Living Evidence Brief

Addressing the Politics of the Health Human Resources Crisis in Canada

21 & 22 March 2023

Version 3

McMaster University | HEALTH FORUM

EVIDENCE >> INSIGHT >> ACTION

Living Evidence Brief (Version 3): Addressing the Politics of the Health Human Resources Crisis in Canada

21 & 22 March 2023

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.

Authors

Kaelan A. Moat, PhD, Managing Director, McMaster Health Forum

François-Pierre Gauvin, PhD, Senior Scientific Lead, Citizen Engagement and Evidence Curation, McMaster Health Forum

John N. Lavis, MD PhD, Director, McMaster Health Forum, and Professor, McMaster University

Funding

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

Conflict of interest

The authors declare that they have no professional or commercial interests relevant to the evidence brief. The funders played no role in the identification, selection, assessment, synthesis, or presentation of the research evidence profiled in the evidence brief.

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.

Acknowledgments

The authors wish to thank Saif Alam, Peter DeMaio and Karthik Sharma at the McMaster Health Forum for assistance with mapping the collection of 'best' evidence syntheses to values and writing declarative titles, Sarah Soueidan and her colleagues for assistance on the jurisdictional scan that informed the previous version of this brief, and Zaim Khan and his colleagues for reviewing the research evidence about approach elements. We are grateful to Steering Committee members and merit reviewers for providing feedback on previous drafts of the evidence brief. The views expressed in the evidence brief should not be taken to represent the views of these individuals.

Citation

Moat KA, Gauvin FP, Lavis JN. Living evidence brief version 3: Addressing the politics of the health human resources crisis in Canada. Hamilton: McMaster Health Forum, 21 & 22 March 2023.

Product registration numbers

ISSN 2817-1888 (online)

Table of Contents

KEY MESSAGES

'Big P' and 'small p' politics continue to loom large as the underlying explanation as to why little progress has been made to address the health human resources (HHR) crisis in Canada. This is despite a remarkable number of new ad hoc initiatives (e.g., a new federal investment in provincial and territorial (PT) health systems and PT announcements about new HHR policies), as well as long-standing ones (e.g., the federal/provincial/territorial (FPT) Committee on Health Workforce). During the last two stakeholder dialogue and last two citizen panel interactions, participants emphasized that building the future PT health systems we want in Canada and addressing the HHR crisis as part of this process will require government policymakers, organizational and professional leaders, Canadians and other health-system stakeholders to agree on the values that should underpin our collective efforts. In addition to identifying the importance of values, our ongoing interactions with dialogue and panel participants have contributed to an evolving sense of the problem, elements of a potentially comprehensive approach for addressing the problem, and implementation considerations, which are addressed in this evidence brief.

An evolving sense of the problem

Three key issues have been identified as a result of our evolving sense of the problem:

1) there are many recent jurisdiction-specific decisions to address aspects of the HHR crisis, some of which may require additional policy initiatives to ensure the benefits outweigh potential harms (e.g., jurisdiction-specific recruitment approaches that increase cross-jurisdiction competition for health workers)
2) new FPT agreements may have been expected to raise expectations, but are being announced in a context where many Canadians have grown increasingly frustrated (e.g., continued feelings of worry about the future of health systems in Canada, and a sense that more needs to be done to hold PT governments accountable for the impacts they achieve 'on the ground' with the new funds)
3) as yet no structures and processes have been developed to craft the 'vision' for the future, broker trade-offs to develop PT strategies, and establish the dedicated leadership to execute the strategies (e.g., no forums to identify where different organizations involved in 'small p' politics may be willing to 'give up some ground' for the greater good or in exchange for gaining ground in other domains).

Despite the challenges, there is room for optimism given an alignment around values that need to underpin health-system transformation and efforts to address the HHR crisis.

Three elements of a potentially comprehensive approach to addressing the problem

In response to this evolving understanding of the problem three elements of a potentially comprehensive approach to addressing it have been identified for consideration:

1) establish a mechanism for engaging diverse Canadians in crafting a vision for the core features of PT health systems and the health workforce needed to 'power' it
2) create the structures and processes to broker trade-offs among organizational and professional leaders to develop PT strategies
3) establish the dedicated PT leadership to execute the strategy.

We identified evidence syntheses about each of these elements that may lead to a better understanding about how aspects of them could be operationalized (e.g., facilitators of successful citizen engagement) and some of their proposed benefits (e.g., positive associations between individual leadership competencies and strategically oriented and collective leadership structures that can help drive system transformation).

Implementation considerations

While there are several barriers to and facilitators of moving forward with the elements, the biggest barrier may be identifying the right PT leadership to advance the elements, while the biggest window of opportunity is the potential for Canadians to channel their frustrations into creating a 'social movement for change.'

REPORT

This is the third version of the 'living' evidence brief about 'addressing the politics of the health human resources crisis in Canada'. This version focuses on aspects that emerged as particularly important during the second stakeholder dialogue convened on 19 and 20 January 2023, and the second (and last) citizen panel hosted on 17 February 2023.

As described in the first two versions of this 'living' evidence brief (and the 'living' citizen briefs) – which are available here – 'big P' and 'small p' politics continue loom large as the underlying explanation as to why little progress has been made to address the HHR crisis in Canada. This is despite a remarkable number of new ad hoc initiatives (e.g., a new federal investment in provincial and territorial (PT health systems and PT announcements about new HHR policies), as well as long-standing ones (e.g., the FPT Committee on Health Workforce).

