Living Evidence Brief

Addressing the Politics of the Health Human Resources Crisis in Canada

19 & 20 January 2023

Version 2

McMaster University | HEALTH FORUM

EVIDENCE >> INSIGHT >> ACTION

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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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KEY MESSAGES

As described in the first version of this 'living' evidence brief, for nearly 30 years health-system leaders in Canada have: 1) collectively acknowledged the many problems in health human resources (HHR) planning and management, and largely agreed on the policy solutions; and 2) made little progress in operationalizing these solutions. Politics loom large as the underlying explanation. In this second version of the evidence brief we address the key features of the problem, elements of a potentially comprehensive approach for addressing the problem, and implementation considerations, with an emphasis on those aspects that emerged as particularly important during the first of four 'living' stakeholder dialogue interactions convened on 22 and 23 November 2022, and the first of two 'living' citizen panel interactions convened on 9 December 2022.

What's the problem?

Four key features of the problem include:

1) **'big P' and 'small p' politics have hampered progress towards addressing the HHR crisis in Canada**, and this occurs across all levels of health systems in Canada (e.g., elected politicians governing federal/provincial/territorial (FPT) jurisdictions, leaders of health authorities/organizations providing strategic direction for and oversight of care delivery, leaders of health workplaces and practices, leaders of organizations focused on specific categories of health workers)
2) **the values that will enable us to move beyond the politics have not been agreed upon**, making it difficult for decision-makers to operationalize them through policy decisions that can address the challenges associated with the HHR crisis
3) **discussions about the appropriate policy solutions – and the evidence underpinning them – haven't been connected to discussions about values**, which further contributes to difficulties in moving beyond the politics
4) **the HHR crisis disproportionately affects some groups of health workers** (e.g., young health workers, female health workers, and health workers who are provided with time-limited opportunities in the system to address acute crises, but may not be supported to pursue a lifelong career in the system), **and is experienced differently by some groups** (e.g., younger cohorts may prioritize higher hourly rates over long-term job security with a single organization).

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

There are three elements of a potentially comprehensive approach that should be considered in moving forward to address the politics of the HHR crisis in Canada:

1) identify the agreed-upon core values that decision-makers across the country and at all levels within health systems must follow in planning and managing HHR
2) ensure that actions taken at all levels of the health system to address the HHR crisis are designed to operationalize these core values
3) ensure citizens and health workers hold (and are supported to hold) decision-makers accountable for operationalizing these core values.

What implementation considerations need to be kept in mind?

With numerous initiatives now underway to address the HHR crisis in Canada, implementation considerations primarily relate to how the three approach elements can help to inform these initiatives and related efforts across Canada. Specifically, identifying windows of opportunity and 'ways in' for the insights at all levels is important to facilitate this integration and identify potential next steps.

REPORT

As described in the first version of this 'living' evidence brief – which was prepared to inform deliberations on 22 and 23 November 2022 – over the last 30 years health-system leaders in Canada have: 1) collectively acknowledged the many problems in HHR planning and management and largely agreed on the high-level policy solutions; and 2) made little progress in operationalizing these solutions. Politics loom large as the underlying explanation.

A remarkable number of ad hoc initiatives are underway to respond to the current HHR crisis across provincial and territorial (PT) health systems. 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)
- 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).

Aim of this 'living' evidence brief

In this second version of the evidence brief we address the key features of the problem, elements of a potentially comprehensive approach for addressing the problem, and implementation considerations, with an emphasis on those aspects that emerged as particularly important during the first of four 'living' stakeholder dialogue interactions convened on 22 and 23 November 2022, and the first of two 'living' citizen panel interactions convened on 9 December 2022. Like the first version, it mobilizes the best-available evidence, insights from a documentary and website review of Canadian FPT jurisdictions, and the views and experiences of key informants. This second version is also much more streamlined, as was suggested by participants in the first stakeholder dialogue interaction. It was prepared to inform a second stakeholder dialogue involving 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.

