FOCUSSING UPSTREAM: THE ROLE OF MEDICAL EDUCATION IN ENCOURAGING DIVERSITY IN THE ORGANIZATION AND DELIVERY OF HEALTH SERVICES

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May 3, 2009

MacLeod Memorial Lecture
The Association of Faculties of Medicine of Canada Annual Conference
Edmonton, Alberta

Wendell MacLeod was a charismatic pioneer in social medicine and medical education. As first Dean of Medicine at the University of Saskatchewan, he taught that understanding the social, economic, and political world in which people lived was critical to good medical education and practice -- and made it the core of the curriculum. My words today, in honour of Dr. MacLeod, will hopefully carry on those worthwhile goals.

The theme of this conference is “diversity”. Diversity is a term that can be interpreted in a number of ways. I want to focus on the way Canada's healthcare system is structured, healthcare services are funded, and the implications for the next generation of health professionals.

My remarks today will focus on the need for diversity in the way you and your students deliver, and are paid for delivering, health care services. My remarks will also address the need for you, as medical educators, to train your students for this new world. As Wendell McLeod’s successors, like him, you need to ensure that your students understand the social, political and economic world in which they will live and work.

Let’s begin by talking about the structure of our healthcare system. We’ve taken an ‘all or nothing’ approach up until now: Medicare must remain structured exactly as it was when it was created more than forty years ago! Every attempt at change is met with emotional diatribes by people claiming to be friends of Medicare. It is as if the world of healthcare was frozen in the late 1960’s and should never be allowed to change. Imagine if you taught your students that the way they should treat their patients was exactly the same way patients were treated 40 years ago.

The Canadian healthcare system is essentially funded and structured in one way, even though individual provinces manage their own health care systems. This single approach -- with no diversity -- has polarized our country by pitting public against private health care, and has stalled badly needed progress.

I want to suggest that a little diversity in the way we organize and deliver health care services can help us address some of the growing concerns about the future of our healthcare system. Most importantly, a little diversity will help to get the change process started.

One of the things that most surprised me when I began my work on healthcare issues nearly a decade ago was the extent to which healthcare service providers – the medical team -- are closed minded about changes to the structure of the healthcare system.

It's not that they are averse to change. In fact, medical professionals are taught to be prepared to modify or change the way they perform procedures -- or adjust the drugs they prescribe -- to take into account new developments in the medical field. This is the reality of evidence-based practice in the 21st century and the culture of continuous learning in medical education.

So it's surprising to me how medical professionals can be so open minded and accept change so willingly with respect to their professional skills, while simultaneously being close minded to changes to the structure and funding of Medicare system itself.

Indeed, if I wanted to be facetious, I would congratulate all of you for having accomplished the extremely difficult pedagogical task of producing graduates who are so open minded in one part of their brain and so close minded in another. I realize, however, that this outcome is unintended. Nevertheless, it must change.

So my first request of you tonight is that you open your students' minds to the need for change in the structure of our health care system. Because the current system MUST change if it is to survive!

I realize that some of the things I am about to say – or have already said - may not be appealing to many of you. Nevertheless, they need to be said. I hope that they help you think a little

differently about some major health policy issues. In so doing, I believe I am fulfilling the objective of the Wendell McLeod Memorial lecture -- to provide you with a thought-provoking presentation at the start of your annual conference.

Some Facts on our Healthcare Structure

Let me begin by first making some observations about the nature of our healthcare system:

1. It is a service business that has traditionally been organized largely for the convenience of service providers and not for the convenience of the patients who are its customers. It is therefore NOT a patient-centered or customer-focused business;

2. Productivity improvements – which have been dramatic over the past twenty years -- have NOT been reflected in lower costs as they would be in any other business. For example, cataract surgery improvements which have taken place over the last two decades have not lowered the price of this surgery relative to other medical procedures. This is largely because fee increases for the medical profession are usually given as the same percentage increase for each procedure (or specialty) and, as a result, do not reflect productivity improvements. I suspect that this is done so that different medical specialties do not compete with each other for a buyer share of the financial pie. They all get equal shares in terms of equal percentage increases.

