Health Canada's comments to the consultation of the Commission of the European Communities on the Green Paper on the European Workforce for Health

INTRODUCTION:

Health Canada is pleased to share its experience on ways our country has chosen to tackle challenges facing the health workforce in Canada. The Canadian workforce is facing similar issues as the EU health workforce. There are similarities between the actions taken in Canada and those proposed in the *Green Paper on the European Workforce for Health*. This paper describes Canadian commitments to secure an optimal health workforce and highlights Canadian initiatives that have demonstrated success or potential in each of the areas for possible action in the EU Green Paper.

In Canada, the organization of the health care system is largely determined by the Canadian Constitution, in which roles and responsibilities are divided between the federal, and provincial and territorial governments. The provincial and territorial governments have most of the responsibility for delivering health and other social services. The federal government is also responsible for some direct delivery of services for certain groups of people, including First Nations people living on reserve and Inuit. Primary responsibility for training, hiring and retaining health professionals resides with the provinces and territories; however, the federal government as the sixth largest jurisdiction is involved in hiring and retaining health professionals.

As in the EU, Canada's population is aging. Data from the 2006 Census show a continuing trend in the aging of Canada's population. There was a record number of seniors (13.7% of the total population was aged 65 years and over) while, on the other hand, the proportion of people under age 15 in Canada was at an all-time low (17.7%). Overall the largest increase was in the 65 and over age category (11.5%).[1] According to population projections by Statistics Canada, seniors could account for more than one out of every four individuals in the population by 2056.[2]

The aging health workforce is a concern in Canada. The average age of people in health occupations in Canada was 41.9 in 2005. That is 2.3 years older than the average age of the general Canadian workforce. The younger age occupations include many of the rehabilitation professions, dental hygienists and technicians, ambulance attendants, and opticians. Some of the older age occupations include physicians, nurses, dentists and denturists, optometrists and chiropractors.[3] Between 2003 and 2007, the average age of the physician workforce increased by 1.3 years[4], and the average age for all Canadian registered nurses increased by one-half a year[5].

The EU Commission reports that approximately 70% of the healthcare budgets are allocated to salaries and other charges related to the employment of the health workforce. Similarly in Canada, it is estimated that between 60 to 80 cents of every

health care dollar is spent on the health workforce, and this doesn't include the cost of educating health care providers[6]. About 1 in 10 of all Canadians (1.5 million) work in health and social services. Physicians and registered nurses (RNs) are the two largest groups of health professionals, accounting for just under half of all health care workers. In 2005, there were two physicians for every 1,000 people in Canada which is comparable to other OECD countries such as the US and the UK, but below that of Germany and France. In contrast, the average number of nurses per 1,000 population in Canada was higher than the OECD – 10 versus 9.[7]

In Canada, there have been recent increases in the numbers of professionals working in each of the key health professions, notably an increase of 2,895 physicians between 2002 and 2006, which represents growth of 4.9% for a total of 62,307 physicians; and an increase of nearly 22,000 Registered Nurses (RN) between 2002 and 2006, for a total RN workforce of 252,998 in 2006.

Despite these advances, Canada continues to face health human resource (HHR) challenges. Shortages of health professionals are most pronounced in rural communities. In 2004, 9% of physicians and 18% of nurses worked in rural Canada which is home to 21% of the population. Furthermore, advocates note that demand for health professionals will increase as the population ages, at the same time as large numbers of health professionals transition into retirement.

DESCRIPTION OF CANADIAN COMMITMENTS:

The sustainability of Canada's HHR is an issue which has received increased attention in recent years. Canada faces a number of challenges in terms of supply, mix, distribution, retention, recruitment and training. First Ministers have repeatedly stressed the need for appropriate planning and management of HHR in order to ensure that Canadians have access to the health care providers they need.

