

Commission on the
Future of Health Care
in Canada



Commission sur
l'avenir des soins de santé
au Canada

DISCUSSION PAPER NO. 38

Changes and a Few Paradoxes: Some Thoughts on the Health System Personnel

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November 2002

Catalogue No. CP32-79/38-2002E-IN

ISBN 0-662-32972-4

Although the views expressed in the papers are those of the authors, each paper was subjected to an independent peer-review process. The Commission would like to thank the Institute of Health Services and Policy Research (IHSPR), of the Canadian Institute of Health Research, for their oversight and administration of the peer-review process. The work of the authors, the reviewers and IHSPR will serve to make these papers an important contribution to the Commission's work and its legacy.

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Highlights

- Was the change made helped or hindered by management policies and practices?
 - Paradox 1: Need for a vision of the health system, but difficulty of proposing one
 - Paradox 2: Need for change, but low priority given to change
 - Paradox 3: Need for personnel, but lack of consideration for personnel
- Overall, has the planning of human resources in the health sector been a success or a failure?
What changes should be made to human resources planning in the health sector?
 - Paradox 4: Group-based planning, but increased need for mobility and flexibility
- Are policies and practices regulating professional practices up-to-date and in accordance with the goals of the modern health system?
 - Paradox 5: Scope of professional practice and competence
- Are educational programs producing a workforce that is meeting the needs of a changing and increasingly integrated health environment?
 - When should changes be introduced in training: before or after changes have been made?
 - Several changes are still only being talked about.

Executive Summary

The Commission has examined the way in which the nature and quality of personnel management policies and practices have helped or hindered change in the health system by asking one general question and three more specific questions. The answer to the first question examines whether the change made has been helped or hindered by the nature and quality of human resources management policies and practices in the health sector. The examination of this question revealed several paradoxes.

The first paradox is that the vision of the health system has a significant impact on the personnel and, paradoxically, that it is difficult to propose a vision. The current system is a medical care and hospitalization system, where changes aim to subdivide medical practice in order to make it less expensive. A complete redefinition of the health system could result in different roles for professionals and would require a major change in the structure of services offered. When such a decision is made, by taking into account the various viewpoints, more long-term changes will be planned, rather than continuing to divide up tasks in the current curative system.

The second paradox, in response to the change issue, is that even though change seems to be important, it is given low priority, as demonstrated by the lack of concern for certain factors that help or prevent change from being concretely implemented. Among these factors, we will mention three. First, examining the gains and losses, compensating for losses and having incentives to help make decisions when there are losses. Giving priority to change also means monitoring its implementation and, in particular, ensuring support to make the necessary adjustments, experiment with unexpected effects, and readjust accordingly. Finally, it also means focusing on the resistance within structures and integrating structural incentives in order to counter organizational inertia.

A third paradox is that while change is achieved through personnel, it tends to overlook it. Several approaches can be used to demonstrate the importance of personnel. First, viewing it as an asset and taking good care of it, by focusing on the quality of life at work, the career development of professionals, and the quality of services provided. Change must also be based on a more realistic understanding of human beings, which suggests that a change in behaviour is possible if the individual has the intention to change, but only with the necessary resources and factors that facilitate decision-making; even in these circumstances, an individual may reconsider his or her behaviour several times before deciding to take action. This is best described as a five-stage spiral process. Next, emphasizing the importance of participating in decision-making rather than the quality of communication when the decision is conveyed to the personnel, after having been made by managers and politicians. Finally, taking personnel into consideration entails justifying changes in a way that makes sense in light of the goals of adjusting or improving care and services.

This brief overview of planning required the examination of various methods, which in response to the Commission's question did not allow to conclude on either a success or a failure. Rather, it emphasized the paradox between various ways of planning that meet different objectives: training-based planning seems to promote the vision that professionals have of the

health system, whereas the vision that attempts to meet the demand does not have the required data; the vision based on effective practice must come to terms with an ambiguous definition of current tasks, which are often fragmented, leaving patients to deal on their own with various professionals. This aspect highlights the difficulty of conceptualizing planning and the lack of data to carry out an actual planning exercise. Lastly, it emphasizes the inability of current planning methods to make professionals independent. It is a complex activity that has to deal with several paradoxes and does not provide an answer to the fundamental question regarding the best way to organize health personnel.

The question dealing with policies and practices regulating professional practices shows that the professional system is not in question. Despite its limitations, that system seems to protect the public. The paradox raised by this question lies in the desire to preserve the professional structure and, at the same time, introduce the notion of competence, which is somewhat antithetical since it implies narrower professional scopes of practice, in favour of an idealized notion of collaboration and interdependence. However, interdisciplinarity requires a clear definition of roles, functions and the contributions of every individual, as well as a good understanding of the goals of partnership. It requires the juxtaposition, in the same context, of a given professional scope and the notion of competence; although these concepts differ, they are used in the same way in the paradoxical debate. Combining the notion of competence with the notion of scope of professional practice may result in increased flexibility, which nevertheless remains secondary to a definition of the roles and mission of the health system.

The last question concerns training and it is very difficult to offer a conclusive answer, since it raises more questions than it provides specific answers. It first considers when training should introduce changes and briefly examines practical training. It is often suggested that professionals should be better prepared for practice in a variety of clinical environments and that they should be trained on the continuity of care. The questions raised reveal that certain changes that were to be introduced are still more a part of the present debate than a clinical reality.

