THE VANCOUVER VISION

Forward in Concert

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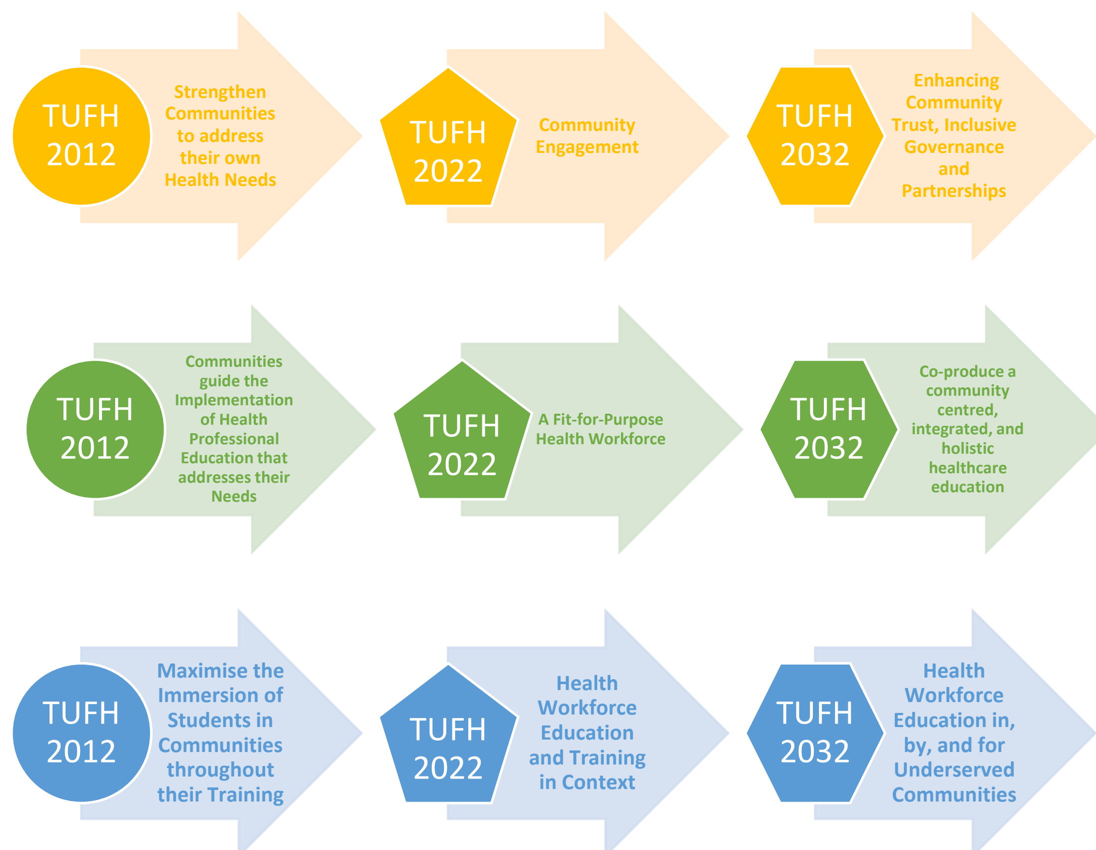
The TUFH 2022 Declaration

