CANADA'S HEALTH WORKFORCE: ENGAGEMENT REPORT

An Assessment by the Canadian Academy of Health Sciences

March 2023

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INTRODUCTION

This report provides a brief summary of the engagement process undertaken as part of the Canadian Academy of Health Sciences' (CAHS) assessment on Canada's health workforce. The engagement process was guided by three working groups and the Indigenous Health Workforce Committee who provided leadership in the design and implementation of this process. We greatly appreciate the insights from all engagement participants. Information gleaned from this engagement process was used to frame and complement our academic evidence review[1] and is reflected in the final assessment report on *Canada's Health Workforce: Pathways Forward*.

In this report we describe:

- why and how we undertook this engagement process,
- the key actors and organizations who participated, and
- what thematic insights were shared by engagement participants.

OUR ENGAGEMENT PROCESS

A key aspect of our assessment was to engage with various organizations from a broad range of key actor groups in the health workforce in order to:

- hear about challenges, local adaptations, and possible approaches to easing health workforce issues,
- consider how proposed leading policies and practices gleaned from the academic review process resonated with their current needs, and
- collect perspectives on the highest priorities for action.

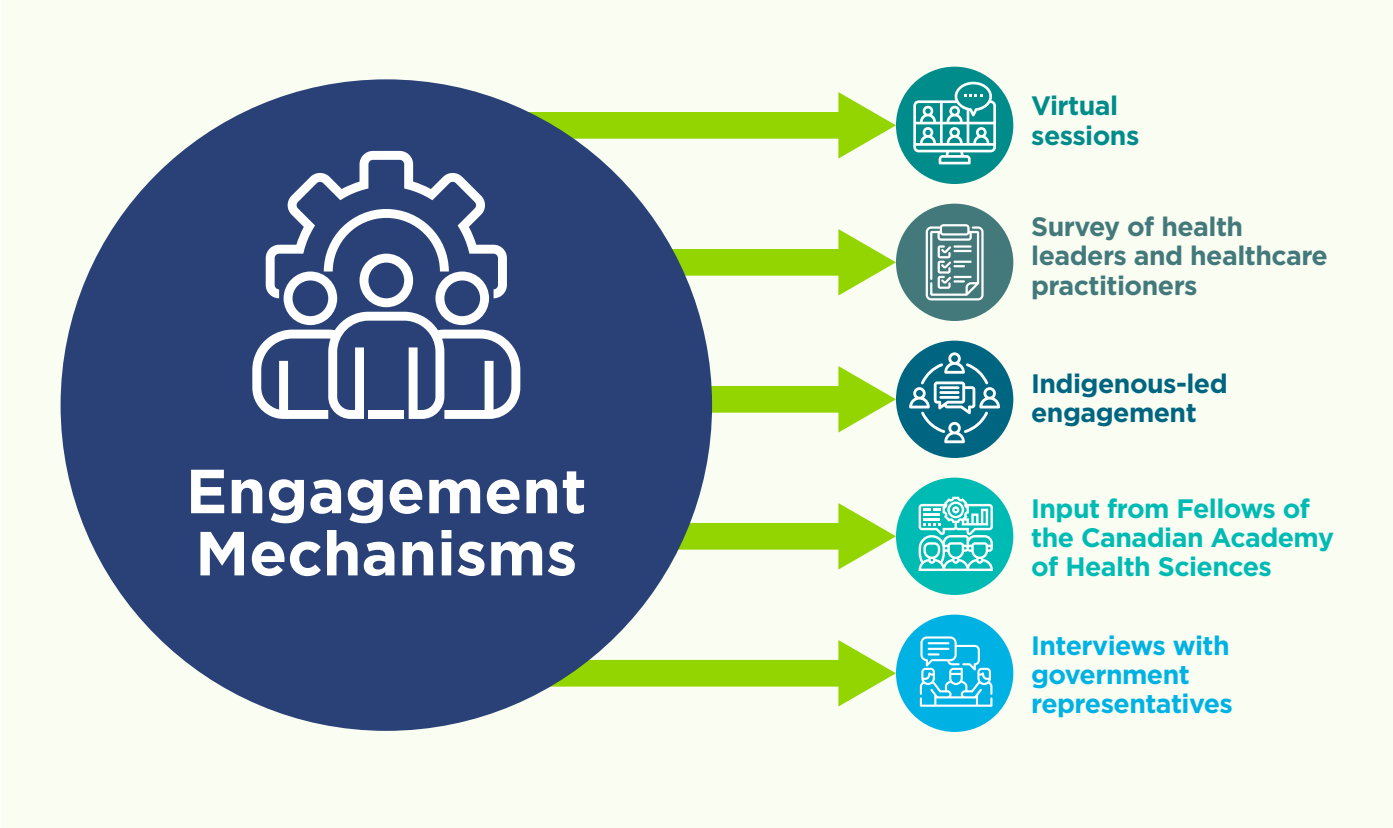
Collecting information through various engagement mechanisms is a way to identify gaps in knowledge and practical challenges that may not be captured by research or policy evidence. As such, this consultation process offered the opportunity for members of the Canadian health workforce and other key actors at all levels to provide their insights. We heard from frontline healthcare practitioners and the organizations that represent them, through to health leaders and provincial and territorial government representatives. They were all invited to share their perspectives on existing areas of need as well as possible strategies to support the health workforce and improve their ability to provide care to Canadians. In line with the pan-Canadian scope and aims of this assessment, we took a regional and thematic approach for this engagement, rather than one that was organized by profession or practitioner group. Further details about who participated are described below.

