The Authors Respond

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The value of putting one's work in the public domain is the feedback, discourse and dialogue that the work generates. The format and the process that *Healthcare Papers* offers on timely and relevant topics for healthcare is an exceptional opportunity for feedback, discourse and dialogue. The 13 responses to our paper have made the effort worthwhile and offer incredible value added to the lead papers. The number, depth and diversity of responses to the Shamian and El-Jardali, and Clements, Dault and Priest papers are testimony to the importance of these topics and to the agenda of healthy workplaces and teamwork. Having two complementary lead essays strengthens the discussion and "moves the agenda forward" as emphasized by most commentators.

Several of the papers have made a strong case as to the importance of the integration of the two lead papers – viewing them as being two sides of the same coin. While each paper stands on its own, the commentaries on our papers reflect some common themes, which emphasize the need to move forward the healthy workplace agenda at all levels in order to bring real changes at the front lines. Healthy workplaces for healthcare workers are an essential component of reforming the healthcare system. Changing the work environment for health workers enables us to attain the goals of our healthcare system, which are to provide access to quality, effective, patient-centred, team-based and safe health services. Strelioff, Lavoie-Tremblay and Barton point out that reducing wait times, increasing access to care and ensuring patient safety would not be achieved unless healthcare organizations become healthy workplaces. A number of authors delve into challenges and discuss ways to facilitate changing the working environments of

healthcare workers. One critical point made by many authors is the need to ensure that the positive changes that are currently occurring at the policy level are being translated at an accelerated pace into the front lines in terms of healthy healthcare workers and a better healthcare system.

Our success in translating the current changes into the practice environment and for the front-line workers will be based on a number of approaches, as emphasized by numerous authors:

1. The way we link healthy workplaces to critical indicators such as wait times, access and patient safety (Strelioff, Lavoie-Tremblay and Barton; Clements, Dault and Priest)
2. Micro-innovation and the macro-resources – "coordinate, evaluate and replicate" (Laschinger; Silas)
3. The roles and responsibilities of governments, organizations, individuals and the general public to ensure that the healthy workplace philosophy is firmly embedded in the healthcare system (Matthews and MacDonald-Rencz)
4. Accreditation as a change agent (Nicklin and Barton), performance measures, indicators and public reporting (Nicklin and Barton; Matthews and MacDonald-Rencz; Strelioff, Lavoie-Tremblay and Barton; Smadu and McMillan; Kerr and Mustard)
5. Collaboration among all stakeholders and the Quality Worklife–Quality Healthcare Collaborative (QWQHC) (Matthews and MacDonald-Rencz; Clements, Dault and Priest; Strelioff, Lavoie-Tremblay and Barton; O'Brien-Pallas; Laschinger)
6. The need for good theory, a clear framework and continued research to understand and improve the workplace, especially well-designed and controlled intervention studies (Leiter; O'Brien-Pallas)
7. A pan-Canadian inter-professional approach to developing, implementing and evaluating policy interventions (Kerr and Mustard; Smadu and McMillan); and an effective inter-professional workforce and teamwork (Grinspun; Clements, Dault and Priest; Jones and Way; Oandasan)
8. The integration of patients and families into the healthy workplace and team agenda (Ward)

To carry on the discussion introduced by many of the authors, this response paper focuses on common themes and messages; furthermore, we highlight additional issues for further discussion and debate.

Real Change

To move ahead with the healthy workplace agenda, a number of authors emphasize the need to build on our current empirical and practical successes in terms of policy intervention, implementation and evaluation and sharing of knowledge on best practices. The notion of bringing real positive changes to the workplace at the front lines has been emphasized in several papers. While many authors recognize the need for more work to ensure effective, faster and sustainable changes to the practice environment at the front lines, little information is provided on how best to do this consistently across the country.

