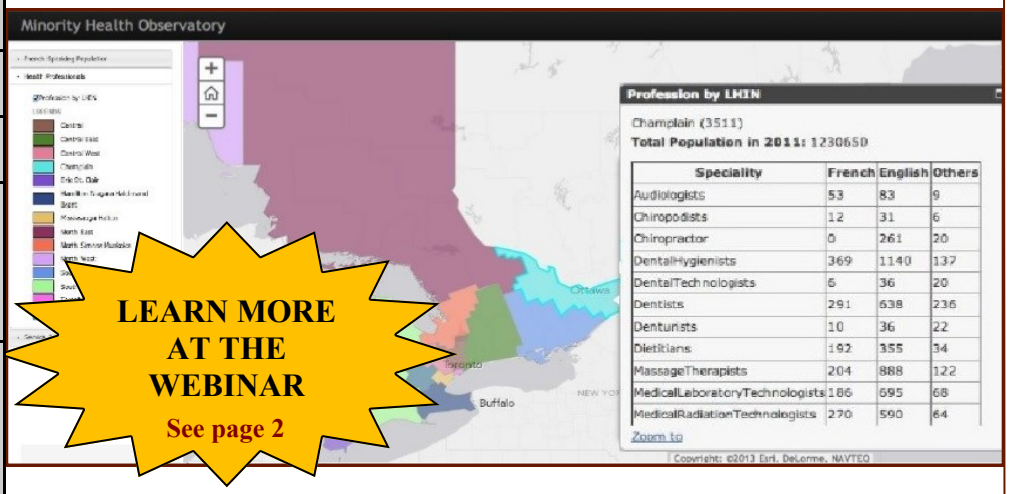
CHHRNews
CANADIAN HEALTH HUMAN RESOURCES NETWORK
NEWSLETTER
VOLUME I ISSUE 4

CHHRN HHR INNOVATION SERIES:

The Geoportal of Minority Health

INSIDE THIS ISSUE:

High quality data in health is essential to decision making in health policy and planning. However, data is often missing or incomplete for certain populations. The Geoportal of Minority Health aims to fill these knowledge gaps and improve knowledge about health and access to health services of the Francophone minority population of Ontario. This initiative was established through funding from the Ministry of Health and Long-Term Care of Ontario (MOHLTC) in 2013-2014.



The Geoportal has enabled the development of:

1 . A centralized geographic database comprising:
   1) socio-economic data associated with different linguistic variables ,
   2) data on health professionals including their ability to provide services in official language minority populations
   3) national health surveys , and
   4) points of health services;

2 . A geographic information system (GIS) that allows spatial analysis of data and an online mapping application. GIS allows you to create, organize and present spatially referenced data and to produce plans and maps as depicted above.

The Geoportal is an infrastructure of information, that can be used helps to improve knowledge of social and structural factors underlying health disparities that disproportionately affect minority populations. It is a base of information useful to a wide range of knowledge users: health workforce planners for minority health, LHINs, public health and community organizations as well as researchers. Our research team recently filed a request for funding to continue work on Geoportal as a Health Observatory of Minority Health (OSM) and also aims to expand the activities of the observatory at the pan-Canadian level.

CHHRN Fireside Chat Series

INNOVATIONS IN HHR

The Canadian Health Human Resources Network and CHNET-Works! is hosting a new series of Fireside Chat Webinars on HHR Innovations across the country from December 2013 to March 2014 and are providing HHR innovation teams the opportunity to showcase their innovations and facilitate discussion with a wide range of stakeholders across the country. CHHRN is sponsoring this new series in order to increase awareness about these key HHR innovations taking place across the country and to facilitate important discussion around scaling up, successes and lessons learned from these innovations teams.

Upcoming Fireside Chats:

- **Of Walls, Moats, and Ceilings: Reconceiving HHR in the Era of Quality Improvement**
  Date: February 20th 2014
  Time: 1:00pm-2:00pm (EST)

- **Transforming Musculoskeletal Care in Alberta: Moving Upstream with Collaborative Teams in Primary Care**
  Date: March 6th 2014
  Time: 1:00pm-2:00pm (EST)

- **The ROI in Team– Developing a Return on Investment Framework for Team-Based Care**
  Date: March 12th 2014
  Time: 1:00pm-2:00pm (EST)

- **Geoportal of Minorty Health**
  Date: March 19th 2014
  Time: 12:30pm-1:30pm (EST) English
  2:30pm-3:30pm (EST) French

- **Occupational Therapists in Community Mental Health**
  Date: March 25th 2014
  Time: 1:00pm-2:00pm (EST)

Download Podcasts and Presentations:

- **Interprofessional Teams in the Chinook Primary Care Networks**
- **Enhancing Primary Care Delivery in the Inner City Through Interprofessional Team Work**

For more information about the HHR innovations webinars visit:
www.hhr-rhs.ca

CHHRN Fireside Chat Series

INNOVATIONS IN HHR

Presenter Experiences

"Our team really appreciated the opportunity to share our innovation with others across Canada and beyond! The planning and facilitation of the webinar were excellent with wonderful support throughout the process. We were pleased with the level of interest with those who attended the chat and also had lots of interest expressed via email after the fact. Thank you very much for this opportunity! We would highly recommend it to others!"

