

Collaborative health care teams in Canada and the USA: Confronting the structural embeddedness of medical dominance

ABSTRACT

KEY WORDS

Sociology, collaborative health care teams, medical dominance, structural embeddedness, primary care, mental health care, Canada, United States of America

There has been a renewed interest in collaborative models of health care delivered by 'interdisciplinary teams' of providers across several health care systems. This growing phenomenon raises a host of issues related to the management of professional boundaries and the contemporary state of medical dominance. In this paper, we undertake a critical analysis of the factors both promoting and impeding collaborative care models of primary and mental health care in Canada and the USA. The data our arguments are based upon include a combination of documentary and interview data from key stakeholders influential in various collaborative care initiatives. Based on these data, we develop a conceptual model of the various levels of influence, focusing in particular on the macro (regulatory/funding) and meso (institutional) factors. Our comparative policy and institutional analysis reveals the similarities and differences in the influences of the broader contexts in Canada and the USA, and by extension the different ways that the structural embeddedness of medical dominance impinges upon and reacts to recent policy changes regarding collaborative health care teams.

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Introduction

There has been a renewed interest in collaborative models of health care delivered by 'interdisciplinary teams' of providers in many health care systems. The impetus is in part a response to real, perceived or projected shortages of physician human resources and in turn access to health care services (Goodwin et al. 2005: 856; Patel et al. 2000:117). Many policy documents echo Besrou (2002:4) who states that 'effective solutions to problems of access

and continuity can only result from close working relationships between the different actors involved.' Such collaborative models implicitly draw upon health care providers that are considered to be at least partly substitutable where physicians are in short supply. The move towards team-based care can also be seen as an attempt to curb rising health care costs; that is a move towards the lowest cost or 'most appropriate provider' (cf. Health Canada 2004). For example, Canadian health service researchers, Pitblado and Pong (1999:4), have argued that:

'it is well known that some of what physicians do can be done, and can be done quite effectively and possibly at lower cost, by other providers such as nurse practitioners ... psychologists, etc. in appropriate settings and in collaboration with physicians.'

Other costs savings are anticipated because there would be a reduction in health service duplication and inefficiencies and overuse of hospital emergency rooms (College of Family Physicians of Canada 2000).

The move towards more extensive use of collaborative health care teams raises a host of issues related to the management of professional boundaries and by extension, to the contemporary state of medical dominance. It could be argued that some state regulators and health care managers (and in the case of public health care systems, these can be one in the same) have persistently moved in the direction of breaking down the boundaries between provider groups with the intention of making health human resources more responsive to changing conditions, such as increasing or decreasing consumer demand and provider supply. One regulatory tool to achieve these ends is the move towards overlapping rather than exclusive scopes of practice. Although such reforms are often viewed as having the consequence of curbing medical dominance – either intended or unintended – we will argue here that such efforts often reveal what we will refer to in this paper as the *structural embeddedness*¹ of medical dominance. We explicate this by undertaking a critical analysis of the factors both promoting and impeding collaborative care models by drawing upon data from a comparative analysis of primary and mental health care in Canada and the US.

Collaborative health care teams and medical dominance

There are numerous definitions or types of health care teams. One key distinction is made between multidisciplinary, interdisciplinary, transdisciplinary and transprofessional teams which differ according to their levels of collaboration and disciplinary focus (EICP 2005b:1; Opie 1997:264). For the purpose of this paper, we employ the more generic term, *collaborative*, to indicate teams that are interdependent and at least attempt to share power and responsibility. Health care teams are not a particularly new phenomenon but there has been a recent push

in many health care systems towards their more extensive use not just within hospital units (Patel et al. 2000) but also in other health care organizations and community settings (Dieleman et al. 2004). When teams are examined either within the health services and medical sociology literatures, however, they tend to be those working within institutions rather than in the community (Griffiths 2004 and Brown 2000 being notable exceptions).

Much of the health services literature on health care teams tends to focus on the efficacy of teams by examining patient outcomes and satisfaction among team members. It is argued that a team approach not only improves outcomes, it also improves the productivity of the participating health care providers (Dieleman et al. 2004; Opie 1997). Less attention has been paid in this literature to the organisational resources to support collaborative team work, despite its importance not going unnoticed.

The bulk of the sociological literature on health care teams tends to focus on interprofessional relations within teams. Several researchers call attention to how professional boundaries are constructed, maintained, and negotiated through the everyday actions and rhetoric used by health care providers (Griffiths 1997; Hindmarsh and Pilnick 2002; Mizrachi et al. 2005). Allen (1997, 2000, 2001, 2002), for example, describes how the boundary between nurses' and physicians' work in the hospital has blurred in that some of the tasks undertaken by nurses, such as prescribing medicine, were clearly within the traditional domain of medicine (see also Hughes 1988). Physicians, by way of contrast, have rarely been noted as taking up traditional tasks of nursing.