Introduction

The succession of changes in the health system have had a significant impact on personnel.¹ It seems that neither new investments, new technologies, nor administrative controls have resulted in real progress in making the system more effective and efficient, especially with regard to the public's health. Health system reforms would provide an opportunity to identify the place and role of personnel and introduce changes to it. Implemented changes seem to have considered the financial dimension, i.e. the escalation of health system budgets and the ways to counter it, more so than the primary mission, i.e. services provided, direct care and the personnel to fulfil this mission. Although it is true that personnel represents a significant expense in the health system, it is nevertheless an essential element. The Commission examined the way in which the nature and quality of personnel management policies and practices have helped or hindered change in the health system by asking one general question and three more specific questions.

Several recent reports from specialists in the field of health system personnel have already informed the Commission on the current situation, changes implemented and the main issues involved. The goal is to answer the Commission's questions about changes in the professional workforce by referring to a selected literature to support a personal vision based on years of practice, teaching, research and work as a nurse, and by using paradoxes in order to guide the reflection on personnel management policies and practices. The evidence reveals several findings and paradoxes and it may seem pointless to mention them. However, a careful examination shows that they appear to play a critical role in the present situation. This approach will allow us to better convey what seems essential, and hopefully contribute to the reflection on the topic.

General Question

To what extent was the desired change helped or hindered by the nature and quality of human resources management policies and practices in health, for example, education, laws and regulations, certification, licensure, accountability, etc.?

The answer to this question depends on the prior definition of the term change, which can take on several meanings. Above all, a change is a break, an adjustment and a process; it is not a goal. Should the various alternatives proposed for the current system be described as changes? We have a medical care and hospitalization system, and this has not changed. We have changed the way of doing things and the roles of professionals and interventions, without calling into question the curative orientation of the system. Yet, there is a lot of evidence regarding the limitations of such a system to improve the public's health and, consequently, there are valid reasons for calling the vision of the system into question. Or should change perhaps be reserved for a fundamental questioning of the Canadian health system and the means it is using to improve health, such as those found in Canadian law, i.e. calling into question the medical care and hospitalization system? This study prefers the second alternative, where the desired change first addresses the vision of the health system without challenging the principles underlying the Canadian system, in particular, universality. It is suggested in this report that before examining the changes in personnel, a re-examination of the vision of the health system and its goals would be in order, taking into consideration the means used to achieve those goals, for which the contribution of personnel is essential. This choice implies that, generally, minor modifications within the current system will not be described as changes in this brief study.

Paradox 1: Need for a Vision of the Health System, but Difficulty of Proposing One

Calling the current system into question is particularly difficult to do given the number of actors and competing goals that often succeed in focusing attention on their own interests. The goal of a health system should or must be better health, meeting the expectations of the public and fair contribution to the financing of the health system (Biscoe, 2001). These goals must resolve the conflicts between several objectives, and that is why it is difficult to propose a vision. Among the conflicts, some pertain to society, such as the fair distribution of health care regardless of socio-economic status; others have to do with professionals who wish to preserve clinical autonomy by organizing care in their own way and by receiving compensation that reflects the perception of their own value; and the conflict within the system between the exercise of economic and budgetary control over health costs and the ability of government to finance for years to come (Biscoe, 2001). Moreover, these conflicts are determined by social decisions about the level of resources allocated to health, the organization of services and the financing of health and service programs, as well as the quantity and type of care provided (O'Brien-Pallas, Birch, Baumann and Murphy, 2001). Such a situation should prompt us to carefully examine the ideal perspective in this quest for financial balance and fiscal responsibility. Inevitably, choosing among priorities implies that other objectives are considered less important. The political nature of health organizations, where informal alliances and negotiations over various objectives allow for compromises, may make politicians hesitant to reveal the trade-offs made (Bach, 2001) in order to sustain the operational system.

These elements help to perpetuate the impression of the system's inertia in the turmoil created by a rapid succession of narrowly-focused changes in the short term.

At present, our health system is a medical care and hospitalization system, which already represents a form of compromise. This system favours medical practice as a means to achieve better health for the public, and conflicts are thus channelled into a medical practice subdivision exercise. For example, the proposal to allow nurses to replace doctors, which would be less costly in many cases, would mean dividing up tasks. In such a system, the pursuit of financial balance and fiscal responsibility – a source of conflict between the health system and society – could be addressed by controlling costs. The unsuccessful efforts of recent years in financing should prompt us to re-examine the vision at the heart of the current Canadian system and the conflict between the interests of that system and better health for the public. Furthermore, the current financial situation and the rise in civilization diseases associated with lifestyle further underline the conflicting viewpoints and call for a careful examination of the curative care that medicine provides. Expensive technology that allows more precise diagnoses is not a treatment; thus, it is difficult to improve health in this manner (Fournier, 1999), although this area may be of interest. Investing in a precise diagnosis without available treatment in cases where the problem is incurable perhaps does not constitute a priority investment, except in the area of research and for some of the actors involved. However, this type of expenses will probably not attract attention in the curative context, even though an effort is underway to control costs.

