



***INVESTING IN OUR
MOST IMPORTANT HEALTH SYSTEM ASSETS - PEOPLE...***

**A PROPOSAL TO ESTABLISH
A NATIONAL HEALTH HUMAN RESOURCES INFRASTRUCTURE FUND**

**A SUBMISSION TO THE
HOUSE OF COMMONS STANDING COMMITTEE ON FINANCE
2010 PRE BUDGET CONSULTATIONS
AUGUST 14, 2009**

WHO WE ARE

The Health Action Lobby (HEAL) is a coalition of national health and consumer associations and organizations dedicated to protecting and strengthening Canada's health care system. It represents more than half a million providers and consumers of health care. HEAL was formed in 1991 out of concern over the erosion of the federal government's role in supporting a national health care system.

MEMBERS OF HEAL

Alzheimer Society of Canada
Association of Canadian Academic Healthcare Organizations
Association of Faculties of Medicine of Canada
Canadian AIDS Society
Canadian Association of Medical Radiation Technologists
Canadian Association of Occupational Therapists
Canadian Association of Optometrists
Canadian Association of Social Workers
Canadian Association of Speech Language Pathologists and Audiologists
Canadian Chiropractic Association
Canadian College of Health Service Executives
Canadian Counseling Association
Canadian Dental Hygienists Association
Canadian Dermatology Association
Canadian Healthcare Association
Canadian Home Care Association
Canadian Hospice Palliative Care Association
Canadian Institute of Child Health
Canadian Medical Association
Canadian Mental Health Association
Canadian Nurses Association
Canadian Orthopaedic Association
Canadian Pharmacists Association
Canadian Physiotherapy Association
Canadian Podiatric Medical Association
Canadian Psychological Association
Canadian Public Health Association
Canadian Society for Medical Laboratory Science
Canadian Society of Nutrition Management
Canadian Society of Respiratory Therapists
Catholic Health Association of Canada
CNIB
College of Family Physicians of Canada
Dietitians of Canada
National Council of Women of Canada
Paramedic Association of Canada
Practical Nurses of Canada
The Royal College of Physicians and Surgeons of Canada

For more information on the activities of HEAL, please visit our web-site at: www.physiotherapy.ca/heal

EXECUTIVE SUMMARY

The implementation of Medicare in the 1960s required a major investment in capacity-building to train health professionals. The *Health Resources Fund Act* – introduced by the federal government in 1966 played a key role in enabling a significant expansion in training capacity across the provinces for a range of health practitioners. Over forty years later, with the challenges associated with an aging workforce and a higher volume and complexity of population health needs, the Health Action Lobby (HEAL) believes that bold action is once again required.

Experienced health providers are retiring or otherwise exiting the field. Moreover, the volume and complexity of chronic and emerging diseases challenge both the health of Canadians and the health system. As a result, while health providers need to look at ways in which inter-professional collaboration can improve the efficiency of the system and the effectiveness of services delivered, we also need to re-invest in the supply of health human resources to ensure that Canadian have access to timely and appropriate care. These challenges are further compounded by the pressures of living within an increasingly global marketplace that is intensifying its competition for health providers.

To address this issue, HEAL is of the view that now is an important time to build on the range of positive steps that the federal government has taken in terms of its recent policy commitments focused on specific elements related to health human resource planning.

More concretely, HEAL sees a legitimate role for the federal government to strengthen its working relationship with the provinces and territories, and health providers through the creation of a time-limited, issue-specific and strategically targeted fund – *A National Health Human Resource Infrastructure Fund* – designed to accelerate the training capacity in the health system.

The *National Health Human Resource Infrastructure Fund* we propose would be in existence for 5 years and valued at a total of \$1.0 billion. In specific terms, the funding would cover the three essential and symbiotic elements that provide the capacity or infrastructure elements required to train and develop additional health providers and future leaders of the health system. These include:

1. The *direct costs* of training providers and developing leaders.
2. The *indirect or infrastructure costs* associated with the educational enterprise.
3. Resources that improve the country's *overall data management capacity* when it comes to health human resources.

