Health Council of Canada Conseil canadien de la santé

TAKING THE PULSE

# MODERNIZING THE MANAGEMENT OF HEALTH HUMAN RESOURCES IN CANADA:

## Identifying Areas for Accelerated Change

Report from a National Summit
June 23, 2005

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Modernizing the Management of Health Human Resources in Canada:
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Report from a National Summit - June 23, 2005
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## ABOUT THE HEALTH COUNCIL OF CANADA

The Health Council of Canada was created as a result of the 2003 First Ministers' Accord on Health Care Renewal to report publicly on the progress of health care renewal in Canada, particularly in areas outlined in the 2003 Accord and the 2004 10-Year Plan to Strengthen Health Care. Our goal is to provide a system-wide perspective on health care reform for the Canadian public, with particular attention to accountability and transparency.

The participating jurisdictions have named Councillors representing each of their governments and also Councillors with expertise and broad experience in areas such as community care, Aboriginal health, nursing, health education and administration, finance, medicine and pharmacy. Participating jurisdictions include British Columbia, Saskatchewan, Manitoba, Ontario, Prince Edward Island, Nova Scotia, New Brunswick, Newfoundland and Labrador, Yukon, the Northwest Territories, Nunavut and the federal government. Funded by Health Canada, the Health Council operates as an independent non-profit agency, with members of the corporation being the ministers of health of the participating jurisdictions.

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# EXECUTIVE SUMMARY

On June 23, 2005, the Health Council of Canada brought together over 120 key players in health care to address what the Council believes is the most pressing challenge facing our health care system – health human resources. More than one million people work in our health care system, providing care to Canadians on a daily basis. They are the backbone of the system – the provision of high quality, accessible health care services depends on having the right people, with the right skills, in the right settings.

First Ministers recognized the importance of health human resources (HHR) in their health care renewal accords of 2003 and 2004. As part of strategies to reduce wait times and improve access to health care, Canada's federal, provincial and territorial governments made significant commitments to reform the workforce aspects of our health care system. Governments agreed to:

- ensure that the right information is available to support HHR planning on a national basis;
- create opportunities for health care providers to learn and work in interprofessional teams;
- ensure that all parts of Canada have an adequate supply of health professionals;
- report to the public on their action plans by December 31, 2005, including targets for training, recruitment and retention of health professionals.

Modernizing the way health care professionals are educated and engaged in their vital work requires a collaborative and coordinated approach among many players – universities, colleges, regulatory bodies, employers, unions, professional associations, and governments. The Health Council convened the summit on health human resources to focus on practical, short-term solutions. This report attempts to capture the lively discussion and encouraging examples of innovation brought forward at that forum, organized into four theme areas. The recommendations were developed by the Council following the meeting. While we asked participants for feedback on an earlier draft of this report – and were rewarded with a vigorous response – we did not seek the endorsement of any individual or organization. The synthesis of discussion and the recommendations are the Health Council's responsibility alone.

Along with a substantial appetite for progress evident at the summit, there was also a good dose of frustration concerning the slow pace of change. While many of the strategies highlighted here are not new, the day's dialogue clearly spoke to a collective interest in moving forward to address the critical issues: burnout, shortages and inequitable distribution of care providers, structural barriers to reforming care delivery, and disconnected planning efforts across the country, among others.

Throughout the summit, participants called for better mechanisms to share knowledge from experience across Canada and internationally. There was a strong sense that a great deal of innovation is occurring, but planners, educators and health care providers are frustrated in not having easy access to that information. Hand-in-hand with this problem is the need for more rigorous evaluation research, to understand why innovations succeed or fail and how

they affect patient outcomes in the long term. Such research requires better data collection, timely analysis, and common definitions so that outcomes from activities in different jurisdictions can be more easily compared. We need such research to understand what works in large systems and what doesn't. But we cannot simply wait for those answers. There are a number of promising models that we encourage the country to consider now.

## Recommendations

Based on current commitments on funding and reform, we have set a number of specific targets which we believe are achievable within two to five years. The Health Council acknowledges that substantial efforts are underway toward many of these objectives – yet we challenge governments, professional associations, regulatory bodies, employers, unions, and educators to go further, to work together and to work with us in reporting back to Canadians on their progress. Action on each of these recommendations requires collaboration among key stakeholders, but active leadership is essential.

### 1) Expand opportunities for interprofessional education and post-graduate collaborative practice.

*Lead responsibilities:*
- Universities and colleges to design new programs;
- Governments to fund programs;
- Employers and unions to create workplaces supportive of teamwork.

*By 2008:*

a. Each of Canada's university health sciences programs should offer an interprofessional educational program through collaboration among appropriate disciplines.
b. Incentives such as tuition subsidies should be available to encourage students and post-graduate trainees to enter interprofessional education programs.
c. A collaborative practice workplace fund should be created to enable primary health care settings to provide high-quality interprofessional care and education (for example, to fund mentorships and logistical support for such costs as transportation in rural areas and information technology).
d. All health professionals – both new graduates and the existing workforce – should be able to access an interprofessional clinical learning experience.

### 2) Create more interim training and certification steps along pathways to health careers.

*Lead responsibilities:*
- Universities and colleges to design and implement programs;
- Governments to fund programs;
- Regulatory boards to work in partnership with educational institutions and professional associations to design and accept new credentials;
- Employers and unions to embrace new roles for providers.

*By 2010:*

Existing health science programs in each jurisdiction, in partnership with college-level training institutions, should offer tiered pathways in the health professions.

## 3) Increase the numbers of First Nations, Inuit and Métis professionals in the health workforce.

*Lead responsibilities:*

- Universities and colleges to implement, in partnership with governments as well as with Aboriginal leadership, national organizations, and communities;
- Employers to develop recruitment and retention programs for Aboriginal graduates.

*By 2008:*

a. Colleges and universities should complete an assessment of their internal capacity to support Aboriginal students (e.g. financial support for education and living expenses, and psycho-social supports such as mentoring and peer counseling) and take action to improve insufficient supports.

*By 2010:*

b. Outreach and support programs to encourage Aboriginal students to consider a health professions career should be established.
c. The number of Aboriginal students in health professions programs should rise to at least four per cent of total enrolment (to achieve a minimum of proportional representation).
d. An interprofessional educational cohort program for Aboriginal students in a range of health professions should be established.

## 4) Strengthen a national approach to managing the role of international graduates in meeting Canada's health human resource needs.

*Lead responsibilities:*

- Certification agencies and regulatory bodies to develop assessment processes;
- Governments to fund and to reform regulations as required;
- HHR planning authorities to specify the role of international graduates in future HHR planning;
- Federal government, in partnership with provinces and territories, to jointly develop and implement policies on ethical recruitment.

*By 2008:*

a. Assessment processes to enable the integration of international graduates in regulated health professions should be standardized across Canada.
b. The contribution of internationally-educated health care providers should be clearly articulated in HHR plans.
c. Federal government, in consultation with provincial and territorial governments, should report publicly on progress in collaborating with international health organizations on implementing ways to improve the ethical recruitment of health care professionals.

## 5) Enhance opportunities for professionals to work to optimal scope of practice to ensure the system's capacity to meet local patient and population health needs.

*Lead responsibilities:*

- Governments, regional health authorities, employers, unions, professional associations, educators and regulators.

*By 2008:*

a. Professional associations and health professions regulators should engage with employers and governments to foster better understanding of the uniqueness and commonalities in key health professions.
b. Regional health authorities and other employers should review current workforce roles in existing health care settings to assess where people are working to optimal scope of practice and where, with appropriate supports, the workforce could better meet local patient and population health needs.

*By 2010:*

c. Changes should be implemented in how work is organized to better match skills and scopes of practice to patient/client needs, and progress on these changes should be publicly reported.

## 6) Accelerate the shift to provider payment schemes that stimulate interprofessional teamwork.

*Lead responsibilities:*

- Governments, professional associations, and employers.

*By 2008:*

Alternate methods of compensation should be promoted so that the proportion of publicly-funded providers paid through flexible alternative schemes has increased by least 20 per cent.

## 7) Resolve concerns about liability in collaborative practice.

*Lead responsibilities:*

- Professional liability protection organizations, governments, regulators, and patient safety organizations.

*By 2007:*

a. A common understanding of liability issues in collaborative practice and what remains to be done to resolve them should be publicly reported.

*By 2008:*

b. An integrated approach to professional liability and accountability consistent with patient safety, risk management, and teamwork should be collaboratively developed.

8) **Invest in financial and non-financial incentives to improve recruitment and retention, and report publicly on the progress of healthy workplace initiatives.**

*Lead responsibilities:*

- Health care employers.

*By 2008:*

a. Employers – in collaboration with researchers, professional associations and unions – should use comparable indicators on workplace health to publish annual assessments in such areas as employee retention and satisfaction and other aspects of work life quality.
b. Through public reporting on indicators of workplace health, employers should regularly demonstrate improvements in the quality of work life in health care settings.
c. Employers should increase by 10 per cent above current levels the time staff spend attending professional development opportunities and providing career mentoring and coaching.

9) **Ensure that HHR planning is based on population health needs, fully integrated across jurisdictions, and properly resourced.**

*Lead responsibilities:*

- Federal, provincial and territorial governments in partnership with regional health authorities to improve and report on planning;
- The Canadian College of Health Service Executives to develop competency requirements in interprofessional HHR planning.

*By 2008:*

a. Population health needs should be the building blocks of forecasting tools used by governments and others to plan for health human resource requirements.
b. Federal, provincial, territorial and regional health human resource plans should be mutually integrated.
c. Governments and others should report publicly on their forecasting tools for HHR planning.
d. The growth of management skills in planning should be supported by the requirement for competency in HHR planning in an interprofessional care environment.

## Next Steps

The recommendations put forward here point to the need for action in specific areas, and the Health Council urges the responsible stakeholders to begin immediately to meet the timelines presented. We plan to report publicly on interim progress towards these goals as part of our mandate to monitor and report on health system renewal. Human resource issues will also form a major part of the Health Council's second annual report to Canadians on health care renewal, coming in January 2006. We look forward to continued dialogue and progress.

## MESSAGE FROM THE CHAIR

Why is the issue of health human resources so important? Simply stated, none of the pressing challenges facing Canada's health care system can be met without focusing on the people who make the system work. Take wait times, for example: we cannot ensure timely access to care without having the right providers and support services in place all along the patient journey – not just the surgeons but whole teams of professionals in our hospitals, in rehab services and home care, and behind the scenes in planning, sharing information, and keeping the workforce healthy and productive. Our laudable national public health goals – which include reducing disparities in health and preventing disease through healthier living – cannot be met without having primary health care teams in every community where Canadians live.

How might the landscape of our health care workforce look different by 2010? We could see many more young people from First Nations, Inuit and Métis communities studying to enter health professions. Every new graduate could have the opportunity to learn from interprofessional teams where collaboration to enhance patient outcomes is the foundation of quality care and timely access. Established professionals could be delivering care where it is needed most; they could feel satisfied and supported by a system that enables flexible work arrangements and looks creatively at how to make the best use of people's talents. And we could see a reliable national plan for educating and employing health care workers across the country, instead of the fragmented series of local and regional planning efforts which we see today.

Ambitious? Perhaps, but these are some of the changes envisioned in this report from the Health Council's national summit on health human resources, held in Toronto on June 23, 2005. The Council believes the goals we present here are achievable. We also recognize that this will not be simple. The one-day meeting brought together leaders from every aspect of our complex health care workforce – education, professional organizations, labour relations, research, regulation, management, government and front-line care. They shared their observations, strategies and hopes for health care renewal in this country. There was a great deal of goodwill evident at the meeting, but also evident was the need for further work to commit to collaborative action and move forward together.

The Council remains optimistic that the country can build on the momentum created by the tremendous investments now being made in health care renewal. Throughout the report, we present ideas and examples of initiatives that summit participants brought forward – the kind of innovations that could and should be implemented in a broader context. This year's summit was a consultation, and participants continued the dialogue by commenting on a draft of this report. I am grateful for the energy and openness of this discussion, and I encourage readers to delve into the ideas presented here and let us know what you think.

*Michael Decter*
*Chair, Health Council of Canada*

# INTRODUCTION

The provision of high quality, accessible health care services depends on having the right people, with the right skills, in the right settings. How their work is organized and supported, whether they have the skills and technology to care for our changing population, whether providers can practice where they are needed most – these factors will determine whether Canada's significant plans and public investments to modernize our health care system will flounder or succeed.

First Ministers recognized the importance of health human resources (HHR) in their health care renewal accords of 2003 and 2004 (Appendix I). As part of strategies to reduce wait times and improve access to health care, Canada's federal, provincial and territorial governments made significant commitments to reform the workforce aspects of our health care system. Governments agreed to:

- ensure that the right information is available to support HHR planning on a national basis;
- create opportunities for health care providers to learn and work in interprofessional teams;
- ensure that all parts of Canada have an adequate supply of health professionals;
- report to the public on their action plans by December 31, 2005, including targets for training, recruitment and retention of health professionals.

In our first annual report to Canadians, *Accelerating Change* (January 2005), the Health Council of Canada expressed a strong belief that these health care renewal goals can only be achieved by a collaborative and coordinated approach. To assist decision-makers in this arena, we convened a national summit on health human resources on June 23, 2005, in Toronto. The Council is pleased to present this report of that meeting.

The one-day meeting, titled *Modernizing the Management of Health Human Resources in Canada: Identifying Areas for Accelerated Change*, brought together 120 Canadian leaders and international guests. Their various fields of work paint a picture of the complex and challenging landscape through which health care renewal must travel – education, research, regulation, professional organizations, labour relations, technology, government, and the management and delivery of front-line care.

The forum was planned with a key outcome in mind – a set of practical solutions which can be implemented in our current system within the next one to three years. By the day of the meeting, a new backdrop had emerged – the Supreme Court of Canada decision on private health insurance in Quebec. This ruling has sharpened public interest in understanding solutions to wait times and the human resource issues which contribute to delays and access problems in health care. The ruling has added a new urgency to the need to strengthen Canada's HHR systems, to ensure that stop-gap measures do not drain the workforce and decrease access to timely and effective care.

The summit was primarily a consultation – an opportunity for the Health Council to take the pulse of progress on health human resources. It provided a forum for people from diverse

sectors to talk openly on difficult issues, and participants took lively advantage of the day. After overview presentations, participants engaged in a series of small workshops. Lists of participants, speakers and workshops are appended to this report, and many of the presentations are available on our website, w*ww.healthcouncilcanada.ca*, along with video segments from the meeting.

This report builds on a state-of-the-debate survey by Health Council staff, *An Environmental Scan of Current Views on Health Human Resources in Canada: Identified Problems, Proposed Solutions and Gap Analysis* (June 2005). Participants received this scan in preparation for the Summit and it is also available on our website. The scan was organized along four theme areas – education and training, scopes of practice, workplace practices, and planning – and this report follows the same framework. Also in preparation for the summit, the Canadian Institute for Health Information (CIHI) produced a valuable resource, *Canada's Health Care Providers: 2005 Chartbook* (June 2005), an update to their 2001 report on the country's health care workforce. Both are available at *www.cihi.ca*.

The Council did further research after the meeting to expand on the many strategies brought forward at the summit – to make our report useful for a broader audience and to develop recommendations for action. To further the consultation process, we asked participants for their feedback on a draft of this report. The responses were thoughtful, detailed and by turns challenging and supportive. We are grateful for this continued participation and stress that we did not seek the formal endorsement of any individual or organization represented at the summit. We have carefully considered this feedback in finalizing the report, but readers should keep in mind that the content and conclusions of the report remain the responsibility of the Health Council.

## A note on terminology

Some of the strategies discussed in this report are relatively new, and a number of terms are in use to describe them. For clarity, we have chosen to use the following terminology: By *interprofessional education*, we mean education and training environments in which students from two or more professions learn with, from and about each other to improve collaboration and the quality of care. *Interprofessional care* describes a service delivery model in which two or more types of health care professionals (not necessarily co-located) collaborate to deliver care. We use *collaborative practice* interchangeably with interprofessional care.