The key message that can be concluded from the commentaries is that although the two lead essays are on two different topics, they surprisingly complement each other and have many common underlying concepts. As such, we note that teams are one of the essential building blocks in

attaining healthy workplaces. Furthermore, the numerous papers that discuss the role of the inter-professional agenda as a key national agenda at this time are further strengthening the team and workplace health. The inter-professional agenda is being advanced both by the federal government and several provinces, such as Ontario. This agenda requires enormous integration and collaboration among regulatory, policy, education and service sectors. The comments by Ward add an additional layer to the attainment of workplace health, teamwork and inter-professional practice. His argument that patients and families have to be considered as part of the team and take part in the workplace initiative is a powerful proposition that could advance this work to a truly more patient-centred reality with enhanced shared clinical decision making (Grinspun).

The point made by Leiter that the healthy workplace initiatives and related investments made in them were a few steps removed from the day-to-day work life of nurses needs to be debated further. While we agree with many authors about the need for faster and sustainable changes to the practice environment at the front lines, we recognize that some governments have made targeted initiatives at the front lines by investing directly into day-to-day work life. For example, Ontario and British Columbia have purchased new hospital beds and patient lifts designed to prevent back injuries among hospital and nursing home staff. Ontario has provided funding for more than 13,000 bed lifts in hospitals, long-term care homes and rehabilitation centres to help prevent injuries (Ontario Ministry of Health and Long-Term Care and Ministry of Training, Colleges and Universities 2005). In 2004–2005, Ontario provided funding to help hospitals convert to safer medical equipment, including safety-engineered sharps devices. While we acknowledge that this one approach on its own is unlikely to make a major change at the front lines, we believe it is an important step that can contribute to a successful change.

Further Research and Evaluation

Several of the papers have put forward the areas where further work and research needs to be undertaken. Leiter argues for an enlightening framework for guiding workplace health initiatives at the front lines. His proposed Mediation Model provides a direction that focuses on experiences that are integral to staff members' day-to-day work life, and on developing and evaluating strategies for enhancing the quality of work life pertaining to workplace health. This necessitates the continuation and development of new research to understand and improve the workplace, especially well-designed and controlled intervention studies, as O'Brien-Pallas; Laschinger; Kerr and Mustard; Smadu and McMillan; Silas; and Matthews and MacDonald-Rencz point out. In addition, evaluation research and practical tools are needed to evaluate policy interventions and innovations to indicate whether the front-line healthcare workers are experiencing better working conditions. The development and dissemination of new research should continue in order to bring sustainable changes at the policy and practice levels. To change the way policy-makers think about healthy workplaces, research is needed to help develop indicators that clearly show the link between healthy workplaces, patient outcomes and system performance.

As this issue goes to print, the *Findings from the 2005 National Survey of the Work and Health of Nurses* (2006) has been released by Statistics Canada, Health Canada and the Canadian Institute for Health Information

(CIHI). This is the first ever national survey of the work and health of nurses. This work was undertaken to provide a national perspective and evaluation of the impact of policies and work on the ground. It is hoped that this survey will be repeated on regular intervals and will provide national monitoring and evaluation, together with other instruments like accreditation (Nicklin and Barton) and the Quality Worklife-Quality Healthcare Collaborative (QWQHC) (Strelioff, Lavoie-Tremblay and Barton).

There are several problematic findings that, unless improved, will hinder workplace health and teamwork – findings such as nurses regularly working overtime, one-third of the nurses classified as having job strains much higher than in the general female workforce, and one in five nurses holding more than one job (twice as many nurses held more than one job than in the general female employment group). The most troubling findings show that work stress, low autonomy and lack of respect are strongly associated with health problems among nurses (Statistics Canada, Health Canada and CIHI 2006). These findings and others among nursing and other professions (Smadu and McMillan; Kerr and Mustard; O'Brien-Pallas; Silas) are the source and proxy the same time of workplace health. This new report by Statistics Canada, Health Canada and CIHI – which has been developed in partnership with various nursing groups, scientists, employers and policy-makers – sets the tone for future surveys by which we can continue to evaluate the impact of policies and actions on the ground on the health of all categories of workers and patient outcomes.

