

Interview with Penny Ballem

Entretien avec Penny Ballem

Steven Lewis talks with Penny Ballem about the challenges of integrating physicians into health reform, federal–provincial relations and health information management.

Penny Ballem is a former Deputy Minister of Health for British Columbia and a Clinical Professor of Medicine at UBC. She has a long-standing interest in teaching across all health disciplines and in clinical and policy research. During her tenure as Deputy Minister of Health, Dr. Ballem served on the board of the Canadian Institute for Health Information, as a member of Canada Health Infoway, as Liaison Deputy Minister for the Canadian Council for Donation and Transplantation and as co-chair of the Pan Canadian Public Health Surveillance Information System Project. She recently talked with **Steven Lewis**, health research and policy consultant based in Saskatoon, adjunct professor of health policy at the University of Calgary and Simon Fraser University, and contributing editor of *Healthcare Policy*.

Steven Lewis discute avec Penny Ballem des défis d'intégration des médecins dans la réforme de la santé, des relations fédérales–provinciales et de la gestion des informations sur la santé.

Penny Ballem, ancienne sous-ministre de la Santé en Colombie-Britannique, est professeure de médecine clinique à l'Université de la Colombie-Britannique. Tout au long de sa carrière, elle a été à la fois professeure clinicienne et administratrice du secteur de la santé. À titre de sous-ministre, la Dre Ballem a siégé au conseil d'administration de l'Institut canadien d'information sur la santé et a été membre d'Inforoute Santé du Canada. Elle était sous-ministre déléguée auprès du Conseil canadien pour le don et la transplantation ainsi que coprésidente du projet pour un système pancanadien de surveillance des informations en matière de santé publique. Récemment, la Dre Ballem s'est entretenue avec **Steven Lewis**, consultant en recherche et politiques de santé établi à Saskatoon, professeur auxiliaire en politiques de santé à l'Université de Calgary et à l'Université Simon Fraser ainsi que collaborateur à la rédaction de *Politiques de Santé*.

SL: You've been a practising haematologist, a senior hospital executive and a deputy minister. Doctors are central to the system and they're very powerful – both collectively and individually. How successful have we been in Canada in aligning the physician agenda with the health reform agenda?

PB: We have a lot more work to do to make autonomous practitioners a more integrated part of our health system and for them to see this as an advantage rather than as one more way to make their life miserable. Most physicians see their role solely in regard to individual patients and not in relation to the broader needs of the public. Not surprisingly, our medical associations in Canada tend to support system change if it does not conflict with their members' economic interests. However, change in response to the public interest is more difficult.

That said, there's been a big shift from the old days where the only system leadership positions really available to doctors were to be a chief of staff in a hospital or the vice-president of medicine. Now we have doctors who are CEOs and deputy ministers, as well as serving in various senior leadership roles in healthcare organizations. In addition, it is encouraging that an increasing number of doctors are getting some formal training in management and business. Having physicians in leadership positions does make a difference as we work to continually reform our health system.

SL: Some have suggested that one way to get physicians more aligned with the broader agenda is to integrate them more fully into the regional health authorities. Do you think that's necessary, and if so, do you think that it's going to be feasible any time soon?

PB: Yes. Ideally, to really serve the public needs and interests, and get value for money from the huge taxpayer investment in our healthcare system, you have to have the physicians integrated and aligned at the regional level. If we were to follow the lead of most other international jurisdictions, the physicians' compensation should flow through the region, because their work is integral to the function and goals of regional healthcare structures.

But funding for physicians constitutes a large part of overall government spending, and the physician compensation file is a complex one. The risk is that some regions will manage the relationship – the labour relations, the compensation issues – well and others won't. To a certain extent, that's why governments have hung onto the physician file and manage it themselves, with variable amounts of input from the health sector.

Primary care physicians are a huge issue, because they tend to be the most isolated in the system, particularly if they're not involved in hospital work, which in the most populated parts of our country (the urban areas) they're not. They often experience the interface with the many parts of the system as an added burden versus something that should enable them to do a better job. To me, the first job of any health region should be to bring its primary care physicians into a more integrated role in the region, recognizing that they are a critical part of a high-quality healthcare system.

SL: In Canada we've begun, gingerly, to talk about pay for performance (P4P) to improve quality, effectiveness and efficiency in physician practice. The international literature seems mixed on the effectiveness of P4P. Do you think it is a major part of the quality and efficiency solution for Canada?