[1] Our evidence review consisted of a structured, rapid umbrella method culminating in a review of more than 5,000 peer-reviewed articles and a separate review of more than 250 policy documents. A review was conducted for each of the three working groups and the Indigenous Health Workforce Committee.

ENGAGEMENT MECHANISMS

We invited key actors and organizations to participate through five engagement mechanisms from July to November 2022 (Figure 1). Information about how to participate in the engagement process was disseminated through multiple communication channels, including emails to more than 1,000 organizations, the Canadian Academy of Health Sciences website, social media, word of mouth, and news releases.

Figure 1. The five engagement mechanisms.



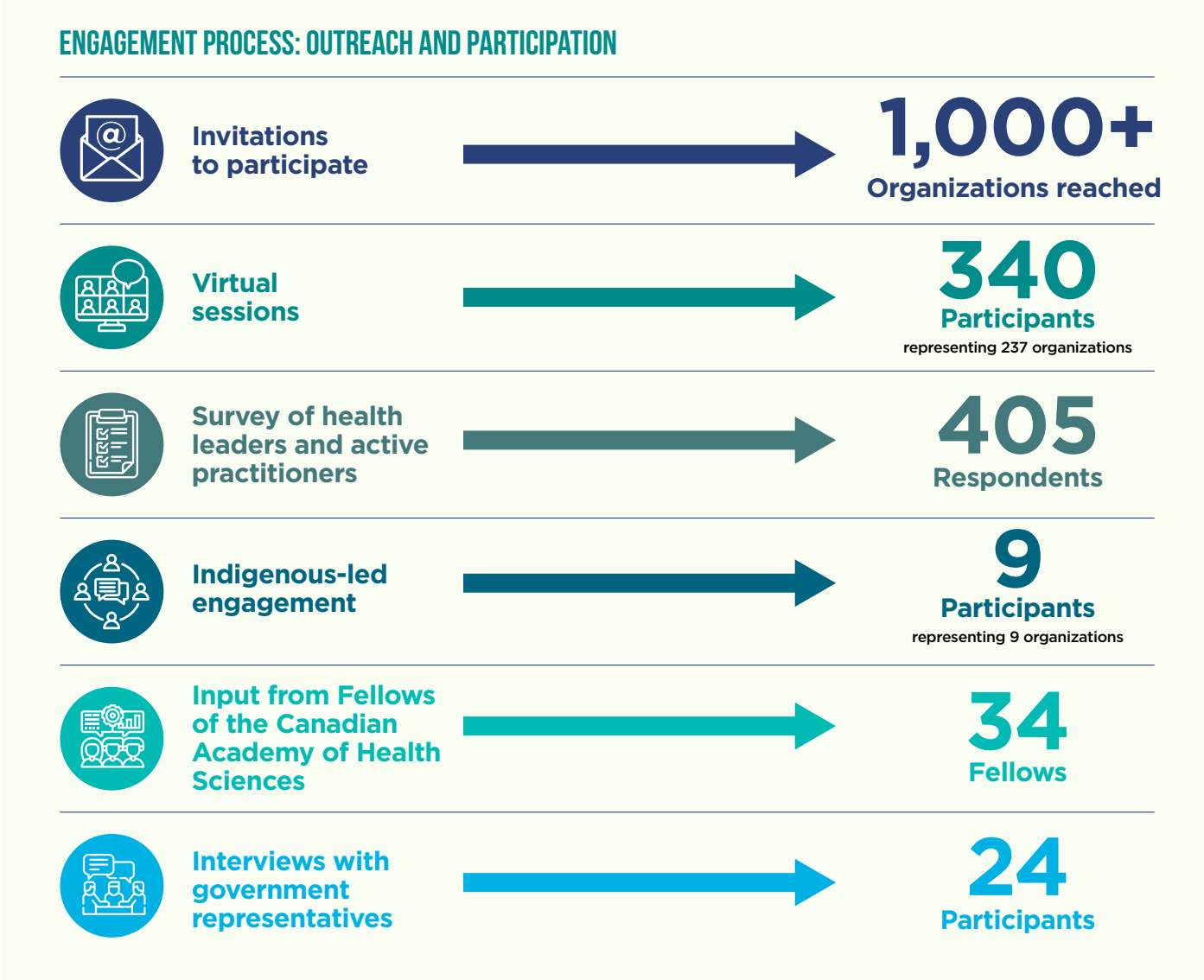
The multiple mechanisms were offered to promote equitable and accessible participation – reaching a diversity of key actors across of Canada. Each mechanism was offered in English and French. More information about dissemination and recruitment is provided below for each mechanism.

