

Putting Health Care During the Past Decade in Context: An Interview With Dr. Judith Shamian

Laurie N. Gottlieb: *The past decade has been a period of great change in health care, nursing, and nursing scholarship. Can you review some of the major changes in health care during this period and put them in context, considering the political, social, and economic landscape?*

Judith Shamian: The early part of the 1990s was marked by downsizing investment in health care. The health-care system underwent some hard times, which included layoffs, reduced seats for nursing education, and deep cuts for the system. Canada was in a major deficit position. The legacy of the prime minister at the time, Jean Chrétien, and the finance minister, Paul Martin, is that they turned the Canadian economy [around, transforming Canada from] a country with a significant deficit and a poor economic performer among the G7 [Group of Seven] to one of the best-performing countries among the G7, with a significant surplus. The surplus allowed them both to reinvest in health care and to pay down the national debt in the late 1990s. At the beginning of 2000 several provincial and territorial agreements were signed between the provincial and territorial premiers and the prime minister that outlined the investments of the federal government in the health-care system.

While the federal government was investing billions of dollars in the health-care system, it also continued to relinquish its moral and legal authority of holding the provinces and territories accountable for the funds they received. The federal government has become more a banker of the health-care system than a partner in decision-making. We see this on many fronts, such as in the minimal enforcement of the *Canada Health Act*, lack of a national home care policy, lack of comprehensive primary health care, lack of national health human resources strategy, and more. In 2009 we find ourselves in Canada once again in a worldwide economic crisis. The impact of this economic crisis on the health-care system will play itself out over the coming months and years.

What are some of the reasons for this shift?

It's mostly political and it's mostly the horse-trading of what provinces and territories want from the federal government and what the federal government wants from the provinces. Our health-care system is mostly

funded by public dollars, so when the economy gets into trouble it has a serious impact on health-care funding.

Has there been any shift in ideology towards health care?

Until the Harper government came into power and until the environment became such a major concern worldwide, health continued to be the number one concern for Canadians. Quality of health care and access to services were the major drivers of some of the agreements in the late 1990s and early 2000s. Therefore health was central to every provincial and every federal election. That has shifted in the last 3 to 4 years, and it's becoming increasingly worse. In our most recent federal election [2008], while many of the polls suggested that the public still places health as number one on the party platforms' agenda, the issues that were debated and promoted by the various political leaders were very thin on health. The first Speech from the Throne [in November 2008] contained very little on health. This is a serious shift, and it doesn't mean that we've solved all the health-care problems. If the agenda has shifted because we thought that health concerns have been resolved, that would be great. But that's not the case. I believe there's a larger political agenda to take health off the table so provinces can quietly invest less and get out of various health-care services they offer. For example, if you look at the legal landscape in Quebec, in 2008 legislation was enacted that allowed for the privatization of over 300 procedures outside of the publicly funded system — publicly funded, privately delivered. And the argument shifted in a very interesting way, where everyone talked about "Oh, we all support the publicly funded system but we'd like to see private delivery." Which is brilliant in the mind of the naysayer because they can guarantee revenue and profit stream that otherwise wouldn't be there. There aren't too many Canadians who'll pay \$5,000 to get a procedure done if they can get it in the publicly funded and publicly delivered [not-for-profit] system.

Have there been other changes?

I think regionally — what I told you was more at the macro, international level.

What were the other pressures at the international level?

We can't ignore the impact of SARS on the whole public health agenda — infectious disease — and discussions around chronic disease. They have all surfaced during the past 5 to 10 years. I think bioterrorism became another issue of major concern; we don't hear much about it, but it really gained a lot of attention after 9/11. As of late 2008 we are also

entering a new world order with the international economic collapse. It's too early to predict its impact on international health, but it is safe to assume that it will have a major impact on poverty and other social determinants of health that affect health status and a country's health systems.

You mention bioterrorism and its impact on health care. Link the two for me.