3. The primary changes to the healthcare system over the last 20 years have focused on how to reduce the costs paid by governments – but at the same time, spending on health care as a percentage of GDP has increased.

4. Consequently, because the focus has been on reducing, or constraining, input costs, measures of service quality do not enter the healthcare debate. Again, this would not be true for any other service industry. The quality of service provided by all doctors is not

the same. After all, fifty percent of your students do graduate in the bottom half of their class!

5. A consequence of this focus on input costs is that governments end up rationing the supply of healthcare services on the basis of how much they can afford -- not on the basis of actual need for service.

6. Finally, very little research has been done on more efficient ways to organize the system so that costs are constrained and service to patients improved.

What do these observations have to do with you as medical educators? The answer is that they have everything to do with you.

Your students will end up working in this industry. Indeed, they will become the leaders of this industry. Yet, you do not see yourselves as having the responsibility to prepare these future leaders for thinking about how to make the healthcare system work better for their patients, for the governments that fund it, and for themselves.

I believe that you have this responsibility. Your task is not just to produce well-trained technicians -- called doctors – but to produce people who can also help their industry to evolve.

I know that this is a radical idea to many of you. But it is one you must take seriously if you are to produce graduates who will survive and prosper as the industry evolves. It is also an idea with which Wendall MacLeod would strongly agree.

Examples of Challenges

Here are some examples of the problems caused by the current approach to organizing and funding healthcare.

If an ambulance arrives at an emergency department and there is no available space for the patient, then the ambulance waits until a bed is available. Consequently, that particular ambulance – and the trained paramedics -- are not available for other emergency calls.

In many cases, there are no beds in the emergency department because many patients there are waiting for an acute care bed to open up. And acute care beds are often taken by patients with long-term care or rehabilitation needs who are waiting for beds to open up in other facilities such as nursing homes. With this domino effect, patients in all these situations are using higher cost medical services than their condition requires. This is clearly extremely inefficient.

Another example that is very much on my mind these days as Chair of the Mental Health Commission of Canada is the percentage of people coming to emergency with a mental health or substance abuse problem.

While exact statistics are not available, a large percentage of the people showing up at emergency are having a mental health episode or substance abuse problem. The majority of these people don't require the specialized equipment and services of an emergency room. They could be treated in a less expensive and more expeditious way by an emergency facility targeted specifically for them.

For example, the Centre for Addiction and Mental Health in Toronto has its own emergency department. Police in Toronto who've apprehended someone with a mental illness know that they can hand over the patient in a matter of minutes -- rather than the hours it might take in a general hospital emergency department.

Such a simple change – if more widespread -- would significantly decrease overcrowding in emergency rooms and reduce emergency room waiting times. Again, this is not happening.

I’m sure you have your own personal examples of situations that just cry out for a fix – often a relatively easy fix.

What then are some of the things that can be done to improve the Medicare system?

I propose two significant changes, both of which would directly impact your students once they graduate. Therefore, you must explore these ideas -- and many others -- with them while they are still students.

Number One -- Funding

First, the fundamental way in which the healthcare system is funded needs to change. The system must become one in which the money is attached to the patient, not the hospital. I’m not talking about medical savings accounts -- but instead about eliminating hospital base budgets. I’m talking about making government funding to hospitals – and to private clinics – based on both clinical volumes and quality measures, with the volumes paid for as patients come to the hospital.

As long as budgets are allocated on an annual basis to institutions, the healthcare system will never become patient-centered. If the healthcare system doesn’t become patient-centered, it will never become the service business it ought to be -- and which Canadians deserve.

What happens today is that the patient is not viewed as a source of revenue, but rather as a consumer of financial resources which are fixed on an annual basis by the provincial government. Thus the patient is seen as a drain on those resources.

I strongly believe that the change to viewing a patient as a source of revenue would be the biggest single step to improve the quality and efficiency of the healthcare system. This is the

way all other service organizations operate. There is no reason that the healthcare system should not be the same.

Let me elaborate a bit.

