Growing Health(y) Workers

by

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Abstract

This paper examines an employer-driven partnership aimed at attracting young people to careers in health services through summer internships. Research questions focus on this recruitment aim and examine the extent to which it is reflected in the organization of the internship, its likely effectiveness as a policy solution given the multi-faceted reasons for labour shortage, and implications for the type of learning that may benefit young people. We conclude that student interns would benefit from broader educative aims that encourage an understanding of the players and forces affecting workplace change.

Introduction

> [T]he knowledge-based economy means an ever-increasing demand for a well-educated and skilled workforce in all parts of the economy and in all parts of the country. … [O]ur learning system must be strengthened if we are to meet the skills and labour force demands of the next decades. ("Knowledge Matters," Government of Canada 2002)
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> There are three main sources for new additions to the labour force: Alberta's education system, in-migration from other provinces, and immigration from other countries. ("Prepared for Growth," Government of Alberta 2001)

As the above quotations suggest, Canadian policy makers are concerned about ensuring an adequate supply of skilled workers partly through strong education systems at both secondary and post-secondary levels. School-to-work transition has become a preoccupation among policy-makers and educators as well as parents and students (OECD 1999). Federal and provincial polices have focused on expanding high school work experience programs as well as encouraging high school completion. Governments in Canada, as in other industrialized countries without strong institutionalized connections between schools and the workplace, have also encouraged the development of education-industry partnerships (OECD 2000, Taylor 2002). Such partnerships are intended to mobilize employer support for work experience and career education programs, which is important given the traditionally limited role played by employers in the transition process (OECD 1999).

This paper begins with discussion of a provincial partnership in Alberta, Canada that provides selected senior high school students with opportunities to work in health care settings during the summer months while accumulating high school credits. Public sector employers initiated this partnership as part of their strategy to address labour shortages within the health care field. Our purpose in this paper is to examine the "recruitment" aim of the internship both in terms of its influence on the organization of the work experience program and its credibility as a policy solution. Our research questions are:

- How does the internship program work and to what extent is the recruitment goal reflected in the organization of the program?
- What are the reasons for occupational shortages in health services and does this kind of high school program make sense as part of a policy solution?

- Given this analysis, what type of learning about work in health care should such programs promote?

The focus of this study on the type of work that students are being prepared for ("demand" side) as well as the role of schools in developing a skilled workforce ("supply" side) encourages an exploration of issues that cannot be considered in the same depth in studies that examine work experience initiatives across a variety of sectors (Huddleston 2000, Petherbridge 1997, Watkins 1987). It also represents a different approach from case studies that focus on a small number of worksites or students (Fuller and Unwin 2003, Hodkinson and Hodkinson 1999). Our approach is influenced by the idea that ensuring a high quality of work for young people should be as important to policy-makers as preparing employable students (cf. Lowe, 2000). From this perspective, the social policy question of "how work can be reformed to permit fuller use of people's current education and learning capacities" is as important as asking "what work requires of schools" (Livingstone 1998, p. 10). The question of what kind of learning should be promoted by work experience programs is also critical.

The primary data informing this paper include interviews with representatives from three health regions (employers), three unions, a provincial broker (CAREERS the Next Generation), the health department, and a school coordinator (see Table 1). As part of the larger project, focus group interviews were conducted with 14 students and 8 mentors involved in the program in August and September 2004. All interviews were recorded and transcribed. Finally, our surveys of students and mentors in the fall of 2004 provide contextual information.

Table 1: List of Interviews

Interview #	Organization	Date
1	Rural regional health authority	March 2004
2	CAREERS field directors (2 participants)	August 2003
3	School coordinator, Calgary	March 2004
4	Rural regional health authority	March 2004
5	Urban regional health authority	March 2004
6	Provincial union	March 2004
7	Provincial union	March 2004
8	Provincial union	April 2004
9	Provincial health department (3 participants)	April 2004

History of the health services internship program

> The Government of Alberta has consulted with key stakeholder organizations. These organizations have agreed that while shortages can be found in many sectors, they are expected to be especially severe in health care, information and communications technology, and construction. ("Prepared for Growth," Alberta Government 2001)

The idea for developing a high school health services career pathway began to be voiced in the late 1990s when a provincial health workforce steering committee asked Human Resource (HR) leaders from the recently formed Regional Health Authorities (RHAs) to work on recruitment and retention initiatives in the area of health services (Interview 1). A representative from a RHA

comments, "back then we had a dire nursing shortage facing us. We had other professions that we'd have two and three-year vacancies in" (Interview 1). One of the HR leaders was aware of the work of a provincial broker called CAREERS the Next Generation (CAREERS)[1] and contacted them to examine the plausibility of developing a model to attract youth in Alberta to careers in health as part of a long-term recruitment strategy.

The intention was to build on CAREERS' relationships with school districts and schools in communities across the province. The vision for the health services pathway included a summer work experience placement (internship) in various sites and occupational areas, input into high school curricula related to health services, and attempts to better articulate high school and post-secondary curricula and to make health pathways more transparent to students. The summer internships were initially seen as most relevant to rural regions, which were concerned about attracting local youth back to their regions after they complete further education. However, as plans for a three-year pilot unfolded, two urban regions also expressed interest and together provided funding of approximately $100,000 a year. In addition, Alberta Health and Wellness (the health department), contributed $470,000 over the three years (Interview 9). It is noteworthy that Alberta Learning (the education department) was not involved in directly funding this initiative, although it does support CAREERS.