Our engagement process took a cumulative and iterative approach that allowed us to apply insights from earlier rounds to those that occurred later in the process. This approach provided flexibility to incorporate new information about proposed leading policies and practices. We adopted this approach given the rapidly evolving nature and broad scope of the current health workforce crisis.

Insights from the engagement process were used to: support findings from our academic evidence review, capture Canadian-specific nuances, identify promising programs or initiatives, and demonstrate or fill evidence gaps. Together, the findings from the academic evidence and insights from the engagement sessions were distilled into 26 leading policies and practices which are detailed in the assessment report.

In total, 812 participants representing 245 organizations across Canada participated (Figure 2).

Figure 2. Outreach and participation across the engagement mechanisms.



Virtual sessions

The Academy invited over 1,000 organizations from the following groups to participate in two rounds of 90-minute virtual consultations that occurred in July and October 2022:

- organizations working with and representing Indigenous Peoples,
- systemically disadvantaged healthcare practitioner groups (e.g. Black people, people of
- colour, newcomers, 2SLGBTQIA+),
- organizations working in rural and remote Canada,
- provincial and territorial groups, and
- federal and pan-Canadian organizations.

The purpose of the 11 sessions in the first round was to inform participants of our engagement process, share academic evidence and gaps, and gauge participants' alignment with proposed leading policies and practices. These sessions had 227 participants from 158 organizations.

We also invited organizations to complete an online survey and submit any existing policy documents. A total of 43 organizations submitted 102 documents. A list of organizations that submitted policy documents is provided in the Appendix.

The second round of six sessions provided the opportunity to validate any revisions made to the proposed leading policies and practices and to identify implementation strategies. Participants were divided into small groups and led through a brainstorming exercise on implementation by a third-party facilitator. Following this exercise, participants joined a larger discussion and voted on prioritized ideas based on impact and ease of implementation. A total of 113 participants attended these sessions from 79 organizations.

Across the virtual sessions, we asked participants to self-identify with a particular key actor group or organization (Figure 3) as well as their reach (e.g. provincial, territorial, or pan-Canadian; Figure 4). In terms of key actors, professional associations were the most highly represented. In terms of reach, pan-Canadian organizations were most highly represented.

Figure 3. Key actor groups represented by the engagement participants across the two rounds of virtual sessions.

