McMaster University | HEALTH FORUM

Dialogue Summary

Addressing the Global Health Human Resources Crisis

6 July 2023

Background

In partnership with the Canadian Nurses Association, the Canadian Medical Association and the International Council of Nurses, the McMaster Health Forum convened a stakeholder dialogue on addressing the global health human resources (HHR) crisis on 6 July 2023. Thirteen participants – a mix of health-system leaders, health professional leaders and a citizen leader – deliberated about the problem, elements of a potentially comprehensive approach for addressing it, implementation considerations and possible next steps for different constituencies.

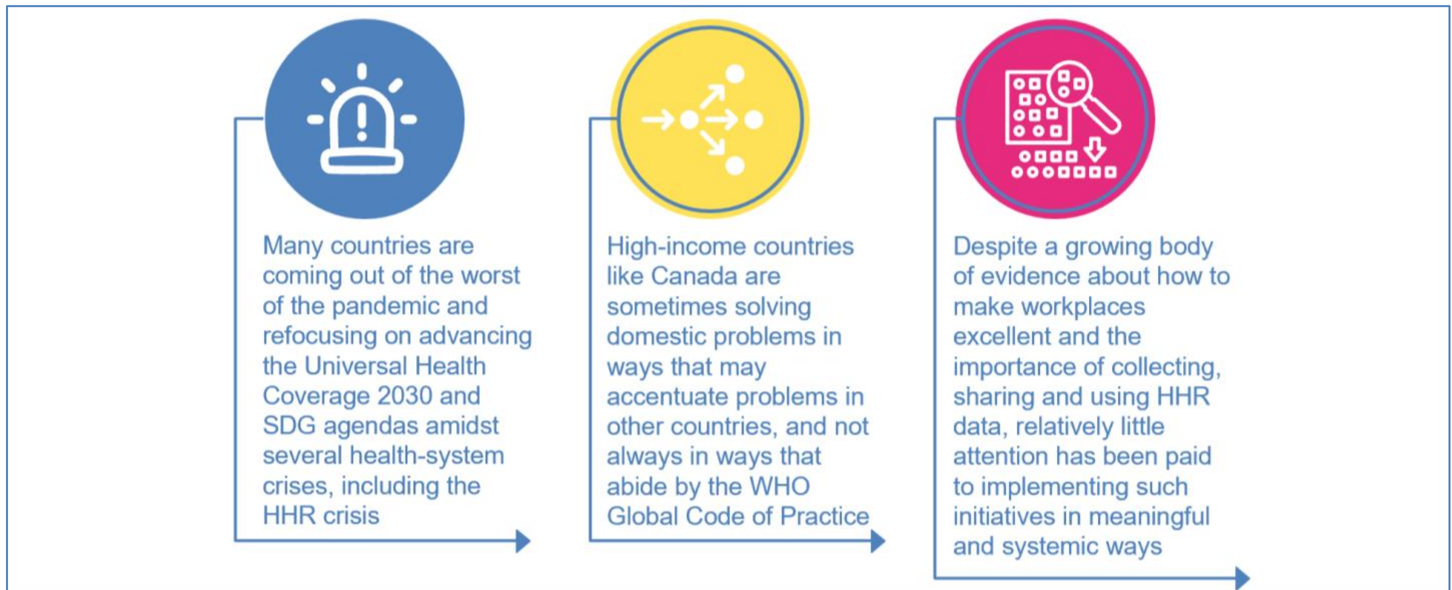
Box 1: Background to the stakeholder dialogue

The key features of the stakeholder dialogue were:
1) it addressed an issue currently being faced in many jurisdictions internationally
2) it focused on different features of the problem, including (where possible) how it affects particular groups
3) it focused on three elements of a potentially comprehensive approach for addressing the issue
4) it was informed by a pre-circulated evidence brief that mobilized research evidence about the problem, three approach elements and key implementation considerations
5) it was informed by a discussion about the full range of factors that can inform how to approach the problem and possible elements of an approach to addressing it
6) it brought together many parties who would be involved in or affected by future decisions related to the issue, including a citizen leader who brought their own unique perspectives
7) it ensured fair representation among policymakers and stakeholders
8) it engaged a facilitator to assist with the deliberations
9) it allowed for frank, off-the-record deliberations by following the Chatham House rule: "Participants are free to use the information received during the meeting, but neither the identity nor the affiliation of the speaker(s), nor that of any other participant, may be revealed"
10) it did not aim for consensus.

