values. These processes could include:

- conducting a stakeholder-mapping exercise to identify the government policymakers, system and organizational leaders, professional leaders and citizen leaders (including those who bring patient perspectives to bear) who should be engaged in developing and finalizing a list of norms and values
- identifying the appropriate organization(s) to act as a secretariat and facilitator of the process
- convening a working group or steering committee to establish the terms of reference for the process (including the methods used to engage key stakeholders and identify and refine the list of norms and values) and clarify the timelines and anticipated outcomes of the process (e.g., a statement of values, a charter, etc.)
- making publicly available the outputs of the process, disseminating the key messages to those in a position to act.

We identified five evidence syntheses – two low quality and three medium quality – that addressed components of element 1, although none of them were specific to the development of norms and values to underpin collective action on HHR policymaking. The two low-quality syntheses addressed aspects of how norms and values could be defined in different health-system decision-making contexts.(10; 11) The first of these two syntheses focused on describing the types of frameworks available to drive priority setting processes specifically, but highlighted efficiency and equity as values alongside other themes that could be related to the definition of norms and values underpinning priority setting more generally (e.g., satisfaction, stakeholder engagement, stakeholder empowerment, transparency, use of evidence, revisions, enforcement, and community values).(10) The second low-quality evidence synthesis focused specifically on health and social-care guidance development and identified a number of important social values that ought to underpin these efforts, including utility and efficiency (effectiveness and cost effectiveness), justice and equity, autonomy, solidarity, participation, sustainability, transparency and accountability, and appropriate methods of guidance development.(11)

The three medium-quality syntheses provided insights that could be useful in understanding how collaborative processes can enable the development of norms and values.(12-14) Specifically, one of these syntheses identified important factors that help promote successful collaborations across a number of settings including communication, trust, respect, mutual acquaintanceship, power, shared goals and consensus, patient-centredness, task characteristics and environmental factors.(12) This same synthesis found that the formalization of collaborative efforts was important in efforts that span multiple organizations. Another synthesis focused on how best to pursue nursing stakeholder identification and engagement in HHR planning

and development.(13) While this synthesis didn't find any specific evidence about approaches for nursing stakeholder identification, it did find that establishing governance structures and ensuring aimed planning and monitoring through a unified strategy were essential components of collaborative HHR planning processes. The third synthesis focused on the importance of political skill in managing and promoting health-services change, and found that nurses, health-system administrators and leaders all used political skills to manage stakeholder interests, and that these skills were often used to successfully engage stakeholders, build networks and facilitate improvements in policy and management processes.(14)

We summarize the key findings from these evidence syntheses in Table 8, with more detailed findings from each synthesis provided in Appendix 4.

Table 8: Summary of key findings from evidence syntheses relevant to Element 1 – Develop the norms and values that need to underpin collective action to manage the 'HHR commons'

Category of finding	Summary of key findings
Benefits	• No syntheses identified
Potential harms	• No syntheses identified
Costs and/or cost-effectiveness in relation to the status quo	• No syntheses identified
Uncertainty regarding benefits and potential harms (so monitoring and evaluation could be warranted if the option were pursued)	• No clear message from studies included in a systematic review o Developing the norms and values that can underpin efforts to manage the 'HHR commons' o Establishing the appropriate processes that will enable the further development of norms and values
Key elements of the policy option if it was tried elsewhere	• **Developing the norms and values that can underpin efforts to manage the 'HHR commons'** o Two low-quality syntheses identified utility and efficiency, justice and equity, autonomy, solidarity, participation, sustainability, transparency and accountability, as important values in different decision-making contexts (10; 11) • **Establishing the appropriate processes that will enable the further development of norms and values** o One medium-quality synthesis identified characteristics that enabled collaborative decision-making processes including: communication, trust, respect, mutual acquaintanceship, power, shared goals and consensus, patient-centredness, task characteristics and environmental factors, particularly when these are formalized) (12) o Another medium-quality synthesis found that establishing governance structures and ensuring aimed planning and monitoring through a unified strategy were essential components of collaborative HHR planning processes, and another medium-quality evidence synthesis highlighted the importance of political skill in enabling health-services change processes (13; 14)
Stakeholders' views and experience	• No syntheses identified

Element 2 – Identify the policy levers available to provincial/territorial government policymakers and system/organizational leaders

This element focuses on ensuring the norms and values established through the process described in element 1 are adhered to through the policy levers available to government policymakers at the PT level and to system/organizational leaders within these jurisdictions. An initial list of the policy levers includes:

