PositionStatement

PAN-CANADIAN HEALTH HUMAN RESOURCES PLANNING

CNA POSITION

The Canadian Nurses Association (CNA) believes that successful human resources planning in the Canadian health sector requires a collaborative, collective and integrated effort among governments (federal, provincial/ territorial and regional), health professionals, educators, regulatory bodies, employers, unions and others. Moreover, CNA believes that a coherent approach is required to link the many policy levers — education; employment, labour and industry; immigration; social justice; economic and fiscal — that affect the career life cycle of the health professional.

Effective planning must span the full continuum of care, including illness prevention and health promotion, public health, screening, diagnosis, acute care (primary, secondary, tertiary and quaternary), chronic disease management, rehabilitation, long-term care, survivorship and palliative care.

CNA believes that effective planning results in Canadians receiving the right services from the right provider(s) at the right time and the right place. Planning must be undertaken with the goal of providing Canadians with timely, needs-based access to high quality, effective, efficient, patient-centred, safe health services.

Continued investment in data development and linkages, technical expertise and health human resources research is required to enhance Canada's capacity to achieve effective pan-Canadian human resources planning in the health sector.

CNA recommends the implementation of a common framework for human resources planning in the health sector, which includes the following 10 elements:

1. ***Needs-based planning*** — Planners need to adopt an approach that anticipates the current and emerging health needs of individuals, families, communities and populations as determined by demographic, epidemiological, cultural and geographic factors. This will be advanced through:

    • a patient-centred care approach;

    • a focus on the needs of disadvantaged individuals, communities and populations to reduce health and social disparities and promote health equity;

    • in-depth analysis of population surveys and epidemiological data;

    • benchmarking based on regional variation;

    • community orientation, engagement and involvement;

    • a particular focus on rural, remote and underserviced areas; and

    • a review of the most appropriate mix of health professionals within and between disciplines.

2.	*Collaboration among disciplines* — Health professions need to communicate with one another and coordinate their efforts in the best interests of the patient. This will be achieved through:

- the promotion of interprofessional collaborative education and practice;
- enabling regulatory frameworks;
- appropriate liability coverage for all professions;
- infrastructure support for collaboration;
- funding models that support collaboration; and
- optimization of the contribution of each health professional (working to full scope of practice).

3.	*Recognition that the health workforce is a national resource* — Amendments to Chapter 7 of the *Agreement on Internal Trade* provide for full labour mobility for health professionals who wish to relocate between provinces/territories. This will be advanced through:

- the adoption by health professions of national standards for licensure/registration;
- the recognition of regional centres of excellence for delivery of health services;
- the establishment of a national approach to education and training that preserves and promotes high educational standards; and
- education and continuing education of health professionals that equips them with the competencies necessary to meet populations' health needs.

4.	*Self-sufficiency* — Canada must strive for greater self-sufficiency in the education and training of health professionals. This will be advanced through:

- improved workforce projection models;
- sufficient enrolment opportunities and clinical placements for Canadians in health sciences education programs;
- adequate infrastructure and qualified faculty to support education, continuing education and refresher or bridging programs;
- improvement in student retention rates; and
- support for putting into practice the integration of international graduates who are permanent residents or citizens of Canada.

5.	*Recognition of the global environment* — The work of health professionals is becoming increasingly globalized in terms of the exchange of scientific information, mutual recognition of qualifications between countries and the movement of people. This fact can be optimized through:

- implementation of the World Health Organization's Global Code of Practice on the International Recruitment of Health Personnel and the CNA position on ethical nurse recruitment;
- application of the Pan-Canadian Framework for the Assessment and Recognition of Foreign Qualifications;
- the maintenance of high standards of education and teaching; and
- the promotion and support of retention strategies in developing countries.

6. ***Inclusive policy planning and decision-making*** — Policy planning and decision-making in health human resources must include representation from all stakeholders involved, including governments, regional health authorities, professional associations, educational institutions, regulatory authorities, unions and consumers. This will entail:

- the establishment of a mechanism to coordinate planning and decisions related to human resources in the health sector;
- the participation of non-governmental representatives (including health-care providers) in government policy development initiatives; and
- the promotion of provider and client representation at regional health authorities and institutional governance bodies.

7. ***Effective human resources policies*** — Through comprehensive approaches, health professionals should be afforded supportive working environments designed to optimize performance, attract and retain, and reduce the waste of staff time and skill. Specifically, this means:

- recruitment approaches that address both professional and personal factors;
- comprehensive retention approaches;
- managing the multi-generational workforce;
- optimizing the performance of the existing workforce (increasing productivity); and
- research to determine the potential for repatriation.