Box 1: Background to the second version of the 'living' evidence brief

The second version of this 'living' evidence brief has been updated based on insights that emerged during the first 'living' stakeholder dialogue interaction on 22 and 23 November 2022 and the first 'living' citizen panel interaction on 9 December 2022. These insights informed a reframing of the problem, elements of a potentially comprehensive approach for addressing it, and key implementation considerations, reflecting our evolving understanding of the political context, the issues in play, and the actions being taken to respond to the evolving context and issues. Like the first version, it 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 FPT 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 judgments 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 this version of the evidence brief involved four steps:

1) conducting a thematic analysis and summarizing the insights that emerged from the first dialogue interaction in a dialogue summary, and the first citizen panel interaction in a panel summary, and using these insights to reframe key sections of the brief
2) regularly convening the project Steering Committee comprised of representatives from the partner organization, key stakeholder groups, and the McMaster Health Forum to help inform this reframing
3) identifying, selecting, appraising and synthesizing relevant research evidence for sections of the brief that were reframed based on the steps above
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.

The three approach elements for addressing the problem were not designed to be mutually exclusive and could be pursued in a number of ways. This version of the evidence brief will again be revised based on key insights from the second 'living' stakeholder dialogue interaction and the second 'living' citizen panel interaction. The goal of the dialogue is to spark insights and generate action by participants and by those who review the dialogue summary.

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.

THE PROBLEM: POLITICS AND A LACK OF AGREEMENT ON VALUES HAVE HAMPERED PROGRESS TOWARDS ADDRESSING THE HHR CRISIS

During the first dialogue interaction, three key aspects of the problem emerged as warranting the most attention:

1) 'big P' and 'small p' politics have hampered progress towards addressing the HHR crisis in Canada
2) the values that will enable us to move beyond the politics have not been agreed upon
3) discussions about the appropriate policy solutions – and the evidence underpinning them – haven't been connected to discussions about values
4) the HHR crisis disproportionately affects some groups of health workers and is experienced differently by some groups.

Each of these aspects of the problem are addressed in turn below.

'Big P' and 'small p' politics have hampered progress towards addressing the HHR crisis in Canada

Both 'big P' politics and 'small p' politics are a key reason for a lack of progress in addressing many aspects of the HHR crisis in Canada. These politics play out at different levels, including among:

1) elected politicians governing FPT jurisdictions
2) leaders of health authorities/organizations providing strategic direction for and oversight of care delivery
3) leaders of health workplaces and practices (e.g., hospitals, long-term care facilities, primary-care practices)
4) leaders of organizations focused on specific categories of health workers (e.g., regulatory colleges, education/training bodies).

Regarding the **'big P' politics**, what matters most are the decisions made by the elected politicians in provinces and territories. Important aspects of 'big P' politics at play in the context of the HHR crisis include:

- elected politicians in PT jurisdictions can choose to take action in their own right in virtually all aspects of the HHR crisis, and can also choose to work together with fellow elected officials from across the country to advance pan-Canadian solutions
- most provinces and territories currently have a majority government, many of them right-leaning and conservative, with more than two years before the next election, which means that there may be opportunities for current PT governments to take bolder action in their own jurisdictions and to work together across jurisdictions in the short to medium term.

Regarding the **'small p' politics**, what matters most are the decisions made by the leaders of various organizations in PT jurisdictions. Table 1 provides examples of how both 'big P' and 'small p' politics play out at different levels.

Another important level that ought to be considered is the international level, where multilateral organizations (e.g., the World Health Organization and International Labour Organization) and country representatives have established global codes of practice meant to guide priority issues like the international recruitment of health personnel.(1) This level is important in that the various organizations and country representatives involved in addressing global HHR challenges can contribute to how we think about the agreed-upon values underpinning our response to the HHR crisis in Canada, and the ways of operationalizing them (e.g., ethical recruitment of internationally trained medical graduates).