In the 2003 First Ministers' Accord on Health Care Renewal, the federal, provincial and territorial (F/P/T) governments made a commitment to work together to improve HHR. In response, the federal 2003 Budget provided $85M to address pan-Canadian HHR needs, including $5M for the first year, followed by $20M annually for the next four years. These funds have formed the basis for Health Canada's Pan-Canadian Health Human Resource Strategy which was approved by the Treasury Board in 2004 with ongoing funding of $20M annually. In the 2004 Health Accord, the First Ministers reaffirmed their commitments to improving HHR.

The Pan-Canadian Health Human Resource Strategy (HHRS) seeks to respond to the Accord commitments by securing and maintaining a stable and optimal health workforce in Canada and supporting overall health care renewal. The HHRS is comprised of three initiatives:

- Pan-Canadian HHR Planning;

- Interprofessional Education for Collaborative Patient-Centred Practice (IECPCP); and
- Recruitment and Retention of Health Care Providers/Professionals.

The first component, the Pan-Canadian HHR Planning Initiative, is to address the lack of appropriate data, forecasting models, research on HHR, and collaborative planning. It seeks to achieve the following objectives:

- Enhance and strengthen the evidence base and capacity for coordinated HHR planning to better support F/P/T, jurisdictional and nationwide activities; and
- Create a culture in which key HHR issues of jurisdictional, inter-jurisdictional and pan-Canadian concern can be identified and addressed.

The second component, the Interprofessional Education for Collaborative Patient-Centred Practice (IECPCP), is key to achieving system change and to ensuring that health care providers have the necessary knowledge and skills to work effectively in interprofessional teams within the evolving health care system. The IECPCP seeks to achieve the following objectives:

- Promote and demonstrate the benefits of interprofessional education for collaborative patient-centred practice;
- Increase the number of educators prepared to teach from an interprofessional collaborative patient-centres perspective;
- Increase the number of health professionals trained for patient-centred collaborative practice before, and after, entry-to-practice;
- Stimulate networking and sharing of best educational approaches for collaborative patient-centred practice; and
- Facilitate interprofessional collaborative care in both the education and practice settings.

The third component, the Recruitment and Retention (R&R) Initiative, addresses the current and impending imbalances in the supply of health care providers across a wide variety of disciplines. As the health workforce continues to age, demand for services increases, and the workplace becomes increasingly global, the need to appropriately recruit and retain HHR becomes progressively more essential. The R&R seeks to achieve the following objectives:

- Increase interest in health careers, both generally and in specific areas of shortage;
- Increase diversity of health care providers to reflect the Canadian mosaic;
- Increase the supply of health care providers to ensure availability, when and where needed;
- Reduce barriers for internationally educated health care 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.

Stemming from the First Ministers' 2004 Accord, the federal government committed an additional $75M over five years in Budget 2005 for the Internationally Educated Health Professionals Initiative (IEHPI). The $75M has two separate streams of funding – $61.5M for provincial and territorial initiatives, and $7.4M for pan-Canadian initiatives. The Internationally Educated Health Professionals (IEHPs) are an important component of the Canadian health care workforce. They have historically assisted Canada in meeting its demand for health professionals and will continue to do so given our shortage.

The IEHPI seeks to achieve the following outcomes:

- Preparedness and integration: IEHPs will be aware of the route to practice for their given profession, will be oriented to the Canadian health care system, and can self-assess their readiness to complete exams;
- Assessment: credentials are verified and IEHPs have access to licensure assessments and examinations;
- Faculty development: faculty, clinical instructors and community-based preceptors are trained and available to provide assessments and clinical training for IEHPs
- Clinical placement: IEHPs have access to clinical placements and upgrading programs
- Integration – employment: IEHPs are able to integrate into the health workforce; and
- Regional collaboration: jurisdictions collaborate to maximize impact of investments.

In 2004, as part of the 10-Year Plan to Strengthen Health Care, First Ministers agreed to increase the supply of health professionals based on an assessment of the gaps, including targets for the training, recruitment and retention of professionals by December 31, 2005. All governments, federal/provincial/territorial, committed to making their plans public and to report regularly on progress. Most jurisdictions submitted reports on their health human resource action plans which indicated that jurisdictions have increased enrolment in professional schools and initiated new recruitment and retention strategies in order to address shortages in health human resources.