- governance arrangements that mandate adherence to these norms and values among regulatory colleges (e.g., mandating their participation in a national HHR database, their approach to addressing technology-enabled healthcare work, and their acknowledgement of licensure from other jurisdictions), educational institutions (e.g., mandating their participation in a national HHR database), and the organizations directly involved in the provision of care (e.g., prohibiting their poaching of human resources from other Canadian jurisdictions)
- financial arrangements that incentivize adherence to these norms and values among health authorities and health organizations (e.g., penalizing health authorities and health organizations that poach human resources from other Canadian jurisdictions) and educational institutions (e.g., rewarding institutions that provide accelerated on-boarding of new internationally educated health workers)
- delivery arrangements that help to operationalize these norms and standards or accommodate them efficiently among health authorities and health organizations (e.g., ensuring that models of care optimize the existing supply of health workers and efficiently and equitably leverage technology-enabled healthcare work)
- behaviour-change or implementation strategies that support the changes in organizational and individual behaviours needed to operationalize these norms and standards (e.g., using audit and feedback approaches to identify when there is suboptimal adherence to the norms and values by organizational and professional leaders and to adopt appropriate strategies to help them 'course correct').

While we have started this list of candidate policy levers, we encourage dialogue participants to add to the list, particularly with policy levers likely to be viable in the current political context.

We didn't identify any evidence syntheses or single studies that were relevant to element 2.

Element 3 – Identify the policy levers available to federal government policymakers that would incentivize adherence to these norms and values

This element focuses on ensuring the norms and values established through the process described in element 1 are adhered to by PT governments during health-system decision-making processes (and particularly those with implications for how the 'HHR commons' are managed). An emerging list of the policy levers available to the federal government include:

- the full range of governance, financial and delivery arrangements, as well as behavioural/implementation strategies (as described in element 2) in the areas where the federal government has authority over health-system decision-making and can directly operationalize these norms and standards
  - e.g., First Nations and Inuit healthcare
  - e.g., armed forces' and veterans' healthcare
- financial arrangements (specifically funding arrangements) in areas where the federal government has influence over health-system decision-making in PT health systems because of direct investments and/or the transfer of funds and can adjust these financial arrangements to incentivize adherence to these norms and standards
  - e.g., hospital-based and physician provided care (through the terms laid out in the Canada Health Transfer)
  - e.g., home and community care, mental health and addictions, long-term care, virtual care (through bilateral agreements with the provinces and territories)
  - e.g., digital health (through Canada Health Infoway investments)
  - e.g., possibly pharmacare and dental care coverage (through additional investments that may be negotiated in the future)

- establishing strategic direction in areas co-developed with PT partners, or in areas where there are strong arguments for intergovernmental cooperation or economies of scale, that can help to operationalize these norms and standards in particular domains
    - e.g., strategies (and corresponding pan-Canadian health organizations) in cancer control (CPAC), mental health (MHCC), substance use (CCSA), as well as in dementia, tobacco control and nursing
    - e.g., action plans for chronic pain, and frameworks leading to action plans (in antimicrobial resistance, diabetes, suicide prevention).

Again, while we have started this list of candidate policy levers, we encourage dialogue participants to add to the list.

We didn't identify any evidence synthesis or single studies relevant to element 3.

Additional equity-related observations about the three approach elements

In the next version of the living evidence brief, we will incorporate observations about the equity dimensions of these three approach elements.

IMPLEMENTATION CONSIDERATIONS

The barriers to and facilitators of implementing the elements can be best understood in terms of the steps taken across FPT jurisdictions in Canada:

1) the concrete actions that have been taken (or not taken) to address HHR challenges in Canada at the FPT levels
2) the statements/commitments made by FPT governments towards a credible commitment to shared norms and values for HHR planning.

In Table 9 below, we summarize the high-level findings from a jurisdictional scan of actions taken by governments at the federal and at the PT level. Overall, all jurisdictions in Canada are implementing at least some actions that are focused on addressing HHR challenges and, in general, such efforts have been expanded due to additional pressures placed on health systems across Canada by the COVID-19 pandemic. However, the initiatives vary in terms of breadth and scope, and in some instances may act as barriers to collective management of the 'HHR commons' through shared norms and values (e.g., efforts to recruit health workers from other provinces and territories).

Furthermore, many statements by healthcare officials support the need for short- and long-term actions to improve the HHR situation in Canada. Many of the more immediate efforts identified focus on improving workforce supply through stronger recruitment and retention efforts (including from the pool of international health workers who may be eligible to work in Canadian jurisdictions), as well as creating supportive working environments to address issues such as burnout and mental health.