Table 1: Examples of how 'big P' and 'small p' politics play out at different levels in the context of the HHR crisis

Levels		Examples
'Big P' politics	Elected politicians of FPT jurisdictions	● Federalism, and in particular the division of power that grants provinces and territories authority over health-system decision-making, including over HHR, within their own jurisdictions ● There is little integration of health-system decision-making across PT boundaries ● FPT health ministers are not putting themselves on a crisis footing to use the many tools available to them immediately ● There are confrontational relationships (often about funding) between the federal government and PT governments o For example, in November 2022, PT premiers 'walked away' from the FPT meeting where they were supposed to talk about pan-Canadian solutions to the HHR crisis (2)
'Small p' politics	Leaders of health authorities/organizations providing strategic direction for and oversight of care delivery	● Many leaders are not providing clear direction about what the future health system needs to look like (and hence what HHR will be required) o This would require them to make winners and losers of different parts of the system ● Many leaders are not ensuring that they have the data necessary to actively plan and manage the workforce in their jurisdiction o This would require them to mandate and fund many organizations to provide high-quality data, and to do so in a way that is acceptable given existing or future privacy legislation
	Leaders of health workplaces and practices (for example, hospitals, long-term care facilities, primary-care practices)	● Many organizations are not putting staff well-being and manageable staff workload at the centre of their organizational mandate o They often 'deflect blame' by saying that they need more funds to do so, or that they have other priorities to pursue
	Leaders of organizations focused on specific categories of health workers (for example, regulatory colleges, education and training bodies)	● Some regulatory and education and training bodies appear to put the needs of their own category of health workers ahead of the needs of other categories of health workers and/or patients

The values that will enable us to move beyond the politics have not been agreed upon

Despite ongoing awareness of the long-standing problems underpinning the HHR crisis in Canada, as well as high-level agreement about the policy framework for addressing these challenges (detailed in the first version of this evidence brief and used to organize the collection of 'best' evidence syntheses included in Appendices 1-3), little attention has been given to defining a shared set of values that can underpin efforts to address the

crisis. Agreement around shared values is an important factor in enabling decision-makers to work together to address a priority policy issue like the HHR crisis.(3) A lack of such agreement in the context of the Canadian HHR crisis over the last 30 years may help to explain how 'big P' and 'small p' politics have scuppered ongoing efforts to make progress in addressing it during this time.

Discussions about the appropriate policy solutions and the evidence underpinning them haven't been connected to discussions about values

The policy framework for HHR planning and management has been discussed and largely agreed upon at a high level for decades, but hasn't gotten traction, at least in part because discussions about the appropriate policy solutions haven't been connected to discussions about values. Once a shared set of values is agreed upon, clarifying which policy solutions are most appropriate for operationalizing the values, and determining what is known from the 'best' evidence about the policy solutions (i.e., high-quality, up-to-date evidence syntheses) is an important step towards overcoming 'big P' and 'small p' politics.

The HHR crisis disproportionately affects some groups of health workers and is experienced differently by some groups

An important element of the problem that requires further discussion is how the HHR crisis disproportionately affects some groups of health workers. During the first stakeholder dialogue and citizen panel interactions, three groups were identified that may be particularly affected by the crisis:

1) young health workers who typically face lower pay and less control over schedules, and who may face more challenging work demands
2) female and racialized health workers who typically make up the majority of the lower-paying health professions (for example, personal-support workers are often women from racialized communities)(4; 5)
3) health workers who are provided with time-limited opportunities in the system to address acute crises, but may not be supported to pursue a lifelong career in the system (for example, asylum seekers who provided care in long-term care facilities during the pandemic to obtain permanent residency).(6)

Some groups may also experience the crisis differently. For example, some young health workers may have different conceptions of what they want from their jobs as compared to older workers. For example, younger workers may prefer higher hourly pay and more control over their schedules as opposed to a salary with benefits and a pension, and with very little control over their schedule. Racialized health workers may be more likely to experience racism when patients, families and caregivers, as well as their co-workers, are under acute stress because of the HHR crisis. In the context of

Box 2: Equity considerations

A problem may disproportionately affect some groups in society. The benefits, harms and costs of the approach elements to address the problem may vary across groups. Implementation considerations may also vary across groups.

One way to identify groups warranting particular attention is to use "PROGRESS," which is an acronym formed by the first letters of the following eight ways that can be used to describe groups†:

- place of residence (e.g., rural and remote populations)
- race/ethnicity/culture (e.g., First Nations and Inuit populations, immigrant populations and linguistic minority populations)
- occupation or labour-market experiences more generally (e.g., those in "precarious work" arrangements)
- gender
- religion
- educational level (e.g., health literacy)
- socio-economic status (e.g., economically disadvantaged populations)
- social capital/social exclusion.

