

Commentary: Burning Platforms, Icebergs and Tipping Points – Canada Needs a Single Socially Accountable Healthcare System

Commentaire : Plateformes en feu, icebergs et points de basculement – le Canada a besoin d'un système de santé unique socialement responsable

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Abstract

Leslie et al.'s (2022) article caused me to reflect on the complexities and contradictions that are Canada. Healthcare in Canada is a hodgepodge of different health systems all assembled under the umbrella of the *Canada Health Act* (1985). Canadians expect medicare to deliver high-quality healthcare close to home wherever they live. For this aspiration to become a reality, there needs to be a single pan-Canadian health system focussed on the health needs of the populations being served. This socially accountable healthcare system is likely to be achieved only if there is a chorus of support across Canada for meaningful pan-Canadian health reforms.

Résumé

L'article de Leslie et al. (2022) me porte à réfléchir aux complexités et contradictions qui caractérisent le Canada. Les soins de santé y sont un méli-mélo de plusieurs systèmes de santé, tous réunis sous l'égide de la Loi canadienne sur la santé (1985). Les Canadiens s'attendent à ce que l'assurance maladie fournisse des soins de haute qualité près de chez eux, où qu'ils vivent. Pour que ce souhait devienne réalité, il faut un système de santé pancanadien unique axé sur les besoins des populations desservies. Ce système de santé socialement responsable ne sera atteint que si les grandes réformes pancanadiennes de la santé bénéficient du soutien d'une pluralité de personnes au Canada.

This Is Canada

Leslie et al. (2022) present the case for pan-Canadian regulation and licensure of health professionals, drawing on the Canadian Institutes of Health Research's Best Brains Exchange sessions of October 2019, and suggest that now is the time to act in the context of the COVID-19 pandemic. As I read the article, I began to reflect on the complexities and contradictions that are Canada.

I was visiting Ontario in 2001 at the time that the Ontario government announced that there would be a Northern Ontario School of Medicine (NOSM). The announcement came when I was attending the Annual Rural and Remote Conference of the Society of Rural Physicians of Canada (SRPC). It was notable that one of the most attended sessions in the conference was on the topic of portable licensure. Rural physicians in Canada and around the world like to travel and work in other rural settings (SRPC 2021).

In 2002, I moved to Canada from Australia to take up the role of founding dean of NOSM (Krotz 2021; Tesson et al. 2009;). It soon became clear to me that the term "national" cannot be applied to Canada unless all 14 governments agree. The Ontario government's decision was to establish one school of medicine for the whole of Northern Ontario under the auspices of two universities: Lakehead University in Thunder Bay and Laurentian University in Sudbury, 1,000 km apart. I well remember the comment in an early meeting with leaders of health professional training in Northern Ontario that bringing the northwest and the northeast together was "against the natural order of things."

Also in 2002, the report by the Commission on the Future of Health Care in Canada (Romanow 2002) was long on endorsement of Canadian values and the continuation of Medicare, and short on recommendations for structural reform to ensure the long-term viability of Canada's universal health insurance program. The reality is that Canada has 17 health systems, including three federal government-run health services. Essentially, healthcare in Canada is a hodgepodge of different health systems, all assembled under the umbrella of the *Canada Health Act* (1985).

People living in remote, rural and Indigenous communities in Canada are at the margins of healthcare access and health outcomes (PHAC, CRaNHR and CIHI 2006). In addition, people living near provincial and territorial borders, as well as the health professionals who serve them, are subject to complicated cross-border arrangements. There is clearly a strong case for a pan-Canadian health system that delivers on the promise of the *Canada Health Act* (1985).

Pan-Canadian health professional regulation is likely to facilitate cross-border movement and service delivery of health professionals in remote, rural and Indigenous communities; however, most people will not notice improvements in access to or quality of care. My question is whether pan-Canadian regulation of health professionals will really make any material difference for most people in Canada, particularly those in remote, rural and Indigenous communities.

Engineering Durable Change

Leslie et al.'s (2022) article suggests that the COVID-19 pandemic presents a “*burning platform*” to catalyze the necessary measures required for mobilizing a unified pan-Canadian approach to licensure and registration” (p. 22). They highlight short-term changes that were instituted in the context of the pandemic. However, they also acknowledge that “[w]hile these measures facilitated certain health workforce responses, many are time-limited emergency measures” (Leslie et al. 2022: 23).