We did not aim for consensus because coming to agreement about commitments to a particular way forward can preclude identifying broad areas of agreement and understanding the reasons for and implications of specific points of disagreement, as well as because even senior leaders typically need to engage elected officials, boards of directors and others about detailed commitments.

Participants' views and experiences and the tacit knowledge they brought to the issues at hand were key inputs to the dialogue. The dialogue was designed to spark insights – insights that can only come about when all of those who will be involved in or affected by future decisions about the issue can work through it together. The dialogue was also designed to generate action by those who participate in the dialogue, and by those who review the dialogue summary.

Summary of deliberation about the problem



Dialogue participants emphasized two important features of the problem as it relates to advancing universal health coverage and the Sustainable Development Goals (SDGs):

- there are many global crises that are competing for the attention of government policymakers around the world (e.g., the war in Ukraine, climate change and the rising cost of living), and prioritizing investments in health and the health system requires political will, which can be difficult to secure and sustain
- many government policymakers feel they have already addressed the HHR crisis through the targeted actions they have already taken in their own jurisdiction (e.g., increasing enrolment and using financial incentives to recruit and retain), which means there is little perceived urgency in addressing ongoing challenges.

Participants made four observations regarding how government policymakers and system and organizational leaders are solving domestic HHR problems in ways that accentuate problems in other countries:

- while it is widely acknowledged that policymakers and other leaders cannot 'recruit their way out of the HHR crisis,' many – including many in Canada – use international recruitment of health workers (nurses in particular) as a way to 'solve the problem right now' (and only six or seven countries account for 70% of such recruitment)
- they also engage in recruitment activities that contravene the World Health Organization (WHO) Global Code of Practice, or ignore what is happening 'on the ground,' with many bilateral agreements not incorporating monitoring and enforcement mechanisms (e.g., despite national governments agreeing to a moratorium on recruiting from 55 particularly vulnerable countries, employers and private-sector entities still recruit from these countries)
- more than half of countries do not have a workforce plan, which can lead to short-sighted decision-making with cross-border consequences
- when workforce planning exists, it often fails to account for the different needs across sectors (e.g., hospital care vs. long-term care), settings (e.g., rural vs. urban environments) and jurisdictions (e.g., smaller Caribbean countries may have less capacity for producing new nurses, an acute cost-of-living crisis that makes it difficult to retain nurses, and a twenty-year wait for citizenship; federal jurisdictions like Canada and the U.S. may have significant variability across their provinces and states, and regulatory bodies operating at this level that are not interested in initiatives like national licensing).

They also made nine observations about the problem of too little attention being paid to implementing initiatives that aim to make workplaces excellent (or to 'improve work environments,' as some stakeholder dialogues preferred to frame it):

- decision-makers in many countries focus on solutions that address the supply and demand of health workers because the complexity of engaging the full range of stakeholders (or partners) – including employers, managers and administrators working at many levels in the health system – in improving work

environments is perceived as too great and they 'don't even know where to start' (particularly in sectors, settings and jurisdictions where political pressures or market forces drive many workplace decisions)

