AN ENVIRONMENTAL SCAN OF CURRENT VIEWS ON HEALTH HUMAN RESOURCES IN CANADA:

Identified Problems, Proposed Solutions and Gap Analysis

Prepared for the National Health Human Resources Summit
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Executive Summary
The Health Council of Canada strongly believes that the health care renewal goals established by the First Ministers cannot be achieved without a collaborative and coordinated approach to resolving the complex issues of health human resources. Successful health care reform will depend on the provision of effective, efficient, accessible, sustainable, high-quality services by a workforce that is present in sufficient numbers, appropriately trained for the new models of delivery, and equitably distributed across the country. This reality highlights the urgent need to modernize how we manage health human resources in Canada.

Effective management of health human resources requires a committed and sustained effort. Leaders responsible for educating, training, employing, regulating, and funding the health care workforce must work together, along with researchers and experts in the field of health human resources. To this end, the Health Council has convened a Health Human Resources Summit to initiate dialogue and examine solutions and success stories.

In preparation for the Summit, the Health Council staff have conducted an environmental scan of current views on health human resource issues in Canada. Specifically, the scan:

- identifies the key policy positions of stakeholder organizations and governments related to four theme areas (education and training, scopes of practice, workplace issues, and health human resource planning);
- highlights the solutions proposed by stakeholders and governments; and
- explores the range of gaps between identified problems and the proposed solutions.

The scan is not meant to be a comprehensive inventory of initiatives across the country nor is it a literature review.

The following matrix summarizes the findings of the environmental scan. More detail can be found in the full report and its appendices.
<table>
<thead>
<tr>
<th>Identified Problems</th>
<th>Education and Training</th>
<th>Scopes of Practice</th>
<th>Workplace Practices</th>
<th>Planning</th>
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<tbody>
<tr>
<td></td>
<td>Lack of self-sufficient supply in all professions. Not enough reliance on international graduates already in Canada. Lack of infrastructure to support increased enrolments and assessments of international graduates. Too few training positions. High tuition costs. Lack of multidisciplinary education programs (pre-professional) and training opportunities (continuing education). Lack of workplace training in general. Lack of culturally appropriate education and training programs.</td>
<td>Scopes of practice differ across jurisdictions as do titles. Lack of clear statements of scopes within team practice. Lack of clarity about accountability and liability within team practice. Changing practice patterns have created service gaps (e.g. obstetrics).</td>
<td>Burnout, heavy workload and overtime, high absenteeism. Early retirement for some groups (e.g. nurses). Insufficient recruitment and retention programs. Lack of attention to health, safety and wellbeing of workers. Inequitable distribution of personnel. Shortage of information for most professions, other than doctors and nurses.</td>
<td>Lack of needs-based planning frameworks. Shift to new models of care without consideration of HHR impacts. Aging health care workforce. Changing work/life balance expectations of young professionals.</td>
</tr>
<tr>
<td>Proposed Solutions</td>
<td>Education and Training</td>
<td>Scopes of Practice</td>
<td>Workplace Practices</td>
<td>Planning</td>
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</table>
|                    | Increase number of funded education and training positions for all professions.  
Regulate tuition increases and increase student financial support; subsidize tuition (through the institutions or directly).  
Increase number of multidisciplinary university and college programs; standardize requirements for core competencies.  
Standardize credential assessment and establish bridging programs.  
Increase number of faculty members and preceptors.  
Integrate culturally appropriate curriculum and training opportunities. | Harmonize relevant legislation and regulations across jurisdictions.  
Develop new models of liability insurance  
Reform tort law.  
Create mechanisms to facilitate collaboration. | Improve working conditions including workload issues, flexible work hours and benefits.  
Expand recruitment and retention options to include opportunities for spouses, supports for families, locum support and continuing education.  
Target bursaries to areas of undersupply.  
Create mechanisms to facilitate collaboration. | Develop a pan-Canadian planning framework.  
Link supply management to population health needs.  
Improve data collection for all professional groups, regulated and unregulated. |
<table>
<thead>
<tr>
<th>Gap Analysis</th>
<th>Education and Training</th>
<th>Scopes of Practice</th>
<th>Workplace Practices</th>
<th>Planning</th>
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<tbody>
<tr>
<td>No agreement on balance between self-sufficiency of supply, recruitment of international graduates, and upgrading of international graduates already in Canada but not working in health care.</td>
<td>No agreement on balance between self-sufficiency of supply, recruitment of international graduates, and upgrading of international graduates already in Canada but not working in health care.</td>
<td>No sense yet of how much of the shortfall will be mitigated once professions are working at their full scope of practice.</td>
<td>Lack of consensus on strategies, incentives and actions.</td>
<td>No clear linkage between new delivery models and planning efforts.</td>
</tr>
<tr>
<td>Faculty and infrastructure requirements not factored into funding.</td>
<td>Faculty and infrastructure requirements not factored into funding.</td>
<td>Unclear how much overlap currently exists as scopes evolve and practice patterns change (e.g. midwives, family physicians and obstetricians all do low risk delivery).</td>
<td>Lack of consensus on strategies, incentives and actions.</td>
<td>Lack of mechanisms to bring players together, despite recognition of need for collaborative approach.</td>
</tr>
<tr>
<td>Effects of increased tuition unknown.</td>
<td>Effects of increased tuition unknown.</td>
<td>Extent of current under-utilization or over-utilization of skills not well understood.</td>
<td>Extent of current under-utilization or over-utilization of skills not well understood.</td>
<td>Extent of current under-utilization or over-utilization of skills not well understood.</td>
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<tr>
<td>Educational requirements and licensure criteria not consistent.</td>
<td>Educational requirements and licensure criteria not consistent.</td>
<td></td>
<td></td>
<td>Extent of current under-utilization or over-utilization of skills not well understood.</td>
</tr>
<tr>
<td>Multidisciplinary education and training programs not widely available.</td>
<td>Multidisciplinary education and training programs not widely available.</td>
<td></td>
<td></td>
<td>Extent of current under-utilization or over-utilization of skills not well understood.</td>
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<tr>
<td>Implications of new delivery models on HHR requirements not clear.</td>
<td>Implications of new delivery models on HHR requirements not clear.</td>
<td></td>
<td></td>
<td>Extent of current under-utilization or over-utilization of skills not well understood.</td>
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<tr>
<td>Contributions of different professions not well understood.</td>
<td>Contributions of different professions not well understood.</td>
<td></td>
<td></td>
<td>Extent of current under-utilization or over-utilization of skills not well understood.</td>
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<tr>
<td>Level of support for workplace training unclear.</td>
<td>Level of support for workplace training unclear.</td>
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<td></td>
<td>Extent of current under-utilization or over-utilization of skills not well understood.</td>
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There is a great deal of activity in Canada focused on our health care workforce. Learning from history, governments and stakeholders recognize that health human resource management is not a one-time effort but requires careful and ongoing attention. There is also recognition that simple or quick solutions mask the complexity of the enterprise. As governments chart the course of health care renewal, health human resource requirements need to move in parallel. Changes to the way health care professionals are educated, trained, employed, funded and regulated are needed to support the First Ministers’ commitments on national health care renewal.
Introduction
The health care sector is both labour intensive and labour reliant. As a result, the delivery and quality of health care is strongly dependent on having enough well-trained health care providers to meet patient needs. In Canada, our supply of providers is being challenged by demographic trends, an aging workforce, technological advancement, preferences for greater work-life balance and past policy decisions.

In its first annual report, *Health Care Renewal in Canada: Accelerating Change*, the Health Council of Canada recognized that successful health reform efforts are closely linked to the availability of health human resources. In this paper, the term "health human resources" refers broadly to people who provide health care or health services to the public. It includes a mix of regulated and unregulated workers, unionized and non-unionized, and those individuals working in publicly and privately funded delivery models. Recently, it has been suggested that health service executives and leaders should also be considered part of the health human resource capacity discussions in this country.

The Council strongly believes that the health care renewal goals established by the First Ministers cannot be achieved without a collaborative and co-ordinated approach to resolving the complex issues of health human resources. Successful health care reform will depend on the provision of effective, efficient, accessible, sustainable, high-quality services by a workforce that is present in sufficient numbers, appropriately trained for the new models of delivery, and equitably distributed across the country. This reality highlights the urgent need to modernize how we manage health human resources in Canada.

Effective management of health human resources in Canada requires a committed and sustained effort. Leaders responsible for educating, training, employing, regulating, and funding the health care workforce must work together along with researchers and experts in the field of health human resources. To this end, the Health Council has convened a
Health Human Resources Summit to initiate dialogue and examine solutions and success stories. The Summit is focused on four theme areas:

- education and training issues;
- scopes of practice;
- workplace issues; and
- planning efforts.

As well, the Summit has a special focus on Aboriginal health human resources and on the rehabilitation and oral health sectors.

In preparation for the Summit, the Health Council staff have conducted an environmental scan of current views on health human resource issues in Canada. Specifically, the scan:

- identifies the key policy positions of stakeholder organizations and governments related to the four theme areas;
- highlights the proposed solutions that are shaping the current planning and policy development process; and
- explores the range of gaps between identified problems and the proposed solutions.

**Methodology**

Information for the scan was collected in three ways:

- A search of the websites of key health system stakeholders for relevant position papers and policy-related media releases (A list of selected key stakeholders is included in Appendix I);
- Letters to selected stakeholder organizations and to governments requesting information on pre-existing position statements to supplement the website information (See Appendix II); and

- A brief review of information in major reports published by stakeholder organizations in Canada.

We have used a framework originally developed by Bleich et al. (2003) in their problem-solution gap analysis of the nursing workforce crisis in the US. The framework, as outlined in Figure 1, assisted in cataloguing the problems and solutions identified by stakeholders and governments and in assessing the gaps.

**Figure 1: Organizing Framework for Environmental Scan**

<table>
<thead>
<tr>
<th>Themes</th>
<th>Education &amp; Training</th>
<th>Scopes of Practice</th>
<th>Workplace Practices</th>
<th>Planning</th>
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<tr>
<td>Analysis</td>
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<td>Identified Problems</td>
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<td>Proposed Solutions</td>
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<td>Gap Analysis</td>
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An itemized summary of problems and solutions as identified by stakeholders and governments can be found in Appendices III-VIII. The following section contains the gap analysis.
Theme I: Education and Training

Issues related to education and training include curriculum content, workplace training, continuing education and in-service training, accreditation, and the balance between Canadian-trained and international graduates.

Gap Analysis

- There is not clear agreement on whether to pursue self-sufficiency of supply, to balance Canadian-trained professionals with international graduates, or to focus upon upgrading international graduates already in Canada but not currently working in health care. Different groups have differing views.

- Faculty and infrastructure required to support increased enrolment levels may not be sufficient, particularly in smaller jurisdictions. There are concerns that these educational supports are not included in new funding.

- Stakeholders perceive that increasing education costs will limit the enrolment and diversity of the student populations pursuing health professions. There is little evidence yet on the effect of higher tuition fees for students.

- Educational requirements for the same profession vary across jurisdictions. Lack of consistency has implications for public understanding of skill sets, mobility of personnel, workplace flexibility, and institutional accreditation requirements.

- Almost all stakeholder organizations and all governments recognize the importance of multidisciplinary practice teams. And they recognize that educating and training students collaboratively will be required to support this shift in the delivery. However, there are only limited opportunities currently available for such educational programs and workplace training.