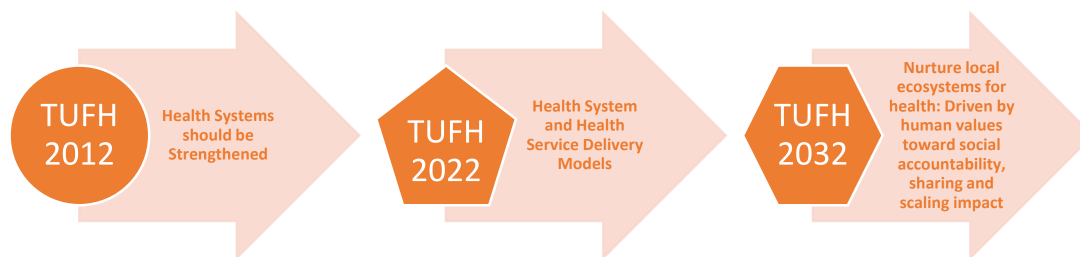
CONTEXT

In August, ***TUFH2022*** gathered members from around the world in a hybrid model of knowledge sharing and vibrant discussion through which participants developed wisdom to determine our collective approach to an ever-changing world; a world currently in crisis on a range of issues. To aid in making wise choices, a pre-conference day started with a review of developments since the *Thunder Bay Communique* was adopted by participants in *Rendez-Vous 2012* - five world conferences in one, including ***TUFH2012***. Through a process involving the Appreciative Inquiry approach focusing on the 4D method (**Discover, Dream, Design, and Deliver**), the global citizens gathered on the traditional and unceded territory of the xʷməθkwəy̓əm (Musqueam) Nation at the University of British Columbia (UBC) campus in Vancouver collectively distilled the essence of that Communique into four themes and **discovered** what relevant achievements had occurred to this point. They then **dreamed** what we might collectively achieve in the next ten years and **designed** what we must **deliver** in order to help build a healthier and more just world.

THEMES

The overarching themes and dreams are reflected in the following series of arrows, all thrusting towards that future:





NEEDS AND COMMITMENTS

The following pages expand upon these arrows, defining the meaning of each dream and the pathways on which we must embark to achieve them. They then turn to define what is needed for their successful achievement and the commitments that we must severally and collectively make as we take our first steps towards a still uncertain future.

It is clear that whatever that future brings forth (and who could have foreseen the toxic cascade of climate change, Covid, galloping inequities, and iniquitous wars we now confront) we must build and engage *complex adaptive relationships,* developing *learning health systems* in close *concertation* with the *communities* we serve. These relationships must embrace all professions and include attention to learning, research, application, integration, and above all, authentic engagement with the societies we serve, from the local through to the regional, national and global scales.

Important steps towards actually **Delivering** on the **Dreams** and **Designs** are outlined in the pages that follow—not only within each theme, but also in the collectivity of ideas and commitments that are expressed. Thus, each theme has focused on "*What is needed"* to achieve these aims and the "*Commitments*" undertaken to help build the world of 2032.

There is no shortage of rhetorical intent to address our current global and local crises. However, this ***Vancouver Vision*** seeks to outline practical steps and commitments to activities on the part of those at ***TUFH2022*** that represent the first steps on the path to a healthier and more just world by the time of ***TUFH2032***. ***TUFH***, with its rich and growing range of partners, should see itself as a key enabler in translating the fine rhetoric of global agreements and statements (e.g. Alma Ata, WHO papers related to health workforce, World Health Reports, Astana, COP, etc.) into applied and practical actions on the ground—in education, research, application, integration, and engagement. As part of this commitment, *Education for Health* and the *Social Innovations Journal* can communicate developments and their assessments into the literature and TUFH can convene appropriate collaborations and planning events as the need arises.

In all of the above activities, the communities and other perspectives of the **Partnership Pentagram Plus** should be present as co-producers of knowledge and co-developers of educational and research priorities, actions, and impacts.[1] The relationships thus envisioned should be explicitly developed as complex adaptive and learning health systems. As such, it is the *relationships* embedded within the network that need to be constantly nourished and supported. The future should be built upon the *strengths* and *resilience* of all partners through such processes as *Appreciative Inquiry*. The building

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[1] The Partnership Pentagram Plus is a model for creating socially accountable health systems, which is adapted from the Boelen WHO Health Partnership model (policymakers, health administrators, health professionals, academics, and community members) by the addition of linked sectors (e.g. industry and not-for-profits). For a more detailed overview and an example of its application at a provincial level in Canada, see: Markham R, Hunt M, Woollard R, Oelke N, Snadden D, Strasser R, Betkus G, Graham S. Addressing Rural and Indigenous Health Inequities in Canada through Socially Accountable Health Partnerships. BMJo. 2021. 11: e048053. <https://doi.org/10.1136/bmjopen-2020-048053>.