Deborah Kopansky-Giles,
Fok-Han Leung,
Kelly Horner
St. Michael's Interprofessional Teamwork Webinar

What did you enjoy most about your experience?

"The friendly and professional support by Dot (animateur of CHNET-Works!) and Chantal (research coordinator for CHHRN). The run through with Dot in particular made me more at ease since it was my first online presentation. It was very professionally done."

Thanks and take care,
Reneée Misfeldt
Chinook Primary Care Network Webinar

Participant Feedback

"Due to fiscal constraints and remote location, the Fireside chat series had been a invaluable source of professional development for me and my staff."

Anonymous Participant
St. Michael's Interprofessional Teamwork Webinar

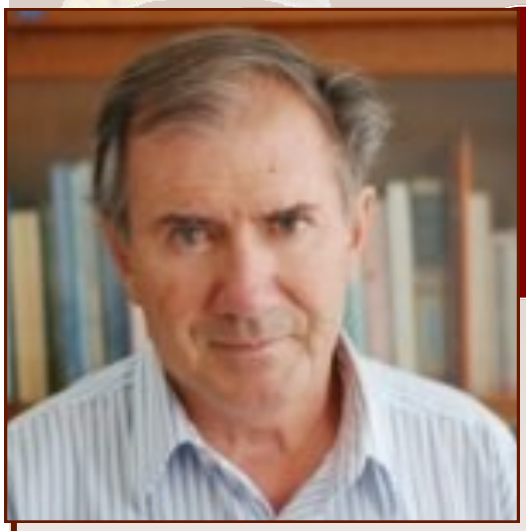
"Content was very relevant and good use of my time. It is hard to take time out of a busy schedule to participate but I am very glad I did."

Anonymous Participant
Chinook Primary Care
Network Webinar

To register and participate in the next fireside chat visit:
www.chnet-works.ca

CHHRN

International Health Human Resources Advisory Committee



Dr. Gilles Dussault

Professor,
Institute of Hygiene and Tropical Medicine
University of New Lisbon, Portugal

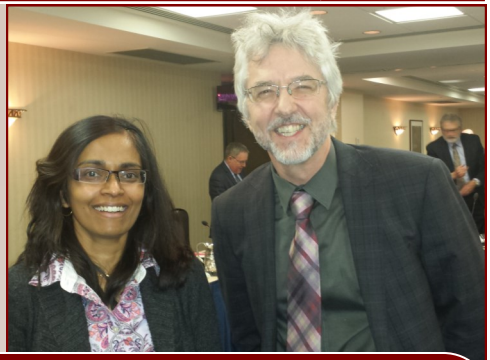
Gilles Dussault is Professor at the Institute of Hygiene and Tropical Medicine (IHMT), Lisbon, Portugal and Coordinator of the World Health Organization Collaborating Center on Health Workforce Policy and Planning. Before joining IHMT in August 2006, he worked as Senior Health Specialist at the World Bank Institute (Washington D.C.). He was responsible for the Health Sector Reform and Sustainable Financing" Program in French, Portuguese and Spanish-speaking countries. Between 1985 and 2000, he was Professor and Director (1990-91, 1998-2000) of the Department of Health Administration, University of Montreal. Between 1974 and 1985, he was Professor in the Department of Industrial Relations at University Laval, in Québec. His research interests include the production of health services, and health workforce policies. Since 1986, he has been much involved in international cooperation projects in Africa, Europe, Latin America and Asia. Between 2002 and 2004, he was a member of the Joint Learning Initiative on Human Resources for Health, a landscaping and advocacy major international initiative launched by the Rockefeller Foundation, which published the influential Report Human Resources in Health: Overcoming the Crisis, 2004, (Harvard University Press, www.globalhealthtrust.org). He has been member of the World Health Organization Global Advisory Group on Nursing and Midwifery, and has also participated in various working and advisory groups in a number of other international organizations.

