Living Dialogue Summary

Addressing the Politics of the Health Human Resources Crisis in Canada

19 & 20 January 2023

Version 2

HEALTH FORUM

EVIDENCE >> INSIGHT >> ACTION

Living Dialogue Summary v2:
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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Dialogue

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SUMMARY OF THE DIALOGUE

During deliberations about the problem, participants focused on the 'big P' politics influencing health-system decision-making as a whole (rather than about health human resources, or HHR, or about 'small p' politics). They noted that:

- leaders have not engaged Canadians to build agreement around the values that should underpin our provincial and territorial (PT) health systems in 2023 and beyond
- leaders haven't modernized the Canada Health Act or found other ways to shift Canadians' collective understanding about what should constitute the core features of our PT health systems given our shared values (e.g., it's much more than physicians and hospitals)
- leaders have failed in driving bold system-level transformations (or evolutions) that move beyond single crises (like HHR)
- leaders are locked into decision-making cycles that focus on short-term and narrowly targeted 'fixes' that risk exacerbating existing fragmentation and creating unintended consequences.

When the discussion did centre on HHR, participants focused on four challenges: 1) education, training and system-entry pipelines that don't function efficiently or equitably; 2) workplaces that are not safe and healthy (or excellent); 3) aspects of 'small p' politics that have been overlooked (e.g., the role of large for-profit corporations as employers, the unionized nature of the health workforce, and the role of the media); and 4) the perspectives of patients, families and caregivers (and 'the payer' more generally) are often overlooked.

In discussing the elements of an approach to address the problem, participants primarily focused on the list of values (the first element described in the pre-circulated evidence brief) and secondarily the actions needed to operationalize them (second element). They suggested the following revised list of values:

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

Participants gave some attention to supporting patients to hold decision-makers to account for building the system we want (third element), and some recognized that supporting providers to do the same is important, but can also introduce challenges when winners and losers will be created by health-system transformations.

In discussing implementation considerations, participants raised two overarching challenges. The first challenge is that there is no forum to broker discussions about building the future health systems we want. The second challenge is our assumption that getting agreement on the values and operationalizing them will help overcome both 'big P' and 'small p' politics in HHR. Participants also raised some potential barriers to, and facilitators that may support, the implementation of specific values.

Most participants agreed the following next steps should be considered urgently, particularly in light of forthcoming federal, provincial and territorial (FPT) meetings in February 2023:

1) establish a forum of key stakeholders from across the country to broker agreement around the features of the future health systems we want
2) establish a 'solidarity pact' about this agreement that can be signed onto by the leaders of organizations involved in 'small p' politics to present a unified front to FPT first ministers and their cabinets
3) identify existing initiatives and assets that can be leveraged as we move forward to operationalize the values in our actions to address the HHR crisis

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SUMMARIES OF THE FOUR DELIBERATIONS

DELIBERATION ABOUT THE PROBLEM

During deliberations about the many facets of the problem that contribute to the health human resources (HHR) crisis in Canada, participants spent most of the time discussing the first of the four issues outlined in the evidence brief (with much less time spent on the second, third and fourth):
1) 'big P' and 'small p' politics have hampered progress towards addressing the HHR crisis in Canada
2) the values that will enable us to move beyond the politics have not been agreed upon
3) discussions about the appropriate policy solutions and the evidence underpinning them haven't been connected to discussions about values
4) the HHR crisis disproportionately affects some groups of health workers and is experienced differently by some groups.

In discussing the first issue, participants focused on the 'big P' politics influencing health-system decision-making as a whole (rather than about HHR, or about 'small p' politics). They noted that:
- leaders haven't engaged Canadians to build agreement around the values that should underpin our provincial and territorial (PT) health systems in 2023 and beyond
- leaders haven't modernized the Canada Health Act or found other ways to shift Canadians' collective understanding about what should constitute the core features of our PT health systems given our shared values (e.g., it's much more than physicians and hospitals)
- leaders have failed in driving bold system-level transformations (or evolutions) that move beyond single crises (like HHR)
- leaders are locked into decision-making cycles that focus on short-term and narrowly targeted 'fixes' that risk exacerbating existing fragmentation and creating unintended consequences (e.g., the Ontario government's announcement of the 'As of Right' rules that would see health workers licensed in other Canadian jurisdictions recognized immediately in Ontario).

