Looking ahead: shifting tides

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This month, my second last as Executive Director and CEO, Vital Signs will focus on some of the current and future challenges facing Canada's health care system, family medicine, and the College.

Family medicine has a firmly established and important place in Canada's health care system. With about 40% of all first-year residency positions in Canada's 17 medical schools being in family medicine and slightly more than 50% of the medical doctors in the country being family physicians, our specialty plays a vital role in academic medicine and in practice. Canadians consistently report how highly they value having family doctors—their greatest concern is the difficulty they can have finding one or gaining access to timely appointments (a situation at least partly the product of 2 decades of poor physician resource planning, but one that is improving in many communities).

Family physicians are essential to primary care in Canada, but they are also important providers of secondary and tertiary care—a fact often ignored and underestimated by those who identify family doctors solely with primary care or consider family physicians to be interchangeable with other important first-line providers. Family physicians are fully trained medical doctors able to carry out a complete differential diagnosis and medical workup for every problem presented to them. Their 6 to 7 years of medical education and training enables them to provide the care, or to refer and then understand and support the more advanced levels of care, needed by their patients.

Starfield et al showed that those with the best access to comprehensive continuing care provided by their primary care physicians had the best health outcomes.[1] For years Canada was at the top of the list for access to family physicians and for health outcomes. It is likely not just a coincidence that slippage over the past decade in the health outcomes of Canadians has paralleled the difficulties in accessing family physicians. Keeping both family medicine and Canadians healthy long into the future are priorities for our nation that should be addressed hand in hand.

Changing practice

To meet changing population needs, scopes of practice have continuously evolved within every medical specialty and health profession. These changes have usually been accompanied by resistance within and tension between the professions. This generation is no different. And what is happening in Canada is no different than what is occurring in other countries, where overlaps in scopes of practice have created competition for patient care, rather than the desired collaboration among the professions and enhanced access for patients.

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Expanded scopes of practice need to be better understood for what they are—the addition of 1 or more defined services to those already approved as the core services that can be provided by a given health professional. But those in any given health profession who have been approved to offer expanded services as part of their practices have not suddenly acquired the entire compendium of knowledge and skills of another profession and should not be allowed to present themselves to the public in any way suggesting such. Patients need the care and services that can be contributed by many different health professions, but they need to have them working together in strong system-supported teams, not in competitive silos.

Misgivings related to overlaps in scopes of practice should not be limited to what is unfolding between physicians and allied health professionals. There should also be concern regarding the tensions developing between physicians who acquire added competencies to provide services that are also provided by other medical specialty colleagues. Just as expanded scopes of practice do not make pharmacists or nurses into medical doctors, they also do not make family physicians with added surgical skills into specialist surgeons or general internists with added mental health competencies into psychiatrists. To achieve standing as fully qualified specialists in these areas in Canada, one must first complete residency training in the given specialty area and then successfully pass the certification examinations of the Royal College.

Research shows that while the services of other health professions are of value, it is the continuity of care provided by personal primary care or family physicians that results in the best population health outcomes.[1]

To produce these outcomes, however, family physicians must provide their patients with a comprehensive basket of medical services, using all the diagnostic and procedural knowledge and skills they acquired in achieving their medical degrees. How family physicians are trained, how they maintain their knowledge and skills, and what they decide to include in their practices determine the value they can and will offer the people of Canada. Patients need family physicians who incorporate the 4 principles of family medicine into their practices, including being a skilled clinician.

The CFPC offers Certification in one specialty in Canada: family medicine. The next decade will likely see the College offer increasing opportunity through residency or practice-eligible routes for family physicians with special interests or focused practices to earn certificates of added

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competence in defined clinical areas. But such certificates are not primary certifications or specialty designations. Our College's main responsibility and accountability is, and should remain, to train and produce family physicians who provide comprehensive continuing care. Enhanced skills in given areas can add to the value offered by these family physicians, but that value will be lost if too many end up in practices focused *only on providing care in the area of special interest.* We need most family physicians to incorporate enhanced skills within broad-scope practice. One of the main objectives clearly enunciated by the CFPC Board in approving a new section for those with special interests was to have our College play a more active role in reversing the trend of too many family physicians practising only in areas of special interest. To achieve this, others beyond our College, including licensing bodies, hospital privileging boards, and medical schools, must do their part. Medical school appointments and promotions in defined clinical areas should be offered to family physicians with special skills in these areas while encouraging them to maintain broad-scope community practices. Hospitals that demand full-time commitment from family physicians seeking hospitalist or emergency department appointments must reverse these policies, enabling these physicians to maintain at least part-time community-based family practices.