8. ***Healthy and safe workplaces*** — The importance of workplace environments and policies to positive health outcomes is recognized in research. Strategies to support health and safety include:

- best practice or leading practice approaches such as those identified by the Quality Worklife – Quality Health Care initiative and the Registered Nurses' Association of Ontario Best Practice Guidelines;
- educational programs;
- the promotion of a culture shift to encourage help-seeking behaviour;
- the mitigation and management of nurse fatigue through safe workloads;
- elimination of violence in the workplace;
- adequate funding aimed at preventing unsafe practices; and
- accountability processes to track safety and health outcomes.

9. ***Balance between personal and professional life*** — Planners must take into account the expressed desire among the new generation of health professionals and others for a balance between their professional and personal lives. This means efforts to:

- reflect balance in educational curricula;
- learn from international experience; and
- factor work-life balance and work characteristics into supply planning.

10. ***Supporting best practices*** — Health professionals must have access to the resources they need to keep abreast of advances in scientific knowledge and to acquire new skills. They should also have opportunities to apply their skills to new challenges over the course of their careers. This can be achieved through:

- opportunities for re-entry and advanced training;

- career development/progression;

- continuing professional development and education; and

- leadership identification and development.

BACKGROUND

Canada has been experiencing HHR challenges in many professions for a number of years. For example, in 2007 there was an estimated shortage of nearly 11,000 full-time equivalent registered nurses (RNs) in Canada.[1] Moreover, if the health needs of Canadians continue according to past trends and no new policies are implemented, Canada will be short 60,000 full-time equivalent RNs by 2022. The same study published by CNA demonstrated that the combined effects of six policy scenarios would be sufficient to eliminate the RN shortage within 15 years. These policies include:

- reducing RN absenteeism by half;

- reducing RN exit rates to 2% for RNs under the age of 60 and to 10% for those 60 and older;

- reducing attrition rates in RN entry-to-practice education programs from 28% to 15%;

- increasing enrolment in RN entry-to-practice education programs by 1,000 per year;

- increasing RN workforce productivity by 1% (non-cumulative); and

- reducing international immigration by 50%.

Increasing enrollment is contingent on a number of factors including an adequate supply of qualified nursing faculty. National 2009-2010 faculty statistics indicate:[2]

- only 32.4% of faculty are permanent;

- 53.5% of permanent faculty were 50 years of age or older;

- schools were unable to fill 101 full-time positions, representing a 4% vacancy rate; and

- 62.1% of schools cite a shortage of nurse practitioner and master's and doctorally prepared nurses seeking academic positions as a challenge limiting their ability to recruit new faculty.

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[1] (Tomblin et al., 2009)

[2] (Canadian Nurses Association & Canadian Association of Schools of Nursing, 2012)

Planning for the workforce that delivers health services is primarily the responsibility of individual provinces and territories and has traditionally been characterized by several key trends:

- the focus has tended to be on supply-side planning, based on past utilization which views health professionals as costs to the economy;

- planning approaches have treated health professional groups in isolation of one another;

- planning is based on traditional service delivery models; and

- insufficient collaboration between the education system and the health system.[3]

In 2003, as part of the 2003 Health Accord, first ministers stated that collaborative strategies were to be undertaken to strengthen the evidence base for national planning, promote inter-disciplinary provider education, improve recruitment and retention and ensure the supply of needed health providers.

In 2004, as part of the *10-Year Plan to Strengthen Health Care*, first ministers agreed to continue to accelerate their work on HHR action plans and/or initiatives to ensure an adequate supply and appropriate mix of health-care professionals.

Increasingly, provincial and territorial governments have turned to recruitment of internationally educated health professionals as a strategy to solve the health professional shortage. This has come under scrutiny by many, resulting in calls both domestically and internationally for a made-in-Canada approach and ethical recruitment.[4, 5] In 2009, the Forum of Labour Market Ministers released *A Pan-Canadian Framework for the Assessment and Recognition of Foreign Qualifications* to support immigrants in using their skills and experience to the fullest within the Canadian labour market.[6]