As part of the 2004 10-Year Plan, the federal government also committed $100 million to increase the number of Aboriginal health care professionals. In 2005, it launched the five-year Aboriginal Health Human Resources Initiative (AHHRI). The AHHRI is intended to:

- Provide conditions for optimizing the future supply, mix and distribution of the First Nations, Inuit and Métis health workforce in ways that are

responsive to the unique and diverse health needs of First Nations, Inuit and Métis;
- Achieve and maintain an adequate supply of qualified First Nations, Inuit and Métis people; and,
- To facilitate the adaptation of health care educational curricula so that the cultural competence of graduates providing health care services to First Nations Inuit and Métis is improved.

HIGHLIGHTS OF CANADIAN ACHIEVEMENTS BY AREAS OF THE EU GREEN PAPER

Health Canada would like to share some of its exemplar experiences according to the areas raised in the EU Green Paper.

1. Demography and the promotion of a sustainable workforce

The EU Green Paper notes, as an area for action, to ensure better conditions for health workers, including staff motivation and morale. Canada has introduced the Healthy Workplace Initiative under the Pan-Canadian HHR Strategy focussing on front-line methods to identify innovative ways to foster healthy workplace practices and positive change within the workplace. The Initiative is part of the Recruitment & Retention component of the Strategy and has funded eleven provincial projects and four national projects to enhance the evidence-base to show that healthy workplace interventions make a difference to the health of front-line workers. Projects collected data that demonstrated reductions in absenteeism and injury among health care workers as well as their related costs. Health Canada supported the creation of the Quality Worklife - Quality Healthcare Collaborative (QWQHC), a partnership of 13 national professional associations representing health professions, employers, and unions, to develop and promote a national framework and strategy on quality of worklife to improve health system delivery and patient outcomes.

In December 2006, a National Survey on the Work and Health of Nurses was conducted in partnership with the Canadian Institute for Health Information (CIHI) and Statistics Canada. It is the first nationally representative study of Canada's three categories of regulated nurses (Registered Nurses, Licensed Practical Nurses, Registered Practical Nurses). The study provides a benchmark against which to measure progress in the areas of quality work environments for nurses. Likewise, a National Physician Health Survey in 2004 and 2007 was developed by the Canadian Medical Association in collaboration with the CIHI and the Royal College of Physicians and Surgeons of Canada to establish a baseline of data on the mental and physical health of Canadian physicians in practice to assist in HHR planning.

The EU Green Paper indicates that recruitment campaigns that take advantage of the growth of the proportion of over-55s in the workplace and encourage "return to practice"

by those who have left the workforce are under consideration. In Canada, the Canadian Federation of Nurses Unions through their project on Retaining and Valuing Experienced Nurses have identified successful approaches in both current workplace practices and collective agreements that have resulted in increased retention of experienced nurses (45+) in the workforce.

Health Canada funded successful recruitment initiatives for Aboriginals. Aboriginal student support programs have been put in place in a number of medical schools and nursing schools across the country to support increased enrolment of Aboriginal students, and help them succeed in their studies. Canada has seen a six-fold increase in the amount of bursary and scholarship funds available for Aboriginal health career students, with over $3M now available annually. Canada has increased the number of Aboriginal students receiving bursaries and scholarship to study health careers, from 129 students in 2004 to 284 students in 2008. A total of 72 Aboriginal students are being supported through the National Aboriginal Achievement Foundation (NAAF) awards to study in high cost fields, including 58 medical doctors, 9 PhD students in medical fields and 5 students at the doctoral level.

Health Canada has also supported initiatives in curriculum development to promote increased recruitment of Aboriginals. The Department formed strong partnerships with professional associations, colleges and universities. For example, Health Canada is working with the Association of Faculties of Medicine of Canada (AFMC) and the Indigenous Physicians Association of Canada (IPAC) to lay foundations for long term improvement in the cultural competency of medical students and support development of culturally appropriate curricula. In addition, a number of tools have been developed from these partnerships that will be used by Canada's 17 medical schools to help decrease barriers to admission, and increase enrolment of Aboriginal students. Similar work is underway to address the same issues with respect to the curriculum for nurses.

