Policy Memo
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Duncan Sinclair and Don Drummond

Calling the Shots on Health Workforce Planning

Our Canadian 'system' of health and healthcare services has no governing body to articulate its vision, set its policy direction, or oversee management of its affairs. None exists either with responsibility for health human resource planning (HHRP), a complex process aiming to ensure on-going availability of the workforce, a mix of professionals and others, educated, trained, deployed, and supported in adequate numbers to meet the present and future needs of the people they are to serve. This paper recommends the creation of a governance process to call the shots on HHRP in Canada, its provinces and territories, and where it counts most, in the diverse communities and regions in which health and healthcare services are delivered to the people who need and want them.

The Stakeholders?

Five categories have been described previously: [1]

- Governments: Constitutionally the provinces and territories are primarily responsible but the federal government also plays a significant role
- Workers: Health and healthcare professionals and other workers are organized by province/territory and/or nationally into more than twenty different categories, each with regulatory colleges, advocacy organizations, and/or unions
- Educational and training organizations: Universities, colleges, teaching hospitals, et cetera, and regulatory bodies that certify the qualifications of their graduates and trainees
- The care- and support-giving organizations and institutions in which health providers work: Hospitals, nursing homes, home care agencies, individual and group practices, and the team-work organizations into which they are evolving[2]
- People of the communities and regions served: Representatives of those who look to the organizations and institutions listed above to meet their needs for health and healthcare support services

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[1] Drummond and Sinclair 2022 (ref to Governance IM 1)
[2] Accountable Care Organizations (ACOs)/Ontario Health Teams (OHTs)

Clearly both senior levels of government must have a 'say' in HHRP governance given the heavy investment of public funds both in the 'system's' on-the-ground provision of health and healthcare services throughout the different regions and communities of Canada and in the education and training of its workforce. HHRP is an issue important to the country as a whole, to the provinces and territories, and particularly to the many and diverse local and regional jurisdictions most concerned to ensure that qualified and capable health service providers are available to them to discharge their responsibilities to meet their populations' health and healthcare needs. HHRP is also, of course, of keen vocational interest to healthcare professionals and other workers and their advocate organizations, and the educational and other institutions in which they are taught, trained, and gain experience. And, above all, HHRP is vital to the people who are the beneficiaries of health's support and care and the institutions and organizations through which the workforce provides them.

HHRP's Complexities

These realities include five disparate but related factors:

- **Education:** While varied depending on the field, the education of most health professionals requires years of time, both at the career's beginning and continuing; it is also expensive. Learning in the university or college classroom is more than matched by its associated clinical training experience. Both are basically career-long activities made essential by continuing changes in health and healthcare services that are the fruits of contemporary research, creation of new knowledge and technologies, and the ever-changing needs of the population, notably, at present, its ageing. The outcomes of today's HHRP can be anticipated to affect the 'system' over the subsequent 30 to 35 years of its workers' careers.

- **Competencies/Scopes of Practice:** Related are the desirable changes that flow from the increasing competencies required of health service providers derived from progress in the effectiveness of their education and clinical experience that enable their increased productivity and that of the health and healthcare 'system' generally. Every health service worker should be both enabled and provided with personally challenging and financially rewarding incentives to work to the upper limits of his or her competency/scopes of practice. Those scopes should be free of restrictions imposed by current billing entitlements or other profession-specific rules and regulations. HHRP over the mid- to long-term is particularly challenged to predict the degree to which current rules and regulations that essentially allow scopes of practice to be 'owned' by specific professions, can be changed. Teamwork, as it becomes predominant especially in primary care, will demand more and more role substitution. It will increasingly be the only way for primary care teams to meet the needs especially of their elderly patients as already scarce geriatricians, rheumatologists and other medical specialists with expertise in chronic physical and mental conditions retire; they cannot be replaced in the time available as the already high population of Canada's aged people peaks. Good

examples of such role-sharing changes in recent years are the advent of nurse practitioners to complement family physicians in many roles and engaging pharmacists in the provision of Covid vaccinations in the on-going pandemic. Such augmentation of the service capabilities by the members of multi-professional provider teams is highly desirable not only to enhance their productivity and also control healthcare's high costs.

- **Mobility of Providers:** Given the desirable mobility of health service personnel (and Canadians generally) throughout the country, HHRP is of national concern, an issue reinforced by the fact that the education of health service personnel and their work subsequently is paid for to a very significant extent with money derived from differing public purses. The mobility of different categories of health service personnel by community, region, nationally, and internationally varies widely, depending largely on the relative attractiveness of employment opportunities[3] available, including their rates of recompense. No jurisdiction, whether province, territory, individual community or region is or should be close to 'water-tight' with respect to its health service personnel. Of concern related to the mobility of the workforce is the absence of national standards for licensure and unique identifiers for almost all regulated providers of health and healthcare services. A federal-provincial-territorial agreement to facilitate nationally recognized licensure, particularly for the most mobile, doctors and nurses, should be an urgent priority.