Many of these sociological studies either explicitly (Griffiths 1997, 1998) or implicitly (Coombs and Ersser 2004) draw upon Strauss et al.'s (1963) concept of a negotiated order and more broadly on Freidson's (1970) concept of medical dominance, in particular medicine's control over other health care occupations. Opie (1997) highlights the dominance of medical discourses to the neglect of others (such as nursing) in collaborative health care teams.

Coombs and Ersser (2004: 245) refer to this as 'medical hegemony of the decision-making process' and describe similar phenomena of the devaluing of nursing knowledge and nurses' role (vis-à-vis medicine). Hindmarsh and Pilnick (2002: 158) describe collaborative teamwork as 'a practical accomplishment that emerges despite the fact that team members often have unequal power or status.'

The micro focus of these studies, while important, is insufficient in explaining the social phenomena surrounding collaborative health care teams. We need also to attend to the meso and macro level factors that either facilitate or impede collaborative models of care that cut across professional boundaries. Indeed, as Tousijn (2002) has argued, medical dominance also entails control over work, over the market, and over policy-making – what Freidson (1970) called the *context* of care. Moreover, these macro and meso factors are not inconsistent with the negotiated order perspective employed in some of these studies described above. Indeed, Allen argues that Strauss [particularly his later work (1978)] highlights the importance of the structural context of negotiations and constraining effects of organisational policies. Drawing upon Strauss, Svensson (1996) highlights how changes in the organisation of nursing have increased the opportunities for nurses' involvement in decision making, but at the same time nurses are wary of crossing boundaries and tend to only do so when the organisational context compels them. Similarly, Goodwin et al. (2005:857) and Snelgrove and Hughes (2000:661) emphasise that organisational factors affecting medicine, such as increasingly heavy workloads, also influence the blurring of boundaries. Very little research, however, has focused on the broader/macro factors that influence the success in implementing collaborative care models, particularly outside of institutional settings.

The purpose of our examination is to focus the analytical lens on the structural context, not just at the organizational, but also at the broader policy and institutional level, that influences the development and successful implementation of

collaborative health care teams. Our analysis is comparative across two countries – Canada and the USA – and is illustrated by two cases in primary and mental health care². These cases were chosen because they tend to be community-based so that part of our analysis will be to see the potential impact of making collaborative practices more organisationally embedded.

Methods

A multi-method, qualitative approach was employed in this investigation. Data sources included documents from primary and secondary sources pertaining to collaborative health care teams in Canada and the USA. These were complemented with a series of interviews with key professional and policy stakeholders involved in these decision-making and implementation processes.

We began by reviewing the published academic literature on collaborative primary and mental health care (i.e., secondary sources) and the grey literature (e.g., primary source policy documents, government reports and reports by various stakeholder groups). The analysis of these documents was ongoing throughout the study and served as a basis for the identification of key informants to be interviewed, the questions they would be asked and the development of a preliminary list of factors influencing the development and implementation of collaborative health care teams we would investigate further.

Interviews were conducted with a total of 55 key informants to explore their views on the factors affecting collaborative care in their jurisdiction. Participants were selected through purposive sampling to ensure that key stakeholder positions were represented. The Canadian cases largely focused on Ontario with supplementary data from other provinces with interest in collaborative health care teams; the US data are derived primarily from New York State with additional data from other states with contrasting regulatory contexts including California and Florida. In both cases representatives from national organisations were interviewed. All interviews followed a semi-structured guide, were conducted by telephone and lasted between 30

and 60 minutes. The initial interview guide focused on questions about the process and factors influencing the decision of who provides what forms of primary and mental health care in their particular area. Structured probes were also included to highlight the influence of different regulatory approaches and funding arrangements.

The interviews were tape recorded and transcribed and, along with key segments from the documents, were then analysed thematically. In some cases themes emerged directly in response to our interview questions with others emerging from our iterative review process between the documents and the interviews. The rich array of factors raised by our informants and from the documents led directly to a process of thinking about how to place these various factors into a coherent and theoretically informed framework which we outline below.

Conceptual framework

Figure 1 presents the conceptual framework which emerged from our analysis. At the heart of this model are professions with overlapping scopes of practice that work within collaborative health care teams. The factors that influence collaborative practice at the *micro* level – which we will not focus on in our analysis here – include interpersonal relations between team members and any previous experience team members have had working with interdisciplinary teams. Factors at the *meso* level include the existence of institutional arrangements that either foster or hinder collaborative practice within hospitals or other health care institutions and community settings, and the existence of educational programs (either entry-to-practice or continuing) that foster interdisciplinary practice. The broader, *macro* factors we highlight in our analysis include the influence of regulations around scopes of practice and economic factors, which include both coverage of services (public or private) provided by different potential team members and remunerative models, such as salary or fee-for-service. Liability issues – which cross economic and regulatory domains – are also influential at the macro level.