- The implementation of multidisciplinary teams is in its infancy in most parts of Canada. There are concerns that the ways in which different professionals contribute to patient care are not clearly understood. And how this change in
health care delivery will affect health human resource requirements – as well as education and training needs – is also unclear.

- For those already working in health care, the workplace becomes the focal point for training on team-based care, multidisciplinary teams, and the like. There is very little information available about the scope of workplace training and a growing concern that, despite the desire for change, supports required are not in place (for example, time away from direct patient care to participate in the training programs).

**Theme II: Scopes of Practice**

The scopes of practice theme includes issues related to health care professionals practicing to their full scope of practice, the implementation of collaborative care models, liability and insurance, and entry to practice criteria.

*Gap Analysis*

- Scopes of practice, professional titles and licensure criteria for the same profession can differ across jurisdictions.

- There is a sense of confusion at present as to who can do what – some groups argue that they are not being used to their full scope of practice, while others argue that their scope should be expanded. In some circumstances, health care providers feel they are working above their legal scope, which impacts patient safety and generates legal risks.

- Scopes of practice for health professionals appear to be determined at different levels: the regulated scope of practice set by the licensing body in law; the scope of practice defined by the employer; and the scope of practice which actually occurs in the clinical setting due to necessity.

- Practice patterns are changing in relation to services provided, particularly in family medicine. The implications for other professions is unclear. Current
population-to-profession ratios may stay the same, but the mix and level of services are changing.

- There is a lack of clarity regarding liability issues when care is delivered in a team environment. With respect to liability, team practice is currently incompatible with regulatory authorities and professional insurance plans that are focused on individual accountabilities.

- Physicians and nurses have been the primary focus of discussions to date on scopes of practice. Given that multidisciplinary teams will involve providers other than physicians and nurses, more information is needed on the nature of the impact on their scopes of practice, and how to maximize their productivity while working in new delivery models.

- While many stakeholder organizations and governments recognize the need for legislative and regulatory changes to support evolving scopes of practice, it is not clear whether these changes will happen consistently across the country.

- It is unclear whether funding models are being designed to take into account multidisciplinary care or in recognition of professionals working to their full scope of practice.

- It is unclear to what extent clarified scopes of practice and delivery models that support professionals working at full or expanded scopes will mitigate the current inequitable distribution and perceived shortfalls in the supply of health human resources.
Theme III: Workplace Practices

The workplace practice theme describes issues related to strategies for recruitment and retention and healthy workplace practices to improve job satisfaction and reduce burnout.

*Gap Analysis*

- Despite robust evidence which suggests that improving working conditions in the short and long term is key to maximizing productivity and meeting growing service demands, stakeholders recognize that there has not been a lot of action in this regard.

- There does seem to be a consensus that improved working conditions are essential to attracting an adequate supply of new health care providers to meet future population health needs. However, there appears to be less agreement that enhanced working conditions can significantly reduce problems with retention of existing health care professionals.

- Much of the focus on recruiting and retaining is on nurses and physicians, but little information is available on strategies to recruit and retain other health care providers, such as pharmacists and midwives.

- Stakeholders recognize that improving the quality of the workplace will require collaboration among researchers, practitioners, union and management representatives who must agree on the needs of specific workplaces and the appropriate responses. However, there is little information on the best mechanism to implement this collaborative approach to workplace health.

- While stakeholders agree on the importance of quality workplaces – and there is wide recognition of the importance of financial and non-financial incentives as effective recruitment and retention mechanisms – there is little consensus on strategies, incentives (particularly non-financial incentives) and priorities for action.
• Thus far, the focus has been largely on financial incentives, but there is surprisingly little evaluation of the impact of those incentives on improved recruitment and retention.

• It is difficult for health care workplaces to engage in longer term health human resource planning and the development of their workforce, given government budget cycles and budget pressures.

Theme IV: Health Human Resources Planning

The health human resources planning theme includes issues related to evidence-based approaches to health human resource planning and the link to population health needs; the supply of professionals to meet population health needs and targets to achieve estimated requirements; the unmet needs of remote, rural, and more recently urban, communities; and the need for national databases.

Gap Analysis

• Currently, Canada does not have a health human resource strategy at the national level. Provinces and territories have developed their own plans and a pan-Canadian health human resources framework is being developed through the Conference of Deputy Ministers.

• Other than for physicians and nurses, data-gathering activities for the health care professions is primarily limited to tracking the numbers of personnel. The Canadian Institute for Health Information (CIHI) is working on a minimum dataset on health human resources which will greatly improve the amount and type of information available for planning purposes.

• There is limited information on those professions that are self-regulatory (such as pharmacists, midwives, and chiropractors) and none on unregulated workers. In the shift to new delivery models, evolving scopes of practice and increased use of multiple health professions, these information gaps are critical.
• Historically, professional associations have been the major source of health human resource information, forecasting and supply estimates. All are predicting increasingly large shortfalls. However, there is no systematic process of forecasting.

• Governments are increasingly investing in information management activities but only for selected health professions.

• Despite a recognized need for collaboration in planning, there is no clear mechanism for timely information gathering to support current planning efforts linked to population health needs.

Concluding Remarks

There is a great deal of activity in Canada focused on our health care workforce. Learning from history, governments and stakeholders recognize that health human resource management is not a one-time effort but requires careful and ongoing attention. There is also recognition that simple or quick solutions mask the complexity of the enterprise. As governments chart the course of health care renewal, health human resource requirements need to move in parallel. Changes to the way health care professionals are educated, trained, employed, funded and regulated are needed to support the First Ministers’ commitments on national health care renewal.

Governments have a clear role to lead in this endeavour but other stakeholders must be part of the process. It is encouraging that governments and health care stakeholders in this country understand this reality and wish to move forward. The question now is how?

The position statements and reports reviewed for this environmental scan provide varied perspectives on the nature and scope of the health human resource environment in Canada. To a lesser degree, they also offer solutions for averting what many perceive to be a looming crisis. Some of the proposed solutions are concrete and specific; others less so.
From our review of position statements, it is clear that the scope and diagnosis of the health human resource problem in Canada is still being defined. Many of the solutions proposed focus on increasing supply. Less explored is the impact of more effective management and utilization of the existing workforce. This is particularly important when considering that many of the supply-side solutions to capacity concerns are longer term in nature.

Definitional issues are also evident in discussions about the importance of multidisciplinary teams. The lack of a common understanding about the nature, scope, composition and impact of multidisciplinary teams makes it difficult to discern whether this shift in delivery models will or won’t mitigate some of the health human resource problems predicted for the future.

Health care renewal efforts in Canada may be hampered without clarity on these issues. The Health Council of Canada hopes to play a role in stimulating national collaboration in this critical area of renewal. The Health Human Resources Summit is intended to be a first step.
Appendix I: Selected key stakeholder organizations consulted (website search)

Aboriginal Nurses Association of Canada
Association of Canadian Academic Healthcare Organizations
Association of Canadian Occupational Therapy Regulatory Organizations
Canadian Alliance of Physiotherapy Regulators
Canadian Association for Community Care
Canadian Association of Advanced Practice Nurses
Canadian Association of Occupational Therapists
Canadian Association of Schools of Nursing
Canadian Chiropractic Association
Canadian College of Health Service Executives
Canadian Council of Technicians and Technologists
Canadian Dental Association
Canadian Federation of Chiropractic Regulatory Boards
Canadian Federation of Nurses Unions
Canadian Healthcare Association
Canadian Medical Association
Canadian Medical Protective Association
Canadian Mental Health Association
Canadian Nurses Association
Canadian Nurses Protective Society
Canadian Pharmacists Association
Canadian Physiotherapy Association
Canadian Psychological Association
Chronic Disease Prevention Alliance of Canada
College of Family Physicians of Canada
Conference of Pharmacy Registrars of Canada
Dietitians of Canada
Federation of Medical Regulatory Authorities of Canada
Inuit Tapiriit Kanatami
Medical Council of Canada
National Aboriginal Health Organization
National Association of Pharmacy Regulatory Authorities
New Health Professionals Network
Opticians Association of Canada
Paramedic Association of Canada
Royal College of Physicians & Surgeons of Canada
Victorian Order of Nurses
Appendix II: Governments and selected key stakeholder organizations consulted (request letter)

Government of Canada
Government of Alberta
Government of British Columbia
Government of Manitoba
Government of New Brunswick
Government of Newfoundland
Government of the Northwest Territories
Government of Nova Scotia
Government of Nunavut
Government of Ontario
Government of Prince Edward Island
Gouvernement du Quebec
Government of Saskatchewan
Government of Yukon

Aboriginal Nurses Association of Canada
Canadian Alliance of Physiotherapy Regulators
Canadian College of Health Service Executives
Canadian Federation of Chiropractic Regulatory Boards
Canadian Federation of Nurses Unions
Canadian Healthcare Association
Canadian Medical Association
Canadian Medical Protective Association
Canadian Nurses Association
Canadian Nurses Protective Society
Canadian Pharmacists Association
College of Family Physicians of Canada
Conference of Pharmacy Registrars of Canada
Federation of Medical Regulatory Authorities of Canada
National Aboriginal Health Organization
Royal College of Physicians & Surgeons of Canada
Appendix III: Education and training

Canadian Association of Schools of Nursing (CASN)

Solutions:
- Specific financial support for nursing schools and increasing the number of professors for the many areas of nursing is crucial to end the crisis in the supply of nurses and nurse practitioners. Increased financial support for nursing education and research will result in higher levels of university prepared nurses required to care for Canadians.

Canadian Association of Schools of Nursing (CASN) and the Canadian Nurses Association (CNA)

Joint position statement on flexible delivery of nursing education programs, 2004

Solutions:
- Flexible programs promote access and increase educational opportunities for nurses through the use of creative program delivery models including communication technologies and other methods to enhance access to learning.
- Flexible delivery of baccalaureate, master’s, doctoral, specialty and continuing education program in nursing is essential to Canadian nurses.
- Flexible delivery can respond to nurses’ needs for life-long learning to help nurses:
  - attain, maintain and enhance their knowledge and skills as changes occur in the health system;
  - provide safe high quality evidence based nursing care;
  - balance family, work and educational commitments.
- Regarding educational preparation for entry to practice, both organizations believe that a baccalaureate degree in nursing is the educational entry-to-practice standard for registered nurses in Canada and governments have the responsibility to:
  - provide funding necessary for high quality baccalaureate entry-level programs, including supporting the conversion of diploma programs into baccalaureate programs;
  - provide sufficient numbers of seats in nursing education to meet the health care needs of Canadians;
  - foster collaboration between the nursing community and the ministries of health and foster education to ensure that nursing education is responsive to current and future needs.
Canadian Chiropractic Association (CCA)

CCA on multidisciplinary teams

Solutions:
• Support inter-professional co-operation and collaboration.
• Federal and provincial ministers to take a harder look at removing the barriers to inter-professional collaboration in the interests of ensuring that patients get the most appropriate care from the health professional who is best qualified to provide it in the most cost-effective manner.

Canadian Federation of Medical Students (CFMS)

Medical Education System: The Perspective of Canadian Medical Students (position statement, 2003)

Problems:
• A system in which Canadian medical graduates (CMGs) are not guaranteed access to postgraduate medical education (residency positions, or PGME) is unacceptable. Canadian students might be less willing to make the significant investment of time and resources, resulting in fewer applications to medical school. In the long term this could seriously compromise Canada’s ability to be self-sufficient in health human resources.
• Granting IMGs equal access to Canada’s PGME could flood the residency system. The Canadian PGME system is already at capacity. This is unlikely to change over the next five years as the system struggles to absorb the increasing number of CMGs secondary to increases in medical school enrolment.