A variety of visions and suggestions to re-direct the health system have emerged in recent years. As many have suggested, a major redefinition of the health system could mean a larger primary care system associated with a reduced hospital system, which would be more efficient and better equipped (Smith and Preker, 2001). The report from Alberta, *A Framework for Reform*, suggests concrete ways to direct the Alberta health system towards health and away from illness. Many studies show the limitations of curative interventions and their sometimes exorbitant costs and limited results in terms of improving the public's health. A change involving a different mix of curative, preventive and promotion interventions provided by the system would undoubtedly have an impact on personnel. For example, attempting to achieve a balance between the two opposed visions of the health system, that is offering curative services and at the same time investing more in the prevention of problems which our knowledge allows us to act on seems difficult. A medical care and hospitalization system presents contradictory curative objectives and promotion/prevention objectives because different professionals usually strive towards these goals and compete with each other for resources.

While it is true that society will not be in a position to finance the growth of the curative medical care and hospitalization system, the mission of the health system will have to be specified accordingly. To date, the health system has not succeeded in proposing a vision that reconciles the objectives and roles of professionals with those of society, as shown by the budgetary debate. The health system and society should have the maturity to debate priorities, make their decisions explicit, and extend the debate beyond financial and medical considerations, which seem to monopolize the majority of current discussions. This debate is crucial to any examination of change in personnel, since it means either several modifications in the fragmentation under medical control, or a redefinition of the links between different professions and, for some, even running the risk of losing their autonomy and influence. Only then will it be

possible to specify the nature of the work assigned to personnel and consider long-term changes, rather than carrying out adjustments, modifications and the division of tasks within the current curative system. This aspect of the paradox underlines the difficulty of making decisions, mainly due to conflicting viewpoints, especially if the disruptions caused are politically difficult.

Paradox 2: Need for Change, but Low Priority Given to Change

This paradox entails reflecting on the fact that there is a constant issue of change, but paradoxically, it seems to be given low priority, as demonstrated by the lack of concern for some of the factors that foster or thwart change. Among these factors, we mention three: the difficulty of talking about change in terms of financial gains and losses for the system, the monitoring of change over a sufficiently long period, and the resistance to changing structures.

A major factor of the political process is the promotion of change that generates greater benefits than costs (Smith and Preker, 2001), suggesting that in any change there are winners and losers (Bach, 2001; Smith and Preker, 2001). An important lesson learned from reform in several countries is that many influential actors believe, rightly or wrongly, that the reform has a detrimental effect on their status, their working conditions and their compensation (Bach, 2001). Thus, resistance to change from personnel is probably based on a desire to avoid losses.

An approach that exposes gains and losses has the advantage of not requiring the approval of everyone as a precondition. Employees are able to compromise and tolerate personal losses, especially if they find answers to the following questions: in the name of what, which principle and what vision? Human beings are often thought of as only seeking to maximize their profits, whereas concrete examples and theoretical models suggest that motives are much more complex (discussed at greater length in Godin). At the same time, it is important to ensure that the costs of change to improve the system are not assumed by individuals (Smith and Preker, 2001), particularly when this involves a career change, relocation, training or losses in compensation or status. Rather than pretending that everyone wins, what is missing in the changes that have been carried out and those which are planned is a recognition of the losses suffered and a justification of them, as well as compensation mechanisms for those losses. Incentives have to allow professionals to focus on service to individuals and the desired changes to undertake, with the understanding that their personal losses will be compensated. Such mechanisms already exist in collective agreements, but there is a tendency to view them from an administrative standpoint as constraints, thus preventing a fair understanding of their role in managing change. Moreover, change may produce savings, and efforts should be made to increase their visibility, which may be limited if these gains are spread among personnel. In short, giving priority to change involves highlighting savings and losses, using incentives to facilitate decisions when there are losses, evaluating existing mechanisms, compensating losses and making savings visible for personnel.

Another aspect that would draw attention to the priority given to change would be monitoring it for a sufficiently long period. In Great Britain, radical attempts to change personnel policies in the early 1990s failed because the Minister of Health did not provide concrete support and did not guide hospitals which were supposed to implement personnel changes. This made the local managers wary, since they believed they were receiving ambiguous messages about the priorities

set by government for personnel reform (Bach, 2001). General policies are thus not enough to specify the priority given to a particular change. This priority is better perceived if it is accompanied by implementation guidelines and, in particular, support to make the necessary adjustments, to experiment with unexpected effects and to readjust accordingly. It should not be assumed that an initiated change will not raise problems until it is fully implemented.

Furthermore, a rapid succession of changes makes their introduction difficult and does not reflect their importance. Thus, giving priority to a change means monitoring the progress of implementation until it has been stabilized and fully integrated into existing procedures before initiating another change. While everyone agrees that changes are necessary and can identify those that are being considered, there is an impression that a low priority is actually given to these changes. Some are even talking about the inertia of administrators and clinicians, referring to them as two silos that operate with different information and make little effort to reconcile their viewpoints. The perception that a low priority is given to change may only be a false impression, resulting from the opposition of stakeholders who are in a position to promote the status quo (Smith and Preker, 2001). In short, the importance of a change will be better perceived if it is carried out in conditions that ensure its implementation.

Change and the priority given to it can be considered from another perspective, that is the resistance of structures. In this category, unions and legislation can be given as examples of institutions created to reduce the scope of change (Smith and Preker, 2001), as well as the health system institution itself, which must maintain stability so individuals who need care and related services can rely on it. More specifically, any change in the organization threatens its stability and, for this reason, structural factors will cause resistance to change.

