

Concept Idea Canada Research Chair: The Social Organization of Health Care

Concept for Canada Research Chair: *The intersections of everyday work that produce “health care”*.

Everyday in Canada many people produce and consume “health care”. Policy makers and administrators grapple with the enormous challenge of resource distribution to support a healthy populace. Regulated health care professionals work with individuals and communities using their specialized knowledges about prevention, health promotion and the management of illness and disease. As well, non-regulated professionals (e.g., home support workers, personal trainers) are paid to use their knowledge and experience to contribute to the important work of keeping Canadians healthy. Consumer demand for “alternative” approaches to health continues to grow, with a concurrent increase in the number of businesses established to address these interests and demands. There is also a huge “workforce” of unpaid labour involved in informal care-giving work such as meal preparation, hygiene practices and personal help and advice that many Canadians rely upon for their health and well-being. How all these varied activities coordinate with, and organize, one another is not well understood. Not enough is known about how the official health care system interacts with and subsumes, or is supplemented by, other practices aimed at promoting people’s health and well-being.

This research chair would implement a research program into the social organization of health care with three main themes (and examples of research questions are included)

- 1) Critical research into the social organization of Canadian health care with emphasis on the intersection of multiple forms of knowledge (expert, administrative, local) as they influence and impact the public’s experiences in the broad continuum of “health” approaches, services, and care delivery
 - a. How people’s experience with disabilities is organized in relation to the formal and informal provision of home support?
 - b. What impact does the dialogue with “health trainers” have on people’s health behaviours in the short and long term? How do these relationships and behaviours intersect with “body image” as it is portrayed in the contemporary “fitness media”? How is “health” marketed within these intersecting discourses? How/when do people’s fitness behaviours intersect with formal apparatuses of publicly funded health care?
- 2) Deepening understanding about how the many community, policy, technological and institutional forces that foster and maintain health, interconnect with the educational preparation of health care workers
 - a. What do student nurses understand about early discharge of patients from hospitals in relation to policy, practices, and recovery? What/how are student nurses taught about the work and responsibilities of families in relation to reduced length of hospital stay? How does the nursing discourse on family centred care support or disrupt the hospital efficiencies that are captured through early discharge?
 - b. What role does family have in the rehabilitation trajectory of older adults with joint replacements and how is this understanding reflected in the education of health providers?
- 3) The development of strategies that would address the tensions and troubles that arise at the community level in relation to the coordination of disparate, differently located and valued, knowledge about the production of health
 - a. What are the experiences of families who have a child with special needs as they care for and foster positive child development within the current contexts of funding and care provision? What changes are required so that families are central to policy and practices?

- b. How do women experience victim support services as helpful in fostering recovery and healing? What are the differences in how support services are perceived and how they actually are implemented?
- c. How does a medicalized view of pregnancy and birth (for example the increasing application of ultrasound technology during pregnancy) shape women's experiences of childbearing?

In the formal health care system there is increasing interest in “knowledge transfer”; that is, the uptake, of scientifically generated evidence-based knowledge for health care delivery. An underlying feature of knowledge transfer is concern about sustainability, accessibility and quality of the Canadian health care. This trend in Canada (and around the world), is characterized by increasing reliance on expert, technologically driven forms of knowledge that are being used to regularize treatment regimes, resource use, and the timing and duration of professional intervention. The technologies emphasize service and accountability to the health care “customer”. Traditionally, nurses, doctors, and other professionals have been trained as experts whose accepted place was to use their training, experience and judgement to decide the plan of care. Health care recipients were positioned as passive recipients of care, rather than active, knowledgeable consumers of health services. The technologies of the information-age have reorganized the activities of health care professionals, but how health professionals and their patients learn about, and adapt to the technological forms of knowledge is not well understood. Nor is how this trend intersects, or should intersect with new curriculum for nurses and doctors; or how this sort of knowledge intersects with the unwaged work of caregivers (predominantly women). A range of new businesses (service brokers, personal trainers) and new health media create and fill new positions in the knowledge and provisioning gaps. No longer can it be taken for granted that a health professional is in charge of this sphere. Rather, our current and future reality is a burgeoning field of self-definition of wellness and strategies for self-help. For many, relationships with professionals are becoming partnerships, where new skills in negotiation and evaluation are needed, as the “client relationship” now includes seeking out and establishing successful relationships with professional members of the public health care system or help available through the marketplace.

