Moving Towards National Health Human Resource Planning in Canada: Still Looking for a Home

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Presentation Outline

- Policy Context for HHR National Planning During 1990s
- Policy Context for HHR National Planning From 2000 Onwards
- Barriers & Facilitators for Implementation?

Why National Focus?

- Yes, health care is a provincial jurisdiction.
- But,
  - Labour markets are becoming international in scope;
  - Labour mobility under international trade agreements is a often requirement (although enforcement mechanisms are weak);
  - Some provinces are recruiting internationally;
  - Federal immigration policy and Federal health care transfers creates national dialogue space.

Why National Focus?

- Talent migrates across provincial borders.
- Increased competition amongst provinces for same personnel.
- Increasing regional disparities.
- Self sufficiency as a policy goal.

Why Planning Focus?

- Canadian experience tends to encourage some planning and analysis at the high (surplus) and low (shortage) points of the demand and supply cycle.

- This encourages intermittent efforts focused on quick fixes yet educating, training and deploying the appropriate personnel takes years.

Why Planning Focus?

- No thought given to the effects of policy reforms on the people working in the system.
- Effects of cutbacks now surfacing in work force surveys and lack of satisfaction, increased stress and burnout.

Why Planning Focus?

- Complex and interdependent actors in multiple jurisdictions with unaligned accountabilities.
- Governments do one thing, educational institutions do another, and regulatory authorities do a third.

National HHR Planning – Not a New Idea

- 1989 – Alberta work cooperatively with other jurisdictions to improve mechanisms to identify health manpower needs and coordinate appropriate training and educational opportunities throughout Canada, but particularly within the western provinces.

National HHR Planning – Not a New Idea

- 1991 - Premier's Council on Health Strategy (Ontario) calls for a national coordinating policy in HHR as provincial planning has national and regional implications.

- 1991 – report to Conference of Deputy Ministers of Health calling for nationally coordinated provincial/territorial HHR policies built upon a commonly understood objective and framework.

National HHR Planning – Not a New Idea

- 1995 – long-term physician resource plans should provide for coordination at an inter-provincial and national level.

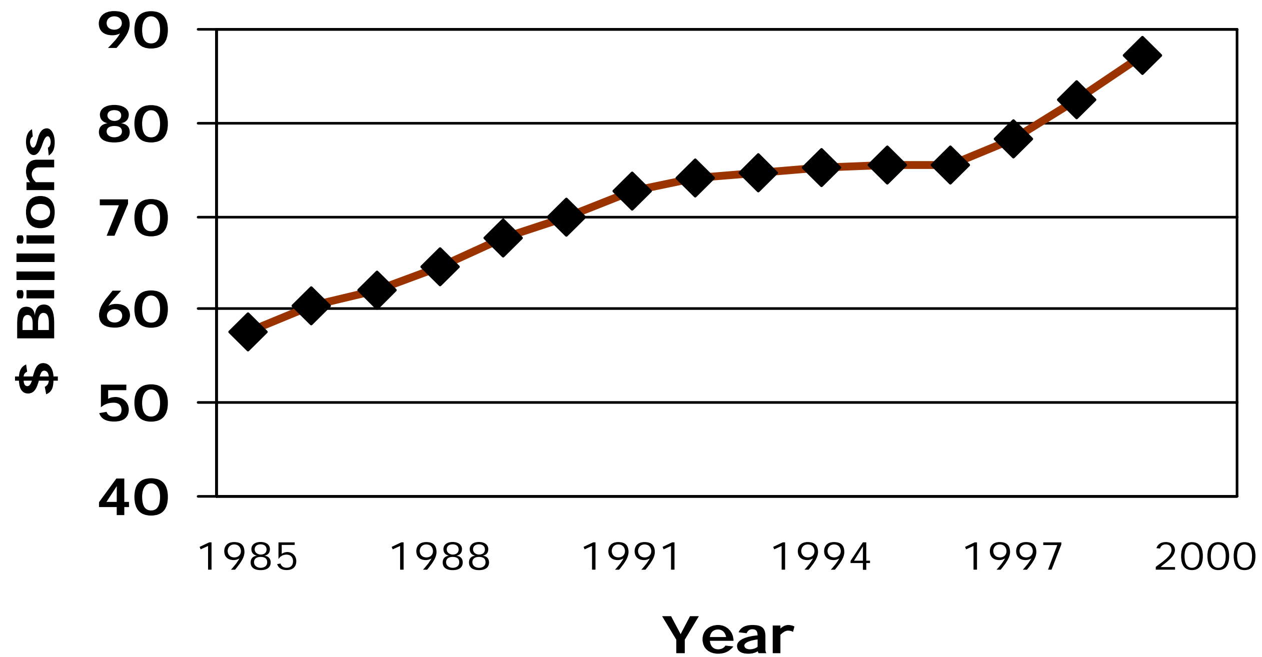
  (National Ad Hoc Working Group on Physician Resource Planning)

- 1998 – Canadian Medical Forum is established and both Task Force One and Task Force Two are clearly focused on a national strategy.