With the change I am proposing, government -- as the insurer, the source of funds -- would purchase services from the most efficient -- and hence lowest-cost -- service provider who also meets established quality standards. We need to let go of the myth that the higher the cost, the better the quality.

For example, the quality needed for a specific service may not necessarily require the health professional with the most training. Nor does the service need to be provided at a tertiary hospital. It is ridiculous to do a tonsillectomy at a teaching hospital, with all its expensive overhead, when it could be done just as well, and a lot cheaper, at a community-hospital.

Our quality standards must also reflect the reality that higher-cost institutions, such as teaching hospitals, have an important role to play in dealing with challenging medical cases – cases which often cannot be handled in a community hospital.

The idea of having government buy services from the lowest cost provider, regardless of whether it is a public or privately owned institution, may seem radical. But let's remember that the original intent of universal Medicare back in Tommy Douglas's day was that government would be the insurer of the program – not the provider of services. Tommy Douglas, the leader of the Saskatchewan NDP Party, was the 'father' of Medicare, for those of you too young to remember! In its original concept, government would pay the bill, once the service had been provided. That is how insurance works.

The change I am proposing would significantly increase the number of specialized clinics providing high-volume services. Because of the high volumes, these clinics would be able to

provide services at a significantly lower per unit cost than the same service provided by a general hospital, since the facilities at the specialized clinics would only be those needed for that particular procedure or service – not the wide range of equipment and services that now must be provided at hospitals. This would save government money and thus help to constrain health care costs.

This should also help provide faster service to patients, but not if government continues to ration services. The government must meet the legitimate needs of patients, its customers. An insurance company doesn't say: "Well, we've paid for 1000 procedures this year and that is our limit. You are number 1001, so we can't fund you." That is not how an insurance company responds. Neither is it how government, as insurer of the system should respond!

It would also mean that government would be indifferent to who actually owns the clinics. Government would be concerned **only** with price and quality of the service and not whether the clinic was owned by a private corporation, a not-for-profit organization, or the public sector.

As you are likely aware, we already have healthcare pioneers who are successfully using this model. Just think of the Shouldice Clinic for hernia operations in Ontario. The Cambie Surgery Centre in Vancouver for orthopedic surgeries. And here in Alberta, we have the Gimbel Eye Centre, a leader in innovative use of technology for eye care.

One of the great myths of Canadian healthcare is that Tommy Douglas argued in favor of hospitals owned by the public sector. Nothing could be further from the truth. The objective of Medicare was to ensure that no individual would go personally bankrupt, or lose their farm – as he put it -- as a result of becoming sick and having to pay hospital or doctor's bills. That objective can be achieved entirely independently of who owns the service facilities.

Finally, consider the impact such a funding change would have on governments. Currently governments ration the supply of services by controlling the size of the healthcare budget. This rationing is largely hidden from the public because of global institutional funding. By moving to a service-based funding model, the public would be able to see the impact of rationing on the supply of services and therefore decide if they were prepared to pay higher taxes to reduce the rationing. Every poll ever done in this question has shown that Canadians would indeed be prepared to pay higher taxes for improved health care services. Unfortunately, the public is never given the opportunity to make this choice.

As you consider this, also consider how medical professionals might be trained differently in the future – training that must include more education about health systems and different healthcare models. Training that might teach healthcare professionals the skills and knowledge they need to become more entrepreneurial --- and also more collaborative in their working relationships with other healthcare professionals.

Number Two -- Measuring Outputs

My first proposal was about changing how we fund healthcare. The second change I am proposing is for the healthcare system to focus on measuring outputs rather than inputs.

As I said earlier, the only input that is measured now is money. That input is constrained and services are rationed as a result.

In a patient-centred system, the only measure that really matters is the quality of the service. That means what we provide to patients, as well as how we provide it.

Output measures will be critical as patients seek to get their healthcare services from facilities and individuals with the best record for quality and service. This, of course, is exactly what

happens in any other service industry when we look for a plumber or a carpenter or a computer technician who has a reputation for outstanding quality and timely service.