Accountability

A number of authors pick up on the theme of accountability, responsibility and performance (Smadu and McMillan; Grinspun; Nicklin and Barton; Matthews and MacDonald-Rencz; Strelioff, Lavoie-Tremblay and Barton; Kerr and Mustard). We do agree with Smadu and McMillan that the public, including healthcare workers, should know the performance of healthcare organizations on healthy workplace indicators, and that employers should be accountable and responsive to healthcare workers. This necessitates the development of comparable indicators on workplace health in order to make comprehensive assessments and benchmarking. In an indirect way, Matthews and MacDonald-Rencz hint at the same issue when they emphasize the role and responsibility of governments, organizations and individuals to ensure that the healthy workplace philosophy is firmly embedded in the healthcare system. Smadu and McMillan suggest that this can be done through building on existing successful performance reporting initiatives and benchmarking tools, such as the hospital report on acute care, and expanding them beyond hospitals to include all sectors of the health system, such as home care, long-term care and public health.

Accountability, responsibility and performance should be required at three levels: macro-, meso- and micro-. At the macro-level, the Health Council of Canada can play an important role through public reporting on healthy workplace targets. This can provide the public with information on the progress achieved by provinces and territories, which will allow governments to benchmark themselves in terms of their achievements on the healthy workplace agenda across Canada. Silas points to such mechanisms in her discussion about the means for better accountability. At the meso-level, governments should integrate healthy workplace indi-

cators within the performance contracts, and performance agreements between governments and employers. Matthews and MacDonald-Rencz argue that governments should be accountable through their policies and funding formula; hence, a possible option for consideration is the feasibility of integrating certain healthy workplace indicators within the funding formula to healthcare organizations. At the micro-level, Matthews and MacDonald-Rencz make it clear that "organizations should be accountable through performance contracts, accountability agreements and retention rates." They add that organizations should be "held accountable by the government, communities and their current and prospective employees … individuals should be held accountable by their peers and colleagues and formally noted through performance appraisals." On this point, we add that employers should demonstrate that employee health and well-being are an integral part of their strategic plans (i.e., the way they do business). In addition, healthy workplace indicators and numerical targets should be included in their strategic plans. Overall, Clements, Dault and Priest put it right by saying that accountability needs to be shared between governments, organizations and health professionals.

The theme that was further emphasized by Silas about unions is critical. Her argument demonstrates the need for clear collective agreement language on healthy work environment factors such as workload, ratios, full- and part-time work availabilities, continuing education, mentoring responsibilities and health and safety. She lays out significant challenges that are facing nurses' unions across Canada in terms of safe staffing and professional authority. On a positive note, many unions are acknowledging that collective agreements can be a facilitator to creating quality practice environments for healthcare professionals. The British Columbia Nurses' Union (BCNU) 2006 Collective Agreement could set a positive precedent in that regard. It highlights the importance and responsibility of unions, but at the same time alludes to the importance of a partnership with unions. To carry the discussion on this theme one step further, the challenges facing many unions show the need for a coordinated and collaborative approach to encourage stakeholders and front-line leaders to work in partnership with unions in exploring new ways and opportunities to remove barriers to workplace health.

At the leading edge in the area of workplace health is the whole use of work-life indicators within the accreditation processes. We strongly agree with Nicklin and Barton, who describe accreditation as a catalyst to move healthcare organizations toward healthier work environments. The authors highlight the significant progress achieved by the Canadian Council on Health Services Accreditation (CCHSA) in strengthening work-life standards. Those standards will be released early January and will apply to 2007 accreditation surveys. Certainly, the continued examination of work-life indicators within the accreditation processes is required to determine if the health of the workplace and its link to patient outcomes is adequately measured.

The "work-life pulse" employee survey described by Nicklin and Barton is quite interesting since it allows for the investigation of large organizational and work unit issues related to work life with an individual tool. It also allows organizations to identify specific work units that are exemplary or deficient in their quality of work life. Due to these benefits, the CCHSA will make the survey available as part of the accreditation program in Canada.