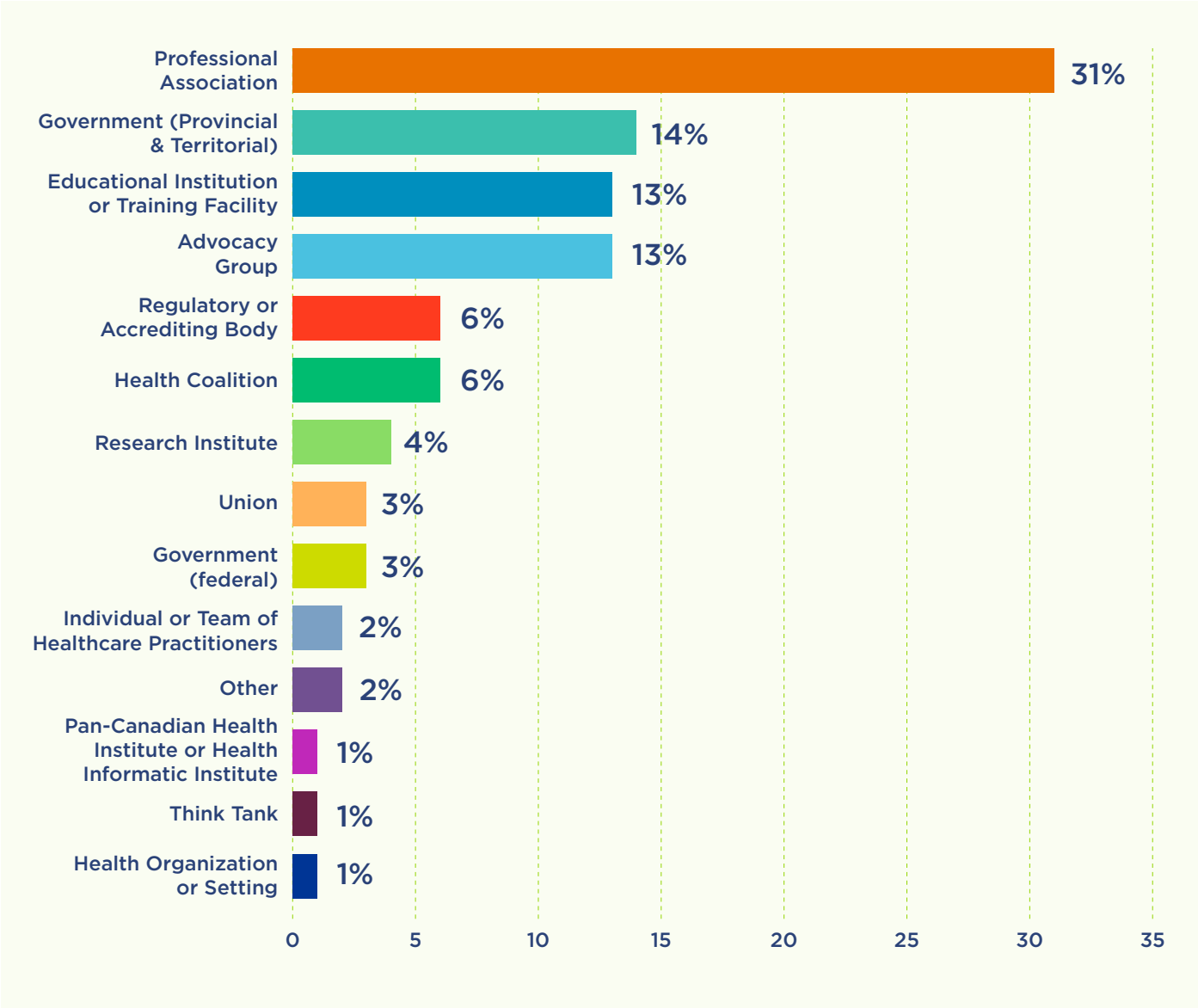
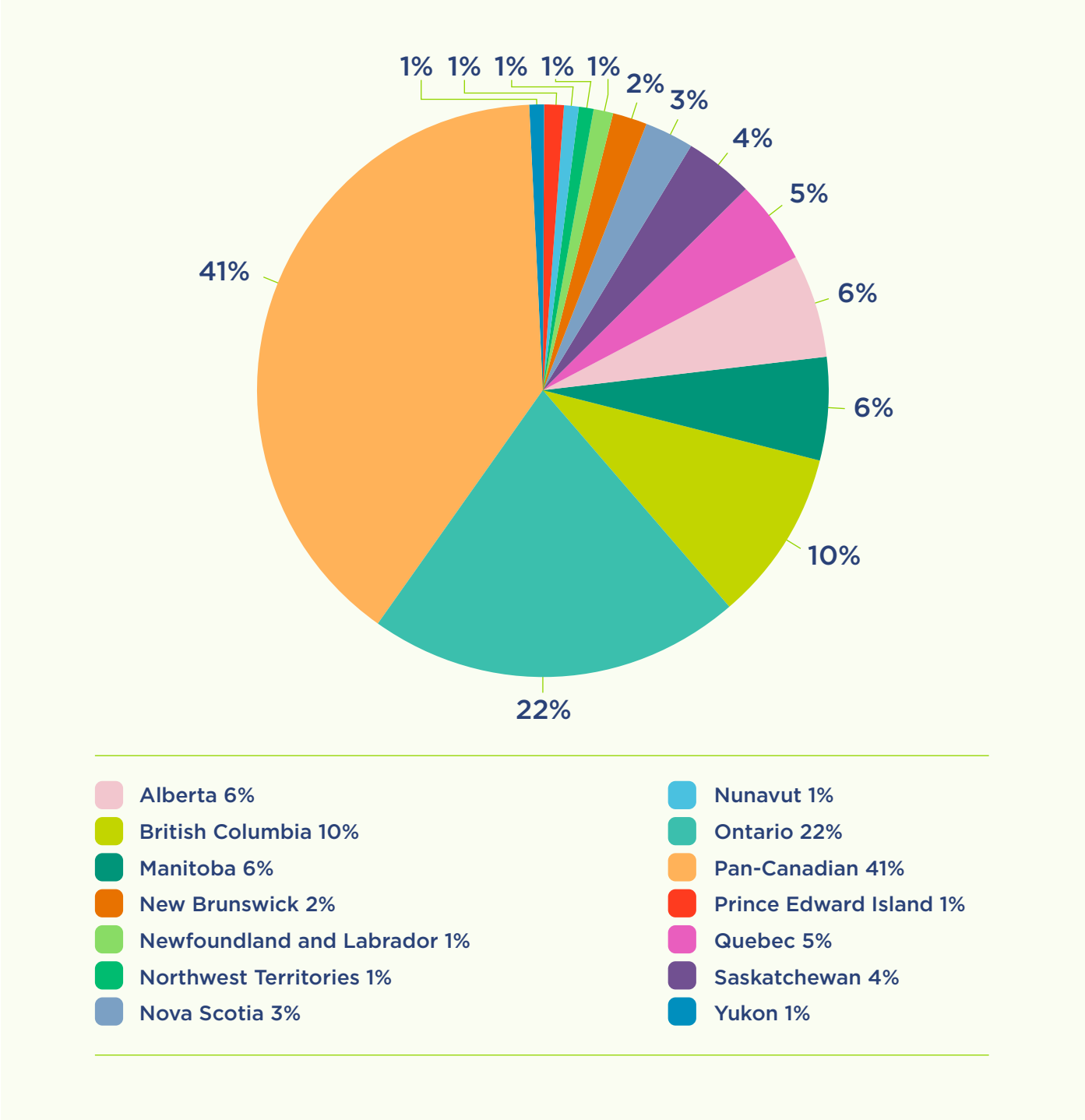


Figure 4. Regional representation across the two rounds of virtual sessions.



