Deconstructing and strengthening Canada's health human resource strategy

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Introduction

As the first wave of the 2019 coronavirus (COVID-19) swept across Canada, our initial planning response was centred around immediate issues such as Personal Protective Equipment (PPE) and Emergency Room (ER) or Intensive Care Unit (ICU) capacity.[1] With early interventions, including physical distancing and broad lockdowns, provinces could flatten the curve or at the very least limit a surge of cases that would overwhelm our health system.[2] However, our experience with the first wave of COVID-19 has unearthed a longer-term health systems issue that deserves immediate action: that of inadequate Healthcare Human Resource (HHR) planning and utilization. Specifically, we have identified the following key gaps in Canada's HHR strategy:

1. Canada lacks robust, needs-based national HHR data collection and forecasting

An inadequate supply of healthcare workers (HCWs) affects the ability to fight the pandemic. As frontline HCWs are at an increased risk of contracting COVID-19, regions may see drastic reductions in their front-line workforce.[3] This problem is worsened by inherent shortages in HCWs. This was borne out overseas in New York and parts of Italy.[4,5] Even in Canada, staffing shortages in long-term care resulted in the federal government exhausting almost its entire armed forces to bolster medical capacity in just two provinces.[6] Plans and structures, therefore must be in place to recruit and redeploy HCWs in acute and non-acute settings to respond to pandemics.

2. Current accountability and reporting structures between the federal government and provinces/territories are not clear, transparent, or visible to the public

Currently, the Federal, Provincial, and Territorial Public Health Response Plan for Biological Events (FPT-PHRPBE) bridges the gap between federal and provincial/territorial responses, but it is unclear if its reporting structure is truly operationalized.[7] It is difficult to identify which federal, provincial, and territorial bodies are accountable for each aspect of HHR planning, and this lack of transparency is detrimental to our ability to strengthen our HHR workforce.

3. There is a clear lack of robust planning for HHR needs in community care settings

Canada's initial COVID-19 planning focused on predicting and preparing for surge capacity in acute care settings, and efforts were largely targeted at bolstering physical resources (e.g. PPE, ventilators, overflow hospital spaces) and acute care human resources (e.g. physicians, nurses, respiratory therapists).[1] Although these efforts were necessary, it became apparent that the bulk of COVID-19's impact was occurring outside of acute care institutions. Of all Canadian COVID-19 deaths, 85% occurred in long-term care institutions (LTCs), representing some of the highest international mortality proportions in long-term care settings.[8] While many hospitals did not see the increase in patient volumes they had planned for, community settings such as LTCs, shelters, and prisons are understaffed and most at risk.[9] Canada's most vulnerable, stigmatized and marginalized citizens are at risk for being disproportionally affected by COVID-19.[10]

We therefore propose 3 key areas of action to strengthen Canada's HHR planning moving forward.

Area of action 1: invest in needs-based data collection

To inform pandemic planning and decision making, governments require data on current HHR, community needs, and projections of spread. Unfortunately, this data collection is regionally and professionally isolated. Outside of the military, the government would be challenged to identify what resources are needed or available.

Canada needs a national health workforce planning agency to fill this gap, as is done in other countries with more successful COVID-19 responses.[11] This agency could engage in the collection of provincial data regarding the current healthcare workforce, develop needs-based forecasts for health resource planning, and develop plans, models, and procedures for pandemic redeployment. Besides immediate pandemic response, such an agency would increase our ability to harness national data and research for overall health systems strengthening for generations to come. Lack of foresight and planning in this department may lead to severe shortages in the healthcare workforce that can overwhelm the healthcare system. This was made clear in Italy, where a lack of HCWs, PPE, and overloaded health system resulted in an exponential growth in cases and high mortality rates up to 8-12%.[12]

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Area of action 2: develop a federal accountability plan for HHR oversight

As mentioned, the FPT-PHRPBE is a complex and difficult-to-find governance structure that is responsible for HHR oversight in Canada.[13] Although there is an organizational chart outlined on their document, it is unclear what is under provincial/territorial jurisdiction and what is under federal jurisdiction. This plan is also difficult to understand and locate, and inaccessible to various levels of government and the public alike.

Canada must follow the lead of countries like New Zealand that have robust accountability structures for HHR oversight.[11] One way to operationalize this is to have an accessible and up-to-date centralized COVID-19 response website that states the roles of each jurisdiction and relevant body in a format understood by the public. Making lines of accountability clear to the public from the federal government downwards signals to Canadians that we are aware of our jurisdictional responsibilities and are unified across our provincial and territorial borders. Lack of federal accountability and leadership in the United States led to the country being overwhelmed with cases despite its strong healthcare capacity. The United States comprises 5% of the world population but constitutes over 25% of the world's COVID-19 cases.[14,15]

Area of action 3: understand our care needs in the community and strengthen our community workforce

To avoid repeating such calamitous outcomes in LTCs, prisons, shelters, and other community settings, it is imperative that provinces identify essential personnel (i.e. outside of direct medical staff) across the entire spectrum of community care. For example, New Zealand's robust pandemic plan articulates the impact of a surge on phone triage personnel, public health educators, community pharmacists, doctors, nurses, funeral home workers, and coroners. In Ontario, the Minister of Health has pushed for contingency plans, including recruiting a back-up pool of workers with transferable skills (e.g. food service preparation) to fill in gaps in the LTC workforce. We must learn from these jurisdictional solutions and provide robust national guidance on how to operationalize these contingency plans.

To this effect, we propose a new Federal Health Transfer to provinces that supports the collection of data regarding personnel needs in community care settings during non-pandemic times, the projection of expected surge needs of this workforce and the projections additional resources, such as living accommodations, transportation, and hazard pay that may be needed to support this workforce. A Community Care HHR Working Group should be established at the national level with provincial/territorial representation to provide guidance to provinces/territories on how to collect the above data, how to make surge projections, and how to allocate funds across the community care sector. By setting this guidance nationally, we can ensure equitable and accessible deployment of surge resources across provinces/territories in the event of a second COVID-19 wave or future pandemic.

Implementation challenges

While we believe these solutions would be beneficial to Canada's pandemic response, there are several implementation challenges. First, lack of cooperation with all provinces/territories may cause insufficient compliance and adoption of recommended solutions. For instance, the Government of Quebec, "considers Health Human Resources planning to be its exclusive responsibility".[16] Such individualistic and fractured responses can be avoided by ensuring appropriate representation from provinces and territories. This will also provide flexibility in adoption of our solutions, so each province and territory can tailor it to best fit their unique needs and challenges. Second, because federal and provincial funding is limited, our recommendations will require managing and redirecting funds. This is further complicated by short-lived windows of opportunity in public policy implementation.[17] The COVID-19 pandemic has highlighted faults in our healthcare system and provides a minute window of opportunity for implementing innovative health system changes. We recommend the government take decisive action. If the window of opportunity is exceeded, the public will lose interest in pandemic planning and it will no longer be a priority. We may find ourselves no more prepared during the next global outbreak.

Conclusion

Canada's response to the COVID-19 pandemic has exposed limitations in our HHR planning. First, to address the lack of needs-based national HHR data collection and forecasting, we must implement a national health workforce planning agency. This agency would be responsible for data collection, both within and outside of a pandemic, in order to ensure we have robust longitudinal data collection systems in place across the nation. Second, we must develop a federal accountability plan for HHR oversight clear to both those responsible and the public. Finally, we must acknowledge that any robust HHR plan must also anticipate the needs of community organizations to be successful. By addressing these 3 current gaps, we can ensure that Canada's healthcare system is strong and ready to face future pandemic events.

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