It seems that the pandemic has helped with short-term changes. However, it is not certain if the fact that these changes that occurred will provide the impetus for meaningful long-term change. Rather than the “burning platform” analogy, the phrase “melting iceberg” may provide the basis for genuine reforms. As Leslie et al. (2022) note, “[s]trong federal and provincial/territorial political leadership is required to provide the momentum needed to overcome initial resistance or inertia and propel political will to move forward on pan-Canadian reform” (p. 23). This aligns with Kotter and Rathgeber’s (2006) message in their fable *Our Iceberg Is Melting: Changing and Succeeding Under Any Circumstances*, which is a tale of “resistance to change and heroic action, seemingly intractable obstacles and the most clever tactics for dealing with those obstacles” (Book Cover).

During my 17 years as NOSM’s dean, I participated in multiple provincial and federal initiatives that focused on health workforce planning and production, health services delivery and addressing health inequities. NOSM was established as an Ontario government strategy to address the health needs of the region, improve access to quality care and contribute to the economic development of Northern Ontario. Its Social Accountability mandate to improve the health of the people of Northern Ontario provided the basis of developing “Distributed Community Engaged Learning” as its distinctive model of medical education and health research (NOSM University 2018). NOSM has been successful in graduating physicians and other health professionals who have the skills and commitment to provide care where it is most needed in rural and underserved communities (Hogenbirk et al. 2021; Mian et al. 2017; Strasser et al. 2018). Many NOSM graduates are now faculty members, and an increasing number have taken on academic leadership roles in the school.

Actual Experience

Meanwhile, I was a member of the Ontario advisory tables on health workforce and equity in health quality, as well as the Federal/Provincial/Territorial (FPT) Physician Resource Planning Advisory Committee (PRPAC), the Postgraduate Medical Education (PGME) Collaborative Governance Council and the SRPC College of Family Physicians of Canada (CFPC) Task Force that developed the Rural Roadmap for Action (Advancing Rural Family Medicine: The Canadian Collaborative Taskforce 2017). Both at provincial and pan-Canadian levels, forecasting and planning of the physician workforce were hampered by inconsistent and incomplete data availability within and between jurisdictions, and generally a lack of agreed common ground and clarity regarding the desired outcomes. For example, the PRPAC – a

subcommittee of the FPT Committee on Health Workforce (Government of Canada 2016) – oversaw the development of a pan-Canadian physician resource tool (Slade et al. 2014) that itself was building on previous work undertaken by the Ontario Ministry of Health and Long-Term Care. When I stepped away in 2019, there had been over a decade of development work but the planning tool was not yet being utilized because not all provinces and territories had agreed to supply the data. In addition, there were ongoing considerations as to which organization would be responsible for the ongoing collection of data and management of the database, although the Canadian Institute of Health Information was the most likely candidate.

The PGME Collaborative Governance Council (<https://pgme-cgc.afmc.ca/node/21>) was established as a result of a recommendation in the 2012 Future of Medical Education in Canada Postgraduate Vision to “Establish Effective Collaborative Governance in PGME” (CFPC, Collège des médecins du Québec and Royal College of Physicians and Surgeons of Canada 2012: 6). This recommendation stated that “[r]ecognizing the complexity of PGME and the health delivery system within which it operates, integrate the multiple bodies (regulatory and certifying colleges, educational and healthcare institutions) that play a role in PGME into a collaborative governance structure in order to achieve efficiency, reduce redundancy, and provide clarity on strategic directions and decisions” (CFPC, Collège des médecins du Québec and Royal College of Physicians and Surgeons of Canada 2012: 6). The PGME Collaborative Governance Council was developed to resolve contentious issues across organizations. The council was dissolved after four years because of tensions between organizational autonomy and priorities and the collective vision. In their article on the PGME Collaborative Governance Council, Herbert et al. (2021) concluded by asking the fundamental question as to whether a consensus-based decision-making process can ever be achieved among organizations with overlapping mandates and, in some cases, hierarchical structures.