Survey of health leaders and healthcare practitioners

A pan-Canadian survey was conducted by a third-party research firm, *Environics Analytics*, between September and November 2022. The target audience included:

- health leaders, healthcare administrators, and policy decision-makers involved in workforce planning, policy, management, education, or training, and
- healthcare practitioners working in various roles (e.g. physicians, nurses, pharmacists) and settings (e.g. acute care, long-term care, mental health).

Survey respondents were asked to self report whether they considered themselves health leaders or healthcare practitioners based on these definitions. To ensure a diversity of perspectives, in collaboration with Environics, we supported the dissemination of the survey specifically to health leaders and healthcare practitioner groups representing systemically disadvantaged populations. A total of 116 health leaders and 289 active healthcare practitioners responded to the survey, of which 111 respondents self-identified as belonging to a systemically disadvantaged group.

Survey respondents were tasked with prioritizing proposed leading policies and practices and identifying which key actor groups (i.e. health leaders, provincial, territorial, or federal government) would best be able to implement these policies. Respondents were also tasked with identifying enablers that could promote implementation by each of these groups. Environics provided anonymized responses that were presented in aggregate for further analysis.

Indigenous-led engagement

Under the direction and leadership of our assessment's Indigenous Health Workforce Committee, we used a targeted approach to engage with Indigenous organizations and groups from across Canada. Organizations were invited to participate in a two-hour virtual session that took place in October 2022. *The Firelight Group*, a third-party Indigenous-owned firm with expertise in engagement, was brought in to support the development and delivery of this session.

Participants were invited to comment on and discuss key questions with the objective of generating ideas on implementing leading policies and practices that emerged from our review of the academic evidence and the previous engagement sessions. Participants also identified proposed leading policies and practices that resonated with them.

A single representative from nine First Nations and Inuit organizations participated. While invited, no Métis organizations were able to participate. Participants were asked to self-identify the type of organization and the region in which they operated. Of the participating organizations, all but one was pan-Canadian and included a combination of Indigenous advocacy groups, professional associations, educational institutes, and service providers.

The representatives were affiliated with the following healthcare practitioner groups: health managers, midwives, nurses, and physicians.

Input from Fellows of the Canadian Academy of Health Sciences

To supplement our rigorous internal and external peer-review process, we invited Fellows of the Canadian Academy of Health Sciences[2] to review proposed leading policies and practices and identity opportunities and top priorities for pan-Canadian or federal action between October to December 2022. A total of 34 Fellows from eight provinces with expertise across 18 healthcare practitioner groups provided feedback.

Interviews with government representatives

In order to understand whether the proposed leading policies and practices resonated with provinces and territories, we invited representatives from all provincial and territorial governments to participate in 30 to 60-minute, semi-structured interviews with one or more of the Assessment Panel Co-Chair(s). These consultations occurred across two iterative rounds with the findings of the first round applied to the second. All interviews took place online (via Zoom) or by telephone. The first round occurred in June and July 2022 and the second round occurred in September and October 2022. Across the two rounds of consultations, 24 government representatives from 12 provinces and territories participated.

The objective of the first round of consultations was to:

- inform them about our assessment process,
- give them the opportunity to forward their most relevant policy documents,
- understand their current health workforce initiatives, and
- identify their largest health workforce pressure points.

The objective of the second round of consultations was to:

- offer an opportunity to consider and comment on proposed leading policies and practices found in the academic evidence,
- discuss possible systems-level implementation issues, and
- provide regional examples of health workforce initiatives (e.g. programs, policies) as well as context-specific challenges.

[2] Fellows of the Canadian Academy of Health Sciences serve as unpaid volunteers, are nominated by their institutions and peers, and are selected in a competitive process based on their leadership, academic performance, scientific creativity, and willingness to serve.

WHAT WE FOUND: SUMMARY OF THEMATIC INSIGHTS

There was broad alignment on the prioritization of proposed leading policies and practices needed to address key health workforce challenges across the various key actors groups represented within the engagement participants (e.g. professional associations, government representatives, health leaders). All key actors and organizations in the health workforce were seen to have a significant role in implementing priority areas. We have summarized insights from engagement participants across the following themes:

- Indigenous Peoples and the health workforce,
- Rural and remote communities,
- Systemically disadvantaged populations,
- Support and retention,
- Deployment and service delivery, and
- Planning and development.

Where there was divergence of opinion or a distinctive perspective within a particular theme, we have differentiated participants by engagement mechanism (e.g. virtual session participants, survey respondents, Fellows, government representatives, Indigenous engagement participants).

Indigenous Peoples and the health workforce

There was wide recognition by engagement participants in both non-Indigenous and Indigenous-led consultations that there was a need to prioritize Indigenous health workforce needs and to gain a deeper understanding of the inequities experienced by Indigenous Peoples. Participants emphasized that implementation efforts should be Indigenous-led. A summary of Indigenous-specific health workforce needs is presented in the Indigenous-led engagement section.