Quantum change, that is, a complete reorientation, disrupts the existing organizational categories, on which planning depends. Consequently, a change of this nature tends to give rise to resistance or is often ignored (Mintzberg, 1994, p. 187). [Translation]

Integrating structural incentives to counter this organizational inertia would be one way to give priority to change. The paradox between a desired change and a perception of low priority affects the health system's capacity to initiate changes. Priority given to changes would draw attention to the winners and losers, would monitor change over a sufficiently long period, and would take into account structural resistance.

Paradox 3: Need for Personnel, but Lack of Consideration of Personnel

This third paradox reflects the fact that the health system depends on its personnel to fulfill its mission, while at the same time the system seems to consider personnel as a hindrance. Recent literature on this topic includes four key reports from Quebec (Clair, 2001), Ontario (Sinclair, 2000), Alberta (Mazankowski, 2002) and Saskatchewan (Fyke, 2001). The perspective given by these reports of human resources in the health system seems to be based on one key finding: There is a widespread climate of gloom and exhaustion within the health system, which is mainly caused by the work overload of professionals, and, more specifically, by management short-term decisions.

Any change considered within a budget restructuring perspective will necessarily come up against the paradox between the personnel's needs and the decision to cut staff, a significant source of "expenditures", often perceived by employees as a lack of consideration. For example, when governments decrease financing, the health system cuts jobs and requires personnel to be more flexible in order to control budgets. There is no doubt that the Canadian health system relies on the work and competence of its professional staff, of which nursing represents nearly 65% (Statistics Canada, 1997). The performance of the health system therefore depends on the knowledge, skills and motivation of the individuals responsible for providing services (WHO, 2000). Besides these characteristics, recent studies show that the number of professionals involved in providing care and services has a significant impact, especially on the mortality rate. This has been brought to the fore in the case of nurses, on whom the majority of studies have focused (Aiken, Lake and Smith, 1994; Fagin, 2001). Any decision to cut personnel or change their functions may be perceived as challenging their usefulness, thereby contributing to the sense of gloom and exhaustion.

To date, a rapid succession of targeted, short-term changes have taken place. Meanwhile, the expected surplus of personnel has turned into a shortage, in an overall context where numerous other problems need be dealt with. Employees have suffered disruptions, and this has made the health professions less appealing. The idea that the health system is a source of employment offering competitive benefits likely to attract a sufficient workforce must now be abandoned. This loss of appeal has been revealed by a public debate and policies in the field of personnel management, which seemed to focus more on the difficulties following compulsory retirement and job cuts, rather than on planning changes in personnel and on creating pleasant work environments. The overall impression is that physical resources are more important than individuals. It can be said that this is an important element of the current paradox in which "the administration of things is substituted for the management of people." (Enriquez, 1997). According to Koehoorn, Lowe and Schellenberg (2002), senior managers who make decisions to modify personnel are often more concerned about cost-cutting and short-term efficiency than quality of life at work or the effects on patients (WHO, 2000). Managers should obviously be concerned with the management of resources and their use, but they should also give adequate attention to the service offered by the health system and the individuals involved: management includes management of people. Adding financial concerns to personnel concerns may indeed complicate management, since what management is trying to accomplish affects the staff. Losing sight of employees may therefore be another way of adding problems that could have been prevented. Fiscal constraints have led to all kinds of unexpected adjustments in health system personnel, which are apparent in the fact that professionals consider their working conditions difficult, whereas the public perceives a threat to the survival of the health system. We will need to change the thinking of managers and the organizational culture in order to acknowledge and give long-term support to the health sector personnel, rather than carry out changes that do not emphasize the importance given to the staff. The focus on the difficulties of the health system personnel will in turn make it necessary to put forward a new approach to personnel management in order to clearly convey the attention given to employees in implementing changes.

In short, the personnel is the best instrument to facilitate change in the system with maximum effect when it is strategically linked to appropriate management, relevant policies and equivalent financing (Biscoe, 2001). The paradox between the importance and the lack of consideration of

personnel has other dimensions. Considering employees does not simply mean being concerned with salaries and working conditions, since they are not the only things that motivate health professionals. Several strategies are recommended to ensure that the system adequately considers employees, and, in particular, re-evaluates personnel management functions and redefines its mission (Biscoe, 2001).

Other measures may also be considered in order to increase the validity of this paradox, notably recognizing personnel as a strategic asset, adopting a more realistic understanding of human beings, encouraging participation in decision-making and proposing changes that make sense to the professionals, as discussed in the following sections. Taking personnel into consideration means recognizing that the complexity of the health system resides in individuals and not in the structures. In the changes, there is a simplification of that which is complex, i.e. individuals, by reducing them to rational beings that will react to change in a linear way and in the desired manner, based on policies, if they are given accurate information; what is simple, i.e. the structure, is made more complex. Recent models in the field of behavioural change suggest that such a change is possible if the individual has the intention to change, but only with the necessary resources in the environment and factors facilitating decision-making (Godin, forthcoming). In this model, the complexity of the elements involved is emphasized. Godin suggests that the intention is defined by eight variables grouped into three categories, whereas the development of an individual is best described as a spiral process with five stages, taking into account individual and environmental characteristics. In short, changes in organizations should be based on a notion of the individual that goes beyond that of a rational being with predictable behaviour, by taking into account recent knowledge in the area of human behaviour patterning, which introduces a more complex model where the environment plays a vital role.