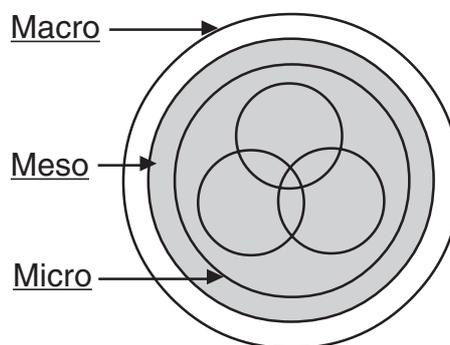


Figure 1: Conceptual model of factors influencing collaborative models of health care

In the sections that follow, we present an overview of some of the key meso and macro factors influencing collaborative primary and mental health care in Canada and the USA.³ We focus in particular on the macro economic and regulatory factors and meso institutional arrangements as they emerged as the most relevant to the structural embeddedness of medical dominance theme we develop here.

Collaborative primary health care

Primary care most often refers to the *first contact* with the health care system. In Canada, the primary care division of labour is organised mainly around family physicians (FPs) and general practitioners (GPs) working in solo and small-group practices that are owned and managed by physicians who in turn receive fee-for-service (FFS) reimbursement by the various provincial/territorial ministries of health (Hutchinson, Abelson and Lavis 2001).⁴ Primary care nurse practitioners (NPs) – registered nurses who have additional training in the assessment, management and diagnosis of common illnesses and complaints (Birenbaum 1994) – have recently been reintroduced⁵ into the system but their numbers remain relatively small with 300 NPs graduating from educational programs in Ontario (the first province to regulate NPs) from 1995–2000 (Sidani, Irvine and DiCenso 2000). Prior to recent primary care reform initiatives, less than 10% of primary care physicians in Canada worked in multidisciplinary practices (Hutchinson, Abelson and Lavis 2001).

The primary care division of labour in the US is more diverse than it is in Canada due in part to the smaller percentage of FPs and GPs providing comprehensive, continuous care; (20% of the US outpatient physician work force are family physicians (AAFP 2005) with some states having only 11% of their complement of physicians in family practice versus 48% in Canada (Hawley 2004; Kralj 1999). This has resulted in the expansion of the primary care role of specialist providers in the USA, such as pediatricians, gynecologists and internists, as well as a greater variety of non-medical primary care providers. This latter group includes physician assistants (PAs) – health care providers licensed to practice medicine under physician supervision – in addition to NPs. These non-medical primary care providers are more numerous in the USA than in Canada with reportedly over 100,000 NPs and nearly 50,000 PAs. There are now, collectively, more NPs and PAs providing primary care than there are family physicians (Green et al. 2004). US health system reform efforts have attempted to emphasize the importance of primary care and have been the impetus for the recent growth in PA and NP programs (Mullan 2002). Nevertheless, most FPs/GPs in the USA are in private practice and almost half still practice single-handedly (Bindman and Majeed 2003:631).

Across both countries, there has been a focus on collaborative health care teams as part of the renewal of primary care (cf. Bureau of Primary Health Care 1995). In a recent Health Accord, the federal and provincial governments in Canada promised that, by 2011, 50 percent of Canadians would have access to a multi-disciplinary team of health providers, 24 hours a day, 7 days a week (Canadian Nurses Association 2005:2). In the USA, managed care organisations have fostered the development of new team arrangements to perform tasks that had originally been in the domain of the primary care physician (Bindman and Majeed 2003:633). The full implementation of these teams, however, has experienced both barriers and facilitators at the macro and meso levels revealing the structural embeddedness of medical dominance.

Regulatory factors

One of the key macro factors influencing collaborative primary care is professional regulation, which is a provincial/territorial or state jurisdiction in both countries. Some models of professional regulation can prove to be a barrier whereas other models can foster teamwork. For example, Besrou (2002:15) has argued in the Canadian context that:

'the legal and regulatory framework, particularly as it governs the responsibilities held by each of the professions, represents more of a hindrance to getting professionals to collaborate than the source of leverage it should be.'

The most problematic model or framework is that which regulates health care providers by exclusive scopes of practice. This effectively eliminates the possibility of the sharing of tasks necessary for functional collaborative care. The kind of model adopted in such provinces as Ontario, British Columbia and Alberta, where regulation takes the form of 'controlled acts'⁶ which could be shared is much more amenable to teamwork (Besrou 2002:16).

In Ontario, for example, the *Regulated Health Professions Act (RHPA)* controls the activities of 23 health professions by setting out 13 'controlled acts' which can only be performed by certain regulated health professionals. Physicians can perform 12 of the acts and may delegate the performance of those acts to others under their direct supervision. NPs⁷ have three additional 'controlled acts' beyond that of a registered nurse that they share with medicine – communicating a diagnosis, prescribing and ordering a form of energy – all of which they can practice independently. Such overlapping scopes of practice better enable collaboration by allowing substitution of available providers to perform certain activities (Hall 2005).

