Poor health workforce planning is costly, risky and inequitable

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Cite as: *CMAJ* 2019 October 21;191:E1147-8. doi: 10.1503/cmaj.191241

Planning for the right number and mix of health workers — in the right place, at the right time — is an ongoing struggle in Canada's health care systems. Health workers represent these systems' greatest financial input, accounting for more than 70% of direct health care costs in Canada, and as much as 8% of a provincial budget for physicians only.[1,2] Considering the cost of not just employing but also training health workers, and how important this workforce is to overcoming important health care problems like improving patient access to medical services and reducing wait times, it is time Canada made collection and analysis of accessible, high-quality health workforce data and strategic health workforce planning a critical priority. However, despite numerous calls for a coordinated approach to planning the health workforce, and the availability of adaptable models for data collection and workforce planning among peer nations, little action has been taken.

The bulk of expenditures for the health workforce includes salaries, wages, fees and contracts. Indirect costs for training, planning, regulation and workforce management also contribute to public expenditures. Although the health workforce is growing at twice the rate of the labour force in general (103% v. 47% from 1987 to 2017),[3] there is increasing concern about whether the supply of health workers can meet the needs of today's population or will be able to handle future demands on the health system.[4]

The 2007 Framework for Collaborative Pan-Canadian Health Human Resources Planning stressed that "the status quo approach to planning has the potential to create both financial and political risks, to limit each jurisdiction's ability to develop effective sustainable health delivery systems and the health [workforce] to support those systems."[5] The first recommendation of a 2010 report by the Parliamentary Standing Committee on Health was to establish "a new arm's length national observatory on health [workforce] with a broad-based membership that would promote research and data collection."[6] Research on the health workforce is key to proper forecasting and planning. Yet, the Pan-Canadian Vision and Strategy for Health Services and Policy Research reported that investments into health workforce research from 2007 to 2012 accounted for only 2.8% of all federal, provincial and territorial health services and policy research funding.[7] Thus, more than a decade after the introduction of the framework, the approach taken to planning Canada's health workforce remains largely unchanged.

KEY POINTS

- We do a very poor job of health workforce planning in Canada, in large part because of inadequate health workforce data.
- Inadequate health workforce data have economic costs because poor data limit planning models, tools and processes necessary for workforce planning.
- Not knowing exactly who comprises the health workforce and how they work also has important equity implications, especially as the health sector consists predominantly of women.
- Canada must make collection of high-quality data on the health workforce and strategic planning in the health workforce an urgent priority.

An essential foundation of integrated health workforce planning and research is gathering high-quality, standardized, comprehensive, linkable data across the health professions. At a pan-Canadian level, the Canadian Institute for Health information produces reports for a subset of health professions on an individual basis, falling short of capturing the interprofessional reality of how health care is delivered today. The Canadian Institute for Health information itself is constrained by the data sources it draws upon, which are fragmented and incomplete. Further, its guidance[8] on which standardized data elements should be collected has not been universally or uniformly applied.

The Health Professions Database in Ontario, which annually collects key data elements on the health workforce from each of the regulated health professions, is a promising initiative. Reports on these data, however, are not publicly available, nor are the data sets readily accessible to health workforce planners. As noted in the framework, poor health workforce data have economic costs because of the limitations they impose on planning models, tools and processes.

Some industries spend vastly more on workforce planning. For example, the BuildForce Canada agency has a $4.5-million annual budget for workforce planning in the building and construction industry — a sector, it is worth noting, that is dominated

by men.[9] By way of contrast, we know that more than 80% of the health care workers we count are women,[10] and this does not include those caring for older adults at home and in long-term care. Moreover, women's participation in the health sector is outpacing that of men's (111% increase in number of female health workers since 1987 v. 74% increase in number of men).[10] Indeed, the health and social services sector has the highest number of women workers, making health workforce issues critical to gender equity.[11] Thus, poor data on and planning in the health workforce are of notable gender equity concern.

Moreover, with the exception of self-reported census data, Canada has no data at all on the Indigenous identity of health workers, even in the most promising case of the Health Professions Database in Ontario. Nor do we collect data on the visible-minority identity of health workers or those with disabilities. These are critically important oversights, making the experiences and representation of these workers invisible to analysis and remediation. For example, there is no basis from which we can say that we are responding to the Truth and Reconciliation Commission's calls to action to "increase the number of Aboriginal professionals working in the health-care field" and "ensure the retention of Aboriginal health-care providers in Aboriginal communities."[12]

Not fully knowing who is in our workforce means we cannot support our health workers appropriately, or address pay equity, discrimination or the other unique concerns held by women, Indigenous health workers, workers with a visible-minority identity or those with disabilities. Furthermore, we cannot anticipate how the workforce is going to change and build a workforce for the future that is responsive to population and health system needs.

Canada lags behind key comparator nations in collecting critical data on its health workforce. In 2008, Australia created a centralized health workforce agency (www.ahpra.gov.au/About-AHPRA.aspx) to collect standardized data from 15 health professions, including Aboriginal and Torres Strait Islander health practitioners. In the United States, the National Center for Health Workforce Analysis (https://bhw.hrsa.gov/national-center-health-workforce-analysis) produces a chartbook on 35 health professions that includes data on age, sex, race and ethnic diversity. This feeds into a network of arm's-length health workforce research centres. The United Kingdom annually publishes data at the National Health Service level (https://digital.nhs.uk/data-and-information/areas-of-interest/workforce/workforce-minimum-data-set-wmds) on several items, including age, sex and ethnic background, for more than 20 professions working in National Health Service hospitals, community health services, general practitioners' offices and independent health care facilities.

Canada needs to shift from inaction to strategic direction in health workforce data collection and planning. This will require sustained and coordinated efforts to collect and render safely accessible the critical data elements needed to undertake robust equity-informed, integrated health workforce research and planning across the country.

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Competing interests: None declared.

This article was solicited and has not been peer reviewed.

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Contributors: All authors contributed to the conception and design of the work. Ivy Bourgeault drafted the manuscript. Sarah Simkin and Caroline Chamberland-Rowe revised it critically for important intellectual content. All authors gave final approval of the version to be published and agreed to be accountable for all aspects of the work.

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