The first two elements are required to alleviate bottlenecks in the ability to help individuals transition from the classroom to the practice settings as safe and effective practitioners. The third sets the stage for evidence-informed planning and decision making for the future. In this brief, HEAL provides greater detail on the issues, benefits, and details of this proposal. The full proposal is also available on the HEAL website.

Recommendation

“That the Government of Canada create a strategically-targeted, time-limited National Health Human Resources Infrastructure Fund to increase the supply of health providers that are trained to provide Canadians with access to quality health services.”

1. INTRODUCTION

The Health Action Lobby (HEAL) is a coalition of 38 national health and consumer associations and organizations dedicated to protecting and strengthening Canada's health system.¹ HEAL represents more than half a million providers and consumers of health services in Canada. It was established in 1991 with a view to exchanging knowledge, developing consensus, and providing strategic advice to governments and others on a range of pan-Canadian health policy issues.

In the spirit of contributing to the House of Commons Standing Committee on Finance's deliberations leading to Budget 2010, HEAL welcomes the opportunity to propose one program spending measure by the federal government that can make a significant difference when it comes to improving the flexibility, adaptability and performance of the health system.

Specifically, HEAL recommends to the Government of Canada to establish a *National Health Human Resource Infrastructure Fund (NHRIF)* that is time-limited, issue-specific and strategically targeted in nature. The *NHRIF* is designed to support and complement the health human resource priorities of the provinces and territories, by accelerating the production of health care providers to address immediate and longer-term challenges related to timely access to a range of health services. By investing in human capital development through the *NHRIF*, HEAL strongly believes that improved access to health and health care plays a crucial role in Canada's future prosperity.

2. INVESTING IN OUR MOST IMPORTANT ASSETS – PEOPLE

If the health system is to thrive and not simply survive, then we must ensure continued investment in our most prized health system assets – health providers. Over the past decade, there have been increasing concerns that Canada is not producing a sufficient number of health providers to meet current and the future health needs of Canadians.^{2 3 4 5}

The issue is exacerbated as a growing number of health providers look to retire and/or leave the health system, or in some cases limit their workload relative to the number of entering clinicians or new trainees, and at a time where a growing number of aging Canadians will be turning to the health system for diagnosis and treatment.⁶ At the same time, the health needs of Canadians are becoming more complex as a result of chronic disease and an aging population.⁷ Moreover, these challenges are not unique to Canada - resulting in an intensified global competition for talent when it comes to health providers.^{8 9 10}

What are the consequences of these trends? The most obvious are the linkages to inappropriate wait times, which in turn have adverse affects on health status and health outcomes, compromised safety, sub-optimal utilization of health care resources and unnecessary stress and strain on patients, families, and health care providers themselves.^{11 12 13} This in turn impacts the health of Canadians and by extension their productive contributions to Canadian society.

At the same time, it is incumbent on the health provider community to look at different ways – such as through inter-professional collaboration – in which we can organize and deliver a range of health services in an efficient and cost-effective manner.

Such concerns have been consistently registered by many organizations that represent the spectrum of health providers in Canada and by the health regions, communities, and organizations where they work as well as in several seminal reports.^{14 15 16 17 18} With this shared understanding and consensus, the critical policy question remains: in addition to increasing transfer payments and the wait time fund that has been distributed per capita across the provinces and territories, what specific role should the federal government play?

While the provinces and territories hold the constitutional and jurisdictional responsibilities over the funding and allocation of training positions – in the view of HEAL, there is a legitimate, strategic, and complementary role and need for the federal government to support and accelerate a pan-Canadian health human resource strategy for training the full spectrum of health providers across the country.