The most challenging aspect of the 'big P' politics issues noted by several participants is that addressing them is likely outside of their individual spheres of control, given they require attention by the most senior elected politicians in the country (i.e., Canada's first ministers and members of their cabinets). However, one participant noted that all of the dialogue participants did hold leadership positions within their respective organizations, and some did have the ability to influence conversations that contribute to shaping some of the big-picture federal, provincial

Box 1: Background to the living stakeholder dialogue

The stakeholder dialogue was the second 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, as well as the insights gathered from the first dialogue interaction and a living citizen panel
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 three citizen representatives who brought their own unique perspectives, as well as those surfaced by participants at the living citizen panel on the same 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"
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 territorial (FPT) conversations about healthcare. As such, several dialogue participants agreed that every participant should feel accountable as leaders for helping to drive these shifts in the national conversation, thereby helping to influence 'big P' politics in ways that gain traction – both towards a collective acknowledgment that they are some of the most pressing problems that need to be addressed in Canada, and an impetus to act to address them.

When participants did centre on HHR specifically, they complemented the points in the evidence brief and focused on discussing four observations. The first observation is that we haven't consistently ensured that education, training and system-entry pipelines function efficiently or equitably. Specifically, participants noted the following:
- there is no 'student' status for internationally educated health workers (and hence benefits that accrue from such status), and there are many challenges for them in obtaining a licence to practise in Canada (including prohibitively expensive exams)
- there are few if any available mentors to help integrate new health workers into PT health systems
- PT health systems don't have the receptor capacity for newly trained health workers (i.e., there are no teams in which those trained in team-based environments can practise).

One participant from Manitoba provided an illustrative example of existing structures that support the integration of internationally trained workers through mentorship and a payment mechanism, but most agreed that this type of initiative is the exception across Canada, rather than the rule.

The second observation by participants is that we haven't done enough to create safe and healthy (or excellent) workplaces. In discussing this observation three specific challenges were raised:
- health workers were burned out before the pandemic, and are even more so now
- there is little to no control given to health workers in determining where they work (i.e., the settings) or the hours they work, which contributes to a loss of autonomy and has a negative impact on well-being and job satisfaction
- the safety of health workers is defined too narrowly (e.g., it doesn't include key elements like psychological safety, particularly among racialized staff), and is rarely considered an important contributor to patient safety more generally (despite one participant noting that there is growing evidence which suggests this is the case).

Many participants – and particularly the citizen partners in attendance – acknowledged that this observation was also one of the main issues discussed during the citizen panel that preceded the second dialogue interaction.

The third observation by participants is that there are aspects of 'small p' politics that matter, but tend to be overlooked. Specific examples provided by participants included:
- the politics that play out in large for-profit organizations that employ many health workers and are thus very important in conversations about supporting healthy workplaces (e.g., pharmacies)
- the highly unionized nature of the health workforce (which requires an 'industrial relations' lens)
- the tendency of the media to highlight tensions among health-system stakeholders, which can 'stir the pot' rather than help support cohesion in efforts to addressing pressing challenges.

The fourth observation was that the perspectives of patients, families and caregivers (and the 'payer' more generally) have routinely been overlooked by health-system leaders and decision-makers – particularly their perspectives about the factors driving the HHR crisis (rather than their perspectives about how the crisis affects them as patients, which are cited frequently by senior decision-makers and the media). In discussing this oversight, some participants suggested that citizens and patients may have a strong affinity with health workers (which was also borne out as a key issue during the citizen panel that preceded the dialogue), but they have declining trust in health-system leaders.

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

In discussing the elements of an approach to address the problem, participants primarily focused on the list of values (the first element) and secondarily the actions needed to operationalize them (the second element), and suggested the revised list of five values outlined below.

1) **Start building now the future health systems we want** (previously second in the list)

In discussing this value, participants emphasized the need to set a new course for all 14 Canadian PT health systems in a way that reflects Canadians' values, while remaining centred around the needs and realities of patients, families and caregivers. As part of operationalizing this value, participants also discussed the need to recognize that transforming delivery arrangements to help implement this new course in health systems across the country will mean:

- there will be winners and losers among health organizations and health workers, which will require considering how to navigate the 'small p' politics that will likely emerge as a result
- there will be a need to align education, training and system-entry pipelines to these transformed delivery arrangements.