Based on insights emerging from the first interaction in the 'living' stakeholder dialogue, and the first interaction in the 'living' citizen panel, the following three groups were identified as warranting attention:

- young health workers
- female health workers
- health workers who are provided with time-limited opportunities in the system.

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Many other groups warrant serious consideration as well, and a similar approach could be adopted for any of them.

† The PROGRESS framework was developed by Tim Evans and Hilary Brown (Evans T, Brown H. Road traffic crashes: operationalizing equity in the context of health sector reform. *Injury Control and Safety Promotion* 2003;10(1-2): 11–12). It is being tested by the Cochrane Collaboration Health Equity Field as a means of evaluating the impact of interventions on health equity.

HHR planning specifically, there has been a lack of ensuring equity, diversity and inclusion (EDI) principles are integrated into decision-making processes, particularly among organizations functioning as employers.(7)

Citizens' views about key challenges related to the problem

In the first interaction of the 'living' citizen panel convened in December 2022, a group of 17 citizens from across Canada – diverse in terms of age, gender, geographical location, ethnocultural background and socio-economic status – brought their unique perspectives to bear on the problems related to the politics of the HHR crisis. While panellists generally agreed about the influence of both 'big P' and 'small p' politics on impeding our ability to resolve the crisis, they also raised a number of challenges that are most important to them:

- patient experiences are suffering due to the crisis
- health workplaces do not seem to be managed responsibly and respectfully
- personal and professional interests seem to be guiding health-system leaders
- health workers seem to be rarely engaged in policy and organizational decisions
- some health workers are affected differently by the crisis
- there is a decline in trust in health-system leaders, which is fostered in part by their lack of accountability for solving the crisis.

These challenges were framed by panellists as both consequences of the crisis and drivers of the crisis (in that they are creating a feedback loop reinforcing each other). In Appendix 5, we provide additional details about how citizens discussed each of these challenges during the panel.

THREE ELEMENTS OF A POTENTIALLY COMPREHENSIVE APPROACH FOR ADDRESSING THE PROBLEM

During the first dialogue and panel interactions three elements of a potentially comprehensive approach emerged as those that should be given consideration in moving forward to address the politics of the HHR crisis in Canada:

1) identify the core values that decision-makers across the country and at all levels within health systems must follow in planning and managing HHR
2) ensure that actions taken at all levels of the health system to address the HHR crisis are designed to operationalize these core values
3) ensure citizens and health workers hold (and are supported to hold) decision-makers accountable for operationalizing these core values.

These same elements were considered by citizens attending the first interaction in the 'living' citizen panel. In the sections that follow, we briefly describe each element, key insights that emerged about them during the

Box 3: Mobilizing additional research evidence about approach elements for addressing the problem

The evidence identified in this version of the evidence brief was mostly the same as for the first version. For elements that were significantly reframed, we used the same methods as in the first brief to identify the available research evidence. We primarily searched 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 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.

'living' stakeholder dialogue and 'living' citizen panel, as well as what is known from 'best' evidence when applicable.

Element 1 – Identify the core values that decision-makers across the country and at all levels within health systems must follow in planning and managing HHR

As described in the problem section, the core values that decision-makers at all levels within PT health systems must follow to manage HHR have not been clearly defined and agreed to. As a result, the core values – and most importantly those that can be agreed upon by decision-makers – have not been an explicit consideration in many of the ad hoc initiatives underway to respond to the current HHR crisis. The lack of effort to identify and agree on values may reinforce the barriers created by 'big P' and 'small p' politics, and sustain the status quo at a time when transformative change is needed.

During the first dialogue interaction participants identified a list of six values that should be considered as a starting point from which to build upon in addressing this aspect of the problem (Table 2).

