

# Health Human Resources Planning in an Interdisciplinary Care Environment: To Dream the Impossible Dream?

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*“There has been a lot of rhetoric in the past about the need for integrated planning. This rhetoric must now gradually give way to breathing life into the concept by reforming the ways in which governments interact with each other and with the providers of health and social services.*”

*“Interprofessional education has been defined as ‘occasions when two or more professions learn from and about each other to improve collaboration and the quality of care’ (CAIPE 1997). Much that has been written about interprofessional education (IPE) and the interprofessional team has concentrated on two or at most three professions, primarily medicine, nursing and pharmacy. Educational programs described in the literature tend to focus on activities involving students, practitioners or both. Very little has been written about the structural changes that need to be made within universities, colleges and the healthcare industry such that IPE becomes a joint responsibility across a number of jurisdictions that may then effectively influence institutional practice.”*

A statement made, perhaps, in any one of the recent reviews of Canadian healthcare? No. These comments were made by Maureen Law, then Associate Deputy Minister of Health and Welfare, Government of Canada, at a conference on Canada's healthcare system in 1984.

Healthcare renewal is under way again in every province and territory in this country. At the heart of these efforts is a stated desire to reorganize and expand the ways in which primary healthcare services are provided to Canadians. Common elements across all these efforts include a team approach to service delivery; the enrolment or rostering of patients, or both; 24-hour access to services, seven days a week; a variety of funding formulas; and increased emphasis on prevention and health promotion.

Embedded in the redesign is some form of interdisciplinary, multidisciplinary or collaborative care. Terms abound – one of the issues that needs resolution – but the intent is similar. Clearly, there is a wish to make better use of the many health professionals equipped to deliver primary healthcare services and to integrate them into a seamless process for patient care.

Along with the focus on renewed primary healthcare and interdisciplinary delivery is the recent recognition that changes in the design of delivery models and programs need to be tightly linked to health human resources planning. If the personnel requirements are not incorporated into renewal efforts, renewal efforts are more than likely to fail.

Canada, along with many other

jurisdictions, has a history of not paying attention to its healthcare workforce. Historically, we have swung – some would even say whipsawed – between periods of perceived shortages to periods of perceived oversupply, with the primary policy response of increasing or decreasing the numbers. And historically, we have planned within the confines of individual health professions rather than population health needs or team-based care.

Analysis and planning are increasingly sophisticated, but now we face the added challenge of an interdisciplinary care environment. Although a number of provincial and national healthcare reports have recognized the need to stop planning in profession-specific silos, little practical advice is offered to move toward planning for an interdisciplinary environment.

Here are some issues to bear in mind as planning efforts are undertaken:

### **1. Define interdisciplinary**

Is the word “interdisciplinary” just a fancy word for teamwork, or is something else envisioned? Clearly, the view is that patients should be able to access a variety of health professionals, depending on health need, in one location. The Province of British Columbia describes interdisciplinary practice as allowing “clinicians to develop and strengthen the natural links existing between family medicine and other health professionals.” The Province of Manitoba talks about a principle of intersectoral/interdisciplinary care that requires the skills and services of numerous sectors and disciplines to

address the determinants of health. The Province of Newfoundland and Labrador describes interdisciplinary primary healthcare as “an approach to primary healthcare delivery which emphasizes universally accessible, continuous, comprehensive, coordinated primary healthcare provision for a defined population through the shared responsibility and accountability of physicians and all other primary healthcare providers.”

Regardless of the term, the question remains: Is there a primary caregiver and, if so, who is it? Do we envision a system in which patients are still seen first by a family physician who then draws upon other professionals as required, or do we envision a system in which patients are first seen by someone other than a family physician, perhaps a registered nurse or nurse practitioner, who then draws upon other professionals as required? The implications for planning are quite different. There isn't one model that will suit all circumstances, but the need for clarity about the nature of the team is necessary across all.

## **2. Identify services to be provided through interdisciplinary practice**

Prevention, health promotion, screening, education and counselling, chronic disease management, mental health, case management, organizing facility placements or home support – these are all services that could be, and to varying degrees are, provided in primary healthcare settings. Are these the services included in interdisciplinary practices? Identifying core and

complementary services will be vital to planning efforts.

## **3. Understand scopes of practice**

Early experience in Canadian jurisdictions promoting interdisciplinary care indicates that ongoing support and facilitation are required to clarify roles and responsibilities. Health professionals who have not previously had the opportunity to collaborate are not always clear on the competencies and skills of others. A clear understanding of the contributions of different health professions is necessary for planning in an interdisciplinary environment.

Simultaneously, some professions are actually looking to expand their scope and to add competencies previously in the domain of others. For examples, the Canadian Pharmacists Association has proposed that pharmacists undertake routine immunizations, triage and screening for specific chronic diseases and for diagnostic purposes. This could provide flexibility and cost-effectiveness in developing models of care, or duplicate existing efforts and increase costs, depending upon the planning models used.

## **4. Develop data**

Basic data for physicians and nurses are available through the Canadian Institute for Health Information (CIHI). Very minimal data on other professions exist and are not centrally collected. CIHI is working on creating a minimum dataset for regulated health professions in Canada that will facilitate interdisciplinary planning, but it is still in the developmental stage. And for some of the

professions with smaller numbers, the data may not exist to populate the dataset. Significant investment is required to support and improve data collection.

As well, population health data will be required at the regional and local levels on a regular basis to support planning for health needs rather than service utilization.

### **5. Identify a mechanism for planning**

Ministries of health or ministry-funded organizations, such as the Atlantic Health Human Resources Association or the Western and Northern Health Human Resources Planning Forum, are the most likely leads on health human resources planning. However, much of the data required lie elsewhere, as do the educational and training levers, the authority to set regulatory policies and work-related employment practices. A collaborative mechanism is needed to pull together government departments, professional associations, regulatory bodies, employers and unions, and education and training institutions to align planning initiatives. The sectors must become less isolated and more integrated if interdisciplinary practice is to succeed. Planning for that success depends on multiple sources of information and on decision-making authorities' working together. This requirement must be mandated.

### **6. Recognize implementation barriers**

True health human resources planning for an interdisciplinary care environment cannot move forward until some of the policy barriers are resolved. Many funding models are geared

toward one health professional – often a physician – and are not designed to remunerate a team or an organization. Health professions' regulatory environments are predicated on individual health professionals' accounting to their professional colleges. Again, this system is not team-based. Malpractice insurance programs are designed for individual professionals; as a result, notions of professional liability in an interdisciplinary environment are ambiguous at present. These issues are all surmountable but need to be resolved if interdisciplinary planning is to occur.

I hope that in 20 years we as a country will not still be lamenting the need for interdisciplinary primary healthcare, but instead will be leaders in demonstrating planning efforts to support such care. There is clearly political will in Canada to move forward – every government has indicated its support.

It isn't an impossible dream, but it will require different behaviours from those funding, delivering and planning care – collaborative behaviours that recognize each has a role to play in supporting healthcare renewal for Canadians.

*The views expressed in this commentary represent the views of the author and do not necessarily represent the views of the Health Council of Canada.*