3. THE FEDERAL ROLE IN CAPACITY-BUILDING FOR HEALTH HUMAN RESOURCES

Notwithstanding the important commitments that were outlined in the 2004 Health Accord by the federal government,¹⁹ HEAL would observe that there are important historical precedents that highlight the supportive and complementary role of the federal government in the area of expanding health human resource capacity across the country.

The most important of these is the 1966 *Health Resources Fund* – valued at \$500 million.²⁰ The *Health Resources Fund Act* was “...to provide for the establishment of a Health Resources Fund to assist provinces in the acquisition, construction and renovation of health training facilities and research institutions.”^{21 22}

Recognizing the changes in the health system and its delivery mechanisms over the past 43 years, there are important opportunities to apply the fundamentals that underpin the *Health Resources Fund* to today’s national policy circumstances. That said, HEAL recognizes and applauds a number of policy measures that have been introduced by the federal government that have focused on more effective health human resource planning.

For example, Human Resources and Social (formerly Skills) Development Canada (HRSDC) and Health Canada have co-funded six sector studies in the health field. These have included \$3.95 million for a physician sector study, \$1.8 million for a nursing sector study and, most recently \$1.5 million for a pharmacy sector study. These contributions have been vital in bringing together diverse stakeholders to identify the challenges and strategies ahead for effective health human resource planning in Canada.

In 2003, the federal budget included \$90 million over five years to improve national health human resources planning and coordination, including better forecasting and the expansion of professional development programs to promote inter-professional education and collaboration. It also provided \$25 million to the Canadian Health Services Research Foundation to increase the capacity of nurse, physician and other health executives to apply research in decision-making.²³

Federal contributions have also begun to make a difference in the integration of internationally educated health professionals. In 2002, the Canadian Taskforce in Licensure of International Medical Graduates (IMGs) was established, bringing together an unprecedented array of national and provincial/territorial governmental and professional organizations.

Health Canada has also funded a series of projects under the Inter-Professional Education for Collaborative-Centered Care (IECPC) which are facilitating organizations to demonstrate new models of care and efficiencies in the utilization of health human resources.²⁴

In March 2004, the federal government provided \$4 million to support the Task Force’s 6 recommendations.²⁵ Also in 2004, HRSDC supported the Canadian Nurses Association in undertaking a diagnostic project on internationally educated nurses in Canada and this subsequently led to a task force. Work continues in these areas.

Building on these successes, the 2005 federal budget provided \$75 million over 5 years to accelerate and expand the assessment of internationally educated health professionals.²⁶ These funds are being used to expedite the credential recognition process for five additional professions, including pharmacy, medical laboratory

technology, medical radiation technology, physiotherapy and occupational therapy.²⁷ They have enabled the launch of several national and provincial/territorial initiatives thus far, such as the establishment of an internationally educated health professional centre in Ontario and programs targeted at integration in Manitoba and Nunavut.²⁸

However, as welcome and important as these investments have been, they were not designed to provide the infrastructure needed to significantly increase domestic capacity and hence self-sufficiency in training health providers – one of the principles set out in the 2006 *Framework for Collaborative Pan-Canadian Health Human Resources Planning*.²⁹

With this in mind, HEAL is of the view that now is an important time to build on the range of positive steps that the federal government has taken in terms of its recent policy commitments focused on specific elements related to health human resource planning. More concretely, HEAL sees a legitimate role for the federal government to strengthen its working relationship with the provinces and territories, and health providers through the creation of a time-limited, issue-specific and strategically targeted fund designed to accelerate the training capacity in the health system.

Recommendation

“That the Government of Canada create a strategically-targeted, time-limited National Health Human Resources Infrastructure Fund to increase the supply of health providers that are trained to provide Canadians with access to quality health services.”