Despite the prescribing authority given to NPs, other regulatory barriers remain. Numerous other pieces of legislation – from pharmacy to laboratory to ambulance service acts – can inhibit their effective scope of practice. In the province of Manitoba, for example, *The Pharmacy Act* recognized only physicians, dentists and

veterinarians as legitimate prescribers (Canadian Nurse Practitioner Initiative 2005:31). There are also limits placed on the kinds of diseases and disorders NPs can diagnose, the drugs they can prescribe and the tests that they can order. Changes to these regulations often require consultation with related health professions, most notably medicine. Two exceptions can be found in Alberta and British Columbia, which have recently moved towards a more open formulary for NP prescribing (Canadian PCKI 18).

Although the typical regulatory model in the USA is by scope of practice, it is also often written into regulations in most US states that NPs require collaborative practice agreements with a collaborating physician and that PAs must practice under the supervision of a physician. This is particularly detailed for prescriptive privileges. Whereas PAs have dependent prescribing rights (i.e., always under supervision by physician) in 47 states, NPs have independent prescribing rights in a quarter of states and some form of collaborative or supervised prescribing rights, albeit under their own name, in the remainder (Hutchinson et al. 2001:1244). This regulatory model intuitively fosters greater collaboration but under stricter medical authority than that which exists in most Canadian provinces.⁸ Some have argued, however, that there is greater flexibility in everyday practices in the USA (US PCKI 5). The requirement for supervision, for example, is often not strictly enforced.

Economic factors

Coverage of services, funding and remunerative models are three key economic factors influencing collaborative primary health care in both Canada and the USA. Indeed, the financial arrangements surrounding the implementation of Medicare in Canadian provinces has had a profound impact on the ability to develop collaborative working arrangements in primary care settings. In many cases, the public insurance scheme was a source of funding for physician services that was not available for non-physician providers outside of hospitals. Funding non-physician providers to work with physician providers is thus an important barrier to developing collaborative care

models in primary care (Canadian PCKI 10). Creative approaches were often adopted to include these providers in collaborative care programs under traditional institutional arrangements. For example, funding could be diverted from another program or alternatively, a collaborative care program could be established as a demonstration research project, which would secure funds for non-physician care providers (Canadian PCKI 1). The challenge with diverting funds from existing programs or with research-based funding is of stability of funding for these programs over the long term.

Funding for NPs, for example, has been difficult to arrange in a primary care system that is still predominantly organized around FFS reimbursed medical providers. As Besrou (2002:21) argues:

'there are nurse practitioners trained in the profession who are not working in this capacity. The main reasons given for this situation are (that) the required positions are not adequately funded (and) current methods of compensating physicians work against the integration of nurse practitioners into a collaborative practice of primary health care delivery.'

FPs/GPs in most provinces with FFS payment are not reimbursed for the administrative costs related to working with NPs nor for the time required for consultations (Canadian PCKI 7). Funding for NPs, when available, tends to be project-based rather than institutionalised (EICP 2005b:ii). For example, a Primary Care Transition Fund was created out of the previously mentioned Health Accord but this was mainly directed to support research and demonstration projects of multidisciplinary team-based primary care initiatives rather than to provide long-term stable funding (Health Canada 2004: 3). Further, the meso-level institutional arrangements associated with funding agencies' documentation requirements can prove to be a burden to participants in collaborative care arrangements (EICP 2005b:ii).

In the USA, there is a greater variety of funding arrangements for primary care than in Canada. This has the effect of providing greater incentives for interdisciplinary primary health care delivery,

by enabling flexibility in funding collaborative activities. For example, in capitated models of payment – where funding is allocated according to a standardised formula per patient rather than on the number of services provided – there are incentives to employ NPs and PAs because they can provide similar services to physicians often at lower costs (cf. Roblin et al. 2001). A review of NPs and PAs in the U.S. by the Bureau of Health Professions (2001:15) states:

'economics served the non-physician providers. They were less expensive than new physicians, and in the climate of cost containment, they were ideal alternatives. They could provide basic care, leaving the more difficult patients and problems to the physicians.'

More recently, two additional advantages have accrued to USA NPs that are not available in Canada. First, several states now authorise direct reimbursement to NPs by private and commercial insurers (US PCKI 5). Second, NPs now can be reimbursed by Medicare at a rate of 85 % of the physician fee schedule amount, regardless of geographic location or setting (American College of Nurse Practitioners 2006).

