Living Dialogue Summary

Addressing the Politics of the Health Human Resources Crisis in Canada

21 & 22 March 2023

Version 3

HEALTH FORUM

EVIDENCE >> INSIGHT >> ACTION

Living Dialogue Summary v3:
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.

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Conflict of interest

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Dialogue

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Table of Contents

SUMMARY OF THE DIALOGUE 4

SUMMARIES OF THE FOUR DELIBERATIONS 4

DELIBERATION ABOUT THE PROBLEM 5

DELIBERATION ABOUT ELEMENTS OF A POTENTIALLY COMPREHENSIVE APPROACH TO ADDRESS THE PROBLEM 7

DELIBERATION ABOUT IMPLEMENTATION CONSIDERATIONS 9

DELIBERATION ABOUT NEXT STEPS FOR DIFFERENT CONSTITUENCIES 10

SUMMARY OF THE DIALOGUE

During the deliberation about the problem, participants focused on the three main components of the problem presented in the evidence brief:

1) there are many recent jurisdiction-specific decisions to address aspects of the health human resources (HHR) crisis, some of which may require additional policy initiatives to ensure the benefits outweigh potential harms
2) federal, provincial and territorial (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 provincial/territorial (PT) strategies, and establish the dedicated leadership to execute the strategies.

Discussions surfaced participants' mixed views about these components, with divergent thoughts about key issues such as whether there should be proactive steps taken to mitigate the potential downsides of approaches adopted to address the HHR and broader health-system crises, who should be held accountable for health-system transformation (including whether Canadians themselves should be held accountable), the shared values (or, increasingly, a lack of shared values) underpinning what Canadians expect to see from their health systems, as well as whether they considered there to be any effort to establish a clear 'vision' for health systems. During these discussions, most participants did agree that there were insufficient efforts to engage citizens in meaningful ways as part of strategy development and execution at the system level, and that we do not invest sufficiently (or sustain investments) in change-management approaches.

During the deliberation about the three elements of a potentially comprehensive approach for addressing the problem, participants generally agreed that:

- 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 – is essential, and that the appropriate structures and processes need to be established to ensure citizens' insights about the vision of the core features of PT health systems are authentically elicited and acted upon at the system level (not just the organizational level)
- element 2 – create the structures and processes to broker trade-offs among organizational and professional leaders to develop PT strategies – may be too challenging to pursue, even if warranted
- element 3 – establish the dedicated PT leadership to execute the strategy – is an area that has not received as much attention as it should, and a clear need has emerged for focusing on how to build change-management capacity in PT health systems.

Participants deliberated about potential next steps, and emphasized two broad areas that could be considered as promising ways forward:

1) undertake efforts to identify the right structures and processes that will enable a diverse array of Canadians to play increasingly important roles in designing, executing and ensuring accountability for health-system transformations, and ensure these efforts include:
   - an emphasis on training system and organizational leaders on how to provide appropriate and culturally sensitive 'ways in' that are attentive to diversity and equity considerations
   - 'ways in' for innovative approaches like design-thinking, solutions development and 'hackathons' that could inject fresh thinking into the process
   - respect for peoples' time (including through remuneration)
2) establish change-management capacity as a key area of focus in advancing health-system transformations (and the health workforce needed to enable these transformations).

SUMMARIES OF THE FOUR DELIBERATIONS

DELIBERATION ABOUT THE PROBLEM

During the deliberation about the problem, participants focused on the three key components as presented in the evidence brief:
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.

In general, mixed views emerged about each of these components, which are summarized 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

When discussing this particular component of the problem, participants diverged in their views. On the one hand, some participants agreed that moving quickly to address the HHR and broader health-system crises should also include being proactive in mitigating the potential downsides of chosen approaches. One example raised was the rapid opening up of licensure across the country, which could enhance health-worker mobility (which most participants agreed is a positive outcome). However, some participants noted that this same approach could potentially undermine efforts to create a 'primary-care home' for Canadians and ensure continuity of care, particularly if increased mobility leads to inconsistent access to a single provider for patients.

On the other hand, some participants suggested that it is not helpful to publicly point out the need for any compensatory actions when 'removing barriers.' One participant supported this point by noting health-system leaders are often too focused on the potential risks of taking action, which has led to inaction in the past, and would continue to stifle progress towards executing the health-system transformations needed across Canada.

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

Box 1: Background to the living stakeholder dialogue

The stakeholder dialogue was the third 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.

Participants raised three main issues related to this component of the problem. First, many participants agreed that Canadians remain worried about the future of health systems in Canada. In particular:

- some participants noted and many agreed that Canadians no longer have universal access and first-dollar coverage for the programs, services and products they need
- one participant stated that leaders continually 'lower the bar' of expectations among Canadians, as a never-ending cycle of crises within and beyond health systems means that even getting the basics right becomes challenging
- several participants acknowledged that many health-system leaders are speaking in platitudes about engaging Canadians in system-planning efforts without putting in place the right structures and processes to accomplish this, which further contributes to Canadians' frustrations.