Solutions:
• Only CMGs should be granted access to the first iteration of the Canadian Residency Matching Service (CaRMS) process. The CFMS feels very strongly that the Canadian PGME system must accommodate all CMGs. Furthermore, the system must always function in the best interest medical students studying in Canada before it looks to accommodate the global applicant pool.
• If visa physicians are allowed access to the CaRMS match rather than a separate pool of positions, they should be granted access to the second iteration only. Training of visa physicians has been and should continue to be an important component of our PGME system.
• A distinct pool of PGME training positions solely for visa trainees should be created.
• The Canadian medical education system should create physician resources that are adequate for the needs of our health care system.
• Adequate measures should be in place to evaluate the quality of visa trainees and visa physicians before they are adopted by our system.
CFMS on inter-professional education

Solutions:
- Medical school curricula should continue to reflect the importance of the interdisciplinary team by encouraging education of the various roles that each discipline plays.
- Various stakeholders within the medical communities should continue to promote a flexible and accessible system, at the undergraduate and postgraduate level.

Double Jeopardy: The CFMS Position on the Threat of Escalating Medical School Tuition Fees Limiting access to Medical Education in Canada, 2000

Problems:
- Despite the strikingly evident need to rejuvenate and renew the MD population in Canada, it is becoming more apparent that the current trends are limiting access to many potential future physicians. Rising tuition fees and an insufficient number of medical school seats are robbing Canadians of a diverse physician workforce, and slamming the door on a very talented group of people.

Solutions:
- Impose a moratorium on differential tuition fee increases until such decisions and their effects are fully evaluated;
- Increase financial, needs-based assistance to become at par with tuition increases;
- Expand the number of seats in medical school and residency to both increase flexibility for career choice and meet the demands of the Canadian population accessing care;
- Ensure that the current accreditation process guarantees that the admissions procedures for entry into Canadian medical schools, and the environment in which candidates are making these choices, selects students on the basis of academic merit, not financial status;
- Fund curricular activities fully (e.g. rural electives) to help maintain the cultural diversity of the classes, as opposed to having students absorbed by tertiary care settings and urban learning environments. Evidence supports the exposure of medical students and to rural environments during medical school as a successful recruitment technique;
- Discourage coercive measures for recruitment of students both prior to and after completion of their medical degree, recognizing that return of service programs, in a climate of escalating tuition fees, are involuntary and coercive;
- Study methods for fair, ethical repatriation of Canadian physicians trained outside of Canada until Canadian schools establish a self-sufficiency with the requirements of the health care system;
Canadian Medical Association (CMA)

Problems:
High tuition fees, coupled with insufficient financial support systems, will have a significant and detrimental impact not only on current and potential medical students, but also on the Canadian health care system and public access to medical services.

Solutions:
- Increase government funding to medical schools to alleviate the pressures driving tuition increases; any tuition increase should be regulated and reasonable; financial support systems for students should be developed in advance of any tuition increase, be in direct proportion to the tuition fee increase, and provided at levels that meet the needs of students.
- Build in flexibility at undergraduate, postgraduate and re-entry levels of medical education, with the recognition that the requirements for specialists services may change.
- Establish and maintain a ratio of 120 postgraduate training positions per 100 medical graduates.

Canadian Medical Association (CMA), Canadian Healthcare Association (CHA), Canadian Pharmacists Association (CPha), and Canadian Nurses Association (CAN)

Joint statement, 2004

Solutions:
- Supports a pan-Canadian strategy for HR in the health sector and a mechanism to bring together stakeholders, to link health, labour, immigration and education policies, and to ensure needs-based planning approaches that incorporate new knowledge and research.
- Immediate and substantive investment is needed to revitalize education and employment in professions, such as nursing, pharmacy, technologists, and medicine.
- Investment is required to support the integration of international health professionals and to encourage productivity among the existing health workforce.
- Enrolment in Canadian health science education programs must be increased, continuing education must be improved, and full-time permanent jobs must be created.
- Over the longer term, investments are needed in multidisciplinary and other alternative delivery models, as well as research on evidence-based productivity, health outcomes and national licensure.
Canadian Nurses Association (CNA)

CNA on nurse practitioners (NP)

Solutions:
- CNA believes that the completion of graduate education in nursing is the most effective means of acquiring NP competencies. To maximize and sustain benefit to the health care system, the NP role must be formalized through the availability of appropriate education, supportive legislation and remuneration mechanisms.
- CNA recommends that government, policy makers, employers, unions, regulatory bodies, nursing organization, education providers and other health professionals work together to achieve a national framework which would guarantee a co-ordinated approach to ensure effective integration of the NP role into the health care system, facilitate competency verification, enhance labor mobility for NPs, strengthen education programs, and foster research that contributes to evidence-based practice.

CNA on regulation and integration of international applicants into the Canadian health system

Solutions:
- Ensure that internationally educated nurses to have access to timely information as well as tools and resources (e.g. transition courses) to assist them in meeting regulatory requirements such as demonstrating language proficiency and passing the Canadian Registered Nurse Examination (CRNE). Assistance should also be made available with respect to achieving successful clinical and cultural integration into the Canadian health care environment.
- Maintain public protection while providing internationally educated nurses with the best opportunity to achieve their full potential in practicing their chosen profession in this country. CNA has developed a regulatory framework for the integration of international applicants.
- Develop a consistent national approach to the assessment of credentials and competencies, language proficiency and other regulatory requirements. CNA is currently working with nursing regulators (registered nurses, registered psychiatric nurses and registered/licensed practical nurses), governments, educators, employers, unions and internationally educated nurses to examine the regulatory processes across Canada.
- Establish a national assessment service to create an evidence-based standardized approach to the assessment of internationally educated nurses (IENs) that includes an assessment of educational preparation, prior learning assessment and recognition (PLAR), clinical competency assessment such as supervised practice, and a standard language test such as the Canadian English Language Benchmarks Assessment for Nurses (CELBAN).
- Establish nationally standardized and flexible bridging programs to ensure IENs have the competencies required to meet Canadian nursing standards.
- Develop strategies to address the financial challenges incurred by IENs who enroll in bridging programs.
Solutions:
As one of the stakeholder groups involved in this three-year labour market analysis, CNA supports the recommendations put forth in the Phase I Final Report. Specifically, CNA supports the following recommendation and suggested actions made regarding education and training:

- Develop innovative approaches to expand clinical experiences in nursing education. This includes undertaking a study of how to maximize current clinical and education resources as well as carrying out research that examines the effectiveness of inter-professional education in terms of improved patient/client, provider and system outcomes.

- There is a movement towards collaborative teams and innovative inter-professional educational opportunities. Inter-professional education offerings may generate graduates with collaborative competencies and that effective interdisciplinary primary health care teams will generate improved patient, provider and system outcomes, promote quality care, and improve access by Canadians to the appropriate provider at the appropriate time and thus decrease unacceptable wait times. An important component of this is changing the way we educate health care providers, including nurses, to ensure they have the knowledge and training to work effectively together in collaborative, patient centered teams. There is currently a paucity of evidence that interprofessional education will generate effective collaborative practice.

Canadian Physiotherapy Association

Problems:
- CPA recognizes that it can be increasingly difficult for clinical physiotherapists to work in contract, temporary, or part-time arrangements that may make it more difficult to co-ordinate with student’s schedules and needs. Many organizations do not adequately support or acknowledge clinical preceptors in their clinical education role, or choose not to offer clinical education to students at all.

Solutions:
- Provide appropriate training to clinical preceptors/instructors within academic institutions and health care facilities.
Canadian Post-M.D. Education Registry (CAPER)

CAPER on international medical graduates (IMGs)

**Problems:**
- Until Canadian medical schools increase the number of medical graduates and these new graduates become practicing physicians, Canada will require the services of physicians who have trained outside Canada.

**Solutions:**
- It is estimated that annual medical school enrolments will have to increase to 2,500 by 2007 simply to maintain the current physician-to-population ratio at 1.9/1,000 (CIHI 2004).
- Moreover, an injection of 500 IMGs is also needed each year to sustain the current physician-to-population ratio (Association of Canadian Medical Colleges 2003).
- Government of Canada recently launched a foreign credential recognition initiative identifying physicians, nurses and engineers as a top priority.

Canadian Society of Medical Laboratory Science (CSMLS)

**Problems:**
- There is a shortage of laboratory professionals.
- Nearly half of Canada’s medical laboratory technologists are expected to retire over the next 13 years.
- The risk of a severe shortage is greatest in Nova Scotia where there is no training program for medical laboratory technologists.

**Solutions:**
- Ensure that there is a sufficient number of qualified medical laboratory professionals.
- Commit more dollars (provincial education and health ministries) to fund training programs. Only with proper investment in the training of laboratory technologists - including funding of essential clinical experience - can Canada expect to meet the challenge of emerging health threats.
- Create at least 300 new training positions within the next decade; ensure that those positions are filled. Funding for new training positions is only part of the solution to a much larger problem.
- Create a national campaign to recruit young people into careers in medical laboratory science.
- Establish a new training program in British Columbia.
• Establish at least two new training programs in Ontario, one of which should be located in the North.
• Double the number of training positions in existing programs in British Columbia, Ontario, Saskatchewan and Manitoba.
• Carefully monitor the human resource supply in Alberta, New Brunswick, Newfoundland and Quebec.
• Adjust the number of training programs as required due to the increased demand for medical testing by an aging population.
• Create additional training positions for PEI students in neighbouring Atlantic training programs.
• Prepare medical laboratory technologists to function within multidisciplinary health care teams. The body of knowledge required by entry level medical laboratory technologists must evolve beyond a purely technical focus to include broader-based skills such as critical thinking, problem solving, and communication.
• Ensure that future entry-level general medical laboratory technologists are equipped with the skills and knowledge required to provide high quality medical laboratory services.
• CSMLS supports multi-skilling provided that competency-based assessment is performed to document that individuals have developed those value-added skills and has met the professional standards of the appropriate professional societies/regulatory agencies.

The Canadian Task Force on Licensure of International Medical Graduates (IMGs)

Recommendations to the Conference of Deputy Ministers of Health, 2003

Solutions:
• Integrate IMGs into physician resource plans by ensuring there is adequate capacity and funding for their assessment and training.
• Work toward standardized evaluation leading to licensure.
• Expand or develop supports/programs to assist IMGs with the licensure process and requirements in Canada.
• Develop programs to support faculty and physicians working with IMGs.
• Develop capacity to track and recruit IMGs.
• Establish a national IMG research agenda that would include evaluation of the IMG licensure recommendations and the impact of the strategy on physician supply.
The College of Family Physicians of Canada (CFPC)

Family Medicine in Canada: Vision for the Future, 2004

Problems:
• Family doctors support new models of primary health care that offer incentives to work in
teams. However, medical students are concerned that the role of family physicians could be
greatly diminished in some of these models, with family doctors’ responsibilities becoming
blended with or even replaced by those of other primary care providers.

Solutions:
• Need to demonstrate the importance of family doctors as greatly valued and highly respected
at the forefront.
• Efforts to promote interdisciplinary collaboration should continue to recognize the unique
value and importance that each health care provider brings to the care team through their
special education, training and experience. Models should be patient centred to ensure ease
of access to the most appropriate and preferred provider with the right skill mix and should
also take into account the changing practice preferences of providers.