## Acknowledgements

The Health Council gratefully acknowledges the many people and organizations who helped to make the summit work and to create this report. In particular, we thank:

- our government partners and stakeholder organizations, who provided background information for the environmental scan produced in preparation for the meeting;
- our speakers (Appendix II);
- all participants, who freed up busy schedules to attend and who further assisted in reviewing sections or drafts of this report (Appendix III);
- the team of workshop facilitators and recorders, led by Elaine Todres of Todres Leadership Counsel – Kimberly Bain, Fadi El-Jardali, John Housser, Kathryn MacDonald, Lisa Maslove, Judith Maxwell, Bev Nickoloff, John Ronson, Colleen Savage, Donna Segal, Arlene Wortsman;
- the Health Council's Working Group on Health Human Resources – Jeanne Besner (chair), Albert Fogarty, Duncan Fisher, Michel Leger, Danielle Martin and Elizabeth Snider;
- Jo-Anne Boluk of Corp Du Jour Ltd., who expertly coordinated the event;
- the team at George Brown College, St. James Campus, which hosted the event –the Facilities Management Department led by Dave Rideout and assisted by Carole Fortune, Benton Simon and the information technology team, and Hospitality Services led by Jeannine Pharand-Theyer, as well as Chartwells Food Service;
- the secretariat of the Health Council, for their many roles in planning, implementing and reporting on the summit.

# CURRENT ENVIRONMENT

More than one million people work in the health care system in Canada, providing health care to Canadians on a daily basis.[1] Many of their services are publicly funded but many of these people work in settings funded through private insurance plans or direct payment by patients and their families. Collectively, they are the backbone of a highly complex system yet they have only recently become the focus of attention, as policy makers have recognized health care renewal in this country cannot succeed without the right workforce.

What do we know about the health care labour market in 2005? What follows are some general trends derived from background work done by the Canadian Institute for Health Information (CIHI) and the Health Council.[2] These trends raise questions about the management of health human resources in Canada and have implications for how we design future delivery systems and their requisite personnel requirements.

### *The largest group of health professionals in the Canadian health care system are nurses, followed by physicians. We know relatively little about the rest.*

There are more than 30 different health professions and occupations currently working in Canadian health care. By far the largest group is nurses at over 40 per cent of the health care workforce. This includes registered nurses, licensed practical nurses, and registered psychiatric nurses. Physicians are the second largest group at nine per cent leaving the remainder distributed among a variety of professions as indicated in Figure 1. While we know a fair amount about nurses and physicians, we know relatively little about many of the groups who make up the other 50 per cent of workers in the Canadian health care system.

### *The supply of health professionals has varied over time.*

Historically, the supply of health professionals in this country has not been a managed enterprise. In all the professions there have been increases and decreases over time, apparently unrelated to the health needs of the population. Figures 2 – 4 review the numbers of health care providers per 100,000 population for a six-year period (1994 – 2002) as follows:

- There has been no change in physicians – staying at 188 per 100,000;
- There has been a decrease in nursing: RNs have decreased from 804 to 734 per 100,000, and LPNs have decreased from 282 to 191 per 100,000;
- There has been a decrease in medical laboratory and radiation technologists from 282 to 191 per 100,000;
- There has been an increase in pharmacists (from 73 to 84 per 100,000), psychologists (from 14 to 20 per 100,000), social workers (from 44 to 77 per 100,000), and in all of the rehabilitation professions.

The question is why the changes? Was the reduction in nurses planned because an assessment was made that lower hospitalization rates and lengths of stay would require fewer nursing hours, or was it related to reduced funding levels for acute care institutions?

How does the decrease in technologists relate to the increased purchasing of diagnostic equipment? Is the rise in social workers and psychologists related to increased mental health stress in the population? Does the rise in all of the rehabilitation professions signal a greater disease burden? Were these changes planned progressions or were they relatively random?

### *The supply of health professions varies across provinces and territories.*

Figures 5 – 10 review the status of different health professions in each of the provinces and territories. Again, there are large differences across the country. Why does Newfoundland and Labrador have 118 family physicians per 100,000 while Ontario has 85? Why does PEI have 994 RNs per 100,000 while BC has 665? Why does New Brunswick have eight chiropractors per 100,000 while the Yukon has 29? Why does Saskatchewan have 94 medical laboratory technologists while Quebec has 39?

No doubt provincial and local differences in the health of residents can explain some of the variation, but what other factors account for these differences?

### *Jurisdictions compete for the same personnel and jurisdictions with resources win.*

In the absence of a national or coordinated recruitment plan, provinces and territories compete with each other for a limited pool of providers. Figure 11 shows the migration of physicians within Canada over a five-year period. British Columbia, Alberta and Ontario have recruited the largest number of physicians and Newfoundland and Labrador, Quebec and Saskatchewan have lost the greatest number. The practice continues to date – recently the Calgary Health Region recruited two high profile surgeons from The Hospital for Sick Children in Toronto.

### *Canada is not self-sufficient in training health professionals and relies on international graduates to fill a service need.*

Historically, Canada has always relied on international graduates to fill a gap in supply. The countries of origin have changed over time: we rely less now on graduates from UK, Ireland and Europe and more on graduates from South Africa, Asia and India. The ethics of this behaviour is increasingly being questioned and has led to a proposal from these regions that they be compensated for the loss of their personnel. If the push to decrease reliance on international graduates becomes stronger, what are the implications for Canadian training systems?

Figure 12 outlines international medical graduates as a percentage of the total medical workforce. Again, there are differences across jurisdictions. Saskatchewan has the highest percentage with over 50 per cent of its medical workforce being internationally educated and Quebec has the lowest at 11 per cent.

### *How particular health professions are defined, accredited and regulated varies from province to province to territory.*

Accreditation, scopes of practice and registration requirements differ across the country. This affects how the public understands the skills sets of various health care providers. It also has

implications for mobility of personnel, workplace flexibility and institutional accreditation requirements. For example, the number of registered midwives in Canada has grown from less than 100 in 1993 to 450 today. Still, only six jurisdictions have made midwifery a regulated health profession (Table 1).

*Practice is changing over time.*

Both the volume and type of services being provided by different personnel are shifting based on individual decisions by practitioners. Nowhere is this more apparent than in medicine. Figure 13 describes the changes in family medicine activities over an eight-year period. These changes have significant implications for health human resource planning as other professions may fill in the gaps. For example, in 1993, one in four family physicians provided obstetrical services compared to only 16 per cent in 2001.

*There is a mismatch between the career interests of graduates and available post-graduate training positions.*

Figure 14 outlines the gap between the career choices of medical graduates and the number of family medicine training positions available. Table 2 provides similar numbers for specialists. Spaces in family medicine go unfilled while new physicians choose other specialties despite more competition for these training seats.

*Part-time and casual work comprises a large percentage of some occupations, particularly in institutional settings.*

Figure 15 provides the percentage of full-time, part-time and casual nurses for each province and territory. There is significant variation across the country and, while we do not know if these differences reflect the preferences of the individuals involved, what is clear from these data is that change is constant and varies from province to province to territory. Each change has a discrete impact on overall labour market planning and forecasting. Do we have appropriate mechanisms to track and interpret this dynamic environment for policy makers and planners?

*Figure 1: Health Professions as a Percentage of Total Health Care Labour Force, Canada, 2003*

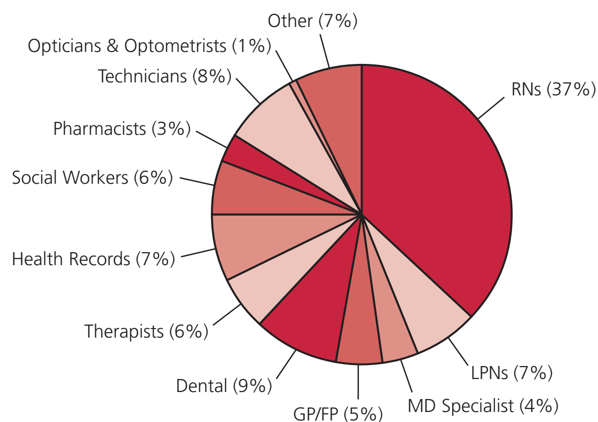
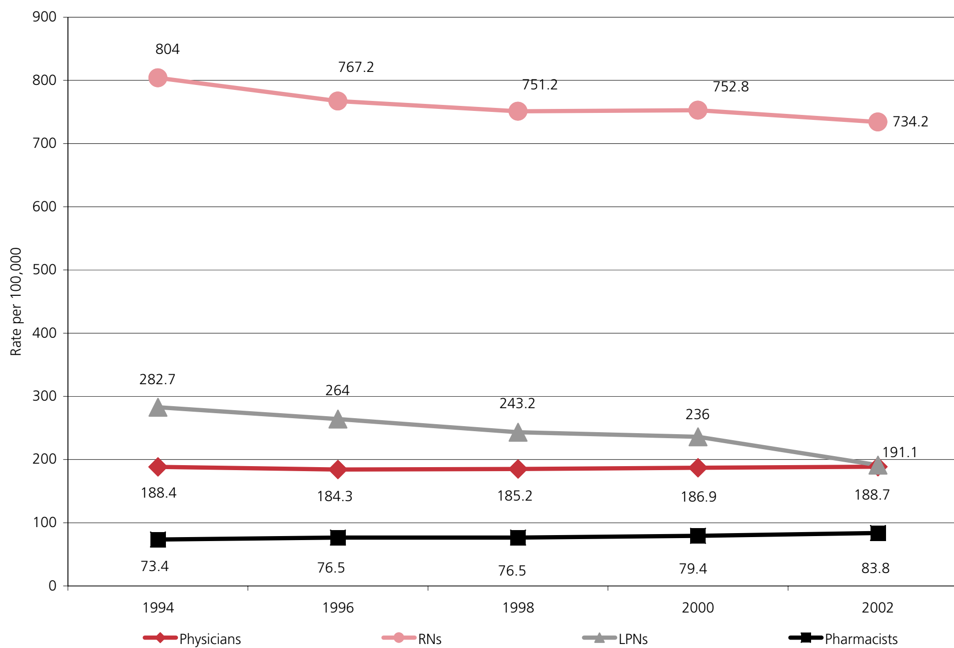



*Figure 2: Health Professions per 100,000, Canada, 1994-2002: Physicians, Registered Nurses, Licensed Practical Nurses, Pharmacists*




Note: Scales differ on some graphs. All data represent numbers of people, not full-time equivalents.

*Figure 3: Health Professions per 100,000, Canada, 1994-2002: Medical Laboratory Technologists, Medical Radiation Technologists, Psychologists, Social Workers*

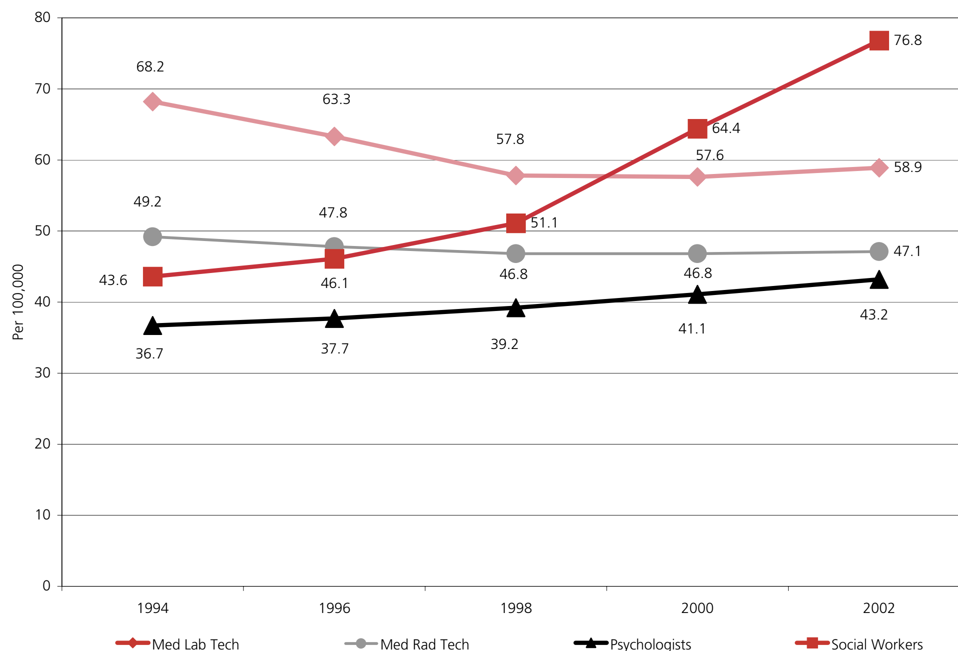



*Figure 4: Health Professions per 100,000, Canada, 1994-2002: Chiropractors, Occupational Therapists, Physiotherapists, Respiratory Therapists*

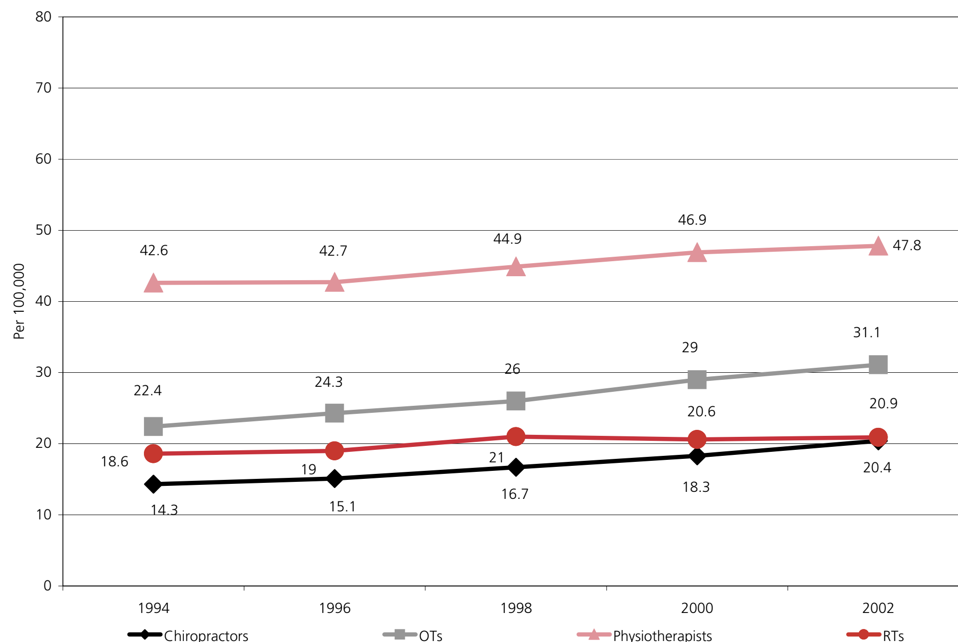


*Figure 5: Physicians per 100,000 by Jurisdiction, 2003*

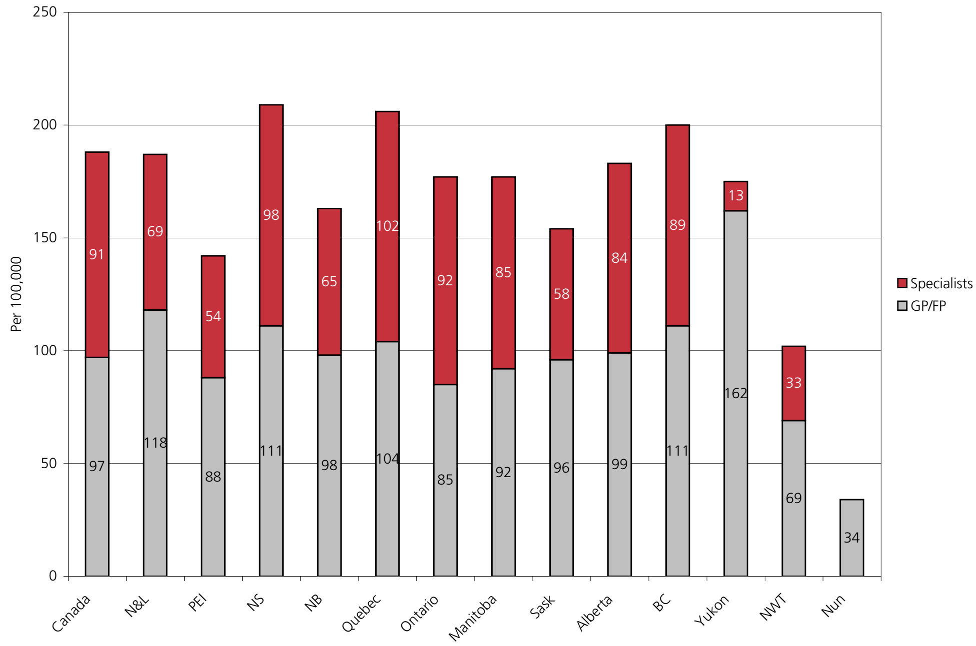



*Figure 6: Registered Nurses, Licensed Practical Nurses, Registered Psychiatric Nurses per 100,000 by Jurisdiction, 2003*