and maintenance of these required relationships take time and the concept of "sharing 10 cups of tea" to initiate them was fully endorsed at the ***TUFH2022***. It is upon such relationships that effective collective action can be based. Too often, undertakings have been embarked upon in simply "business-like" and transactional activities with the expectation that organizational and governance structures will ensure achievement. The current state of tepid and divisive achievement in response to global crises provides evidence that this approach can be both ineffective and counterproductive. A crisis mentality expressed as "don't just stand there—do something" is, like the former training of emergency physicians, outmoded. It needs to be replaced by "don't just do something—do the right thing". In a complex world with complex problems that defy simple (or even complicated) solutions, the doorway to the right thing is through effective relationships and in the community being served. This is evidenced through the themes outlined below.

The "community" thus engaged must extend beyond simply the health systems, and beyond even the human community, to embrace in full the ecosystems on which we all depend and whose integrities are being challenged by human activity. *Ecosystem approaches to health* not only offer engagement of these essential underpinnings of population health, but also ways of imagining and creating the health systems needed to help prevention and healing of both populations and planet. Thus, even within human communities it must extend to embrace multiple ways of seeing, knowing, and doing. This was particularly evident in the robust reflection of Indigenous knowledge and action present at ***TUFH2022*** and is embedded in the Commitments summarized in the sections to follow.

As a part of this effort, youth and student voice must be engaged at every stage in designing and constructing the envisioned future. Throughout the learning life cycle from entry to retirement, there needs to be enhanced attention to the numerous transitions involved— from undergraduate to postgraduate, to initial practice, to mid-career continuing professional development, and, finally, to mentorship as retirement approaches. This area will require research on needs and efficacy so that the evolution of practitioner development is intentional. It must maintain the community engagement that is central to understanding and addressing the health and wellness needs of the communities to which the schools and their graduates are socially accountable. For example, by ***2032***, health workforce education (HWE) facilitated career pathways (FCP) will begin with well-resourced equitable access to education for people in underserved, underrepresented communities, including Indigenous communities, that helps them to be successful in applying for HWE programs. These HWE program selection and admissions processes favour applicants from underserved and underrepresented populations, including Indigenous peoples, to facilitate the "grow your own" FCP. HWE graduates are fit-for-purpose, skilled, and socially accountable practitioners who are located in underserved, underrepresented communities providing care that addresses the health needs of the community that they have the privilege to serve. These practitioners are guided by the values of respect, dignity, humanity, cultural humility, and adaptability so that they earn the trust of their communities.

The educational and community issues and relationships outlined above are equally relevant in both urban and rural settings, across nations and cultures, and for healers, generalists and specialists in each of the professions engaged in the path to 2032. The importance of *engaged interprofessional collaboration* cannot be overemphasized.

SCALE

To move forward constructively towards ***TUFH2032***, it will be essential that the actions described above and detailed in the body of this ***TUFH2022*** Declaration take place with as much coordination as is feasible across the vast scale "from the village to the globe": from local neighborhood, through regional and national, to the global scale. This should reflect effective communication and due respect with the scale above and the scale below. This will allow us to avoid the trap of spreading blame and

inaction instead of actions that contribute to a positive impact of the governmental, administrative, academic, professional, economic, civil society, and local communities acting in concert.

CONCLUSION

This *Summary* and the detailed *Context, Needs,* and *Commitments* that follow outline important steps towards actually **doing** what is outlined in the ensuing pages—not only in each theme but also in the collectivity of ideas and commitments that are expressed. To fail to define and then take those steps together is to diminish hope for the joy we dream of sharing at ***TUFH2032***.