Taking personnel into consideration entails recognizing it as a strategic asset that is carefully nurtured, being concerned about the quality of life at work, the career development of professionals, and the quality of services provided. According to Smith and Preker (2001), concern should also be shown for the relationship between the individual and the organization (culture, policy and structure). A better consideration of employees and better relationships between them, managers and government would certainly help to develop a shared vision of the importance of personnel, including the importance of managers, who also need to be re-evaluated, as suggested in the Clair Report (2001). Furthermore, while problems are at the heart of the debate, the understanding of what employees accomplish on a daily basis is still not clear. There is thus an urgent need for a clear vision of the health system and the role of its personnel, since without qualified, motivated and committed staff, the State, through the health system, cannot play its role in the current context (Koehoorn, Lowe and Schellenberg, 2002). Leadership needs to be exercised in order to refocus changes on the fact that they are mainly carried out through health system personnel and by considering employees as an asset for the system.

Taking personnel into consideration involves proposing changes that make sense to them and encouraging them to participate to change, based on what was mentioned earlier. Moreover, the resistance of professionals to change is understandable, since the change required is not experienced as a necessity. These professionals are trained to focus on the clinical aspect of a case, whereas changes are justified from a financial perspective, an aspect with which they are generally not familiar and on which they have little information. Moreover, although they have

the necessary information concerning the financial reasons, they are probably not concerned about this aspect; they are more interested in the clinical aspect. For example, they may be asked to be flexible in order to adjust and improve care and service rather than cut expenses, which is often the exclusive concern of managers. Justifying changes in a way that makes sense to the individuals who are being asked to make the changes appears to be quite simple. Associated with other measures, this nevertheless shows consideration for health personnel.

Taking personnel into consideration means allowing them to participate in decision-making (Smith and Preker, 2001). This participation is so critical that decentralization, which increases the role of professionals in the system, seems to be favoured (Bach, 2001) and their increased commitment is expected. Decision-making needs both management and clinical data that personnel holds, which illustrates the importance of participating in decision-making. In the health system, differences in knowledge, values and attitudes between various categories of professionals, between professionals and individuals who need their care and services, and between professionals and the government should be considered when changes must be carried out (Biscoe, 2001). Differences of this nature make it difficult to communicate information in an egalitarian and rational way when participating in decision-making and subsequently developing policies. Taking into account the variety of viewpoints shows consideration for the individuals involved in the change process.

Rather than encouraging participation in decision-making, the focus is often on the quality of communication, even though the decision is conveyed to the staff after it has been made by managers and politicians. A principle often mentioned is the degree of transparency and simplicity of proposed changes, which has a significant impact on implementation (Bach, 2001). From this perspective, a policy will succeed if it can ensure that employees understand what their role is in the overall change. Many believe that this simple communication task has not been executed or has failed, which would explain the lack of success of some changes. This lack of success probably has other explanations. For example, the very principle of transparency in conveying planned changes stems from a simplification of human beings, whereas the resistance to change is directly linked with the degree to which communication is effective (Smith and Preker, 2001). While this position may be valid, it is not a guarantee of success. It is not necessary to simplify personnel's attitude toward change to such a point that a stimuli-response type situation is created, whereby good policy would be well received. Individuals do not change their behaviour based on this type of model, since numerous other factors play a role in encouraging genuine participation in decision-making, with all the efforts that this requires from the personnel, in addition to the efforts already made in providing care and services.

In short, change occurs through personnel, but the strategic importance of personnel in the health system is not generally mentioned in these changes. This paradox is a reminder that changes are carried out by employees that are viewed as an asset, to whom the proposed changes are justified based on reasons related to care and who participate in decision-making, since a more realistic understanding of human beings has been adopted. This paradox appears to play a role in the difficulty of making changes.

Question 1

Overall, has the planning of human resources in health been a success or a failure? What are the main strengths and weaknesses of the current approaches on a national, provincial and territorial scale? What changes should be made to the planning of human resources in the health sector?

Workforce planning aims to balance the number of workers and their location in the organization, that is, the right person at the right place at the right time. To achieve this type of balance, Egger, Lipson and Adams (2000) suggest that there must also be coordination with the health system mission. The very orientation of the system would thus be the fundamental element of personnel planning, as discussed in the first paradox. Until very recently, the growth in professional staff was controlled by training, which adjusted supply to needs. Such a concept was based on the idea that a continuous flow of professionals could be expected. In this context, planning was not necessary and was often not done, since it was thought that planning had little or no connection with health policies and the needs of the public (O'Brien-Pallas et al., 2001).

It is important to remember that surpluses of health professionals were expected following the changes undertaken in the health system (Dussault, Fournier, Zanchetta, K rouac et al., 2001; Mitchell, 1998; Pew Commission, 1995). It now seems obvious that other elements linked with these changes are instead announcing shortages. In this context, planning the number of specialized personnel by controlling admissions in professional programs becomes problematic due to the rather long time it takes to adjust to the needs. Moreover, this type of training requires significant efforts from individuals and creates incentives to preserve the investment already made. Consequently, training prevents rapid fluctuations in the response to demand. In other words, there is an element of irreversibility in planning based on the admission of students in a professional program that must be taken into consideration and which does not seem to reflect the rapid changes that now appear to be required in the health system.