In line with the EU's possible area for action, raising awareness of health careers in schools, Canada has supported the development and implementation of a national $2M multimedia campaign on health care providers by the Canadian Medical Association and the Canadian Nurses Association. Health Canada also funded the College of Family Physicians of Canada to develop promotional strategies to enhance the image of family medicine in undergraduate medical curriculum.

2. Public health capacity

The Green Paper suggests that EU countries provide more visibility for health and safety in the workplace and Canada made great strides in this area with the Healthy Workplace Initiative (HWI) through its eleven provincial and four national projects. For example, investments were made in Prince Edward Island to reduce the risk of musculoskeletal injury and develop provincial strategies, standards and resources to ensure safe and healthy workplaces. The Quality Worklife – Quality Healthcare Collaborative organizes an annual HWI workshop for knowledge exchange and in 2008

held a National Summit where over 40 organizations signed the Healthy Healthcare Leadership Charter.

Canada is active in another area for action in the EU Green Paper: strengthening capacity for screening, health promotion and disease prevention; and collect better information on population health needs. In Canada, a federal/provincial/territorial Joint Task Group on Public Health Human Resources proposed a pan-Canadian framework to strengthen public health capacity which identified core public health competencies as one of the foundational building blocks in that framework. As requested by the Joint Task Group, the Public Health Agency of Canada undertook several consultations and the *Core Competencies for Public Health in Canada* was published in 2008. The generic core competencies provide a baseline for what is required to fulfill public health system core functions such as population health assessment, surveillance, disease and injury prevention, health promotion and health protection. The framework also identified the development of consistent information or data on the public health workforce as one of the strategies under the goal aiming to increase all jurisdictions' capacity to plan for the optimal number, mix and distribution of public health skills and workers.

3. Training

There has been an increase of 541 government funded first-year educational opportunities in Canadian medical schools between 2002 and 2007 for a total of 2,569 seats in 2007[8]. In addition, during the 10-year period from 1995 to 2004, many of the health professions saw an increase in the number of graduates.[9]

The EU Commission has identified continuing professional development as an action area to improve quality and patient safety. The previously referenced Interprofessional Education for Collaborative Patient-Centred Practice (IECPCP) initiative is one of Canada's key strategies to address these issues. The initiative has been committed to increasing learner, educator, patient, and provider satisfaction with their health care experience through the development of interprofessional education and practice improvements. Twenty learning projects sponsored by educational institutions and health authorities received funding to develop interprofessional curriculum and practice tools for classroom and clinical settings and to increase the provision of interprofessional learning opportunities for pre and post licensure students. For example, the Memorial University of Newfoundland has developed interprofessional learning blocks and modules that have now been embedded into existing pre-licensure courses for medical, nursing, pharmacy and social work students.

The EU Green Paper notes the potential creation of an EU mechanism such as an Observatory on the health workforce which would assist Member States in planning future workforce capacity, training needs and the implementation of technological developments. At present, Canada does not have a formally designated Health Human Resource Observatory. However, the federal/provincial/territorial Advisory Committee on Health Delivery and Human Resources (ACHDHR) is the pan-Canadian body,

involving government and non-government stakeholders which collaborates, under the direction of the Conference of Deputy Ministers of Health on key HHR issues of priority to the country.

As a federal state which has dispersed constitutional division of powers for health care, Canada's federal/provincial/territorial (F/P/T) governments supported the development of *A Framework for Collaborative Pan-Canadian Health Human Resources Planning.* The Framework was approved by F/P/T Ministers of Health in October 2005. While the Framework recognizes the jurisdictional responsibility for health system design and HHR planning, it affirms that jurisdictions cannot plan in isolation and realizes the value of a pan-Canadian approach to HHR planning. The Framework describes the challenges in HHR planning, identifies collaborative priorities, and sets out specific actions that jurisdictions can take together. The Framework remains in constant evolution.