Health professionals and researchers cannot take for granted that we know how people take care of their and their families' health, including when, how, and why they professional consultation and intervention. Much of past and current research focuses on health care intervention (joint replacement, cancer treatment, heart attack), and where waiting time, and costs creates problems. The proposed research program would expand that focus, and explore another level of health, health care and health work that relates to, and is influenced by the former, but about which we know very little. The responsibilities of this research chair would include planning and conducting research into this newly emerging social organization of health care. Successful conceptualization of the area to be researched requires a close collaboration with the local community – whose members are active in what we propose is a “burgeoning field” of new social relations of health care. Establishing research partnerships with local health and human service organizations would be an integral component of the chair's work. As well, the chair would network more broadly with administrators and provincial bureaucrats to foster reflexive and responsive health policy. The chair would be expected to build on the collegial affiliations among health and human service faculty to support the scholarship of teaching, practice and research. Within the development of this proposed Canada Research Chair there is enormous potential for broad interdisciplinary involvement with faculty not just from nursing (health and human services) but from recreation and leisure, sociology, psychology, anthropology, criminology and First Nations studies. The new Vancouver Island medical school might also be expected to participate in the research and curriculum development that this CRC “concept” would generate.

This chair focuses on large social questions necessitating critical examination that also require strong multidisciplinary lenses to understand and uncover new insights. The context of MU-C as a mid size institution with strength in applied approaches to research, faculty who are immersed in practice (field activity) and committed to social change position us well. There are established relationships among faculty members in Nursing, Social Services, Child and Youth Care, Psychology, Sociology, Women's Studies, First Nations and Political Science. Health and Human Services have existing relationships with a great many governmental and nongovernmental organizations within the mid-island region (For example, to name just a few, students and faculty have been involved with the Alzheimer Society; Bread of Life Centre; Chemainus Band; Hospice; Enchanted Woodland Childcare Centre; Haven House; Girl Talk; NRGH; the Multicultural Society; Forward House; Edgewood and the Nanaimo Correctional Centre). The people at Malaspina University-College and within the mid-island community have well developed formal and informal infrastructure and networks in place. Within this community context, the research conducted by the research chair has the potential to have a great deal of local relevance for service delivery. As well, the type of research being proposed within the concept of "the social organization of health care" would have broad practical application to program administration and policy making.

1. The research undertaken by this chair would most likely be within the paradigm of critical social theory and the feminisms. Phenomenological methods, grounded theory, participatory social action research, institutional ethnography and narrative inquiry are examples of some of the research approaches that could be used to examine the phenomena of interest.
2. The chair would foster existing collaborations among local governmental and non governmental organizations to generate a reputation for distinction in the application of knowledge for teaching and practice in the health and human services.
3. The chair would be involved in developing and submitting research proposals to funding agencies such as CIHR and SSHRC.
4. The chair would develop lead and/or support research teams with members from a variety of disciplines.
5. An office of the chair would be located among the health and human service offices. The chair would hold workshops and inservices for faculty, students and the community to support the scholarship of teaching, practice and research. The chair would be visible and accessible to students via classroom involvement as an invited lecturer. The chair would provide on site support for faculty and student research projects as they relate, broadly, to the social organization of health. The chair would also be visible among community organizations as an important centre of critical analysis.
6. The chair would independently and collaboratively write and publish research findings. The chair would develop systems for editorial support for faculty who are writing and publishing. The chair would support and facilitate the dissemination of the chair activities at related meetings and conferences.