The whole discussion around anthrax and so on, or communicable diseases, or the technology of being able to spread gases — because of these events each government has allocated many more funds to public health and general security. It had a large impact on the economy for a while and made the developed countries realize that they can't ignore public health.

You talked of regionalization. Could you elaborate?

Regionalization has continued to dominate the management of health care. We used to talk about 10 provinces and 3 territories and the federal government — in effect, we were talking about quasi-14 health-care systems. With the establishment of and the power invested in health authorities, we now talk about many more systems, because each health authority makes decisions to run its own operation differently. While, on the face of it, regionalization itself sounded like a brilliant idea, there is insufficient evidence, as far as I am aware, to demonstrate its impact. From my perspective, looking at home and community care in my current position as president and CEO of VON [Victorian Order of Nurses] Canada, I've started to reflect on whether regionalization has done harm to this sector rather than good. We need research on these issues.

Can you give me an example?

For example, several provinces have reduced their services for homemaking as they do not consider it essential for health. The reality is that a few hours of home support with cooking and other chores can keep individuals at home for many years without the need to place the person in a long-term-care facility. When you sit around the table of a health authority and you negotiate budgets, inevitably acute care consumes a lot of the resources. One would have thought that, because there is a clear understanding that the more you invest in the community the more you can alleviate your acute-care pressures, there will be investment in the home and the community agenda, but that doesn't seem to be the case.

And just relate this to regionalization. I'm missing something, because you say that it would be a good idea and it turned out not to be such a good idea.

[There are] two main areas to consider. First, when regionalization was put in place it was expected that it would lead to a coherent integration of the various sectors (acute care, LTC, home care, and others). The second expectation was that funding would be allocated in a more rational way that would meet the needs of the communities. Neither of these expectations has been met. It would be very helpful to have studies evaluating the outcomes of regionalization.

Are there any other significant changes?

In terms of the social agenda and the political agenda, we have an aging population with the baby boomers who will have a significant impact on our health-care system. And the other thing that is happening is that one in five Canadians is a family caregiver. And, again, no attention to those issues.

Given all these changes, what do you think have been the biggest challenges that nursing faced during this period and how did nursing respond?

The biggest fallout from the early 1990s economic policies that led to mergers and downsizing of the health-care system was the downsizing in human resources, together with removal of funding to the health-care and education sectors. We went from annual graduating classes of anywhere from 9,000 to 12,000 in the late 1980s to as low as 4,000 to 5,000 in the 1990s. When we emerged from this downsizing period and started to re-invest in health care, we realized that we didn't have the people to take on the positions. In addition to the reduction in the number of graduates, we also lost several graduating classes to the United States, because there were no positions generally and full-time positions in particular here in Canada. Another major impact was in work life and working conditions, and that impacted the professional sense of belonging and having the commitment to the organizations. We have seen a significant change in nurses who continue to be committed to patient care and to patients but who are not as committed to the organizations and to the teams they work with.

What about the elimination of leadership and management positions that was part of downsizing? That must have had an impact — not only the shortage of nurses but the lack of manpower and leadership to ensure quality nursing care.

This started in the 1980s when organizations went into what was called "program management." It shifted the power, the influence, and the control from the position of the senior nursing person and the senior

nursing team to an array of physicians, health-care administrators, and financial types, and in many places removed line responsibilities of nursing leadership. This trend led to a shift among emerging nurse leaders toward professional roles such as nurse practitioner positions, education, clinical nurse specialist. We currently do not have a bell curve or age curve in leadership. The research of Dr. Heather Laschinger of the University of Western Ontario shows very clearly that we have a very flat age group of 45 years and over between frontline, middle-line, and senior line. There's limited interest among the younger generation in management positions in the current environment and current structures. Another issue is that we have four generations of nurses in the workplace while the majority of the leadership comes from another, older generation [baby boomers]. Any failure to understand the generation differences in the workforce will further complicate workplace issues.