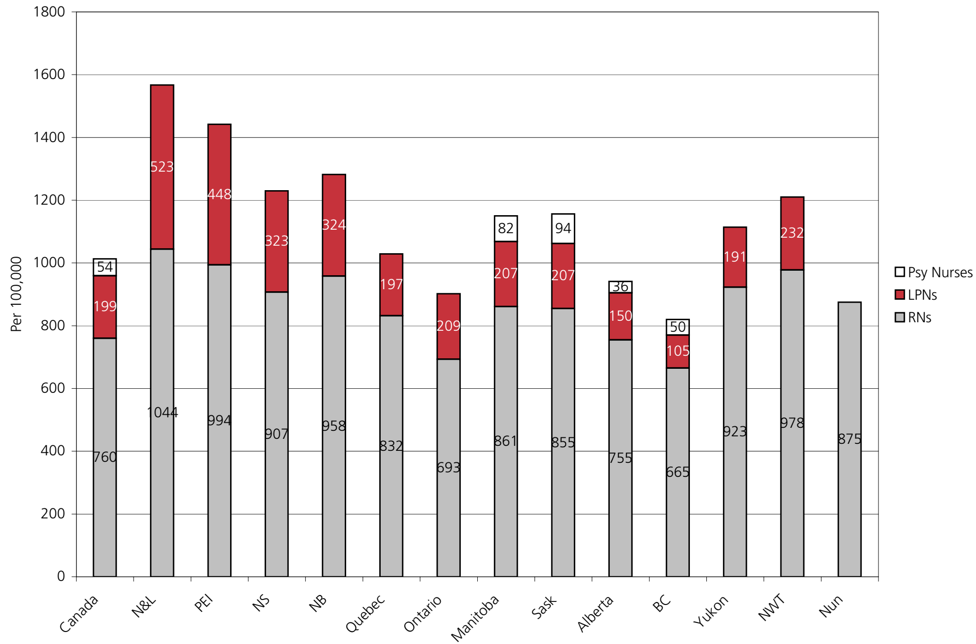


*Figure 7: Pharmacists, Psychologists, Optometrists per 100,000 by Jurisdiction, 2003*

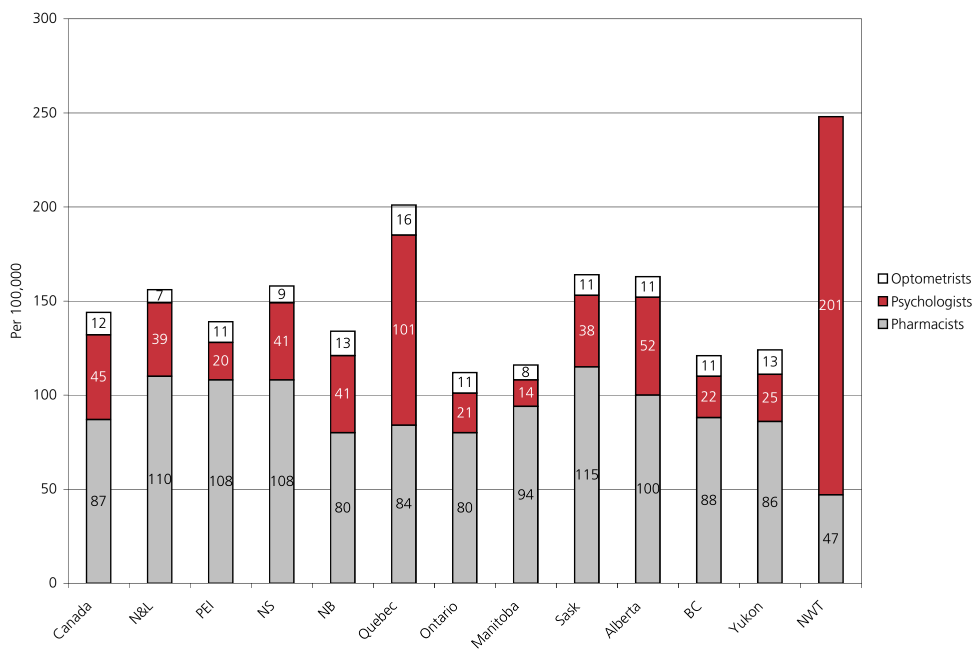



*Figure 8: Rehabilitation Health Professionals per 100,000 by Jurisdiction, 2003: Physiotherapists, Occupational Therapists, Chiropractors*

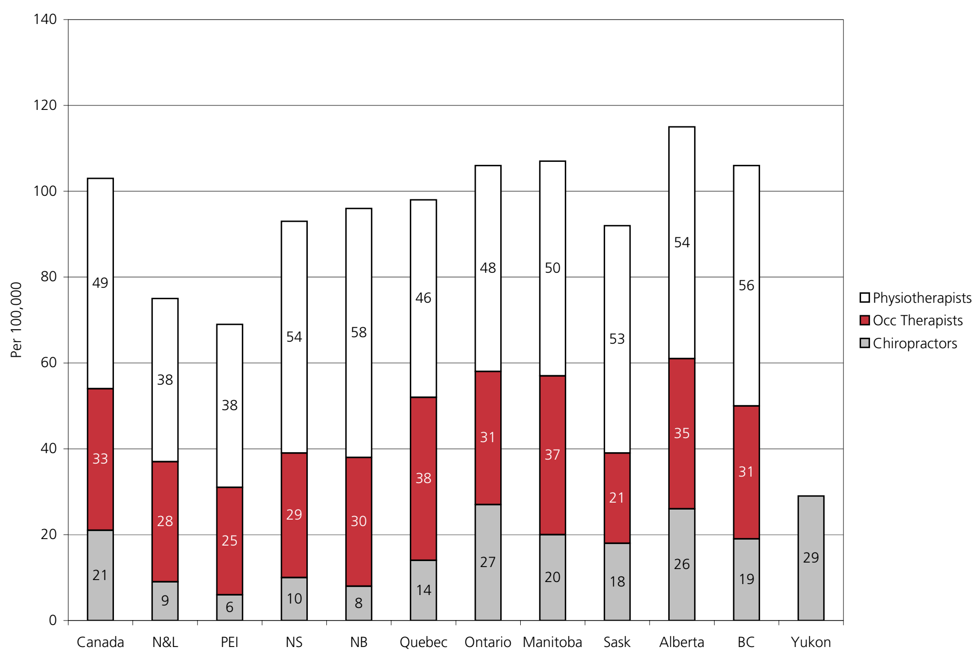


*Figure 9: Oral Health Professionals per 100,000 by Jurisdiction, 2003: Dentists, Dental Hygienists*

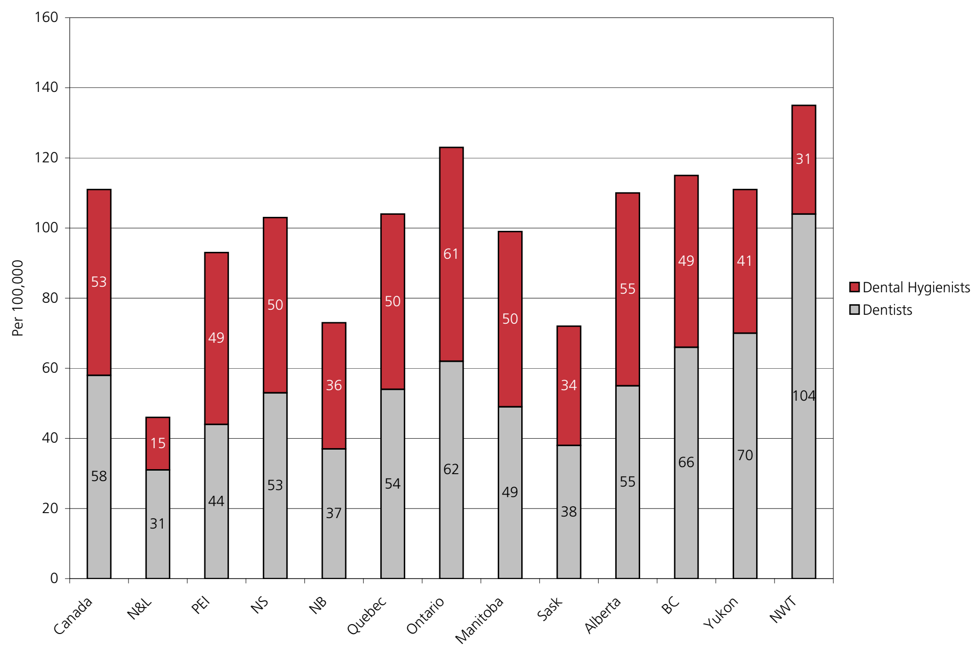



*Figure 10: Medical Laboratory and Radiation Technologists per 100,000 by Jurisdiction, 2003*

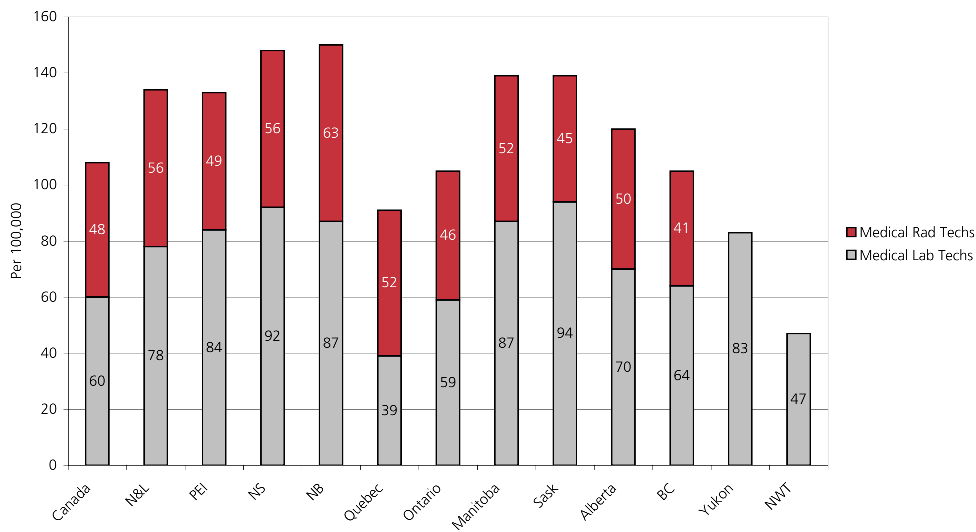


*Figure 11: Physician Migration Within Canada, 1999-2003*

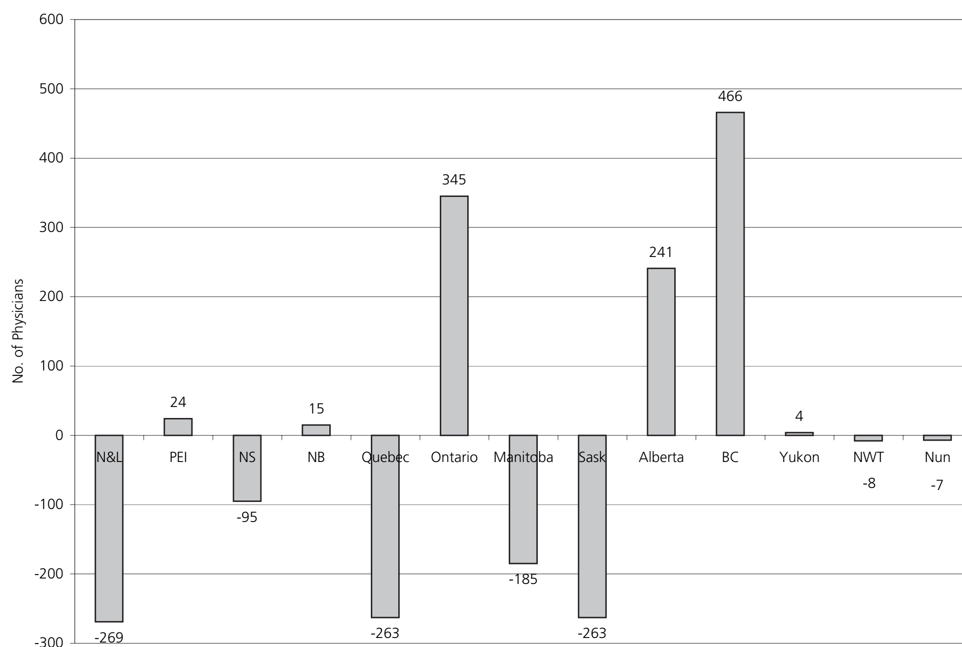



*Figure 12: International Medical Graduates as a % of Total MD Workforce, 2003*

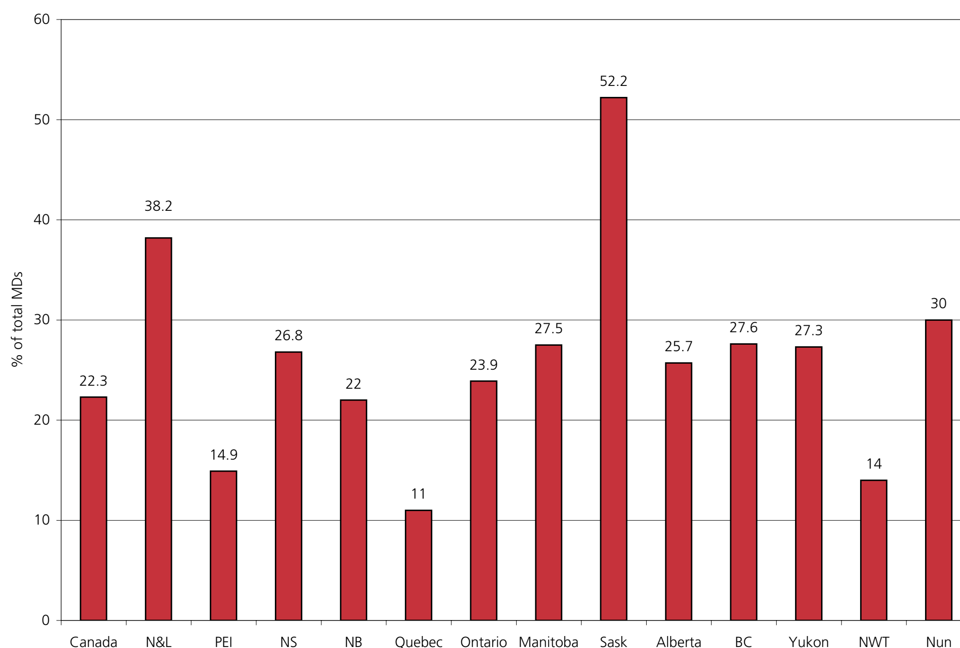


*Table 1: Regulation of Midwifery, 2005*

| | Regulatory Status |
|---|---|
| British Columbia | Regulation in effect. |
| Alberta | Regulation in effect. |
| Saskatchewan | Act passed but not proclaimed. |
| Manitoba | Regulation in effect. |
| Ontario | Regulation in effect. |
| Quebec | Regulation in effect. |
| New Brunswick | Not regulated. |
| Nova Scotia | Not regulated. |
| Prince Edward Island | Not regulated. |
| Newfoundland & Labrador | Existing legislation dating from 1920 is considered inactive and is to be replaced. |
| Northwest Territories | Regulation in effect. |
| Nunavut | Not regulated. |
| Yukon | Not regulated. |

*Figure 13: Changing Participation Rates in Family Medicine Activities, 1993-2001*