In Canada, he chaired international evaluation committees of major research organizations in (Canadian Heath Services Research Foundation, Occupational Health and Safety Research Institute- Quebec). He is member of editorial committees of peer-reviewed journals. He is the author or co-author of 12 books and monographs, more than 80 articles in peer-reviewed and professional journals. More recently, he co-authored A universal truth: no health without a workforce, launched at the 3rd Global Forum on Human Resources for Health, in Recife (Brazil) by the Global Health Workforce Alliance and the World Health Organization.

CHHRN is very pleased to have Dr. Dussault as a member of the CHHRN International Advisory Committee which benefits greatly from his knowledge, expertise and advice.

"*Health workforce development challenge is far from having been met. Many countries, such as Australia, Canada, the UK or the Nordic countries are showing the way, most other countries are not on track. Researchers must continue to study and analyze good practices and above all learn to communicate convincingly with policy and decision-makers*." ***Gilles Dussault***

National Health Human Resources Update



Update on Work of the Physician Resource Planning Task Force Technical Steering Committee

In June 2012, the Conference of Deputy Ministers of Health (CDM) directed its Committee on Health Workforce to work with the Association of Faculties of Medicine of Canada (AFMC) to examine ways in which to advance Recommendation One of the Future of Medical Education in Canada Postgraduate Project Report, "ensure the right mix, distribution and number of physicians to meet societal needs." The CDM established the Physician Resource Planning Task Force in the spring of 2013 to facilitate the collaboration and coordination of pan-Canadian physician human resources planning in support of the Deputy Ministers of Health/Deans of Medicine Working Group. The Task Force is co-chaired by Ontario and the AFMC, and focuses on advancing:

- a process for addressing physician imbalances across identified specialties;
- a pan-Canadian physician planning tool to better understand the complexities of physician supply; and
- accurate information to support decision-making by those considering and currently pursuing medical education, both in Canada and abroad.

As part of the Task Force work, a Technical Steering Committee (TSC), co-chaired by Ontario and the Canadian Post-M.D. Education Registry (CAPER), was created to oversee the development of a pan-Canadian physician workforce planning tool. The TSC is comprised of health human resources planning experts from Federal/ Provincial/Territorial Governments and national stakeholder organizations. During its inaugural meeting on November 8, 2013, members discussed the broad parameters of the pan-Canadian physician workforce supply tool, and the anticipated inclusion of the needs-based component in future phases of this work. A project manager was hired in January 2014. The project team is currently engaged in developing a Request for Proposals to recruit an independent contractor to build the supply tool. It is expected that a contractor will be engaged in spring 2014 in order to: carry out targeted expert consultations; propose a tool development methodology; develop a supply-based pan-Canadian physician resource planning tool; and present the tool and its outputs to the TSC and Task Force in the fall of 2014.

Ms. Soma Mondal
Manager, Health Workforce Evidence & Innovation Unit
Health Human Resources Strategy Division
Ontario Ministry of Health and Long-Term Care
Co-Chair, Physician Resource Planning Task Force
Technical Steering Committee

Mr. Steve Slade
Director, Canadian Post-M.D. Education Registry (CAPER);
VP Data and Analysis, Association of Faculties of Medicine of Canada (AFMC)
Co-Chair, Physician Resource Planning Task Force Technical Steering Committee

OP-ED in HHR

Why we have too many medical specialists: Our system's an uncoordinated mess

By Morris Barer, Globe and Mail|08/29/13

The most surprising thing in the recent coverage of the Royal College of Physicians and Surgeons of Canada study, which notes that as many as one in six newly graduated medical specialists can't find a job, is that anyone finds these results startling. They're not if you've been paying attention.

The die was cast about fifteen years ago, when the medical schools of the country convinced the provincial Ministers of Health at the time that Canada faced a dramatic shortage of physicians that could only be addressed by a massive ramp up in domestic medical school capacity. The result was an almost doubling of first year entry numbers, from about 1,575 to around 3,000 per year. Once you consider this fact, the arithmetic is breathtakingly easy, and the startle factor disappears.

Canada now has as least 85 percent more new physicians ready to enter practice each year, on average, than physicians retiring. And this is before considering Canadians who have gone to medical schools abroad and then returned to Canada hoping to practice here, or medical graduates from other countries. The numbers of both entering practice here have also increased dramatically over the past decade, and there is considerable pressur particularly from Canadians who have gone abroad for training (currently from 3,500 with more joining every year) and organizations representing them, to increase numbers even further.

It is not that the "one in six" implies that Canada now has an overall surplus of specialists, any more than the widespread claims of shortage in the mid-1990s meant, then, that we had an overall shortage of physicians. We had then, and we have now, an inability or unwillingness as a country to develop plans and policies designed to train and deploy physicians in a sensible manner.

