Letter to the editor in response to: "Interprofessional collaboration and healthcare costs: a brief literature review"

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Conflict of Interest Statement: None to declare.

In "Interprofessional Collaboration and Healthcare Costs: A Brief Literature Review," Diaz provides strong insight into how interprofessional collaboration (IPC) in healthcare can be a cost-effective strategy in different healthcare settings.[1] Diaz should be praised for looking at IPC from a utilitarian point of view as all Canadian provinces spend most of their fiscal budget on healthcare as of 2015.[2] Manitoba's per capita health expenditure is higher than the national average, spending approximately $7000 CAD per person.[3] IPC in healthcare is a complex phenomenon with various dynamics, practice- and system-level factors, and patient needs to be considered. It is more than co-locating practitioners. Here, I underscore two considerations for determining cost-effectiveness.

First, does the composition of the IPC team matter? When establishing IPC teams, should a physician be required? These questions become critical in Canada's rural and remote areas as only a limited number of healthcare providers exist in certain communities. The studies listed in Diaz's review may be indicative of physician centredness, as all of them had a physician as part of the IPC team. However, in rural and remote areas, physicians may be scarce and nurse practitioners may often be the primary source of care for several rural communities.[4] Therefore, it is not fully elucidated whether the composition of the IPC team makes a significant difference in health outcomes and cost savings for the healthcare system and patients. It is also not clear whether these findings are limited to urban areas.

Second, IPC is not a simple, distinct intervention. There are many ways IPC can be implemented, which may impact the extent of reduced healthcare costs. For example, a health centre in Slovenia implemented IPC by having physicians make the initial diagnosis for patients with the subsequent health plan including a more diverse IPC team as part of direct patient care.[5] Whereas, a clinic in Toronto used shared patient charts and interprofessional ward rounds to benefit from interprofessional expertise where it was needed.[5] These two examples use IPC in different ways, and one may reduce costs more than the other. To the author's knowledge, there has not been any study quantitatively measuring or estimating healthcare cost reductions when using different IPC models. It would therefore be of value to determine which processes may yield the greatest efficiencies.

The inclusion of interdisciplinary teams as part of healthcare reform contributes to improved health outcomes. However, the variability and differences from one healthcare setting to another must be considered to gain a better understanding of which methods may yield the greatest cost efficiencies without adversely affecting patient care. Cost-benefit analyses require more objectively defined and measured IPC processes and structures to generate evidence of efficiency and best practices for the future.

References

[1] Diaz F. Interprofessional collaboration and healthcare costs: a brief literature review. University of Manitoba Journal of Medicine. 2019;2(1).

[2] Barua B, Palacios M, Emes J. The Sustainability of Health Care Spending in Canada; 2016.

[3] Anderson K, Wasilewski B, Farrell P, Titeu A, Callery B. Primary Care Reforms in Ontario, Manitoba, Alberta, and the Northwest Territories A Rapid Review Prepared for the Canadian Foundation for Healthcare Improvement; 2018.

[4] MacLeod MLP, Stewart NJ, Kulig JC, Anguish P, Andrews ME, Banner D. Nurses who work in rural and remote communities in Canada: a national survey. Human Resources for Health. 2017;15(1).

[5] Mickan S, Hoffman SJ, Nasmith L. Collaborative practice in a global health context: Common themes from developed and developing countries. Journal of Interprofessional Care. 2010;24(5).

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