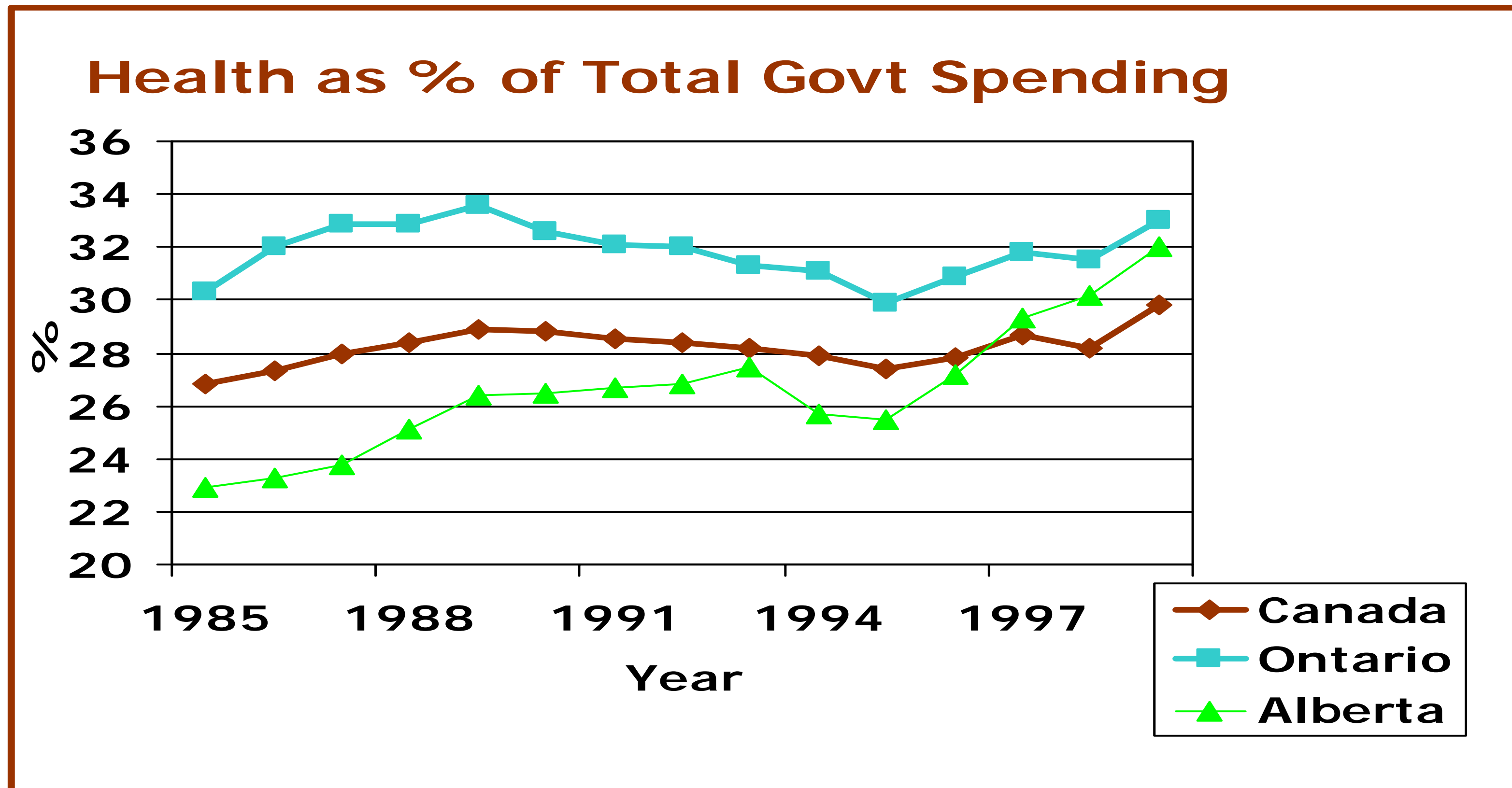
Policy Context – 1990s

- Fiscal overlay on health policy decisions.
- Both federal and provincial governments struggling with history of deficit financing, downturn in the economy.
- Health perceived to be largest consumer of government resources.