Dialogue participants and citizen panel participants emphasized that building the future PT health systems we want in Canada and addressing the HHR crisis as part of this process will require government policymakers, organizational and professional leaders, Canadians and other health-system stakeholders to agree on the values that should underpin our collective efforts. Five values emerged as a result of these deliberations:

1) start building now the future health systems we want
2) make workplaces 'excellent' for health workers and hold employers accountable for this
3) recruit ethically
4) share more and better HHR data
5) build on PT wins for the benefit of all Canadians.

In addition to these values, our ongoing interactions with dialogue participants, as well as the citizens who were engaged in our 'living' citizen panel, have contributed to an evolving sense of the problem, elements of a potentially comprehensive approach for addressing the problem, and implementation considerations, which we'll focus on in this version of the brief and during deliberations at the stakeholder dialogue it was prepared to inform.

Aim of the third version of this 'living' evidence brief

In this third version of the evidence brief we provide an updated framing of the issues, with an emphasis on those aspects that emerged as particularly important during the first two of four 'living' stakeholder dialogue interactions and the two 'living' citizen panel interactions. Like the first and second version, it also mobilizes the best-available evidence,

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

The third version of this 'living' evidence brief has been updated based on insights that emerged during the first and second 'living' stakeholder dialogue interactions and the two 'living' citizen panel interactions. 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 last 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 evidence brief involved five steps:

1) conducting a thematic analysis and summarizing the insights that emerged from the second dialogue interaction in a dialogue summary, and the second 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) conducting an additional jurisdictional scan to identify FPT initiatives that have been implemented to address the HHR crisis
5) 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 third 'living' stakeholder dialogue interaction. The goal of the dialogue is to spark insights and generate action by participants and by those who review the dialogue summary.

insights from a documentary and website review of Canadian FPT jurisdictions, and the views and experiences of key informants. This version aims to be a further streamlined version than the last. It was prepared to inform a third 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.

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: INITIATIVES TO ADDRESS THE HHR CRISIS AS WELL AS BROADER SYSTEM NEEDS MAY ONLY GET US PARTWAY 'THERE'

Calls for accelerated health-system transformation across Canada are growing louder, with initiatives such as the Public Policy Forum's Future of Health Care project serving to amplify the need for decision-makers at all levels to move now from current crises (including the HHR crisis) towards widespread, people-centred, health-system renewals in every province and territory.(1) However, there are three key aspects of an evolving sense of the problem that warrant attention, given they may hinder progress towards health-system renewal efforts:

1) there are many recent jurisdiction-specific decisions to address aspects of the HHR crisis, some of which may require additional policy initiatives to ensure the benefits outweigh potential harms
2) new FPT agreements may have been expected to raise expectations, but are being announced in a context where many Canadians have grown increasingly frustrated
3) as yet no structures and processes have been developed to craft the 'vision' for the future, broker trade-offs to develop PT strategies, and establish the dedicated leadership to execute the strategies.

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

There are many recent jurisdiction-specific decisions to address aspects of the HHR crisis, some of which may require additional policy initiatives to ensure the benefits outweigh potential harms

As the HHR crisis has intensified in Canadian health systems over the last year, PT governments have made decisions to implement a number of solutions (see Table 1). There are many similarities across jurisdictions, with most focusing on recruitment and retention (often with financial incentives underpinning them) and investing in the supply of health workers by increasing 'seats' in professional education programs. While these initiatives signal a willingness among government policymakers to take important steps towards addressing elements of the crisis, there are some potential harms that may create additional policy challenges that will need to be addressed in the future, including:

1) a lack of coordination among jurisdictions around their recruitment and retention initiatives is likely to create growing competition for the existing stock of Canadian health workers, as well as for health workers being trained in countries that are traditionally sources of internationally trained health workers in Canada (e.g., the Philippines) – all of which could exacerbate challenges in 'have not' jurisdictions for which recruiting and retaining health workers has historically been a challenge
2) regional agreements that aim to enable greater healthcare-worker mobility across specific PT borders – such as the introduction of a joint physicians and surgeons registry in Atlantic provinces – risk undercutting efforts to establish something similar at the pan-Canadian level by creating regional 'blocs'
3) the rapid introduction of changes to professional licensing requirements (such as in Ontario) may create the conditions for a rise in 'virtual only' models of care that are not integrated into the broader health system and could contribute to further fragmentation and coordination challenges.

Table 1: Recent provincial and territorial decisions about addressing the HHR crisis