Innovation

An important pan-Canadian initiative emphasized by many authors is the QWQHC. As Nicklin and Barton observe, it is a good example of partnership and collaboration. This innovative group initiative, which is composed of 11 national stakeholder organizations and experts, is in the process of developing its action strategy, to be released in March 2007. An important part of this strategy is developing and disseminating a standard set of healthy workplace indicators at the system and organizational levels. It will embrace evidence-based management practices in healthcare organizations. This collaborative forum will help create more opportunities for innovation and knowledge exchange. It has an important role to play in disseminating best practices at the front lines, both at the national and international levels. It has the potential of being a "one-stop shop" for best practices, knowledge gaps for further research, innovation and healthy workplace initiatives. We believe that the different approaches about the next steps that are discussed in the lead papers and the commentaries will help enrich the action strategy and guide some of the priority actions of the QWQHC.

In their papers, Smadu and McMillan and Kerr and Mustard pick up on an important point related to translating healthy workplace innovations from one profession to another, which includes physicians and unregulated health professions. Smadu and McMillan bring to our attention some key findings from the Nursing Sector Study and its counterpart in the physician community, Taskforce Two: A Physician Human Resource Strategy for Canada. Both studies provide evidence on the impact of work environments on the health of nurses and physicians. For instance, the authors describe the vulnerability of physicians to the influences of stress and burnout in the workplace.

While we agree with Smadu and McMillan's suggestion about a multidisciplinary approach to healthy workplace research, policy and practice that reflects the importance of creating a work environment to fit the inter-professional and team practice approach, we take the opportunity to raise a challenge in this regard. This challenge relates to existing organizational structures – particularly, that physicians are not employees of healthcare organizations. The challenge involves how to include them in the current and future efforts to improve workplace health. New ways of thinking and doing should be developed to address this challenge. The QWQHC could be a suitable forum to initiate this discussion. In addition, this group of experts might consider addressing the gaps mentioned by Kerr and Mustard, particularly "how healthcare workers from outside the regulated health professions can participate in and benefit from healthy workplace and teamwork activities, and how certain segments of the healthcare sector, such as long-term care and home care, have been relatively neglected in comparison with the rest of the sector."

Many authors emphasize the bottom-up approach in terms of workplace innovation. Silas and Matthews and MacDonald-Rencz bring up the importance of micro-innovations in promoting workplace health. While Silas mentions that the top-down approach may not bring positive changes fast, she points out that evidence to inform policy making should come from the workplace itself. Once again, this necessitates the development of practical mechanisms to monitor, evaluate, document and disseminate learning from micro-level innovations. This is another area where the QWQHC could play a leading role in the future.

Concluding Remarks

Almost all authors raise the discussion on the link among healthy workplaces, health human resources (HHR) retention and patient outcomes. This demonstrates the need to keep the healthy workplace agenda within the pan-Canadian HHR strategies. Early retirement, voluntary leaving of the health workforce, the active recruitment of our HHR by neighbouring countries and retention within and between provinces and territories are all serious issues for us to keep in perspective and for which we must find solutions. In reality, with all the policies and programs, unless we deal with workload and employment issues, we will not be able to turn workplaces to healthy, attractive and high-performing settings.

HHR members save lives (World Health Organization 2006). And to enable them to do this effectively, we need to save them from working in poor work environments. We must continue to find innovative ways to (1) persuade policy-makers and organizational leaders that the solution to at least some of the HHR problems in Canada is related to healthier workplaces; (2) make employers and stakeholders appreciate the costs of unhealthy workplaces so that they become eager to pay for efforts to create healthy ones; and (3) make governments, employers, stakeholders, providers and the general public demand healthy workplaces.

Our response is that one approach on its own is unlikely to drive and accelerate a major change at the front lines. Together, the different approaches recommended by many authors might lead to successful change. Concerted efforts, innovation and collaboration are needed to ensure healthy workplaces centred in policy and practice.

We appreciate that many experts and stakeholders have taken the time to comment on our paper. Clearly, this is due to the importance of this policy agenda. Such an interest in healthy workplaces for healthcare workers should keep us motivated to stay the course and move forward.

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