Inuit Health Human Resources

Problems:
• Lack of appropriate care due to limited access to health professionals beyond community
health nurses;
• Lack of knowledge among health care providers about the cultural context, ways of relating
and issues specific to Inuit patients;
• Inability of most health care providers to speak Inuktitut, the language spoken by most Inuit;
• Lack of integration of Inuit health knowledge within the health care system;
• Lack of continuity in care due to staff turnover.

Solutions:
• Children and youth: Ensure that they have a strong foundation in literacy and health related
subjects. Ensure that they have the information, tools and support to graduate from high
school and go on to post-secondary training. Ensure that the standards in the schools are
equal or better than those in the South (so students do not have to upgrade to go on). Give
students information about health career opportunities through school and extracurricular
activities (camps, trips to the local health centre/hospital, presentations). Make sure that they
are people able to support the students including career counselors, elders and other mentors.
• Inuit in the health care field: Support Inuit who are currently in the health care field to do
dwell in their jobs and develop their careers through ongoing mentoring, support, financial
support and training. For example a community health representative (CHR) may wish to
become a nurse; a clerk interpreter, an X-ray tech; an administrative assistant, a medical interpreter.

- **Non-Inuit in the health care field:** Provide ongoing information sharing about Inuit ways, values and health knowledge as well as Inuktitut so that they are able to deliver culturally safe services. Support them in the job (through training, decreased overtime, etc.).

- **Inuit knowledge:** Integrate Inuit health knowledge into the health care system; look to Alaska for successful models.

- **Post-secondary:** Ensure there is a continuous support for Inuit students in post-secondary education: academic, financial, family, childcare, etc. Support transition programs between high school and post secondary. Support college and university health programs being offered in the North. Support dialogue between the schools in the land claim areas.

**National Aboriginal Health Organization (NAHO)**

**Solutions:**

- Systemic changes within current education systems and curriculum is needed.

- Community driven and controlled education systems along with culturally responsive curricula are cornerstone to retention and training of the upcoming workforce.

- Transformative changes within current Canadian accreditation processes which would include concepts of cultural competency and safety and ultimately lead to the much needed changes within medical curriculum.

- Further work is needed to understanding the scope of workplace training for multidisciplinary team care, continuing education, in-service training and international graduates specific to Aboriginal peoples.

**National Association of Pharmacy Regulatory Associations**

**Problems:**

- Canada cannot rely on international pharmacy graduates (IPGs) to meet growing needs.

- For every student admitted into the first year of one Canada’s nine pharmacy bachelor degree programs, there are five applicants turned away.

**Solutions:**

- Recognize the international experience and credentials of immigrants, but this must be accomplished within a framework that supports the regulatory bodies in ensuring that licensed pharmacy professionals provide competent patient care, and that public protection is assured.
• Uphold consistent core competency requirements and also recognize the need for increased capacity in our domestic educations programs.

• Explore remediation opportunities to work with unsuccessful IPG candidates that are already residing in Canada, to help them meet the core competencies and licensing requirements.

**Victorian Order of Nurses (VON)**

*Solutions:*

• VON supports the Council’s call for a broad focus on facilitating health care teams, instead of zeroing in on the supply issues for particular professions.
Appendix IV: Scopes Of Practice

Canadian Medical Association (CMA)

*Physician resource planning: CMA policy update, 2003*

**Problems:**
- Need for more clearly defined scopes of professional activity and optimal interactions among primary care physicians, general specialists and sub-specialists, particularly in the large urban areas where these three groups co-exist. It is also relevant to define the role and most appropriate interactions with other healthcare professionals, including but not limited to specially trained nurses, nutritionists, physiotherapists and pharmacists.

Canadian Medical Association (CMA), Canadian Nurses Association (CNA) and Canadian Pharmacists Association (CPha)

*Joint statement, 2003*

**Solutions:**
- Policy decision taken in the area of scope of practice must put patients first.
- Scopes of practice should be grounded in principles that reflect commitment to professionalism, lifelong learning and patient safety.
- Recognition of the need for legislative and regulatory changes to support evolving scopes of practice is critical.
- Health professionals must be involved in decision making process in this area.
- CMA, CNA and CPha propose the following principles and criteria to ensure safe, competent and ethical patient care should guide the development of scopes of practice of health care providers:

**Principles**

- **Focus:** Scope of practice statement should promote safe, ethical, high-quality care that responds to the needs of patients and the public in a timely manner, is affordable, and is provided by competent health care providers.

- **Flexibility:** A flexible approach is required that enables providers to practice to the extent of their education, training, skills, knowledge, experience, competence and judgment while being responsive to the needs of patients and the public.

- **Collaboration and co-operation:** In order to support interdisciplinary approaches to patient care and good health outcomes, physicians, nurses and pharmacists should engage in collaborative and co-operative practice with other health care providers who are
qualified and appropriately trained and who use, wherever possible, an evidence-based approach.

- **Co-ordination:** A qualified health care provider should co-ordinate individual patient care.

- **Patient choice:** Scopes of practice should take into account patients’ choice of health care provider.

**Criteria**

- **Accountability:** Scopes of practice should reflect the degree of accountability, responsibility and authority that the health care provider assumes for the outcome of his or her practice.

- **Education:** Scopes of practice should reflect the breadth, depth and relevance of the training and education of the health care provider. This includes consideration of the extent of the accredited or approved educational program(s), certification of the provider and maintenance of competency.

- **Competencies and practice standards:** Scope of practice should reflect the degree of knowledge, values, attitudes and skills of the provider group.

- **Quality assurance and improvement:** Scopes of practice should reflect measures of quality assurance and improvement that have been implemented for the protection of patients and the public.

- **Risk assessment:** Scopes of practice should take into consideration risk to patients.

- **Evidence-based practices:** Scope of practice should reflect the degree to which the provider group practices are based on valid scientific evidence where available.

- **Setting and culture:** Scopes of practice should be sensitive to the place, context and culture in which the practice occurs.

- **Legal liability and insurance:** Scopes of practice should reflect case law and the legal liability assumed by the health care provider including mutual professional malpractice protection or liability insurance coverage.

- **Regulation:** Scopes of practice should reflect the legislative and regulatory authority, where applicable, of the health care provider.
Canadian Medical Protective Association (CMPA)

Problems:
• Collaborative practices pose equally significant threats to health care delivery by blurring established responsibilities and raising new questions with regards to accountability and liability. These ongoing changes pose new liability challenges for physicians in particular.
• While it may be difficult to quantify, it is increasingly evident that these concerns are having a “chilling effect” on physicians’ willingness to participate in these new delivery models. This situation threatens to undermine the potential benefits to be accrued by collaborative practices and by the shifting of certain procedures out of the high-cost hospital setting.

Solutions:
• Liability challenges associated with these new delivery models must be addressed to ensure a viable and sustainable system.
• The principal solution to this issue is relatively straightforward: there should be a legislated requirement for all health care professionals to have adequate professional liability protection in place as a condition of licensure.

Canadian Nurses Protective Society (CNPS)

Problems:
• There is currently no legislated title common to all Canadian jurisdictions to identify registered nurses with a legislated extended scope of practice.
• There are concerns regarding patient safety when staffing is reduced to levels nurses consider unsafe to proper patient care.
• There is concern about the nurse’s ability to continue to provide safe care to patients when required to work many hours of overtime, including double shifts, without rest.

Solutions:
• See below for the CMPA / CNPS joint statement on liability protection for nurse practitioners and physicians in collaborative practice.
Canadian Medical Protective Association (CMPA) / Canadian Nurses Protective Society (CNPS)

Joint statement on liability protection for nurse practitioners and physicians in collaborative practice, 2005

Problems:
- When a patient commences a legal action regarding health care treatment, it is likely that all health care professionals who were involved in the treatment, as well as the institution or facility where that treatment was rendered, will be named as defendants. A finding of negligence by the court may have a financial impact on the defendant(s) in three ways: (1) direct liability; (2) vicarious liability and (3) joint and several liability. For this reason:
  - It is essential for physicians and nurse practitioners working in collaborative practice to verify that all members of the collaborative practice team and the facility or institution have adequate professional liability protection in place at the beginning of the work relationship and on an ongoing basis.

Solutions:
- All members of the collaborative health care team and the institution or facility must have appropriate and adequate professional liability protection to protect themselves and the patients they treat.
- Providers should take the following steps will help decrease the health care professionals’ risks when working collaboratively:
  - have appropriate and adequate professional liability protection and/or insurance coverage;
  - confirm the continuing appropriate and adequate professional liability protection and/or insurance coverage of the other members of the collaborative health care team.

Canadian Nurses Association (CNA)

Quality Professional Practice Environments for Registered Nurses: position statement, 2001

Solutions:
- Models of care must recognize the unique role of nurses in the health care system and allows nurses to practice to the full scope of their education and experience.
- Nurses at all levels in the organization must be involved in decision-making affecting nursing practice, client care or the work environment.
- Registered nurses must determine how and when unregulated health care workers can safely assist in the provision of tasks associated with nursing care. At no time should the safety of clients be compromised by substituting less qualified workers when the competencies of registered nurses are required.
Canadian Nurses Association (CNA) & Canadian Association of Schools of Nursing (CASN)

Joint statement on educational preparation for entry-to-practice, 2004

Solutions:
- A baccalaureate degree in nursing is the educational entry-to-practice standard for registered nurses in Canada.
- The responsibility for supporting baccalaureate entry to practice is shared among individual nurses, nursing regulatory bodies, nursing organizations, employers, educational institutions and governments.
- At present, entry-to-practice for nurse practitioners (NP) varies across the country. However, in March 2006, the Canadian Nurse Practitioner Initiative (CNPI) will recommend entry-to-practice criteria for primary health care NPs in Canada.

The College of Family Physicians of Canada

Problems:
- Family doctor shortages and the changing practice patterns of other specialists have created gaps in the availability of certain services, e.g. mental health and obstetrical services.
- More family doctors are moving into focused areas of practice; this creates a further reduction of the already shrinking pool of family physicians available.

Solutions:
- Personal, comprehensive, continuing care provided by family physicians practicing in or linked to groups, networks, or teams should be the cornerstone of family practice.
- Remunerative incentives should be introduced in every province and territory for provision of comprehensive care by family physicians and family practice groups, networks and teams.
- Family physicians should be recognized and provided with the education and practice support needed to enable them to be an integral part of Canada’s public health system.

National Aboriginal Health Organization

Solutions:
- Scope of practice is an area in need of further future research, partnership and collaboration.
Appendix V: Workplace practices

Canadian College for Health Services Executives

Leadership issues

Problems:

- The difficulty attracting and retaining senior leaders, burnout and rapid turnover, the aging of the senior ranks, the absence of succession planning, the challenges associated with training and mentoring the next generation of leaders, and the difficulty of persuading potential leaders to take on more demanding leadership roles are all worrisome signs that a leadership crisis is looming, if not already here.

- It is difficult to find leaders with the requisite breadth and depth of experience that is essential in leading today’s multifaceted health organizations. There is also growing apprehension about the retention of qualified leaders. The heightened demands and increasing politicization of senior roles often means that qualified candidates consider other career opportunities.

Solutions:

- Leadership issues should be included in the comprehensive HHR strategy to address shortages.

Canadian Medical Association

Problems:

- The geographic distribution of physician resources is an issue. There should be incentives that can be successful in retaining personnel over the long term.