Jurisdiction	Solutions adopted to address the HHR crisis
British Columbia	Introduction of B.C.'s Health Human Resources Strategy focusing on: • retaining health workers (e.g., through making workplaces better) • balancing workloads and staffing levels through adjustments to health-system arrangements (e.g., expanding team-based care, expanding pharmacist, paramedic and first responders' scopes of practice) • recruiting new health workers • increasing supply through education and training initiatives (e.g., adding new 'seats' in medical schools and in midwifery programs)
Alberta	Introduction of the Alberta Health Workforce Strategy, focusing on: • retaining health workers by supporting a safe, engaging, and meaningful work environment • recruiting new health workers from across Canada and the world • growing workforce capacity by educating and training more health workers • introducing collaborative, proactive, and evidence-based approaches to long-term workforce planning
Saskatchewan	Launch of a four-point Health Human Resources Action Plan, and the establishment of a new independent Saskatchewan Healthcare Recruitment Agency, with an emphasis on: • recruiting hundreds of new health workers from abroad (through the establishment of a memorandum of understanding with the Government of the Philippines and a call to unlicensed internationally educated health workers living in Canada who may be eligible to join the province's workforce), as well as newcomers interested in working in the healthcare sector • accelerating training, assessment and licensure pathways for internationally educated nurses, and adding more training seats in education health professional education programs • incentivizing health workers to work in rural and remote areas through return-of-service agreements, and other financial incentives such as student loan forgiveness, graduate retention programs and clinical placement bursaries • retaining, through the addition of more permanent, full-time positions for high-demand professions in rural and remote areas, providing mentorship and peer-to-peer supports and a First Nations and Métis recruitment and retention strategy
Manitoba	Introduction of a new health human resource action plan, which focuses on: • retaining health workers through additional supports for well-being (e.g., improving workplace safety and working conditions, reducing administrative burden and providing mental health supports) financial incentives (e.g., reimbursements for support programs and licensing fees, hourly premiums for weekend hours, additional compensation for full-time workers) • training health workers, including increasing the number of future workers trained through undergraduate professional education programs, and through an expansion of the Undergraduate Nurse Employee program to support nurses returning from retirement and internationally educated nurses • recruiting more health workers who are qualified and wish to practise in Manitoba, through a nurse-referral program, a returning-nurse program and financial incentives (e.g., tuition rebates and incentives for returning retirees, plus addressing constraints associated with testing costs), as well as through a modernized memorandum of understanding with the Government of the Philippines
Ontario	Targeted efforts related to health human resources in Bill 60: *Your Health Act, 2023* • 'As of Right' rules to automatically recognize the credentials of health workers registered in other provinces, as well as the introduction of a new temporary class of licence by the College of Physicians and Surgeons of Ontario for physicians to expedite the registration of out-of-province and internationally educated physicians
Quebec	Implementation of the Opération main-d'oeuvre, which was introduced in 2021 and aims to tackle workforce shortage in certain priority areas through a set of targeted measures, such as: • accelerated training to become a nurse assistant • measures to improve everyday life for nursing and cardiorespiratory care personnel • financial incentives for return • financial incentives for job retention
Atlantic Canada	Introduction of a new physicians and surgeons registry with other Atlantic provinces to support cross-jurisdictional practice in the region

New Brunswick	New investments in the recruitment and training of nurses, as well as efforts to expand the scope of practice among pharmacists to diagnose and prescribe
Nova Scotia	New Nova Scotia Action for Health Plan, which includes solutions focused on: • recruitment (through efforts like streamlining licensing and recruitment processes, and the establishment of the Office of Healthcare Professionals Recruitment Community Fund) • retention of current health workers in the province (through efforts to support professional development, resilience and job satisfaction)training and education (through efforts such as opening more medical school and residency seats in priority clinical areas)
Prince Edward Island	Introduction of a number of financial incentives to drive recruitment and retention efforts including: • new financial recruitment incentives to attract and retain nurses and midwives • new financial incentive programs to support retention (including the Retention Incentive Plan, Retirement Retention Program and the Priority Vacancy Program) to retain health workers and fill key vacancies throughout the system Investments in education and training infrastructure to support the creation of a new faculty of medicine
Newfoundland and Labrador	Focus on recruitment and retention of health workers through: • the establishment of a new Assistant Deputy Minister for the recruitment and retention office, and an increase in staffing in regional health authorities to support recruitment and retention efforts • the introduction of many financial incentives to attract and retain health workers (e.g., Come Home 2022 incentive to attract expatriate Newfoundlanders who are health professionals to return to practise in the province, Internationally Educated Nurses Bursary, incentives for retired family physicians to return to practice, the New Family Physician Income Guarantee, and the Family Practice Start-up Program, nursing retention, signing and overtime bonuses) • the introduction or expansion of programs for Internationally Educated Nurses Bridging Program, and the Extraordinary Every Day campaign. Additional efforts include expanding scopes of practice for nurses and increasing the supply of health workers through increases in the number of seats in medical and nursing schools from nursing programs and personal care attendant programs
Yukon	New investments to support the recruitment and retention of healthcare staff in the territory, including retention packages and signing bonuses for nurses, as well as bursaries and reimbursements
Northwest Territories	The development of a Human Resources Plan, which aims to: • increase the number of Indigenous and Northern residents pursuing careers in health through bursaries, mentorship and access to employment programs • attract and retain professionals by supporting professional development, academic support, learning and mentorship, as well as targeted marketing campaigns to attract new graduates and physicians, and health, safety and wellness initiatives Introduction of initiatives to recruit and retain health workers, which includes: • bonus payments for nurses, midwives and medical laboratory technologists • a friend and family travel program (which includes bursaries to cover certain costs like travel for family) • international travel reimbursements for workers interested in work in NT • a referral program which provides incentives for government employees to refer registered nurses and nurse practitioners who are hired, and licensing fee reimbursements
Nunavut	Introduction of a Roadmap to Strengthen the Nunavut Nursing Workforce, which focuses on: • workforce planning and evaluation • recruitment • professional development • creating a positive professional practice environment • developing nursing leadership in the territory. Implementation of targeted incentives such as the Bring a Friend or Family Member incentive to attract nurses to work in the territory during the peak holiday season when demands are highest

