Living Dialogue Summary

Addressing the Politics of the Health Human Resources Crisis in Canada

22 & 23 November 2022

Version 1

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Dialogue Summary:
Addressing the Politics of the Health Human Resources Crisis in Canada

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McMaster Health Forum

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

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Conflict of interest

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Dialogue

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SUMMARY OF THE DIALOGUE

During deliberations about the problem, participants agreed broadly that politics – both 'big P' politics and 'small p' politics – are a key reason for the lack of progress in addressing the many health human resources (HHR) challenges in Canada. Participants emphasized that politics need to be considered at many different levels, including among:

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

Participants generally agreed that 'big P' politics were those that shaped interactions among elected politicians at FPT levels, whereas 'small p' politics were those that shaped interactions among those working at the other levels listed above.

In discussing elements of a potentially comprehensive approach to address the problem, participants broadly agreed on the importance of the six norms and values raised during deliberations:

1) adopt a crisis footing in tackling the health-system crisis in each province and territory, including its HHR dimensions
2) plan now for the health system we want in each province and territory, including its HHR needs
3) make workplace/practice excellence the driving force for HHR improvements
4) mandate that all 'players' contribute 'usable data' to a common HHR database for their province or territory and, where possible, later knit them together into a pan-Canadian database
5) engage in ethical recruitment from other sectors within a province or territory, from other provinces or territories, and from other countries
6) seek wins in each province and territory and, where possible, later knit them together into pan-Canadian efforts.

The actions that need to be taken at different levels to address HHR challenges – while adhering to these values – were also discussed.

In discussing next steps, participants focused on ensuring the themes that emerged during the dialogue were used to:

- inform a planned citizen panel on the same issue (e.g., through a simplified citizen brief that reflected discussions on 'big P' and 'small p' politics', and decision-making at different levels)
- revise the evidence brief for the next dialogue interaction so that it is streamlined and emphasizes the most important aspects of the discussion
- identify additional stakeholders who should be engaged in future dialogues (and in particular, citizens and patients, as well as health workers who better reflect equity-deserving groups, such as young health workers, female health workers, and internationally trained health workers
- frame the next three dialogue interactions in ways that advance the conversation and support movement towards concrete solutions.

SUMMARIES OF THE FOUR DELIBERATIONS

DELIBERATION ABOUT THE PROBLEM

During deliberations about the problem, participants agreed broadly that politics – both 'big P' politics and 'small p' politics – are a key reason for the lack of progress in addressing the many health human resources (HHR) challenges in Canada. Participants emphasized that politics need to be considered at many different levels, including among:

- elected politicians governing federal/provincial/territorial (FPT) jurisdictions
- leaders of health authorities/organizations providing strategic direction and oversight for care delivery
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- leaders of organizations focused on specific categories of health workers (e.g., regulatory colleges, education/training bodies).

Participants generally agreed that 'big P' politics were those that shaped interactions among elected politicians at FPT levels, whereas 'small p' politics were those that shaped interactions among those working at the other levels listed above.

When discussing 'big P' politics, several additional themes emerged during deliberations among participants, including:

- it may be more useful to focus on understanding HHR challenges and solutions to these challenges at the provincial and territorial (PT) level rather than at the pan-Canadian level, with the recent breakdown in talks among FPT health ministers illustrating the ongoing challenges working across jurisdictions in Canada
- we need to move away from 'laundry lists' of recommendations, and towards clarity about who is accountable for ongoing HHR challenges and for developing potential solutions to address them (this theme was also relevant to discussions about 'small p' politics)
- election cycles continue to force elected politicians to view challenges in four-year windows, which does not enable the necessary long-term planning required to address many of the root causes of the HHR crisis.

Several themes also emerged during discussions about the influence of 'small p' politics, including:

Box 1: Background to the living stakeholder dialogue

The stakeholder dialogue was the first of four planned interactions that are part of a 'living' stakeholder dialogue that supports a full and evolving discussion of relevant considerations (including research evidence and citizens' insights) about a high-priority issue, in order to inform action. Key features of the dialogue were:

1) it addressed an issue currently being faced in Canada
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 policy issue
4) it was informed by a pre-circulated evidence brief that mobilized both global and local 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
7) it ensured fair representation among policymakers, stakeholders and researchers
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" and
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 health-system 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 and the video interviews with dialogue participants.

- leaders engaged in 'small p' politics fail to agree on specifically who needs to do what differently and how the solutions should be implemented in PT health systems, despite high-level agreement about the solutions for addressing HHR challenges
- the role of employers (who also represent the players at all levels involved in 'small p' politics) has been overlooked, so the evidence and insights from well-established fields like human resources and management have not been leveraged to address HHR challenges
- the interconnectedness of health systems (both within and across PT jurisdictional boundaries) hasn't informed most decisions taken to address HHR challenges, which can lead to unintended consequences, as well as missed opportunities to help transform health systems more broadly in ways that address other long-standing issues, such as access to primary care.