4. THE NATIONAL HEALTH HUMAN RESOURCE INFRASTRUCTURE FUND

The *National Health Human Resource Infrastructure Fund* we propose would be in existence for 5 years and valued at a total of \$1.0 billion. In specific terms, the funding would cover the three essential and symbiotic elements that provide the capacity or infrastructure elements required to train and develop additional health providers and future leaders of the health system. These include:

1. The *direct costs* of training providers and developing leaders (e.g., cost of recruiting and supporting more community-based teachers/preceptors).^{30 31}
2. The *indirect or infrastructure costs* associated with the educational enterprise (e.g., physical plant (housekeeping, maintenance); support for departments (information systems, library resources, occupational health, etc.); education offices, and the materials and equipment necessary for clinical practice and practical training.^{32 33 34 35}
3. Resources that improve the country’s *overall data management capacity* when it comes to health human resources, and in particular, facilitate the ability to model and forecast health human resource requirements in the face of the changing demand for health services (it is noted that Health Canada has directed some of its 2003 HHR funds to the Canadian Institute for Health Information to expand data collection for five additional professions).

The first two elements are required to create additional education and training positions. While colleges and universities can accept more students and provide incentives for incoming students, a bottleneck occurs in the transition of the student from the formal to the practical parts of their training.³⁶

The increased workloads on experienced practitioners as a result of colleagues retiring, limiting their practice or exiting the field; the increasing complexity of population health needs both from the prevalence of chronic disease and the emergence of new disease and pandemics; and the changing Canadian demographic, increase the personal costs and likelihood of an experienced clinician undertaking the clinical training role.³⁷

This is not only a problem in ensuring new clinicians meet graduation and licensure requirements. It is also a problem of ensuring that clinicians receive the mentorship they need to be safe, competent, and confident practitioners who will choose to remain and maintain a career in the field and also train future clinicians.

Healthcare organizations are therefore challenged to design and implement the incentive structures needed to attract and retain clinical trainers. They are also challenged to meet the expectations of licensing bodies and professional colleges. For example, organizations that accredit the programmes that train health providers set out standards and expectations of facilities that train them. In addition, these healthcare organizations require additional supplies, materials, physical space, and equipment to support student needs.

The third element of HEAL's proposal – data management capacity, is essential if we are to more clearly understand the causes of the boom–bust cycle of health workforce supply in Canada; demonstrate accountability and effective use of resources, and engage in future evidence informed practices and decision making. For example we do not presently know the detailed costs of educating and training the full range of health professionals in Canada.

HEAL's rationale for the amount of one billion dollars is based on the infrastructure needed to leverage per capita investments. As indicated earlier, the 1966 *Health Resources Fund Act* provides an important precedent for a successful federal program spending measure. In 1966, \$500 million was committed to this fund.³⁸ In today's figures, this is estimated at approximately \$3.1 billion.³⁹ Our proposal reflects the fact that government, policy-makers, researchers, funding bodies, professional colleges and associations, clinicians and administrators are also developing, implementing and investing in innovations and complementary strategies that will further leverage these dollars.⁴⁰

5. WHY IS THIS IMPORTANT?

In the view of HEAL, the creation of the *NHHRIF* is a critical policy initiative when it comes to capacity-building and ensuring the longer-term sustainability of the health system. In specific terms, it will help to:

1. Accelerate the supply of health providers in the system at a time when many are retiring or leaving the health system
2. Address the growing demands on the health system from an aging population and a population with increasing rates of chronic diseases, co-morbidities, and disease complexities
3. Serve to sustain the gains that we have made when it comes to reducing wait times in the five priority areas from 2004 and to reduce wait times for other services
4. Allow the federal government to contribute in a complementary pan-Canadian fashion to the supply of health professionals while giving the provinces and territories maximum flexibility in terms of developing a plan of action; and
5. Accelerate the introduction of new models of care by ensuring sufficient opportunities to inculcate leading practices in a future generation of clinicians; and
6. Increase the availability of data and analytical capacity for accountability, planning, and future decision-making purposes.