The current shared emphasis on addressing the HHR crisis among FPT governments as well as the similarities in challenges faced and solutions being pursued will undoubtedly help to facilitate pan-Canadian discussions about the issue. However, the longstanding fragmented (and sometimes competitive) approaches taken by provinces and territories in their efforts to address HHR challenges within their own jurisdictions means that there will be a significant barrier to effectively managing the 'HHR commons' in Canada until a collaborative framework and adherence to a collectively defined set of norms and values is established. As noted above, the 'breakdown' of negotiations among FPT health ministers in early November indicate the challenges involved in obtaining agreement between the federal government and PT governments.

Table 9: FPT actions to address HHR challenges and commitments towards shared norms and values

Jurisdiction	Actions that have been taken to address HHR challenges	Statements/commitments made towards a credible commitment to shared norms and values for HHR planning
Federal	*Planning and development* • The federal government launched the *Pan-Canadian Health Human Resource Strategy* over a decade ago, including a focus on internationally educated health workers, and jointly developed with the provinces and territories *A Framework for Collaborative Pan-Canadian Health Human Resources Planning* • Health Canada (in collaboration with PT governments in some instances) also launched the Workforce Solution Roadmap in 2022, and conducted the FPT Virtual Care Summit to address the importance of digital health in HHR • Health Canada appointed a Chief Nursing Officer in August 2022, which emphasized the importance of this role in supporting HHR planning • Health Canada recently announced the expansion of the temporary foreign worker program (which was framed in part as a way to help improve the recruitment of international health workers) in September 2022 *Deployment and service delivery* • Several initiatives have been pursued to increase the number and improve the distribution of health workers in Canada (and many of these concepts are embedded in the initiatives outlined above) *Support and retention* • The Government of Canada announced recruitment and retention allowances to triple through to 2025 for Indigenous Services Canada, to improve access to nurses in remote and isolated communities	Many statements and commitments have recently been made by the federal Minister of Health, including: • establishment of the Coalition for Action for Health Workers, with the first meeting held on 1 November 2022 • the 2022-2023 Departmental Plan released by Health Canada also includes solutions to address HHR issues, and the Minister of Health's mandate letter includes commitments to supporting provinces and territories to hire new family doctors, nurses (and nurse practitioners) as well as to expanding the number of family doctors and primary health teams in rural areas
Provinces and territories	*Planning and development* • Most jurisdictions have released strategies and plans to improve the recruitment, training, and retention of health workers (e.g., British Colombia is investing $4.4 million in health worker education and training at post-secondary institutions, Ontario is investing $2 million through the Recruitment and Retention Incentive Program to help recruit and retain skilled PSWs and nurses into retirement homes in the province, Nova Scotia established a recruitment program to enable streamlined access and hiring of staff in the continuing-care sector, Prince Edward Island has a Health Recruitment and RN Stabilization Strategy which includes an investment of $1.4 million additional recruitment initiatives) • Some jurisdictions are issuing work permits and expanding their immigration strategy to attract skilled workers to attach to skilled newcomers (e.g., Alberta's Advantage Immigration Strategy, Quebec's new work permit for Quebec skilled workers), while other jurisdictions have undertaken efforts to attract health	Several health-system leaders (including ministers of health and premiers, and leaders of influential professional organizations) from across PT jurisdictions have explicitly expressed their willingness to enhance workforce recruitment and retention, either through including HHR strategies in their budgets or through action plans, as well as through efforts to support and retain existing workers

Jurisdiction	Actions that have been taken to address HHR challenges	Statements/commitments made towards a credible commitment to shared norms and values for HHR planning
	workers from other jurisdictions within Canada to fill health workforce staffing shortfalls *Deployment and service delivery* • Most jurisdictions continue to actively support the development of models of care with implications for how the health workforce is utilized (e.g., home- and community-based care, virtual care, and multidisciplinary team-based care) *Support and retention* • Many provinces are investing in health profession-related education, training, incentive programs, and mental health supports for healthcare staff (e.g., Ontario is investing $12.4 million over two years to provide existing and expanded mental health and addictions supports for all frontline health workers across the province) • Some initiatives are also targeting the imposition of overtime to help reduce burnout risk (e.g., Quebec is eliminating mandatory overtime for nurses)	

As a reminder about additional enhancements we will make in the next version of the evidence brief, we will:
1) incorporate insights (as well as additions and corrections) by dialogue participants
2) add equity considerations (and a box describing our methods)
3) add citizen insights from the upcoming citizen panel
4) replace the hyperlinked titles of relevant evidence syntheses with 'declarative titles' that provide more of a description of the key findings.

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APPENDICES (see separate document)

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