New federal/provincial/territorial (FPT) agreements may have been expected to raise expectations, but are being announced in a context where many Canadians have grown increasingly frustrated

Recently, a new set of FPT agreements has been announced that were expected to reassure Canadians about the future of health systems in the country. The Government of Canada's offer to the provinces and territories was released on 7 February 2023, and has since led to agreements-in-principle between the federal and PT governments (with British Columbia, Alberta, Saskatchewan, Manitoba, Ontario and the Atlantic provinces having reached agreements through bilateral negotiations).(2) The agreements include a total of $46 billion in new healthcare money for the provinces and territories over the next 10 years, through a 5% annual increase in the Canada Health Transfer. They also consist of four priority target areas for the new money. Three of the priority areas focus on a vision for broader health-system transformation:

1) access to high-quality family health services when patients need them, including in rural and remote areas, and for underserved communities
2) access to timely, equitable, and quality mental health, substance use and addictions services
3) a modernized health system that ensures:
    - patients have access to their own electronic health information that is shared between the health professionals they consult
    - provinces collect, use and share depersonalized health information
    - Canadians are informed of progress with key common headline indicators.

The other the priority area, as well as a number of other key aspects laid out in the agreements-in-principle also focus on addressing aspects of the HHR crisis as part of the solution towards broader health-system transformation. Specifically, the agreements specify the following efforts are expected:

- creating a resilient and supported health workforce that provides Canadians high-quality, effective, and safe healthcare services
- making commitments to streamline foreign credential recognition for internationally educated health professionals, and commitments to 'advance labour mobility for key health professionals.'

Despite the optimism that may come along with these agreements, they are being announced in a context of growing public concern and frustration about the state of health systems in Canada. During the two citizen panels that were convened in December 2022 and February 2023, participants expressed concerns about the state of PT health systems, a sense of hopelessness about our collective capacity to resolve the HHR crisis and move ahead with system-transformation initiatives (and a growing frustration about the 'big P' and 'small p' politics holding us back), as well as the perceived lack of accountability among health-system leaders for achieving impacts 'on the ground.' These findings resonate with recent public opinion polls. For instance, Leger and The Association for Canadian Studies surveyed 1,554 Canadian adults in January 2023. The survey revealed that approximately 86% of people surveyed across the country said they are worried about the state of healthcare.(3) An Ipsos survey published in February 2023 revealed that Canadians want greater federal funding, but demand concrete strategies and accountability from PT governments, with a majority indicating that provincial leaders need to do more to show what their plans are for new federal dollars.(4) Finally, recent ombudsman's reports from B.C. and Ontario highlighted rising complaints about healthcare services in these provinces, and many other jurisdictions across the country are grappling with similar pessimism.(1; 5; 6)

As yet no structures and processes have been developed to craft the 'vision' for the future, broker trade-offs to develop provincial and territorial (PT) strategies, and establish the dedicated leadership to execute the strategies

Despite the aforementioned initiatives underway to address the HHR crisis, and a number of examples of efforts at the PT level to help advance broad health-system transformation (see Table 2 for some examples), there are no structures or processes in place in many jurisdictions for government policymakers, organizational leaders, professional leaders, and members of the public to collectively craft the 'vision' for the future. More pragmatically, there are no fora for brokering agreement – particularly among the key

stakeholders often involved in 'small p' politics at the PT level – about the trade-offs associated with the bold decisions needed to drive health-system transformation efforts, or with decisions about how to help the health workforce to thrive as a result of this transformation. This undermines the possibility of a unified approach to system planning in which key stakeholders are willing to 'give up some ground' for the greater good or in exchange for gaining ground in other domains.

In addition to the lack of structures and processes, there is also no shared understanding about roles and responsibilities, or an appropriate leadership structure for driving the types of change-management processes required to execute a 'vision' for the future of health systems in Canada (while addressing the HHR challenges). Simply put, despite a growing number of renewed calls for re-imagining our health-systems in Canada, nobody has raised their hand to make this happen.

Table 2: Examples of provincial and territorial efforts to advance health-system transformation in Canada