Funding primarily covered the salaries and travel costs of two field coordinators hired by CAREERS to liaise between employers, school districts, and schools. As the pilot neared its end in late 2003 and early 2004, discussions about the future of the project began. Although the two urban regions indicated that they were no longer willing to continue to bear the costs for all nine RHAs, regions agreed to continue to support the program with a reduced budget and a different funding model that would share costs more equitably. Government representatives suggested that the pilot had been very positively received (Interview 9).

The summer internships for high school students are the most developed component of the health services pathway to date. Although there have been attempts to develop a set of competencies for students in different career clusters within health services, high school option courses related specifically to careers in health services are only offered in a few high schools and no articulation agreements had been developed with post-secondary institutions at the time we spoke to field directors (Interview 2).

A snapshot of the program in 2003

Summer internships (lasting an average of 6 weeks) were offered to approximately 270 students across the province in 2003. The idea was to attract grade 11 students who would intern for two consecutive summers. According to a survey of mentors,[2] around three quarters of placements were provided in public RHA owned and operated facilities in 2003 while the remainder were in private for profit and not for profit facilities (Sabetghadam, Taylor, and Brigham 2003). Responses to our survey of student interns[3] suggest that 84 percent were female and 96 percent were between 16 and 18 years of age (Taylor, Sabetghadam, and Brigham 2003). Two thirds of intern respondents had achieved an average grade of 80 percent and 91 percent had achieved an average grade of 70 percent or better in their previous year of school. Ninety percent of respondents planned to go to university. Considering that less than a quarter of grade 12 students in Alberta achieve average grades greater than 80 percent, this program clearly attracts high academic students (Taylor et al., 2003).

The majority (88 percent) of respondents in 2003 had worked at part time paid jobs in the past but of those, less than a third said that this work was related to health services (Taylor et al., 2003). The top two reasons for applying to the internship were "career exploration" (86 percent indicated) and "an interesting summer job" (72 percent) compared to "money" (41 percent). Similarly, when asked to indicate what factors were most important to them in future work, the majority of respondents indicated enjoyable, satisfying or fulfilling work, helping others, and working with others as the most important factors. They mentioned stability, good pay, and job security less often. This is consistent with findings from other studies of the work aspirations of high school students (e.g., Lowe and Krahn, 2000).

Field directors and a school coordinator discussed selection and hiring processes in the two largest centres—Calgary and Edmonton (Interviews 2 and 3). In Calgary, each public high school was allowed to submit two or three applications from first year interns to the field director, depending on whether or not they had second year interns also applying (Interview 3). There were close to 50 placements provided to students in 30 or so high schools across the two school districts. However, the number of positions available to first year interns was small in actuality because of the high number of returning interns (Interview 3). Students were guaranteed one interview and competition was intense. For example, a coordinator suggests that his school received 12 applications and forwarded two names of students to be interviewed (Interview 3). It was similar in Edmonton, where less screening was done at the school level and the field director received 250 student applications for approximately 60 positions. In contrast, in some rural areas, field directors noted that it was difficult to find interested students.

At least two urban regions earmarked a small number of positions for Aboriginal students. In some cases, the Band administration from nearby Reserves paid the students (Interview 2). Other districts were looking into this type of arrangement for the future, according to a representative from a rural RHA (Interview 1). In addition, several facilities applied for government wage subsidies. On average, students were paid an honorarium equivalent to approximately $6 per hour, which is close to the provincial minimum wage (Taylor et al., 2003). Students also received a high school credit for every 25 hours worked.

Whether students should be paid and how much was an issue for respondents. On one hand, paying students indicated a valuing of their work and recognition of the opportunity costs associated with summer work for college-bound students. In addition, the pay was not high compared, for example, to that received by the majority male students involved in a similar internship in the technology sector (Taylor Forthcoming).[4] But on the other hand, health facilities were used to providing unpaid clinical placements for post-secondary students and therefore appeared to feel pressure to ensure that students were productive, perhaps detracting from learning goals. A school coordinator describes the (arguably gendered) culture of health care as follows:

> [In some private facilities] the managers were told [by their superiors] that they had to find the funding for an intern if they were going to take one. … And all of a sudden [students] were going to interviews where they were being told "well, we have no money to pay you." And health care is a tough one because, this is my belief, is that there's sort of a feeling that people that go into health care are caring sorts of people. They want to make a difference. And so they will, how do you put this? They'll do it for free. … You know there are enough people wanting to get into health care so the competition is there and these [employers] can get second or third year university kids to come and do an unpaid internship. (Interview 3)

The recruitment goal and the organization of the program

> We directly supported CAREERS the Next Generation to support [the health internship]. … I mean, we have an interest in ensuring [labour] supply. (Alberta Health and Wellness respondent, Interview 9)

The fact that RHAs and government were primarily motivated to participate in the program in order to interest young people in health careers appeared to affect the organization of the program in some ways but not in others. Most notably, the limited educational aims of the program, the competitive nature of student selection, and the focus on return on investment in evaluating the program reflect the motivations of employers and the health department. However, the lack of attention to articulating the program more closely with post-secondary education and the general failure to track students are areas where practice deviated from the recruitment aims.

Miller, Watts and Jamieson (1991) outline several aims of secondary school work experience programs. Using their typology, the health services internship can be seen to encompass three primary aims as follows:

- Expansive: to broaden the range of occupations students are prepared to consider in their personal career planning;
- Sampling: to enable students to test their vocational preferences before committing themselves to a particular career; and
- Placing: to enable students to establish a relationship with an employer, which may lead to the offer of a full time job in the future. (p. 18)

In contrast, aims related to enhancing students' understanding of classroom concepts, making aspects of curriculum more meaningful to students, or enabling students to develop their understanding of the world of work were less central.