Policy Cycle – 1990s



Policy Context – 1990s



Response to Policy Context 1990s

- Perceived need to control costs – too many people, too many hospital beds, find a cheaper way to deliver services, more integration and coordination.

- Federal cuts to provincial transfers and provinces respond in variety of ways.

Response to Policy Context – 1990s

- Hospital mergers and closures.
- Establishment of Regional Health Authorities.
- Imposition of fee awards for physicians.
- Experimentation with fee discounts.

Response to Policy Context – 1990s

- Attempts to limit coverage and delisting.
- Cuts to undergraduate medical school positions.
- Freeze on funding for residency positions.
- Mild push for new providers – eg. nurse practitioners and midwives.

Policy Disconnect

- Health policy focus on cost savings, constraining increases, and more efficient service delivery.
- Personnel were seen as part of cost problem and thus notion of paying fewer of them or paying less.
- Little interest in expanding coverage, buying new technology, using new providers, or contemplating new care models.

Policy Disconnect

- Also starting to see real tension in federal-provincial relationships.
- National planning would require viewing personnel as assets not cost centres and would require fed-prov cooperation.
- Discussions about the need for national HHR planning didn't resonate with policy context of the time.

National HHR Planning – Not a New Idea (Round 2)

- 2000 – First Ministers agree their governments will work to coordinate efforts on the supply of health care personnel and work together to identify approaches to improve education, training, recruitment and retention.

- 2000 - Canada's first Nursing Strategy is released.

National HHR Planning – Not a New Idea (Round 2)

- 2001 – Saskatchewan Commission on Medicare proposes a provincial HHR Council to be linked national work on HHR issues.

- 2002 – NB Premier's Health Quality Council supports strong HHR planning focus for the province and "federal initiatives in this area are also supported."

National HHR Planning – Not a New Idea (Round 2)

- 2001 – HRDC sponsors five health sector studies of labour market issues (although each was independent of the others).

- 2002 – new F/P/T/ Advisory Committee Structure to the Conference of DMs folds HHR into the health services delivery committee.

National HHR Planning – Not a New Idea (Round 2)

- 2002 – Senate Committee encourages a stronger federal role:
  - National Coordinating Committee to collect data, share best practices, study productivity;
  - Work with the provinces to establish national standards to IMG evaluation and accelerated registration processes;
  - Sponsor an independent review of scopes of practice.

National HHR Planning – Not a New Idea (Round 2)

- 2002 Romanow Commission recommends a Health Council of Canada focus on HHR to:
  - Data collection, analysis and reporting;
  - Review education and training programs and recommend to provinces how to improve integrated programs;
  - Develop a comprehensive plan for addressing issues related to supply, distribution, education and training, $, skills and patterns of practice.

National HHR Planning – Not a New Idea (Round 2)

- 2003 First Ministers Accord states collaborative strategies are to be undertaken to:
  - Strengthen the evidence for national planning;
  - Promote inter-disciplinary provider education;
  - Improve recruitment and retention;
  - Ensure the supply of needed health providers.