In considering both 'big P' and 'small p' politics together, one participant suggested that the lack of progress in addressing HHR challenges could mostly be attributed to the latter, given narrow interests and 'turf wars' that make joined-up decision-making across the various levels of the system impossible. In illustrating this point, the same participant said that "even when we agree more than we disagree, we still can't get anything done." Another dialogue participant offered an alternative view, suggesting the current crisis has created a different context – one in which those traditionally involved in 'small p' politics are now more willing to take direction from government policymakers and other system leaders, which could help to support a more joined-up approach.

DELIBERATION ABOUT ELEMENTS OF A POTENTIALLY COMPREHENSIVE APPROACH TO ADDRESS THE PROBLEM

Over the course of two virtual sessions, participants deliberated about three elements of a potentially comprehensive approach to address the problem:

1) develop the norms and values that need to underpin collective action to manage the 'HHR commons'
2) identify the policy levers available to provincial/territorial government policymakers and system/organizational leaders
3) identify the policy levers available to federal government policymakers that would incentivize adherence to these norms and values.

After the first session, the facilitator presented a summary of six norms and values that were raised at various points during the discussion by participants to that point (which related to element 1), and examples of actions that could be taken at various levels to adhere to these values (which related to elements 2 and 3). This summary is presented in Table 1 below.

Participants broadly agreed on the importance of the six norms and values, with the following issues raised for additional consideration:

- more emphasis should be placed on ensuring excellent patient care and experiences, and efforts should be made to engage citizens and patients in helping to further develop the list of norms and values, with one participant suggesting the need to consider this group (or the civil society organizations and leaders representing them) as one of the levels of decision-making that should be incorporated as a column in the table
- challenges related to racism and cultural, psychological and physical safety in the workplace need to be reflected in the norms and values as well as the actions associated with adhering to them
- retention of our existing health workers in Canada should be a primary focus and reflected in the norms and values
- government policymakers (including elected politicians) need to:
  - prioritize doing things differently to provide more care/services with the resources we already have (e.g., utilizing 'untapped' resources to support rural/remote efforts)

  - signal the importance of these norms and values as a way to set a philosophical tone for how leaders at all levels should run health systems across the country
  - work to establish a new 'social contract' with Canadians that sets expectations for what the public health system can and should deliver for them
- data needs to be up-to-date (ideally 'real time'), reflect both the public- and the private-sector workforce, and be integrated in ways that allow local solutions to be used by others (i.e., rather than one new centralized database).

Deliberations focused on element 2 (identify the policy levers available to PT government policymakers and system/organizational leaders) and element 3 (identify the policy levers available to federal government) were merged into one broader discussion, and primarily focused on participants' views about the actions that could be taken at different levels, which are presented as the cells in Table 1. Within these deliberations several themes emerged:

- need to acknowledge that many 'players' would prefer direction to come from provincial and territorial governments than to have to broker compromises within and across categories of health workers (and once that direction is set, need to establish clear accountability about who does what)
- need to distinguish the type of HHR planning that happens at the level of a provincial or territorial government from the type that happens at the level of individual workplaces/practices (and to do a better job at learning from the latter)
- need to recognize that there is limited and uneven capacity to support the implementation of agreed-upon approaches across provincial and territorial health systems
- need to support the required changes in behaviour at all levels through targeted approaches (e.g., public reporting)
- need to clarify the domains where pan-Canadian action is truly required (e.g., adjusting immigration rules) or where federal support is needed (e.g., to support smaller provinces and territories in executing changes)
- need to also consider international frameworks (e.g., International Labour Organization's codes of practice), and consider whether international stakeholders should be included as one of the key levels where action is taken (and thus reflected as a column header in the table).

Table 1: Summary of norms and values for addressing the HHR crisis raised by dialogue participants and examples of actions at different levels