Institutional factors

Related to the broader regulatory and particularly the economic factors noted above is the influence of various institutional arrangements that foster or hinder collaborative care. In Canada, new institutional models of collaborative primary care delivery⁹ have emanated from the primary care renewal initiatives at the federal and provincial levels and some have been financially supported through the Primary Care Transition Fund. Indeed, a recent overview of these initiatives states that 'teamwork and interdisciplinary collaboration is now expected from health care providers working in primary health care organisations or participating in networks of providers' (Scrimshaw 2005:2). In the province of Ontario, these initiatives began with the development of Family Health Networks (FHNs) that consist of at least five family physicians who freely decide to collaborate with each other and

other health care professionals such as NPs (Besrou 2002:10). The most recent initiative is the Family Health Team (FHT) model that broadens the interdisciplinary base of providers to also include nurses, pharmacists, social workers, psychologists and other health care providers depending on local needs and circumstances (Ontario Ministry of Health and Long Term Care 2004a). FHTs are initiated and led by physicians and current policy requires that each FHT contain a physician. This demonstrates the institutionalisation of medical dominance even within the newest models of primary care reform.

Both of these models also altered economic factors removing the disincentives to collaboration associated with exclusive FFS remuneration and lack of insurance coverage for non-medical providers. The models include flexibility in compensation that may include a blending of capitation, FFS, lump sum payments and special allowances made directly to the network or team (Besrou 2002:10). Indeed, the bulk of recent increases to physician funding is dedicated to these new models and has created significant financial incentives for GPs/FPs to join.

The pluralistic organisation of primary care in the USA has provided some of the inspiration for the recent changes in Canada (Lamarche et al. 2003:9). One of the most salient is the Health Maintenance Organisation (HMO) model whereby a wide range of comprehensive health care services (not just primary care) are available to a prepaid group of clients. Such integrative models have been bolstered by the growth of managed care (cf. Mullan 2002), and are generally supported by medical organizations with the stipulation of medical supervision. The AAFP (2004) for example, states:

'integrated practice arrangements should include a licensed physician ...supervising one or more non-physician health care providers (physician assistants, advanced registered nurse practitioners, certified nurse mid-wives, various levels of nursing personnel and other non-physician providers) and possibly other physicians working as an interdependent team. ... The team member assuming lead responsibility for various aspects of patient

care will ultimately be determined by matching team members' clinical competencies and skills with patient needs.'

Similar supervisory language is implicit in recent Canadian initiatives indicative of a more professional coordination (i.e., medically dominated) rather than truly collaborative approach (Lamarche et al. 2003:9). Thus, despite the attempts to develop new institutional arrangements to promote collaboration, medical dominance may be resilient in practice.

Collaborative mental health care

In Canada, several factors have fostered interest in collaborative models of mental health care. First, long waits for referral to specialists and shortages of psychiatrists and family physicians (Goel et al. 1996; Pitblado and Pong 1999) have placed considerable pressure on practising family physicians. Thus, a substantial and growing proportion of mental health care is delivered by FPs/GPs (Arboleda-Flórez and Saraceno 2001) despite there being numerous potential provider groups – psychologists, social workers, and in some provinces, psychiatric nurses. Where providers are in short supply, there is a kind of creeping increase in scope of practice for available providers (Canadian MHKI 1). As a result, FPs/GPs have indicated their need for support from other mental health professionals in mental health service delivery (Craven et al. 1997) and for the expansion of shared mental health care (Kates et al. 1997).

A number of models of 'shared' or 'collaborative' mental health delivery have emerged in recent years in Canada. The simplest involve sharing care exclusively between family physicians and psychiatrists. Increasingly, however, consumer and provider organisations are calling for the inclusion of a wider array of interdisciplinary mental health providers to offer complementary services such as counselling and psychotherapy services (Bland 2002; Gagne 2005). The Canadian Mental Health Association (2003: 23) recommended '*interdisciplinary linkages between physicians and psychologists, nurses, social workers, occupational therapists and addiction counselors.*' The importance of

collaborative mental health care has also resulted in the development of the Canadian Collaborative Mental Health Initiative (CCMHI), which was funded by the federal government to create strategies to encourage primary health providers to work together (Pawlenko 2005).

In the USA, a similar array of mental health provider groups exists, the largest group being mental health social workers, followed by counsellors and psychologists (116,000, 96,000 and 36,000 respectively as of 2004 (Bureau of Labour Statistics 2006 a,b,c). An additional group is psychiatric NPs whose increase in numbers has been balanced by the decrease in psychiatric nurse specialists (Merwin and Fox 1999:905). There is a similar push towards collaborative mental health care in the U.S. as in Canada. Several HMOs and managed care organisations provide excellent examples of collaborative care arrangements (Macfarlane 2005). There is also growing recognition of the importance of integrating primary care and behavioural health in the USA over the last decade, including reports from the Surgeon General and the Institutes of Medicine, and a growing evidence base to support these models (Unutzer et al. 2006). There is, however, no national policy guiding a broad-based movement to enhance the capacity of mental health care.