Jurisdiction	Examples of efforts to advance health-system transformation
British Columbia	• Introduction of new compensation models for family physicians (e.g., longitudinal family physician payment model (LFP) introduced in 2022) • Implementation of pilot projects that are pushing forward significant transformations to clinical practices and systems (e.g., the Clinical & Systems Transformation (CST) project with Vancouver Coastal Health in 2022) • Development of strategic plans (e.g., Province of B.C. Digital Health Strategy in 2019; B.C. Digital Health Initiative in 2020)
Alberta	• Development of strategic plans (e.g., Transformational Roadmap 2019–2024 in 2019, and Alberta Innovates – Digital Health Transformation in 2022) • Engagement of external bodies to help inform transformation initiatives (e.g., Alberta Health Services performance reviews conducted by Ernst & Young LLP)
Saskatchewan	• Development of strategic plan (e.g., Saskatchewan Health Authority Roadmap 2022-23)
Manitoba	• Establishment of new organizations to provide strategic oversight of the health system (e.g., Shared Health Manitoba introduced in 2019) • Development of strategic plans (e.g., Health System Transformation Blueprint for Change in 2019 and the Manitoba Health, Seniors and Active Living Transformation Program Charter in 2020)
Ontario	• Establishment of new organizations to provide strategic oversight of the health system (e.g., Ontario Health in 2019), and new integrated systems of care for an attributed population of Ontarians (e.g., Ontario Health Teams)
Québec	• Development of strategic plans (e.g., MSSS Strategic Plan for 2019-2023, and the 2022–2025 Québec Life Sciences Strategy in 2022), and discussions about creating a new agency (Santé Québec) to separate management and operation functions
New Brunswick	• Development of strategic plan (e.g., Stabilizing Health Care: An Urgent Call to Action in 2021)
Nova Scotia	• Changes to emergency care, supports for paramedics and improving access introduced in early 2023 • Development of strategic plans (e.g., Action for Health in 2022, Advancing Nova Scotia's Health Care Through Information Technology Leadership in 2022)
Prince Edward Island	• Targeted reform efforts such as the introduction of primary care access clinics, the Pharmacy Plus program, and new dedicated ambulance transfer units • Development of strategic plan (e.g., Health PEI Strategic Plan 2021-2024 in 2021)
Newfoundland and Labrador	• Development of strategic plan (e.g., Health Accord for Newfoundland and Labrador: A 10-Year Health Transformation Initiative in 2022)
Yukon	• Development of strategic plan (e.g., Putting People First report in 2022)
Northwest Territories	• Launch of demonstration projects focused on primary-care reform in 2019 that will inform efforts to develop a vision for transformational change in Northwest Territories)
Nunavut	• Development of strategic plan (e.g., Model of Care Redesign for Nunavut in 2018, and the Territorial Client and Family Engagement Plan in development as of 2023)

Despite the challenges, there is room for optimism given an alignment around values that need to underpin health-system transformation and efforts to address the HHR crisis

We should be optimistic that we can make strides towards both crafting a 'vision' for the future and addressing the HHR crisis as part of this vision, given an apparent alignment around values, which can be used to create cohesion among key stakeholders in reform efforts. In particular, the priorities outlined in the new FPT agreements, as well as the recommendations for addressing the HHR crisis that were put forward on 6 March 2023 to the government by the bipartisan Standing Committee on Health, align with and reflect the values identified by participants at previous dialogue interactions and the citizen panels (see the previous section). Table 3 provides an overview of how the FPT agreements and the recommendations from the Standing Committee on Health align with these values.

Table 3: Alignment of values with FPT priorities and Standing Committee on Health recommendations

Values identified by stakeholder dialogue and citizen panel participants	Priorities outlined in new FPT agreements	Recommendations to the Government of Canada from the Standing Committee on Health

Start building now the future health systems we want	• Access to high-quality family health services when they need them, including in rural and remote areas, and for underserved communities
	• Access to timely, equitable, and quality mental health, substance use and addictions services
	• A modernized health system that ensures:
	  ○ patients have access to their own electronic health information that is shared between the health professionals they consult
	  ○ provinces collect, use and share depersonalized health information
	  ○ Canadians are informed of progress with key common headline indicators
		• In consultation with provinces and territories, and advised by diverse experts from the health community, develop a national strategy on the promotion and implementation of effective healthcare teams across Canadian society to ensure patient issues are treated by the appropriate member of the healthcare team to get the best care possible (**recommendation 11**)
		• Work with the provinces and territories to expand access to long-term care beds, home-care services, and palliative care (**recommendation 13**)
		• Work with the provinces and territories to improve Canada's preventive health strategies and increase federal investment in preventive health measures (**recommendation 14**)
		• Work in collaboration with the provinces and territories as well as Indigenous Peoples and stakeholders to expand digital infrastructure, and other system improvements, to increase access to high-quality, safe virtual care, where appropriate (**recommendation 15**)

Make workplaces 'excellent' for health workers and hold employers accountable for this	• A resilient and supported health workforce that provides them high-quality, effective, and safe healthcare services	• Work with the provinces and territories, and/or utilize powers within its purview, to create incentives for health workers to encourage the retention, and return, of health workers to help address the workforce crisis (**recommendation 16**) • Work with the provinces and territories to provide incentives to attract more physicians into family care and retain them (**recommendation 17**) • Work with the provinces and territories to implement a Pan-Canadian Mental Health Strategy for health workers (**recommendation 20**)
Recruit ethically	• A focus on streamlining foreign credential recognition for	• Collaborate with provincial and territorial governments and consult with organizations involved in recruiting internationally trained health

	internationally educated health professionals	workers, as well as Immigration, Refugees and Citizenship Canada where necessary, to streamline and simplify the process to recruit from countries known to train health workers in excess of their domestic needs (**recommendation 1**) • Collaborate with provincial and territorial governments to provide more residency positions for international medical graduates (**recommendation 2**) • Collaborate with provincial and territorial governments and professional regulatory bodies to improve upon and expand pathways to licensure for international physicians who have already completed their residency and who practised abroad, such as the National Assessment Collaboration's (NAC) Practice-Ready Assessment (PRA) program and other similar initiatives (**recommendation 3**) • Support expedited pathways to licensure and practice for internationally trained healthcare professionals (**recommendation 4**)
Share more and better HHR data	• A modernized health system that ensures: o Canadians are informed of progress with key common headline indicators	• In collaboration with provinces, territories and Indigenous Peoples, continue its work in developing a Pan-Canadian Health Data Strategy to improve Canada's collection, access, sharing and use of health workforce data and lay the foundation for a world-class health data system (**recommendation 9**) • Collaborate with the provinces and territories to create and implement a Pan-Canadian Health Human Resource Strategy to facilitate better identification of gaps in the healthcare workforce and more efficient action to address those gaps (**recommendation 10**)
Build on PT wins for the benefit of all Canadians	N/A	• Work with the provinces and territories to explore and share best practices in alternate payment mechanisms, specifically towards alleviating physician burnout (**recommendation 12**) • In partnership with provinces, territories, Indigenous Peoples and stakeholders, share best practices in an effort to reduce administrative burdens on healthcare professionals, where appropriate, to ensure that time is not unnecessarily taken away from patients, and to reduce the significant contributor of administrative burdens to burnout (**recommendation 19**)
Other elements included in agreements and recommendations that focus on addressing the HHR crisis	• Advance labour mobility for key health professionals	• Collaborate with provincial and territorial governments and professional regulatory bodies to facilitate the licensing and, where necessary, additional education and training needed for licensing of nurses and other healthcare professionals working in fields where existing programs are unable to address the workforce shortages (**recommendation 5**) • Collaborate with provincial and territorial governments to increase the number of residency