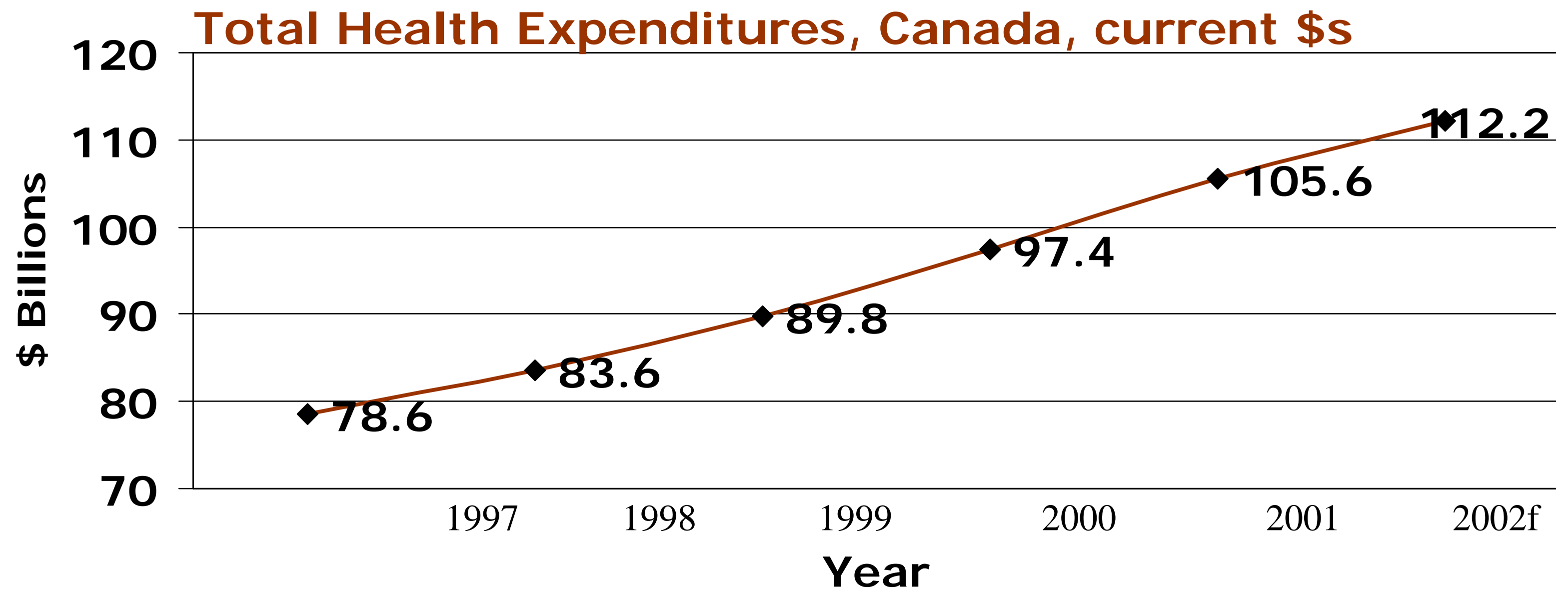
National HHR Planning – Not a New Idea (Round 2)

- 2003 Federal Budget commits $90 million over 5 years (later reduced to $85 million) to improve national health human resources planning and coordination, including better forecasting of health human resource needs.

Policy Context 2003

- Intergovernmental sensitivities have replaced fiscal overlay.
- Money is flowing back from the federal government but many provinces still experiencing deficits.
- Increasing public impatience with federal-provincial wrangling.

Policy Context 2003



Policy Disconnect

- Despite new funding, national consensus on need for action, intergovernmental processes have mixed track record in terms of implementation.
- Public opinion, funding are ahead of the ability of intergovernmental negotiations to deliver action.
- Look to other health system leaders for leadership.

Barriers to Implementation

- Policy levers (education and training, pricing for services, location of service, types of services, regulation of services) are in multiple hands – large amount of goodwill required and voluntary cooperation just within one profession.

- Added complication of integrating with other health professions at the planning level.

Barriers to Implementation

- Data – ongoing access to high quality data not there yet. A number of limited datasets being maintained, not linked. Usually designed for a purpose other than planning.

- CIHI process to access data difficult.

- And, paucity of data for allied health professions.

Barriers to Implementation

- Planning methodologies not well developed in Canada.
- Focus largely on supply side (we have those numbers).
- Large gaps in types of data required to make a shift to needs-based methods.

Barriers to Implementation

- In the middle of system redesign (renewal) - not clear yet what primary care networks will look like nor how they will connect to secondary and tertiary services nor to LTC, home care, mental health etc.

- Policies for pharmacare, home care, public health services and health promotion activities still under discussion.

Barriers to Implementation

- Perception of professional “turf” and unwillingness to cooperate on issues (fact or fiction?).
- Health professions regulatory frameworks not well understood across the country.

Facilitators of Implementation

- Funding earmarked for national coordination and planning.
- Linkage of HHR to system design issues in the advisory structure to the Conference of DMs.
- New governments at the provincial level and new leadership at the federal level may change the intergovernmental dynamic.

Facilitators of Implementation

- Some professions – medicine taking the lead – demonstrating desire to focus on national efforts and to think broadly about public health needs.
- Focus of primary care renewal on team care and multidisciplinarity supports integrated planning. Opportunity to try on the ground what will be required nationally.

Facilitators of Implementation

- 2001- Priority-setting exercise by national health services research organizations identified HHR as number one research priority.

- Substantial investments in HHR modelling and policy research – stronger and larger research community interested in linking with decision makers to support evidence-based policy.

- “We must realise collectively that letting policy develop by default, disinterest, or insufficient will, is itself a policy strategy, but one that can only be expected to bring about satisfactory results by those who believe in winning lotteries.”

  Report to the F/P/T Conference of Deputy Ministers of Health, 1991

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