Regulatory factors

The professional regulatory factors raised in the case of collaborative primary care are relevant to mental health care with three issues specific to mental health care. The first is that some mental health providers are excluded from omnibus overlapping scope regulatory packages. For example, in the Ontario context, social workers are not regulated under the RHPA but rather in a separate regulatory act. This potentially limits the possibility that social workers can have an overlapping scope of practice (i.e., share controlled acts) with other mental health care providers on collaborative teams but some of the economic facilitators (described below) help minimise this barrier.

The second issue pertains to prescriptive privileges. As noted earlier, prescribing medic-

ations is a regulated activity not enabled by psychiatric nurses, psychologists and social workers. This limits the scope of activities each group of providers can bring to the collaborative care team. While NPs have prescribing rights, in practice the limits placed on the types of medications that they can prescribe effectively restricts what they can contribute to the mental health teams, as there are virtually no medications for mental illness that they are legally allowed to prescribe or monitor independently. As one of our informants noted:

'there's only one medication of all the medications for nurse practitioners that resembles a psychiatric drug and that's lorazepam....No antidepressants. No antipsychotic. There's no medication for the side effects of some of these medications'.

(Canadian MHKI 1)

A third issue is the lack of regulation of psychotherapy – which along with medication, is one of the two main mental health treatment modalities. In all Canadian provinces, psychotherapy is not a controlled act and there are no restrictions on who can provide it. As one of our informants noted, 'it is... in essence an unregulated activity except when it is provided by a practitioner who happens to be regulated' (Canadian MHKI 3).¹⁰ This lack of regulation also holds true for counselling. Thus, although the restrictions on prescriptive privileges can limit collaborative care, the lack of regulation of psychotherapy can be seen to foster collaboration because many different provider types can provide these services. Indeed, many specialise in psychotherapy including some family physicians¹¹ because of the lack of restrictions.

Similar to Canada, psychologists and social workers in the USA do not have prescriptive privileges but NPs do, albeit limited by their collaborative practice arrangements. But because these are negotiated on an individual basis they can be more responsive to psychiatric pharmacopoeia than the standard primary care formularies that exist in Canadian provinces (with the exceptions of Alberta and British Columbia). Legislation granting these rights to psychologists

with specified additional training has been passed in the states of New Mexico and Louisiana (APA Online 2002; Millard 2004; Williams-Nickelson 2006); there has been less discussion of this issue in Canada. As in Canada, there are many providers of psychotherapy and counselling services in the USA, but a licence to practise is required in all but two states (Bureau of Labor Statistics 2005a).

Economic factors

Similar remunerative, funding and coverage of services issues noted in the case of primary care – such as the disincentives that come with FFS medicine – are also relevant to collaborative mental health care. As one informant noted, 'you (physicians) can always bill fee for service, but you can't find the same funding to support a counselor' (Canadian MHKI 10). In addition to the difficulties reimbursing the few NPs who work in mental health care, there are also difficulties in funding psychologists and to a lesser extent other mental health care providers. As noted by Mcfarlane (2005:25), 'separate budgets for mental health care providers and general physicians can also be barriers to collaborative arrangements.' Part of the issue with respect to doctoral level psychologists is not only that they not have coverage under public health care, they are also more expensive to fund through pilot collaborative care projects (Canadian MHKI 11). This can limit their inclusion in collaborative mental health models. Indeed, very few collaborative care initiatives in the province of Ontario include psychologists, although nurses and social workers are frequently included as counsellors. Moreover, several of the collaborative mental health demonstration projects that have been funded through the primary care transition fund officially ended in March 2006, and it is unclear what, if any, sustainable funding for these programs will be available.

Economic factors are equally important as barriers to developing collaborative treatment of mental health care in the USA. Most models for financing care that use fee-for-service, 'carve-out', or capitated arrangements tend to work against integration of mental health and primary health care. 'Carve-out' insurance plans, for example,

finance mental services separately from general medical benefits. Goldberg (1999) argues that shared-risk capitation models in which mental health care and primary health care share common capitation and risk are the only models that provide incentives for the integration of care. Such models have existed for years in staff-model HMOs. Third-party payment systems not only hamper integration they also undervalue care not provided by specialists (Alfano 2005). Less of a funding barrier exists for psychologists in the USA than in Canada because in the USA Medicare, Medicaid, as well as several private health insurance plans, can be billed directly.