The report's author is correct in noting that there is no quick fix here. The Royal College's plan to convene a meeting early next year to discuss a nationally co-ordinated approach to health system work force planning may be a useful start. It is difficult to imagine the recommendations that might emerge from such a meeting being worse than the current uncoordinated mess.

At present, policy decisions, or often the lack thereof, are failing to meet the needs of new trainees– or of patients. For example, there are no national (and few provincial) mechanisms in place to channel new

graduates into the specialties where they are likely to be most needed rather than into the specialties most needed by teaching hospitals or most favoured by students.

And despite the fact that we live in a hyper-active era of tweets and blogs in which the new generation seems to be constantly 'connected' there is no structured electronic 'meeting place' for job hunters and job seekers. New graduates are somehow failing to figure out where the jobs are (and there are, in fact, plenty of communities desperately seeking specialists).

In some cases, at least, the new specialists are simply the victims of the completely predictable fallout from that earlier medical school expansion. When those ministers of health agreed to fund an approximate doubling of medical school places, what did they think would happen when those students started graduating? Was there a plan in place to ensure that the complementary resources that are required for their practices would also be funded and in place?

In a word, "no". For example, operating room capacity– or at least 'working capacity', meaning an available operating suite plus the funds, supplies and complementary staff to operate it– has not kept to pace. To make matters worse, the capacity is not used efficiently, and some of those who control that capacity are not all that keen to share with their younger brethren.

The consequences in our future– many more new physicians looking for practice opportunities each year, than old physicians retiring– are as predictable as what we are seeing in the Royal College findings today.

Ministries of Health need to engage now in two separate but related conversations– one about policies designed to take advantage of all these new highly skilled and motivated physicians available to Canadians, and a second about how to avoid repeating old policy mistakes down the road. Memories, it seems, have a short half-life; mistakes don't.

Morris Barer is an advisor with EvidenceNetwork.ca, Professor in the Centre for Health Services and Policy Research (CHSPR), School of Population and Public Health, UBC, and the lead for the western hub of the Canadian Health Human Resources Network (CHHRN).

THE GLOBE AND MAIL

CANADA'S NATIONAL NEWSPAPER • FOUNDED 1844

Learn about the activities taking place through the new national physician resource planning task force

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CHHRN Theme Feature

HHR Planning:

Using Evidence to Meet Population Healthcare Needs: Successes and Challenges

INVITED ESSAY
HealthcarePapers

HealthcarePapers, 13(2) July 2013: 9-21

Dr. Gail Tomblin Murphy, & Mr. Adrian MacKenzie

ABSTRACT

In order to respond effectively to the health needs of Canadians, healthcare planners must directly consider these needs when planning and delivering services. However, Canada's various healthcare systems have traditionally been organized based on historical levels of service provision as opposed to population health needs. A number of innovations in care delivery redesign in Canada have already been developed as part of efforts to foster a more effective and sustainable healthcare system. This paper presents two of these as case studies illustrating some of the main challenges in trying to identify and address healthcare needs, as well as some potential solutions to those challenges.

Healthcare planning in Canada – including health human resources (HHR) planning – has tended to be organized on the basis of historical levels of service provision as opposed to the health needs of populations (Birch and Chambers 1993; Cameron 2009; Tomblin Murphy et al. 2007). Most recently, there has been a growing awareness that to be effective and equitable, healthcare planning – including HHR planning – must be more systematically based on actual healthcare needs (Birch et al. 2007; Bloor and Maynard 2003; Duckett et al. 2012; Eyles and Birch 1993; Kephart and Asada 2009; Newbold et al. 1998; Tomblin Murphy et al. 2012c). In fact, a number of Canadian governments (Advisory Committee on Health Delivery and Human Resources 2004, 2007; Alberta Health and Wellness 2008; British olumbia Ministry of Health 2012; HealthForceOntario 2008; Manitoba Health 2006; Nova Scotia Department of Health 2005; Nunavut Health and Social Services 2005; Saskatchewan Ministry of Health 2011) and other healthcare stakeholders (Canadian Institute for Health Information, Health Canada, Statistics Canada 1999; Canadian Nurses Association/Canadian Medical Association 2005; Health Action Lobby 2006; Pan American Health Organization 2005) have endorsed needs-based approaches to HHR planning. Despite this apparent support, however, much decision-making in Canada about healthcare resource allocation in general (Smith et al. 2013) and HHR specifically (Nova Scotia Health Research Foundation 2012) is done on the basis of historical and political factors as opposed to healthcare needs. Continuing to plan in this way will perpetuate existing inequities and inefficiencies in how healthcare is planned and delivered (Birch et al. 2007; Evans 2009; Lewis 1998). Improving equity and efficiency in healthcare planning and delivery will become even more imperative as growth in Canadian healthcare spending continues to outpace economic growth (Canadian Institute for Health Information 2012).

is done on the basis of historical and political factors as opposed to healthcare needs. Continuing to plan in this way will perpetuate existing inequities and inefficiencies in how healthcare is planned and delivered (Birch et al. 2007; Evans 2009; Lewis 1998). Improving equity and efficiency in healthcare planning and delivery will become even more imperative as growth in Canadian healthcare spending continues to outpace economic growth (Canadian Institute for Health Information 2012).