APPENDICES

Appendix 1: Community-Driven Health & Wellness

What has been done since TUFH2012:

Active community participation through interdependent partnerships for mutual benefit in co-development and co-delivery of: health workforce attraction; recruitment and retention; education and training pathways and programs; and health service delivery. In recent years, strategies and tactics to implement genuine community engagement have been reflected in: the *Community Engaged Medical Education* movement led by the Northern Ontario School of Medicine (NOSM) in Canada and Flinders University Australia; the *"start local" approach* to health service delivery models, health system design framework and financing outlined in the 2020 *World Bank Discussion Paper Reimagining Primary Healthcare Workforce in Rural and Underserved Settings*; and the British Columbia intersectoral *Pentagram Partnership Plus with Appreciative Inquiry* and Deliberative Dialogue, as well as multilevel collaborations, approach that has brought about practical and positive change in rural and Indigenous communities.

What is needed:

- Communities can only engage when they have someone to engage with; it is challenging for the communities to provide insights and feedback when there is no one to engage with.
- Bringing healthcare close to the community.
- Building trust and relationships with communities and people in those communities.
- Working closely with people in building partnerships that are long-lasting.
- Understanding that we are all accountable for our health.
- Empowerment: helping people realize that they have the power to guide their health.
- Empowering communities to define what health means to them.
- Engaging communities from the beginning of any undertaking.
- Moving from empowerment to capacity building because communities are already empowered.

- Identifying and defining the word "community". Community is multi-dimensional, and we all wear different hats that we call community.

Commitments:

- Anchoring ourselves in the community and being part of/immersing ourselves deeply into the community; being part of the socioeconomic development of a community.
- Start engaging communities at an early stage.
- Moving from empowering communities to empowering healthcare providers to do the work that they are supposed to do.
- Moving away from competition, especially the notion of publish or perish in academia, and towards partnerships and working together in research when all parties are working towards a common objective.
- Building *intentional* and *trusting* relationships, recognizing that this takes time and allowing for it to do so ("*ten cups of tea*").
- Placing community at the centre of all projects and programs.
- Having champions within community.
- Respecting and recognizing other people's cultures.
- Community-responsive research (i.e. consult the community on research needs).
- Community inclusion in interventions.
- Inclusive governance.
- Active recruitment from and development of community health workers in rural and marginalized settings.

Appendix 2: A Socially Accountable Workforce

What has been done since TUFH2012:

Health workers, including the right mix of specialists and generalists, with the right skills, providing the right care, in the right place, at the right time to deliver high-quality health care that meets the health needs of the population. In relation to this theme, developments during the last decade included: the 2016 *WHO Strategy Human Resources for Health 2030*; the *Remote Rural Workforce Stability Framework* (2019); and the updated *WHO Policy Guideline on health workforce development, attraction recruitment and retention in rural and remote areas* (2021).

What is needed:

- Co-production:
  - Working together on creating knowledge.
  - "Iterative and collaborative processes involving diverse types of expertise, knowledge and actors to produce context-specific knowledge and pathways towards a sustainable future."
  - Community-led, collaborative process.

- Community-centred:
  - Community at the centre.
  - Community is the key stakeholder, leading the creation and execution of health workers education in collaboration with other perspectives represented in the Partnership Pentagram Plus.
  - Communities can identify their own needs and should be supported in that process.
  - Regular feedback on the relevance of the health workforce education from community.
- Integrated:
  - The full spectrum of life-long-learning from initial education to retirement is linked with strategies for each transitional phase.
  - Interprofessional skills and community/rural health embedded in the curriculum at all levels.
- Holistic:
  - Recognizing the social determinants of health as key factors.
  - Focus on prevention, e.g. public health interventions.
  - Healthcare system not only for the ill persons.
  - Diverse understanding of health and wellbeing.
  - Welcoming traditional medicine practices in health workers education.
- Healthcare Education:
  - Teaching about all aspects of health.
  - Physical, environmental, social, emotional, mental, and spiritual.