- The current practice environment created by the drastic reduction in health care expenditures has made the job of recruitment more difficult then ever.

- The demographics of the Canadian population is adding to the challenges of medical practice.

- The population is aging and requiring more care.

- Physicians are expected to increase their practices to cover the exit of their fellow practitioners who have retired or set up practice in "greener pastures" elsewhere.

- Amidst these new health care strains the public is becoming exasperated by what is seen as the dismantling of the public health care system. The retention of established physicians occupies a much larger percentage of the public sympathy that remains.
• Changes in the nature of practice are occurring – largely in the family medicine area. Family physicians are providing less service after hours or on call than they once did.

Solutions:
• Solving geographic maldistribution will require the following:
  - Programs designed to attract physicians to and retain them in under serviced communities. Such programs should develop comprehensive and flexible incentives and address the professional, personal, and social needs of physicians in the context of career planning.
  - Opportunities for personal development, financial incentives, locum support, spousal employment prospects and education opportunities for children are key factors that need to be addressed.
  - Increased numbers and values of bursaries for electives in rural areas.
  - Designated retraining spots for those currently completing under-serviced commitment.
  - Aggressive recruitment and incentives for those in family practice programs, who are more likely to provide rural service and have been surprisingly overlooked in recruitment strategies to the present.

Canadian Nurses Association (CNA)

Quality Professional Practice Environments for Registered Nurses: position statement, 2001

Solutions:
• Nurses have an obligation to their clients to demand practice environments that have the organizational and human support allocations necessary for safe, competent and ethical nursing care. A quality nursing professional practice environment is one in which the needs and goals of the individual nurse are met at the same time as the patient or client is assisted to reach his or her individual health goals, within the costs and quality framework mandated by the organization where the care is provided.

• CNA is committed to providing ongoing opportunities and support for nurses to acquire and maintain competence, such as continuing education; formal education; in-service; and mentoring.

• Policies must be implemented across all settings that promote the health, safety and personal well-being of nurses. This occurs when the following are done:
  - Policies support zero tolerance of workplace violence.
  - There is up-to-date, well-maintained equipment and enough space – based on the involvement of direct care providers in decision-making – to meet the needs of clients.
  - Nurses have the flexibility to schedule their hours of practice balancing personal needs with the needs of the organization.
- The individual nurse controls when and if he/she is able to work overtime or extra hours. Inability to work overtime should not be considered “job action.”
- The work environment fosters open communication.
- Supportive policies and protocols are in place for nurses to address professional practice issues.
- Supportive policies and protocols are in place for nurses to address ethical issues, including issues of whistle blowing.

_CNA on patient safety, 2003_

**Problems:**
- The escalating shortage of registered nurses, the use of inappropriate staffing practices and the under staffing and under-skilling of health care services pose a significant threat to patient safety and contribute to incidents of failure to rescue.
- The practice environment enables or hinders nurses and other health care professionals in their ability to provide safe care. Developing and supporting quality professional practice environments is a responsibility shared by practitioners, employers, governments, regulatory bodies, professional associations, educational institutions, unions and the public.

**Solutions:**
- Providing for patient safety involves a wide range of actions at the level of the individual nurse, the profession, the multidisciplinary team, the health care organization and the health care system. These actions must include adequate clinical support for nurses by nurse managers. It is also critical to patient safety that nursing care data are collected and interpreted at the national level to support research on best nursing practices.

**National Aboriginal Health Organization**

**Solutions:**
- Promote supportive, culturally safe environments, both with educational institutes and within the workplace to foster recruitment and retention of the aboriginal student body and Aboriginal and non-Aboriginal health professionals.
National Research Reports

Problems:

- Between 1997 and 2002, the absenteeism rate for RNs increased by 16.2 per cent and, each year, the rate among full-time workers was about 50 per cent higher than among part-time workers. Moreover, the 2002 absenteeism rate for RNs working full time was 83 per cent higher than it was in the general labour force. That year, a total of 19.6 million hours were lost to absenteeism - the equivalent of 10,808 full-time positions (CLBC 2002).

- Reducing absenteeism among RNs to the Canadian average in 2001 would have put the equivalent of 3,500 full-time positions back into the system (CLBC 2002).

- The average age of retirement for nurses is 56. Assuming that all RNs work until age 55, Canada is poised to lose 64,248 RNs to retirement or death by 2006, an amount equal to 28 per cent of the 2001 work force (O’Brien-Pallas 2003).

- Currently, there are 44,499 RNs under 35 years of age; this is 19,749 fewer than the number of pending retirees. (CIHI 2004).

Solutions:

- 16,000 additional nurses are needed to achieve the same ratio of nurses-to-population today as Canada enjoyed 10 years ago (CNAC 2002).

- Better terms and conditions of work could effectively reduce this shortage by over 35 per cent (CNAC 2002).

Nursing Sector Study – Building the Future: An Integrated Strategy for Nursing Human Resources in Canada, 2005

Solutions:

- Use evidence-based practices to inform staffing decisions including retention and recruitment decisions.

- Implement effective and efficient mechanisms to address workload issues and improve patient, nurse, and systems outcomes.

- Create work environments that maximize patient, nurse and system outcomes.

- Improve and maintain the health and safety of nurses.

- Develop innovative approaches to expand clinical experiences in nursing education.

- Maximize the ability of nurses to work to their full scope of practice.
Appendix VI: Health Human Resources Planning

Association of Canadian Medical Colleges

Problems:
- The current production of physicians will not meet future demand.

Solutions:
- To maintain the existing physician-to population ratio of 1.9:1,000, Canada needs to increase annual medical school enrolment to 2,500 by the year 2007 from the current level of approximately 2,000.
- 500 more international medical graduates are also needed each year to offset exits from the system through emigration and other routes.

Canadian Association of Radiologists:

Problems:
- There are currently 150 full-time vacancies for radiologists in Canada (representing 8 per cent of the total radiologist workforce). This number is almost 300 per cent higher than in 1995 (before the effect of cutbacks). The vacancies are government-approved positions and are indicative of an access to care problem for Canadian patients.
- 30 to 40 radiologists per year intend to retire in the next few years and close to 10 per cent of the existing workforce is already more than 65 years old.
- Given that the Canadian population is expected to increase by 18 per cent over the next 20 years, an estimated shortfall of more than 500 radiologists by 2024 can be expected if nothing is done to correct the situation. And this estimate does not take into account that the elderly population will increase by 63 per cent in the same period, which will further increase the demand for medical imaging services.
- While the current radiologist-to population ratio is 1:18,000, a more appropriate target is 1:13,000.

Solutions:
- Increase immediately the number of radiology residency positions in Canada (by at least 25 per cent).
- Offer more flexibility in career choices for medical students across Canada by allowing changes in training programs during residency.
- Increase re-entry positions in radiology to give practicing physicians the opportunity to enter a residency program.
- Create a retention and repatriation program for Canadian radiologists.
Problems:

- While Canada needs to graduate at least 2,500 new doctors every year to meet the needs of Canadians, only an estimated 1,773 will graduate this year (2005). Just as importantly, the average age of Canadian physicians is 49 years, while 30 per cent are 55 or older.
- Some 3,800 Canadian doctors are expected to retire in the next two years, more than double the rate of recruitment.
- Canada ranks 24th out of 30 OECD countries in terms of access to physician;
- Close to 4 million Canadians (one in six) don't have access to a family physician;
- 25 per cent of Quebec residents don't have access to a family physician;
- 60 per cent of physicians are limiting the number of new patients they see, or are not taking new patients at all;
- 26 per cent of physicians plan to reduce the number of hours they work compared with only 4 per cent who plan to increase the number of hours.
- Physician resources planning are complex. An affordable balance must be struck between population health needs and expectations, and the supply of professional activity and distribution of physicians.
- The unique needs of Canada’s remote rural communities and especially its dispersed northern populations must be considered.
- In planning for supply, it is essential to project not only the number of physicians but also some measure of their likely level of professional activity.
- Changes in lifestyle among physicians and demographic composition (e.g. an increasing proportion of women) are affecting Canadians’ access to physicians.
- Another factor is the impact of new practice models and types of payment that are being developed in order to enhance comprehensiveness of care for individual patients. The current shift to alternate payment and collaborative care models may, or may not, increase the administrative portion of a physician’s workload and decrease the number of patients seen and treated, thus increasing the need for additional physicians.

Solutions:

- Canada needs to graduate at least 2,500 new doctors every year to meet the needs of Canadians.
- To develop and implement initiatives in physician resources planning, governments must work co-operatively with the medical profession to design policies that are both sensitive to the needs of the population and affordable. Thus, there is a need to build in flexibility,
especially in the complex areas of enrolment and training policies. As well, effective planning requires ongoing and meaningful consultation.

- For physician resource planning to be most effective, the following conditions must be met: (a) physician resources policies must be reviewed jointly by government and the profession, including its undergraduate and postgraduate educations sector, on an ongoing basis within a five-year planning cycle, and (b) attempts to manage growth in physician supply through changes in undergraduate enrolment or postgraduate medical training positions must consider all factors that contribute to an adequate physician workforce. These include the number of Canadian graduates, the supply and mix of international medical graduates, attrition rates, and changing practice patterns.

- Planning for provision of physician services to meet changing health care needs should focus on having the right physicians in the right places doing the right things. This requires an assessment of the supply, distribution and scope of activity of different physicians groups and other health care professionals. It must also recognize the shifts in service delivery that occur with development of new technologies, and the changing prevalence of some disease states.

- The balance of family physicians and specialists as well as the types of specialty services that are available influence the nature of medical services. Planning must recognize the impact on physician supply of the current emphasis on 24/7 access to a wide scope of physician and health care services. Planning must consider the increase in public concern regarding access to family physicians plus demand for more highly advanced services provided by subspecialists.

- CMA recognizes the important contribution that international medical graduates (IMGs) have made and continue to make toward the provision of medical services, teaching and research in Canada. However, the objective of seeking reasonable self-sufficiency for the full range of physicians must be paramount. Self-sufficiency is defined as ensuring that the annual output of the undergraduate and postgraduate sector of Canadian medical schools meets the medical service needs of the Canadian public. The correction of existing deficiencies in physician number and assurance of an adequate future supply will allow a larger segment of Canadian citizens and landed immigrants to successfully compete for medical school entry. It will reduce the need to attract physicians from abroad, often from countries whose requirements for physician services exceed those of Canada.

- In this context, it is also important to facilitate both the retention of physicians who train in the Canadian postgraduate system and the repatriation of those who have emigrated. This requires advocacy for working environment and a healthcare infrastructure, including its academic component, that would promote such retention and repatriation.

- There is a need for a sufficient number of post-MD positions to accommodate Canadian graduates, international medical graduates and retraining of licensed physicians wishing to retain in one of the specialties.

- A new health reinvestment fund, to be cost-shared by the federal government and the provinces, should be established to address the critical shortage of health care providers.
A National Health Human Resource Strategy is needed to help end the health human resources boom-and-bust cycle by building an integrated approach to health human resource planning. A national HHR strategy would take into account demographic shifts; it would also recognize the need to increase the number of postgraduate medical training positions to ease the backlog of several hundred international medical graduates already in Canada but unable to get into training programs to meet competency requirements needed to practice in Canada.

**Canadian Nurses Association (CNA)**

*Brief to the House of Commons Standing Committee on Finance, 2002*

**Solutions:**

- The federal government should play a significant role in the development of an integrated pan-Canadian strategy which addresses education, workplace and employment issues, as well as scope of practice, continuing education and training.