Consistent with this imperative, governments across Canada have invested in a wide range of programs aimed at improving the effectiveness and efficiency of their respective healthcare systems. During recent meetings of the Federal/Provincial/Territorial Advisory Committee on Health Delivery and Human Resources, members spoke to the importance of needs-based planning for the health system and the workforce. They shared a number of innovative care delivery programs aimed at better meeting healthcare needs in their respective jurisdictions. In this article, we present the cases of the two of these programs, implemented on opposite sides of the country, whose effectiveness has been or is presently being evaluated. We will thereby identify some of the challenges that may be encountered in implementing such approaches, as well as some potential strategies for overcoming these difficulties. The first program – the Model of Care Initiative in Nova Scotia, or MOCINS – was implemented at the provincial level. The second – Care Delivery Model Redesign, or CDMR – was designed and implemented by the Vancouver Island Health Authority (VIHA).

KEY EXERPTS:

"Continuing to plan on the basis of historical and political factors as opposed to healthcare needs will further result in inequities and inefficiencies in how healthcare is planned and delivered."

"There is suspicion that any change directives coming from organizational leaders are motivated chiefly by fiscal restraint– that 'this is just an excuse to cut the budget.'"

"Critical to success is regular, consistent and effective communication about the initiatives."

"It seems only prudent to invest perhaps 5% of a program's cost to find out exactly what was purchased with the other 95%."

Visit the CHHRN HHR Planning Theme Page to Read Full Report:

www.hhr-rhs.ca

CHHRN Theme Feature

Rural, Remote and Aboriginal:

Canada's most vulnerable: Improving health care for First Nations, Inuit and Métis seniors

Health Council of Canada , November 2013

To gather information for this report, the Health Council conducted interviews with senior officials from provincial, territorial, and federal governments and from First Nations, Inuit, and Métis organizations. We also hosted regional meetings across Canada to learn what is being done for seniors in their communities and where problems still exist. Many participants were health professionals and members of First Nations, Inuit, or Métis communities; some were seniors as well (see Methodology, page 64).

Although social, economic, and historical factors are widely recognized as the primary cause of health disparities, participants told us about system problems that are getting in the way of good health care for seniors in their communities. These are described in the section Pressure points and politics.

Many identified innovative practices that are breaking through these barriers and improving the care of Aboriginal seniors. We have synthesized key findings from these practices in the section Changing landscapes and key approaches.

In the final section, Partnerships and progress, 12 innovative programs are presented through a series of interviews with health care providers and policy-makers. As their stories demonstrate, change often begins with questioning the status quo and reaching out to build new partnerships.

At the cross-country sessions, participants told us that hearing from others who had resolved similar problems gave them a sense of hope, possibility, and determination to discuss new ideas back in their own communities. The Health Council hopes this document will stimulate similar discussions about the care of Aboriginal seniors across the country, and inspire new directions from governments, communities, and health care providers.

Download full report on the Health Council of Canada website:
www.healthcouncilcanada.ca

CHHRN Theme Feature

Mobility & Migration:

Report from the WHO HRH Global Forum

Recife, Brazil November 11, 2013

The Third Global Forum for Human Resources for Health is the largest event ever held on human resources for health, with more than 1300 participants from 85 countries, including 40 Ministers of Health.

In December 2013, the Global Health Workfroce Alliance resleased the following announcement:
The World will be short of 12.9 million healthcare workers by 2035; today, that figure stands at 7.2 million. A World Health Organization (WHO) report released in December 2013 warns that the findings– if not addressed now– will have serious implications for the health of billions of people across all regions of the world.

The report, A Universal Truth: No health without a workforce, identifies several key causes. They include an ageing health workforce with staff retiring or leaving for better paid jobs without being replaced, while inversely, not enough young people are entering the profession or being adequately trained. Increasing demands are also being put on the sector from a growing world population with risks of noncommunicable diseases (e.g. cancer, heart disease, stroke etc.) increasing. Internal and international migration of health workers is also exacerbating regional imbalances.

