Engine or Boat Anchor? The Health Professional Training Establishment in HHR Innovation

Ancre ou pleins moteurs? Institution de formation professionnelle et innovation dans les ressources humaines en santé

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Abstract

Educational institutions have largely failed to provide innovative responses to emerging health human resources (HHR) needs. Reasons include the prevailing ratio policy, which simply increases the supply of professionals; university funding protocols; a guild structure that isolates health professions rather than integrating them; and current credentialing for entry to practice, which both controls and further balkanizes the professions. Providing integrated health services will require (a) embedding interprofessional education and collaborative practice in accreditation requirements, (b) coordinating educational programs via intergovernmental committees and (c) embedding interprofessional collaborative learning in clinical training.

Résumé

Les institutions d'enseignement ont échoué dans leurs propositions de réponses novatrices pour combler les besoins urgents en matière de ressources humaines en santé. Parmi les raisons derrière cet échec se trouvent les politiques de ratio qui prévalent et ne font

qu'augmenter le nombre de professionnels de la santé; les protocoles de financement dans les universités; une structure de guilde qui isole les professions de la santé au lieu de les intégrer les unes aux autres; et les processus actuels d'accréditation pour le droit de pratique, lesquels contrôlent et balkanisent davantage les professions. Pour offrir des services intégrés de santé, il faut (a) inclure la formation interprofessionnelle et la pratique collaborative dans les exigences d'accréditation, (b) coordonner les programmes de formation au moyen de comités intergouvernementaux et (c) inclure l'apprentissage collaboratif interprofessionnel dans la formation clinique.

Post-secondary institutions are renowned for sitting at the cutting edge of orthodoxy. Tzountzouris and Gilbert (2009) discussed at some length the part that educational institutions play in identifying and responding to emerging health human resources (HHR) needs. They came under criticism for assigning these institutions a rather passive role, and failing to outline their potential for leadership. It is worth exploring briefly some possible reasons for this apparent passivity.

The past 100 years have seen a near-exponential growth in the number of different health occupations. As it is (not exactly) written in the Book of Ecclesiastes: "Of the making of many health occupations there is probably no end." It is possible that this proliferation is about to end, and we shall see no more new health occupations, but it is highly improbable. As science carves the human body into ever smaller bits, the temptation to recruit more and different workers to its management and care will probably be too great to overcome. HHR planning will continue to be challenged by the dendritic growth of those occupations – and its financial implications. (More on this below.)

These occupations now appear like snowflakes – no two are exactly alike. Yet snowflakes all share the same hexagonal template, and they are shaped by the conditions of the cloud through which they form and fall. Sounds a bit like health occupations.

In many senses, education for these occupations represents what Rittel and Webber (1973) have called a "wicked problem." Wicked problems are difficult or impossible to solve. Their solutions depend on incomplete, contradictory and changing requirements that are often difficult to recognize. And they are confounded by complex interdependencies between actors and agents. If ever there was a wicked problem, innovation in health professional training is surely it. What could be more complex than relationships between government, post-secondary institutions, the healthcare industry – and the professions?

If we think about it, from a strictly selfish point of view, it makes sense for training establishments to respond to perceived HHR shortages by saying: "You need more of our kind of graduates? Well, just give us more money and we'll be happy to give you more of them."

New money for more students buys all manner of rewards – more faculty means more research, means more prestige, means more bargaining power, means more space – and so on, ad infinitum. A demonic bargain has been struck.

Nominandum est rutrum rutrum – it's time to call a spade a spade. The ratio policy mostly serves the interests of the health professions themselves. The policy isn't closely correlated with the concerns of patients/clients and the care they need. Research that addresses HHR from a ratio perspective shows that such initiatives too often focus on staff types – more Xs, Ys and Zs. The initiatives are rarely focused on staff members' skills. Neither are they focused on how those skills might be used most effectively to improve patient care. We are now aware that HHR problems cannot be solved if the policy response is simply to increase supply.

Let's square this ratio issue with the growth of health occupations. As John Tzountzouris and I attempted to show, the development of new health and human services occupations is a complex mix of new knowledge, new technology, occupational aspirations – and, of course, egos. How new practitioners are prepared, organized, deployed and paid will directly influence their ability to provide high-quality care within our changing health system. And of course, training for new health occupations triggers a need for more new money and ascent on the credentials ladder.

As the 20th century passed, something became clearer and clearer to those aspiring to turn newly developed health occupations into professions that got respect. They recognized that the credential that marked entry to practice was the key to financial well-being and political influence.