Community-centred, collaborative, co-created <u>institutions</u>

- Community and its needs are placed at the centre of the healthcare workforce education process. Engaging and empowering relationships and self-actualization, in turn, are necessary components of professional development. No community should be left behind.
- The traditional hierarchy of educational institutions needs to be addressed, with shared leadership being developed as a part of health education.
- Adequacy of necessary resources—human, social, and financial - must represent a joint effort in prioritization. Ensuring the sharing of resources and being held accountable for the communities and individuals which are parts of the community. Creating feedback mechanisms where the community can engage with the curriculum, their needs, and the future direction of health education.

Community-centred, collaborative, co-created <u>student recruitment</u>

- Admission procedures must reflect the kinds of practitioners needed to address the specific community cultures.
- Opportunities for students from disadvantaged settings, such as rural and Indigenous communities, must be available.
- Students with affinity for rural and community health should be fostered throughout their education.

Community-centred, collaborative, co-created <u>content</u>

- Responsive and dynamic education and curriculum aimed at building an adaptive skill set which will enable future practitioners to respond to the changing needs of the community.
- Restructuring health care education to prioritize and support comprehensive general care.
- Encourage students in exploring pathways other than super-specialization.
- Recognizing the value of Indigenous and non-Western knowledge and incorporating it into the curriculum.

Community-centred, collaborative, co-created health system

- Health & healthcare delivered and supported by an interprofessional team with a collective responsibility to "we".
- A system in which a team is assigned and takes responsibility for a community of individuals and is supplied with adequate resources, appropriately incentivized, and held accountable.

Commitments:

To achieve the new state, it will be necessary to create an enduring community of practice at the global level through TUFH; a community of practice dedicated to promoting educational change that is dedicated to the values of trust, courage/bravery, equity, empowerment, respect, and humility. These key attributes represent the core competencies of leadership to be developed in each professional school and brought to the development of effective collaborative and community-based interprofessional learning.

As a part of this effort, youth and student voice must be engaged at every stage in design and construction of the envisioned future. Throughout the learning life cycle from entry to retirement, there needs to be enhanced attention to the numerous transitions involved—from undergraduate to postgraduate, to initial practice, to mid-career continuing professional development, and, finally, to mentorship as retirement approaches. This area will require research on needs and efficacy so that the evolution of practitioner development is intentional. It must maintain the community engagement that is central to understanding and addressing the health and wellness needs of the communities to which the schools and their graduates are socially accountable.

Accreditation systems, as systems of continuous quality improvement, should assess and feedback accomplishments in these transitional realms as well as interprofessional, community-engaged education. Engaging in the International Social Accountability and Accreditation Think Tank (ISAATT) project is a part of this process.

TUFH, with its rich and growing range of partners, should see itself as a key enabler in translating the fine rhetoric of global agreements and statements (e.g. Alma Ata, WHO papers related to health workforce, World Health Reports, Almaty, COP, etc.) into applied and practical actions on the ground—in education, research, application, integration, and engagement. As part of this commitment, Education for Health can communicate developments and their assessments into the literature and TUFH can convene appropriate collaborations and planning events as the need arises.

In all of the above activities, the communities and other perspectives of the Partnership Pentagram Plus should be present as co-producers of knowledge and co-developers of educational and research priorities, actions, and impacts. The relationships thus envisioned should be explicitly developed as complex adaptive and learning health systems. As such, it is the relationships embedded within the network that need to be constantly nourished and supported, and the future should be built upon the strengths and resilience of all partners through such processes as Appreciative Inquiry.