According to Markham and Birch (1997), planning can be done on the basis of three approaches: needs, workforce demand and use. The first approach, planning based on needs, should be carried out using data that cannot currently be obtained, which makes this approach unusable. As regards planning based on workforce demand, it is difficult to carry out because of a discrepancy between the number of professionals reported in government planning documents and the actual number of professionals presently found in the care environment. The main challenge with this type of planning is dealing with clinical and administrative databases that do not provide information on the needs of the health system, the outcomes of the care provided by the staff, or the costs (O'Brien-Pallas, Birch, Baumann and Murphy, 2001). At present, this second form of planning is complicated.

The third form of planning, that based on personnel management use, has yielded satisfactory results in the context of shortage when it has used three types of strategies: more efficient use of available personnel due to better geographic distribution; when applicable, increased use of multi-skilled individuals; and better matching of skills and functions (WHO, 2000). Planning based on management allows effective tasks to be taken into consideration, the division and subdivision of each person's tasks in order to deliver several types of unrelated services, and

their assignment to individuals based on their skills. Planning of this nature raises several questions: Who determines the tasks? Do the tasks primarily serve the needs of the institution and professions and subsequently the needs of the individuals under care? Is the matching of these tasks with the goals of the organization and those of the health system being monitored? These are important questions, since professionals complain that their skills and knowledge are not being fully used. This is a source of waste that has a demoralizing effect on personnel. Furthermore, these questions indicate a concern for quality and continuity of care. In fact, the division of duties leaves patients to deal alone with the continuity between various professionals in the system. It is therefore extremely important to examine the work styles in order to gain a better understanding and to ensure a better match between tasks and needs (Gauthier, 2000).

The preceding paragraph underlines both the distinction and the complementary nature of clinical and organizational aspects of workforce planning. The clinical aspect deals with the work content of professionals and the time required, whereas the administrative aspect deals with the number of individuals, in view of the clinical requirements, and with resources, costs and the organization of services. Planning that does not encompass these two aspects will certainly prove to be problematic. For example, the large number of female doctors has exacerbated shortages because they envision their career differently. The responsibility of professionals within care and interdisciplinary teams is changing and, as a result, new roles are emerging (OIIQ, 2001). Planning should be able to take these changes into account.

In sum, this brief overview of planning, which has examined various methods, does not allow us to conclude on success or failure. Rather, it brings to the fore the paradox between various ways of planning that meet different objectives: planning based on training seems to promote the professional's vision of the health system, whereas planning aimed at meeting demand does not have the required data; planning based on effective practice must come to terms with an ambiguous definition of current tasks, which are often divided, leaving patients to deal alone with various professionals. This brings us to a new paradox.

Paradox 4: Group-based Planning, but Increased Need for Mobility and Flexibility

The preceding section clearly underlined that planning health sector personnel suffers from a lack of conceptualization, that is, numbers are strung together without clearly knowing what they represent in reality. Planning generally done by groups of professionals is often referred to as "silo planning." This type of planning is also based on a hierarchical vision of health personnel, in which one group determines the required number of professionals from other groups. This has several ramifications. First, the focus of the personnel planning analysis tends to be a profession, specifically, doctors and nurses (Bach, 2001), with the medical profession dominating the health system despite the fact that it makes up only about 10% of the total complement of professionals. Such a situation causes fragmentation into sub-occupations and planning that assumes relatively permanent roles for different groups. To all intents and purposes, planning is based on medical needs and the number of doctors. Planning of this type could be effective provided that medicine standardizes its practice, thereby facilitating workforce planning. Considerable efforts are

currently being made in this regard, particularly with the trend toward basing clinical decisions on credible data and practice guidelines.

In the first part of the paradox concerning professional groups, the current difficulties in planning may only be a consequence of the model used, that is, planning based on medical needs and the fragmentation into sub-occupations of other professions in a system that is almost exclusively curative, rather than an actual planning failure. Moreover, the health system is based on competencies, behaviour indicators required of professionals in order to increase the ability of the workforce to meet the demand (Bach, 2001). By attaching importance to the skills rather than to the individuals, it is assumed that the flexibility offered by decompartmentalization and interdisciplinarity will provide a solution to the problems of personnel shortages (Clair, 2001; Fyke, 2001; Mazankowski, 2002). In a curative system, the decompartmentalization of professions other than medicine seems to be favoured in order to achieve this objective, with implications for planning. According to O'Brien-Pallas, Birch, Baumann and Murphy (2001), it is done in an intermittent way, varies in quality and is focused on a particular profession.

Another way of planning, one in which medicine would be a group among others, would be to consider each group independently from one another. This radically different approach assumes the autonomy of each profession. In addition, this type of planning requires an examination of the use of various types of professionals within the health system. To differentiate between what currently exists, it would entail direct access of the public to various professionals, rather than rely mostly on medical practice and prescription and hospitalization. The shift to ambulatory care that has led the practice in less traditional contexts, such as the community or in the home, may benefit from this type of planning. Personnel planning would change while remaining focused on forecasting the number of professionals required. The main difficulty in this scenario would be to specify what these various professionals would do and, accordingly, estimate the number required. A qualitative aspect should be added. What is needed is probably profession-based planning, which could take into account the flexibility required and collaboration with other professionals. Since this would likely offer many different variations, it is difficult to accurately predict the number of professionals required. This last strategy would include a concern for employees' skills, whereas the methods are only concerned with the quantity of personnel. The next section deals with some aspects inherent to this type of planning. In sum, the limitations of the existing models are better understood, but planning is a complex activity that must come to terms with several paradoxes and that does not provide an answer to the fundamental question related to personnel planning, especially since it is concerned more with the number of employees than with what they are supposed to do.