PB: Practising medicine is complex, and we've come to P4P so late – it's just not an integral part of our culture. Governments that also struggle with pay for performance in their own bureaucracies have begun to institute some P4P principles in physician agreements, with mixed success. I'm a big believer in the potential of P4P, and I hope we don't throw it out if early experience is mixed or even a failure. We should build on, and try to understand, the key elements that make for success and leapfrog over the failures. Canada still has a long way to go in terms of having compensation models that reward performance and incentive activities that benefit the public and are auditable to hold people accountable.

SL: Up to now, pay for performance schemes have mostly targeted activities that are easy to count and procedures that are easy to do.

PB: I think that's probably accurate.

SL: By contrast, we don't see P4P aimed at rewarding high-quality care for people with multiple chronic diseases or the complex frail elderly, where success is harder to define and it is difficult to say what ought to be done in all circumstances. So P4P can skew practices towards certain activities and away from others, and influence the choice of residencies among medical school graduates. And we end up a country with 10 times as many paediatricians as geriatricians.

PB: Exactly.

SL: So what do we do about that – how do we shift the focus of medicine, including prospective residents, towards the unmet needs and unsolved quality problems?

PB: If the governments continue to be the payer, they need to help push the profession to deal with these inequities, which in the end put the public at risk. They need to say, "We're not going to move everyone ahead at the same rate. We need to start to close the gap between the top of the pecking order and the bottom, and you medical associations need to support us on that." Some – to take your example of geriatricians – will have to move from the very bottom of the pecking order to somewhere closer to the middle or the mid-high range. P4P incentives that align with public need are certainly one way to accomplish the goal more effectively.

SL: Governments have known about these inequities and gaps for decades. Are they just incompetent negotiators? Have they ceded too much authority to decide what physician categories will earn for doing what, the result inevitably being the current mal-distributions? You're at the table. What are the two or three things that governments absolutely need to do to start turning this around?

PB: First of all, the government has to be clear about what it needs to serve the public interest. How many geriatricians, practising in what model of care, are going to

meet the needs of the public? If there are twice the number of plastic surgeons in one province versus another, which one is the more efficient model of care, and how do you use a physician contract to get there? In Ontario, paediatricians are doing primary care. Does that make sense, and should a physician contract be designed to change this situation over time?

When the only lever that you have with physicians is the fee-for-service payment schedule, it's tough. You have to have a plan, you have to know where you want to go and then you have to figure out the incentives to build into your negotiation strategy. That's a tough gig, and given the amount of money we are spending on physicians, we still have a long way to go. Interestingly, I think the public in Canada also needs to assist with a more informed approach, because ever since the 1960s and the great Saskatchewan battle over the beginning of medicare, the public's general response in relation to physician negotiations has been, "Oh, for God's sake, whatever it takes, give it to my doctors because I want them to be there when I get sick."

Doctors in general in Canada are very well paid, but what is key is that the investment in our doctors and their models of compensation be designed to reward them for work patterns and activities that support the evolving needs of the public and of patients.

SL: That leads us back to primary care. The recommended movement towards a more interdisciplinary, comprehensive primary healthcare model doesn't appear to be catching hold in Canada. There are the early adopters, but no subsequent tidal wave. Physicians appear to prefer physician assistants working under their direction to the real partnership models alongside nurse practitioners, pharmacists and others. Do you think the interprofessional collaborative vision was pie-in-the-sky to begin with? What's the future of primary healthcare?

PB: I think we're making slow progress. There are some great examples of this working – the South Community Birth Program, started in 2003 in Vancouver, is a wonderful example. However, in general, this is one of the areas where there needs to be more overt leadership at the level of the College of Physicians and Surgeons, the medical associations and even the Canadian Medical Protective Association. Canada lags behind the rest of the world in the use of such professionals as midwives, nurse practitioners, pharmacists and other allied professionals to meet the growing needs of the public. In some provinces, the medical regulatory colleges have dragged their feet in terms of working with other professional colleges to enable scope-of-practice changes that could improve access for the public, enhance quality of care and reduce physician burnout. There is also still tension about who leads the team, with a tendency of physicians to feel they must be in charge. I have a family member who is a speech pathologist. She works in the community with children with autism. She's overseeing teams working weekly with profoundly disabled children. She's far better trained to lead the team in providing care to these children than the family physician, the psychiatrist or

the paediatrician, who may see these children only a few times a year. They are important members of the team, but just because they are doctors doesn't always make it appropriate, or even feasible, for them to be in charge.