Table 2. Core values that decision-makers across the country must follow in planning and managing HHR

Core values identified
1. Use a crisis footing as an opportunity to improve many aspects of the health system • Use a crisis footing to motivate action, both to address current challenges like those with HHR issues, as well as to develop policies that can lead to widespread transformative change
2. Plan now for the system we want • Plan now for the health system we want in each province and territory in future, including its HHR needs • For example, ensuring excellent patient and provider experiences, fostering a culture of team-based care (as opposed to, for example, solo physicians) and accountability for quadruple-aim metrics, enabling health workers to deliver the full range of services they are trained for, finding an appropriate balance between in-person and virtual care, and moving beyond a 'payment' system to articulating the design of an optimal care-delivery system
3. Make workplaces better for health workers • Make workplaces that value quality, respect and excellent practices the driving force for HHR improvements, and ensure they are flexible enough to meet the needs of a diverse workforce
4. Share data • Mandate that everyone who is able contributes data that can be added to a common HHR database for their province or territory and, where possible, later bring them together into a pan-Canadian database
5. Recruit health workers ethically • Engage in ethical recruitment of new health workers from other sectors within a province or territory, from other provinces or territories, and from other countries, which includes abiding by the 'WHO code of practice on the international recruitment of health personnel' that touches on points such as: o Ensure approaches to recruitment are transparent, fair and don't undermine the sustainability of 'source province/territory/country' health systems o Ensure approaches to recruitment are not in conflict with or contravene the legal responsibilities of health workers within their 'home' health system (e.g., return-to-service agreements) o Facilitate circular migration of health workers so that both 'source provinces/territories/countries' and 'destination provinces/territories/countries' benefit from health workers' skills and knowledge o Ensure the recruitment, employment and treatment of migrant health workers is in accordance with the laws of both 'source provinces/territories/countries' and 'destination provinces/territories/countries' o Ensure that terms of employment are based on objective criteria (e.g., levels of qualification and years of experience) o Ensure the equal treatment of internationally and domestically trained health workers, as well as those recruited to work on a temporary basis and those recruited to work on a permanent basis

○ Take measures to ensure that migrant health workers have opportunities to strengthen their training (including orientation about the health system to which they are recruited), education, and qualifications while progressing in their careers ○ Commit to engaging in HHR planning efforts that reduce the need for recruitment from 'source province/territory/country' health systems ○ Support other jurisdictions (including other countries) technically and financially in their HHR development efforts when they require assistance ○ Share recruitment-related data nationally and internationally ○ Adhere to the above principles when entering into bilateral and/or regional and/or multilateral arrangements related to the recruitment of health workers • Find ways to compensate countries and organizations that lose from recruitment practices
6. Build on PT wins for the benefit of all Canadians • Seek wins in resolving the HHR crisis in each province and territory and, where possible, later bring them together into pan-Canadian efforts • Clarify the few domains where pan-Canadian action is required or where federal support is needed

These values were also 'road tested' among citizens at the first 'living' citizen panel interaction. Of the six values, the second (plan now for the system we want) and third (make workplaces better for health workers) were emphasized as key. Panellists also raised additional values-related themes for consideration (either as part of the six values above, or as stand-alone values), including:

- respect Canadians' support for universal access to medically necessary care
- use an equity, diversity and inclusion (EDI) lens
- work towards shared accountability
- engage citizens and patients, as well as health workers, in policy and organizational decisions
- leverage technologies to reduce workload
- give health workers the freedom to work where they are needed most
- embrace variability in how the core values are operationalized across PT health systems.

In the first version of this 'living' evidence brief, we identified five evidence syntheses that provided insights about efforts to establish norms and values (see Appendix 4), which are also relevant for this element. When preparing this version of the brief, we found no new evidence syntheses about this element.

Element 2 - Ensure that actions taken at all levels of the health system to address the HHR crisis are designed to operationalize these core values

The only way that the core values outlined in element 1 can help to address the HHR crisis in Canada is by operationalizing them through concrete actions. During the first 'living' stakeholder dialogue interaction, participants suggested several actions that can be taken at different levels of health systems in Canada to operationalize the values that they identified. Examples of these actions are provided below in Table 4. Insights about additional actions for operationalizing values raised by citizens at the citizen panel are included in Appendix 6.