The findings were released at the Third Global Forum on human Resources for Health together with recommendations on actions to address workforce shortages in the era of universal health coverage. The main recommended actions include:

- Increased political and technical leadership in countries to support long-term human resources development efforts.
- Collection of reliable data and strengthening human resources for health databases.
- Maximizing the role of mid-level and community health workers to make frontline health services more accessible and acceptable.
- Retention of health workers in countries where the deficits are most acute and greater balancing of the distribution of health workers geographically.
- Providing mechanisms for the voice, rights and responsibilities of health workers in the development and implementation of policies and strategies towards Universal Health Coverage.

While the report highlights some encouraging developments, for example, more countries have increased their health workforce, progressing towards the basic threshold of 23 skilled health professionals per 10 000 people, there are still 83 countries below this basic threshold. But it is the future projections that raise the loudest alarms. In a stark assessment, the report says that the current rate of training of new health professionals is falling well below current and projected demand. The result will be that in the future, the sick will find it even harder to get the essential services they need and preventative services will suffer.

Whilst the largest shortages in numerical terms are expected to be in parts of Asia, it is in sub-Saharan Africa where the shortages will be especially acute. On education and training, for example, in the 47 countries of sub-Saharan Africa, just 168 medical schools exist. Of those countries, 11 have no medical schools, and 24 countries have only one medical school.

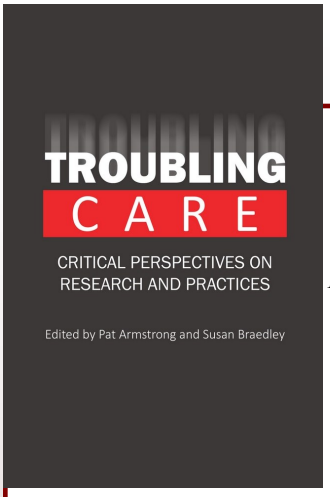
Universal Health Coverage aims to ensure that all people obtain the health services they need without suffering financial hardship when paying for them. In the Americas, 70% of countries have enough health care workers to carry out basic health interventions, but those countries still face significant challenges linked to the distribution of professionals, their migration and appropriate training and skills mix.

All countries are urged to heed the signals of shortages. For example, in developed countries, 40% of nurses will leave health employment in the next decade. With demanding work and relatively low pay, the reality is that many young health workers receive too few incentives to stay in the profession.

For more information about this report contact:
Glenn Thomas: thomasg@who.int

CHHRN Theme Feature

Quality of Worklife:



Troubling Care: Critical Perspectives on Research and Practices

Edited by Pat Armstrong and Susan Braedley

"*What is happening to care in Canada is troubling. At the broadest level, we are moving from caring and sharing as widely held public ideals to greedy and mean, not only in practice, but increasingly as policy goals*."

With this provocative introduction, and using long-term residential care as a case study, this book asks how we can plan, organize, distribute and offer care in Canada in ways that treat those who need it and those who provide it with dignity and respect. Through fourteen contributions from an interdisciplinary team of researchers, the book argues that researchers, policy makers and health care providers must "trouble" care, disrupting our preconceptions and critically examining the often taken-for-granted categories through which we assess and evaluate care.

Readers are invited to think through care theories, caring work, care practices and care policy, in order to reimagine care as a necessary social good in which we all have a stake. Based upon research-in-progress, these health researchers employ a feminist political economy lens to reveal some of the "real" costs and benefits of care. Contributions range widely, from physician Joel Lexchin argument for an evidence-informed approach to anti-psychotic drug use to sociologist Hugh Armstrong analysis of the political implications involved in health statistics to cultural studies researcher Sally Chivers' discussion of creativity as a means to re-value those suffering with dementia.

Highlights:

1. Gender matters when we talk about care. Contributions show the ways gender influences what counts as skill in care work, occupational health and safety for care workers, and policies affecting care.
2. Care is a dynamic and changing field in a rapidly changing world. Chapters on new technologies and innovations in care, the long-term care labour force and changing resident popu-lation in residential facilities demonstrate that care is a social relation that affects - and is affected by - political, economic and social change.
3. Values matter when we talk about care. Implicit throughout, but explicit in chapters on care as a concept, on the ethos of care and on the politics of care, these authors argue that care must be valued as a necessary and central public good in any democratic and equitable society.

For more information visit www.hhr-rhs.ca

Susan Braedley

HHR Research Spotlight

Pat Armstrong

Dr. Pat Armstrong is a sociology professor at York University, where she has taught for 21 years. She has co-authored a large number of articles and books on health policy including *They Deserve Better: The long-term care experience in Canada* and *A Place to Call Home: Long term care in Canada*.