While instrumental aims related to career exploration and job sampling aims are no doubt important to students and parents as well as employers, American evidence about experiential programs suggests that those which show the most consistent impact on students' psycho-social development were more "school-like" and less "work-like," partly because of the increased opportunities for reflection and inquiry (Miller et al. 1991, p. 35). From a critical perspective, educationally-driven programs may also provide more opportunity for teachers to consciously examine their pedagogical choices in relation to work experience programs (Thornton Moore and Hughes 2003; Simon, Dippo, and Schenke 1991). For example, rather than taking the structures of the workplace in terms of forms of knowledge, skills, and social relations of power as given and stable and socializing students into habits and values such as punctuality, accountability, and deference to authority, educators may envision work-based learning as an opportunity for students to better understand and critique existing work systems, to imagine alternatives, and to become active participants in workplace change (Thornton Moore and Hughes 2003).

The fact that interns were usually evaluated primarily by employers based on a checklist of how they performed in areas such as "attitude, efficiency, initiative and teamwork"[5] suggests that the health services internship tends to based on a *functionalist* model of pedagogy (Thornton Moore and Hughes 2003). In our view, a deficiency of this approach is that students are likely to conclude the work experience with little understanding of the past and present organization of healthcare work places; the mandates and interests of government, RHAs, unions, and professional associations; and the forces impacting the field.

In addition to the limited educational aims of internships, the recruitment motivation is evident in the competitive nature of student selection. As indicated above, the vast majority of students are

high academic achievers who are university-bound. This outcome is due to the scarcity of positions relative to the numbers of interested students and the failure to align the program with a diversity of career pathways. Most participants acknowledged the current elitism of the program. For example, a participant from a rural RHA commented:

P[6]: If I had a student as a result of their work experience that said "I'm not likely to go on to university or tech school. I worked in Continuing Care and I loved it and I think I want to take a 13 week personal care attendant course"… I'd grab them in a minute.
A: And do those students get the opportunities to participate?
P: I think at this point those may be the students whose marks are such that they end up getting selected out…
A: What can you do about it?
P: If we had a community that said… we really need personal care attendants. Can you talk to the kids and say "we aren't just after university grads"? (Interview 1)

The problem is that most communities are unlikely to identify personal care attendants as a shortage because the relatively low entry-to-practice requirements are more likely to result in adequate labour supply. However, from an educational perspective, if work experience programs are to address the needs of students who are most likely to experience difficult transitions, the almost exclusive focus on university-bound students is problematic. In this regard, the interest of RHAs in hiring Aboriginal students is promising. But if the motivation is primarily financial (e.g., because Bands will pay students), if the level and quality of positions are downgraded as a result, and/or if workplace supports are not in place for these students, this approach is unlikely to be effective.

A final area where the influence of the recruitment aim of internships can be seen is in the evaluation of the program by RHAs. For example, a RHA participant suggested that it is very important to the sustainability of the program for it to have credibility in the "eyes of the major stakeholders," leading to the following exchange:

A: And who do you see as those key stakeholders?
P: CEOs and the chairs, the RHAs, deputy minister, people at Alberta Health…
A: And what do you mean by credibility? What kinds of things are they looking for?
P: What they perceive to be return on investment.
A: And how is that measured?
P: Different ones, different ways. For some of them, it's how much money they're having to put into it. For others, it's how much time it takes their supervisors to do the mentorship. For others it's measuring how difficult it is for them to recruit candidates vs. what they put into this program to make a long-term investment. (Interview 1)

It is noteworthy that students and educators are not seen as major stakeholders.

Another RHA participant added that in urban areas, where it is easier to attract post-secondary graduates because of the proximity of universities and colleges, the program is more difficult to justify:

> A grade 11 kid might be six or seven years [in further education]. I can't track him [sic] that long. In a rural region, no question. And they've got the ability to offer bursaries and the rest of it. I'm not going to get that kind of funding from government here because I can't demonstrate that need. … [M]y workforce planning strategies would not include backing up that relationship-building piece that far. (Interview 5)

This participant adds that an Aboriginal focus would be easier to justify in this region because of pressures to diversify the workforce. The focus on return on investment by the health department and RHAs therefore influences the organization of the program in different ways in different

regions. Most important to recognize is that this focus limits the ability to engage in long-term planning and encourages activities that result in an over-supply of labour, particularly where the costs of that oversupply are not borne by employers (cf. Livingstone 1998).

The preceding discussion suggests areas where the recruitment aim noticeably affects the organization of the internship program. However, there are other areas where this aim seems to have been forgotten. For example, it has been mentioned that little has been done to date to articulate the high school health services pathway with post-secondary programs. This could involve establishing agreements with post-secondary institutions to recognize students' prior learning associated with the internship through credit or advanced standing. It may also involve developing work placements related to under-subscribed post-secondary programs where there is a documented demand for graduates.

Interestingly, although rural regions reportedly have most trouble attracting staff, only one had taken the internship program to its logical conclusion in terms of tracking students. A representative from this RHA describes how they "tweaked" the model to fit their needs:

> We go out and find the students first. We have a lengthy interview process. We've spent a lot of time in recruiting. …We only take eight students every year. We're looking for students that we believe ….have shown a real interest in a potential career path [in health services], …they've shown us that they could be successful… they're also people that are really well-connected to their communities. (Interview 4)

This region received between 70 and 80 applications for the eight positions. In addition to the unique feature of finding students first and then seeking placements related to their interests, interns were guaranteed summer work in the region for the duration of their post-secondary studies following successfully completed internships. Interestingly, no other region, to our knowledge, formally tracked students following the internship.