- there has been a lack of focus on building the necessary leadership capacity among nurses who could help drive improvements in work environments (with nurses often viewed as 'functional doers' rather than 'thoughtful strategists'), and nursing leaders in many jurisdictions have lost control over budgets and staffing
- there has been a failure to acknowledge the importance of nurses who play the dual role of bedside caregiver and manager as key contributors to establishing workplace culture, and there has been a 'hollowing out' of this cadre of nurses as a result of the COVID-19 pandemic
- the new generation of nurses being integrated into the workforce hold different values than generations past (e.g., prioritizing work-life balance, flexibility and higher pay over things like long-term job security and benefits, as well as 'democratizing the workplace') and this isn't being taken into account in HHR planning decisions
- health systems have become 'dehumanized' and have made caring activities in general and the role of nurses in particular 'invisible' to many, which contributes to low morale and a lack of respect towards the nursing profession (by other health workers, system and organizational leaders, and patients)
- the lack of action on making workplaces excellent amplifies other long-standing issues affecting nurses and other health workers – including workplace violence, racism and poor management and leadership – all of which create a vicious cycle by further contributing to challenges with recruitment and retention
- making workplaces excellent is a long-term process and it can be difficult to sustain momentum for such a process, and – complicating matters further – such a process needs to be embedded in broader system transformations that are focused on the 'wicked problems' we face (as one participant noted, 'no amount of yoga will fix a broken system') and that meaningfully engage diverse citizens
- little effort has been made to measure key components of health worker experience (e.g., workload, including administrative burden) or to share data when they exist (both within and across health systems)
- pockets of excellence are not being learned from and scaled up across sectors, settings and jurisdictions, and some countries like Canada have accordingly been dubbed the 'land of pilot projects.'

Summary of deliberation about elements of a potentially comprehensive approach to address the problem

During the deliberation about element 1, dialogue participants identified four actions needed to support ethical recruitment:

- share and learn from promising practices within countries (e.g., the creation of the Alliance for Ethical International Recruitment Practices in the U.S.) and between countries (e.g., countries working together to leverage existing training 'centres of excellence' and engaging in multilateral agreements to train and supply nurses across multiple jurisdictions)

- use available levers to ensure private-sector recruitment is done in an ethical way (e.g., creating a 'seal of approval' that can signal when recruiters, and large employers that recruit directly, are following a process that aligns with the WHO Global Code of Practice and are willing to have their practices monitored, and surveying nurses when they arrive in a new country to determine the extent to which their experiences with recruiters align with the Code) and partner with (rather than 'name and shame') those who can do better
- use available levers to ensure employers are adhering to the Code when hiring new international health workers (e.g., by accrediting organizations, auditing contracts and surveying employees to ensure working conditions are appropriate and as promised at the time of recruitment)
- promote self-sufficiency in the health workforce to discourage poaching as the main solution for shortages, including putting a greater focus on retention efforts linked to element 2 (making workplaces excellent), and more generally frame it as a national security issue.

Participants also identified four actions needed to support the creation of excellent workplaces for nurses and other health workers, which was the focus of element 2:

- develop the leaders needed to make workplaces excellent, which includes:
    - working with managers (including middle managers who are often 'the managers of the managers') to develop and implement a positive workplace culture (and to avoid 'hurt people hurting people')
    - integrating leadership capacity development into professional training programs (e.g., creating opportunities in nursing schools to develop knowledge and skills needed to lead effectively and to create excellent workplaces)
    - supporting access to leadership-development programs for existing professionals through funding support (including from private-sector entities interested in social investments), the use of hybrid formats (e.g., synchronous and asynchronous, virtual and in-person) and with flexible work schedules that allow them to pursue these opportunities (e.g., time off)
- establish accountability among organizations through the better collection of data and insights about health worker experiences and through the integration of these metrics into health-system monitoring, and commit to using these data and insights for ongoing learning and improvement
- create accreditation and other national standards (such as the National Standard of Canada for Psychological Health and Safety in the Workplace), as well as toolkits, that can be adopted by employers and those involved in their oversight
- engage the public to hold employers to account for making workplaces excellent (which will have a direct positive impact on the quality of care), and work with government to identify available financial levers that could be used to drive change (e.g., tying hospital CEO compensation to patient safety and health outcomes and to health-worker satisfaction metrics).

During discussions about element 3, participants singled out four needed actions:

- establish baseline measures to better assess the actual migration of the nursing workforce, and identify opportunities to leverage existing data sources to enhance reporting (e.g., immigration and visa databases)
- ensure efforts to overcome data challenges are pursued both within and across jurisdictions, and engage the right stakeholders or partners (e.g., policymakers, system and organizational leaders, professional leaders and those working in other areas like immigration)
- tie investments in health systems to requirements to commit to better health workforce data (with Canada's efforts to link recently negotiated funding transfers to the provinces and the creation of a centre of excellence for data provided as one illustration of how this could be done)
- invest in more research that focuses on the connection between the workforce (e.g., skill mix, workload) and patient safety and health outcomes, as well as public reporting that makes these connections.