Appendix 3: In-Community Education & Training

What has been done since TUFH2012:
A facilitated career pathway approach that supports underserved and underrepresented populations in "growing their own" health workforce, beginning at high school level and flowing through targeted selection into health workforce undergraduate education in community and clinical settings that graduates are expected to serve. This is to be followed by training of graduates in context, and subsequent professional development and career opportunities in those settings. Developments for this theme since 2012 included: the 2013 *WHO Guidelines Transforming and Scaling Up Health Professions Education and Training*; expansion of *immersive longitudinal integrated education* with service learning/work integrated learning around the world; implementation of *Rural Generalist Pathways* following the Cairns Consensus on Rural Generalist Medicine (2014); the implementation in Canada of the Northern Ontario School of Medicine *(NOSM) Rural Generalist Pathway* in Canada (2020) and adoption of *Social Accountability* into the *Accreditation* standards for medical and other health workforce education in Canada (2016) and around the world.

What is needed:

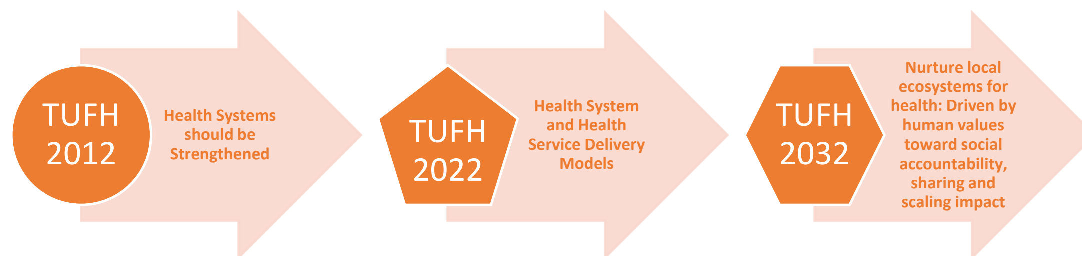
- Community engagement through:
  - interdependent and mutually beneficial partnerships between communities, health services, and academic institutions.
  - active community participation that recognizes and values community members' knowledge and expertise as of equal importance to those of academic institutions and health professionals.
- Indigenous ways of knowing and being, such as health beliefs and traditional healing, should be woven into education and training. Cultural safety and cultural humility should be embedded in HPE curricula.
- Immersive community engaged education (ICEE):
  - prolonged placements in communities where students are expected to provide care after completing their education and training.
- A "grow their own" healthcare workforce:
  - interprofessional integrated clinical teaching and learning in underserved communities at undergraduate and postgraduate education levels.
- A visible, accessible, and well-resourced pathway from "cradle to grave":
  - access to distributed graduate studies (Masters and PhD) to enable career progression, including academic careers, without having to move to a larger centre. This would bring continuous professional development opportunities closer to community health staff will helping the health professionals' families to feel at home and happy to stay.
- The transition to practice and continuing service in underserved communities should be supported through local and distance continuous professional development (CPD), skills updates, and ongoing, active community participation.
- Essential infrastructure:
  - high-speed broadband internet to enable completion of academic coursework online, rather than travelling to the academic centre.

- suitable space and equipment in clinical settings for individual and group learning, as well as patient-client interaction.
- safe and comfortable housing for students and their families.

Commitments:

- Institutions commit to increase education about, and exploration of, social accountability and community engagement to ensure organizational support in advocating for dedicated funding.
- Connect with like-minded individuals and organizations for mutual support with aligned values in proceeding with community engagement.
- In the spirit of intentionality, training institutions should commit to seek out language and concepts, from underserved communities in order to consolidate common understandings and purpose.
- Start local to "walk the talk": employ an assets or strengths-based approach, sit with communities to listen and learn about their world views, and value community knowledge and expertise.
- Co-development, co-production, co-delivery, and co-evaluation of immersive community engaged education with Partnership Pentagram Plus partners.
- Set own benchmarks and indicators of success that are measured and monitored collaboratively.
- Celebrate success and recognize excellence amongst all partners.
- Develop and implement needs-based student financial aid to mitigate financial challenges for students from underserved and underrepresented communities.