- In particular, the federal government must lead the research and data collection necessary to support the development and evaluation of the strategy.

- The federal government should create an Institute of Health Human Resource to:
  - conduct research on productivity and organization of HHR including health care delivery models, skills mix and team structure, and effectiveness of interventions;
  - provide support for nursing education and capacity building;
  - facilitate access to continuing education and life-long learning;
  - co-ordinate incentives to attract health professional to rural and remote areas.

- The federal government should ensure the future of our publicly funded, not-for-profit health system by:
  - investing in the development of a pan-Canadian framework for human resource planning in the health sector;
  - investing in measures to successfully integrate foreign-educated nurses into the Canadian health system;
  - allocate funding for the development and implementation of a human resource plan to support the provision of quality health services to First Nations and Inuit peoples;
  - leading the development of a pan-Canadian framework within which provincial and territorial governments can develop and co-ordinate their plans for recruiting and retaining human capital in the health sector. The framework would include principles such as:
    - interdisciplinary practice
    - needs-based care
    - integration across all provinces and territories
o being fiscally responsible
o being comprehensive including all components of the health sector
o include short-, medium- and long-term planning, and
o utilize all health providers to their maximum capability.

CNA on collecting data to reflect the impact of nursing practice: position statement, 2001

Solutions:
• Registered nurses and other stakeholders in health care delivery require information on nursing practice and its relationship to client outcomes.
• A co-ordinated system to collect, store, and retrieve nursing data in Canada is essential for health human resource planning and to expand knowledge and research on determinants of quality nursing care.

Canadian Society for Medical Laboratory Science

Problems:
• Nearly half of Canada's medical laboratory technologists will be eligible to retire over the next 10 years.

Solutions:
• Develop a more integrated and evidence-based approach to health human resource planning; effective human resource planning can't be done in isolation, nor can it be done without accurate data.
• Centralize health human resource planning under the leadership of the Health Council of Canada, as recommended in the Romanow report; governments and health care providers must work together to make this happen.
• Establish a national data base to identify the scope of the problem and define the short- and long-term needs.
• Co-ordinate and share labour market information to help determine accurate projections at least three to five years in advance.
• Co-ordinate and share educational program information to ensure that a sufficient number of positions are available to train future medical laboratory technologists.
The College of Family Physicians of Canada

National Physician Survey (NPS), 2004

Problems:

- Demographic shifts identified in the NPS are producing profound changes for the health-care system that will need to be tackled by government decision makers.
  - A tight physician supply is negatively impacting access to care and wait times for Canadians. This finding will be exacerbated as about 10 per cent of pathologists, internal medicine specialists, general surgeons and otolaryngologists plan to retire in the next two years.
  - Highlights of the regional data contain other dire projections – e.g. some 10 per cent of physicians in Newfoundland and Labrador are planning to leave the province in the next two years.
  - A large number of physicians are reaching retirement. If the survey data is translated to the physician population as a whole, as many as 3,800 doctors plan to retire entirely in the next two years alone. This is more than double the current rate of recruitment.
  - Women are now dominating entry into the field, making up over half of all new physicians coming out of medical school. On average, female physicians work about seven fewer hours a week than their male colleagues. The primary reason women are working fewer hours is they tend to have additional family responsibilities.

Solutions:

- There should be 2,500 medical school entry positions in Canada by 2008.
- Medical schools should modify admission criteria to encourage more successful applicants from Aboriginal, rural, remote and other underserved communities.
- Medical schools must allocate a minimum of 45 per cent of all PGY-1 positions across Canada to family medicine and encourage and support students to select these positions for residency training.
- Health planners, in collaboration with medical organizations, must define what is considered to be an appropriate, sustainable mix of Canadian and international medical graduates to meet the ongoing needs of Canadians.
- There is a need to develop appropriate national targets and benchmarks that are patient-centered and that support the appropriate use of health human resources, including family doctors.
Dietitians of Canada

Problems:

- There is an inadequate number of nutrition practitioners proportionate to community needs and lack of population needs-based funding mechanism to support access to nutrition services; however, the number of dietitians required to address the unmet need for nutrition services is unknown and will require additional work to define.
- An adequate number of registered dietitians working as members of interdisciplinary primary health care teams are needed to effectively implement Canada’s population health/healthy living strategies.
- The lack of population needs-based funding has created inequitable access to required nutrition services, in spite of repeated demonstration that nutrition services are cost effective.

Solutions:

- Population-health strategies require a minimum ratio of one public health nutrition position for each 50,000 people.

National Aboriginal Health Organization

Solutions:

- HHR planning must be innovative so as to address the demand for access to traditional healers, healing practices and midwifery.

National Association of Pharmacy Regulatory Authorities

Problems:

- Canada is facing a shortage of approximately 7 per cent to 9 per cent of the pharmacy workforce, or some 2,000 to 2,500 pharmacists.

Nursing Sector Study – Building the Future: An Integrated Strategy for Nursing Human Resources in Canada, 2005

Solutions:

- Develop a pan-Canadian approach to nursing education in collaboration with the provincial, territorial and federal governments to prepare the number of qualified graduates needed to meet workforce needs.
- Enhance data collection to improve human resource planning.
- Use a Health Human Resource Planning Framework based on population health needs to plan for nurse resources.
- Develop standards to support the creation of unique identifier for nurses to facilitate longitudinal tracking of nurses throughout their education and careers in order to track interprovincial mobility, provide data to facilitate workforce projections, and forecast requirements for educational programs.
Appendix VII: Federal / Provincial / Territorial Health Human Resources Initiatives

FEDERAL AND F/P/T INITIATIVES:

The following information was provided by Health Canada, May 2005.

1. **PAN-CANADIAN HEALTH HUMAN RESOURCE STRATEGY**

The overall goals of the Pan-Canadian Health Human Resources Strategy are to secure and maintain a stable and optimal health workforce in Canada and to support overall health care renewal. These goals will be achieved through the implementation of three broad initiatives:

- Pan-Canadian HHR planning
- Inter-professional education for collaborative patient-centred practice (IECPCP)
- Recruitment and retention

The activities that support the objectives of the Pan-Canadian HHR Strategy are outlined below.

*Pan-Canadian HHR Planning*

The Pan-Canadian HHR Planning initiative will help to ensure that Canada has enough of the right types of health care providers in order to meet the needs of Canadians, now and in the future.

Key activities under the Pan-Canadian HHR Planning Initiative include: the enhancement of HHR data, modelling, and forecasting; and the development of the *Framework for Collaborative Pan-Canadian Health Human Resources Planning*. These activities are described in greater detail below.

*HHR Data Enhancements:*

**Minimum Data Set Project**

With partial funding from Health Canada, the Canadian Institute for Health Information (CIHI) has developed a national minimum data set (MDS) to guide HHR data collection for other health professions in Canada. Public consultations for the MDS were conducted for this project. The final report was posted on the CIHI website in February 2005.
HHR Databases Development Project
Health Canada has a multi-year contribution agreement with CIHI to develop, for the first time, national, supply-based database and reporting systems for the following health professions: pharmacists, occupational therapists, physiotherapists, medical laboratory technologists, and medical radiation technologists.

HHR Education Data Enhancement
Health Canada and Statistics Canada are collaborating to assess and report on the education indicators necessary to monitor the supply of health professionals. These reports will enable decision makers to better understand how health profession students determine their careers and will permit examination of the reasons for attrition and career change in various health professions. The collection of this data will assist in HHR planning. In keeping with the collaborative approach, Statistics Canada has consulted the federal, provincial, and territorial ministries of health and education, health provider organizations, CIHI, HHR researchers, and other related organizations to determine the needs associated with education data.

HHR Modelling and Forecasting:
Pan-Canadian Inventory, Assessment and Gap Analysis of HHR Models and Forecasting Capacity: The intended outcome of this activity is the development of an evidence base concerning federal, provincial, and territorial modelling capacity to assess supply of and needs for health providers.

Framework for Collaborative Pan-Canadian Health Human Resources Planning:
The federal, provincial, and territorial governments have initiated work on a Framework for Collaborative Pan-Canadian HHR Planning. They are developing a collaborative approach based on successful examples of health human resource planning among jurisdictions. The purpose is to facilitate collaboration and avoid the risks and duplication associated with the current jurisdiction-by-jurisdiction approach to HHR planning. The Framework is being developed by the HHR Planning Subcommittee.
Inter-professional Education for Patient-Centred Collaborative Practice (IECPCP)

The IECPCP initiative of the Pan-Canadian HHR Strategy seeks to facilitate the adoption of IECPCP across all health care sectors. The broad goals are to contribute to improved patient and provider satisfaction and, ultimately, to improve patient outcomes. The specific objectives of the IECPCP initiative are to:

- promote and demonstrate the benefits of IECPCP;
- increase the number of educators prepared to teach from an interdisciplinary collaborative patient-centred perspective;
- increase the number of health professionals trained for patient-centred interdisciplinary practice at the level of entry to practice, graduate education and continuing education; and
- stimulate networking and sharing of best educational practices for collaborative patient-centred practice.

A five-year undertaking, the IECPCP Initiative has embarked on several exciting activities in support of its objectives. For example:

**Year One (2003/2004: Building the Foundation)**

- A National Expert Committee to guide the Initiative was established.
- Best practices for inter-professional education were identified through a literature review and environmental scan.
- Ten discussion and synthesis papers were commissioned exploring important issues concerning IECPCP, including:
  - attitudes, perceptions, structural and regulatory barriers to interdisciplinary education;
  - principles and methods of interdisciplinary education and collaborative patient-centred practice; and
  - required faculty development to implement IECPCP.
- Publication of a bilingual monograph of the above research is planned to be released for the winter of 2005.
- Study tours of five sites in the UK took place in February 2004 to gather information on international developments in IECPCP.
- A strategic communication framework was developed to disseminate information concerning the Initiative.
- A national stakeholder meeting attended by over 100 participants took place on March 31, 2004.

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Environmental Scan of Current Views: Background Paper for the National Health Human Resources Summit
Health Council of Canada
• Discussion papers on accreditation issues and a dissemination plan were commissioned.

• A call for proposals for a two-cycle funding program was developed and is available on Health Canada's HHR website at: www.health-human-resources.ca.

**Years Two - Five (2004 - 2008): Collaborative patient-centred practice learning and network project funding**

• The two-cycle call for proposals will begin funding priority projects in the spring of 2005 for projects lasting until March 2008. Funding for the second cycle will begin funding projects in November 2005.

**Recruitment and Retention**

The Recruitment and Retention Initiative of the Pan-Canadian HHR Strategy seeks to address the above issues by accomplishing the following objectives:

• increase interest in health careers, both generally and in specific areas of shortage;

• increase the supply of health care providers to ensure availability when and where needed;

• reduce barriers for internationally educated health providers;

• improve utilization and distribution of existing health care providers; and

• make current workplace environments healthier for health care workers and, in doing so, support the provision of high quality care.

The following are brief descriptions of several projects funded and activities taking place under the Recruitment and Retention Initiative.

**Enhancement of Physician Health Human Resources in Rural Canada:**

Health Canada funded Society of Rural Physician in Canada to develop strategies to strengthen the recruitment and retention of rural physician and to enhance existing rural medical education programs.