These are two very interesting and important points you are making. How does this next generation learn and profit from experience without that mentoring and modelling? And who are they going to learn it from?

I don't see anyone dealing with this issue. When I was at the Office of Nursing Policy at Health Canada, we put the topic of workplace health on our policy agenda. It's an area of focus that is now embraced by all. I hope that by building healthy work environments we will be able to support and retain novice nurses.

I now want to talk about nursing research, nursing scholarship, and what is needed from nursing scholars to respond to all these challenges. First, how did nursing scholarship, nursing research, either shape the debate or respond to these challenges?

At the beginning of 2000 we found ourselves in an interesting situation. While the demand for nursing faculty was growing in order to produce the growing number of nurses that are required to meet the practice demand, at the same time the research funding available to nurse scientists expanded too. With the shift from MRC [Medical Research Council] to CIHR [Canadian Institutes of Health Research], some of our dreams and advocacy came through. Canada moved from primarily biomedical bench research funding to a more population-based bio-psycho-social funding paradigm. Nursing faculties and nurse scientists were in a race to both meet educational needs and grow the capacity of scientist and nursing research. In a very short time frame of 10 to 15 years we have made amazing strides. Hopefully this will continue to grow as university schools of nursing receive significant donations and scientists get major grants. We need to make sure that we continue to build capacity that can compete in the national and international funding arenas. The other area where I think nursing has taken serious initiatives

is in the field of health-services research. One of the things that has happened in the last 10 years, of which Canada should be very proud, is the establishment of CHSRF [Canadian Health Services Research Foundation]. CHSRF has made a very significant contribution to this country and to nursing in drawing attention to health services, educating decision-makers and policy-makers about the importance of data. The federal government, in the late 1990s, established a 10-year nursing research fund that helped to support and advance nursing research and scholarship. The federal investment in the prominent granting agencies has slowed down now, but hopefully there is an awareness that in order for Canada to take its place in the G8 we need to continue to invest in research.

Link the dots between those political, economic, and social challenges we talked about in the first part of our discussion and how nursing scholarship or research responded.

In the early 1990s there were a handful of senior nurse scientists who were slowly building small programs of research by having a couple of doctoral students, having researchers, and literally working in a small shop. Once the opportunity opened up and funding became available, they were very well positioned to be successful in a competitive research environment nationally and internationally.

We've had different models of how to build nursing research. I think the model we've looked at was the American model, and the Americans were 10 to 20 years ahead of us by having a nursing institute as an institute in NIH [National Institutes of Health] for the advancement of nursing science. The nursing community in Canada was hoping to have a similar model here when the CIHR was established. The political readiness to have a nursing institute just wasn't there.

On the other hand, the minister of health in 1999, Allan Rock, in addition to the establishment of the CHSRF also established a \$25-million nursing fund to be spent over 10 years focusing on health services and clinical research. This investment in health-services research led to significant development of health-services research generally and among nurse scientists in particular. While the investment in health-services research made it possible to build both capacity and knowledge, to transform the system, we have not seen the same type of investment in clinical nursing research. Some of the experienced nursing scholars are funded well through the CIHR system. Others, primarily from resource-poor settings, don't do as well. [What] we're starting to see is more interdisciplinary and multi-site collaboration, which will strengthen scholarly productivity.

The focus and investment in interdisciplinary practice came out of the FFM [First Ministers' Memorandum] when I was at the Office of Nursing Policy. It's one of the things that I consider my legacy. I hope that the initiatives triggered by the FMM investment in interdisciplinary practice will transform our practice and research.

And people were really scared when they saw the shortages — about what was going to happen.

It took a while for FPT [Federal, Provincial, Territorial] decision-makers to accept that we were heading into a nursing shortage. In the late 1990s many of the individuals who sat around the FPT Health Human Resources table didn't think there was going to be a nursing shortage. They believed that there was no shortage and [that the shortage] was a nursing-infused idea. By 2001 people understood that the shortage was real and there were data to help [people] to understand the challenges we were facing in Canada. Once it was widely accepted that we were entering a shortage, the solutions started to be developed and a nursing plan was passed by all ministers of health across the country.