The preceding discussion suggests there are some areas where the recruitment aim is reflected in the organization of the program and others where it is noticeably absent. Data from surveys with mentors of students in the workplace also suggest that the recruitment aim was not their first priority. For example, the most common reason for involvement in the internship was "to promote the organization as a good corporate citizen (29 percent) while only 16 percent suggested that it was "to address a long term workforce requirement in the organization" (Sabetghadam et al., 2003).

This finding is consistent with the suggestion of Ahier, Chaplain, Linfield, Moore and Williams (2000) that one of the limitations for developing a more formal system of work experience was the fact that employers view it more as a charitable act than a long term investment. But in contrast to front line employees, HR leaders from RHAs did not view it primarily as a charitable act. Because it is seen as part of a long run recruitment strategy, the question of whether the internship represents a feasible policy solution to the problem of occupational shortages is important to consider.

Reasons for shortages in health care occupations

The emphasis on the recruitment aim of health services internships leads one to assume that high school students have not shown an interest in entering post-secondary programs related to health care occupations. As we demonstrate in this section, this is far from the case. This prompts us to look more closely at the idea of "shortage" and to ask such questions as: How is the term

"shortage" being defined? Who is defining the term? Are shortages specific to particular occupational designations, to particular regions, or to particular types of facilities? Are shortages a temporary phenomenon or are they more systemic? How are future labour force needs determined? And finally, what are the reasons for shortages?

Responses to some of these questions came out in interviews. For example, representatives from unions and RHAs tended to agree that there were "hard to recruit" occupational areas. In this regard, participants in different regions mentioned pharmacists, lab technologists, nurses, physicians, physical therapists (PTs), occupational therapists (OTs), respiratory therapists (RTs), physiotherapists, speech language pathologists (SLPs), psychologists, dieticians, sonographers, health records technicians, and cardiology technicians as areas of shortage. In addition, participants agreed that rural areas generally find it much more difficult to attract qualified professionals.

However, the severity of shortages was more difficult to gauge in discussion. For example, a representative from a RHA suggested that although students should be encouraged to consider health care occupations, the term "shortage" needed to be put in perspective:

> When I'm talking about a shortage, I might be talking about 2 or 1.05 or 2.75 FTE. Now for me that's huge because that may mean we can't deliver our service. But you know, you're talking about 200 kids applying for those [post-secondary seats]—there may be only 5 seats. (Interview 5)

Therefore, the extent of shortage needs to be considered and jobs are not necessarily guaranteed. For example, when asked if it was currently an "employers'" or "employees'" market in nursing, the same RHA representative replied: "I think it's an employees' market if you were talking about a rural region. But for [urban areas] it can be to some degree an employers' market" (Interview 5). Some positions were also more vulnerable than others, as a union representative describes: "Rec therapists are an easy one for people to cut because a lot of people, I think, have a perspective that it's kind of fluff that they provide" (Interview 6). Interestingly, this was a very popular placement for student interns.

Most participants referred to the influence of government policy and funding in workforce planning. For example, Bill 11, the *Health Care Protection Act* was passed in Alberta in September of 2000 and allowed regional health authorities to contract with for-profit companies for in-patient medical and surgical procedures. It therefore introduced a great deal of uncertainty into the system. While the impact of this bill to date has been less significant than expected (e.g., contracts for private providers accounted for only .15 percent of the provincial health budget in 2004), Premier Klein recently indicated that more radical health reforms are needed and are forthcoming (Henton 2004).

In addition, several respondents mentioned political changes in the 1990s during the restructuring and downsizing of the public sector that occurred after the election of the new premier in 1993. To provide a sense of the magnitude of these changes, Plain (1997) suggests that, accounting for inflation, there was a 25 per cent per capita decline in total health care spending between 1992 and 1998. Most of this decrease was carried out through funding cuts. Since approximately 70 percent of the annual health budget is expended on labour costs, this was significant (Scott-Findlay, Estabrooks, Cohn, and Pollock 2002). Between 1993 and 1995, between 2,000 and 3,000 nurses were laid off (Scott-Findlay et al. p. 350).

In addition, the governance of the system changed with the creation of 17 regional health authorities around 1994, which were later reduced to 9 authorities. Although this new structure

accomplished the goal of streamlining the system, it resulted in the loss of a large number of senior and middle management personnel. Concerns were also expressed by a variety of groups about their loss of input and control in the system and about the fact that RHA members were appointed by the government rather than democratically elected (Plain 1997). The "breakneck" pace of reforms meant that the system has had little stability or predictability in the past decade. It has therefore been difficult to forecast the needs of various professionals not only because of changes in technology and health care needs but also because of political decisions.

Respondents agreed that the quality and availability of workforce-related data are also poor. For example, a union representative said that the province's data collection has been sporadic and the type of information collected is inconsistent across RHAs (Interview 7). Government and RHA respondents agreed that they "don't have much data to project shortages" (Interview 9). As a result, the health department has relied on employer reports of "difficult to recruit" areas. A government survey of the 17 RHAs in 1998 confirms that workforce planning was also sporadic—three RHAs apparently did no HR planning while another five did it on an "ad hoc" basis" rather than annually (Scott-Findlay et al. 2002). To try and address problems, a Health Workforce Information Network was being developed. However, a government respondent argued that even with such data, it would be challenging to predict labour demand across the health sector (Interview 9).

Projecting workforce needs is difficult because of the many factors involved. For example, in discussions with interview participants and in policy reports, the following reasons were given for "shortages" across different occupational areas:

- Changing needs related to population growth and demographic changes
- "Credentials creep"
- Lack of workforce renewal
- Workforce management issues

Some of these factors are clearly more controllable by players within the system than others. The last three are arguably more subject to negotiation among government, employers, unions, and professional bodies and are the focus of our discussion.