Table 3. Actions that can be taken at various levels that operationalize the core values

Core values	Examples of actions that can be taken to operationalize the core values at different levels of health systems in Canada
1. Use a crisis footing as an opportunity to improve many aspects of the health system	**FPT governments** • Establishing and staffing the 'command' tables needed to drive change in areas that matter to citizens (e.g., lack of primary-care provider, surgical backlogs) **Health authorities and organizations providing strategic direction for and oversight of care delivery** • Judging their own performance based on whether agency staffing is steadily declining as workplace/practice environments improve
2. Plan now for the system we want	**Health authorities and organizations providing strategic direction for and oversight of care delivery** • Establishing models of care (and related performance standards) to meet current and future patient needs, and to allow for all health workers to provide care to their full scope of practice • Including community-based healthcare and social-service providers in their strategizing and oversight **Health workplaces and practice environments** • Giving priority to both work life and workload **Organizations focused on specific categories of health workers** • Adjusting training and licensure pipelines to reflect the evolving competencies needed (and the technology-enabled replacement of some forms of work) • Enabling health professionals to deliver the full range of services they are trained for • Educate other organizations (and the workers they focus on) about what different professional categories can do
3. Make workplaces better for health workers	**Health authorities and organizations providing strategic direction for and oversight of care delivery** • Ensuring that provider experiences are a focus of performance measurement and management **Health workplaces and practice environments** • Using accreditation processes and 'magnet hospital' principles to drive improvements to provider experiences
4. Share data	**FPT governments** • Mandating who collects and shares what types of data, and making it available in multiple formats for different user groups **Health authorities and organizations providing strategic direction for and oversight of care delivery** • Packaging data in ways that can be used to tell local stories **Health workplaces and practice environments** • Using dashboards to inform workplace and practice HHR decision-making
5. Recruit health workers ethically	**FPT governments** • Discouraging the active offer of time-limited incentives to health workers in other jurisdictions who would not otherwise have considered a move

	• Entering into agreements with other jurisdictions to facilitate the circular migration of health workers across multiple PT health systems • Approaching HHR planning efforts with an explicit aim of reducing the need to recruit health workers from other jurisdictions to meet local health-system needs
6. Build on PT wins for the benefit of all Canadians	**FPT governments** • Creating a mechanism to identify and scale up best practices from individual provinces and territories **Health authorities and organizations providing strategic direction for and oversight of care delivery** • Deciding what actions to take when there aren't enough applicants for a given category of health workers **Organizations focused on specific categories of health workers** • Enabling interprovincial mobility whether or not pan-Canadian action is taken

Part of choosing the actions that should be taken to operationalize the values is determining what is known from the 'best' evidence about the potential benefits, harms, costs and cost-effectiveness, the key factors that influence whether and how they are effective when implemented, as well as stakeholders' views and experiences about them. As described in Box 4, in preparing the first version of this 'living' evidence brief, we searched for and organized the 'best' evidence syntheses in relation to the domains of the long-standing HHR policy framework, highlighting the distribution of these syntheses across the domains (see row headers in Appendices 1-3). Our goal in preparing the second version of the evidence brief was to better understand what the 'best' evidence syntheses identified can (and cannot) tell us about the types of actions that can be taken to operationalize the values described in element 1. This was accomplished by summarizing the key messages arising from each synthesis about each policy domain in the form of a 'declarative title,' which are now also captured in the appendices. A preliminary review of the declarative titles from identified 'best' evidence syntheses resulted in the following high-level observations about the types of messages that can be taken about operationalizing three of the six values addressed by available evidence syntheses:

- messages related to operationalizing the value statement '**plan now for the system we want**' include:
  - technological solutions appear to be effective at supporting health worker educational interventions and for supporting the delivery of care (i.e., telehealth and virtual-care solutions)
  - alternative models of organizing care teams and deploying providers' skills are promising and can be promoted by putting the right enabling factors in place
- messages related to operationalizing the value statement '**make workplaces better for health workers**' include:
  - the state of mental health and resiliency of the health workforce appears to be the most studied policy framework sub-element
  - there is fairly clear evidence that the health workforce suffers from stress and mental health challenges
  - there is some (mixed) evidence that mindfulness interventions can be effective at improving workers' well-being, whereas there is very limited evidence supporting the use of other interventions to promote well-being
- messages related to operationalizing the value statement '**recruit health workers ethically**' include:
  - rural clinical rotations and recruiting providers from rural areas are potentially effective ways to increase the recruitment and retention of healthcare providers in rural and remote areas, but it is important to recognize a range of policy and social factors that impede retention and recruitment.