		positions, particularly for family medicine (**recommendation 6**) • Work with the provinces, territories, and professional regulatory bodies to establish pan-Canadian licensure for health professionals (**recommendation 7**) • Work with the provinces, territories, and professional regulatory bodies to optimize the scope of practice for primary-care professionals, including nurse practitioners and pharmacists (**recommendation 8**) • Collaborate with the provinces and territories to develop strategies to recruit, train, and adequately support, health workers for rural, remote, and northern communities (**recommendation 18**).

THREE ELEMENTS OF A POTENTIALLY COMPREHENSIVE APPROACH FOR ADDRESSING THE PROBLEM

During the first two stakeholder dialogue interactions and citizen panels, ongoing deliberations and an evolving sense of the problem suggest the following three elements of a potentially comprehensive approach should be given consideration in moving forward to address both broader system-level issues in Canada, as well as the more specific challenges associated with the HHR crisis:

1) establish a mechanism for engaging diverse Canadians in crafting a 'vision' for the core features of PT health systems and the health workforce needed to 'power' it
2) create the structures and processes to broker trade-offs among organizational and professional leaders to develop PT strategies
3) establish the dedicated PT leadership to execute the strategy.

In the sections that follow, we briefly describe each element as well as what is known from 'best' evidence when applicable (see Box 2). In Appendices 1-3, we also provide an updated collection of 'best' evidence syntheses focused on solutions for addressing the HHR crisis (which was developed to inform deliberations in previous versions of this brief). This collection has been updated to include data about which values the syntheses address (see Box 3 on the following page). We provide a high-level summary of what is known from evidence syntheses about solutions for operationalizing these values in Appendix 4.

Element 1 – Establish a mechanism for engaging diverse Canadians in crafting a vision for the core features of PT health systems and the health workforce needed to 'power' it

This element focuses on establishing an approach for engaging Canadians (including patients, families and caregivers) in a 'social movement for change' that focuses on rethinking health systems in Canada. This could be pursued by developing a strategy that draws on one or more of the following goals, which span a spectrum of public participation approaches:

1) informing (e.g., through educational materials)
2) consulting (e.g., by opening up avenues for public commentary, convening focus groups and conducting surveys, or holding public meetings)
3) involving (e.g., delivering workshops or engaging in deliberative polling)
4) collaborating (e.g., establishing citizen advisory committees, engaging in consensus-building and participatory decision-making processes)
5) empowering (e.g., establishing citizen panels and juries, holding ballots or delegating decisions to them).(7)

This element also includes efforts to ensure Canadians can hold (and are supported to hold) health-system leaders to account for both crafting a 'vision' for the core features of PT health systems and the health

Box 2: 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 previous versions, but for elements that were significantly reframed, we used the same methods as in the first and second briefs 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.

workforce needed to 'power it.' Canadians could be engaged through one comprehensive approach that addresses both crafting a 'vision' and identifying solutions to address health workforce issues, or through separate mechanisms assigned to each of these areas of focus. Existing initiatives in Canada that could serve as inspiration for such an approach include the Imagine Citizens' Network in Alberta (see: https://imaginecitizens.ca/), which is a provincial network of people and community-oriented partners that offers Albertans, as health citizens, collaboration pathways to deliver person-centred healthcare, through partnership between citizens and other stakeholders in health-system redesign efforts.

We identified several evidence syntheses that focus on the importance of citizen engagement in health-system governance, particularly as a way to support greater accountability, and also for citizens to act as 'value consultants' to guide decision-makers.(8) We also found several syntheses about promising citizen-engagement models, including citizen panels, consensus conferences, deliberative polls, and much more.(9-14) These syntheses generally found a lack of evidence about what citizen-engagement methods are most effective in what context, due to the limited number of robust evaluations.(10; 11; 14; 15) However, they revealed potential instrumental benefits of citizen engagement (for example, integrating citizen values and preferences in policies and decisions) and developmental benefits (for example, raising public awareness and improving citizen understanding of complex policy issues).(9-14; 16) These syntheses were also included in the citizen briefs prepared to inform the two citizen panels we convened on the topic, and additional details about the key findings can be found in the technical appendices available here.