Between the spring and fall of 2006, stakeholders, including ministries of Education, research entities, national Aboriginal groups, health sector organizations, health professionals associations, and professional regulatory bodies were consulted on the Framework and its associated Action Plan. The Framework was revised and published in March 2007. This engagement process has strengthened the commitment of governments and stakeholders to work together in addressing HHR challenges.

4. Managing mobility of health workers within the EU

The Green Paper proposes to create an EU-wide forum or platform where managers could exchange experiences. In Canada, in June 2002, the Conference of Deputy Ministers (CDM) of Health, which reports to the Ministers of Health, established the previously referenced F/P/T Advisory Committee on Health Delivery and Human Resources (ACHDHR) at the Assistant Deputy Minister level. Its role is to provide policy and strategic advice to the CDM on the planning, organization and delivery of health services including HHR issues; identify emerging issues and develop recommendations for the CDM; and provide a national forum for discussion and information-sharing of F/P/T HHR issues. The focus of the ACHDHR is to ensure Canada has the HHR to support the health system of the future. The ACHDHR conducts work and intervenes in a variety of areas. Subcommittees or task groups are created and most often include government as well as external stakeholders and decision makers. An example of a deliverable produced by the HHR Planning Subcommittee of the ACHDHR would be *A Framework for Collaborative Pan-Canadian Health Human Resources Planning.*

The ACHDHR also created a Modelling Working Group in 2004/05 to promote collaborative HHR data and modelling activities and networks that support F/P/T policy and planning requirements, sharing of knowledge and the formation of partnerships. The Working Group developed a paper on HHR modelling definitions and principles which provides a common understanding of modelling for developers and users. The

Working Group also organized an HHR modelling workshop in 2005 and 2007 to share modelling experiences among HHR modellers, policy makers, and researchers.

Another ACHDHR Task Group on Self-Sufficiency produced a paper entitled *How Many Are Enough? Redefining Self Sufficiency for the Health Workforce*. A definition of self-sufficiency was approved by the CDM and a stakeholder consultation took place subsequently. The definition will be adjusted accordingly.

The ACHDHR Coordinating Committee on Entry-to-Practice Credentials established a review mechanism approved by the Ministers of Health for submissions related to proposed increases in entry-to-practice credentials. Each year, the committee reviews submissions by health professional organizations.

5. Global migration of health workers

Canada is on a similar path as that noted in the EU Green Paper. The EU Green paper suggests putting in place a set of principles to guide recruitment of health workers from developing countries and introducing methods for monitoring. The ACHDHR Self-Sufficiency Task group is currently developing a paper on the ethical recruitment of health professionals for Canada.

Canada recognizes that there are many internationally educated health professionals who live in Canada or come to Canada but are subsequently unable to practice their chosen profession. To assist in addressing this issue, Health Canada under the Internationally Educated Health Professionals Initiative (IEHPI), together with Human Resources and Skills Development Canada, provided funding to increase provincial international medical graduate (IMG) assessment capacity and to create: a central web-site of information for IMGs; a national consortium to harmonize the assessment process across the country; faculty development program for teachers of IMGs; online self-assessment tool to assess readiness to write qualifying exams; increased access to evaluating examination offshore prior to migration; a web based orientation program about cultural; legal and ethical organization of medicine in Canada; and a new database to track IMGs.

As suggested by the EU Green Paper, Health Canada is collaborating with the WHO in its work to develop a global code of practice for the international recruitment of health personnel. In this process, Health Canada is consulting with provincial and territorial Ministries of Health, other federal Departments and non-governmental stakeholders.

6. Data to support decision making

Canada has undertaken work in the three areas identified by the EU for action: harmonising or standardising health workforce indicators, setting up systems to monitor flows of health workers, and ensuring the availability and comparability of data on the

health workforce, in particular with a view to determining the precise movements of particular groups of the health workforce.

The Canadian Institute on Health Information (CIHI) funded by Health Canada captures data on many health topics, including different professions which make up Canada's health care workforce. CIHI offers comprehensive national and provincial/territorial portraits of these groups, including their supply, distribution and migration and, in some cases, their education and service utilization.