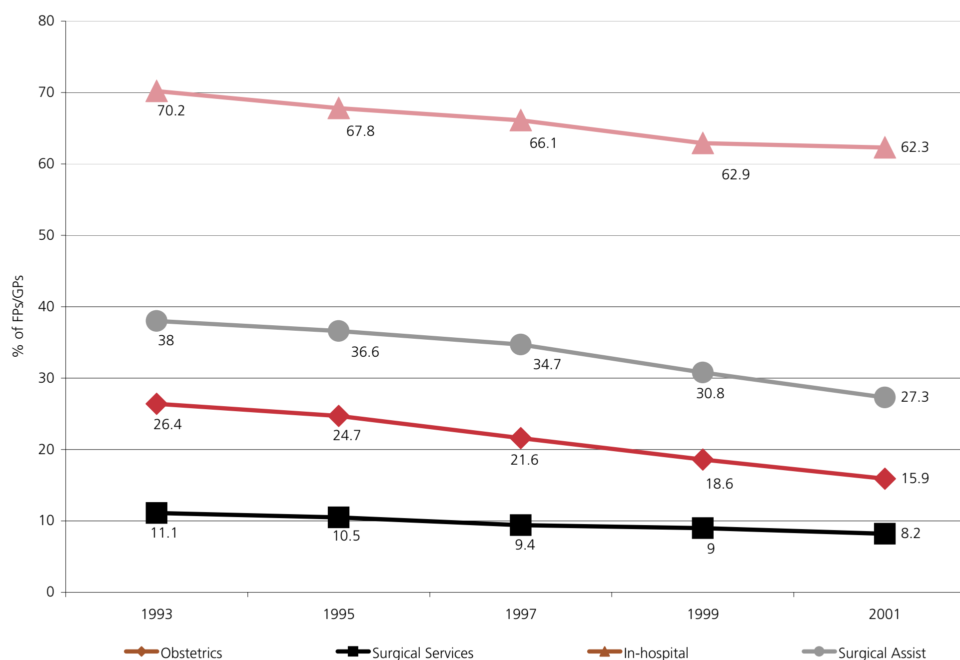


*Figure 14: Choosing Family Medicine, 1994-2005*

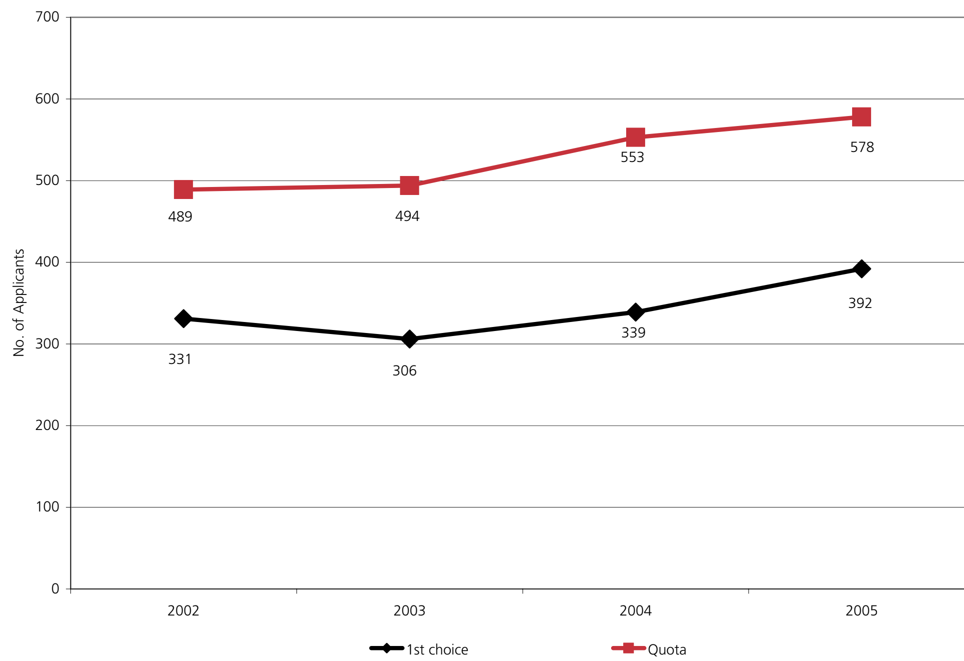
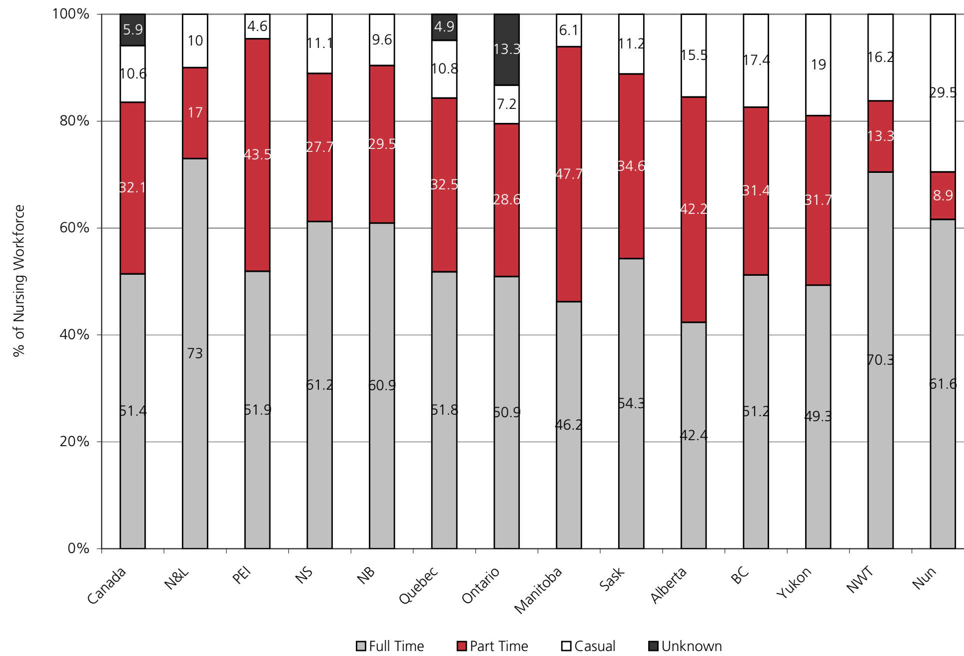



*Table 2: Choosing Physician Specialties, Canada, 2005*

| Specialty | 1st Choice | Quota |
|---|---|---|
| Dermatology | 15 | 6 |
| Diagnostic Radiology | 69 | 49 |
| Emergency Medicine | 59 | 27 |
| General Surgery | 60 | 71 |
| Ophthalmology | 32 | 19 |
| Pediatrics | 98 | 78 |
| Plastic Surgery | 26 | 14 |

*Figure 15: Full-time, Part-time and Casual Work for Nurses, 2003*



## ACCELERATING CHANGE IN HEALTH HUMAN RESOURCES

This section synthesizes what we heard at the summit about how Canada can modernize the management of health human resources. It highlights participants' ideas on strategies for change and showcases examples of innovation. Finally, the Health Council makes recommendations for action by the many stakeholders who hold the keys to progress on health human resources.

Many of the examples of innovation are too recent and small-scale to have been rigorously evaluated. We need such research to understand what works in large systems and what doesn't. But we cannot simply wait for those answers. There are a number of promising models that we encourage the country to consider now.

The summit confirmed our belief that Canada's problems of health human resources will not be solved simply by adding more money. Indeed, governments committed significant new funding to HHR in the 2003 and 2004 accords – an important effort to "buy change," as Romanow advised.[3] But participants told us repeatedly that solutions also require new approaches to planning, a collective commitment to innovation, and smarter use of the people and funding we have now. As representatives from the New Professionals Health Network stated, the people who make our health care system work must have the right supports to do their jobs better and to stay healthy themselves (Box 1).

1

*The New Health Professionals Network (NHPN) represents over 20,000 people training and/or working in nursing, medicine, pharmacy, social work, occupational therapy or physiotherapy. Michael Garreau, NHPN co-chair and president of the Canadian Nursing Students' Association, told the summit:*

"We truly believe that patient care must be improved by strengthening Medicare. That means a national commitment to [among other mechanisms] ... comprehensive health human resource strategies. ... New health professionals are up to the task. But we need the funding, resources, payment mechanisms, institutional structures and supports, and planning to make this happen."

The full text of presentations by members of the New Health Professionals Network is available at *www.futurefaceofmedicare.ca*.

In order to make real and lasting progress, we also need to recognize how interdependent are the various aspects of the health care system. For example, a workplace that supports staff training in collaborative practice not only enhances opportunities for new approaches to patient care; such employers may also find that workers are more satisfied, less likely to look for early retirement, and more able to foster the integration of new graduates who have themselves been educated in interprofessional care.

There was a great deal of goodwill evident at the summit, but also a good dose of frustration concerning the slow pace of change. While many of the strategies highlighted here are not new, the day's dialogue clearly spoke to a collective interest in moving forward to address

these critical issues, among many: burnout, shortages and inequitable distribution of care providers, structural barriers to reforming care delivery, and disconnected planning efforts across jurisdictions. All require collaboration among key stakeholders, but active leadership is essential.

In each of our recommendations, we have tried to reflect the discussion at the meeting. Based on current commitments on funding and reform, we have set a number of specific targets which we believe are achievable within the next two to five years. The Health Council acknowledges that substantial efforts are underway toward many of these objectives – yet we challenge governments, professional associations, regulatory bodies, employers, unions, and educators to go further, to work together and to work with us in reporting back to Canadians on their progress. By 2010 we should expect that the HHR landscape will present quite a different picture than it does today.

## Theme 1: Education and Training

In our first annual report to Canadians on health care renewal, the Health Council called for accelerated change in several areas related to education and training. If collaborative practice in interprofessional teams is the vision of the future, then the education and training system for health workers needs to reflect that vision. And if we are to improve service delivery and health status in Aboriginal communities, then we must encourage more Aboriginal Canadians to consider health careers, while integrating knowledge from traditional cultures into health professional education. The 2003 First Ministers' Accord and the 2004 10-Year Plan to Strengthen Health Care committed governments to promote progress in both of these areas. A small number of promising initiatives are underway but more are needed. In addition, the question of whether Canadian jurisdictions should continue to actively recruit internationally-educated professionals, rather than plan to be self-sufficient in preparing our own health care providers, was also examined at the summit.

### Interprofessional education

A recurring theme at the summit was the need to expand on some promising initiatives in interprofessional education to build a workforce skilled in working effectively in health care teams. Such collaborative practice is widely recognized as key to solving many of Canada's health human resource problems. New ways of sharing responsibilities for patient care have huge potential to make our health system more sustainable, more effective, and more responsive to population health needs such as chronic disease prevention and management (Box 2).

2

Interprofessional education is the process of health professions learning together to promote collaboration and in the delivery of health care. It involves developing mutual understanding of and respect for the contributions of various disciplines. Students learn through shared problem-solving and by including patients in decision-making in their health care. Professions involved may include pharmacy, social work, nursing, medicine, and a range of other disciplines such as public health, dentistry, rehabilitation sciences, and health care technology, as well as traditional or native healing.

The Interprofessional Education for Collaborative Patient-Centred Practice Initiative (IECPCP), led by Health Canada, is a major undertaking to nurture this transformation in health care delivery.[4] Funds totaling $19.3 million are supporting two-year projects (running between 2005 – 2008) to promote and demonstrate the benefits of interprofessional education in a wide range of settings and types of care delivery.

Two universities in Canada have established interprofessional programs for health sciences education. Several others are starting programs on a smaller scale or are supporting student-led initiatives (Box 3). Colleges, which educate a significant number of health care providers (including – among many other fields – nursing, medical laboratory and radiation technologists, paramedics, and assistants in gerontology, dental hygiene and medical

information), are also at various stages of implementing interprofessional education models.[5]

The summit highlighted a number of specific strategies to accelerate change in interprofessional education.

*Use funding to stimulate change.*

Significant investments may be required to push innovation in interprofessional education and training. Funds should be dedicated for this purpose – for such things as administrative support and additional training for faculty and mentors. This does not necessarily mean spending more, but instead using money more creatively.

*Cultivate collaboration between ministries of health and education.*

To achieve reform in planning for education in the health professions, ministries of health and education need to collaborate within and across jurisdictions, as well as with academic institutions and regional health planners. Too often, training seats are funded through one ministry (education), while policies and planning for health care delivery are set in another (health). In an example of how governments can reorganize to articulate and meet common goals, Ontario has recently announced the appointment of an assistant deputy minister to lead a new Health Human Resources Strategy Division; he will report jointly to the Ministry of Health and Long-Term Care and the Ministry of Training Colleges and Universities.

*Involve students.*

Students make valuable contributions to their own learning environments as leaders,

3

At Memorial University of Newfoundland (MUN), the Centre for Collaborative Health Professional Education brings together five disciplines (medicine, nursing, pharmacy, social work, and education) to design, deliver and evaluate interprofessional education for future health professionals. Established in 1999, MUN's centre has become an incubator for research on health professional education and the development of competencies on interprofessional teamwork.

On the other side of the country, the College of Health Disciplines at the University of British Columbia (UBC) leads 15 health and human service programs in interprofessional education and research. As well as coordinating opportunities for students to train together intensively across disciplines, the Division of Interprofessional Education administers courses on complex problems such as patient safety, HIV/AIDS, family violence, and palliative care that demand collaboration.

Newer initiatives include Queen's University Interprofessional Patient-Centred Education Direction (QUIPPED). This program will incorporate an interprofessional team approach into its education and training programs for medical, rehab therapy and nursing students.

At George Brown College in Toronto, the Centre for Health Sciences has embarked on an initiative in interprofessional education which will include more than 16 programs in dentistry, gerontology, information management, nursing, hearing, and fitness and lifestyle management.

recruiters, peer mentors, among many other roles. A particular strength of the interprofessional education program at UBC's College of Health Disciplines is the involvement of the Health Sciences Students Association (HSSA, *www.health-sciences.ubc.ca/hssa*). This group, the first of its kind in Canada but now part of a national movement involving students at 20 universities, passionately promotes the program at area high schools and helps to orient first-year students to the philosophy and values of the program. Comprised of students in midwifery, laboratory sciences, rehabilitation therapy, dentistry, medicine, nursing, nutrition, social work, psychology, and other disciplines, this organization represents the great potential for change that can come through thinking and learning through an interprofessional perspective.

*Ensure that academic and clinical training sites are both supportive and supported.*

Complex logistics are one of the major challenges of interprofessional education. Integrated classes and training opportunities need to be scheduled to mesh with multiple curricula. Students may need transportation and/or accommodation support (for training in rural areas, for example). Along with the necessary financial and administrative supports to make these programs work, faculty and community-based clinical mentors may need time and resources to allow them to learn new ways of educating and evaluating students outside the tradition of single disciplines.

*Make sure there are collaborative practice environments where students can train and work.*

4

Toronto Rehab has undertaken a new approach to clinical placements in rehabilitation and complex continuing care. This specialized teaching hospital hired an interprofessional education leader who twice yearly gathers a team of seven to eight students from the faculties of medicine, nursing, social work and rehabilitation sciences at the University of Toronto. For their eight weeks on site, the student teams are placed with a clinical service that has demonstrated exceptional teamwork – so that students see interprofessional care in action and come to understand the roles of other professions. Their training focuses on problem-solving around individual patients – people recovering from stroke, for example – and understanding how each profession contributes to optimal care.

To achieve progress in this area, we need parallel action on training at a number of levels – pre-professional and on-the-job training, for health care providers as well as for their managers. Students need training that prepares them for this new vision of health care; they need mentors experienced in interprofessional team work; and they need workplaces where collaboration is modeled to attract, support and retain them once they graduate. If we are serious about making teamwork a core competency for all health professionals, no one should graduate from a health care education program without experiencing work with an interprofessional team.

Even if formal interprofessional education programs are lacking, employers can play a leadership role in brokering creatively with their academic partners, as experience at the Toronto Rehabilitation Institute has shown (Box 4). Ideally, however, students should receive interprofessional experience through their college or university as well as during clinical placements.

**Recommendation 1: Expand opportunities for interprofessional education and post-graduate collaborative practice.**

*Lead responsibilities:*

- Universities and colleges to design new programs;
- Governments to fund programs;
- Employers and unions to create workplaces supportive of teamwork.

*With current funding from the IECPCP Initiative as a foundation for change, the Council believes that the following objectives are achievable:*

*By 2008:*

a. Each of Canada's university health sciences programs should offer an interprofessional educational program through collaboration among appropriate disciplines to integrate their curricula.
b. Incentives such as tuition subsidies should be available to encourage students and post-graduate trainees to enter interprofessional education programs.
c. A collaborative practice workplace fund should be created to enable primary health care settings to provide high-quality interprofessional care and education (for example, to fund mentorships and logistical support for such costs as transportation in rural areas and information technology).
d. All health professionals – both new graduates and the existing workforce – should be able to access an interprofessional clinical learning experience.

## Flexible education and entry-to-practice programs

Because of the way health professional education is currently structured in Canada, many opportunities to bring new people into the workforce are missed. Students may embark on a multi-year degree but, for any number of reasons, may not complete it as planned, resulting in substantial loss of public and personal investment. In other cases, students may be daunted by the cost or workload of a full educational program, despite a strong interest in a health career.