One of the best solutions for concerns about changing scopes of practice is team-based care, where family physicians with comprehensive scopes of practice work together with family physicians with special interests to provide the full basket of family medicine services. The CFPC's Patient's Medical Home (PMH) vision embraces this approach. Many new models of primary care now emerging throughout Canada incorporate some of the PMH recommendations. If supported by all key stakeholders, the PMH vision offers Canada an opportunity to meet the goals of the Institute of Healthcare Improvement's Triple Aim Initiative (quality patient care, healthy populations, and a cost-effective system)[2] and to become a world leader in access to timely, effective, well-coordinated primary and secondary care.

While physicians will continue to be essential to team-based primary care, the ultimate success of these newer models will depend on effective interprofessional teams, with central roles for nurses and other allied health professionals. In 2008 the CFPC Board approved a position statement that envisioned each person in Canada having access to a family practice where he or she would have *both* a personal family physician *and* a nurse, plus access to other providers as needed. This vision has now been expanded into the PMH concept. The goal is to improve access to care for the populations being served by supporting family doctors and nurses to work collaboratively within patient-centred family practices. These models should be strongly supported as the future for family practice in Canada.

Education, training, and lifelong learning

Canada's 2-year family medicine residency is by far the shortest training program in the developed world. Most other developed nations have 3- to 5-year programs, with opportunities for enhanced skills training either within the core training period or in an added interval following it. Changes are coming, though, as many disciplines around the world are shifting from time-based to competency-based training. Canada—and the CFPC and the discipline of family medicine—are at the leading edge of this movement. Residents—indeed all seeking Certification in family medicine—will have to demonstrate competence in a menu of clearly defined areas. Competencies will be defined for both core family medicine and enhanced skills areas.

In addition to ensuring that the family medicine residency curriculum includes opportunities for residents to acquire competence in the traditional core elements, there is also a need to focus on areas that have not always been priorities. Every family medicine graduate should be at ease with electronic medical records and the appropriate use of social media. With advances in areas like genomics, pharmacogenetics, and personalized medicine, patients will have to make more ethically challenging health and life decisions, and will often need the expert advice of a trusted medical caregiver—usually their family doctors. Family medicine residency and continuing professional development (CPD) programs must provide opportunities for family physicians to become skilled and knowledgeable in these areas. Medical school curricula and postgraduate family medicine training programs in Canada must also focus on the care of populations, the needs of our aboriginal peoples, and the critical role of the social determinants of health. Family medicine must become a central part of Canada's public health system. Be it related to immunization, management of infectious disease outbreaks, or prevention of chronic diseases, the barriers that currently exist between public health and family medicine must be broken down. The place to start building this role and capacity is at the undergraduate medical school and residency training levels, where acquiring the knowledge and skills related to these responsibilities should become core requirements.

In keeping with the new Triple C curriculum, all family medicine residency programs in Canada will now be required to ensure *comprehensiveness* and *continuity* of care and education, and every experience must be *centred in family medicine.* A psychiatry experience must focus on training a future family doctor, not a future psychiatrist. When possible, clinical experiences should be in family practice settings. Clearly defined core competencies will also mesh with the CanMEDS–Family Medicine roles. This focus on competencies and roles will become integral to the examination and practice-eligible pathways to Certification in Family Medicine (CCFP), and to Mainpro and the Maintenance of Certification programs.