The Rural Roadmap for Action – Directions (Advancing Rural Family Medicine: The Canadian Collaborative Taskforce 2017) was developed over three years by the SRPC-CFPC Task Force and endorsed in Ottawa at the 2017 Rural Health Summit (CFPC and SRPC 2017). In 2018, the SRPC-CFPC Rural Roadmap Implementation Committee (RRMIC) was established to monitor progress and encourage implementation of the 20 recommended actions in the Rural Roadmap. The RRMIC final report card in 2021 showed that not a single one of the recommended actions had been implemented in full and that the recommendation for a standardized measurement system demonstrating the impact of rural health service delivery models was rated as *minimal progress* (Rural Road Map Implementation Committee 2021).

Drawing on these examples, it seems clear that the strategies listed in Leslie et al.’s (2022) Table 2 are unlikely to ensure the successful implementation of pan-Canadian health professional regulation. Success is more likely if strategies are embedded in wider health system reforms that are enabled by broad FPT political and bureaucratic commitments.

Socially Accountable Healthcare

Canadians expect medicare to deliver high-quality healthcare close to home wherever they live.

In Northern Ontario, NOSM's Social Accountability mandate translated into active community participation through community engagement so that NOSM and its programs were developed by Northern Ontario, in Northern Ontario, for Northern Ontario (Strasser et al. 2018). NOSM's success is based on a facilitated career pathway approach that involves recruiting students from underserved, underrepresented populations and delivering undergraduate and postgraduate immersive community-engaged education that prepares NOSM graduates to provide healthcare where it is most needed (Strasser 2021).

Similarly, accessible high-quality healthcare close to home is most likely to be achieved through the socially accountable "start local" approach focused on addressing the health needs of the population being served (Strasser and Strasser 2020). The Health Partnership Pentagram Plus at the local, regional and provincial levels has been used with success in British Columbia (BC) through a collaboration between the BC Rural Coordination Centre and the First Nations Health Authority (Markham et al. 2021).

Leslie et al. (2022) conclude that "[r]ather than continuing down the path of these patchwork responses, now is the time for a pan-Canadian reform" (pp. 23–24). I contend that health professional regulation reform is necessary but not sufficient to achieve the single socially accountable health system that Canada needs. Kotter and Rathgeber's (2006) eight steps provide the way to generate a chorus of support across Canada that brings us from the melting iceberg to the tipping point (Gladwell 2000), which creates the political will to implement meaningful pan-Canadian health reforms, including health professional regulation.

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References

- Advancing Rural Family Medicine: The Canadian Collaborative Taskforce. 2017. *The Rural Roadmap for Action – Directions*. The College of Family Physicians of Canada. Retrieved July 23, 2022. <https://srpc.ca/resources/Documents/PDFs/Rural_Road_Map_Directions_ENG.pdf>.
- Canada Health Act, R.S.C., 1985, c. C-6. Retrieved July 23, 2022. <<https://laws-lois.justice.gc.ca/eng/acts/c-6/page-1.html>>.
- The College of Family Physicians of Canada (CFPC), Collège des médecins du Québec and the Royal College of Physicians and Surgeons of Canada. 2012. *A Collective Vision for Postgraduate Medical Education in Canada*. Retrieved August 10, 2022. <https://www.afmc.ca/future-of-medical-education-in-canada/postgraduate-project/pdf/FMEC_PG_Final-Report_EN.pdf>.
- The College of Family Physicians of Canada (CFPC) and Society of Rural Physicians of Canada (SRPC). 2017, July. *Final Report: Summit to Improve Health Care Access and Equity for Rural Communities in Canada: The Rural Roadmap for Action*. Retrieved July 23, 2022. <https://srpc.ca/resources/Documents/PDFs/ARFM_Summit_Report_ENG_Final_Web.pdf>.
- Gladwell, M. 2000. *The Tipping Point: How Little Things Can Make a Big Difference*. Little, Brown.
- Government of Canada. 2016, April 14. Committee on Health Workforce (CHW). Retrieved July 23, 2022. <<https://www.canada.ca/en/health-canada/services/health-care-system/health-human-resources/committee-health-workforce.html>>.