While maintaining standards for quality of care and public safety, can we reorganize education to capture those students' interests and skills in an appropriate health care position? Can we do better at supporting them to increase their credentials in the future – to help them train for more advanced work?

A tiered pathways approach through modular education and laddered credentialing would provide students the option to graduate into the health care workforce at various stages of training. This strategy has potential to be particularly valuable for Canada's rural and remote areas, where access to services is often limited by a shortage of health care providers. Tiered career options has also been suggested as an important approach to increase the numbers of Aboriginal health professionals, an issue discussed further below.

5

In Nunavut, a 20-year plan for health human resources includes a “closer to home” strategy to help the territory rely less on southern providers and more on Nunavummiut to meet local health services needs. Central to this strategy is a tiered approach to the education of health professionals, using long-distance technology to deliver some of the teaching – to minimize the amount of time students must spend away from home – and a mentorship program designed to support new professionals as they enter and progress in their work. The tiered pathways concept includes:

Tier 1 – Assessment of core competency and access programs (to fill gaps in knowledge).

Tier 2 – Certificate / diploma programs to qualify students for entry-level roles in fields such as maternal care, medical interpretation, dental health, home care, rehabilitation and social work, among others. For example, maternal care workers can support midwives by providing prenatal education about nutrition and newborn care.

Tiers 3 & 4 – Degree programs to qualify nurses, midwives, dentists, pharmacists, physicians, rehabilitation therapists, and others. These programs will be conducted in collaboration with universities in southern Canada, with the vision of creating interprofessional cohorts of Inuit students who will travel and study together.

Tier 5 – Advanced education and experience to develop Inuit leadership in health professional education.

Another goal of this initiative is to ensure that, along with their field of specialty, all health professionals in Nunavut will have good generalist knowledge. Modular training will be mandatory in the following areas:

- Inuit values and culture
- public health
- rehabilitation
- maternal and child health
- mental health – addictions and suicide
- information technology.

Nunavut’s Department of Health and Social Services has embarked on just such a program – a major reform in health professional education in order to address chronic shortages in health human resources by developing a home-grown workforce (Box 5). Colleges and universities in all jurisdictions should investigate how programs can be redesigned and how institutions might collaborate to increase options for students.

**Recommendation 2: Create more interim training and certification steps along pathways to health careers.**

*Lead responsibilities:*

- Universities and colleges to design and implement programs;
- Governments to fund programs;
- Regulatory boards to work in partnership with educational institutions and professional associations to design and accept new credentials;
- Employers and unions to embrace new roles for providers.

*By 2010:*
Existing health science programs in each jurisdiction, in partnership with college-level training institutions, should offer tiered pathways in the health professions.

## Workforce diversity and cultural competency

Despite Canada's commitment to cultural diversity, our health care workforce does not adequately reflect minority groups in our population, a gap which has implications for patient outcomes. Multicultural representation is lacking in some health professions, and there are concerns that rising tuition fees (particularly in medicine) restrict representation by socioeconomic class.[6] The HHR summit focused particularly on the shortage of Aboriginal health professionals – from First Nations, Inuit and Métis communities – and the remainder of this section addresses this issue.

The Royal Commission on Aboriginal Peoples recommended in 1996 that 10,000 Aboriginal health professionals be trained in the next 10 years. As we near the end of that decade, Canada remains very far from achieving this goal and data to track progress are lacking. As Malcolm King (chair of the University of Alberta's Aboriginal Health Care Careers Committee) told the summit, there are at most 200 Aboriginal physicians and about 1,200 Aboriginal nurses practicing, with only a fraction more now in training.[7] Much smaller (and undocumented) are the numbers of Aboriginal dentists, dieticians, pharmacists, social workers, speech therapists, midwives, health administrators and other professions along the spectrum of health care. Simple equity dictates that we do better, but the fact that Aboriginal peoples in Canada are worse off than the general population on almost every measure of health status makes this a particularly urgent issue.

Aboriginal health professionals will enhance health care in a number of ways – whether they work in their own communities or in other settings. They can bring the necessary knowledge of and respect for culture and history to their work. If working in their own communities, they may improve access to care in under-served areas and better enable Aboriginal patients to participate fully in their own care. And they can serve as role models for future professionals and as respected advocates for policies to support the social and economic health of communities.

In addition, we must recognize that, regardless of cultural origin, people in rural and remote communities may have different health care needs compared to urban populations. They also face the added burden of travel with its significant financial and social costs. This is true not only for specialized hospital-based care, but often for services in dental health, rehabilitation, mental health and other aspects of health care which rely on a mix of public and private insurance and out-of-pocket private payment. Despite Canada's increasing urbanization, we must not neglect the factors such as higher unemployment and lower incomes which can contribute to lower health status in rural and remote parts of the country.[8]

The Health Council believes that, in addition to the measures described earlier with respect to interprofessional education, progress to increase the diversity of Canada's health care workforce depends on the following actions:

*Expand efforts to actively encourage Aboriginal students to train in health professions.*

6

Saskatchewan is leading two initiatives to promote mentoring of Aboriginal students in health and science programs. Both are collaborations among the western and northern provinces and territories. One project involves the creation of training materials for mentors and is part of a longer-term endeavor to recruit, retain and support the success of Aboriginal students. The other project is a survey of the jurisdictions to understand current initiatives and gaps in recruitment and retention of Aboriginal health sciences professionals – part of a regional effort to move graduates successfully into the health care workforce and keep them working over time.

Several models exist in Canada – for example, the University of Alberta's Aboriginal Health Careers Program, which will graduate its 37th Aboriginal physician this year. A task group of the Social Accountability Initiative of the Association of Faculties of Medicine of Canada (AFMC) has recently recommended that every medical school adopt a similar program. Other health professions should follow suit. To sustain these programs, we need to motivate students early and ensure the necessary supports are in place for trainees and faculty. One critical long-term approach is for ministries of health and education to invest collaboratively in primary and secondary school education in Aboriginal communities to reduce disparities in school performance, particularly in math and sciences. (Box 6)

Among other things, funding is required to support dedicated mentors and living expense stipends. Currently, there are Aboriginal students ready to enter programs but in some cases no funding to support them.

*Use a "cohort approach" to support students.*

A cohort is a group of students training together – for example, a group of Aboriginal nursing students at the same university. Experience shows that students benefit from learning as part of a group, where they can mentor one another and their numbers can

justify a targeted program. Currently, some universities and colleges have seats in health sciences programs reserved for Aboriginal students but the numbers tend to be too small to create a cohort. Where this is the case, interprofessional cohorts may be a good adaptation of the cohort model. For example, a college or university could work with a remote community to educate a group of students in a range of health professions which the community needs. This approach could not only increase the supply of home-grown health care providers, but also train students collaboratively to give them a solid foundation for future interprofessional practice.

*Work in partnership with Aboriginal and remote communities.*

It is important that communities be involved in designing and implementing programs that will provide them with their future health care providers. Students benefit from maintaining a connection with their cultural community during training, and the community in turn can provide clinical placement opportunities before and after graduation. Adopting an interprofessional cohort approach, described above, is another way to work in partnership with under-served communities. We must recognize, however, that current funding and compensation structures can be an obstacle to this kind of partnership and must be reformed in order for progress to occur.

*Reform curricula. Use competency requirements to stimulate change.*

The summit heard that, at minimum, every medical faculty in Canada should provide cross-cultural education in Aboriginal health practices – to improve care for Aboriginal Canadians and to enhance mainstream medical training. Again, other health professions should also consider following this model. In Alberta's Aboriginal Health Careers Program, teaching about traditional medicine is led largely by the students themselves. This experience deepens students' cultural knowledge, helps them stay connected with Aboriginal elders and other community teachers, and contributes to their role as peer mentors and leaders in the educational environment. To make this kind of learning more than an optional add-on, Canadian colleges and universities – along with accreditation and professional certification bodies – are encouraged to integrate perspectives in indigenous health into their core curricula and competency requirements.

*Collect and publish data on the student population to help track progress over time.*

We do not know how many First Nations, Inuit and Métis students are currently enrolled in all health care education programs or how many Aboriginal Canadians are working in health professions overall. It will not be possible to track progress in this area without better data. Publicly available data should include both the number of students enrolled and the characteristics of supportive programs. Publications ranking college and university programs should assess how well each institution recruits and supports Aboriginal students.

Significant activity is underway to support the growth of an Aboriginal health workforce in Canada. In September 2004, the federal government agreed to invest $700 million over five years to develop and implement a "Blueprint on Aboriginal Health" to improve health services and the health status of Aboriginal people. In this initiative, $100 million is earmarked for

health human resources, and action plans are currently being developed in partnership with Aboriginal leadership such as the Assembly of First Nations. A proposed framework for these plans lays out three key elements which were echoed at the HHR summit:

- increase the number of Aboriginal people in health careers;
- keep health care workers in Aboriginal communities;
- revise current curricula to improve cultural competence in Aboriginal health care for all health professions graduates.

The National Aboriginal Health Organization (NAHO) has undertaken a number of activities related to systemic change and increasing the number of Aboriginal people entering health careers. For example, plans are underway to develop an annual Aboriginal Learning Institute where health professionals, educators, traditional healers, policy makers and others can meet to work together on the many issues related to building an Aboriginal health workforce and integrating knowledge about Aboriginal health in current education programs.

Encouraging also is the presence of professional organizations supporting Aboriginal people in the health professions. For example, Canadian Aboriginal Leadership in Medicine (CALM), whose membership consists of Aboriginal medical students and physicians, holds an annual conference to discuss common issues on health, research and representation in the health sciences. The Aboriginal Nurses Association of Canada (ANAC), founded in 1975, supports the growth of Aboriginal nursing through scholarships, conferences, advocacy and a wide range of resources and initiatives.

### Recommendation 3: Increase the numbers of First Nations, Inuit and Métis professionals in the health workforce.

*The Council believes that the following national goals are achievable in the next three to five years, by building on current activities and funding:*

*Lead responsibilities:*

- Universities and colleges to implement, in partnership with governments as well as with Aboriginal leadership, national organizations, and communities;
- Employers to develop recruitment and retention programs for Aboriginal graduates.

*By 2008:*

a. Colleges and universities should complete an assessment of their internal capacity to support Aboriginal students (e.g. financial support for education and living expenses, and psycho-social supports such as mentoring and peer counseling) and take action to improve insufficient supports.

*By 2010:*

b. Outreach and support programs to encourage Aboriginal students to consider a health professions career should be established.
c. The number of Aboriginal students in health professions programs should rise to at least four per cent of total enrolment (to achieve a minimum of proportional representation).
d. An interprofessional educational cohort program for Aboriginal students in a range of health professions should be established.

## Internationally-educated professionals

Because Canada has not been able to supply all of the people needed to provide health care services across the country, internationally-educated professionals have become an integral part of our health care system. Summit participants questioned whether investments to actively recruit international medical graduates are either ethical or wise. Instead of continuing these practices, participants urged that jurisdictions redirect resources to educate and support health care providers already in Canada.

While greater self-sufficiency is an important national goal, the Health Council recognizes that Canada will not be self-sufficient in the short term and that Canada is a country that welcomes immigrants. International graduates already in Canada and appropriately-trained immigrants who come to Canada of their own volition must be integrated into the health professions. Most importantly, any active recruitment of internationally-educated health professionals must be done ethically – to ensure that Canada is not stripping other countries of practitioners needed there.

Flowing from the 2003 and 2004 health care renewal accords, governments and national organizations are engaged in a number of activities supporting the integration of international graduates. More than $70 million in funding has been earmarked to assist jurisdictions to increase their capacity to assess international graduates. Additional initiatives, supported through funding from Health Canada and other federal departments, include online information and self-evaluation tools for international medical graduates (IMGs) and a national collaboration pursuing common approaches to the evaluation of IMGs across jurisdictions. While these efforts are focused primarily on physicians, a task force is expected to report shortly on issues related to internationally educated nurses, and Human Resources and Skills Development Canada is investigating the situation with respect to other health professions, including pharmacists, occupational and physical therapists, and medical laboratory and radiation technologists.

The Council supports two strong messages from the summit on this subject:

### *Don't use poor planning as a reason for relying on internationally-educated professionals.*

Provincial, regional and national planning efforts must improve to better forecast demand for health care resources and to make the right investments in training and facilitating mobility within Canada.

### *Promote a global accord on health human resources.*

Canada's gain in welcoming international health professionals often amounts to a great loss to their countries of origin. Canada should work with international organizations such as WHO to promote a proposed global accord on health human resources, which would discourage developed countries from poaching professionals trained in developing regions of the world. Under such an accord, developed countries would (a) either commit to achieving self-sufficiency in their supply of health care providers, or (b) make payments to the

countries of origin to compensate them for their loss of investment in training and the potential future impact on the health of their citizens.

**Recommendation 4: Strengthen a national approach to managing the role of international graduates in meeting Canada's health human resource needs.**

*Lead responsibilities:*

- Certification agencies and regulatory bodies to develop assessment processes;
- Governments to fund and to reform regulations as required;
- HHR planning authorities to specify the role of international graduates in future HHR planning;
- Federal government, in partnership with provinces and territories, to jointly develop and implement policies on ethical recruitment.

*By 2008:*

a. Nationally standardized assessment processes should be developed and implemented to enable the integration of international graduates wishing Canadian licensure in regulated professions, and efforts to standardize assessment for those professions with a process already under development should be accelerated.

b. The contribution of internationally-educated health care providers should be clearly articulated in HHR plans.

c. Federal government, in consultation with provincial and territorial governments, should report publicly on progress in collaborating with international health organizations on implementing ways to improve the ethical recruitment of health care professionals.

## Theme 2: Scopes of practice

Scope of practice describes the division of labour within the health care workforce. Working to full scope of practice means that health professionals are able to use their knowledge and abilities as fully as possible. As the Health Council noted in *Health Care Renewal in Canada: Accelerating Change*, changing the who-does-what structure of health care will require changing the way people, money, rules and regulations are organized as well as improving the flow of information. As health service delivery moves into more team-based care, the ways in which providers can best share responsibilities for patients must be better understood. (A background paper exploring the range of definitions of scopes of practice currently in use in Canadian legislation and professional policy statements will be available from the Health Council in December 2005.)

These are considerable challenges and many issues remain contentious. Summit discussion focused on the following strategies to address concerns around scopes of practice and optimize how health care workers are employed.

### Making the best use of our existing workforce

Many of our health professionals are able to perform more complex work than they currently do. This represents a major loss of opportunity – wasted resources, in fact – and the structural and psychological barriers that prevent many professionals from working to their full scope of practice must be overcome. Making the best use of our workforce is critical to keeping the health care system fiscally efficient, effective for patient health, and satisfying to work in.

Tremendous goodwill and creativity are required from employers, employees, unions and regulatory authorities to make this type of change work within collective bargaining and other workplace structures. Perceptions are important. For the public as well as practitioners, optimizing scopes of practice needs to be understood as extensions or enhancements to make care more patient-centred, not as replacements (which can lead to professional turf battles) or as substitution (which patients may see as second class care). Issues of autonomy and hierarchy – who is in charge? – are among the most sensitive and challenging to resolve.

The hurdles to achieving change can be significant: In a recent pilot project in Ontario to increase screening for colorectal cancers, nurses were allowed to conduct a procedure (flexible sigmoidoscopy) formerly only performed by physicians. Despite the safe and effective provision of this screening by nurses, the project was cancelled due to uncertainties about compensation, professional regulation, and liability. A renewed effort is now underway to resolve these issues.[9]

Several provinces have reformed their legislation governing health professions to enable more flexibility in the workplace. Alberta's 1999 *Health Professions Act*, for example, brings 30 self-governing professions under one legislative roof and recognizes that professions

In late 2004, the BC Ambulance Service and the paramedics' union (CUPE Local 837) signed off on an agreement that opens the door for paramedics to work in new environments and take on new challenges. Downtime between dispatch calls, sometimes for hours, had been a fact of life for many ambulance paramedics – unsatisfying for skilled professionals and a poor use of health resources. Both union and management describe the added flexibility as "a culture change" around labour relations and scopes of practice, and the new deal has already propelled several promising initiatives:

*Paramedics working in hospital ERs:* Two hospitals in the Fraser Health region began a trial project earlier this year in which paramedics joined the staff of emergency rooms. During what would normally be long waits with patients until nurses are able to receive them, the paramedics assist with in-hospital transport, triage and treatment, taking some of the burden off over-worked staff and learning new skills as they work alongside hospital emergency care specialists. Results were overwhelmingly positive. With more helping hands, wait times are reduced, ambulance turnaround is faster, and patients get more attention. A few hurdles – such as pay structure – need to be cleared before this new role becomes standard practice, but interest in expanding the program is strong.