- **Population Needs:** The specific demand and need for health service personnel in their many categories will vary widely depending on the characteristics of the populations served by the service providers in their particular community or region. Once largely individual practices and stand-alone organizations, hospitals, nursing and retirement homes, and community service agencies, are gradually being succeeded by the teams referred to above, organized into Accountable Care Organizations (ACOs)[4]. It is at this operational level that the rubber of HHRP effectively hits the road in the form of having available a spectrum of well-qualified providers needed to meet the needs of communities/regions with greater or lesser numbers of seniors approaching or in retirement, industrial workers, Indigenous people, immigrants, in urban, rural, remote, sites, et cetera. Canada's populations and their needs for health/healthcare services are far from homogenous.

- **Retention:** The acute shortages of personal support workers and stress-related early retirements of many categories of nurses during the Covid pandemic illustrates the importance of good up-to-date supply/demand data and information including particularly on the length of workers' retention in their careers and by specific employers. Identification of the many factors that affect health and healthcare workers' job satisfaction and their decisions on how long to continue in their professions and jobs is obviously one of the many factors related to the success of HHRP. Effective planning

[3] and in some cases, specific professional regulations

[4] OHTs in Ontario

will involve centrally the keepers of data and analysts of supply/demand projections, technical work in which a number of federal and provincial/territorial institutions are well experienced; the Canadian Institute for Health Information (CIHI) and Statistics Canada constitute the two major federal bodies while Ontario's Institute of Clinical Evaluative Science (ICES) and Manitoba's Population Research Data Repository (PRDR) are two examples of the latter. All these institutions, vital to all objectively informed planning are also in need of the same absent governance. Good up-to-date data and information must be brought to bear on every aspect of HHRP whether local/regional, provincial/territorial, or national. Independent of what is eventually done to provide effective governance of HHRP, work should proceed without delay on development of reliable sources and methods of collecting the currently fragmented and incomplete data and information essential to planning. That mandate and the resources required to discharge it should be given to the keepers and analysts of data and information straightaway by Canada's federal and provincial/territorial governments working together (see below).

The Structure and Function of HHRP Governance

As pointed out previously[5] it is useful to consider from two perspectives the structure of a governance for HHRP and what it should be charged with doing:

- what would be ideal over the long-term and
- what is potentially do-able in the short i.e., now.

The Ideal

An effective governance structure, both for HHRP and for the health/healthcare 'system' as a whole, would be organized into three hierarchical tiers, national, provincial/territorial, and local/regional.

The **national** tier, would be an independent body of experienced appointees to focus on health human resource policies common to all tiers, supported by staff resources sufficient to consult with the range of stakeholders in HHRP, fully informed by the data and information available. The creation of such a body, obviously highly desirable from day one, has been a long time coming. In the interim, despite the duplication made necessary the other two tiers should not delay formation of the governance structures they need to proceed with HHRP without delay.

The **provincial/territorial** tier would have to be made up, much as now, of separate bodies in each province and territory. Each would provide policy direction to the government concerned and also, together with funding, to the organizations and institutions directly

[5] Reference here to Calling the Shots on Health Workforce Planning, Drummond and Sinclair, Governance IM 2

responsible for the actual provision of health and healthcare services in that province or territory. Each would also consult with the wide range of stakeholders referred to above. Doing so collectively, perhaps under the aegis of the Council of the Federation, could foreclose a wasteful duplication of effort.

The **local/community/regional** tier is conceived to be made up of what are referred to as ACOs)[6], essentially teams of providers and their organizations and institutions committed to discharge the responsibility and be held accountable for meeting all the health and health care needs of the people of the community or region each provider organization serves. It is at this on-the-ground organizational level that effective HHRP both starts and ends.

For this governance structure to be put in place and work, four major changes should be made:

- ACOs should be developed throughout each province and territory
- Every Canadian should be a registered member of one of them
- Each should be funded with the resources equal to the current cost of providing the health/healthcare services consumed by the population it serves, together with
- the administrative resources needed to document the health of that population, its needs, and the data and information needed for HHRP and to discharge its accountability to the province or territory concerned

The provincial/territorial governance should confine its focus to the policy goals and objectives of the health/healthcare 'system' (the **'what'** is to be achieved) delegating to the ACO teams the operational decisions on **'how'** to achieve them in their particular communities or regions.

Governance of the processes and functions of health human resource planning should become 'bottom-up'. Grounded on a comprehensive data and information collection and analysis system coordinated centrally, 'calling the shots' should lie, together with other governance responsibilities, primarily with the governance of each ACO, subject to the policy direction role of and funding by the Ministry of Health or the equivalent of each of Canada's 13 provinces and territories.

Duncan Sinclair and Don Drummond
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[6] In Ontario, Ontario Health Teams (OHTs), previously Local Health Integration Networks (LHINs) and before that District Health Councils (DHCs).