Under the Pan-Canadian HHR Strategy, Health Canada funded CIHI for the development of a national supply-based comparable database for pharmacists, occupational therapists, physiotherapists, medical laboratory technologists, and medical radiation technologists. CIHI is already collecting comparable data on physicians, registered nurses, licensed practical nurses, and registered psychiatric nurses.

In 2005, CIHI produced a guidance document outlining the results of a consultation process designed to identify and validate HHR priority information needs and related indicators and to identify data elements that should be collected in a standardized fashion across Canada. The identification of data elements was needed to support the compilation of national measures and indicators associated with the supply, distribution, practice/employment characteristics, education/training and migration patterns of health personnel in Canada.

In addition, Statistics Canada assessed and reported on the education indicators necessary to monitor the supply of health professionals for the purposes of HHR planning.

CONCLUSION

Like the EU, Canada faces many health workforce challenges given the aging of the population, changing population health needs, and potential increase demand for health services. At the same time, the health workforce is the health care system's greatest asset and cost. Canada's ability to provide access to high quality, effective patient-centered and safe health services depends on the right mix of health care providers with the right skills in the right place at the right time.

The governments of Canada (federal/provincial/terrirorial) have put in place a series of initiatives to address the health human resource challenges and maintain a sustainable health care system. This paper has offered some examples of successful interventions that have made a difference in the country.

Given our federated governmental organization and shared constitutional responsibility for health care, Canada may serve as an example for the EU in its search for innovative ways to increase collaboration between and among countries to improve access to appropriate, effective, efficient, sustainable, and responsive needs-based health care services for all of Europe's population. The initiatives presented in this paper represent Canada's start on dealing with the many HHR challenges we face. Further collaboration and commitments will be required to meet the future healthcare needs of the population.

If helpful, we are prepared to discuss further any of the points raised in this submission for the purposes of clarification or elaboration. In addition, we are available to discuss other areas or experiences which would be helpful to you during your consultation and submission process.

Margaret Gillis
Director
Health Human Resource Strategies Division
margaret_gillis@hc-sc.gc.ca
(613) 954-8608

REFERENCES

1 Health Canada Bulletin, Issue 14, 2007, p. 14-15

2 CIHI, *Canada's Health Care Providers*, 2007, p. 64

3 CIHI, Canada's Healthcare Providers, 2007, p. 65

4 CIHI, Supply, Distribution and Migration of Canadian Physicians, 2007, p. 4

5 CIHI, Regulated Nurses: Trends, 2003-2007, 2008, p. 22

6 CIHI, Canada's Health Care Providers, 2007 p.9

7 CIHI, Health Care in Canada, 2007, p. 15

8 Association of Faculties of Medicine of Canada, Canadian Medical Education Statistics, 2008, p. 12

9 CIHI, *Canada's Health Care Providers*, 2007, p. 28

OTHER SOURCES

Canadian Institute for Health Information (CIHI), *Canada's Health Care Providers,* 2007; and other physician and nurses publications.

http://secure.cihi.ca/cihiweb/en/hhr_publications_e.html

F/P/T Advisory Committee on Health Delivery and Human Resources (ACHDHR), *A Framework for Collaborative Pan-Canadian Health Human Resources Planning*, March 2007. http://www.hc-sc.gc.ca/hcs-sss/hhr-rhs/strateg/index-eng.php

Health Canada, *Pan-Canadian Health Human Resource Strategy Annual Report*, 2004-2005, 2005-2006, 2006-2007
http://www.hc-sc.gc.ca/hcs-sss/hhr-rhs/strateg/index-eng.php

Joint Task Group on Public Health Human Resources, *Building the Public Health Workforce for the 21st Century, a Pan-Canadian Framework for Public Health Human Resources Planning,* October 2005

http://www.phac-aspc.gc.ca/php-psp/pdf/building_the_public_health_workforce_fo_%20the-21stc_e.pdf