Boundaries of the "Healthcare Workplace" Must Be Expanded

COMMENTARY

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ABSTRACT

There is merit in considering the lead papers within a context of the current social and political landscape, the status of our healthcare system and the role of public policy to drive change. In doing so, it becomes clear that the notion of workplace must extend beyond what has been traditionally confined to physician offices and healthcare facilities, and the traditional workforces within. Until the concept of health workforce include patients, unpaid care providers and new healthcare roles, and the concept of workplace includes communities and homes, we miss the identification of problems and the possible solutions to them.

As part of preparing to write this commentary, I was interested to re-read the essays in a 2002 edition of *Healthcare Papers* on the topic of supply, demand and management of health human resources. Then, the evolution of the *healthcare team* concept was a central theme in the invited essay by Canadian Institute for Health Information authors, and the intersection of workforce data and research evidence with policy-making was central to another. The editor-in-chief noted then that many of the issues raised "are not new. They have been raised at almost every forum or review of Canada's healthcare system" (Leatt 2002). The message was repeated in most of the commentaries that followed.

In this edition, the invited essays by

Judith Shamian and Fadi El-Jardali and by Dave Clements, Mylène Dault and Alicia Priest are appreciated because they provide a knowledge update on the themes of workplace health and the healthcare team, and suggest directions for research and policy initiatives. In doing so, they remind us that the issues remain, more knowledge is required and much of what is known remains to be translated into practices and policy. Progress continues to be slow, and we should not be surprised. As Carolyn Tuohy (1999) pointed out in her seminal work, *Accidental Logics: The Dynamics of Change in the Health Care Arena in the United States, Great Britain, and Canada*, the evolution of healthcare is a path-dependent process. Policy shifts can be instituted at certain times and not others, and are as much dictated by factors in the broader political landscape as the healthcare arena.

Our essayists' recommendations may well define much of the future direction of the Canadian healthcare system. My contribution is to cast them in the light of the current status of our healthcare system and the social and political landscapes that surround it; this serves as the base for my argument that the healthcare workplace is much more than acute care or other institutional settings, and the healthcare workforce is composed of many more than the paid care providers we have identified for decades. Although Shamian and El-Jardali define the workplace as "mechanisms, programs, policies, initiatives, actions and practices that are in place," there is a need to underscore the variations in *where* healthcare is now provided and *by whom*. By not doing so, we are avoiding the identification of research and policy initiatives and directions.

As a brief reminder, there has been evolution of the system since the Canada Health Act of 1984, when hospital and physician offices were implicitly understood to be the workplace, health professionals its workforce and acute care the business at hand. The reduction of acute beds in Canada was accomplished in the late 1980s and 1990s by using new technologies combined with early discharge programs. Work done previously by paid care providers was now moved to the home and community, with expectations that most care would be assumed by family and friends. There was a marked shift from acute to chronic disease and, so, marked increases in longevity and morbidity of patients.

Take cancer. As the population ages, more cancer is detected and treated with success. It is now estimated that 16% of cancer care funds are directed to follow-up of patients who have been treated, and the growth of this percentage is likely to continue. Take cardiac disease. Although cardiac disease is no longer the leading cause of death in our country, associated morbidities remain a significant problem. Uncontrolled congestive heart failure (CHF) is still the leading cause of the admission of seniors to emergency departments. Estimates suggest that 12% of health dollars are directed to management of the disease. Take neurodegenerative disorders such as Alzheimer's disease. They extract an increasing demand on the healthcare expenditures and a devastating toll on families and unpaid support networks.

Interesting questions surface. Cancer care has the best organized diagnostic and treatment processes in Canada, but the industry continues to be prodded by the growing cancer population. This was highlighted in a recent series in *The Globe and Mail*. In the articles on December 9, 2006 (Anderssen 2006), patients reaffirmed their right to be intimately involved in the management of their disease – in other

words, their right to be a member of the healthcare workforce. The patient navigator was mentioned, a new health worker with the task of guiding patients through the complexity of diagnosis, treatment and aftercare in the discontinuous entity called the healthcare system. Why do patients continue to call for participation in the treatment of their disease? Why have we unsuccessfully integrated care for so many of them? Why can't we make treatment more patient friendly? Where are the navigators for other diseases?

From the National Survey on the Work and Health of Nurses

More than **one in three** nurses (37%) reported inadequate staffing levels in their last shift worked. One in eight said their nursing team had provided fair or poor care.

http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=AR_1588_E&cw_topic=1588

CHF is a condition that responds well to medication. Yet, the system has not successfully transferred structured patient treatment from the hospital to the home and community. Why not? How can we engage patients and their families to better manage this condition at home? If CHF could better be controlled and monitored at home, patient numbers in the emergency room should decrease. What has the system contributed to the healthy workplace of those with Alzheimer's disease who remain in their homes, particularly for the workforce that is largely composed of loved ones who are unpaid?

Each example echoes an important reminder to healthcare providers, policymakers and researchers: service to the public remains the primary purpose of the healthcare system. The unpaid workforce is critical to its sustainability and, so, should be included in strategies for research and policy initiatives. As much as we need to address policy in healthcare, we need to address policy in the community. Judith Maxwell has written to this concern. She noted "that Canada should be preparing for this demographic shift (the older elderly) by establishing the community services needed by these elderly and their family caregivers (most likely to be spouse or the children). The alternative is to accept that many will end up in far more expensive hospital or long-term care long before they should" (Maxwell 2006).

For at least two decades, healthcare leaders have stressed the importance of integrated, multidisciplinary teams in managing disease and improving health, particularly at the level of community. Clements and colleagues highlighted some of the barriers delaying its progress, and Shamian and El-Jardali noted the lack of action on implementation of many recommendations arising from the work of the Canadian Nursing Advisory Committee. I worry that vital research about the role of patient, family and community may be even further delayed by the growing focus on the current political landscape of accountability, at the federal level in particular. The value audits of many federally funded programs including the Canadian Institutes of Health Research suggest that the provinces may find it more difficult to extract more funds for healthcare research. At the provincial level, health authorities are being called

upon to demonstrate accountability, and one consequence may be increased restrictions on expenditures.

While we must pay attention to the policy realm, innovation and solutions are unlikely to come from policy or government. As Michael Peckham (2000) noted, "The impetus for innovation on which the future of the system rests will arise very largely from solutions derived and implemented by medical and other staff with the system itself." I would add patients and families as another category of solution makers. But the status quo remains, as illustrated by Clements and colleagues' reference to proceedings from a forum of researchers and decision makers on issues related to effective teamwork.

I do support the recommendation of the forum for an independent body to lead the work on teams. It is similar to a recommendation that I made in an earlier issue of this journal (Ward 2002). However, there was an absence of discussion of the role of the patient and family – which must be of discomfort to the ventilator-dependent patient at home who manages his or her care team of unprofessional employees and unpaid workers in a high-risk work environment, and to the patient who is dependent on home dialysis.

As Tuohy (1999) pointed out, changes within healthcare have accommodated the wishes of the powerful and, at best, can be described as incremental. But the healthcare system is here to serve the public by providing access to the best possible care, regardless of provider or place. Failure to acknowledge this, as we tend to do, will lead to further entrenchment of the current system and make meaningful change more difficult in the future.

References

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