> "Credentials creep"
> There is a move afoot in many of the disciplines to increase, we call it "credentials creep." So physical therapy is moving to a mandatory Masters degree. Occupational therapy likewise. … our technical disciplines used to be a two year program for x-ray technologists for example. They're moving toward a degree-based training. … You used to have lab assistants come off the street, we'll train you to be able to do what we need you to do. And probably starting in the mid-90s within the hospital sector for sure and I think the private lab sector as well, the move has been to be a lab assistant you need a NAIT or SAIT [college] program and need to be registered. … Pharmacy technicians, again, very much used to be trained on the job. Now within the hospital sector in Alberta, you can't get a job unless you have [completed] a recognized program. (Interview 6)

Interview respondents from both RHAs and unions agreed that credentials for entry to-practice had increased in a number of occupational areas. According to a union representative, increases were due partly to the desire by professional groups to raise their level of respect and level of service. This is consistent with the neo-Weberian argument that educational credentials are as related to the ability of professional groups to control access to occupational power as they are to technical job requirements (cf. Collins 1979, Murphy 1988). However, a representative from a

RHA added that technological change and increased specialization have also contributed to this trend (Interview 4). Respondents from both unions and RHAs agreed that "credentials creep" has made it more difficult to meet workforce needs. For example, a change in the length of programs impacts the supply of graduates in the short term.

However, increases in entry-to-practice requirements during a time of fiscal pressure also has the potential to change the composition of the workforce, as a union representative suggests:

> One of the things we've seen become almost extinct is the dietary technician. Over the years, the hospital sector…has moved to having fully fledged dieticians and then aides. …In the 80s and 90s we still had an intermediate grouping. … And I have a bit of a suspicion that the whole 90s era of "we've got to save money, we've got to cut funding" is trying to get the least expensive worker to provide the services. (Interview 6)

Another union representative agreed that there has been a move to go to "lesser skilled, lesser educated" and "unregulated" health professionals (Interview 7). In contrast, a representative from a RHA discussed this same trend in terms of "knowing your needs," as follows:

> [Credentials creep] usually raises your salary rates. That's something we watch quite closely to make sure that what we're paying for is in fact what we need. … you've got to stay on top of your needs. You can't just go with the flow and say everybody's got to have a baccalaureate in nursing and everybody's got to be a registered nurse. (Interview 4)

Whether in response to cost pressures and credential inflation or a lack of qualified professionals, employers appeared to be looking more closely at the relationship between credentials and actual work. The result may be a shift in the complement of staff. For example, when asked if RHAs are hiring more paraprofessionals as a result of increasing credentials, a RHA representative replied "some regions tell me that's the case, yeah" (Interview 1). A government respondent agreed that there "seems to be an increase in careers in assistant positions" (Interview 9). The preceding discussion suggests that an up-skilling thesis does not neatly describe the changes that are occurring in health care and that young people cannot assume that obtaining university credentials will guarantee work (cf. Livingstone 1998).

In the struggles between employers and professional groups over credentials, students may also get caught in the middle. For example, a union representative commented:

> [Name of RHA] will go over and do big promos at [name of urban college] to try to get people into the workforce sooner. And since they've been doing that, the number of exits with the diploma [in nursing] has gone up. But then those students don't necessarily get a job and they're going to be pressured, I believe, their whole career to go back and get their degree. (Interview 7)

Closer to home in terms of our focus on the health internship, a school coordinator comments:

P: [T]he kids in rehabilitation at [name of hospital] … were asked to come back. They were told, we'll give you a job.
A: You mean, full time?
P: Yeah, full time. They would have taken them back full time and they were able to do that sort of thing because of the amount of training that might be necessary for certain jobs in that area. … But what I hope would come out of that is that the student would see a need to go to some sort of post-secondary [education]. (Interview 3)

Lack of workforce renewal

A report by the Canadian Nursing Advisory Committee (CNAC 2002)[7] documents a drop in the number of nurses per capita across Canada between 1990 and 2001 and suggests that losses came about as a result of layoffs due to cutbacks, retirements, and a reduction in the number of seats in nursing education programs. In Alberta, Canadian Institute for Health Information (CIHI) data indicate that the number of employed registered nurses per 10,000 population dropped from 80.3 in 1994 to 73.6 in 2000. Alberta ranked 10th of the 13 provinces and territories in Canada in 2000 in this area.[8] Similarly, Alberta ranked 9 of 10 provinces in the number of licensed practical nurses (LPNs) per 10,000 population in 2002.

A union representative noted the effect of lay-offs, commenting that cuts in the 1990s were "way too deep" and that the system was still trying to recover (Interview 7). According to both union and RHA participants, the effect of restructuring and cutbacks affected not only the many health professionals who either accepted part time or casual work, retrained, or sought work elsewhere, but it also affected families and others who were aware of the negative impacts on workers. At the same time, an aging workforce has resulted in large numbers of retirements, as a union representative suggests:

> I was just reading the report from the office of nursing policy out of Ottawa, and their numbers for Alberta were that in the next three years there's going to be 6,000 nurses that qualify for retirement. Will we have educated 6,000 in the next three years? No, nowhere near it. (Interview 7)