SL: Students in all disciplines seem quite happy to collaborate and work in teams. There's a generational shift about workloads and preferred lifestyle. But yet again, most people say the movement towards collaborative practice is stalled. The primary health-care revolution, if it ever got started, has been put down, and what we are getting are pretty conventional, traditional, hierarchical models.

PB: There are some excellent examples in Canada where we have moved on and have discovered the richness of an interdisciplinary model. For everywhere else, we've all got to get over ourselves and start to agree on and drive home some key messages. One is that interdisciplinary care is best practice. We're far behind the rest of the world on this point, to be honest. And I think the health sector in this country has tended to step aside and leave it to the government to carry the ball on moving the collaborative practice agenda ahead. I think that's unfair and an abdication of our responsibility.

SL: One of the dilemmas is that both federal–provincial relations and even inter-provincial cooperation are at a low ebb in this country; there isn't very much common ground at the policy and governmental tables, and so medical associations and others can whipsaw provinces and territories to achieve their goals rather easily.

PB: Hmm.

SL: You've been around those tables. Do you think there's a growing recognition that the jurisdictions need some common strategies that they stick to, or even some elements of negotiations that they can pursue in common across the country?

PB: I had the privilege to co-chair the Federal–Provincial, and chair the Provincial Conference of Deputies for a year. It was an amazing experience. Across all political lines, the provinces and territories did a lot of good work together, and usually were on the same page. They're all getting hammered in the media and their respective legislatures for the same things. The issues are just very tough problems to solve, and they require a lot of hard work and persistence.

To me, the most difficult dynamic was the federal–provincial–territorial relationship. There are tremendous opportunities for the federal government to be an enabling force that could help the provinces move ahead on their difficult health agendas – the creation of a national public drug plan, even if we start with expensive drugs for rare diseases, is an excellent example. This would end the chaos of the diverse plans currently in existence across the provinces and territories and would be a huge step forward for Canada.

I feel quite discouraged about how ineffective we have been in convincing the federal government to play a role in an area such as this, which would enable progress but not require it to get entangled in the service delivery area.

SL: Let me put another perspective on the table. The provinces essentially got

a huge amount of mainly unconditional money from Ottawa, just what they asked for. All they've done is entrench a pattern of very high healthcare spending growth, without getting many substantive results. So is there any way to get some negotiated, but cooperative, conditionality in the cash transfers so that at least the citizens of Canada – who don't really care which level of government is putting the cash on the table, it's all their money in the end – could say, à la Romanow, that the new money bought change?

PB: Yes, I do think that's possible. However, I think the process that leads to these agreements is quite unusual. Just think about this: a \$40-billion transfer to deliver a very complex agenda and set of expectations is negotiated in three days by premiers and a small number of officials. The federal government comes in with an agenda and priorities that, in the case of British Columbia, were misaligned in at least two of the five areas they were investing in.

It was during the last Federal–Provincial First Ministers' Meeting that the provinces said, "Look, we're having a real struggle around public drug plans, and there's no reason why Canada shouldn't have a national pharmacare plan." At the end of the day, the federal government had no interest in that. So we said, let's start with expensive drugs for rare diseases, where it makes no sense for provinces to be acting on their own. No, they didn't want to do that.

To me, until the federal government is prepared to get involved in the delivery of a program where a national approach makes sense – resourcing the education of international medical graduates or funding comprehensive immunization programs are other great examples – it will be a struggle to know exactly what value the public got for its investment.

SL: Are provinces getting value for the doubling of costs in the past decade?

PB: I think we don't take enough time to celebrate where we have delivered real value for money. As an example, Ontario should be extremely proud of what it's done on wait times. They looked at the capacity of the system, they then drove it, and they made it work. They did invest more money, but they knew exactly what they got for it and everyone was held accountable – it was transparent.