Question 2

Are the policies and practices regulating the scope of practice, certification and licensure of professional health groups up-to-date and in accordance with the goals of a modern health system? If not, how could they be modified in order to promote innovation and the desired change while preserving quality and protecting public interest?

There seems to be agreement that several factors combine to create a working environment that is more complicated and much different than in the past (OIIQ, 2001). For example, our society is experiencing significant demographic changes, such as population aging, increased life expectancy, the onset of new health problems, and growing social problems that may result in a larger and more diverse health system clientele. In addition, budget constraints are pervasive, a point we have discussed in the context of conflicting objectives, as well as the implementation of new technologies, which have an impact on the organization of care.

The professional system does not seem to be in question, even though licensing requirements are viewed by many as a vestige of the past century that encourage misuse of resources, errors, duplication of work and a lack of collaboration. Despite these disadvantages, the professional system seems to be achieving its objective of protecting the public, while changes in policies and practices governing the scope of professional practice are being planned. Moreover, the notion of competence is increasingly used to try to address the various limitations of the professional system and to facilitate planning. In this context, addressing the issue raised by the policies and practices regulating the scope of professional practice may entail examining the regulations from the perspective of a paradox between regulating a field of practice and promoting skills.

Paradox 5: Field of Professional Practice and Competence

The paradox lies in the desire to preserve the professional structure and, at the same time, introduce the notion of competence, which, although not the opposite, is nonetheless of a different nature. The paradox arises from efforts to increase the clinical independence of professionals based on a specific field of practice and the increased flexibility expected of them from skill-sharing. The notion of competence has been suggested as a way out of the current impasse due to the division of fields of practice, although many consider that the notion of collaboration and interdependence has become necessary in the integrated health system, in which the interdisciplinary team takes charge of patient care. New ways of managing and organizing services and care, as well as new structures to support this decompartmentalized model, are anticipated. Participative management, which promotes dialogue and discussion between partners, would facilitate collaboration on abolishing the hierarchical structures and replacing them with horizontal systems. In this context, a certain flexibility would be expected in defining roles, whereby skills would serve as indicators and as a way to reduce conflicts between professionals.

The appeal of the competence-based approach is that it would provide a foundation to describe and convey professional practices that are often perceived as a group of disparate activities without much coherence (Bach, 2001). The competence-based approach, which entails focusing on behaviours rather than on the qualifications and fields of professional practice,

could bring down the barriers between occupations and encourage interdisciplinary work and flexibility on the part of professionals. There is an impression that assignments based on the notion of competence could resolve the compartmentalization of fields of professional practice. In short, the paradox lies in the juxtaposition of a specific professional field with a group of skills that allows professionals to be flexible.

The competence-based approach is often viewed with mistrust by professionals, who want to preserve their monopoly on expertise. Many also mention the need to protect against a risky sharing of activities requiring a unique and complex level of skills. For them, the barriers offers protection against the confusion that the competence-based approach could cause.

Thus, the notion of competence is not without its own problems, since it is secondary to a reflection on the role that generally arises from the field of practice, once again emphasizing the paradox at the centre of the two approaches. This approach assumes that a certain distinction persists between the roles. Moreover, the concrete implementation of interdisciplinarity requires a clear definition of the roles, functions and the contribution of every individual, as well as a good understanding of the objectives of partnership. According to the Pew Commission (1995), changes in the fields of professional practice must aim to reduce conflicts between professionals and the confusion among the public. Collaboration and interdisciplinarity will not be without conflicts. Conflict resolution mechanisms and procedures for sharing fields of practice between two or several professions will be important, perhaps more so than the notion of competence.

As for promoting innovation, the shortage of personnel offers an excellent opportunity to transform care and services. It offers an opportunity to refocus on health before illness occurs, when this is possible, because health requires fewer personnel resources. Innovation could consist in offering curative services and simultaneously making a greater effort to promote health and prevent problems, using knowledge to improve the public's health. It could also be an opportunity to offer the public direct access to various professionals without having to go through medicine or hospitalization. When all is said and done, the current shortage is an ideal opportunity to re-examine the procedures and ways of delivering care and the determination of fields of practice, and to review the public's access to various professionals currently under the control of medicine in the public system.

In sum, professional regulations are not yet seen as the best way to ensure the public's protection. Adding the notion of competence creates a paradox when the two are considered as interchangeable. In fact, competencies are based on fields of practice and professional qualifications and must remain secondary to a definition of the professional role and mission of the health system. To increase flexibility, conflict resolution mechanisms linked with interdisciplinary collaboration are desired instead.

Question 3

Are educational programs producing a workforce that has the capacity and necessary perspectives to meet the needs of a changing and increasingly integrated health environment? If not, what changes should be made?

It is quite difficult to offer a definitive answer to this question, which raises several other issues. Training is intended to meet the new requirements of the health system and changes in the system. What exactly does this mean?