Summary of deliberation about implementation considerations

Participants identified three major barriers that may present challenges to taking the actions described above. They also identified three key facilitators that can help to support future actions.

Barriers

Few levers exist to ensure employers, private-sector recruiters and countries engaging in bilateral agreements adhere to ethical recruitment principles

There has been a 'hollowing out' of leaders with the skills to drive the creation of excellent workplaces, and trust in employers has eroded

Most countries lack an approach to health-workforce planning and don't collect the right data to inform one (or share with others)

Facilitators

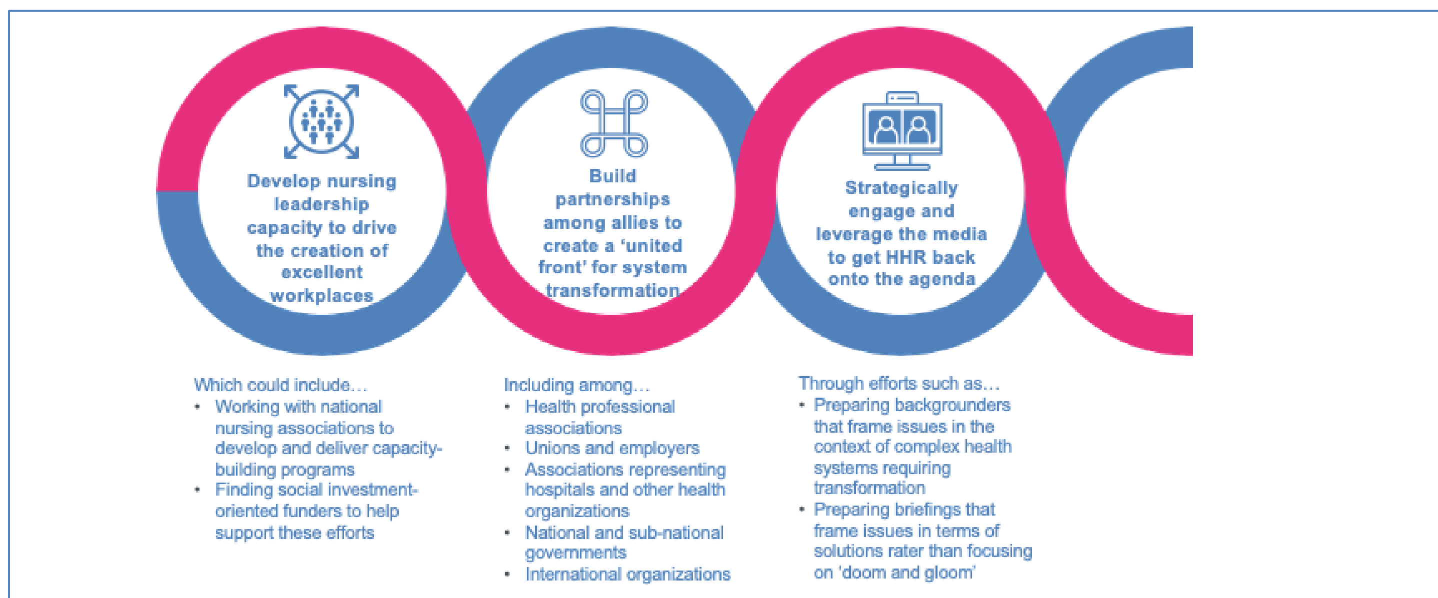
There is a growing number of initiatives focused on ethical recruitment that can be learned from, and the international community is increasingly calling out countries who have room for improvement (like Canada)

Leadership potential – particularly in nursing – represents an untapped resource that has traditionally been underdeveloped and underutilized

Governments are increasingly aware of the benefits that better data (including HHR data) can provide as part of ongoing learning and improvement

Summary of deliberation about next steps

Participants identified three next steps that can be pursued in the near term and led by the individuals who participated in the stakeholder dialogue or the groups with which they're involved.



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