**Family Physicians:**

The College of Family Physicians of Canada committed funding to enhance the image of family medicine to all Canadians, to raise the role of family medicine in undergraduate medical school curricula, and to increase support for family physicians in primary care.
**Health Human Resources Deployment Strategies:**
Health Canada funded Dalhousie University, School of Public Administration to establish a national conference on innovative HHR deployment strategies.

**Promotional Campaign of the Health Care Professionals:**
Health Canada funded the Canadian Medical Association, in collaboration with the Canadian Nurses Association, to develop and implement a multimedia national campaign on health care providers. The objectives of this campaign are:

- To raise awareness that health care providers are worthy of our esteem and respect thereby increasing the moral reward of a health care professional career;
- To raise awareness that health care professionals, in addition to providing exemplary care, offer a valuable service to the public, while at the same time add value to the Canadian economy; and
- To provide positive reinforcement for health care providers.

**Continuing Education for Health Care Providers:**
Health Canada produced a literature review and an environmental scan, which were the basis of a report on continuing education of health care providers in Canada. This report identified the barriers to continuing education access and the best practices for improving access and delivery of continuing education to health care providers in rural, remote, northern, Aboriginal, and inner city communities in Canada.

**Internationally Educated Health Professionals:**

*International Medical Graduates (IMG)*

The Government of Canada has currently committed funding, largely from Health Canada and HRSDC, to implement recommendations from the IMG Task Force. Most of the IMG initiatives are well underway, with an IMG steering committee overseeing their implementation. The IMG Task Force recommendations and the subsequent activities are as follows:

1. **Increase capacity to assess/prepare IMGs**
   Health Canada has committed funding to provinces and territories over three years for assessments of unlicensed IMGs who are Canadian citizens or permanent residents. Each jurisdiction is allocated $60,000 with additional funds proportional to population.

2. **Work towards standardization of licensure requirements**
   A National Assessment Collaboration (NAC), funded by Health Canada and led by the Medical Council of Canada, is pursuing work on a common approach to evaluation of IMGs applying for licensure.
3. **Expand/develop programs to assist IMGs with licensure processes and requirements**

Health Canada has provided $112K to the Association of International Physicians and Surgeons of Ontario (AIPSO) to establish a website, which was launched in April 2005, for IMGs and stakeholders with information on integration into Canadian health workforce.

Additionally, HRSDC has committed funding to the Medical Council of Canada towards the development of a self-assessment tool that will provide candidates with tools to assess readiness and assist them in identifying areas they need to increase knowledge and competence.

HRSDC also has funded the Medical Council of Canada to establish a National Credential Verification Agency to provide a streamlined process for verifying the credentials of IMG.

4. **Develop orientation programs to support faculty and MDs working with IMGs**

Health Canada has committed funding to the Medical Council of Canada to establish an interactive web-based learning program on the cultural, legal, ethical, and organizational aspects of medical practice in Canada.

Health Canada has also committed funding to the Association of Faculties of Medicine of Canada (AFMC) to establish a national faculty development program for those schools working with IMGs and other internationally educated professionals.

5. **Develop capacity to track and recruit IMGs**

HRSDC provided funding to the Canadian Post-MD Education Registry (CAPER) to develop a database that tracks the number, activities, and locations of IMGs.

The Canadian Medical Association (CMA) received $25K from Industry Canada to provide IMGs with electronic tools to create online résumés and search and apply to medical and health-related employment opportunities through the existing medconnexions.ca initiative.

6. **Develop national research program and evaluation of IMG strategy**

The IMG Implementation Steering Committee is planning for the development of a template for the evaluation of the IMG initiatives and the overall strategy.

*Internationally Educated Nurses (IENs)*

A federal, provincial, and territorial task force was established to examine internationally educated nurses. HRSDC funded the Canadian Nurses Association to conduct an analysis on the IENs in Canada. The results of this
analysis and a report released in May 2005 will provide directions to the IENs Task Force.

*Other Internationally Educated Professionals*

The 2005 Budget provides $75 million over five years to accelerate and expand the assessment and integration of internationally educated health care professionals to address Canadians’ concerns about timely access to health care. The funding will be used to evaluate clinical skills, knowledge, language proficiency and prior learning activities of internationally educated health care professionals; and to increase the number of clinical placements for physicians, nurses and other regulated health care professionals.

Consultations have recently begun pertaining to internationally educated occupational therapists, physiotherapists, medical laboratory technologists, medical radiation technologists and pharmacists. These five professions and F/P/T governments met in September and December 2004 to examine common issues and barriers, and recommend common opportunities for change.

*Scopes of Practice:*

Some of the funds under the HHR Strategy have been set aside to conduct developmental work in this area.

*Healthy Workplace Initiative (HWI):*

The main objective of the HWI is to support current actions by health care organizations to create and maintain healthy work environments. This is based on the fact that healthy work environments contribute to positive outcomes for workers and to improved health service quality, cost-effectiveness, and workforce renewal.

Progress depends on addressing symptoms of unhealthy workplaces; focusing on how front-line patient care or related health services are provided; and supporting local initiatives that precipitate improvements in the short-term in one or more of the following areas: work environments; health and well-being of health care staff; and job satisfaction and quality of work life.

The HWI will identify and provide direct funding to support innovative local-level initiatives that promote healthy workplace practices, thus building momentum for positive change and providing a basis for a shared vision of a healthy workplace.
Health Canada provided funding to support innovative HWIs of individual organizations nominated by provincial and territorial governments and selected for funding commencing in Spring 2005. This funding is intended to complement and not replace provincial or territorial government activities and/or their funding.

**First Nations and Inuit Activities under the Pan-Canadian HHR Strategy**

First Nations and Inuit HHR activities are carried out in all three Pan-Canadian HHR Strategy initiatives, and will be undertaken with First Nations, Inuit and the Strategy partners. The objectives of this component of the Pan-Canadian HHR Strategy are to:

- Develop and implement an HHR strategy that will meet the unique health service needs of First Nations and Inuit;
- Respond to the current, new and emerging health services issues and priorities; and
- Integrate First Nations and Inuit HHR activities with the Pan-Canadian HHR Strategy, wherever appropriate.

Among the activities related to First Nations and Inuit HHR are:

- Support National Aboriginal Achievement Foundation’s (NAAF) *Blueprint for Future* career fair program for Aboriginal youth - to provide information on health careers at a series of regional health fairs;
- Provide funding to support the work of the AFN and the Inuit Tapiriit Kanatami (ITK), Canada's national Inuit organization, to engage their involvement in the health human resources planning and implementation processes, and to bring forward the perspective of First Nations and Inuit to the process;
- Northern Ontario School of Medicine: support for Aboriginal medical student “unsuccessful candidate review” study and cultural immersion pilot (matched by Health Canada’s First Nations and Inuit Health Branch Ontario region) - to help make medical school more accessible to Aboriginal students, and to provide practicum opportunities in First Nations communities for medical students;
- Support the National Indian and Inuit Community Health Representative Organization (NIICHRO) project to continue work on the Community Health Representative (CHR) scope of practice & certification issues, to ensure that CHRs are properly prepared to provide quality community health care, and establish a certification process;
- Addressing curricula and admission/support policy changes for medical schools through the Association of Faculties of Medicine of Canada and their Aboriginal Task Group;
• Implementation of NAAF *Health Careers in the Classroom* program - a multi-media health careers promotion program designed and developed for classroom delivery to First Nations youth;

• Work with National Aboriginal Health Organization on CIHI national minimum data set to develop and collect data indicators on Aboriginal health care workers;

• Provide support to the National Aboriginal Health Organization to hold a national forum on Aboriginal Midwifery - April 27, 2005;

• Lead and report on a strategic planning session on Aboriginal health human resources, engaging provincial, territorial, Aboriginal and other health human resources partners - April 28-29, 2005.

2. PRIMARY HEALTH CARE TRANSITION FUND (PHCTF)

Among the common objectives of the PHCTF – which were agreed to by federal, provincial, and territorial governments – are to:

• establish interdisciplinary primary health care teams of providers, so that the most appropriate care is provided by the most appropriate provider;

• increase the proportion of the population having access to primary health care organizations accountable for the planned provision of a defined set of comprehensive services to a defined population; and

• expand 24/7 access to essential services.

Some PHCTF projects that specifically involve HHR are as follows.

*Enhancing Interdisciplinary Collaboration in Primary Health Care: A Change Process to Support Collaborative Practice*

The Canadian Psychological Association has been funded in partnership with other health professional organizations to develop principles and a framework to advance interdisciplinary collaborative care in primary health care settings.

*Helping to Sustain Canada’s Health System: Nurse Practitioners in Primary Health Care*

The Canadian Nursing Association received funding to develop recommendations and processes to support the implementation of the role of the nurse practitioner in primary health care across Canada.
Health Canada’s First Nations and Inuit Health Branch – Nursing Strategy and Health Integration Initiative

The objectives of this initiative are to address long standing recruitment and retention issues for nurses, develop sustainable clinical and professional supports and resources for nurses working in First Nations and Inuit communities, and to develop strategies to increase the number of aboriginal people entering the health care professions, particularly nursing.

PROVINCIAL & TERRITORIAL INITIATIVES

Nova Scotia

The following information was provided by the Government of Nova Scotia, May 2005.

Health Human Resources Planning

- Consultant hired by Atlantic Ministers of Health and Education developing methodology for creating projections related to various health professions.
- Utilizing Health Canada funding for health human resources planning activities, work with the Dalhousie University Faculty of Medicine on a funding review with a focus on social accountability.
- Utilizing Health Canada funding for health human resources planning activities, build enhancements for the InfoWay registry to encompass health human resources planning forecasting.
- Utilizing Health Canada funding for health human resources planning activities, develop and implement an allied health care professional, high school counselling program. Targeting youth involved in career planning, this will provide an awareness of the opportunities that are available in the allied health care professions.
- Utilizing Health Canada funding for health human resources planning activities, consult with stakeholders regarding hardware enhancements required to provide increased access to the web-based, clinical placement tool (HSPnet). Enhancements would ease the process of placing trainees in communities across the province.

Primary Health Care

- Development of regulatory framework for the inclusion of midwives in primary maternity care collaborative teams.
- Building a Better Tomorrow initiative: With Nova Scotia as lead, the four Atlantic provinces are working together to develop and deliver training for primary health care providers to enhance collaborative practice team development. An Atlantic needs
assessment has been completed and the design of education modules is in progress. Delivery is planned to begin by June 2005.

**Nova Scotia Nursing Strategy**

- Continued implementation of the Nova Scotia Nursing Strategy with funding for implementation of specific initiatives to go through the business planning process for fiscal 2005-2006.
- Completion of long-term planning for nursing leadership development scope of practice and nursing education.

**Rural and Remote Recruitment and Retention Strategy for Nurses**

- Approval in principle for rural and remote Recruitment and Retention Strategy for Nurses. Continued implementation of recommendations under this year’s funding and request additional funding through the business planning process for fiscal 2005-2006.

**The Northwest Territories**

*The following information was provided by the Government of the Northwest Territories, Department of Health and Social Services, May 2005.*

**Professional Development Initiative (PDI)**

The Professional Development Initiative (PDI) is intended to provide specific health and social services front line professionals and managers with increased opportunities for professional development, education and training by providing dedicated monies to facilitate professional development opportunities.