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- Herbert, C.P., N. Busing and L. Nasmith. 2021. Collaborative Governance of Postgraduate Medical Education: Can It Be Achieved? *Medical Teacher* 43(12): 1413–18. doi:10.1080/0142159X.2021.1951691.
- Hogenbirk, H.C., D.R. Robinson and R.P. Strasser. 2021. Distributed Education Enables Distributed Economic Impact: The Economic Contribution of the Northern Ontario School of Medicine to Communities in Canada. *Health Economics Review* 11(1): 20. doi:10.1186/s13561-021-00317-z.
- Kotter, J. and H. Rathgeber. 2006. *Our Iceberg Is Melting: Changing and Succeeding Under Any Conditions*. Pam Macmillan.
- Krotz, L. 2021. *Nothing Ordinary: The Story of the Northern Ontario School of Medicine*. Cormorant Books.
- Leslie, K., C. Demers, R. Steinecke and I.L. Bourgeault. 2022. Pan-Canadian Registration and Licensure of Health Professionals: A Path Forward Emerging from a Best Brains Exchange Policy Dialogue. *Healthcare Policy* 18(1): 17–25. doi:10.12927/hcpol.2022.26909.
- Markham, R., M. Hunt, R. Woollard, N. Oelke, D. Snadden, R. Strasser et al. 2021. Addressing Rural and Indigenous Health Inequities in Canada through Socially Accountable Health Partnerships. *BMJ Open* 11: e048053. doi:10.1136/bmjopen-2020-048053.
- Mian, O., W. Warry and R. Strasser. 2017. How Underserved Rural Communities Approach Physician Recruitment: Changes Following the Opening of a Socially Accountable Medical School in Northern Ontario. *Canadian Journal of Rural Medicine* 22(4): 139–47.
- NOSM University. 2018, June 13. Social Accountability. Retrieved August 3, 2022. <<https://www.nosm.ca/2018/06/13/social-accountability/>>.
- Public Health Agency of Canada (PHAC), Centre for Rural and Northern Health Research (CRaNHR) and Canadian Institute of Health Information (CIHI). 2006, September. *How Healthy Are Rural Canadians? An Assessment of Their Health Status and Health Determinants*. Retrieved July 23, 2022. <https://secure.cihi.ca/free_products/rural_canadians_2006_report_e.pdf>.
- Romanow, R.J. 2002, November. *Building on Values: The Future of Health Care in Canada – Final Report*. Commission on the Future of Health Care in Canada. Retrieved July 23, 2022. <<https://publications.gc.ca/collections/Collection/CP32-85-2002E.pdf>>.
- Rural Road Map Implementation Committee. 2021, April. *Rural Road Map: Report Card on Access to Health Care in Rural Canada*. The College of Family Physicians of Canada and the Society of Rural Physicians of Canada. Retrieved July 23, 2022. <<https://www.cfpc.ca/CFPC/media/PDF/Rural-Road-Map-Report-Card-EN-final.pdf>>.
- Slade, S., C. Moffatt and G. Moineau. 2014. Pan-Canadian Physician Resources and Planning Tools/ Ressources Pancanadiennes médicales et outils de planification [Canadian Health Workforce Conference]. Canadian Health Workforce Network. Retrieved August 10, 2022. <<https://www.hhr-rhs.ca/en/tools/chwn-resources/library/english-french/pan-canadian-physician-resources-and-planning-tools-ressources-pancanadiennes-medicales-et-outils-de-planification.html>>.
- Society of Rural Physicians of Canada (SRPC). 2021, July. Advocacy on National Licensure. *SRPC Newsletter for July And August*. Retrieved July 23, 2022. <https://srpc.ca/newsletter_jul_aug>.
- Strasser, R. 2021. “Immersive Community Engaged Education: Community Engaged Learning than Work-Integrated Learning.” In A. Stirling and J. Pretti, eds., *The Practice of Co-op and Work-Integrated Learning in the Canadian Context* (pp. 72–81). CEWIL Canada.
- Strasser, R., J. Hogenbirk, K. Jacklin, M. Maar, G. Hudson, W. Warry et al. 2018. Community Engagement: A Central Feature of NOSM’s Socially Accountable Distributed Medical Education. *Canadian Medical Education Journal* 9(1): e33–e43.
- Strasser, R. and S. Strasser. 2020, August. *Reimagining Primary Health Care Workforce in Rural and Underserved Settings* [Discussion Paper]. World Bank Group. Retrieved July 23, 2022. <<http://documents.worldbank.org/curated/en/304851606975759118/Reimagining-Primary-Health-Care-Workforce-in-Rural-and-Underserved-Settings>>.
- Tesson, G., G. Hudson, R. Strasser and D. Hunt (eds.). 2009. *The Making of the Northern Ontario School of Medicine: A Case Study in Medical Education*. McGill Queens University Press.