Dr. Armstrong held a Canadian Health Services Research Foundation/ Canadian Institutes of Health Research Chair in Health Services and Nursing Research, where she was developing a graduate program to train students in health policy and politics.

MOST RECENT HEALTH HUMAN RESOURCE PUBLICATIONS

Troubling Care: Critical Perspectives on Research and Practices
Pat Armstrong and Susan Braedley (eds.), 2013

Puzzling Skills: Feminist Political Economy Approaches Special Anniversary Issue of the Canadian Review of Sociology
Pat Armstrong, Canadian Review of Sociology, Volume 50 Issue 3, August 15 2013

FORTHCOMING PUBLICATIONS:

Taking gender into account in occupational health research: Continuing tensions.
In Policy and Practice in Health and Safety
Pat Armstrong and Karen Messing

OTHER HHR PUBLICATIONS:

The thin blue line: Long term care as an indicator of equity in welfare states
In Canadian Women's Studies, Spring/Summer 2012, Volume 29, Issue 3, p. 49-60
Pat Armstrong, Hugh Armstrong and Tamara Daly

Structural violence in long-term, residential care for older people: Comparing Canada and Scandinavia
In Social Science and Medicine, 2012,Volume 74, Issue 3, p. 390-398
Albert Banerjee, Tamara Daly, Pat Armstrong, Marta, Szebehely, Hugh Armstrong, Stirling LaFrance

Lifting the violence veil: Examining working conditions in long-term care facilities using iterative methods
In Canadian Journal on Aging, 2011, Volume 30, Issue 2, p. 271-284
Tamara Daly, Albert Banerjee, Pat Armstrong, Hugh Armstrong & Marta Szebehey

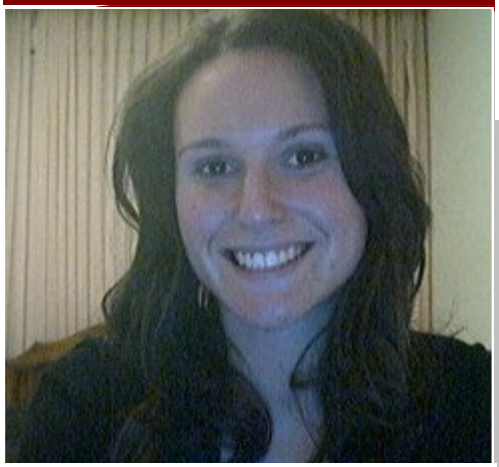
Structural violence in long-term residential care
In Women's Health and Urban Life, 2011, Volume 10, Issue 1, p. 111-129
Pat Armstrong, Hugh Armstrong, Albert Banerjee, Tamara Daly, and Marta Szebehely

Book: Thinking women and health care reform in Canada
Pat Armstrong, Barbara Clow, Karen Grant, Margaret Haworth-Brockman, Beth Jackson, Ann Pederson and Morgan Seeley (eds,) 2012

Book: Critical to care; the invisible women in health services
Pat Armstrong, Hugh Armstrong and Krista Scott-Dixon (eds,) 2008

For more Information visit the Quality of Worklife Theme page www.hhr-rhs.ca

HHR Student Spotlight



Sophia Kam

Sophia Kam is in her second year of study in the Interdisciplinary Rural and Northern Health PhD program at Laurentian University. Prior to this, she completed a honours Bachelor of Arts at the University of Toronto, and a Master of Arts at the University of Windsor. Her political science background has fostered a strong interest in policy formation, decisions, and processes. Sophia is incorporating these interests in her current research endeavor, entitled "Conceptualizations of Family Physician Scope of Practice in Ontario." Between May and December 2013, she has presented provincially, nationally, and internationally on physician scope of practice regarding multiple dimensions of physician governance and practice. Recently, she was invited to serve on a national advisory committee for the Royal College of Physicians and Surgeons of Canada to provide expertise on scope of practice. Additionally, Sophia was awarded a student assistantship at the Centre for Rural and Northern Health Research (CRaNHR) to work on her current research project (summarized below) as part of the Health Systems Research Fund ($3.4M) grant awarded to CRaNHR. Sophia's research interests are numerous, varied, and intersect at the areas of health policy and services. They include: health legislation and jurisprudence, physician governance, medical education (undergraduate through to CPD), physician evaluation/assessment, physician scope of practice, physician migration, recruitment and retention strategies in hard-to-recruit areas, international medical graduates, and their impact on human health resource planning, physician labour supply and distribution.