The second issue raised by one participant related to the first, and was that while many Canadians may be frustrated with the inability of their health systems to achieve what are largely perceived to be shared values linked to single-tier access to medically necessary hospital and physician services, a significant minority of Canadians do not subscribe to these values. This same participant noted that:

- a lack of progress towards addressing the HHR crisis and other health-system challenges may lead this proportion to grow
- Canadians have given up their 'agency' to politicians who now make service decisions for them.

Third, many participants reiterated the point made in the evidence brief (which included insights from the citizen panels held in advance of the dialogue) that Canadians have a real desire to establish a mechanism to hold health-system leaders accountable for the impact they achieve 'on the ground', particularly in the context of new federal investments in PT health systems. Most participants agreed, and also stated that there is currently a lack of ways to hold PT governments accountable. In discussing this aspect of the issue, one participant suggested that accountability for achieving health-system goals needs to be in place at all levels of the health system, including among patients who are increasingly viewed as active partners in moving forward with transformative change.

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

During discussions about this component of the problem, participants diverged in whether they considered there to be a clear 'vision' in place for the future health systems that citizens, healthcare workers and system leaders want in their respective jurisdictions, with Newfoundland and Labrador's recently established 10-year accord given as an example of a broadly participatory process that resulted in the establishment of a clear vision in the province.

Most participants did not speak directly to whether the lack of mechanisms to broker trade-offs in operationalizing PT strategies is a significant problem, although:

- one participant did note how quickly a vision must confront reality (e.g., closing obstetrical services in small communities so more funds are available to address broader social determinants of health) and how difficult it can be to navigate this reality – particularly when it includes service cuts that must be explained to the public
- several participants lamented the lack of meaningful citizen engagement in strategy development and execution at the system level (as opposed to the organizational level where more efforts are being made)
- one participant noted that healthcare workers are even more notably not engaged in strategy development and execution at the system level
- one participant noted that organizational leaders from private for-profit providers are also not being engaged (including in this stakeholder dialogue), yet in some cases they are the more visible ones taking action to make workplaces 'excellent' for healthcare workers.

Finally, several participants agreed that we do not invest sufficiently (or sustain investments) in change-management approaches, while many participants complemented the discussion about change-management approaches with broader comments about planning, execution and reporting. In particular, these participants highlighted the need to:

- be holistic given the many types of organizations and healthcare workers involved in delivering care (e.g., not just planning for physicians and nurses)
- be adaptive given that these complex systems are themselves continually changing as demand shifts (e.g., with an aging population and with growing expectations for virtual-care options) and as supply shifts (e.g., with changing work preferences among healthcare workers and with increasing use of digital solutions across distributed healthcare teams)
- have more robust, independent and understandable reporting about whether new approaches are achieving desired impacts 'on the ground.'

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

When discussing the elements of a potentially comprehensive approach to address the problem, participants mainly focused on the first and second of the three elements that were described in the evidence brief. The key issues raised by participants in relation to each element are outlined below, followed by a summary of where the discussion landed when taking all the elements into consideration together.

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

In discussing the first element, participants generally agreed that diverse citizens' perspectives need to be authentically elicited and acted upon at the system level (not just the organizational level), and that we need to concretely operationalize this in pursuing bold, not incremental, health-system transformation. Some participants suggested how this could be accomplished, including through:

- co-design processes that acknowledge financial, geographic and other constraints, and that identify and negotiate the potential trade-offs between access and quality
- 'market' mechanisms such as annual health team sign-ups.

There were some participants who also observed the citizen panel and brought those perspectives to the discussion. They noted that there was strong interest among citizens in such efforts, as well as in public reporting about system performance that can be used by citizens to hold system and organizational leaders to account. One participant noted that their provincial health system had made significant progress in meaningful citizen engagement at the system level (which proved helpful during COVID-19) and in complementary efforts to engage Indigenous peoples at the system level, while another noted that lessons can also be learned from countries like Brazil and U.S. states like Oregon. Another participant emphasized the importance of leveraging storytelling as a way to make the insights from Canadians tangible for others, as well as for system and organizational leaders.

Participants did not engage in extensive discussions about aspects of the element focused on planning for the health workforce needed to power re-envisioned PT health systems.

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

In discussing the second element, participants generally agreed that there are many challenges associated with brokering trade-offs among organizational and professional leaders to develop PT strategies (or in developing strategies to ensure the health workforce is available to power these strategies). Specifically:

- one participant suggested pragmatically that the brokering of trade-offs would simply not happen without system leaders developing and operating the structures and processes through which organizational and professional leaders come together
- several participants noted the challenges in operationalizing any vision and with sustaining commitments to brokered trade-offs given election cycles and other political and system developments
- one participant stated that they thought an attempt to broker trade-offs is worth a try, but that it wouldn't happen overnight and should be driven by relationship and trust building (and this same participant noted that Health Canada's Primary Health Transition Fund in 2006 and 2007 and the complementary efforts of the Enhancing Interdisciplinary Collaboration in Primary Health Care (EICP) initiative to promote collaboration around transformation initiatives is indicative of how challenging this can be).