I realize that it may be offensive to some of you that I am comparing the provision of healthcare services with the provision of other services that we use in our daily lives. You should not be offended. I am not suggesting that healthcare doesn't require extremely well trained and highly educated professionals. Far from it. Fixing a damaged heart can't be equated with fixing a toilet.

However, the healthcare system needs to be structured so that it can achieve the organizational efficiencies that other service industries have gained over the last several decades. The key to achieving efficiencies is to create incentives that encourage service providers -- be they individuals or organizations -- to provide the most efficient service possible, consistent with high quality standards. Public accountability for the services provided must be built into the system because the service is publicly funded.

Organizational change cannot be directed from a central bureaucracy. The only way to successfully restructure the industry is to create incentives which will cause individuals, operating in their own self interest to make the kind of changes the system requires. We need incentives for both improving efficiency as well as quality. That is why, for example, family practitioners are moving towards being funded on a capitation model rather than a fee per service model.

We also need to ensure that individuals involved in the system are prepared to be open-minded about accepting changes that make the system more efficient and more patient-centred. That is where you come in. As educators of the next generation of physicians, you have an obligation to expose your students to some of the challenging business issues they will have to face in their careers.

In addition to these two major comprehensive changes – a new funding model and a shift to measuring outputs -- there are also three other issues that I would like to mention:

1. The shortage in human resources;
2. Including public input in scope-of-practice rule decisions; and
3. Further education needs for your students.

Human Resources Shortages

We all know that one of the biggest problems facing the healthcare system is a shortage of human resources, especially doctors and nurses.

One of the principal causes of the current shortage was a decision made by governments over two decades ago to reduce enrollment in medical and nursing schools. This decision was based on one recommendation of a set of more than two dozen recommendations in a report commissioned at that time. The fact that a single recommendation was acted upon -- while many others were ignored -- combined with the fact that the recommendations were all interrelated -- is the root cause of our current shortage.

In recent years, the creation of new medical schools, the increased enrollment at established schools, and the improved opportunities for international medical graduates to get licences are helping solve the shortage problem over the long-term.

There are, however, two other reasons reason why we are experiencing human resource shortages: the barriers put in place by rigid scope-of-practice rules and 'credential creep'.

The healthcare professions control their own scope-of-practice rules and the credentials required to be licensed to undertake certain tasks. As is true with all self-regulating organizations, this power gives them a monopoly, and ensures that the decisions which are

made are in the interest of the monopoly. In no other area of public or private endeavor would this type of unregulated monopoly power be acceptable.

While I am not opposed to organizations regulating themselves, I do become concerned when the power seems to be abused or when 'credential creep' seems to be taking place. Consider, for example, the nursing profession. Years ago nurses were trained primarily through three-year nursing programs at qualified hospitals. This was replaced about 20 years ago by the need for a registered nurse to have an undergraduate bachelor of nursing degree.

Are patients treated by these nurses significantly better off as a result of these increased professional standards? And if they are better off, does that benefit actually outweigh the costs of training nurses for an extra two years? And how many potential nurses have we lost as a result of the increase to a five-year program from a three-year program? Healthcare educators such as yourselves need to take the initiative to explore answers to these questions.

With regard to scope-of-practice, only very recently has there been an agreement to start allowing nurse anesthetists to be trained and licensed in Canada. Such professionals have existed in other major industrialized countries for years.

Looking at this issue from the outside, as a policymaker, one must ask why it took so long for this category of professionals to be approved in Canada. The answer, of course, is that power rests with those who control scope-of-practice rules and that control is inevitably used from a position of self-interest.

A similar situation existed not long ago with respect to nurse practitioners. They too were restricted from providing services due to scope-of-practice rules which gave exclusive authority to family physicians. Thankfully, that issue has been resolved and nurse practitioners are beginning to provide a very useful service, particularly in primary-care group practices across the country.

Include Public Input

I think there is a role for self-interest in self-regulating groups, to ensure the profession's standards. But I also believe that major healthcare decisions must involve a broader perspective than just the individuals who are working in the system.

Should control of scope-of-practice rules remain exclusively the domain of each profession – or should some kind of public input be involved too? I urge you to have the various medical specialties review this possibility.