Part of the reason for a lack of new entrants to health professions was the decline in seats in post-secondary programs in the 1990s. This phenomenon is well documented in terms of the nursing profession in Canada. The CNAC report (2002, p. 11) suggests that while the Canadian population increased by 11 percent between 1990 and 2000, admissions to Registered Nursing (RN) seats decreased by 26 percent and the number of nursing graduates decreased by 46 percent. The number of Registered Psychiatric Nurses and Licensed Practical Nurses (LPNs) also decreased notably in this period. The loss of post-secondary seats in Alberta was related to the reduced demand due to lay-offs in the mid 1990s and the closure of Schools of Nursing in the province (Personal communication, Faculty of Nursing, Director of Undergraduate Services, April, 2004). Universities have also seen a decline in government funding in the last decade, which makes it more difficult to deliver programs. Although the government encouraged universities to increase the number of seats in 1999 through Access funding, there are concerns that they will still not meet demand.[9]

However, interestingly, both the CNAC report and all interview participants agreed that there was no shortage of interested students applying for programs. For example, the Faculty of Nursing at the University of Alberta received over 1,000 applications for approximately 140 spots in its Bachelor of Science in Nursing program last year (Personal communication, April 2004). A union representative added:

> [M]ost of the quota faculties have no difficulty filling those seats. They're oversubscribed by many multiples, you know, 10 or more applicants per seat, depending on the qualification. … In the mid 90s we did have a year or two where respiratory therapists … where I believe they had 40 seats in the province and used to have as many as 600 applicants for those 40 seats. (Interview 6)

Both the CNAC report and interview participants acknowledge that part of the difficulty with a significant increase in post-secondary seats is that many programs require clinical placements for students and sites for these placements are very difficult to arrange in a downsized system (CNAC 2002, p. 11). The fact that there is a scarcity of unpaid placements for post-secondary students does not bode well for the expansion of paid internships for high school students.

Workforce management issues

Interview participants from unions and the CNAC report discussed the increase in part-time and casual work, under-utilization of skills in the workplace, a decline in working conditions, and lack of professional development opportunities as factors affecting the recruitment and retention of workers in health care. RHA participants, on the other hand, referred to some strategies and programs that have been introduced to smooth the transitions of new graduates. We elaborate these perspectives below.

Livingstone (1998) notes that the percentage of employees in Canada who worked part time was more than 17 percent in 1994, representing a doubling over two decades. Lowe (2000) adds that involuntary part time workers increased six-fold around the same period. Part time and casual work can be described as *underemployment* when positions are lower paid, have less job security, poorer chances of promotion, inferior benefits, and lower status. CIHI data indicate that the percentage of RNs in Canada in 2001 that were working full time was 53 percent, part time was 34 percent, and casual was 13 percent.[10]

CNAC authors (2002) add that of the 26 percent of publicly employed nurses who worked part-time, 15 percent were involuntary part-time workers who could not find full-time work (p. 66). Authors express two concerns about part time work: first that it makes it difficult for the new practitioner to advance from novice to expert in a timely way, and second, that nurses may choose part time work to avoid the poor working conditions that accompany full time work (pp. 15-16).

Two representatives from RHAs in Alberta described the breakdown for the workforce overall in their regions as one third, one third, one third (full time, part time, casual) (Interviews 4 and 5). This is consistent with Alberta government statistics,[11] which indicate that of the 25,881 RNs employed by RHAs in December 2002:

- 24.6 percent worked regular full time hours
- 36.5 percent worked regular part time hours
- 4.4 percent were working temporary hours
- 30.5 percent were working causal hours
- 4.0 percent were taking a leave of absence

The proportions were quite similar for LPNs.

When asked if the proportions had changed much over the past ten years, a participant from a RHA replied:

P: It hasn't changed much over the last couple of years. What has changed is a demand for what I'd call higher part time jobs … sort of that .7, .8, .9.

A: Are there many people who would like full time work but can't get it, do you think?

P: I don't know about that. I guess, probably our target audience there would be your young grads. … It's probably a challenge for them to find full time work. (Interview 4)

Union respondents agreed that new graduates were most likely to be involuntary part time workers, but suggested that the increase in non-standard work has occurred less in response to employee demand and more in response to the organization of work by employers. For example:

> The employer has not been posting full time positions. … [S]ince the cutbacks in the 90s there's been very few full time positions posted. And even today when there is a horrendous nursing shortage, there are millions of dollars being wasted in nurses working overtime shifts. … If you talk to new grads, if you talk to students out there … full time

> positions are as scarce as hen's teeth. … [T]here are lots of people out there that want full time employment and they can't get it. They're working in these part time jobs. And then they're trying to pick up shifts here and there. And that creates a lot of angst, not knowing if you're going to get that extra shift this month and you've got a mortgage payment, you've got a student loan. (Interview 7)

Despite the argument by government respondents that most of the increase in part-time work in healthcare has been voluntary (Interview 9), a survey of 1,936 health professionals from 16 occupations in Alberta (Price Waterhouse Coopers 2002, p. 22) suggests otherwise. Their employment status was not by choice for 9 percent of those in full time employment, 14 percent of part timers, 23 percent of retired staff, and 39 percent of casual staff and volunteers. These findings suggest the extent of involuntary underemployment.

Although interview participants were not asked about the utilization of skills in the workplace, the CNAC report (2002) argues that maximizing the skills and productivity of those currently in the system would go a long way toward addressing shortages. For example, authors discuss the negative impact of high rates of overtime and absenteeism. RNs in Canada apparently work almost a quarter of a million hours of overtime every week (equivalent to 7,000 full time jobs every year) with the highest rates among nurses in Alberta (CNAC 2002, pp. 14, 65). At the same time, their absenteeism rate is 80 percent higher than the Canadian average (p. 14).