In discussing what this element would need to consider to be a feasible approach:

- a few participants noted that a top-down approach would not work, and that an approach to reach agreement about trade-offs should first be piloted in a small group of professionals (e.g., two or three, not 10) and that the lessons learned about the right approach could eventually be expanded to include more and more groups
- another participant suggested that structures and processes need to be flexible and that they may require adaptations (or even a separate approach) when unique issues associated with particular areas of the health system emerge (e.g., primary care versus specialty care), and that it is likely ongoing brokering will be required (i.e., it can't be a one-off process)
- one participant emphasized that any attempt to broker trade-offs would also require significant effort among all professional groups to better understand what each other does
- another participant noted (and many agreed) that the creation of structures and processes to broker trade-offs can't be led by a single professional group
- one participant suggested that a small set of well-established and tractable goals (e.g., better quality at the same cost, or the same quality at a lower cost), rather than a long list of goals we hope for, would be best for anchoring such a process.

Finally, one participant suggested that the process of brokering trade-offs may be risky as it has the potential to 'suck up all of our energy' with more politics, and instead we should focus on first establishing our vision for the 'ideal' health system, and then engaging key stakeholders in charting a course for how to get there.

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

In discussing element 3, most participants agreed that PT health systems in Canada lack the change-management capacity to drive health-system transformation, although not all participants agreed on what is needed to establish it. In particular:

- one participant argued that PT systems need to invest sufficiently in change-management approaches 'up-front' and in sectors like primary care where such approaches are most needed
- another participant cautioned that change-management capacity in and of itself is not sufficient, and that implementation support is also required, with an emphasis on building the culture to support and capacity for ongoing learning and improvement
- some participants cited examples of organizations that could be leveraged to 'link in' to existing change-management approaches given their mandate (e.g., Healthcare Excellence Canada)

- other participants noted that transformation initiatives from across the country could provide insights to other PT health systems about different approaches available for the establishment of change-management capacity (e.g., the creation of Strategic Clinical Networks in Alberta, which included the establishment of positions and infrastructure focused on supporting system transformation, and the population- and service-based networks recently created in Nova Scotia, which share capacity in areas like data analytics and implementation science in a dynamic approach to change management).

Considering all of the elements together

Taken as a whole, discussions about the three elements of a potentially comprehensive approach for addressing the problem resulted in participants generally agreeing that:

- 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 – is essential, and that the appropriate structures and processes need to be established to ensure citizens' insights about the vision of the core features of PT health systems are authentically elicited and acted upon at the system level (not just the organizational level)
- element 2 – create the structures and processes to broker trade-offs among organizational and professional leaders to develop PT strategies – may be too challenging to pursue, even if warranted
- element 3 – establish the dedicated PT leadership to execute the strategy – is an area that has not received as much attention as it should, and a clear need has emerged for focusing on how to build change-management capacity in PT health systems.

DELIBERATION ABOUT IMPLEMENTATION CONSIDERATIONS

Participants did not spend much time focusing on implementation considerations, although a number naturally emerged during deliberations about the problem and elements of a potentially comprehensive approach. The main barriers identified by participants included:

- barriers to entry for many citizens with respect to getting involved in policy and planning discussions, including the extensive use of jargon and other technical language that may not be easy to follow, and a lack of clarity around what levers exist at various levels of government to move us closer to the health systems we want
- the ongoing power struggle between groups of healthcare professionals (with some participants noting that physicians and registered practical nurses in particular need to 'be on board' with any decision made)
- a disconnect between government priorities (as reflected in recently released PT budgets) and ongoing health-system needs (e.g., many PT budgets don't lay out plans to address HHR challenges or the need for broad health-system transformation).

Participants also suggested a number of factors that may help to increase the likelihood that the elements considered could be pursued, including:

- Canadians are so frustrated that governments will not be able to ignore calls for system transformation for much longer
- physicians and other health professionals are more willing than ever to embrace new ways of doing things that will meet Canadians' needs, given its no longer possible for individual professionals to do their job alone.

DELIBERATION ABOUT NEXT STEPS FOR DIFFERENT CONSTITUENCIES

Participants deliberated about potential next steps, and emphasized two areas that could be considered as promising ways forward:

1) undertake efforts to identify the right structures and processes that will enable a diverse array of Canadians to play increasingly important roles in designing, executing and ensuring accountability for health-system transformations, and ensure these efforts include:
    - an emphasis on training system and organizational leaders on how to provide appropriate and culturally sensitive 'ways in' that are attentive to diversity and equity considerations
    - 'ways in' for innovative approaches like design-thinking, solutions development and 'hackathons' that could inject fresh thinking into the process
    - respect for peoples' time (including through remuneration)
2) establish change-management capacity as a key area of focus in advancing health-system transformations (and the health workforce needed to enable these transformations).

In discussing these areas, some participants also emphasized that there may be a need to think differently in terms of focus (e.g., expanding beyond health systems to think about transformation that is attuned to the social determinants of health and the role of social systems more generally), and the goals we are hoping to achieve (e.g., expanding our focus beyond the quadruple aim given its focus is on an illness system not health more generally).

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