Let me remind you that only a few years ago, malpractice cases were heard exclusively by members of the profession. There was no public involvement in these cases. This process has changed so that there are now public interest members on malpractice panels. This has improved the process without weakening the ability of the profession to regulate itself. The same should be true for the scope of practice and credential decision making process.

I urge you to review scope-of-practice rules and the credentials required to perform certain procedures and services to ensure that they stand up to scrutiny in a patient-centered system and to ensure that decisions that are made are in the public interest, not just the professions interest.

Further Education Needs

I further believe that healthcare educators have a role to play to ensure that future members of the healthcare professions are open to change -- not wedded – or should I say – 'welded' -- to the status quo because they are familiar with it, comfortable with it and it serves their needs. I will leave you to ponder what type of education would best achieve that outcome. This is in

addition, of course, to increasing cultural sensitivity training and other kinds of training to accommodate our increasingly diverse population.

In my position as Chair of the Mental Health Commission of Canada, I would be remiss if I did not raise your consciousness about education and training issues that need to be addressed with respect to mental health. Just as we need cultural sensitivity training to keep up with Canada's growing multicultural population, the healthcare professions also need more training to address the needs of those with mental health problems.

Now, I'm not talking necessarily about academic training. In the mental health field, there are a number of psychologists who are currently arguing that no one should be allowed to practice as a clinical psychologist without a Ph.D. degree. Frankly, nothing could be more absurd.

The quality of work being done by psychologists with Master's degrees appears to be more than adequate. There have been no studies that indicate a need for more academic training for psychologist involved in what is typically called 'talk therapy'.

In fact, research shows that the successful outcome of talk therapy depends most on the quality of the relationship between the client and the therapist – not on academic learning. And, as someone with a Ph.D. myself, I can tell you that there are lots of people with Ph.D.'s who have trouble relating to people. I hope that the psychologists idea dies a quick and silent death.

At the same time, I support recent efforts in Ontario to establish standards for psychotherapy practice apart from credentialing. The *Health System Improvements Act, 2006* became law on May 31, 2007. It deals with a number of important regulatory issues:

1. the creation of a College of Psychotherapy to regulate the practice of psychotherapy and to set standards of practice.

2. It identifies who can refer to themselves as a "psychotherapist" and "registered mental health therapist" in Ontario.

3. The Act sets the practice of psychotherapy as legally deliverable only by those registered in the Colleges of Medicine, Nursing, Psychology, Occupational Therapy, or the new College of Psychotherapy. The Act will allow social workers to practice psychotherapy, although this part of the Act has not yet taken effect.

4. The Act expands the "harm clause" in the *Regulated Health Professions Act* to protect patients from serious bodily harm -- which would include "psychological harm" when receiving health treatment or advice.

In addition to these regulatory changes, there is a real deficiency in the training that family physicians receive with respect to mental health and mental illness. Nearly 80 percent of individuals with a mental health problem have their first contact with the healthcare system through their family physician.

Family physicians are the front line of the mental health system. In that capacity, they need to receive more training in how to diagnose and how to refer patients to the right service provider for treatment. The responsibility for this lies directly with medical educators.

Let me stress that I am not blaming family physicians for their lack of training in mental health. The weakness stems from the lack of attention to mental health issues in the current education of family practitioners. I believe that one reason for this is the stigma that Canadians, as a whole, have about individuals with mental illness.

Several centuries ago, the medical profession severed the head from the body and the amputation exists to this day. ‘Real doctors’ look after physical illnesses -- those from the neck

down. Other healthcare practitioners, called psychiatrists -- regarded by many of their colleagues as not ‘real doctors’ -- look after problems from the neck up. This era of mind-body dualism, as described by Rene Descartes, must end. It’s time to lay Descartes on de table!!

As we are discovering, the head and the body are closely connected. We know, for example, that if an individual remains depressed a year after having his or her first heart attack, the probability of a second heart attack is dramatically higher than if the depression was treated.