A union representative argues that overtime (and particularly the imposition of mandatory overtime by some employers) has contributed to the creation, ironically, of a very unhealthy workforce in health care (Interview 7). In the view of this participant, this environment makes it very difficult to attract and retain workers:

> The workplace is toxic and unless those problems are addressed, they will not be able to keep people. As I said, there's the huge bubble that's ready to retire. The new people that are coming along, they won't put up with the stuff that my generation has. … If you look at the stuff about boomers and x'ers, the stuff that they want out of life and out of their work life is different. They're not willing to say "work is my life," which is what a lot of nurses have done. (Interview 7)

Another union respondent agreed that morale was poor and added that workers in auxiliary nursing and general support positions were also frustrated because their scope of practice was increasing (e.g., LPNs) while their remuneration was not (Interview 8). From this perspective, the "pecking order" evidenced by employers' differential treatment of workers in professional versus paraprofessional job classifications and the resulting inequities across different groups of workers are also important to note and address.

The CNAC report (2002, p. 17) suggests that partly because of a reduction in support staff, nurses spend up to three quarters of their time on work that does not contribute to patient care. They conclude: "some of the shortages that afflict health care workplaces could be eliminated if nurses and other health care practitioners were permitted to work to their full scope of practice." These findings are consistent with data indicating that more than a quarter of workers with a university degree felt overqualified for their jobs (Lowe 2000, p. 93) and that the *performance gap* between educational attainments and actual technical job skill requirements in North America is extensive and increasing (Livingstone 1998, p. 82).

At the same time, the increasing use of paraprofessionals means that the scope of practice for different positions is being renegotiated, and to some extent, employee groups are pitted against one another. For example, a union respondent provides the example of registered nurses opposing

the introduction of LPNs in a particular site (Interview 8). An image of the healthcare workplace as a site of struggle between employers, government, unions, and professional organizations therefore emerges from interviews (and arguably represents an important area of learning for students in work experience programs).

Another area seen by union participants as important for retention was professional development. Respondents suggested that their organizations had worked to include recognition of the need for professional development and continuing education in recent contracts. One noted that another effect of cutbacks in the 1990s was the loss of clinical instructors who provided education to people in units (Interview 7). Similarly, the CNAC report (2002) suggests that a secondary effect of downsizing and budget cuts was the loss of manager positions such as chief nurse, head nurse, and clinical nurse specialists—staff whose roles included mentoring and educating. Authors suggest that nurses across Canada need more subsidized professional development and the ability to take time away from work to update their knowledge and skills.

Related to training in the workplace is the topic of accessing formal education required for advancement. In particular, do employers provide support for assistants to upgrade their skills through informal and formal education? The following exchange with a RHA respondent suggests that this may be limited:

A: Are there many opportunities to work your way up the hierarchy?

P: Not really … An example is the lab techs… you have a lab assistant 1, lab assistant 2, then you have a tech 1, 2, and 3. And you have a similar structure for pharmacy. The fact is you would have to be prepared to take the education program while still working in the lower classification but it's generally two union groups as well … so you can't just transfer along. … It's a lot more complicated and to a large degree the individual would have to take on most of that responsibility and accountability. (Interview 5).

A union participant concurs that if any of the auxiliary nursing groups need to advance their education it is usually "on their own time and their own pocket" (Interview 8).

Although the preceding discussion has focused on problem areas related to the organization of work, there are some indications that employers are responding to worker concerns in certain areas. For example, the 2001 salary settlement of 22 percent over two years gained by nurses in the province partly reflects an interest in retaining workers. In addition, two participants from RHAs referred to programs in their regions that were designed to facilitate the transitions to work of new job entrants. For example, to address the fact that graduates coming into a rural practice are often the sole professional, one region was looking at developing mentoring programs for OTs, PTs, SLPs where they would bring new employees into supernumerary positions for about a three month period (Interview 4). This RHA also partnered with an urban college to offer a rural delivery program for registered nurses.

Another RHA participant had also developed a "supernumerary graduate initiative and undergraduate nursing employee initiative" that allowed the organization to "over-hire and orientate new nurses and tap into that market when it's available" (Interview 5). This program reportedly helped the RHA to reduce vacancy rates for hard to recruit occupational groups by 50 percent. A union participant saw supernumerary programs as a good way to ease new graduates into the workforce (Interview 7). But apparently only a few regions offered such programs and the number of places was limited (Personal communication, United Nurses of Alberta, April 2004).

The preceding discussion suggests that simply encouraging more young people to pursue careers in health care is not sufficient. The reasons for "shortage" are multi-faceted and young people need to be aware of issues in the workplace. The following exchange with a union participant suggests that groups in the workplace as well as schools have a responsibility to young people:

A: So when you hear the regional health authorities saying we want to attract young people into health services and we're going to give them some work experience to do that, what's your response?

P: Well it's very odd isn't it? Like to me the right hand isn't too aware of what the left hand is doing, right? I think that's wonderful that they want to encourage young people to come into nursing and give them a taste of what's going around in the environment. And that's wonderful. Those people need to be supported. New grads need to be supported in the workplace and right now the work environment is very, very toxic. And the burnout rate and the turnover rate of new grads going into the workplace is horrendous. …

A: What kind of information do you think that young people entering the field need?

P: Well I don't think they really understand what they're getting into probably. … I don't want to discourage people from going into nursing. You want to encourage them but I don't want to throw young, bright people into a pit and see them drown. …

A: So it sounds like you are really saying that the workplace needs to change.

P: It does, it does.

A: So it's not just a case of training more people.