Element 2 - Create the structures and processes to broker trade-offs among organizational and professional leaders to develop PT strategies

This element builds on the next steps that participants at the first two stakeholder dialogues put forward for consideration (the dialogue summaries can be accessed here). It could include establishing a forum that engages organizational and professional leaders from across PT health systems to:

1) broker agreement around the core features of the health systems we want now and in the future (and the health workforce needed to power these core features)
2) identify and collectively agree to the trade-offs required to build the health systems we want, including the sacrifices required from each stakeholder group in order to advance the public good
3) establish a solidarity pact about the agreement in order to present a unified front to FPT first ministers and their cabinets.

Box 3: Updating the collection of 'best' evidence syntheses about HHR

In preparing the first two versions 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)
3) we used the results of each synthesis to write a 'declarative title' which highlights the key findings from each synthesis
4) we mapped 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.

In this version of the evidence brief, we updated Appendices 1-3 by adding a column and mapping each 'best' synthesis to the values they addressed (which were identified by stakeholder dialogue and citizen panel participants). We also analyzed the declarative titles across value categories in order to prepare a high-level summary about what is known about approaches for operationalizing each of the values (see Appendix 4).

We didn't identify any evidence syntheses directly relevant to element 2. However, the syntheses identified and summarized in the first two versions of this evidence brief may be of interest to readers given they addressed aspects of collective decision-making in policy contexts where values are important. A summary of these reviews can be found in the appendix tables of those briefs (available here).

Element 3 – Establish the dedicated PT leadership to execute the strategy

This element focuses on identifying the leadership approach (and leaders) needed to support next steps in executing a strategic vision for health-system transformation, and for addressing HHR challenges as part of this process. This approach could include the following steps:

1) defining the roles that health-system stakeholders (including government policymakers) would ideally play in leading next steps to execute the strategy
2) defining the responsibilities that ensure a 'vision' is crafted and articulated with robust inputs from Canadians (element 1) and with buy-in from organizational and professional leaders (element 2)
3) creating the conditions for dedicated and skilled leaders across PT health systems to operationalize the approach.

Inspiration about how to establish components of an appropriate leadership approach can be drawn from past efforts in which strong leadership helped to drive PT health-system transformation at scale. For example, the Health Services Restructuring Commission from 1996 – 2000 in Ontario, which involved the consolidation of previously competing acute-care hospitals in most of the province's urban municipalities, included:

- a legislative mandate which provided the Commission with authority to restructure public hospitals
- 'volunteer' commissioners who were private citizens with widely varying backgrounds and who were viewed as working in the interest of Ontarians
- administrative support and resources to plan and schedule an approach to address the Commission's mandate
- opportunities to forge strong relationships between government and all key stakeholders
- a planned approach to engaging the media as a way to inform and build relationships with members of the public about the goals and approaches adopted to achieve them.(17)

While we didn't find any syntheses directly relevant to element 3, we identified three rapid syntheses (two older syntheses and a more recent synthesis) that collectively provide a summary of health-system leadership frameworks, as well as what is known from the best-available evidence about particular leadership competencies and ways for operationalizing them across a variety of health-system transformation initiatives.(18-20) While these syntheses often identified literature that was focused at the individual level, the most recently updated synthesis drew on 21 systematic reviews and 24 single studies and found that having leadership competencies in place – even at the individual level – may help to promote:

- a more strategically oriented and collective leadership structure in place to support large-scale system transformation
- better interdependence and collaboration across organizations and support for rapid-learning and improvement
- better resource management and greater satisfaction among staff
- improved engagement of patient, families and caregivers
- the potential for better health outcomes
- more accountability and a self-reinforcing culture that promotes leadership capacity.(20)

Additional equity-related observations about the three approach elements

Three groups were prioritized in this brief for equity considerations (young health workers, female and racialized health workers, and health workers provided with time-limited opportunities in the system). It is

important to consider them as providing a 'way in' for applying an equity, diversity and inclusion lens across the approach elements. For example:

- with respect to element 1 (establish a mechanism for engaging diverse Canadians in crafting a 'vision' for the core features of PT health systems and the health workforce needed to 'power' it) and element 2 (create the structures and processes to broker trade-offs among organizational and professional leaders to develop PT strategies), it is essential that the approaches used to identify and engage Canadians and organizational and professional leaders explicitly aim to include the voices of each of these equity-deserving groups
- respect to element 3 (establish the dedicated PT leadership to execute the strategy), representation from these groups should be considered in establishing roles and responsibilities, in the design of plans to execute the strategy, and in efforts to assess the impacts of key components of the strategy if they're implemented.

IMPLEMENTATION CONSIDERATIONS

As a jumping off point for discussions, Table 4 presents a list of potential barriers that may hinder progress towards implementing the elements, as well as facilitators that may be taken advantage of. Overall, the biggest barrier may be identifying the right PT leadership to advance the types of efforts outlined in the elements, while the biggest window of opportunity is the potential for Canadians to channel their frustrations into creating a 'social movement for change.'.

Table 4: Potential barriers to and facilitators of implementation of the elements

	Element 1 - establish a mechanism for engaging diverse Canadians in crafting a vision for the core features of PT health systems and the health workforce needed to 'power' it	**Element 2 - create the structures and processes to broker trade-offs among organizational and professional leaders to develop PT strategies**	**Element 3 - establish the dedicated PT leadership to execute the strategy**
Barriers	• Without explicit buy-in from decision-makers there may be limited 'ways in' for these kinds of insights in existing decision-making processes	• Organizational and professional leaders may not be willing to 'give up ground' when discussing trade-offs if the constituents they represent don't approve • Entrenched 'small p' politics may make the process extremely bureaucratic and cumbersome	• Individuals and organizations well-positioned to take on a leadership position may not have the bandwidth because they're preoccupied with issues management
Facilitators	• There are many 'third party' organizations in Canada that specialize in citizen engagement and could be leveraged to drive this process	• Many leaders are aligned on the values that underpin efforts to develop solutions for addressing the HHR crisis, as well as the core features that health systems in Canada can build towards	• Lessons from successful PT change-management processes are available and can be used to inform an approach (e.g., the establishment of Alberta's Strategic Clinical Networks, cancer care integration in Ontario, etc.)