Participants described initiatives for developing a health workforce that could provide more culturally safe care for Indigenous Peoples. Other initiatives currently underway include recruiting and retaining Indigenous students in healthcare education and training with the ultimate goal of increasing the Indigenous health workforce. There was agreement that efforts to reduce inequities within the Indigenous health workforce through targeted strategies to benefit Indigenous Peoples are needed.

Engagement participants also noted that proposed Indigenous-specific leading policies and practices have broad applications that could extend to health workforce needs of non-Indigenous populations.

Rural and remote communities

Improving recruitment and retention of healthcare practitioners in rural and remote areas was noted as a high priority and the key to better care access and quality in underserved regions.

Engagement participants recognized that building workforce capacity begins with recruiting students from rural, remote, and Indigenous communities and could be facilitated through designated seats for healthcare students with an expressed or special interest in rural and remote communities. Participants also highlighted barriers for urban students to secure rural placements, despite their willingness to relocate to these communities.

Most provincial and territorial government representatives detailed how they face challenges in maintaining a sufficient supply of healthcare practitioners in rural and remote areas. To address shortages, re-examination of service delivery models and recruiting new practitioners through local education and training pathways are underway. Some provincial and territorial government representatives have also focused on building a sustainable itinerant workforce (e.g. practitioner who provides regular, but intermittent care directly or virtually to a community) as a temporary solution when it might not be feasible to find a permanent employee.

There was emphasis on cultural competency training and how it could be supported by community members to help build and sustain long-term relationships within specific populations.

Engagement participants felt that systems-level health leaders had the most important role to play in implementing practices that encouraged healthcare practitioner retention in rural and remote regions through:

- targeted funding from the federal government,
- engagement between provincial and territorial governments, healthcare practitioners, unions, and associations, and
- development of capacity and support from health leaders.

Engagement participants proposed improving housing, transportation, and technological infrastructure to enhance living and working conditions for healthcare practitioners and their families in remote and rural communities.

The role of virtual technology to overcome barriers in rural and remote communities was broadly supported by engagement participants. They suggested that access to mentors, specialist colleagues for patient consults, and training or education, could be facilitated virtually. However, a critical caveat echoed by all participants was the limited availability of high-speed internet access, particularly in remote communities.

Enabling the mobility of practitioners through a pan-Canadian healthcare license represented a source of divergence amongst engagement participants. Many virtual session participants and some Fellows suggested prioritizing the mobility of the health workforce with pan-Canadian healthcare licensure. However, government representatives and other Fellows suggested reserving such a strategy to help increase recruitment to rural and remote communities in emergency situations to avoid exacerbating staff shortages and decreasing continuity of care from transitory practitioners.

Systemically disadvantaged populations

Participants placed high priority on equity, diversity, inclusivity, and accessibility along with cultural competence training and representation of diverse populations in the health workforce for systemically disadvantaged populations. There was also emphasis on improving cultural competence and reflective learning in healthcare education to increase awareness of these issues and to enhance support for disabled practitioners.

Engagement participants ranked increasing diversity of those in training and leadership positions as a high priority. They noted that health leaders had the most important role to play in recognizing and implementing diversity initiatives and providing capacity and support, while suggesting equal roles for provincial, territorial, and federal governments. For example, the federal government could provide leadership capacity and support, while the provincial and territorial governments could provide targeted funding and engage with healthcare practitioners, unions, and associations.

Engagement participants expressed that language proficiency (e.g. in serving French-speaking patients outside of Quebec) and bilingualism should be improved since it has implications for both safety and quality of care.

There was wide agreement that internationally educated healthcare practitioners (IEHPs) are an underutilized group of highly trained practitioners who could fill service gaps. Enhancing their support and integration was widely advocated. Government representatives indicated that they were actively seeking ways to engage IEHPs in both the short and long term within healthcare settings across the country. Participants recommended the following processes to help efficiently integrate IEHPs and their families:

- training and resources (e.g. accelerated training, English/French language support, bridging programs),
- financial support (e.g. income replacement while getting licensed), programs (e.g. employer sponsorship programs[3]), and
- streamlining the licensure and registration process focused on evaluating competency.

[3] Employer sponsorship programs facilitate the hiring, support, and integration of internationally educated healthcare practitioners.

Virtual session participants shared personal challenges they experienced at multiple stages of the licensure process and barriers to employment. These individuals recommended greater coordination of policies between with immigration and licensing authorities for appropriate assessment of professional competence of each applicant. They suggested that all levels of government should take the lead in improving the transparency, fairness, timeliness, and costs associated with bridge training and licensing of IEHPs.

Support and retention

Engagement participants recognized the importance of supportive leadership from supervisors, managers, senior executives of health organizations, and government in creating healthy and safe workplaces to improve the recruitment and retention of the current and future health workforce. There was agreement that protected time for training was necessary to help cultivate agile, empowering, and compassionate leaders.