I realize changing the curriculum for family doctor training will be a challenge and very slow to implement. As a former professor, I know that nothing moves quickly in academic life. But I urge you, as medical educators, to seriously consider changes in the way family practitioners are educated. It’s essential that front-line workers in the fight to improve the mental health of Canadians be adequately trained for the task.

I also think it’s important that the issue of stigma be addressed as part of the medical school curriculum.

When I began working on the mental health problem, some four years ago, I assumed that healthcare professionals would regard a mental illness in the same way as any other illness. That health care professionals would not have the same attitudes towards mental illness as other Canadians. That healthcare professionals would help in the battle against stigma and discrimination.

Unfortunately, this is not the case. Surveys in a number of countries indicate that healthcare professionals have the same discriminatory attitudes toward people with mental illness as the general public. For example, a recent survey in England showed that just about half of the individuals who went to their family doctor because of a mental health issue felt discriminated against by the family doctor. Similar results have been obtained in other countries.

Here in Canada, our Senate committee heard from doctors who said that they would never tell colleagues if they suffered from a mental illness because they feared their colleagues would look down on them. Indeed, a survey in 2007 showed that two thirds of all psychiatrists in Michigan would treat themselves off the record rather than run the risk of having their medical records show they had a mental illness.

When the Mental Health Commission launches its anti-stigma campaign later this year, our initial focus will be targeted at two specific groups: one will be healthcare professionals. It's simply unacceptable for individuals with a mental illness who seek treatment from the Canadian healthcare system to suffer stigma and discrimination because of the nature of their illness. We need to get healthcare professionals out of the dark ages. Again, I believe that part of the responsibility for doing this rests on your shoulders.

Take Care of Yourselves

The second mental health issue I want to raise with you today concerns your own mental health and the mental health of your colleagues. Two statistics illustrate the depth of the problem.

The profession in Canada with the largest number of individuals suffering from stress, depression and other mood disorders is nursing. Clearly the way the system is structured -- and the unreasonable demands placed on nurses -- are having a significant impact on their mental health. Yet no one is doing anything about the problem!

Doctors too are not immune to mental health issues. A British Columbia study estimated the annual incidence of physician suicide from 1991 to 1998 at 21.9 per 100,000 -- versus the general population suicide rate of 13.8 per 100,000. In other words, the suicide rate among doctors was almost fifty percent higher than double that of the population as a whole.

The fact is, healthcare work is very stressful. But healthcare professionals who become sick and take time off -- or who, in the extreme, commit suicide -- are making an already challenging human resource issue even worse, to say nothing of the tragedy posed on the individuals and their families.

It is therefore essential that the profession undertake research to understand the causes of the mental health problems in the profession and what can be done to eliminate them. You owe it to yourselves and your colleagues to address this issue on a priority basis.

A start has been made. I was delighted to see that last year's annual meeting of the Canadian Medical Association passed a series of resolutions to increase the focus on mental health in the medical education curriculum and to recognize mental health issues being experienced by its members.

The Mental Health Commission would be more than pleased to work with healthcare educators to help address these issues. We regard this as a high-priority item.

Conclusion

In conclusion, let me return to where I started. The current structure in funding for the healthcare system is not sustainable in the long run. The Senate committee reached that conclusion seven years ago. The situation has become worse since then.

We have too many reports gathering dust on the shelves. Your profession must show a willingness to accept change in the way that healthcare system is organized. You yourselves must take the initiative to change scope-of-practice rules so that simpler procedures can be done by individuals with less training. You must improve the training for front-line workers in mental health. You must recognize that your members are not immune to mental illness and you must start to address the stresses related to the profession.

I realize these initiatives will be challenging. They will be resisted by individuals who say they are in favor of progress but are really opposed to change. They will be resisted by individuals who believe that only physicians should have input into the organization of the healthcare system.

Your willingness to accept change is absolutely critical. Because of the enormous political pressure which results from a withdrawal of services by healthcare professionals -- particularly doctors -- your profession has, in effect, veto power over any major system change.

While I understand your self-interest, the long-term survival of the healthcare system which Canadians know and love depends on you. I very much hope that you can train your students to accept this challenge. Tommy Douglas and Wendell MacLeod would want that too.

Thank you.