In October 2005, the leaders of 10 national health organizations partnered with more than 45 health-care experts to develop an evidence-informed framework and action strategy for making Canada's public health workplaces healthier and improving the quality of care provided.[7] The members of the Quality Worklife – Quality Health Care Collaborative (QWQHC) recognized that many health-care workplaces are not healthy, that valuable health providers are struggling, and that the quality of patient care is being threatened. The Collaborative believes it is unacceptable to work in, receive care in, govern, manage and fund unhealthy workplaces. Further work has been done by the Registered Nurses' Association of Ontario to create healthy work environments best practice guidelines.[8]

On average, compared to other workers, Canadians in health occupations are more likely to miss work due to illness or disability and be absent for more days.[9] Increasingly, research is confirming ill health to be a function of the broader context of the environments and conditions in which our health providers work.[10] In a 2010 study on nurse fatigue, nurses reported that they felt patients were in potentially unsafe situations due to workload, inadequate staffing and

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[3] (Advisory Committee on Health Delivery and Human Resources, 2007)

[4] (Canadian Nurses Association [CNA], 2007)

[5] (World Health Organization (WHO), 2010)

[6] (Forum of Labour Market Ministers, 2009)

[7] (Quality Worklife – Quality Health Care Collaborative, 2007)

[8] (Registered Nurses' Association of Ontario, 2006-2012)

[9] (Shields & Wilkins, 2006)

[10] Ibid.

nurses working while fatigued — findings corroborated by the literature.[11] The report makes a number of recommendations to mitigate and manage nurse fatigue and promote patient safety.

In 2005, CNA and the Canadian Medical Association released *Toward a Pan-Canadian Planning Framework*, setting out for discussion 10 core principles and associated strategic directions.[12] This document served to inform a 2007 publication by the advisory committee on health delivery and human resources (ACHDHR): *A Framework for Collaborative Pan-Canadian Health Human Resources Planning*, endorsed by the F/P/T ministers of health.[13] It is designed to facilitate the enhancement of partnerships between government and stakeholders and build a case for a pan-Canadian collaborative approach to planning. The advisory committee's framework identifies the challenges and priorities for collaborative action and sets out tangible and specific coordinated actions jurisdictions can take to achieve a more stable and effective health workforce.

Unfortunately, the House of Commons standing committee on health, in its statutory review of the progress in implementing the *10-Year Plan to Strengthen Health Care*, found that only four P/T HHR plans included population health needs, and only four link their targets to the joint CNA/CMA pan-Canadian health human resource planning framework.[14] The committee concluded that the F/P/T framework is not receiving the attention and support from stakeholders it requires to succeed.

A subsequent study by the standing committee in 2010 notes that the ACHDHR may need to focus greater effort on ensuring the framework has the necessary support from both governments and stakeholders to be implemented.[15] The committee also observed that neither Health Canada's pan-Canadian health human resource strategy, nor the ACHDHR's framework are linked to hard targets in terms of increasing the supply of health professionals in Canada. The committee's report makes a number of recommendations in this regard.

In 2009, all governments approved amendments to Chapter 7 of the *Agreement on Internal Trade* to achieve full labour mobility in Canada for workers in regulated professions and regulated trades.

Federal and provincial/territorial reports have highlighted the need to address the under-utilization of professional skills and knowledge and the employment of each member of multidisciplinary teams in the most effective manner. The uniqueness and overlap, both in scope and context of practice, must be understood if we are to design work that best utilizes professional knowledge and skills, while maintaining and improving provider satisfaction and patient outcomes.[16, 17] CNA, in collaboration with the Canadian Council for Practical Nurse Regulators and the Registered Psychiatric Nurses of Canada, recently published the *Staff Mix Decision-making Framework for Quality Nursing Care* (2012), a comprehensive and evidence-informed resource presenting a systematic approach to staff mix decision-making that can be used in all clinical practice settings.[18]

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[11] (Canadian Nurses Association & Registered Nurses' Association of Ontario, 2010)

[12] (Canadian Nurses Association & Canadian Medical Association, 2005)

[13] (Advisory Committee on Health Delivery and Human Resources, 2007)

[14] (House of Commons Standing Committee on Health, 2008)

[15] (House of Commons Standing Committee on Health, 2010)

[16] (CNA, 2003a)

[17] (CNA, 2003b)

[18] (Canadian Nurses Association, Canadian Council for Practical Nurse Regulators & Registered Psychiatric Nurses of Canada, 2012)

In addition to scope of practice issues, collaboration is essential for HHR planning. The range and complexity of factors that influence health and health problems require providers from a broad range of health professions to work together.[19]

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[19] (CNA, 2011)

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