- Is this a call for change in the more general context of the hierarchical organization of the health professions? If so, should the profession at the top of the hierarchy (medicine) be the only one adding new elements to its training? Will it delegate to others some of its current prerogatives, in particular those that give it the impression of being under-utilized? The context of desired interdisciplinarity, present in the debate but very marginal in reality (Schmitt, 2002), seems here to provide a good example.
- Or is it perhaps a new way of providing care and services based on an approach where the entry point into the system is not necessarily medicine? Could it be an interdisciplinary practice that the public could directly access, and that would require much greater clinical independence for all professionals, even though they would collaborate on interdisciplinarity by upgrading skills? If so, all professions would have to make changes to their training.
- Or does it mean widespread changes in the practice environments, or even a requirement of mobility between care and service environments which, by providing less supervision and a reduced presence of professionals, require greater clinical independence of all professionals and, consequently, changes in training?
- Or – and it is necessary to mention the possibility – is it a change brought up in the debate, even though the practice environments have barely changed or the adjustments made have already been incorporated into the training and do not require major changes. For instance, 93% of the programs in U.S. nursing and medical schools already use the competencies suggested by the Pew commission (Brady, Leuner, Bellack, Loquist, Cipriano and O’Neill, 2001). Another important element is the perception of professionals, who consider that their knowledge and skills are currently under-utilized. For example, the Saskatchewan Report (Fyke, 2001) indicates that many complain that their competencies and skills are not fully used, and that if they were, better patient outcomes and system savings would be achieved.

These questions are not easy to answer, especially since they are mutually exclusive: answering in the affirmative to one automatically means answering in the negative to the other. Several other questions may be raised when training changes are discussed. One specifically asks when changes should be made in training programs: should they precede or follow changes in professional practice? Implementing changes in training before changes in practice would likely create some very uneasy graduates, who would be faced with practice environments that do not reflect their expectations; if training changes follow changes in professional practices,

other problems would arise, given the fairly long delays before graduates with the necessary training would come on the market.

Furthermore, insisting on the necessity of changing training could suggest that it is in fact a strategy to force the system to change, by making new professionals individually responsible for change. The overhauling of training programs is certainly justified and may serve as a catalyst for change in the health system, but it may put the burden of systemic changes on beginners. These changes come up against great resistance from existing personnel for reasons that are obvious and others that are not so clearly understood, and which seem to stem from the paradoxes discussed in this study. Intentions of this nature regarding training should be carefully considered and support mechanisms for graduates should be planned if the need arises.

Moreover, changes in training are often called for, with those in the practice environment complaining that new graduates are not able to function autonomously or are even practically incompetent. In light of the repeated criticism heard from the practice environment regarding the training environment, an initial question is whether or not apprenticeship or professional training is required. Apprenticeship training prepares for the execution of standardized tasks and seems at first to best meet the needs of the practice and the needs of a certain form of management of this practice. Furthermore, professional training does not allow beginners to perfectly master the skills and make the links between the knowledge acquired and practice situations. Requiring complete mastery would entail longer training and gradual integration into the service environment. These criticisms are becoming more relevant due to changes in the health system and shortages of workers. Consequently, the clinical environments has difficulty supporting beginners. The latter need specific support in order to develop professionally and become autonomous, and the practice environment is the only ones able to support this professional maturation. Demanding changes in training does not seem to address the real problem.

In addition, practical training adds another fundamental problem to the current situation, especially when it is suggested that professionals should be better prepared to practise in diverse clinical contexts. The health system has traditionally trained professionals in hospitals but is now headed toward out-of-hospital care. This environment does not offer better conditions for hosting and supervising students. In this environment, professionals often work alone or in small groups, and may find it difficult to get away from their duties to provide supervision. The decrease in financing for training associated with changes in the health system limits the ability of the training environment to offer practical training to all students because of staff cuts. It therefore becomes necessary to examine the role of everyone in practical training and in situations where the system has not succeeded in ensuring an internship environment that reflects the work environment, and to implement transition procedures for new graduates. The health system should examine its commitment to practical training and promote effective integration of training and practice in order to benefit from a new generation of competent, well-trained workers who will not decide prematurely to leave their profession because the integration conditions are too difficult (Bauman, O'Brien-Pallas, Armstrong-Strassen et al., 2001; Lindeman, 2000).

Moreover, new approaches to care and services provision increasingly aim at ensuring the continuity of care supervised by professionals. Proceeding in this way adds to training requirements. Training for continuity of care may mean training personnel to be mobile, in order

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to monitor patients over the whole care episode, that is, in the pre-, intra- and post-hospitalization phases. Next, professionals should improve their organizational knowledge of the health system in order to ensure continuity of care across various establishments. However, this type of training will require structural changes in the health system, in particular changes in the employment contracts of several professional groups, which makes it difficult to have increased mobility among the workforce. Continuity once again raises the question of when to introduce training; meanwhile, structural constraints are still in place.

Conclusion

The succession of changes in the health system has had a significant impact on personnel. Several recent reports by specialists on health system personnel have already informed the Commission about the present situation, the changes made, the alternatives and the main issues.

Several findings and paradoxes that arise from the evidence have been examined. This brief study has shown that the debate about change in the health system is widespread and that it would be to its advantage to consider employees as the focal point of care, to give priority to its implementation and to proceed from a collective vision of the health system. The regulation of professionals seems adequate, although it does not clearly show how it can be reconciled with interdisciplinarity, co-operation and practice in a variety of environments. The training of professionals raises important issues regarding the appropriate time to introduce changes in a way that would allow professionals to feel comfortable when the mission of the health system is precisely defined and the nature of the personnel's work and training is subsequently clarified.

Note

- 1 The word personnel will be preferred to the expression human resources in order to highlight the difference between individuals and financial and material resources.

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