In the next iteration of this evidence brief, we will update Appendices 1-3 by mapping all identified 'best' evidence syntheses to the value statements, as a way to provide in-depth insights about what the evidence does (and does not) say about how to operationalize the values, including the types of questions that can be answered by the available evidence.

Element 3 – Ensure citizens and health workers hold (and are supported to hold) decision-makers accountable for operationalizing these core values

Ensuring citizens and providers can hold (and are supported to hold) organizations accountable for operationalizing the core values is important, particularly considering the emphasis placed on ensuring both groups are engaged in decision-making about addressing the HHR crisis by dialogue participants and citizen-panel participants. As a starting point for discussions, three approaches for ensuring citizens and health workers might be considered:

1) support citizens and health workers to join advisory bodies to influence decisions being made by health-system organizations (and call for the creation of such bodies if they don't already exist)
    - for example, many organizations across the country have patient advisory bodies such as the Patient Voices Network in British Columbia, Alberta Health Services Provincial Patient and Family Advisory Council, the Patient and Family Advisory Councils in many organizations in Ontario, the Consultation Forum of the Health and Welfare Commissioner in Quebec, the Patient, Family and Public Advisory Council in Nova Scotia, and many more
2) support patients to join patient-led organizations that can advocate for change (for example, Imagine Citizens Network in Alberta, or Patient Advisors Network), and ensure that organizations representing different groups of health workers (e.g., professional associations) have a seat at relevant decision-making tables
3) make mandatory public reporting of how organizations are operationalizing the core values in their decision-making about HHR (and making progress to resolve the crisis).

In discussing element 3 (albeit with a specific focus on how citizens could hold decision-makers accountable), participants at the first citizen panel interaction also raised the following issues:

- it is important to consider two types of accountability mechanisms
    - those that increase transparency (about HHR policies and decisions, and their impact)
    - those that support greater citizen engagement (to ensure citizens' values and insights shape HHR policies and decisions)
- the core values described in element 1 need to be used in developing a performance framework with which to hold decision-makers to account
- surveys (ideally overseen by independent organizations) that capture patients' and caregivers' experiences should be used as part of the 'feedback loop' that informs learning and improvement related to operationalizing the values
- citizen ambassadors are needed at all levels of decision-making
- citizens and patients need to be involved in discussion about the full range of issues related to the HHR crisis (i.e., beyond how their experiences with staffing shortages affects their care).

Box 4: Updating the collection of 'best' evidence syntheses about HHR

In preparing the first version of this 'living' evidence brief, we used the following approach to identify 'best' evidence syntheses about the components of the HHR policy framework (currently reflected in the row headers of Appendices 1-3):

1) we searched Health Systems Evidence for the 'best' evidence syntheses globally, developing search strategies at the level of the sub-framework elements, which were used to organize the results in (which can be found in the appendix of this version)
2) we determined eligibility for '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).

For this version of the 'living' evidence brief, we updated the collection of 'best' evidence syntheses to better understand the key messages emerging from the evidence included in Appendices 1-3 by:

1) using the results of each synthesis to write a 'declarative title' which highlights the key findings from each synthesis
2) mapping each synthesis to one or more of the following types of questions addressed:
    - understanding a problem and its causes
    - selecting an option for addressing the problem
    - identifying implementation considerations
    - monitoring and evaluating impacts.

We searched the literature to find evidence about public accountability mechanisms more generally, given our previous searches to identify 'best' evidence syntheses about HHR did not find any relevant documents specific to accountability in the context of HHR. We found a recent review about approaches to report health-system performance that are effective at driving continuous improvement and accountability (e.g., through report cards, dashboards).(8) Findings about the impact of public reporting of health-system performance were mixed, with two reviews finding that it can stimulate care quality by focusing on transparency and accountability which supports the engagement in activities to improve care quality, but others reported that it makes little to no difference to healthcare utilization by healthcare consumers or professionals, or to professional performance.