Going back to federal investments in healthcare, it takes commitment and time to allow the building of a proper business case for agreed-upon priorities. Thrash it out and then let's talk about the money that it's going to take, and then everyone can get in front of the TV lights and write the cheques and all be heroes. You can't do it when you get a brown envelope on a Sunday night and by Tuesday morning, in front of TV cameras, the premiers are signing on.

SL: Let's turn to physicians and the health information agenda. Canada, again lamentably, is at the bottom of the G-7 in adoption of IT – the EMR [electronic medical record], particularly. Some argue that you can solve a lot of problems with a health information system that can produce real-time data and reports at multiple lev-

els, from clinical practice all the way to management and governance. Is this a key part of the solution, or do you think we are placing too much hope in it? Do you think we're prepared to invest the money that it's going to take to get there?

PB: Do I think it has the potential to deliver on the quality agenda? Absolutely. It is a vehicle, but it's not the only thing. Most practitioners have no real way to properly assess whether they're consistently delivering high-quality care to their patients. When we developed the online chronic disease tool kit in BC, it was an eye-opener for our practitioners. Once they started to use it (it was Web-enabled), it made a dramatic difference to them in terms of understanding how well they were doing in relation to best practice.

But while we have a group of physicians who absolutely buy into the need for a comprehensive, interoperable health information system, there is a nervousness about what will change in terms of accountability. I think our medical associations have seen what's happened in the National Health Service in the UK, where every primary care practice is being audited and compensation increases are tied to the quality of care delivered and, in some instances, patient outcomes. This is new territory, and we have lots to learn about how well it works.

Are we going to get productivity gains out of the EMR? That has been the business case used to convince government to invest. I think to achieve the promises will require a major shift in how governments do business. A lot of the return-on-investment estimates assume quality will get better, and we will get economies of scale and price reductions. I see those as being high expectations, particularly where physician fees are concerned. Ontario has probably had the best-documented success, where they were able to lower the hospital costs of hip and knee replacements – although not the physician costs. The obvious next step should be to negotiate the whole price, and have the institution and the providers figure out their roles in achieving the volume discount. Like any other sector, if we develop information systems that can enhance productivity, there should be a reduction in the unit cost – just how to achieve this is the challenge.

SL: What about capacity? We have ramped up medical school enrolments in this country by close to 60%, the effects of which will be felt in a few years. All in all, have we done the right thing, or might we find ourselves, a decade down the road, having made a big mistake by not taking the opportunity to change the status quo, instead having opted mainly to make the status quo bigger?

PB: Well, I worry a lot about that. I think we did need to expand – certainly in some parts of the country. BC has never been remotely self-sufficient in educating its own physicians, so we did need to expand. Do we graduate physicians who have a completely different outlook on life and know they're going to practise in a different model and environment, as part of a system to which they're accountable? I think for sure their outlook and expectations are changing – however, there has been slow

progress in the integration of opportunities for cross-disciplinary training. There are some very innovative programs – many of them involving rural rotations or opportunities to serve hard-to-reach populations, but there is a way to go before everyone, both at the undergraduate and postgraduate levels, has these new models as an integral part of their ongoing training. At UBC, where we created the College of Health Disciplines with great enthusiasm and hope for progress, there has been difficulty over the years in obtaining the appropriate support to have an impact on large numbers of health professional trainees.

If you look at high-performing health organizations in North America, such as Kaiser Permanente, the Veterans Affairs health system or Group Health Cooperative in Seattle, the environment drives you into interdisciplinary models, and there's an organizational culture that says, "This is the way we do business." But in the parts of Canada where the compensation model is primarily fee-for-service, we are going to struggle to move this agenda.

SL: As a last word, is there anything that makes you optimistic that we can actually start to fix some of these problems?

PB: One of the things that gives me hope is that we are starting to make better use of the information we collect in Canada – imperfect though it may be. As examples, we have seen the publishing of Hospital Standardized Mortality Rates for the first time in Canada; accountability agreements with clear patient-related outcome and access expectations are now standard with health regions; chronic disease management metrics at the provider level are now starting to be common across the country. This is all a shift from when I started practice. All of this provokes more awareness and transparency in regard to the quality of the service we are delivering, and drives an organized response to improve the results. I think we are learning that we don't have to spend a bazillion dollars and take 20 years to produce the perfect evidence to drive quality improvement. Lots of usable information is sitting right there; it's like a little gold mine we're sitting on. So, let's use it and make things better for Canadians.