REFERENCES

1. Bell B, Black G, Butts J, et al. Taking back health care: How to accelerate people-centred reform now. Ottawa, Canada: Public Policy Forum; 2023.
2. Government of Canada. Working together to improve health care for Canadians. https://pm.gc.ca/en/news/news-releases/2023/02/07/working-together-improve-health-care-canadians: Government of Canada 2023 7 February 2023.
3. Leger, The Canadian Press. Leger/The Canadian Press Survey of 1,554 Canadians and 1,005 Americans. https://leger360.com/surveys/legers-north-american-tracker-january-27-2023/: Leger; 2023 27 January 2023.
4. Ipsos. More money more accountability: Six in seven (86%) Canadians want increased federal investment in healthcare; but six in ten (59%) want provinces to show a plan for better care to get it Toronto, Canada. https://www.ipsos.com/en-ca/news-polls/healthcare-more-money-more-accountability: Ipsos; 2023 6 February 2023.
5. Crawley M. Staffing woes in Ontario's health system drive growth in patient complaints. https://www.cbc.ca/news/canada/toronto/ontario-hospital-complaints-patient-ombudsman-report-1.6769995: CBC; 2023 7 March 2023.
6. The Canadian Press. Complaints about health-care services reach 10-year high, B.C. ombudsperson's report shows. https://www.cbc.ca/news/canada/british-columbia/bc-ombudsperson-annual-report-healthcare-complaints-1.6620785: CBC; 2022 18 October 2022.
7. Patient Voices Network. IAP2 Spectrum of Public Participation: Adapted from the International Association of Public Participation; Accessed online, 10 March 2023 https://patientvoicesbc.ca/wp-content/uploads/2021/03/IAP2Handout-Revised-1.pdf.
8. Abelson J, Forest PG, Eyles J, Smith P, Martin E, Gauvin FP. Deliberations about deliberative methods: Issues in the design and evaluation of public participation processes. *Social Science and Medicine* 2003;57(2): 239-51.
9. Crawford MJ, Rutter D, Manley C, et al. Systematic review of involving patients in the planning and development of health care. *British Medical Journal* 2002;325(7375): 1263.
10. Conklin A, Morris Z, Nolte E. What is the evidence base for public involvement in health-care policy? Results of a systematic scoping review. *Health Expectations* 2015;18(2): 153-65.
11. Nilsen ES, Myrhaug HT, Johansen M, Oliver S, Oxman AD. Methods of consumer involvement in developing healthcare policy and research, clinical practice guidelines and patient information material. *Cochrane Database of Systematic Reviews* 2006;2006(3): Cd004563.
12. Mitton C, Smith N, Peacock S, Evoy B, Abelson J. Public participation in health care priority setting: A scoping review. *Health Policy* 2009;91(3): 219-28.
13. Street J, Duszynski K, Krawczyk S, Braunack-Mayer A. The use of citizens' juries in health policy decision-making: A systematic review. *Social Science and Medicine* 2014;109: 1-9.
14. Lowe D, Ryan R, Schonfeld L, et al. Effects of consumers and health providers working in partnership on health services planning, delivery and evaluation. *Cochrane Database of Systematic Reviews* 2021;9(9): Cd013373.
15. Abelson J, Montesanti S, Li K, Gauvin FP, Martin E. Effective strategies for interactive public engagement in the development of healthcare policies and programs. Ottawa: Canada: Canadian Health Services Research Foundation; 2010.
16. Carman KL, Heeringa JW, Heil SKR, et al. Public deliberation to elicit input on health topics: Findings from a literature review. Rockville: United States: Agency for Healthcare Research and Quality; 2013.

17. Sinclair D, Rochon M, Leatt P. Riding the Third Rail: The Story of Ontario's Health Services Restructuring Commission, 1996-2000. Montreal, Canada: Institute for Research on Public Policy; 2005 August 15, 2005.

18. Lavis JN, Moat KA, Rizvi Z. Issue brief: Fostering leadership for health-system redesign in Canada. Hamilton, Canada: McMaster Health Forum; 2014 4 March 2014.

19. Lavis JN, Moat KA, Tapp C, C Y. Evidence brief: Improving leadership capacity in primary and community care in Ontario. Hamilton, Canada: McMaster Health Forum; 2015 30 January 2015.

20. Moat KA, Waddell K. Rapid synthesis: Supporting transitions to local-system leadership in Ontario. Hamilton, Canada: McMaster Heatlh Forum; 2022 22 March, 2022.

APPENDICES (see separate document)

McMaster University | HEALTH FORUM

>> Contact us

1280 Main St. West, MML-417
Hamilton, ON, Canada L8S 4L6
+1.905.525.9140 x 22121
forum@mcmaster.ca

>> Find and follow us

mcmasterforum.org
healthsystemsevidence.org
socialsystemsevidence.org
mcmasteroptimalaging.org
mcmasterforum