One participant noted that it will also be important for allies of Indigenous peoples to support their efforts to establish Indigenous-governed health systems.

There were mixed views expressed by participants about whether to integrate the notion of using a 'crisis footing' in the framing of this value (previously the first value in the list), given that this could be interpreted as implying that the crisis will soon pass. Several participants also voiced their concern with anchoring on the concept of 'crises' as a value, because it could reinforce decision-making cycles that only focus on short-term fixes for acute crises, rather than broader, long-term (and transformative) change – which was discussed as a key challenge during earlier discussions about 'big P' politics. One participant suggested that the concept of 'crisis footing' could be re-worded as 'seizing every opportunity, including breaking-point situations' to motivate action, both in addressing current HHR challenges and in a parallel process of designing a true 'health system' in each province and territory.

2) **Make workplaces 'excellent' for health workers and hold employers accountable for this** (previously third in the list)

In discussing this value, participants noted that 'excellent' workplaces should do the following:

- give adequate attention to health workers' safety (both physical and psychological) and respect, as well as their mental health and wellness
- provide them with more control over aspects of their work like scheduling, and support work-life balance
- emphasize equity, diversity and inclusion (EDI) considerations in all aspects of their functioning
- engage patients, families and caregivers more consistently in workplace governance and decision-making.

Participants also raised the following system-level actions needed to support the operationalization of this value, including:

- align education, training and system-entry pipelines to workplaces that are increasingly 'excellent' for health workers
- give greater attention to the 'industrial relations' aspect of workplaces and the health system more generally (given how heavily unionized the healthcare workforce is)
- consider a push to get more health organizations to sign up to the Mental Health Commission of Canada's National Standard of Canada for Psychological Health and Safety in the Workplace (and to report publicly on adherence).

3) **Recruit ethically** (previously fifth in the list)

While participants did not spend a lot of time discussing this value, they emphasized its importance in the current context. There was also some targeted discussion about the need to be sensitive to language that may be read as indicating a lack of support for workers in other countries to pursue a better life in Canada (particularly given the way some of the actions for operationalizing this value were framed in the brief). One participant suggested that despite the need for sensitivity around this language, decision-makers across Canada should also recognize that our PT health systems need to be as self-sufficient as possible in developing an adequate supply of health workers rather than viewing internationally trained health workers as the ultimate solution to shortages (which would be in contravention of the World Health Organization's global code of practice on the international recruitment of health personnel, given it may undermine a 'source' country's health system by poaching its health workforce).

4) **Share more and better HHR data** (previously fourth in the list)

Similar to the third value, this value was not discussed extensively during the deliberation, but was emphasized by many participants as extremely important. Several participants weighed in on the importance of data sharing, with most stating that key to this was ensuring greater consistency in the data collected (and shared) across PT jurisdictions in Canada.

5) **Build on PT wins for the benefit of all Canadians** (previously sixth in the list)

This value was rarely discussed in isolation of the other issues raised by participants during the deliberation. When it was discussed, participants noted that:
- the 'big P' politics associated with FPT division of power in healthcare meant that the key actions taken to operationalize the values would ultimately occur at the PT level
- the operationalization of these values will manifest in different types of actions across PT jurisdictions.

Finally, in discussing the elements of an approach to address the problem, participants gave some attention to and mostly agreed with the third element – ensuring citizens and health workers hold (and are supported to hold) decision-makers accountable for operationalizing the core values. However, some participants voiced their concern with the political feasibility of this, particularly in the context of the type of broad health-system transformation implied by the first value listed above. Specifically, some participants commented on the fact that the winners and losers created by large-scale health-system transformations would mean supporting providers to hold decision-makers to account, which might be a challenge – particularly among the losers, who may not agree that it is a value worth operationalizing if they are set to lose something because of it.

