Health Human Resources Planning in Canada: Challenges, Opportunities and Solutions

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Presentation Outline

• The past & future dynamics of HHR planning in Canada
• Two kinds of HHR challenges
  – Sustaining what we have
  – Building the system we want
• A window of opportunity is opening
• A new approach to HHR planning
  – Building from the ground up
  – Collaboration & dialogue
Drawing on CPRN’s Research

• CPRN’s recent Health Human Resources Planning Research
  – HHR Planning in Canada (Romanow Commission)
  – Data Assessment & Trend Analysis for Physicians (Task Force II)
  – HHR Consultation Conference (Sask)
  – Nursing Mobility & Access to Services (CNA)
  – The Taming of the Queue (CMA)
  – The Ethics of Int’l Recruitment (Sask)
Understanding the Context

• HHR Planning is at the root of the reform of health care service delivery
  – Primary Care Reform
    • Scope of Practice Issues
  – Health Education Reform
    • Interdisciplinary education, creeping credentialism, hyper-specialization
  – Access to Care, Wait Times and Care Guarantees
    • The right service provider at the right time in the right place
Past Approaches to HHR Planning

• Past approaches have suffered from multiple but inter-related problems:
  – Profession-specific (e.g. how many docs do we need?)
  – Based on retrospective data (e.g. how many nurses we have + changing pop profile = how many we need)

• This inhibits rather than facilitates change
  – We replicate the system we have, rather than plan for the system we want
HHR Dynamics

• Rooted in the accommodation of powerful interests
  – Provincial Medical Associations
  – Health Professional & Regulatory Bodies & Unions
  – National Stakeholder Organizations (curious)
  – Public affection for providers
• Aided and abetted “turf protection” & the privileging of a hierarchy of professions
• Uneven collaboration between Health & Education sectors
Dynamics Are Changing...

• Growing evidence that new approaches to HHR planning are taking hold
  – More holistic, integrative and forward looking
  – Nursing Sector Study & Task Force II
  – Initiation of a Pan-Canadian Framework
  – C3PR

• HHR must serve reform goals not vice versa

• But the change is incremental, difficult to institutionalize and points of resistance remain
  – Trust is still in short supply and relationships fragile
Types of Challenges

- Type I challenge – Sustaining the system
- Type II challenge – Achieving the system we want
TYPE I CHALLENGES
Sustaining the System

• Shortages/misallocation of human resources
  – Domestic supply (+ Int’l Educ Health Professionals) does not match demand
  – Intergovernmental Competition
• Working harder not smarter
• Misallocation of human resources
  – Rural / Urban divide; Underserved populations
• Keeping up with technology & new professions
• Global Issues (pandemics, mobility, etc.)
Finding Solutions

• Type I challenges easier to identify and solve
  – More training seats increases domestic supply
  – New rural med schools may increase rural supply
  – IEHPs are here to stay but pressure will increase to confront ethics of 3rd World recruitment

• Type I challenges are amenable to the traditional modes of HHR planning – modelling future needs, incremental increases in resources, targeted programs built within a collective bargaining framework

• But even here there are limits
TYPE II CHALLENGES
The System We Want

• New process of professional training
  – New curriculum, interprofessional education, entry to practice issues & over-specialization

• Moving forward on Primary Health Care
  – Scope of practice & interprofessional collaboration

• Access to services & appropriate care
  – Right people, right place, right time
  – Wait time issues and care guarantees
A Window of Opportunity

• The make-up and attitude of health professionals is changing
  – The next generation is VERY different
• The public is anxious for substantive change
  – They know what they want & the trade-offs involved
• Governments are developing new modes of collaboration
  – Pan-Canadian goals built from the ground up
• Stakeholders & Employers want a new role
What Is to Be Done?

• Intersectoral Collaboration Within Gov’ts
  – Health, Education, PSE departments on interprofessional education & entry to practice
  – Health, Labour & Immigration departments on IEHP issues, mobility issues

• Multisectoral Dialogue with Stakeholders
  – Open-ended and iterative
  – Confronting the trade-offs and the conflicts

• Dialogue with Citizens
Something to Remember

• HHR Planning exists on a continuum:
  – It begins in the community/institution, then to the region, then to the province and then across the country

• For all of the models we build, it is about having a person on the ground who is properly trained delivering the right service when it is needed

• Change can be incremental & cumulative BUT in service of a clear vision of the future
Steps for Success

- Intersectoral vision created
- Validate with internal stakeholders
- Dialogue with external stakeholders
- Dialogue with the public
- Revision to vision
- Enactment of the intersectoral vision
- Evaluation of the outcomes
Example: Scope of Practice (1)

What CPRN has learned

- Wide consensus on principle that “everyone works to full scope of practice & training”
- Very little consensus on what that principle means...docs v. nurses, RNs v. LPNs, etc.
- Governments can’t move forward in the face of this confusion from professionals
- Interprofessional dialogue is difficult when conversation remains in the abstract
- Policy needs to be rooted in “what works”
Example: Scope of Practice (2)

- Movement on Primary Health Care can break the deadlock on scope of practice
  - Each PHC team will be different (a team in N. Sask will be different than a team in Toronto)
  - The teams will have to work out the scopes of practice that work efficiently & effectively for them
  - Flexible PHC models needed to serve the community
- These are the lessons that become the basis for policy re education, training and credentials that will guide scope of practice
A Final Note of Optimism

• Good HHR planning has to
  – In service of the system we want not what we have
  – Built from the ground up, not from models imposed from above
  – It must actively ENGAGE stakeholders & the public

• BUT it also requires intergovernmental collaboration & mutual learning
  – Good practice must be replicated & built upon from the local to the regional to the provincial to the national
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