P: No, it isn't. So that's why I find it really difficult that regional health authorities would be putting any effort towards this when once they get them there, they treat them terribly. (laugh) (Interview 7)

Implications for high school internships

> So far, public policy has attempted to address some of the most visible problems that the changing relationship between the education system and labour markets have created in young people's transition to adulthood. … Far too little attention has been devoted to the quality of work that the next generation of workers will experience. (Lowe 2000, p. 105)

In terms of the health care internship, we argue further that too little attention has been devoted to the implications of the recruitment focus for the organization and outcomes of work experience programs for students, to the contradictions associated with this focus, and to the type of learning that would most benefit high school students. While we acknowledge that students and mentors alike expressed high levels of satisfaction with the internship program,[12] the preceding discussion raises questions about the organization and educative purposes of the internship.

We have demonstrated that the recruitment focus is problematic for a few reasons. First, all regions want to attract the best students, which translates into a program that effectively targets high achieving academic students, despite evidence that a range of skills and knowledge are needed in the workplace. As a school coordinator suggests, another approach would be for employers to ensure that placements and the selection process reflect a diversity of career pathways (Interview 3). The earmarking of a proportion of positions for Aboriginal students partially addresses equity, but as mentioned, providing support for these students is important.

Second, the focus on increasing the caliber and supply of employable students without attention to the implicit promise of student success in attaining post-secondary seats and employment is problematic. In this regard, more attention to articulation between high school and post-secondary

pathways and to tracking students is warranted. Third, the recruitment aim tends to overshadow other educational aims focused on the integration of work and school learning, the personal development of students, and an expanded understanding of the world of work. In the absence of such aims, an instrumental and functionalist approach to work education tends to be pervasive. Although students and mentors may not object to this approach, we argue that schools are more than "temp agencies" and educators need to be active partners in all stages of the process. In particular, educators must be concerned about equity issues related to access and to the "hidden curriculum" of work experience programs.

A fourth problem with the recruitment aim is that given our discussion of the multi-faceted reasons for shortages, particularly the various types of underemployment that exist in health care and other workplaces, strategies focused on increasing the supply of qualified graduates without attending to needed changes in the forms and quality of work will serve no one well. Our surveys suggest that young people are primarily interested in achieving satisfying work where they can use their knowledge and skills.

Finally, although we recognize that the health care sector is complex and do not pretend to have addressed the myriad of issues in the workplace, our discussion is intended to highlight the type of learning about work that could be promoted within such an internship. A union participant provides a sense of the kind of information that might be presented to students as follows:

> What has been happening within the particular field? Has the field been growing? I would suggest that they would be well advised to talk to someone like ourselves as far as what we've seen in the hospital sector. But also to the professional organizations—the regulatory body and the professional advocacy bodies—to talk about what they see as the growth potential for those areas. … [For example] it used to be that physical therapists worked exclusively in hospitals or in some publicly funded setting. But then in the early 80s you saw the ability of PTs to bill the government directly for their services. You saw a proliferation of private clinics. Then you get the 90s happening and you've got cutbacks, you've got government slotting the money that was available just for physiotherapy to now cover five different professional disciplines. … And I think students would be well advised to look at what kind of settings those professions would be used in. Are they private, are they public, are they unionized or not? (Interview 6)

Another union respondent agrees that students need such information about the field, adding that new workers tend to be vulnerable. Therefore unions should be more involved in offering students "insight into how you look after yourself" and what supports are available (Interview 8).

A commitment to providing students with a variety of perspectives including those of professional associations, unions, and government would require an expanded partnership. Currently, organized labour has virtually no role in the health internship.[13] If the intention is to develop healthy workers, promoting students' understanding of workplace issues and struggles--as opposed to sanctioning the existing "rules of the game"--must be a central aim of work experience programs.

Endnotes:

[1] CAREERS is an industry-driven foundation that was established with government and private sector funding in 1997. Its mandate is to facilitate partnerships between employers and schools aimed at enhancing school-to-work transition for students in communities across the province. It has also played a key role in promoting the registered apprenticeship program (RAP) by helping high schools to find employers for interested students and coordinating a pre-RAP internship.

[2] Our response rate was 73 percent or 155 of 214 mentors, which is excellent for a mail out survey.

[3] Our response rate was 53 percent or 143 of 268 surveys, which is excellent for a mail out survey.

[4] The gendered aspect of internships is apparent when we compare internships in female and male-dominated sectors and is a topic for further investigation.

[5] This method of evaluation is described both by students and mentors in focus groups and by a school coordinator (Interview 3) in two urban sites.

[6] The initial "P" stands for participant.

[7] While recognizing that nurses are not the only occupational group in health care, we accept to some extent the argument that "as nursing goes, so goes the rest of the system" since the regulated nursing professions make up over one third of the entire Canadian health care workforce (CNAC 2002, p. 3).

[8] Information related to number of RNs and LPNs per 10,000 population is available on the CIHI website (quick stats): www.cihi.ca.

[9] Alberta Health and Wellness indicates that the government approved the addition of 1,651 new first year RN training spaces to Alberta post-secondary institutions between 1999 and 2003. See website: www.health.gov.ab.ca/resources/stats_facts.html.

[10] This information was available on the CIHI website (quick stats): www.cihi.ca

[11] These statistics were available on the Alberta Health and Wellness website: www.health.gov.ab.ca/resources/stats_facts.html

[12] For example, our surveys suggest that 81 percent of students and 86 percent of mentors would recommend the experience to others (Taylor et al. 2003, Sabetghadem et al. 2003).

[13] In surveys with student interns, only 22 percent of the 72 percent who found a placement in a unionized facility indicated that they learned about the role and function of the union in the workplace (Taylor et al. 2003).

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