Emerging health occupations accumulated new knowledge. As they did so, what had heretofore required six months of training, with perhaps a certificate at the end of it, slowly became two years of training with a diploma. As more knowledge accrued, the training period gradually crept to four years – and a first degree. Gradually and inevitably, as more knowledge was acquired, a postgraduate degree replaced the undergraduate degree. As we move into the 21st century, that first postgraduate degree seems to be inexorably moving to a professional doctorate. Steven Lewis has suggested that simply calling all health providers "doctor" might solve the whole imbroglio. Adding more degrees is not innovation that drives system change.

This credentialing issue is, without doubt, a serious problem – how do we figure it into the HHR algorithm? What we have observed is that as these credentials increase, so does the arrival of a new cadre of "helpers." We have more chief assistants to the assistant chiefs. The federal, provincial and territorial Coordinating Committee on Entry to Practice Credentials has learned, to its regret, that stopping the increase in credentials is almost impossible in a federal system that essentially rests responsibility in the provinces.

Health professional training in Canada reflects complex relationships among government, post-secondary education and the healthcare industry. Despite the best of intentions, at times impediments between and among these players make collision inevitable and innovation very difficult.

Our health system is moving at semi-glacial speed towards providing more integrated, *interprofessional collaborative* health services. That care will require clearer, informed and effective collaboration among government, health professional training establishments, the healthcare industry and the broad array of practitioners.

Ratios and new health occupations are major challenges to innovation. But what really

contaminates this already contaminated state of affairs is the rate-limiting fixation on paying for "bums in seats" – a funding protocol that is a major impediment to innovation.

Within Canada, health ministries do not generally fund education directly.[1] Instead, drawing on the old ratio arguments, health ministries tell the post-secondary ministries the number of graduates needed. These numbers are usually expressed as "seats." Post-secondary ministries then develop funding formulas to accommodate the number of graduates requested. These formulas are shared with health ministries and the various post-secondary programs within a province. Seats are then assigned to specific health education programs within universities, colleges and institutes. Over and above problems of general communication and lack of continuity, there are deep-seated barriers to innovation within this system of seat allocation. Why?

Since each seat carries a monetary value, calculated on the basis of historical precedent and type of program, there is little incentive for programs to change their educational curricula to accommodate innovations in teaching and learning, either within the institution or at sites where students learn their practice skills. The price per seat never goes down. Indeed, smart university and college administrations always look for creative ways to put the price up. Price differentials among programs can be significant. They torque the system. This torque severely impedes anything other than the development of superficial relationships between academic programs. To those programs that have, more is usually given. To those programs that have not, entering the game with innovative funding proposals is akin to entering a fortified hill town after curfew. Expect trouble.

Let's be blunt. In 60 years, the "bums in seats" approach to HHR planning has not worked very well. We cannot continue with the notion that simply producing more Xs, Ys and Zs will fix the resource problem. To do so will mean that our planning remains seriously out of joint with those 60 years of grim reality. There are multiple 10-year plans that appear to operate on the mistaken belief that this kind of planning will achieve serenity. Trouble is – hoping for serenity is not policy.

How did we get into this mess? A couple of years ago, I took a look back at the great report of Abraham Flexner (1910) and tried to trace its influence on the development of health professions (Gilbert 2008). Flexner's unintended legacy includes some major impediments to innovation.

The rigorous medical education envisioned by Flexner had an unintended consequence. That consequence was the development and approval of policies that fostered (and continue to foster) a balkanized guild structure across the health and human services professions. That balkanized structure imposed occupational control. The new health professions that emerged in the 20th century might well look to Flexner as their fairy godfather. Policies created to achieve two of Flexner's goals for medicine – university affiliation and full-time faculty – were enthusiastically embraced by emerging health professions. Those policies have played out in a manner that serves to isolate professions rather than bring them together. These professional guilds present some clear realities:

- They live within their own compound of professional associations and learned journals.

- They subscribe to their own belief system through codes of ethics and scopes of practice.
- They erect intellectual fences by dictating entry-to-practice requirements.

Each of these realities inevitably interlocks with the others. Resources committed to the development of one reality spread into a need for resources to be flowed to another. They come to form a mutually reinforcing, cycling process or "virtuous circle" – a process in which a favourable circumstance (or result) gives rise to another that subsequently supports the first. Yet we know that the processes needed to train and deploy health professionals are variegated. Those processes encompass a number of different domains: the way services are funded and organized, the workplace environment, the individual needs of health professionals and population health needs. Within each of these domains there are multiple levers for policy action and multiple organizations with partial or complete responsibility for implementation. It is known that there may be at least 15 distinct policy levers and more than 15 stakeholder organizations involved in policy decisions and implementation.

Flexner's brilliance in moving medicine into the 20th century has proved to be something of a curse. Innovations such as interprofessional education and collaborative practice are extremely difficult to promote across the barriers of guild structures (Gilbert 2005).