DELIBERATION ABOUT IMPLEMENTATION CONSIDERATIONS

The first challenge raised about implementation was that there is no forum to broker discussions about building the future health systems we want among the key stakeholders (and particularly those engaged in 'small p' politics across the country). One participant stated that a lack of such a forum, including a mechanism to reach agreement, means that there is never a unified front when presenting to the elected politicians engaged in 'big P' politics. This participant suggested that overcoming this particular barrier would be essential in trying to get the attention of, and buy-in from, these decision-makers. In reacting to this point, another participant acknowledged this challenge, stating that elected politicians at FPT levels often don't know how to manage the 'small p' politics that unfold, particularly among those representing particular types of health worker (e.g., professional associations), so a forum to broker agreement will be important to collectively craft a set of messages and reduce the noise created by 'small p' politics.

Dialogue participants noted some likely barriers to reaching agreement:

- there are few (if any) examples of individuals and organizations being able to overcome the 'small p' politics and collectively agree on the sacrifices each group must make for the greater benefit of Canadians, even in the context of our growing inability to provide Canadians with the healthcare they need
- there are few (if any) examples of the individuals and organizations usually involved in 'small p' politics being able to 'leave their interest at the door' and present a unified front to elected politicians as a way to grab their attention and create a burning platform that inspires action.

There was also a tension among participants related to the importance of working to define the 'structures' and models of care that need to be in place to achieve the broader vision for the future health systems in Canada. Some participants stated they thought we can already largely predict what the future structures will be as they are already on a clear trajectory towards putting them in place (e.g., in primary care, a physician or nurse practitioner 'quarterbacking' a team of providers) to respond to population-health needs (which these same participants argued can also be largely predicted for the short, medium and long term). However, several participants didn't agree, and stated that the first step should be to reach agreement, as part of the vision, on what the future structures need to be. One participant noted that that even with agreement about, say, models of care, health workers adjust how they function in these models over time (e.g., family physicians have reduced the number of hours they practise), so understanding the types and numbers of health workers needed for various roles in the health system will continue to be a challenge.

The second implementation challenge that dialogue participants raised was about how the core values 2 through 5 could be implemented (although they focused more on values 2 and 4) – both in terms of getting agreement about them at all levels of FPT health systems, and also in terms of identifying the actions that could be taken at these levels to operationalize them. A few participants raised a concern that we have made an assumption that agreement about the values would ultimately help solve the most challenging 'big P' and 'small p' politics issues and enable us to move forward with efforts to address the HHR crisis. This concern was acknowledged by other participants, but many indicated that they viewed solidarity and alignment around such values as a key starting point.

In discussing the implementation of the second value (make workplaces 'excellent') a few participants did identify opportunities to leverage existing initiatives:

- the National Standard of Canada for Psychological Health and Safety in the Workplace is already available to all employers of health workers across the country, and there are many resources that can help to support the uptake of the standard (including on the website of the Mental Health Commission of Canada)
- Healthcare Excellence Canada has an initiative underway with a focus on identifying high-impact solutions for health-workforce retention and wellness, which will create a collective asset map of these solutions, convene a dialogue with key stakeholders to shape and refine a collective approach, and support a launch of the approach as well as its spread and scale.

In discussing the implementation of the fourth value (share data), participants noted that sharing data needs to be expanded to include the concepts of consistency, access and use, with clear and practical illustrations of what this means so decision-makers can envision practical next steps (e.g., CIHI could be engaged to help the regular management and facilitation of data sharing, consistency, access and use). Participants also noted the importance of addressing privacy concerns early in the process of moving towards more shared data.

DELIBERATION ABOUT NEXT STEPS FOR DIFFERENT CONSTITUENCIES

In deliberating about next steps, many participants agreed that the following should be considered urgently, particularly in light of forthcoming FPT meetings in February 2023:

1) establish a forum of key stakeholders from across the country (ideally the leaders from the organizations involved in 'small p' politics') to broker agreement around the features of the future health systems we want
2) establish a 'solidarity pact' about this agreement that can be signed onto by the leaders of organizations involved in 'small p' politics, to present a unified front to FPT first ministers and their cabinets
3) identify existing initiatives and assets that can be leveraged as we move forward to operationalize the values in our actions to address the HHR crisis (e.g., the national standard and health-workforce retention and wellness initiative).