*Critical care transport teams:* This new model ratchets up the skill level of ambulance teams to provide better care to critically ill and injured patients sooner. A nurse and paramedic with advanced life support training pair up to stabilize critically ill or injured patients and get them to hospital. The higher-skilled team (supported by a basic paramedic/driver) improves the chances of good patient outcomes and replaces the need for a doctor or another nurse to accompany the patient in transport, which has often left small communities without key health support for hours. The first team, based out of Trail, serves the Kootenay region by air and ground ambulance, and plans are in the works to expand to six more teams.

As well, the agreement calls for a greater role in public education for paramedics – a new program to train 50,000 high school students in CPR each year is an early outcome of this commitment. And discussions are underway for paramedics to assist smaller communities with public health programs such as providing immunizations.

often have overlapping roles. Such legislation is an important tool, but putting the spirit of it into action can prove challenging. Regulatory reform should also consider ways to promote greater use of professionals who focus on wellness rather than acute care. For example, given the link between oral health and general health, there is concern that the health of people in long-term care facilities suffers as a result of restrictive legislation preventing oral health care workers (dental hygienists and assistants) from working without the direction supervision of a dentist.

Informal mechanisms provide another avenue for professional organizations to deal with roadblocks within professions. The Opticians Council of Canada was created in 2000 to

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As a result of regulating both nurse practitioners and clinical assistants (also known as physicians' assistants), Manitoba is uniquely positioned to take advantage of the skills and interests of a wide range of existing health care personnel. Many of Manitoba's clinical assistants are internationally-educated medical graduates; others come to the profession as paramedics or pharmacists. Nurse practitioners, as the name suggests, come from the nursing profession.

The Canadian Nurse Practitioner Initiative, under the leadership of the Canadian Nurses Association with funding from Health Canada, is a significant national effort currently underway to nurture the integration of nurse practitioners in primary health care. The introduction of physicians' assistants may also be worthy of further investigation. In Manitoba, the use of clinical assistants (also known as physicians' assistants) over the past six years is credited with helping to retain local hospital services such as bone marrow transplants, and clinical assistants will soon become on-site primary health care providers in some of the province's remote northern communities. A major obstacle for the growth of clinical assistants remains a shortage of training opportunities within Canada.

Clinical assistants share many roles in common with nurse practitioners, which currently practice under a variety of titles in all jurisdictions.[10] Whether working in hospitals or in community practice settings, both function as part of interprofessional teams in ways that free up physicians to provide supervision and more specialized care – for example, both nurse practitioners and clinical assistants can assess and diagnose patients, prescribe drugs, perform certain procedures, and plan follow-up care. Nurse practitioners typically function with greater autonomy than do clinical assistants, who are required to work under the supervision of a physician (although the physician may supervise from a different location in some circumstances).

provide a forum for educators and provincial/territorial regulators and associations in this profession to work on common concerns. They have built a national consensus on competencies for opticians after unsuccessful attempts to change provincial/territorial regulations to reduce differences in scope-of-practice definitions across jurisdictions – for example, BC and Alberta allow opticians to conduct vision tests but other jurisdictions do not.

To use our existing workforce better, health care employers and employee representatives (such as unions and associations) should review the roles of existing personnel and ask what additional training and supports will enable them to work to optimal scope of practice to meet the needs of their populations. In British Columbia, a new collective agreement between the province-wide ambulance service and the paramedics union is enabling more effective use of the skills of first responders while stimulating a variety of partnerships to meet community health goals – such as increased staffing in hospital emergency rooms and faster access to critical care in remote areas (Box 7). Manitoba is the only province to license

both nurse practitioners and physicians' assistants, although both roles – which draw from different resource pools – improve access to primary health care and support the delivery of specialized care (Box 8).

**Recommendation 5: Enhance opportunities for professionals to work to optimal scope of practice to ensure the system's capacity to meet local patient and population health needs.**

*The Council believes that barriers to making the best use of the health workforce must be addressed and that the following goals can be met in the next three to five years:*

*Lead responsibilities:*

- Governments, regional health authorities, employers, unions, professional associations, educators and regulators.

*By 2008:*

a. Professional associations and health professions regulators should engage with employers and governments to foster better understanding of the uniqueness and commonalities in key health professions.
b. Regional health authorities and other employers should review current workforce roles in existing health care settings to assess where people are working to optimal scope of practice and where, with appropriate supports, the workforce could better meet local patient and population health needs.

*By 2010:*

c. Changes should be implemented in how work is organized to better match skills and scopes of practice to patient/client needs, and progress on these changes should be publicly reported.

## Recognizing the role of payment structures

Financial incentives play a major role in whether health care providers embrace or resist changes in the mix of skills and responsibilities. How people are paid can either support or inhibit innovation.

In particular, strictly fee-for-service compensation is widely viewed as discouraging collaborative care. Practice settings where teams are funded, rather than having the money flow through individuals, are free to organize care to best suit the needs of the populations they serve and to optimize the skill mix of their staff. Community health centres use this model of compensation in many provinces.

On the other hand, funding structures can discourage providers from practicing in under-serviced communities. Health professionals who work largely in the private sector – such as

rehabilitation services – may find working in smaller rural and remote communities financially difficult. Even in publicly-funded care, fee structures can be an obstacle. For example, specialized mental health services may be badly needed in a small First Nations community but not regularly available if the supervising psychiatrist relies on fees-for-service. In addition, when physicians rely primarily on fee-for-service compensation, expanding the role of other professionals in team-based care may be seen as taking away physicians' income.

To remove financial disincentives to interprofessional practice, governments and professional associations should accelerate the shift to alternative, flexible compensation schemes that are based on more than a simple fee-per-visit. Examples include capitation or rostering (payment based on the number of patients in a health care practice) and full or partial salary. In 2004, just over half of all physicians in Canada reported receiving 90 per cent or more of their income on a fee-for-service basis.[11] Yet, experience in the UK and some parts of Canada shows that compensation reform can be the key to unlocking teamwork (Box 9). In Canada, new models of reimbursement – in some cases instituted through use of the intergovernmental Primary Health Care Transition Fund – have provided the opportunity and incentive to increase the time that various members of health care teams spend on health promotion, disease prevention and management of chronic diseases (Box 10).

The growing popularity of alternative payment plans in every jurisdiction is an encouraging trend. In Manitoba, for example, the share of provincial income to

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*Karen Bloor of York University in the UK presented international research on compensation and economic levers for change in health human resources:*

"The resistance to skill mix change in Australia contrasts with the behaviour of British physicians, especially general practitioners, whose income is not directly threatened by the use of other skill groups. There is evidence that nurses can substitute for doctors, particularly in primary care. Indeed, given the UK GP contract, nurses can generate GP income by providing reimbursed services (e.g. immunization, cervical screening, health promotion) as substitutes for doctors."

10

In Ontario, with the goal of improving access to comprehensive primary health care, family practice physicians have been encouraged to shift to group practice structures through a variety of alternative payment schemes. These schemes reward the achievement of targets for health promotion and disease prevention or the use of certain procedures in chronic disease management. Since 2001, physicians within Family Health Networks, for example, have been compensated according to a blended funding formula including capitation (per-patient) payments based on the age and sex of the physician's rostered patient population, partial payment for fee-for-service claims, bonuses for the achievement of practice benchmarks (such as proportion of patients receiving recommended immunizations), and premiums for the provision of targeted services such as palliative care and obstetrics. More recently, physicians within Family Health Teams are similarly paid.

physicians through alternative payment plans soared from five per cent in 1995-1996 to close to 35 per cent in 2001-2002; in Nova Scotia, this income shift more than tripled.[12] Jurisdictions should build on this trend by implementing a range of flexible compensation schemes for physicians – a critical step in meeting national goals on primary health care reform. The 2003 Accord commits jurisdictions to ensure that, by 2011, at least half of their residents will have access to an appropriate primary health care provider 24 hours a day, seven days a week and that residents will routinely receive needed health care through an interprofessional team.

**Recommendation 6: Accelerate the shift to provider payment schemes that stimulate interprofessional teamwork.**

*To meet commitments on primary health care reform:*

*Lead responsibilities:*

- Governments, professional associations and employers.

*By 2008:*

Alternate methods of compensation should be promoted so that the proportion of publicly-funded providers paid through flexible alternative schemes has increased by least 20 per cent.

## Liability and accountability concerns

Summit participants heard that concerns about liability may inhibit team practice with shared responsibilities. There is a perception that the shift to more collaborative practice may leave individuals vulnerable to disciplinary or legal action on the basis of team decisions. Privacy concerns are also sometimes viewed as a barrier to implementation of collaborative care – that is, are safeguards in place to protect personal information when patient records are shared among a team of providers? Whether these barriers are real or only perceived, participants urged that strategies to resolve these issues be developed.

A major challenge is the fact that our regulatory and malpractice insurance traditions focus on individual responsibility; we do not have experience with structures that hold a team accountable for health care decisions. In the event of a lawsuit, judges may and do apportion liability to individual providers on the basis of their roles in teams. A recent joint communication from two of Canada's major liability protection organizations for health professions – the Canadian Medical Protective Association and the Canadian Nurses Protective Society – underscores the point that liability is individually-based.[13] To further complicate the issues, other health professionals purchase liability protection from private sources, or they may carry no coverage at all since liability protection is not mandatory for all professions in all provinces and territories.

Moving from individually-based to team-based care depends on trust and a shared understanding of each team member's role in patient care. When nurse practitioner training and licensure were introduced in Newfoundland and Labrador in the late 1990s, planners anticipated challenges about liability. However, these fears were overcome through committed leadership and vigorous discussion. Getting everyone in the same room to listen and be heard helped to build a common understanding and enough goodwill to move forward. Joan Marie Aylward, Newfoundland's Minister of Health during these reforms, told the summit that having "the right people with the right philosophy" was the key to resolving concerns about this change. Reforming regulatory structures – an essential step in clarifying legislated scopes of practice – may be challenging, but recent experience in Quebec demonstrates that it can be done (Box 11).

11

In Quebec, new regulations[14] redefine scopes of practice for health care professionals under the leadership of the Conseil interprofessionnel du Québec. David Levine, president and CEO of the Montreal Regional Health Authority, described the new definitions as "greyer but clearer" – that is, they acknowledge overlaps in scopes of practice but provide the flexibility to support a more interprofessional approach.

Essential in enabling these reforms is a new deal in labour relations. Another Quebec law[15] consolidated dozens of health care unions into just four units – nurses, professionals (e.g. social workers, physiotherapists), non-professionals (e.g. maintenance staff), and administrative staff. This significantly simplifies labour relations within each institution – for example, the McGill University Health Centre previously had more than 60 negotiation units; there are now four.

Taken together, these two regulatory changes appear to be powerful tools for re-engineering work and countering problems of staffing shortages. Although they are still too new to demonstrate measurable outcomes, Mr. Levine stressed the importance of building a labour relations climate that supports changes in scopes of practice.

The summit discussions highlighted the need to clarify the current realities of professional liability protection and what remains to be done to resolve concerns. Ambiguities remain as to whether current insurance schemes are truly a barrier to collaborative practice or only perceived to be so. In either case, accountability issues must be addressed so that concerns about liability do not inhibit progress in health care renewal. Summit participants suggested a national initiative to bring people together to clarify the issues and share experience in resolving them. Are new ways of providing liability protection and accountability needed, or can the issues be resolved through helping health care providers and managers build more trust in the workplace? Do we need legal reforms to introduce alternative ways of resolving medical malpractice suits, such as a no-fault system of insurance?

Among current activities in this area, a coalition of 11 health professional associations (The Enhancing Interdisciplinary Collaboration in Primary Health Care Initiative, or EICP) has

studied liability issues with respect to collaborative practice. In their Principles and Framework document (September 2005),[16] EICP notes the need for the following approaches to ensuring that liability concerns do not compromise team care:

- an integrated approach to liability insurance that links the various systems now in place and recognizes shared decision-making in ways that are consistent with patient safety and risk management;
- clear legislated scopes of practice;
- an education program on collaborative health practice for those working in the judicial and legal system.

### Recommendation 7: Resolve concerns about liability in collaborative practice.

*Lead responsibilities:*

- Professional liability protection organizations in collaboration with governments, regulators, and patient safety organizations.

*By 2007:*

a. A common understanding of liability issues in collaborative practice and what remains to be done to resolve them should be publicly reported.

*By 2008:*

b. An integrated approach to professional liability and accountability consistent with patient safety, risk management, and teamwork should be collaboratively developed.

Collaborative practice could also be strengthened by emphasizing the common risk factors for many chronic diseases in our approaches to health care and health promotion. Poor diet, tobacco and alcohol use can contribute to diabetes, cardiovascular disease, cancers, and oral health problems, for example. An important way to move towards this common understanding is to ensure that interprofessional education programs emphasize health protection and the common causes for many health concerns.

## Theme 3: Workplace practices

Health care workers need healthy workplaces, yet the common cry in Canada is that we have too few people working too hard. Staffing shortages and workload problems have led to stress, burnout, and early retirement. The resulting impact on the health of the workforce and the loss of experience and training investment represent a massive and unnecessary burden on our health care system. Progress on health human resources depends on how well we address these issues. Smarter planning and education strategies are key, and these are discussed under other themes in this report. In addition, summit participants highlighted a number of workplace-specific approaches.

### Investing in people: financial and non-financial incentives

Many kinds of non-monetary supports to employees can contribute to a better quality of work life. Simple supports such as flex time and other innovative scheduling can make a big difference in lowering stress and improving work-life balance. As workplaces plan for and assess change, involving employees at all levels – front-line care providers and volunteers, as well as support staff and managers – demonstrates that everyone in the workplace is valued and contributes to the pool of ideas for innovation. In implementing change, it is important to pay attention to details such as acknowledging that change can cause a sense of loss.

Summit participants described a number of ideas and current investments in workplace health and job satisfaction that promise to translate into greater quality of patient care.

12

The Skills Enhancement for Health Surveillance Program is a continuing education initiative of the Public Health Agency of Canada for front-line public health professionals. The program provides web-based access to continuing education in epidemiology, surveillance and information management.

Four of the 14 modules planned are currently available, each requiring 25 to 30 hours of contact time. Students are arranged in teams of 8 to10 and each team works with a trained facilitator, either a public health professional or an academic. Teams may be dispersed across Canada, or a single workplace can form a team and possibly find its own facilitator.

Modules are developed by a 10-member consortium of universities and revised for adult distance education by a team of experts from Memorial University. In addition, a group of universities in Australia is collaborating to produce an Australian version and to share future development of modules. There are no fees.

Students receive a certificate for modules completed and more formal recognition of the program is building. Lakehead University offers partial credit for modules to students enrolled in their Master's of Public Health program; community medicine specialists can earn professional development credits from the Royal College of Physicians and Surgeons; and the Alberta Dental Hygienists Association grants 15 credits to members specifically for the epidemiology modules. The Public Health Agency is exploring recognition from other universities and professional associations. In addition, the program is formally endorsed by the Canadian Institute of Public Health Inspectors and the Canadian Public Health Association.

*Make professional development a regular part of budget planning and provide time for staff to enhance their training.*

Continual learning is a key tool for retention and should be an integral part of planning for the changing demands of health care delivery. Distance education through technology provides opportunities for greater access to enhanced training, particularly for people working in rural and remote areas (Box 12). In under-served communities, supporting local residents to enter and progress in a health care profession may be the best investment to build sustainable services.

*Provide time for people to take on new roles.*

When experienced health care providers move from full-time practice into mentoring new graduates, this shift requires a significant investment in time. Without appropriate supports, integrating new team members can be a drain on productivity and a source of stress for both new entrants and experienced staff. Nursing is one profession that has introduced innovations to address these issues.

For example, in Alberta's Capital Health region hiring a new nursing graduate creates an additional position for the first year, over and above the current staffing allocation. The program is designed to improve job satisfaction for older nurses and increase retention of new nurses. By spreading the workload, this arrangement has been successful in keeping new nurses on the job. Of more than 400 new graduates placed in this role over the past four years, over 90 per cent have remained employed in Capital Health beyond the first two years. The program operates throughout the Edmonton health region – in home care, community health settings and acute care hospitals, with particular attention to high-turnover areas such as emergency departments and intensive care units. The Montreal Regional Health Authority has undertaken a similar program to support newly qualified nurses, a decision which CEO David Levine called "one of our best investments." Yukon is also exploring the costs and benefits of adopting this model.

