Rehabilitation, Respect, Relevance: PT in Tomorrow's Health Care World

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Goals for Presentation

- To explore major contemporary trends in health care
- To discuss possible implications for the profession
- To identify options for how to adapt/respond to emerging trends
- To explore the risks and benefits of various options

Part 1

Health Care Trends: Big Ambitions but Will They Be Realized?

Health System Goals

- Patient-centred, holistic care
- Better quality
- Better value-for-money (VFM)
- Reduced disparities between population groups
- More effective prevention and chronic disease management
- Integrated, effective primary care
- Interdisciplinary collaborative practice
- More self-reliant, health-oriented public

The Gap Between Ambition and Performance

- Unfulfilled big promises (Triple Aim of better care, better population health, better value for money)
- Primary care remains largely physician-driven and FFS payment
- Persistent quality and safety problems
- Uneven progress on access

History Is Not Destiny

- Primary care innovation in pockets and notably Ontario (FHTs, health centres, rostering)
- Spending has flatlined - down 1% per capita per year (real) in last 3 years
- Choosing Wisely campaign now in Canada - aims to reduce unnecessary procedures
- Obamacare succeeding despite opposition and implementation glitches

Cultural Problems That Impede Innovation and Improvement

- Incomplete, unconnected, and untimely information systems
- Accountability for performance is diffused and weak
- Lack of comprehensiveness in public system - 30% privately financed, very high by OECD standards
- Public preoccupied with access, not quality
- Relationships among professions
- Regulation lagging realities of workplace and work force

Consequences of Cultural Norms

- Major variations in practice
- Evidence and tradition often conflict
- Funding and payment mechanisms incompatible with system goals
- Little analytic information available to practitioners
- Focus continues on “downstream” concerns (elective surgery, diagnostics)
- Hierarchy, turf, wariness, disrespect

Appropriateness: The Next Frontier

- At some point society gets diminishing returns from additional volumes of services
- Canada lags behind in capacity to track outcomes over time
- When wait times shorten and capacity increases, the threshold for intervention tends to lower
- If we do not tackle the appropriateness issues we will spend more money for little added value
- Some people will be harmed by overmedicalization of the human condition

Part 2

PT in the Context of Canadian Health Care: The “In”, the “Out”, the Challenges

Rehabilitation: Medicare's Orphan?

- Not identified as a core service by Canada Health Act
- Publicly financed in acute care but essentially privatized elsewhere
- Aging population needs services to improve function and quality of life (often rehab)
- Medicare remains focused on hospitals and doctors
- Creates both threats and opportunities for PT

Why the Workforce Looks Like It Does

- Regulation gave major boost to safety in early part of 20th century
- Increased complexity of health care led to increased specialization
- Expansion of scientific knowledge created impetus for longer educational programs
- Intrinsic societal belief in more education, higher credentials
- Turf = control = power = money

Is the Contemporary HHR World Compatible With System Goals?

- High degree of specialization a challenge to holistic, integrated care
- Professions develop distinct theories and cultures of health and health care which risks fragmentation
- Increasing entry-to-practice credentials makes workforce adjustments long and difficult
- Entrenched hierarchies and power inequalities
- Battles over scope of practice and gatekeeping role

Implications for the Work Force

- The comeback of the generalist, especially in primary care?
- Less autonomous practice, more teamwork
- Greater emphasis on communications, coaching, behaviour modification skills
- More fluid division of labour among occupational categories
- Quest to replace more expensive labour with less expensive labour

Potential Government Responses

- “Credential creep” fatigue – the higher credentials aren’t creating a better system
- Shift locus of health science education to colleges from universities
- Expand scope of practice of technicians and aides
- Explore interprofessional training, team-based practicums
- Pressure to include more systems thinking and quality improvement in curricula

Part 3

Reinventing the Health Care Future: Playing a Major Role on the Policy Stage

Challenges for PT

- Difficult to speak with one voice
  - Publicly insured public providers
  - Entrepreneurial private sector providers
  - Spread out among hospital, LTC, community care, WCB, employee benefits clients
- Service valued but without the urgency of cancer care or the focus of single disease organizations
- Perceived as a “nice to have” more than “must have” (with exceptions such as WCB)
- Academic cohort smaller and less prominent than other professions

Part 4

Stepping Up to the Health Policy Challenge

Health Care Policy Is a Crowded Field

- Many constituencies want to influence the nature and direction of health care:
  - Politicians
  - Professional interest groups
  - Public and patient groups
  - Industry (drugs and devices)
  - Health care organizations
  - Media

What Makes Some More Influential Than Others?

- Power and size (CMA, to some extent CNA)
- Public credibility
- Effective communications
- Ability to articulate a case the public can relate to
- Understanding of governmental processes, pressures, challenges
- Ability to transcend one's own interests to make a strong public interest argument

What Makes Professions Powerful?

- Providing high profile service (police)
- Historical status and resources (physicians)
- Numbers and public credibility (nurses)
- Integration into political world (lawyers)
- Ability to expand roles in essential areas (accountants)
- Ability to unite practitioners on vision and strategy
- Influential academic community

How Do Groups Sabotage Themselves in the Policy Process?

- Inability to speak with a common voice
- Unwillingness to engage in important but potentially divisive debates
- Naked self-interest dominates their agenda
- Public indifferent to the group's issues and perspective
- Inability to create coalition to secure third-party advocates for their positions

Potential Pathways to Influence (1)

- Examine and promote role in primary health care – that's where the future lies for the system
- Develop capacity to produce short, evidence-based white papers and policy papers on topics such as:
  - PT and chronic disease management
  - Cost-effectiveness
  - What PT brings to interprofessional teams
- Influence the health information agenda
  - Functional assessment as part of the EHR
  - Performance indicators and outcome measures

Potential Pathways to Influence (2)

- Develop and implement strategies to heighten public profile, support, and advocacy
  - Survey public on needs and priorities
  - Develop relationships with community organizations (seniors' groups, disability coalitions, etc.)
- Develop sustained media strategy
  - Op-eds and commentaries
  - Rapid response capacity

Potential Pathways to Influence (3)

- Get out ahead of the accountability agenda
  - Commit to evidence-based policy-making
  - Argue for needs-based funding
- Forge strategic alliances
  - Primary care
  - Other rehabilitation occupations
  - HQC