Norms and values	**Examples of actions at different levels**			
	Federal (including the Pan-Canadian health organizations), provincial and territorial governments	**Health authorities/organizations providing strategic direction and oversight for care delivery** (e.g., BC PHSA, MB Shared Health, ON Health and Health Teams)	**Health workplace and practice environments** (e.g., hospitals, long-term care facilities, primary-care practices, community organizations and NGOs)	**Organizations focused on specific categories of health workers** (e.g., regulatory colleges, education/training bodies, professional associations and unions)
1. Adopt a crisis footing in tackling the health-system crisis in each province and territory, including its HHR dimensions • Crisis in the sense of motivation for action, not in the sense of the target for action (i.e.,	Establishing and staffing the 'command' tables needed to drive change in areas that matter to citizens (e.g., lack of primary-care provider,	Judging their own performance based on whether agency staffing is steadily declining as workplace/practice environments improve		

only addressing immediate challenges)	surgical backlogs)			
2. Plan now for the health system we want in each province and territory, including its HHR needs • e.g., excellent patient care and experience • e.g., culture of team-based accountability for quadruple-aim metrics (and not, for example, the legacy of solo physicians) • e.g., appropriate balance between in-person and virtual care • e.g., move beyond a 'payment' system to articulating the design of the care-delivery system		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 health and social-service providers in their strategizing and oversight	Giving priority to both work-life and workload	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 workplace/practice excellence the driving force for HHR improvements		Ensuring that provider experiences are a focus of performance measurement and management	Using accreditation processes and 'magnet hospital' principles to drive improvements to provider experiences	
4. **Mandate that all 'players' contribute 'usable data' to a common HHR database for their province or territory and, where possible, later knit them together into a pan-Canadian database** • Clarify the few domains where pan-Canadian action is truly required (e.g., common data elements)	Mandating who collects and shares what types of data, and making it available in multiple formats for different user groups	Packaging data in ways that can be used to tell local stories	Using dashboards to inform workplace and practice HHR decision-making	
5. Engage in ethical recruitment from other sectors within a province or territory, from other provinces or territories, and from other countries • Clarify that this also means compensating	Discouraging the active offer of time-limited incentives to health workers in other jurisdictions who would not otherwise have			

those who lose from recruitment practices	considered a move			
6. Seek wins in each province and territory and, where possible, later knit them together into pan-Canadian efforts • Clarify the few domains where pan-Canadian action is truly required or where federal support is needed	Creating a mechanism to identify and scale up best practices from individual provinces and territories	Deciding what actions to take when there aren't enough applicants for a given category of health workers		Enabling interprovincial mobility whether or not pan-Canadian action is taken

The framing of the six norms and values outlined in Table 1 were sharpened further in preparing the citizen brief as an input in the citizen panel on 9 December 2022 and included:
1) use a crisis footing as an opportunity to improve many aspects of the health system
2) plan now for the system we want
3) make workplaces better for health workers
4) share data
5) recruit health workers ethically
6) build on provincial and territorial wins for the benefit of all Canadians.

Considering the full array of approach elements

In discussing the approach elements, participants suggested that regardless of the specific details related to the norms and values or the actions that can be taken at different levels, any approach needs to:

- reflect that health systems are a statement of societal value, for which costs can be associated with any investments made to improve things (which may manifest in 'big P' politics about where to get the additional revenues needed to pay for the health systems that Canadians want)
- be able to tell a story that is digestible to the public (rather than writing them off as not being able to engage fully in the details of the issue)
- be clear that any solutions are going to lead to both winners and losers, and to discuss what it means and how to overcome the likely opposition to change by the losers.

DELIBERATION ABOUT IMPLEMENTATION CONSIDERATIONS

During discussions about implementation considerations, the following themes emerged:

- need to play up 'new' aspects of the approaches considered during the dialogue to differentiate them from the standard policy frameworks that have been presented over the last 30 years in response to HHR challenges
- need to ensure that the rapid-learning and improvement approach is integrated in any approach, despite acknowledging that this takes courage (particularly among highly visible decision-makers who will need to admit they may not 'get it right' on the first try)
- need to work within the constraints of government policymakers focused on stabilizing the current HHR crisis (e.g., reducing loss of professionals)
- need to develop a better understanding of how the COVID-19 pandemic has led to changes in behaviour among professionals (e.g., family physicians may now be less willing to run a solo practice as a business in the community, and instead prefer to engage in multidisciplinary team-based care), and among patients (e.g., preference for virtual care and higher willingness to seek care for respiratory illness)

- need to develop a better understanding of shifts in the expectations of the workforce more generally (e.g., younger workers may prefer higher hourly rates now over long-term commitments that emphasize job security and benefits)
- need to view the current workforce as our best opportunity to fix the situation (we can't afford to lose another health worker), while considering the unique aspects of Canada's health workforce (e.g., transient workforce in the north).

DELIBERATION ABOUT NEXT STEPS FOR DIFFERENT CONSTITUENCIES

In discussing next steps, participants focused on ensuring the themes that emerged during the dialogue were used to:

- inform a planned citizen panel on the same issue (e.g., through a simplified citizen brief that reflected discussions on 'big P' and 'small p' politics' and decision-making at different levels)
- revise the evidence brief for the next dialogue interaction so that it is streamlined and emphasizes the most important aspects of the discussion
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