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The Regina-Qu'Appelle Health Region is evaluating the 80-20 model for nurse staffing in hospitals. The project, a collaboration with the Saskatchewan Union of Nurses and following similar research by the University Health Network in Toronto, frees up nurses to spend 20 per cent of their time on learning new skills and training others. The research will examine the impact of this model on workplace issues such as overtime, sick leave and turnover, and on quality of care issues such as medication error and patient satisfaction. In Ontario, the 80-20 model is being introduced province-wide as an option for nurses aged 55 and older, as part of efforts to reduce early retirement. Alberta's Capital Health is also exploring this idea through a proposed "expert nurse mentor program."

The 80-20 model is a related idea that appears to be gaining momentum through experimentation and evaluation. In this model, front-line nurses have 20 per cent of their clinical time freed from their regular working day to focus on teaching, research, or on-the-job mentoring (Box 13). A reduced patient load provides some relief from the physical

demands of nursing, and the mentoring role recognizes their knowledge and expertise. The hope is that older nurses will continue to find their careers satisfying and will be less likely to take early retirement or leave the profession.

*Invest in prevention.*

Innovation to protect the health and safety of health care employees can reduce stress and be cost-effective. For example, British Columbia and Ontario have purchased new hospital beds and patient lifts designed to prevent back injuries among hospital and nursing home staff. These are large investments, but they are expected to pay for themselves through long-term savings in reduced sick leave and disability compensation. Evaluation research is underway to confirm these benefits. Along with infrastructure investments, programs to build a culture of safety within workplaces may be required to ensure that the use of protective equipment becomes routine.

*Create flexible work options and remove financial disincentives to encourage the right mix of people, and to recruit and retain workers.*

Compensation and benefits are fundamental strategies to recruit and retain workers. For example, offering equivalent benefits to part-time providers not only supports people who prefer to work part-time, but may also help to prevent early retirement (Box 14). Flexible work options are needed to recognize the impact of aging on workers' capacity to carry out their demanding tasks on a full-time basis. At the same time, the expansion of full-time opportunities may be necessary to reduce staff shortages and prevent burnout.

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In New Brunswick, union contracts allow for phased-in retirement and also give full benefits for part-time and casual nurses. At age 55, nurses can opt for part-time work, keep their benefits, and begin to collect a pension. This has the double benefit of opening up places for new graduates, while retaining the skills and mentorship of experienced nurses.

*Translate innovations from one profession to others.*

Throughout the day, summit participants called for greater sharing of knowledge about what works in health human resources. This call was particularly strong with respect to workplace practice issues where, not surprisingly, most of the research and innovation comes from nursing. Nurses are the largest health care professional group in Canada, making up more than one-third of the health care workforce, and nursing shortages have created huge pressures on the system in recent years.

Opportunities may exist to translate innovations in nursing workplace practices to other types of care providers. The 80-20 staffing model, for example, could be considered as a way to integrate more workplace training and mentoring into the practice setting for a wide range of health care providers. The Quality Work Life, Quality Care Collaborative – a joint project of the Canadian Council on Health Services Accreditation (CCHSA), the Office of

Nursing Policy at Health Canada, and others – is developing ways to promote and recognize healthy workplaces in the health sector.

More public reporting of measurable results from healthy workplace initiatives is needed – both to increase transparency and accountability and to share information on successes and barriers. A new source of information and ideas is the forthcoming website from the Canadian Health Services Research Foundation (CHSRF) which will provide a compendium of initiatives in health workplace management. Plans for this web resource, expected to be active within the next year, emerged from a knowledge exchange workshop in June, 2005, organized by CHSRF, CCHSA, and Health Canada's Office of Nursing Policy.

### Recommendation 8: Invest in financial and non-financial incentives to improve recruitment and retention, and report publicly on the progress of healthy workplace initiatives.

*Lead responsibilities:*

- Health care employers.

*By 2008:*

a. Employers - in collaboration with researchers, professional associations and unions - should use comparable indicators on workplace health to publish annual assessments in such areas as employee retention and satisfaction and other aspects of work life quality.
b. Through public reporting on indicators of workplace health, employers should regularly demonstrate improvements in the quality of work life in health care settings.
c. Employers should increase by 10 per cent above current levels the time staff spend attending professional development opportunities and providing career mentoring and coaching.

## Theme 4: Planning

There is strong agreement that Canada needs better, more collaborative planning in health human resources. This was a theme that cut across all discussion at the summit. Planning must get out of the silos of single professions, single institutions, and single provinces or territories. With a few encouraging exceptions, planning has relied on forecasting based on data from the past. Instead, planning should be viewed as a tool for shaping the future. However, the data and analyses required to forecast future needs – and to take into consideration the role of market forces and various delivery models – have largely been lacking.

Some jurisdictions have heeded this call and have come together to plan on a regional basis. The summit highlighted ideas and innovations related to these key messages:

### *Plan on the basis of population health needs.*

Planning should start by asking what health services people need and what is the best way to delivery them. Do we have the right mix of providers in the right places to keep patients close to home and reduce the burden of costly transportation and hospital care? How can we do a better job of addressing the unmet needs of remote, rural and under-serviced urban communities? Is the cost of non-treatment greater than the cost of treatment? In many cases, the data needed to answer such questions are not available. The field of dental health illustrates these issues (Box 15).

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Presently in Nunavut, more than 750 children must be transported south for dental surgery each year, at a publicly-funded cost of more than $1 million annually. It is anticipated that the need for these surgeries can be reduced through better targeted prevention and health promotion. Health Canada, working with Nunavut, is focusing a new fluoride/sealant initiative to prevent dental decay in very young children. Nationally, to appropriately target oral health promotion and prevention activities, a new study led by the Chief Dental Officer, Dr. Peter Cooney, will begin to collect national data on the oral health status and needs of all Canadians.

Summit participants stressed the need to invest more heavily in health promotion and chronic disease management. To make our health care system sustainable, we must do a better job of keeping people well. Some regional health authorities are attempting to shift funding to support public health goals, instead of allocating resources primarily in terms of health care service delivery. For example, the Montreal Regional Health Authority – with an annual budget of $5 billion and 84,000 employees – is moving towards population-based funding of its 12 local health networks and away from the traditional model of funding based on patient volumes. This will allow the region to put more resources towards addressing disparities in health status in its population – for example, teen pregnancy. Among girls under age 17 within Montreal's local health networks, pregnancy rates now range from as low as 16 per 1,000 teens to as high as 42 per 1,000.

There are huge implications for the health workforce as more jurisdictions make this shift. Health promotion and chronic disease management require a different deployment of people and skills compared to the health system's current focus on acute care. Our changing goals for public health and health care need to be considered in forecasts for education and recruitment now, in order to ensure we have the right workforce in the near future. The public health workforce is particularly diverse – consisting of physicians, nurses, inspectors, and health promotion and behaviour change specialist, among others – and demand for public health professionals and scientists is expected to increase. Yet a shortfall in advanced training opportunities in public health, particularly for physicians, has left jobs unfilled. A number of initiatives are underway to address these gaps – for example, the Public Health Agency of Canada is leading consultations with universities which operate or are considering a master's in public health (MPH) program; federal funding for scholarships, grants and training positions in public health increased in the 2004 budget; and a number of government and non-government agencies are collaborating to develop a pan-Canadian strategy on the public health workforce.

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For Canada overall, hospital and medical costs to treat dental disorders are second only to the costs of treating cardiovascular disease (1998 data),[17] and people with incomes less than $20,000 a year are half as likely to see a dentist compared to people who earn over $50,000.[18] This suggests that lower-income Canadians may be at greater risk for dental health problems requiring medical attention. However, only six per cent of dental care is funded through public insurance (1999 data).[19]

Addressing the underlying causes of health problems will require working outside the health care system. How people use health services differs among individuals and groups within Canada – whether they use preventive services, at what stage of illness they decide to access services, and what influences these decisions. Again, issues in dental health provide an illustration (Box 16).

*Expand on promising regional planning activities.*

Regional planning efforts in Canada have seen significant progress in recent years. In the east and the west, new organizations have emerged through the joint efforts of ministries of health and education to explore opportunities for coordinated planning and other collaborative initiatives.

Interprovincial collaboration in the Atlantic provinces is conducted through the Atlantic Health Human Resources Association (AHHRA), a non-profit organization created by the governments of New Brunswick, Nova Scotia, Prince Edward Island, and Newfoundland and Labrador to develop a regional planning framework. Through pooled federal and provincial funds, a regional planning study now underway will review training requirements for 30 provider groups and assess the capacity of health and education programs in Atlantic Canada to ensure an appropriate supply of professionals under a range of simulated conditions.

The Western and Northern Human Resources Planning Forum represents one-third of Canada's population – British Columbia, Alberta, Saskatchewan, Manitoba, Yukon, Nunavut,

and the Northwest Territories. In addition to joint strategic planning on health human resources, members of this forum demonstrate active support for capacity building among all jurisdictions, large or small. More than 20 collaborative projects, with funding from Health Canada, are underway or planned (Box 17).

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The Western and Northern HHR Planning Forum is actively moving ideas and experience from one member jurisdiction to another. A number of projects by forum members are described elsewhere in this report. Other current projects include:

- development of common core competences for licensed practical nurses (LPN), building on work accomplished in Alberta;
- a national conference on physician compensation, led by British Columbia;
- assessment of provincial/territorial capacity to measure healthy workplace indicators (such as turnover, autonomy, and workplace culture), led by Yukon;
- knowledge exchange with regional health authorities on best practices for increasing Aboriginal participation in the health sector, led by Manitoba.

These collaborations translate into a rich source of shared data, innovation, and influence – extending the reach of success stories and accelerating the pace of change. They have found that sustained engagement, trust, open communication, and a commitment to non-partisan operation has helped to overcome the inevitable barriers to progress in this complex arena.

There is increasing recognition that planning for health human resources must become a truly collaborative process. Our structures for service delivery and funding, professional regulation, and training are too complex for planning to be effectively carried out by any one government or any single discipline in isolation. Planning should be done through the lens of interprofessional care – because a decision about one service or geographic area will affect multiple services and neighbouring regions.

The summit discussions called for planning to take place at a number of levels – leaving details to the local level (where most service delivery takes place), but building common approaches across regions and nationally to support local decision-making. Common regional approaches are needed to address such issues as barriers to mobility, matching education and training opportunities to forecasted supply needs, and using population health goals as a basis for planning. The progress to date in regional collaboration begs the question whether pan-Canadian planning would be best served by an expansion of these regional efforts or by the creation of a non-governmental national agency, an idea raised at the summit.

### *Create and share better forecasting tools.*

Effective planning depends on the ability to analyze imbalances in supply and demand and to predict future needs and trends. In Edmonton, a home-grown forecasting tool now houses 10 years of data and allows Alberta's Capital Health Region to plan to meet requirements for nurses and other professionals through the year 2010 (Box 18).

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Capital Health in Alberta uses a rigorous planning and forecasting model which has allowed the regional authority to align demand for care with an adequate supply of nurses. This has been accomplished through close collaboration with universities and colleges and the provincial government. Among other outcomes, the nursing vacancy rate has declined from nearly eight per cent in 2001 to just 3.5 per cent in 2004, and the average age of nurses in the region has declined from 44 (the national average) to 41 years. This was achieved in part through the training and recruitment of 1,538 new graduates since May 2001.

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An important development is the creation of a conceptual framework designed to stimulate a new kind of analysis and decision-making in health human resources, starting with the health care needs of the population.[20] This framework takes into account the dynamic interplay among factors that are generally considered only in isolation – from money and training capacity, to trends in health care delivery and technology. Researchers in a national initiative, led by the Canadian Institutes for Health Research and the Canadian Institute for Health Information, are using this integrated model to construct the databases necessary to do smarter planning. It will be some time before the complexity of factors which influence the country's health human resource needs can be incorporated into actual planning, but the commitment to ask "what information do we need?" is a progressive step.

A common theme at the summit was the need for better databases – local, regional and national – using common terminology to support comparable indicators. Interprofessional planning will require merging data from a number of sources. For some professions, regulatory authorities or professional associations are the primary source of national data on health human resources (Box 19).

Since significant aspects of our health care services are currently funded through private sources, it is important not to limit planning to publicly-funded services. Forecasting of workforce needs should recognize the interface between publicly-funded services (such as hospital care) and largely private services (such as physiotherapy). Solutions to wait time problems, for example, will depend on a comprehensive consideration of the patient journey and the roles of all types of health care providers involved. If a patient's recovery from joint replacement surgery requires rehabilitation therapy, then the supply and distribution of physical therapists should be an integral part of planning to reduce wait times for joint replacements. Otherwise, as one summit participant noted, patients "will end up back in the wait lines for surgery." However, physical therapy increasingly takes place outside of hospitals and patients pay directly for these services, either out of pocket or through private insurance.

### *Support the growth of management skills in planning and interprofessional care.*

With the growth of regional management of health service delivery across Canada, regional authorities are now the primary health care employers. It is critical that

employers build a management pool skilled in the use of planning tools and able to support the reorganization of work to make the best use of professionals. Montreal's Regional Health Authority assessed leadership potential in more than 600 employees and provided education through an academic program to enhance their abilities to conduct management activities in an integrated network of health care services. The University of Alberta School of Business launched a similar senior leadership mentoring program for health service management in May 2005.

### Recommendation 9: Ensure that HHR planning is based on population health needs, fully integrated across jurisdictions, and properly resourced.

*Lead responsibilities:*

- Federal, provincial and territorial governments in partnership with regional health authorities to improve and report on planning;
- The Canadian College of Health Service Executives to develop competency requirements in interprofessional HHR planning.

*By 2008:*

a. Population health needs should be the building blocks of forecasting tools used by governments and others to plan for health human resource requirements.
b. Federal, provincial, territorial and regional health human resource plans should be integrated.
c. Governments and others should report publicly on their forecasting tools for HHR planning.
d. The growth of management skills in planning should be supported by the requirement for competency in HHR planning in an interprofessional care environment.

## NEXT STEPS

In the 2003 First Ministers' Accord on Health Care Renewal, governments made a commitment to work together to improve the planning and management of health human resources. Substantial funding has flowed to support HHR initiatives, many of which are highlighted in this report. As of this writing, a framework for collaborative pan-Canadian planning on health human resources – developed by the Conference of Deputy Ministers of Health – was scheduled for release in November, and the Health Council looks forward to each jurisdiction's release of its action plans on health human resources by the end of this year, as agreed to in 2004.

The recommendations put forward here point to the need for action in specific areas, and the Health Council urges the responsible stakeholders to begin immediately to meet the timelines presented. We plan to report publicly on interim progress towards these goals as part of our mandate to monitor and report on health system renewal. Human resource issues will also form a major part of the Health Council's second annual report to Canadians on health care renewal, coming in January 2006. We look forward to continued dialogue and progress.

## REFERENCES

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# APPENDIX I:

## Health Care Renewal Accord Commitments on Health Human Resources

### 2003 First Ministers' Accord on Health Care Renewal (excerpts)

The adoption of innovations and the sharing of best practices by health care providers and managers is critical to making health care more efficient and improving its quality. First Ministers commit to accelerate collaborative work on priority issues with respect to patient safety, health human resources, technology assessment, innovation and research, and healthy living. The federal government is committed to providing funding in support of this work.

Building from this, First Ministers direct Health Ministers to work on the following:

*Health Human Resources*

Appropriate planning and management of health human resources is key to ensuring that Canadians have access to the health providers they need, now and in the future. Collaborative strategies are to be undertaken to strengthen the evidence base for national planning, promote interdisciplinary provider education, improve recruitment and retention, and ensure the supply of needed health providers (including nurse practitioners, pharmacists and diagnostic technologists).

### 2004 10-Year Plan to Strengthen Health Care (excerpts)

*Strategic Health Human Resource (HHR) Action Plans*

There is a need to increase supply of health care professionals in Canada, including doctors, nurses, pharmacists and technologists. These shortages are particularly acute in some parts of the country.

As part of efforts to reduce wait times, First Ministers agree to continue and accelerate their work on Health Human Resources action plans and/or initiatives to ensure an adequate supply and appropriate mix of health care professionals. These plans and initiatives will build on current work in the area of health labour relations, interdisciplinary training, investments in post-secondary education, and credentialing of health professionals. Recognizing the important contribution of health care providers in facilitating reforms, First Ministers commit to involving them in their work in this area.