Institutional factors

In both countries, there has been a continuing shift away from long-term institutional care toward care in community settings (McDaid and Thornicroft 2005). Assertive Community Treatment (ACT) teams are one multidisciplinary team-based approach to care for the seriously mentally ill in the community. ACT teams include mental health staff trained in psychiatry, social work, nursing, substance abuse and vocational rehabilitation that provide treatment, rehabilitation and support services. Team members work in shifts to provide intensive services seven days a week (Ontario Ministry of Health and Long Term Care 2004b). The teams are directed by a coordinator, almost exclusively a psychiatrist, and include a sufficient number of staff from the core mental health disciplines, at least one peer specialist and a program/administrative support staff. Although ACT programs have been widely acknowledged as successful, their penetration remains limited to a few provinces and seven US states (National Alliance on Mental Illness 2006).

The new institutional arrangements being adopted in primary care in Canada also apply to mental health care. The ability to offer collaborative mental health care is an attractive feature to many family physicians involved in the development of models like the Family Health Teams in Ontario described earlier. These new institutional structures will encourage the formation of collaborative mental health service delivery, along with other collaborative primary

care practice. All provinces are creating some form of local primary health care initiative that includes mental health care or recognises that mental health care must be integrated into the scheme (Pawlenko 2005).

In the USA, a substantial proportion of mental health organizations (40% in 1994) were part of one or more managed care networks. Typically these included private psychiatric hospitals and non-federal general hospitals with separate psychiatric services. As in Canada, these rapid changes in mental health service delivery are prompting the use of new organisations of care delivery that support collaborative models. In primary care, the existence of Health Maintenance Organisations and Managed Care Organisations which traditionally 'carve out' behavioural (mental health and substance abuse care) has tended to work against the development of collaborative mental health teams. Nonetheless, several excellent examples exist. These include large co-located multi-specialty group practices, community-governed non-profit health centres and traditional private primary care offices. Indeed, the next trend will be to try to reintegrate behavioural health and primary care, although as we discussed under economic factors there are serious challenges to doing so.

Discussion

In sum, there are clearly important institutional, regulatory and economic factors that both foster and hinder the success of collaborative health care teams as these cases of primary and mental health care in Canada and the USA reveal. What is also implicit in our analysis is the difficulty in teasing apart these macro and meso influences because there is significant overlap and interaction between the different factors. A change in one factor that fosters collaboration, such as regulation enabling overlapping scopes of practice, may confront a barrier in another factor – such as institutional or economic arrangements, necessitating a multi-layered approach to change. As was highlighted in one of the Canadian policy documents, 'legal and regulatory frameworks, as well as adequate financing and funding, are necessary to support the shift to interdisciplinary

collaboration' (EICP 2005a:26). There are also other key macro and meso factors that could also be considered, including supply of both medical and non-medical providers, educational requirements, including interdisciplinary arrangements, and liability/accountability issues. Hutchinson et al. (2001: 1245), for example, argue that collaboration is much more difficult to implement in an environment of competition when there is a surplus of physicians. Similarly, Australian researchers have argued that the short supply of physicians in rural areas is often translated into significant power regarding allocation decisions (Kenny and Duckett 2004: 1059). Thus it is important to note that the diversity of factors raised in this paper are not exhaustive and for this reason the conceptual model we present here should be considered a starting point for further development.

Those macro and meso factors we focus on here do, however, enable us to highlight how medical dominance is sustained in this contemporary era as a structurally embedded phenomenon, and how it prevents models of care that potentially diminish medical power from succeeding. In Canada, this includes legislation and regulations created at a time when professional scopes of practice were more clearly demarcated and medical dominance more powerful (cf. Coburn et al. 1983). This has only more recently begun to change with overlapping scopes of practice legislation and only in some provinces. Medical dominance does, however, continue to be structurally embedded in public coverage of health care services – largely for physicians and hospital/institutional based services. Public funding has been very difficult to extend to other health care providers in the Canadian context, despite other options being allowed under the Canada Health Act. Though this is primarily because of concerns over rising health care costs, paradoxically, this means that public funding covers the most expensive form of care.

In the USA, non-medical health care providers have been more successful in securing coverage by both public and private insurers, which many have argued is due to both lower cost and the peculiarities of American anti-trust considerations.

State regulations governing professional scopes of practice, however, exhibit strong remnants of medical dominance (perhaps even stronger than in Canada); when collaboration is fostered, it often entails significant medical supervision. There is some evidence, however, that everyday practices in the USA (perhaps promoted by cost conscious health care managers) circumvent these more rigid state regulations. This is a theme that would need to be pursued in further research at a more micro level drawing upon the negotiated order perspective which others have used for this level of analysis.

The differences in how medical dominance is structurally embedded in Canada and the USA – particularly with respect to the greater variability in health care funding and institutional arrangements in the latter – implicitly supports Larkin's (1983) crystallisation of the medical dominance thesis. According to his argument, the establishment of the publicly funded National Health Service in the UK helped *crystallise* medical dominance by structuring it into a public health care system thus making it more difficult for other health care professions to become more securely established in the health care division of labour. A similar crystallisation argument could be made of Australia with the establishment of Medibank in the early 1970s even though some have argued more traditionally that it represented a break in the tradition of 'ultimate medical professional veto power in health policy decision making' (De Voe and Short 2003: 343). Larkin's thesis takes a wider lens than this more traditional view of public medical care representing the beginning of the decline of medical dominance (cf. Coburn et al. 1983). He argues that the medical profession may have lost the battle in those jurisdictions where publicly funded medical care has been established but they have gone on to win the war of sustained medical dominance (cf. Groutsis 2003).