The Proposed Project: Conceptualizations of Family Physician Scope of Practice in Ontario

A physician's scope of practice is perceived in various ways. Individual physicians may conceptualize and understand their scope of practice differently based on their practice realities. These understandings and conceptualizations may also differ from those held by legislators, medical regulators, and medical educators. This construct also varies drastically from one jurisdiction to another, yet, it is central to numerous elements of physician governance and practice. The lack of clarity around scope of practice has relevance for the medical practice of both domestically and foreign trained physicians. Physician migration necessitates an enhanced understanding of scope of practice to ensure competence for specific scopes of practice. How and why scopes of practice change also warrant investigation. Emphasis is placed on scope of practice during the front end of physician careers. Yet, scope of practice can change throughout physician careers. Despite numerous inquiries about factors affecting scope of practice, there is a lack of clarity in conceptualizations of physician scope of practice in the literature. To address this dearth in the literature, this research aims to achieve a more comprehensive understanding of the scope of practice of family physicians with primary practice addresses in Ontario. Broadly, this research seeks to determine how different stakeholders concerned with various areas of physician governance and practice conceptualize family physicians' scope of practice. Specifically, this research seeks to determine the common conceptual elements of scope of practice, where the differences lie, and the implications of these nuances in conceptualization.

To learn more about Sophia or to share your thesis/research in our upcoming newsletter, visit the Student Spotlight theme page www.hhr-rhs.ca

Upcoming HHR Research Funding Opportunities

1 CIHR Open Operating Grant

Registration Deadline: February 3rd 2014
Application Deadline: March 3rd 2014
Anticipated Notice of Decision: June 27th 2014
Funding Start Date: October 1st 2014

2 CIHR Knowledge Synthesis Grant

Application Deadline: April 1st 2014
Anticipated Notice of Decision: October 1st 2014
Funding Start Date: October 1st 2014

For more information about these opportunities visit:

www.researchnet-recherchenet.ca

CHHRN Letter of Support

We are very pleased to provide letters of support for upcoming research proposals in HHR– from the CIHR Meeting, Planning and Dissemination Grants, the Open Operating Grants and Partnership for Health System Improvement Grants and beyond. These letters outline the many resources available to members as well as the provision of in-kind support through CHHRN's knowledge brokering capacity including knowledge dissemination of HHR research through pan-Canadian webinars and the opportunity to showcase your research on the CHHRN website, social media and newsletter.

For more information contact:
info@hhr-rhs.ca

Join the Network!
Membership is
FREE!!!

Upcoming Events in HHR

UBC CENTRE FOR HEALTH SERVICES AND POLICY RESEARCH

2014 CHSPR Policy Conference

Date: February 25th 2014

Venue: Vancouver, BC

For more information:
www.chspr.ca

COMING SOON: Information about featured speakers, registration, and conference-related

Hosted by ONESIEN

Partners in Education and Integration of Internationally Educated Nurses 2014 Conference

Date: May 1-2, 2014

Venue: Holiday Inn Toronto (Yorkdale), ON

CAHSPR ACRSPS
Canadian Association for Health Services and Policy Research / L'Association canadienne pour la recherche sur les services et les politiques de la santé

CAHSPR Conference 2014

Date: May 13-May 15, 2014

Venue: Toronto, ON

For more information:
www.cahspr.ca

Join the CAHSPR HHR Theme Group!! **Visit www.cahspr.ca for details**

Better research ... better decisions ... better health

CANADIAN NURSES ASSOCIATION

2014 Annual Meeting and Biennial Convention

Date: June 16-18, 2014

Venue: Winnepeg, MB

For more information:
www.cna-aiic.ca

HHR Tools and Resources

CHHRN Online HHR Library & Data Directory

The CHHRN online library contains over 5,400 French and English resources including:

- Journal articles as well as citation and summary information for restricted publications with links to full content.
- Grey literature such as reports
- Research0based resource materials
- Power point presentations
- Over 230 (and growing) healthcare database sources

Need to draw a random sample of dentists in Nova Scotia? We have access information for that database. Need background on how those dentists are regulated or recent research results on the availability of dentists there? Those resources are all available – all within the CHHRN Library!

You never know what you might discover!!

For more information visit: www.hhr-rhs.ca

CHHRN Online HHR Expert Directory

The pan-Canadian Health Human Resources Network's Expert Directory (CHHRN-ED) is a searchable online database of key researchers, experts and decision-makers in health human resource issues in Canada . The purpose of the directory is to link expert resources in health human resources research to a range of stakeholders to help build capacity, inform health policy and share innovative ideas and research on important health human resources issues.

Join the Network!

Membership is FREE!!!

For more information visit: www.hhr-rhs.ca

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Canadian Health Human Resources Network