Triple C will also challenge residency programs to carry out ongoing assessments of resident competencies throughout their residency training and to provide timely opportunities to address shortfalls. While most residents will meet the requirements within 2 years, some might need extended training periods. Supervised practice-based postresidency experiences (like apprenticeships) might have to be developed, with medical regulatory authorities (MRAs) providing defined licences for these physicians while they work toward acquiring all of their core competencies and achieving CCFP. Some believe that *all* family medicine residents—not just those who need remedial attention—should have to complete at least 1 year in practice after residency before being granted CCFP. An interval in practice might also be considered as a requirement to be accepted into an enhanced skills training program. Other stakeholders, including medical students, residents, medical schools and faculty, MRAs, and system funders, must all be consulted before decisions regarding this can be made.

The CFPC will continue to play a key role as a standard-setting and accrediting body for both residency training and continuing medical education and CPD, and as the certifying body for the specialty of family medicine. Those who successfully demonstrate that they have acquired the core competencies required of family physicians will be awarded Certification, which they must maintain throughout their careers by meeting the CFPC's requirements. Currently, MRAs across Canada will grant a physician a full unrestricted licence if he or she meets several criteria, including achieving certification from the CFPC or the Royal College. Commitment to CPD throughout a physician's career is vital. It is time for the MRAs to make Maintenance of Certification a requirement for maintenance of an unrestricted licensure.

With 70% to 80% of health care services in Canada delivered by family physicians in primary care settings, there is urgent need for leading-edge research on the effectiveness of front-line medical care—particularly in areas such as prevention and chronic disease management. The Canadian Primary Care Sentinel Surveillance Network has more than 300 family physicians providing invaluable information about chronic disease. The Public Health Agency funding for the CFPC to oversee this initiative should be renewed, and family medicine residents, training programs, and practising family physicians across Canada must see substantially increased support for their research endeavours.

Physician and health human resources

Shortages of physicians, nurses, and other providers in the past decade precipitated the formation of various health human resources (HHR) task forces. The CFPC and each of these task forces recommended that a national HHR oversight body was needed to prevent future shortages. Despite this, little has happened. Nowhere was the HHR shortage more acutely felt than in family practice, where a high proportion of Canadians without family physicians created long wait times for appointments and referrals, and negative effects on population health. While some strategies have been implemented to avert a recurrence, we still do not really know how many doctors and nurses we need for the next decade or where they are needed. We do know that any future HHR strategy must do better in preparing physicians to meet the needs of our rural, remote, and most vulnerable and underserved populations.

Political winds

Nothing stirs the emotions of Canadians like a debate over private versus public health system funding. While to date Canada has been less affected than some countries by the downturn in the world economy, it has not been spared. The resultant pressures on governments to sustain commitments to publicly funded programs in health, education, and social services have been immense.

Despite this, suggestions that we need more open public debate on the future of Medicare, the *Canada Health Act* (CHA), or the options for paying for health services are viewed by some as an affront to our sensibilities. Dialogue about how best to pay for health care in Canada, including consideration of private payment, needs to happen if for no other reason than to help Canadians better understand Medicare. Most Canadians passionately defend our Medicare program, believing it covers all their needed health services and that it is the best system in the world. The truth is that it falls far short. While Canadians are assured of public coverage for all their medically necessary services provided by doctors and hospitals, only about 70% of overall health care expenses are covered. Citizens of many other countries actually receive more publicly funded support—up to 90% in some nations of all of their health care expenses including doctor and hospital bills as well as prescription drugs and home and dental care. Is it not time for this kind of option to at least be discussed in Canada? Might a somewhat lesser amount paid publicly for doctor and hospital services (with total coverage maintained for the most vulnerable), but more paid publicly for dental and home care and drugs for everyone, result in improved health outcomes for all Canadians? Might the preventive care benefits of providing broader coverage outweigh the costs? Is there a political party brave enough to openly debate this? Should the CFPC, which has staunchly defended universality and the single-payer, publicly funded tenets of the CHA, not advocate for a more open public debate, including a full analysis of the effects of other options on preventive care and health outcomes? And if the evidence confirms it is unaffordable for a single public payer to cover 100% of the costs for all necessary services, and that having a small percentage of these costs paid privately by those who can afford it would result in a broader range of publicly funded services and better health outcomes for all, should the CFPC not be supporting a move in this direction? While strongly

supporting Medicare and the CHA, might the CFPC also encourage amendments enabling introduction of limited other sources of payment that might result in access to a broader menu of publicly funded health care services for all?