The key elements which emerge from our analysis are not so much the role of legislation and regulations, but more particularly the form in which public funding and health care provision are institutionally arranged. Perhaps the variability in the US system limits the crystallisation of

medical dominance there more so than in Canada or similarly organised health care systems. In addition to this variability argument, it is important to point out how coordinated action to foster true collaboration is not only needed across the various factors we have discussed, but also across a number of influential institutional bodies – professional, managerial and governmental both at the federal and provincial/state level. An opportunity for such coordinated change exists at least in the short term in Canada through joint federal–provincial initiatives that address some of the institutional challenges to reform. These initiatives have contributed towards collaborative models through the Primary Care Transition Fund which supports the Enhancing Interdisciplinary Collaboration in Primary Health Care (EICP) as well as the Canadian Collaborative Mental Health Initiative (CCMHI) described above. This leverage of federal investment by getting the provinces to agree on where the money will be targeted may be an effective way to shift policy attention but as noted above, sustainability of change may be an issue when these funds cease. Similar integrative efforts were not readily apparent in the USA, and indeed would be even more difficult to enact across not only federal and provincial jurisdictions but across the myriad of institutional players in the American health care system. Perhaps similarly structured and coordinated federal–state systems, such as in Australia, could benefit from the lessons learned from these Canadian efforts.

Endnotes

- 1 This term is partly derived from Alford's (1975) concept of *structured interests*.
- 2 Note that as more mental health services are provided in community settings, a substantial proportion of mental health care is increasingly being delivered in the primary care setting, so there is overlap in the findings across the two cases presented.
- 3 Due to the inclusion of four comparative case studies and space limitations to describe these fully, supporting data from the documents (cited directly) and interviews cited either as primary care key informant (PCKI) and mental health key informant - MHKI will be presented in a condensed form. Readers are encouraged to refer to the following for a richer presentation of data on the mental and primary care case studies respectively: Chapter 2 of Mulvale, G. (2006) doctoral dissertation in the Health Research Methods Programme, McMaster University; Mulvale, G., and Bourgeault, I.L. (forthcoming). Collaborative models of providing mental health care - who ends up doing what and why? *Canadian Public Policy*; and Bourgeault, I.L. (2004) *Who's Minding the Gate: The Primary Health Care Division of Labour in Canada and the United States*. International European Sociology Association Conference on the Professions, Versailles, France, September.
- 4 FPs and GPs differ in terms of their entry into the profession; specifically, entry into general practice followed a one-year rotating internship after graduation from medical school whereas entry into family practice requires the completion of a one to two year residency program (Thuber, A.D. and Busing, N. (1999) *Can. Fam Physician* 45: 2084-2089). However, for the purpose of this paper I will use these terms somewhat interchangeably.
- 5 I deliberately use the term reintroduced because NPs were introduced into the Canadian health care system in the early 1970s but suffered a decline due to many factors including a perceived physician surplus and lack of appropriate funding arrangements (Angus, J. and Bourgeault, I.L. (1993) *Health and Canadian Society* 5(1): 55-81; 83-110).
- 6 Controlled acts include such things as communicating a diagnosis, prescribing a therapeutic pharmaceutical agent, ordering a form of energy (e.g., ultrasound, x-ray), managing labour and childbirth, and other physical procedures such as inserting a needle below the dermis, administering a substance by injection or inhalation.
- 7 NPs in Ontario are actually referred to as Extended Class Registered Nurses (RN(EC)).
- 8 Nova Scotia is the exception that has similar collaborative practice arrangements.
- 9 Institutional initiatives predating the recent surge of interest in team approaches to care in Canada include community health centers (CHCs) in the province of Ontario and the CLSCs in Quebec. Both of these centres support a collaborative approach to care typically involving physicians, NPs, nurses, social workers, health promoters, and community health workers (Ontario Ministry of Health and Long Term Care 2002). Whereas CLSCs have been more numerous than CHCs (147 versus 54 respectively), in both cases, there has been a lack of integration with the bulk of primary care practices of GPs/FPs (Besrou 2002:7).

- 10 In a recent report (April 2006) by the Ontario Health Professional Regulatory Advisory Committee, it was recommended that psychotherapy be regulated, though not as a controlled act.
- 11 Approximately 230 physicians in Ontario practise psychotherapy full time without meeting official training requirements. Efforts to develop educational standards for physician psychotherapists are underway.

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