There is a further consequence of Flexner's placing the study of medicine (and subsequently, many other health professions) within the university. Universities are dominated by the arts-and-science paedagogic model of education, to which the health professions are expected to conform. But this model tends to fasten wheel clamps onto education for practice, which is often relegated to a secondary role. What do I mean by this?

Academic progression through the ranks at universities, and increasingly in colleges, is driven by the requirements of teaching and research. The arts and science course-driven model of teaching does not accord well with interprofessional collaborative, patient-centred learning. Accumulating 48 credits of classroom instruction does not necessarily equate with the acquisition of competency to deliver care. Yet about 60% of student learning is spent in a classroom environment.

How could it be otherwise? Teaching performance is taken as one measure for promotion and tenure. An instructor's research frequently forms a part of the base for that teaching. Faculty members may try both to use innovative teaching methods and to teach innovative approaches to practice. But these efforts must compete with publishing peer-reviewed papers, which remains the pre-eminent criterion for tenure and promotion.

There is, of course, another confounder. The clinical environment must provide skills that enable credentialing for entry to practice. And here the press of the traditional path also holds true. As many students tell us, the refrain, "You may learn that in your classes, but here we do it this way" is not uncommon. The division between "*them*" and "*us*" is palpable. No wonder innovation is very difficult to carry forward.

This brings me to a final impediment to innovation that confronts health professional training establishments – the almost impenetrable thicket of regulation and legislation.

Scopes and competencies are the creatures of regulation and legislation – something that

no university, college or institute program can avoid. Those creatures can both block and facilitate innovation. Professional associations play perhaps *the* most important role in determining competencies and scopes of practice. These associations work closely with regulatory and legislative bodies. They become the gatekeepers of the system.

Competencies and scopes of practice are most often developed in isolation from other professional associations. This isolation makes parts of them reduplicative and often redundant. After all, how many ways can we look at a competency labelled "communication"? As gatekeepers of competencies and scopes of practice, associations can stifle any innovation that post-secondary institutions might wish to introduce.

So with this, my personal list of impediments (which might account for the "passivity" in our original paper), do I see any possible facilitators for HHR innovation?

My first choice for motivating change would be to address professional accreditation. Ultimately, competencies and scopes insinuate themselves into accreditation. If I could choose one mechanism that might support innovation, it would be through existing accreditation protocols of both health education programs and health services programs. I suggest that innovations in ways of learning will take hold only when those innovations are embedded in accreditation. There is no threat more likely to cause deans of faculties (and presidents of universities, colleges and institutes) to have sleepless nights than loss of accreditation. Embedding interprofessional education and collaborative practice in accreditation requirements would have a much greater chance of downstream effects on regulation and legislation.

What gives me hope? Broad and growing awareness of the issue is reflected in several recent reports from a variety of agencies:

- the Accreditation and Interprofessional Health Education initiative funded by Health Canada (AIPHE 2009);
- the Association of Faculties of Medicine of Canada (AFMC 2010);
- the World Health Association (WHO 2010);
- the Western Canadian Interprofessional Health Collaborative (Suter and Deutschlander 2010); and
- the Canadian Medical Protective Association (CMPA 2010).

My second choice for the facilitation of innovation would be intergovernmental committees and the coordination of educational programs. Canada has a mixed model of private and public policy levers to manage both our overall health system and the processes by which health professionals are trained and deployed. This approach can be at odds with achieving optimal supply, mix and distribution of skills. Only intergovernmental committees can grapple with the kinds of issues I have outlined and produce policies that assign resources to supply in new and imaginative ways. To borrow Willie Sutton's famous justification for robbing banks – the ministries are where the money is.

My final choice for the facilitation of innovation would be the establishment of what are called collaborative learning units (CLUs) within health services settings. We need, I think

desperately, to try some new approaches to practice education so that every student's knowledge and skills are both interprofessional and collaborative. Health Canada is funding three major trials across the country of CLUs – an attempt to embed interprofessional collaborative learning in clinical training.

These new units have the potential to influence policy making in a very real way. But we need evidence that this new way of learning actually results in better quality of care. CLUs provide an opportunity for researchers to set up defined evaluation programs and processes, so that evidence can be gathered that fills some of the gaps in our current understanding of interprofessional collaboration. With careful forethought and planning, CLUs could change the way we think about and perform clinical training. This said, however, I am painfully aware of the sceptics in their corners. You know – the ones who say: "I don't believe it; prove it to me and I still won't believe it."

The health workforce is claimed to be the most highly educated in modern societies. But that education too often runs along parallel tracks that never meet. To improve the effectiveness of – and the "value for money" from – that educational investment, we shall have to develop innovative ways of education and training. And those ways will need to recognize the vast range of similarities among the multiplicity of professional preparations, rather than emphasizing the differences. (The snowflake may be an apt analogy.) The necessary changes will require continued patience and perseverance.

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NOTE

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