To facilitate better planning and management of HHR, First Ministers acknowledge the need to foster closer collaboration among health, post-secondary education and labour market sectors.

Federal, Provincial and Territorial governments agree to increase the supply of health professionals, based on their assessment of the gaps and to make their action plans public, including targets for the training, recruitment and retention of professionals by December

31, 2005. Federal, Provincial and Territorial governments will make these commitments public and regularly report on progress.

The federal government commits to:

- accelerate and expand the assessment and integration of internationally trained health care graduates for participating governments;
- targeted efforts in support of Aboriginal communities and Official Languages Minority Communities to increase the supply of health care professionals for these communities;
- measures to reduce the financial burden on students in specific health education programs; and
- participate in health human resource planning with interested jurisdictions.

# APPENDIX II:

## Speakers and Workshops

**Michael Decter**
Chair, Health Council of Canada
*Welcome and Context Setting: Why a Summit? Why Now?*

**The Honourable Tim Sale**
Minister of Health, Manitoba
*Opening Remarks*

**Jeanne Besner**
Chair, Health Human Resources Working Group, Health Council of Canada
**Cathy Fooks**
Executive Director, Health Council of Canada
*Current HHR Environment in Canada: Background Information and Solutions*

**Penny Ballem**
Deputy Minister of Health Services, British Columbia
**Nora Kelly**
Deputy Minister, Health and Wellness, New Brunswick
*Presentation from the Conference of Deputy Ministers*

**Elaine Todres**
Facilitator
*Issues and Challenges: Setup for Workshops*

### *Education and Training Issues*

**Lesley Bainbridge**
Coordinator, Division of Interprofessional Education, College of Health Disciplines University of British Columbia

**Aaron Rizzardo**
Vice-President, Internal Affairs, Health Sciences Student Association
University of British Columbia

**Vernon Curran**
Co-Director, Centre for Collaborative Health Professional Education,
Faculty of Medicine, Memorial University of Newfoundland
*Collaborating for Education and Practice: An Interprofessional Education Strategy for Newfoundland and Labrador*

## *Scopes of Practice Issues*

**Mark Dobrow**
Scientist, Cancer Quality Council of Ontario
Lecturer, Department of Health Policy, University of Toronto
*Scope of Practice Issues for Nurse Endoscopists*

**Joan Marie Aylward**
Former Minister of Health, Minister of Finance and President of Treasury Board
Newfoundland and Labrador
*Scopes of Practice Issues: A Multidisciplinary Approach*

## *Workplace / Practice Issues*

**Shirlee Sharkey**
President & CEO
St. Elizabeth's Health Care, Ontario

**Linda Silas**
President, Canadian Federation of Nurses Unions
*Working Healthy: Innovation in the Healthcare Workplace*

## *Special Focus on Aboriginal HHR*

**Cornelia Wieman**
Centre for Indigenous Health
University of Toronto
*Aboriginal Health Human Resources*

**Malcolm King**
Professor, Department of Medicine
University of Alberta
*On Training Aboriginal Health Professionals in Canada*

## *Health Human Resources Planning at a Regional Level*

**Peter Vaughan**
Chief HHR Officer
Department of Health, Nova Scotia
*HHR Planning at a Regional Level*

**Peter Gibson**
Executive Officer
Western & Northern HHR Planning Forum, British Columbia Health
*Collaboration in HHR Planning – An Effective Partnership Experience from the Western & Northern HHR Planning Forum*

## *International Perspectives*

**Karen Bloor**
Senior Research Fellow, Department of Health Sciences
York University, United Kingdom
*International Perspectives on Health Human Resources*

**Charles Godue**
Chief, Human Resource Development
Pan American Health Organization, Washington

## *Special Focus on Oral Health & Rehabilitation*

**Peter Cooney**
Chief Dental Officer
Health Canada
*Oral Healthcare in Canada*

**Karima Velji**
Vice President, Professional Practice and Chief Nursing Officer
Toronto Rehab Institute

## *Health Human Resources Issues for Regional Health Authorities*

**Wendy Hill**
Chief Operating Officer, Capital Regional Health Authority,
Alberta
*Health Human Resources: Planning for the Future*

**David Levine**
Président-directeur général, Agence de développement de réseaux locaux de services de santé et de services sociaux de Montréal, Quebec
*HR Planning and Allocation in Montreal...old and new challenges for the health and social services network*

## *Presentation by the New Health Professionals Network*

**Danielle Martin**
**Michael Garreau**
**Adam Somers**
**Jessica Diamond**

# APPENDIX III:

## Summit Participants

| Organization | Participant |
|---|---|
| Aboriginal Nurses Association of Canada | Dawn Bruyere<br>Executive Director |
| Academy of Canadian Executive Nurses | Mary Ellen Jeans<br>Secretary General |
| Agence de développement de réseaux locaux de services de santé et de services sociaux de Montréal, Quebec | David Levine<br>Président-directeur général |
| Alberta Health Quality Council | Lorne Tyrell<br>Chair |
| Assembly of First Nations | Valerie Gideon<br>Director of Health & Social Development |
| Canada Health Infoway | Richard Alvarez<br>President & CEO |
| Canadian Alliance of Physiotherapy Regulators | Signe Holstein<br>Executive Director |
| Canadian Association of Advanced Practice Nurses | Sandra Easson-Bruno<br>President |
| Canadian Association of Genetic Counsellors | Christina Honeywell<br>Genetic Counsellor |
| Canadian Association of Interns and Residents | Jerry Maniate<br>President |
| Canadian Association of Medical Radiation Technologists | Richard Lauzon<br>Executive Director |
| Canadian Association of Midwives | Vicki Van Wagner<br>Member |
| Canadian Association of Occupational Therapists | Donna Klaiman<br>Director of Standards and Professional Affairs |
| Canadian Association of Optometrists | Glenn Campbell<br>Executive Director |
| Canadian Association of Schools of Nursing | Patricia Griffin<br>Executive Director |
| Canadian Association of Speech-Language Pathologists & Audiologists | Ondina Love<br>Executive Director |

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|---|---|
| Canadian Chiropractic Association | Graydon Bridge<br>President |
| Canadian College of Health Service Executives | Annette Hewitt<br>Executive Director, Policy and Research |
| Canadian College of Health Service Executives | John Hylton<br>President & CEO |
| Canadian Council on Health Services Accreditation | Wendy Nicklin<br>President & CEO |
| Canadian Dental Assistants Association | Michael Brennan<br>Executive Director |
| Canadian Dental Association | Benoit Soucy<br>Director, Membership and Professional Services |
| Canadian Dental Hygienists Association | Susan Ziebarth<br>Executive Director |
| Canadian Federation of Chiropractic Regulatory Boards | Peter Waite<br>Executive Director |
| Canadian Federation of Medical Students | Sayeh Minoosepehr<br>Past President |
| Canadian Federation of Nurses Unions | Linda Silas<br>President |
| Canadian Health Services Research Foundation | Mylène Dault<br>Senior Program Officer,<br>Management of the Healthcare Workplace |
| Canadian Healthcare Association | Sharon Sholzberg-Gray<br>President & CEO |
| Canadian Institute for Health Information | Louise Ogilvie<br>Director, Health Resources Information |
| Canadian Institutes for Health Research | Christine Fitzgerald<br>Executive Vice-President |
| Canadian Institutes for Health Research,<br>Institute of Health Services and Policy | Morris Barer<br>Scientific Director |
| Canadian Massage Therapist Alliance | Lina Foster<br>Member |
| Canadian Medical Association | William Tholl<br>Secretary General & CEO |
| Canadian Medical Protective Association | John Gray<br>Executive Director & CEO |

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|---|---|
| Canadian Mental Health Association | Penelope Marrett<br>Chief Executive Officer |
| Canadian Nurses Association | Michael Villeneuve<br>Senior Nurse Consultant |
| Canadian Nurses Protective Society | Patricia McLean<br>Executive Director & CEO |
| Canadian Paediatric Society | Ian Wilson<br>Chair, Paediatric Resource Planning Committee |
| Canadian Patient Safety Institute | Carolyn Hoffman<br>Director of Operations, ON to BC |
| Canadian Pharmacists Association | Janet Cooper<br>Senior Director of Professional Affairs |
| Canadian Physiotherapy Association | Pamela Fralick<br>CEO |
| Canadian Practical Nurses Association | Gabrielle Bridle<br>Past President |
| Canadian Psychological Association | John Service<br>Executive Director |
| Canadian Public Health Association | Elinor Wilson<br>CEO |
| Canadian Society for Medical Laboratory Science | Kurt Davis<br>Executive Director |
| Canadian Society of Respiratory Therapists | Douglas Maynard<br>Executive Director |
| Cancer Quality Council of Ontario | Mark Dobrow<br>Scientist |
| Capital Regional Health Authority, Alberta | Wendy Hill<br>Chief Operating Officer |
| Centre for Collaborative Health Professional Education, Faculty of Medicine, Memorial University of Newfoundland | Vernon Curran<br>Co-Director |
| Centre for Indigenous Health, University of Toronto | Cornelia Wieman |
| Chinese Medicine and Acupuncture Association of Canada | Joanne Pritchard-Sobhani<br>English Secretary |
| Chronic Disease Prevention Alliance Canada | Donna Lillie<br>Chair |

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|---|---|
| College of Family Physicians of Canada | Calvin Gutkin<br>Executive Director & CEO |
| Conference Board of Canada | Glen Roberts<br>Director, Health Programs |
| Consortium national de formation en santé | Jocelyne Lalonde<br>Executive Director |
| Council on Post-Secondary Education | Louise Gordon |
| Dalhousie University | Gail Tomblin Murphy<br>Professor |
| Department of Health Care & Epidemiology, University of British Columbia | Lars Apland<br>Project Manager |
| Department of Health Sciences, York University, UK | Karen Bloor<br>Senior Research Fellow |
| Department of Medicine, University of Alberta | Malcolm King<br>Professor |
| Dietitians of Canada | Marsha Sharp<br>CEO |
| Division of Interprofessional Education, College of Health Disciplines, University of British Columbia | Lesley Bainbridge<br>Coordinator |
| Faculty of Nursing, University of Toronto | Linda O'Brien-Pallas<br>Professor and CHSRF/CIHR National Chair, Nursing and Human Resources |
| Federation of Medical Regulatory Authorities of Canada | Fleur-Ange Lefebvre<br>Executive Director & CEO |
| George Brown College | Lorie Shekter-Wolfson Dean, Faculty of Community Services and Health Sciences |
| Government of British Columbia | Penny Ballem<br>Deputy Minister of Health Services |
| Government of British Columbia, British Columbia Health, Western & Northern HHR Planning Forum | Peter Gibson<br>Executive Officer |
| Government of British Columbia, Ministry of Health Services | Craig Knight<br>Assistant Deputy Minister, Strategic Policy, Legislation and Intergovernmental Relations |
| Government of Manitoba | Tim Sale<br>Minister of Health |
| Government of Manitoba, Health Workforce, Manitoba Health | Bev Ann Murray<br>Assistant Deputy Minister |

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|---|---|
| Government of New Brunswick,<br>Department of Health & Wellness | Nora Kelly<br>Deputy Minister |
| Government of New Brunswick,<br>Department of Health, Planning & Medicare Services | Andree Robichaud<br>Assistant Deputy Minister |
| Government of New Brunswick, Health and Wellness | Lyn St. Pierre-Ellis<br>Director, Health Workforce Planning Unit |
| Government of Nova Scotia, Department of Health | Jim Houston<br>Director of Intergovernmental Affairs |
| Government of Nova Scotia, Department of Health | Peter Vaughan<br>Chief HHR Officer |
| Government of Ontario, Ministry of Health | Diane McArthur<br>Director, HHR Strategy Division |
| Government of Ontario, Ministry of Training,<br>Colleges and Universities | Shamira Madhany<br>Director, Colleges Branch |
| Government of Prince Edward Island,<br>Department of Health and Social Services | Susan Mackenzie<br>Director of Corporate Services |
| Government of Saskatchewan,<br>Department of Learning | Kevin Veitenheimer<br>Director, University Services Branch |
| Government of Saskatchewan, Saskatchewan Health | Bonnie Blakley<br>Executive Director, Health Human Resources |
| Government of Saskatchewan, Saskatchewan Health | Mike Shaw<br>Associate Deputy Minister |
| Government of Yukon | John Greschner<br>Deputy Minister of Health & Social Services |
| Health Canada | Peter Cooney<br>Chief Dental Officer |
| Health Canada | Ian Shugart<br>Senior Assistant Deputy Minister,<br>Health Policy Branch |
| Health Canada | Robert Shearer<br>Director, Health Policy Research |
| Health Canada, Office of Nursing Policy | Sandra MacDonald-Rencz<br>Acting Executive Director |
| Human Resource Development, Pan American<br>Health Organization, Washington | Charles Godue<br>Chief |
| Internal Affairs, Health Sciences Student Association<br>University of British Columbia | Aaron Rizzardo<br>Vice-President |

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|---|---|
| Medical Council of Canada | Dale Dauphinee<br>Executive Director |
| Métis National Council | Bruce Barry<br>National Health Director |
| Mood Disorders Society of Canada | Phil Upshall<br>National Executive Director |
| National Aboriginal Health Organization | Bernice Downey<br>Executive Director |
| National Association of Canadian Optician Regulators | Caroline MacIsaac-Power<br>NACOR Member |
| National Association of Pharmacy<br>Regulatory Authorities | Ken Potvin<br>Executive Director |
| National Child and Youth Coalition | Robert Armstrong<br>Chair |
| National Indian & Inuit Community Health<br>Representatives Organization | Debbi Dedam-Montour<br>Executive Director |
| National Union of Public and General Employees (NUPGE)<br>(Canadian Health Professionals Secretariat) | Elisabeth Ballermann<br>Executive Board Member |
| New Health Professionals Network | Adam Somers<br>Co-Chair |
| New Health Professionals Network | Danielle Martin<br>Co-Chair |
| New Health Professionals Network | Jessica Diamond<br>Co-Chair |
| New Health Professionals Network | Michael Garreau<br>Co-Chair |
| Opticians Association of Canada | Cathi Mietkiewicz<br>Chair, Opticians Council of Canada |
| Paramedic Association of Canada | Pierre Poirier<br>Executive Director |
| Policy Consultant | Joan Marie Aylward<br>Former Minister of Health |
| Professional Association of Interns<br>and Residents of Ontario | Adam Natsheh<br>President-Elect |
| Professional Practice and Chief Nursing Officer<br>Toronto Rehab Institute | Karima Velji<br>Vice President |

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|---|---|
| Public Health Agency of Canada | David Mowat<br>Director General,<br>Office of Public Health Practice |
| Regina Qu'Appelle Health Region | Dwight Nelson<br>President & CEO |
| Registered Practical Nurses Association of Ontario | Joanne Young Evans<br>Executive Director |
| Royal College of Physicians and Surgeons of Canada | Michel Brazeau<br>CEO |
| Saskatchewan Health Quality Council | Stewart McMillan<br>Chair |
| St. Elizabeth's Health Care, Ontario | Shirlee Sharkey<br>President & CEO |
| Statistics Canada | Michael Wolfson<br>Assistant Chief Statistician,<br>Analysis and Development |
| Federation of National Specialty Societies of Canada | Blake Woodside<br>Vice-President |
| Victorian Order of Nurses Canada | Judith Shamian<br>President & CEO |
| Health Council of Canada | Jeanne Besner<br>Vice-Chair |
| Health Council of Canada | Ian Bowmer<br>Councillor |
| Health Council of Canada | Michael Decter<br>Chair |
| Health Council of Canada | Jean-Guy Finn<br>Councillor |
| Health Council of Canada | Duncan Fisher<br>Councillor |
| Health Council of Canada | Albert Fogarty<br>Councillor |
| Health Council of Canada | Simone Comeau Geddry<br>Councillor |
| Health Council of Canada | Alex Gillis<br>Councillor |
| Health Council of Canada | Steven Lewis<br>Councillor |

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|---|---|
| Health Council of Canada | Lyn McLeod<br>Councillor |
| Health Council of Canada | Bob Nakagawa<br>Councillor |
| Health Council of Canada | Elizabeth Snider<br>Councillor |
| Health Council of Canada | Verda Petry<br>Councillor |
| Health Council of Canada | Les Vertesi<br>Councillor |
| Health Council of Canada | Tom Ward<br>Special Advisor |

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