6. CLOSING REMARKS

Understanding that the future responsiveness of the health system in terms of providing quality health and health care services in a timely fashion largely depends on the availability of health providers, HEAL is of the view that now is the time for the federal government – in close consultation and collaboration with the provinces and territories and providers – to establish a *National Health Human Resources Infrastructure Fund*.

ENDNOTES

- ¹ The HEAL website at: www.physiotherapy.ca/HEAL provides more information about HEAL and a listing of the 38 member organizations.
- ² CIHI, 2007. Canada's Healthcare Providers. Ottawa, Canada. Available: www.cihi.ca
- ³ The Royal Commission, 2002. Building on Values – The Future of Healthcare in Canada. Available: http://www.hc-sc.gc.ca/hcs-sss/alt_formats/hpb-dgps/pdf/hhr/romanow-eng.pdf
- ⁴ Senate Standing Committee on Social Affairs, Science & Technology, 2002. *The Health of Canadians - The Federal Role, Volume Six: Recommendations for Reform*. Available: <http://www.hc-sc.gc.ca/hcs-sss/com/fed/kirby-eng.php>
- ⁵ The Health Council of Canada, 2005. Modernizing the Management of Health Human Resources in Canada: Identifying Areas for Accelerated Change. Available: http://www.chsrf.ca/research_themes/documents/HCC_HHRsummit_2005_eng.pdf
- ⁶ CIHI, 2007
- ⁷ World Health Organization (WHO), 2005. Facing the Facts, Chronic Disease in Canada. Available: http://www.who.int/chp/chronic_disease_report/en
- ⁸ World Health Organization (WHO), 2006. World Health Report 2006-Working Together for Health. Available: <http://www.who.int/whr/2006/en>
- ⁹ Phillips, Jr. R.L., Petterson, S., Fryer, Jr. G.E, Rosser, W. The Canadian Contribution to the US Physician Workforce. Canadian Medical Association Journal, Apr. 176: 1083-1087.
- ¹⁰ Buske, L. Slade, S. 2009. Data Point! Tracking Practice Entry Cohorts of Canadian Post-MD Education Programs. Available: <http://www.afmc.ca/pdf/datapoint/DATAPOINT-may-eng.pdf>
- ¹¹ Canadian Nurses Association, 2009. Targeted Solutions for Eliminating Canada's Registered Nursing Shortage (Report Summary). Available: <http://www.cna-aic.ca/CNA/documents>
- ¹² Association of Canadian Academic Healthcare Organizations (ACAHO), 2009. Wait Watcher's III: Order and Speed, Improving Access to Care through Innovations in Patient Flow. Available: www.achao.org
- ¹³ Canadian Healthcare Association. 2009. Home Care in Canada: From the Margins to the Mainstream. Ottawa: Available: <http://www.cha.ca/documents>
- ¹⁴ The Royal Commission, 2002
- ¹⁵ Senate Standing Committee on Social Affairs, Science and Technology, 2002
- ¹⁶ Busing, N. and Gold, I. 2009. Faculties of Medicine: Important Contributors to Health Human Resource Planning in Canada. Healthcare Papers, 9(2): 25-29
- ¹⁷ Canadian Physiotherapy Association, 2006. Health Human Resource Planning Position Statement. Available: <http://www.physiotherapy.ca>
- ¹⁸ Canadian Association of Medical Radiation Technologists. 2006. Supply and Demand of Medical Radiation Technologists in Canada. Available: http://www.camrt.ca/english/publications/pdf/Supply_and_Demand_Report_2006.pdf
- ¹⁹ In the 2004 Health Accord, the federal, provincial and territorial governments make the following statements: "First Ministers also recognize that improving access to care and reducing wait times will require cooperation among governments; the participation of health care providers and patients; and strategic investments in areas such as: increasing the supply of health professionals (e.g., doctors, nurses and pharmacists)"; "There is a need to increase supply of health care professionals in Canada, including doctors, nurses, pharmacists and technologists. These shortages are particularly acute in some parts of the country."..."As part of efforts to reduce wait times, First Ministers agree to continue and accelerate their work on Health Human Resources action plans and/or initiatives to ensure an adequate supply and appropriate mix of health care professionals". (Source: A 10-Year Plan to Strengthen Health Care).
- ²⁰ Given the leveraged nature of certain components of the Fund (i.e., 50:50 cost-sharing with the provinces), its total value was \$800 million.
- ²¹ Health Resources Fund Act. July 11, 1966. P. 311.
- ²² In effect, the Fund was issue-specific, time-limited, strategically focused – and was divided into three streams: (1) the federal government agreed to provide up to 50% cost-sharing for each proposal that was considered, and could provide a maximum contribution not greater than the provinces percentage of the country's population. (2) The remaining \$175 million could be allocated "from time to time" by the Governor-in-Council; and (3) \$25 million was to be allocated on the basis of joint proposals submitted by the Atlantic Provinces.
- ²³ Department of Finance Canada. Budget 2003 Investing in Canada's Health Care System. Ottawa, 2003.
- ²⁴ Advisory Committee on Health Delivery and Human Resources. Revised Sept. 2006. A Framework for Collaborative pan-Canadian Health Human Resources Planning. Ottawa.