In preparing for the first citizen panel interaction, we also identified documents from the growing body of literature about the importance of citizen engagement in health-system governance, particularly as a way to support greater accountability,(9) and also for citizens to act as 'value consultants' to guide decision-makers.(10) We found several systematic reviews about promising citizen-engagement models, including citizen panels, consensus conferences, deliberative polls, and much more.(11-16) These reviews generally found a lack of evidence about what citizen-engagement methods are most effective in what context, due to the limited number of robust evaluations.(16) However, these reviews revealed potential instrumental benefits of citizen engagement (for example, integrating citizen values and preferences in policies and decisions) and developmental benefits (for example, raising public awareness and improving citizen understanding of complex policy issues).(11-16)

Additional equity-related observations about the three approach elements

The three groups prioritized in this brief (young health workers, female and racialized health workers, and health workers provided with time-limited opportunities in the system) can be used as a starting point for applying an EDI lens across the three approach elements. For example:

- with respect to elements 1 and 2 (identify core values and ensure actions taken to address the HHR crisis operationalize them), decisions related to operationalizing the values of 'plan now for the system we want' and 'make workplaces better' enable us to consider how young health workers' needs are met, while decisions related to operationalizing the value of 'recruit health workers ethically' enable us to address the challenges faced by health workers provided with time-limited opportunities
- with respect to element 3 (ensure patients and health workers hold and are supported to hold decision-makers accountable) each of the groups can be prioritized for engagement in efforts like advisory bodies.

In the next iteration of the evidence brief, we will summarize the equity-related findings from the available synthesized research evidence.

There are other equity-deserving groups that have not been considered in this brief, and it is important to note that the specific challenges they face because of the HHR crisis will need to be considered in refining the list of core values and the actions to operationalize them.

IMPLEMENTATION CONSIDERATIONS

With numerous initiatives now underway to address the HHR crisis in Canada (e.g., the Health Canada-funded and KPMG-led roundtables and symposium, the CAHS assessment, and the Coalition for Action for Health Workers), implementation considerations primarily relate to how the three approach elements can help to inform these initiatives and related efforts across Canada. Specifically, identifying 'ways in' for the insights at all levels is important to facilitate this integration and identify potential next steps. As a jumping off point for discussions, Table 5 presents prompts that can be used to identify windows of opportunity and 'ways in' through key stakeholders and initiatives at different levels.

Table 4: Prompts to identify 'ways in' for insights form the elements at different levels of health systems

Level	Key stakeholders or initiatives	Prompts to help identify 'ways in' for the insights related to the elements
FPT governments	• Coalition for Action for Health Workers • Health Canada-commissioned CAHS assessment • Other initiatives being pursued at the PT level	How can the values identified in this brief, and actions to operationalize them, be integrated into FPT initiatives, and who should they be shared with to facilitate this integration?
Health authorities and organizations providing strategic direction for and oversight of care delivery	• Health authorities and organizations providing strategic direction and oversight within PT health systems (e.g., Alberta Health Services, Ontario Health, Nova Scotia Health)	What role do health authorities and organizations providing strategic direction play in helping to create 'buy-in' for the values and actions to operationalize them? What current initiatives to address the HHR crisis include representatives from health authorities and organizations providing strategic direction and oversight within PT health systems, and who are the key individuals from these organizations to engage?
Health workplaces and practice environments	• HealthCareCan • Accreditation Canada	What efforts are currently being pursued by HealthCareCan and Accreditation Canada that could leverage the insights about core values and actions to operationalize them?
Organizations focused on specific categories of health workers	• Professional associations • Regulatory colleges	How can professional associations be engaged to act as champions for the values (and actions to operationalize them) that resonate most with their members, particularly if they're represented in initiatives underway to address the HHR crisis? What values and actions to operationalize them are most likely to be important to regulators, and what is the best way to engage them in considering how they can be integrated in their own efforts?

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APPENDICES (see separate document)

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