Engagement participants agreed that multi-level policies aimed at recruiting and retaining practitioners are a high priority. Government representatives noted several recruitment initiatives underway to address challenging staffing shortages. Engagement participants expressed that comprehensive and long-term retention strategies should supplement recruitment efforts. Participants suggested that health leaders and all levels of government have important roles to play in creating healthy, safe, just, and equitable workplaces through targeted funding, and discussions with healthcare practitioners, and their unions or associations to further enhance healthcare capacity.

Some provincial and territorial government representatives identified offering greater flexibility in workload and reducing inequity between some healthcare practitioners as a strategy to improve retention. Fellows emphasized the importance of considering the workplace as a comprehensive and holistic system with built-in strategies to address racism and violence, fair compensation, flexible scheduling, and adequate training opportunities in order to improve retention rates.

There was widespread agreement that reducing documentation time by re-assigning non-clinical work to administrative staff was a priority. Most engagement participants believed that the provincial and territorial governments, followed by the federal government, and health leaders, have the largest role to play in implementing strategies to reduce documentation. Government representatives expressed their commitment to reducing documentation time, recognizing it as a priority. Fellows proposed a shift to electronic records, while survey respondents suggested governments could provide infrastructure and technical support, and health leaders could develop capacity and support.

Deployment and service delivery

There was strong agreement that consistency and alignment for practising to top of scope and expanded scopes of practice was a high priority so that team-based models could improve efficiency, lower healthcare costs, and enhance population health. Inconsistencies in scopes of practice, staffing shortages, and misaligned fee models and wage structures was suggested by participants as issues that could begin to be addressed through better sharing of information between provinces and territories. This shared information could be used to identify opportunities for harmonization of scopes of practice and support the mobility of healthcare practitioners as needed to meet population needs.

Engagement participants also offered other solutions including:

- promoting collaboration and communication between practitioners,
- educating the next generation of practitioners to use team-based care and expanded scope of practice for some practitioner groups,
- securing additional funding to support integration of practitioner groups, and
- prioritizing comprehensive primary care.

There was strong support for expanding the use of virtual care to address workforce shortages, especially in rural and remote areas. However, there was also agreement on the need to strike a balance between in-person and virtual care, especially given the lack of reliable internet infrastructure in underserved areas. Enabling strategies included:

- technical support and ongoing training for both practitioners and users,
- equitable access and communication,
- pan-Canadian standards for virtual care, and
- upgrading technologies currently used (e.g. electronic health records).

On the other hand, there was uncertainty around the most beneficial funding and remuneration models for these services. Participants recommended further investigation of other jurisdictions to better understand this complex area.

Planning and development

Participants emphasized that needs-based workforce planning is a top priority and requires an integrated and standardized pan-Canadian health workforce database. Having complete and comprehensive data and policies was generally accepted as the responsibility of provincial and territorial governments. Meanwhile, the federal government was viewed as having a leading role in standardizing definitions for minimum data collection and overseeing the development of an integrated pan-Canadian database. Participants noted that health workforce data was crucial

to effectively plan and address supply shortages in different practitioner groups, care settings, and regions. They advocated creating a centralized information service that could:

- aid in data collection,
- enable forecasting based on population needs and trends such as changes in the population and workforce demographics, and
- support workforce planning.

Several examples of best practices in data collection methods were provided that aimed to enhance collaboration and data sharing between provinces and territories. Provincial and territorial government representatives suggested an integrated provincial-territorial workforce plan for the future. Participants added that this plan should place high priority on aligning the various education and career pathways to address workforce supply across all practitioner groups. They suggested that this could be achieved by:

- increasing the number of educational facilities and faculty positions,
- promoting interprovincial relationships between educational institutions,
- assigning places for students from regions with serious workforce deficiencies, and
- offering mentorship and support for students and early career trainees to reduce attrition from systemically disadvantaged communities.

Indigenous-led engagement

The provision of healthcare for Indigenous Peoples in Canada, including the current and potential landscape of the Indigenous health workforce, is particularly challenging. The Indigenous-led engagement session validated and challenged proposed leading policies and practices identified in our academic review.

Legal and ethical imperative for action

Indigenous participants described the legal and ethical imperative to advance Indigenous health workforce issues around the persistent health and healthcare inequities among First Nations, Inuit, and Métis Peoples in Canada. They also noted the legal obligations of our governments to the United Nations Declaration on the Rights of Indigenous Peoples, along with the ethical responsibility to fully implement the calls to action of the Truth and Reconciliation Commission of Canada.

Relationships and self-determination

A common theme throughout the Indigenous-led engagement session was the need for any action or intervention to be generated on a foundation of meaningful and reciprocal relationships with Indigenous Peoples. It was suggested that by centring Indigenous voices, proposals will find greater success by appropriately understanding the problems and crafting optimal solutions fully aligned with Indigenous rights to self-determination.