While the debate about who pays for what will continue, the federal government has been moving to decentralize responsibility and accountability for health care to the provinces and territories. The Prime Minister's (PM's) political dexterity was demonstrated earlier this year when he moved swiftly to ensure there would be no repeat of the drawn-out federal-provincial-territorial First Ministers' haggling that led up to the 2004 to 2014 Health Transfer "Accord" (which resulted in billions of dollars moving from the federal government to jurisdictions throughout Canada, but with little accountability from the provinces for how the money was spent). The PM decided not to repeat these fruitless debates. Instead he simply announced how much money will flow to the provinces and territories from 2015 to 2025 and assured the Premiers that there will be no federal government strings attached. The Premiers realized they would have to be accountable to one another and to the people in their jurisdictions, leading to a flurry of activity by the Council of the Federation (COF) (ie, the Premiers and their designates) to show the public that they can do this. They have completed some early work, but it remains questionable that they will be able to ensure standards of care for all Canadians over the long haul.

If this experiment fails, the price Canadians will pay will be the further erosion of health care standards and equitable access to high-quality care for all, regardless of where they reside in Canada—ie, the dismantling of what has, for many, defined Canada. The COF is not a government. It is a gathering of government leaders with no responsibility or authority beyond their own jurisdictions. The political imperative for the Premiers will be focused on satisfying those in their own jurisdictions, with re-election always in mind. These needs will remain paramount and will at times supersede doing what is best for *all* Canadians. Provincial and territorial leaders are already overly consumed with making their own ends meet—they do not have the resources or the infrastructure to address problems affecting the nation as a whole. The work that needs to be done for the COF to ensure that health care standards for all Canadians are set and met will therefore not likely be sustainable. We need a strong central government that continues to take pride in protecting access to care for every Canadian and that establishes and monitors national standards, taking action when provinces and territories fail to meet them. The provinces and territories should be responsible for the delivery of services within their own boundaries, but they should not be responsible for the standards needed to ensure equitable access to high-quality health care for every Canadian. The PM's announcement of the funds that will be transferred through 2025 was a good move, but it should have been accompanied by the federal government defining a more forceful future role for itself as the standard setter for the health care of our nation. The CFPC leaders recently shared our concern about the growing absence of the federal government in health care when we met with elected Members of Parliament and appointed officials in Ottawa. The College should continue to advocate for a strong central government role.

Even if there are limits to the diminution of federal authority and accountability, the shift toward decentralization will not stop. The CFPC must prepare for this with its own internal shifts that will further strengthen its Chapters across Canada. Each Chapter must have the resources to act as provincial advocates for family medicine, family physicians, and the patients of family physicians in their jurisdictions. The CFPC centrally must continue to be the standard setter for education, training, Certification, and lifelong learning for Canada's family doctors. It must be the voice of family medicine that is clearly heard by the federal government and by national sister medical and health care associations. It must be the body that unites its parts—its Chapters and the university departments of family medicine—to ensure that the discipline and practice of family medicine are progressing cohesively across Canada. The challenge for the CFPC will be to support and strengthen its Chapters while not abandoning the responsibilities that only a national standard-setting body can achieve. The federal government's approach should not serve as the CFPC's model.

For the future

There will be many substantial challenges facing Canada's health care system, the discipline of family medicine, and family physicians over the next several years. How our profession deals with changing scopes of practice for both family physicians and other health professionals; the role within the College for family physicians with special interests; the introduction of the PMH model and patient-centred, team-based care; the implementation of competency-based training; the need for the CFPC to strengthen its Chapters; the debate regarding affordability of our single-payer, publicly funded system; and shifts of authority for health care from the federal to the provincial and territorial jurisdictions are all issues that will demand CFPC attention. Practising family doctors, family medicine teachers and researchers, medical students, family medicine residents, other allied health professionals, and patients will rely upon the CFPC as a lead voice in addressing the unfolding challenges. These stakeholders must not only hear the CFPC's voice, they must be partners in all the College's efforts.

As we head into 2013 and beyond, the CFPC is well positioned to play the leadership role expected of it in the future of medical education for family physicians and the delivery of high-quality family practice services for Canadians.

References

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