Appendix 4: Systems Thinking in Health & Wellness



What has been done since TUFH2012:

Funding models that incentivize local comprehensive Primary Health Care (PHC), delivered by PHC teams of generalists, and supported by collaborative networks of specialist health services/hospitals, that enhance people's access to specialist services when they are needed. This theme was strengthened by the *UN High Level Commission Health Employment and Economic Growth* (2016); the 2018 *Astana Declaration from the Global Conference on Primary Health Care*; and the World Bank 2021 flagship report *Walking the Talk: Reimagining Primary Health Care after Covid-19*.

Context:

- Nurture:
  - Organically help to grow and reproduce.
- Local:
  - Community-driven and bringing value to community.
  - Once one has evidence around the value of this, then add a voice (advocate), valuing collaboration (e.g. a learning health systems approach), recognizing that it is a journey.

- Ecosystems:
  - Working across silos (e.g. policy domains) and vertically integrated value on the ground and holistically.
  - Build the team around the patient, not the disease.
  - Build the ecosystem for health and wellness around community.
  - With health being nested in all facets of policy.
- Health:
  - Health is more than healthcare.
  - Includes social determinants.
- Human Values:
  - More human health system.
  - Through community, amplifying humanity and human values: trust, relationship, respect, dignity, equity, co-creation with community, inclusivity, and humility.
  - Scaling examples of harmony between community, health providers, and leaders that start in community.
- Social Accountability:
  - Serving society and accountable to each other.
- Sharing:
  - Identifying and communicating.
- Scaling:
  - Supporting growth.
  - Scaling these community-centric health and wellness ecosystems; scale what is working in the clinical interface (e.g. drive to primary care systems, interdisciplinary health providers regulated and unregulated).

What is needed:

- Ways to redesign the system that leverage what is working (e.g. Two Loop Model, Partnership Pentagram Plus), while recognizing the challenges of existing system and interests/interest groups.
- Leadership and advocacy development supporting those values (e.g. compassionate leadership training).
- Resilient, tech-enhanced systems.
- Rural placements: community-empowered, holistic education.
- Spaces for co-production of knowledge, not just transfer.
- Education that is responsive and dynamic.
- Supporting active clinicians to take leadership roles (Vertical Bridging).
- People connected across silos (Horizontal Bridging).
- Strengths-based approach.
- Resource allocation and decision making should be locally driven.
- Mechanisms for spread (i.e. adaptability of the commonality):
  - identify what is working;
  - communicate what it is working;
  - cross-pollinate with others;
  - ask "where can we learn from what's not working"?;
  - operate at variety of scales;
  - employ shared measurement.
- Flip the model – put bottom-up approaches in dialogue with the top-down strategies.
- A language to express value and the costs of indicating priorities for investment in health.
- Ringfencing, if primary healthcare is in the budget.
- Multi-sectoral approach to relationships (e.g. in the policy domain all ministries have impacts or are impacted by health).

Commitments:

- As individuals, we can each live according to shared values on a day-to-day basis.
- Intentionally place ourselves in a bridging position to close the gap between community and decision makers, or across silos.
- Look for examples of what works and a willingness to share (think about and share today what we can replicate at a local level).
- Help communities to step away from expert control, look around at what we have, and then leverage partnerships.
- Develop leadership working in advocacy, particularly intersectoral (Systems Thinking).
- Bring students out of silos and into the ecosystem.

October 20, 2022

- **TUFH 2022 Participants**
- **The Network: Towards Unity for Health (TUFH):** www.thenetworktufh.org
- **Rural Coordination Centre of British Columbia (RCCbc):** www.rccbc.ca
- **BC Patient Safety & Quality Council (BCPSQC):** www.bcpsqc.ca
- **First Nations Health Authority (FNHA):** www.fnha.ca
- **Student Network Organization** www.snotufh.org
- **Métis Nation BC (MNBC):** www.mnbc.ca
- **UBC Office of the Vice-President, Health (UBC Health):** www.health.ubc.ca/
- **UBC Department of Family Practice** www.familymed.ubc.ca/