Indigenous participants recognized that relationship building requires humility and a commitment in time and resources to represent Indigenous Peoples at all levels of governance within teaching institutions and healthcare settings. Additionally, we heard of the need for community and regionally specific cultural competency training undertaken in partnership with Indigenous Peoples.

Meaningful, long-term investment

The impact of the health workforce on Indigenous communities requires significant, meaningful, and long-term investments, rather than on the siloed and short-term criteria determined without input from Indigenous experts. Engagement participants reported that there is an urgent need for long-term funding that is flexible, equitable, and aligned with a service delivery model. The unique context of working in Indigenous health is not generally reflected in the ways in which programs are funded and staff remunerated.

Investments in flexible, community-driven recruitment, and retention in healthcare education and delivery settings

Flexible and targeted recruitment and retention efforts must increase access to adequate and culturally safe healthcare for Indigenous Peoples in Canada. Recruitment programs should target younger students and attend to the social determinants of health of potential healthcare learners through partnerships between education institutions and Indigenous communities and organizations.

Participants noted that funding models should reflect and evolve with new service models. In terms of promising practices, for example, a part-time employment model was identified as a successful program for some physicians working in rural and remote regions in multiple roles allowing them to:

- practice in other areas of medicine,
- gain experience, and
- bring their learning back to the community.

With this increased flexibility, it was suggested that physicians were more likely to stay committed to these communities in a part-time capacity providing continuity of care. A similar program could be broadened to other practitioner groups.

Similarly, a community-based training program that allows Indigenous students to remain in their communities while undertaking a paraprofessional internship was provided as an example. These students remained in their communities training for part of the year and then attended courses at the university for part of the year. Recognizing the barriers faced by Indigenous youth when moving away from their home communities and support networks, this program

provides support for service delivery in home communities along with training well-prepared graduates.

Decolonizing healthcare settings

There is an urgent need to dismantle the unequal power dynamic between western and Indigenous knowledge systems within education and health delivery settings, engagement participants suggested. This dynamic plays a significant role in creating challenges in recruitment and retention of healthcare practitioners.

Cultural safety for everyone working within healthcare settings was viewed as very important, particularly with community and location-specific training. However, according to engagement participants, intentional structural innovations are required, rather than training alone, to generate supportive, and culturally safe environments. For example, increased opportunities for mentorship, particularly between early careers and more established Indigenous healthcare practitioners are needed. Indigenous participants also suggested designated spaces, both spatial and temporal, for Indigenous learners and staff to accommodate a ceremony and gathering place, or a community of practice with opportunities for connection. These spaces are key to creating culturally safe environments for mutual support.

There was strong agreement across Indigenous participants that government, professional associations, and educational institutions must work with local communities and organizations on all activities related to Indigenous staff and service delivery including dedicated Indigenous leadership positions. There was also a call to acknowledge and compensate Indigenous students and staff for the valuable and unique skills they bring to working groups, boards, mentoring, and teaching. Expecting Indigenous students and staff to take on these roles in addition to their regular work, without adequate compensation, leads to burnout and is a barrier to retention. Additionally, including positions in healing and wellness from Indigenous ways of knowing, being, and doing, such as Elders and cultural practitioners, were suggested.

CONCLUSION

Engaging with key actors with knowledge and experience related to the health workforce provided essential context for the current challenges faced by Canada's health systems. This allowed us to develop key evidence-based strategies taking into account the perspectives of those directly and indirectly affected by the ongoing workforce crisis. Once again, we greatly appreciate the extraordinary efforts made by so many participants who contributed to this engagement process.

APPENDIX:

Policy documents submitted by organizations

ORGANIZATION NAME
Advocates for Change in Nursing Policy
Alberta Association on Gerontology
Alberta Health Services
Alliance for Doctors Denied by Degree
Association of Ontario Midwives
British Columbia College of Family Physicians
Canada Health Infoway
Canadian Association of Medical Radiation Technologists
Canadian Association of Occupational Therapists
Canadian Association of Physician Assistants
Canadian Chiropractic Association
Canadian Dental Hygienists Association
Canadian Federation of Medical Students
Canadian Health Leadership Network
Canadian Medical Association
Canadian Nurses Association
Canadian Psychological Association
Canadian Public Health Association
Canadian Society of Palliative Care Physicians
CARE Centre for Internationally Educated Nurses
Centre interdisciplinaire de recherche en réadaptation et intégration sociale (Cirris); Université Laval
College of Family Physicians of Canada
First Nations of Quebec and Labrador Health and Social Services Commission
Health Sciences Association of BC
Internationally Trained Physicians Access Coalition
Manitoba Health
Manitoba Nurses Union
McMaster University
Northern Ontario School of Medicine University
Occupational Medicine Specialists of Canada
Ontario Hospital Association

Ontario Kinesiology Association
Réseau FADOQ
Saskatchewan Union of Nurses
Simon Fraser University
Society of Rural Physicians of Canada
The British Columbia Dental Association
Touchstone Institute
University of Manitoba
University of Waterloo
Vancouver Strategic and Integrated Research
Wilfrid Laurier University
World Education Services