**Community Health Nurse Development Program**

The Community Health Nurse Development Program will contribute to developing a stable registered nurse workforce in NWT Community Health Centers by:

- Assisting the Department of Health and Social Services and its affiliated Health and Social Services Authorities/Board with the succession of existing northern Registered Nurses into the role of Community Health Nurse.
- Facilitating the acquisition of knowledge, skills and abilities required in the role of Community Health Nurse through developmental activities identified through a competency based development program.
Some of these initiatives include, but are not limited to, bursaries. To attract and retain northern students in nursing programs, return-of-services bursaries have been put in place to provide financial support to northern students enrolled in nursing programs.

**Nurse Mentorship Program**

The Nurse Mentorship Program (NMP) integrates new northern nurses into NWT work settings by providing professional development and clinical support for new graduates. The type and duration of support provided is identified through an individualized professional development plan, and is facilitated by a Nurse Educator Mentor.

**Maximizing Northern Employment: Graduate Nurse Placement Program**

The Graduate Nurse Placement Program (Grad Placement) was introduced in 2001 as an aggressive effort to recruit and retain all NWT residents who complete their degree or diploma in nursing by providing nurse graduates with an offer of indeterminate employment.

The program will contribute to establishing and sustaining a registered nurse workforce in the Northwest Territories by:

- Recruiting new NWT nurse graduates to NWT nursing positions; and
- Facilitating the consolidation and development of clinical skills and personal confidence for successful transition to community and work environments by providing professional development opportunities in the workplace.

**Nurse Practitioners Bursary For Part Time Studies**

The Nurse Practitioner Bursary for Part Time Studies is available to NWT residents who are registered with the RNA NT/NU, and who are accepted in a part time program at either the Aurora College Nurse Practitioner Education Program in Yellowknife, or a nurse practitioner undergraduate or masters degree program offered at an accredited post secondary institution in Canada.

**Nurse Practitioner Education Leave Bursary (NP-ELB)**

The Nurse Practitioner Program Education Leave Bursary is available to NWT residents who are accepted in a full time nurse practitioner undergraduate or masters degree program at an accredited post secondary institution in Canada. Bursary applicants must be RNs, licensed to practice in the NWT, and employed by the GNWT or the Hay River Health & Social Services Authority in a full time indeterminate position. Applicants must be willing to return to/remain in the NWT upon graduation to fulfill the requirements of a Return of Service Agreement.
Social Work Mentorship Program

This mandatory program will contribute to retaining social workers in the Northwest Territories by:

- Providing support for newly hired social workers and supervisors, and
- Enhancing the personal and professional development of newly hired social workers and supervisors, thus allowing for successful transition to community and work environments.

Manitoba

The following information was provided by the Government of Manitoba, May 2005.

Manitoba Nursing Strategy: Five Year Progress Report

The Manitoba government has made a commitment to nurses in two key areas:

- training and recruitment of adequate numbers of nurses in a variety of areas of nursing; and
- the retention of nurses in workplaces that respect and maximize the professional skills and experience of nurses for the well-being of patients and clients.

The Manitoba government announced a five-point nursing strategy to address the concerns raised by nurses and other stakeholders within the health care system. Significant progress has been made and there are more actions that can and will be taken. The plan is to:

1. Increase the supply of nurses;
2. Improve access to staff development for nurses;
3. Improve the utilization of nurses;
4. Improve working conditions;
5. Increase nurses’ opportunities to provide input into decision-making.

The Aboriginal Midwifery Education Program

The Aboriginal Midwifery Education Program (AMEP) will provide midwifery students with a blend of traditional Aboriginal and Western methods of practice, and will include both classroom and clinical components. When their education is complete, the midwives will provide culturally appropriate birthing services primarily to remote and northern Aboriginal communities in Manitoba and in Nunavut and the Northwest Territories.
Rural Physician and Health Services Review

A health services review was conducted in the rural Assiniboine Regional Health Authority (ARHA). Highlights of the report’s findings include the following conclusions:

- Challenges faced in the ARHA are similar to those in rural settings across Canada and the world.
- Recruiting and retaining more rural doctors will require larger on-call rotations and less cross-community sharing of on-call responsibilities. The excessive on-call schedules required to serve small emergency rooms must be addressed. In smaller communities that cannot support more than two doctors, current arrangements often require doctors to be on-call for 24 hours every second day.
- Establishing an acceptable on-call system for doctors poses serious challenges to maintaining the ARHA’s 20 hospitals.
- Rural residents want more input into decision making about the future of their health care.
- The Office of Rural and Northern Health needs to continue developing its role in promoting the education, recruitment and retention of doctors and other health care professionals in rural and northern Manitoba.
- Improving rural health care will require co-operation among the province, the RHA, communities, the Office of Rural and Northern Health and the faculty of medicine.

Recruitment and Retention Framework for Rural Doctors

The objective of this framework is to stabilize the supply of doctors in rural Manitoba. Highlights of the new Rural Doctor Recruitment and Retention Policy Framework include:

- reducing on-call and cross-coverage responsibilities for rural doctors;
- supporting flexible methods of payment to address the unique needs of rural doctors;
- supporting rural doctors who work to develop specialties and upgrade their skills;
- improving supports and orientation for rural doctors and their families; and
- continuing support for the work of the Office of Rural and Northern Health.
**Ontario**

*The following information was provided by the Government of Ontario, May 2005.*

Ontario has completed specific health human resources plans for physicians and nurses. The broader health human resources strategy is under development.

Ontario has funded a joint project with the Ministry of Health and Long-Term Care, McMaster University and University of Toronto to design a collaborative service delivery model and interdisciplinary educational curricula for family physicians, nurse practitioners and pharmacists.

Also, Ontario released various reports that have provided advice that has helped inform Ontario’s health human resources planning. These reports are:

- *Physicians for Ontario: Too Many? Too Few? For 2000 and Beyond*
- *Ontario: A Leader in Learning, Report and Recommendations* (February 2005 – Bob Rae)
- *Shaping Ontario’s Physician Workforce: Building Ontario’s Capacity to Plan, Educate, Recruit and Retain Physicians to Meet Health Needs*

The key recommendations from the last report listed above are:

1. Plan physician services to meet needs;
2. Provide appropriate education;
3. Produce the right supply and mix of physician services;
4. Attract and retain physicians where they are needed.

**Newfoundland And Labrador**

*The following information was provided by the Government of Newfoundland and Labrador, May 2005.*

HHR planning began in the province in 1999. Since that time, the Human Resource Planning Unit has completed many reports related to key workforce indicators.

In its final report of July 2003, the Human Resource Planning Steering Committee provided recommendations related to integrated planning, system leadership, appropriate supply, quality workplaces and sufficient data. Below is a summary of key recommendations:

- HHR be incorporated into provincial and regional strategic health planning goals and objectives;
• Provincial and federal governments partner with stakeholders when increased entry to practice educational requirements are being considered, including an analysis of the need for such increases and their impact on the sustainability of the workforce;

• Governments and health boards define minimal competencies for health and community services system managers and develop learning plans on how these competencies will be achieved;

• Educational institutions offering health-related programs monitor key issues affecting availability of faculty;

• Health boards work with educational institutions to increase support of preceptorship;

• Health boards and educational institutions work together to develop comprehensive orientation programs to prepare graduate for the workplace;

• Government support a bursary program;

• Health boards, professional associations, unions and other stakeholders develop a plan to identify and adopt best practices for quality professional practice environments;

• Government and health boards work toward a five-year plan to ensure that a minimum of one per cent pf payroll is dedicated to training, continuing education, and other professional development;

• Governments and health boards establish minimum workload data reporting requirements;

• Health boards implement a standard exit survey to capture information on reasons why employees leave health boards; and

• Government work with professional associations to identify and implement a suggested minimum data set to be submitted by professional associations annually.

**Saskatchewan**

The following information was provided by the Government of Saskatchewan in 2004 for the Health Council of Canada’s 2005 annual report; additional information was obtained from the Government of Saskatchewan website, May 2005.

A 2001 provincial health human resources Action Plan for Saskatchewan Health Care included a plan to retain, recruit, and train health care providers.
**Bursary Program**

The purpose of Saskatchewan Health’s Bursary Program is to retain and recruit needed health care professionals to meet the needs of the people of Saskatchewan. The Saskatchewan Health Bursary is offered to students in a variety of health disciplines. In return for this assistance, a bursary recipient must commit to work in a publicly funded position in Saskatchewan.

The Bursary Program has three components:

1. **Allied Health Provider Bursaries.** This includes a number of health disciplines that are facing the greatest recruitment and retention difficulties. The specific disciplines eligible for bursary assistance changes on a yearly basis in order to adapt the retention and recruitment strategy to ongoing changes in markets and health systems.

2. **Nursing Bursaries.** This includes bursaries for students studying a variety of nursing disciplines, such as those studying to become registered nurses, registered psychiatric nurses, licensed practical nurses, and primary care nurse practitioners. Also included in this category are “re-entry” bursaries for individuals who trained and worked as nurses in the past and wish to return to practice and re-certify in the profession, as well as nurses pursuing masters and doctorate degree for the purpose of becoming a nurse educator.

3. **Physician Bursaries.** As part of broad spectrum of retention and recruitment initiatives targeted at physicians, financial assistance is provided to physicians in various stages and types of education and practice.

The following brief description of provincial and territorial HHR initiatives is summarized from information provided in 2004 by the provincial governments for the Health Council of Canada’s 2005 annual report. Updated information was not made available for this environmental scan.

**Alberta**

Health workforce plan developed with Alberta learning and regional health authorities. Projection model developed by Alberta Health and the Alberta Medical Association.

**British Columbia**

Health human resources plan is developed – part of health goals and separate 10-year plan on health human resources.

**International Rural Placement Program**

The program was established in 2003 to foster rural recruitment of health professionals and to cultivate interprofessional education for client-centered collaborative care.
Quebec
A health human resources plan is under development and linked to a health system redesign currently underway. The province also has some initiatives underway to recruit and retain nurses and physicians.

New Brunswick
The province has completed supply forecast models for all health care professions, including physicians and is participating in the development of an Atlantic education and training forecasting model. The province is working with its Atlantic partners on providing interdisciplinary training to health professionals. This program, Building a Better Tomorrow, is funded through the regional projects envelope of the Primary Care Transfer Fund. The province has initiatives underway for recruiting and retaining health professions.

Prince Edward Island
Phase one of a profile of all health and social service professions is completed. Phase two implementation is underway. Five-year Health Human Resources Plan for the Health System is in the final draft stages. PEI has adopted more of a focus on collaboration at the workplace, as the province does not have a medical school to facilitate interprofessional education. Also, the province has initiatives underway for recruiting and retaining health professions.

Yukon
The government has current focus on recruitment and retention, collaboration in the workplace and interdisciplinary management of chronic diseases.

Nunavut
The government has a current focus on telehealth and recruitment and retention.
Selected References


Canadian Association of Radiologists. 2001. Timely access to quality care - the obligation of government, the right of Canadians. CAR Forum 45(3):3-4.


Canadian Federation of Medical Students. 2000. Double jeopardy: the CFMS position on the threat of escalating medical school tuition fees limiting access to medical education in Canada. This and other position papers are available at www.cfms.org/representation/papers.cfm.


Canadian Nurses Association. 2001. Quality professional practice environments for registered nurses. This and other position statements are available at www.cna-nurses.ca.


In addition, the following organizations prepared a summary of policy position statements for the Health Council of Canada to support this environmental scan:

Canadian Healthcare Association
Canadian Medical Association
Canadian Medical Protective Association
Canadian Nurses Association
Canadian Nurses Protective Society
College of Family Physicians of Canada
National Aboriginal Health Organization
National Association of Pharmacy Regulatory Authorities