Do you think we need to concentrate on a few areas of research rather on many, given the number of nurse researchers we have here in Canada?

I think what could be useful is to build virtual networks, where nurse scientists and scholars from across the country and beyond work together. This could help with capacity-building and smooth out the have and have-not faculties. It could be very useful to map out where the leading research programs and expertise [are] and build networks around them. I worry about small faculties that at times are left behind because they don't have access to expertise and resources.

When I was at the Office of Nursing Policy [1999–2004] we organized several think tanks to move the research agenda in an integrated way. At that time I was hoping we could close the gap and grow research capacity and funding in a strategic way. While we're making some progress, we're not where I hoped we would be. I believe we could benefit from a coordinated approach.

I'm also hopeful that the Harper government will renew the Nursing Research Fund, which comes to an end in 2009.

What are the challenges we can anticipate coming down the pipeline in health care? As researchers what role could we play or should we play? Where should we be putting our efforts and our priorities?

I think we need to figure out the relationship between research and teaching. I think in the next 5 to 10 years we'll see multiple colleges that will grant undergraduate degrees, and many of them will go on to grant

master's and PhD degrees. The challenge will be to build teaching and research capacity simultaneously. The United States has gone through a similar situation — in the 1980s — which led to some of their universities being very research-intensive and others...not as productive. We should try to avoid that happening in Canada. We should learn from the US experience and try to do it better.

There's also an inherent academic challenge between being a researcher and being an educator. And within nursing, because we are a practice profession, a practice discipline, we need very, very competent educators and clinical instructors. But the way most universities are structured, educators are often considered second-rate citizens. So we need to figure out if something can be done where teaching faculty can be tenured based on education and scholarly work so that there isn't this pull and push between scientists and teachers. The other thing that we need to figure out is how to engage our star researchers in undergraduate and graduate teaching without overloading them with teaching responsibilities.

The other big challenge is that we have a shortage of individuals interested in becoming deans. Over the last few years at any given time there have been several vacant dean positions.

There's a growing trend for nurse scholars/researchers to be embedded in the service settings. While this trend can be very helpful in strengthening practice, we need to structure these roles in a way that these individuals can build programs of research while collaborating with service. This is a trend we need to pay careful attention to.

What do you see happening in health care and how do you see nursing positioning itself?

My biggest worry is that the next 3 to 5 years will be marked by continuing privatization and economic downturn. Both privatization and economic downturn will lead to reduced investment in research and will remove available dollars from the public system. I worry that these will lead to a repeat of the early 1990s, when we removed from the system many of the educators, CNS's, and we reduced the number of seats for nursing education and much more. And last, there will be less and less opportunity for scholarly development — staff going to conferences; it will become much more of a service model than a professional discipline model.

What do you need from nurse researchers and nursing scholarship to help deal with this challenge?

Above everything else we need more research on what is the best practice and what are the best interventions to support patients, families, and

communities. And when I say that it doesn't make a difference if a patient is in the hospital or in the community in order [for us] to deal [with the situation] in a comprehensive way, we also need nurse scientists to help us switch from an acute-care lens to a health-care lens with the associated health outcomes. Nurses are the largest group, outside of basic scientists and physicians, who have the skill set to do this kind of research.

To what extent do nurses really value that?

We lost the emphasis on patient-centred care in the 1990s during the last economic downturn and we didn't regain it. We talk the talk, we talk about patient-centred care and the wellness model, we talk about the health perspective, the need to have care inside and outside of institutions, but we don't seem to be able to make it happen. I hope that the nursing community can work together to role-model how to build healthy communities, healthy families, and healthy individuals.

Thank you, Judith, for a most fascinating and insightful interview.

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