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- ²⁵ Health Canada. Federal funding enables more foreign-trained doctors to work in Canada. March 1, 2004. www.hc-sc.gc.ca/ahc-asc/media/nr-cp/2004/2004_08_e.html Accessed 09/21/07.
- ²⁶ Health Canada. Internationally educated health professionals initiative. www.hc-sc.gc.ca/hcs-sss/hhr-rhs/strateg/recru/init-prof-educ/index_e.html. Accessed 09/21/07.
- ²⁷ Human Resources and Social Development Canada. Overview – Foreign Credential Recognition. www.hrsdc.gc.ca/en/ws/programs/fcr/overview.shtml. Accessed 11/25/07.
- ²⁸ Health Canada. Canada's new government invests in initiatives to increase internationally educated health professionals. November 21, 2006. www.hc-sc.gc.ca/ahc-asc/media/nr-cp/2006/2006_112_e.html. Accessed 09/21/07.
- ²⁹ Advisory Committee on Health Delivery and Human Resources. A framework for collaborative pan-Canadian health human resources planning. . Ottawa, Revised September, 2006.
- ³⁰ Ladak, N. 1998. How Hospitals are Funded. Joint Policy and Planning Commission (JPPC), Toronto. Ontario.
- ³¹ Smith P.M., Seeley, J, Sevean, P., Strickland, S., Spadoni, M., Dampier, S. 2007. Costing Nursing Clinical Placements in Canada. Ottawa: Canadian Association of University Schools of Nursing.
- ³² Cameron J.M. 1985. The Indirect Costs of Graduate Medical Education. *New England Journal of Medicine*. May 9;312 (19):1233-8.
- ³³ Pollock L.L. and Levine, M., 1984. The Residency Program in Community Pharmacy Practice. *Canadian Pharmaceutical Journal*. 117(9):430-433
- ³⁴ MacKenzie T.A., Willan A.R., Cox M.A., Green, A. 1991. Indirect Costs of Teaching in Canadian Hospitals. *CMAJ* 1991 Jan 15;144(2):149-52.
- ³⁵ Canadian Society for Medical Laboratory Science. 2007. Simulation-Based Learning in Medical Laboratory Education – Current Perspectives and Practices.
- ³⁶ CIHI, 2007.
- ³⁷ CIHI, 2007.
- ³⁸ This fund was matched by the provinces and territories for a total of 800 million.
- ³⁹ Statistics Canada. Consumer Price Index, Historical Summary. Accessed 12/12/07.
- ⁴⁰ This may include new models of care, care in the community, modernizing infrastructure, investing in research, best practices, etc.