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Professional Competition and its Influence on Access in Primary Health Care

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ABSTRACT

Due to the low availability of family physicians, Canadians are currently experiencing a crisis in access to primary health care (PHC). Interprofessional collaboration, supported by expanded scopes of practice for non-medical professionals, has been repeatedly presented as a potential solution to the challenges that have led to the access crisis. This capstone argues that interprofessional collaboration is likely to remain an ineffective policy goal as long as decision makers continue to neglect the self-serving and competitive character of interprofessional interactions. It argues that collaboration's unacknowledged second face is competition, and that fair and full competition is a likely solution to the access crisis and making good on collaboration's promises. Medical professional dominance in PHC has created an anti-competitive environment that allows physicians to subordinate other professions, leading to under-utilization of non-medical professionals and so the inhibition rather than expansion of access. An example of this is presented in a case study of non-medical prescribing. Reports from the United States and Europe suggest that supporting fair and full competition amongst health professions can improve access. Those reports provide details on the regulatory requirements for creating a health professionals' market that would allow for barrier-free competition, full patient choice, and the fruition of interprofessional collaboration's promise. This capstone concludes that PHC policy needs to move away from collaboration rhetoric and should focus on designing a system that optimizes the competition between health care professions for the benefit of Canadians.

INTRODUCTION

At this moment in time, Canada's primary health care (PHC) system is underperforming and Canada is lagging behind other counties in infrastructure and implementation (Suter et al. 2017; Bell et al. 2023). This underperformance of primary health care in Canada was highlighted in the 2002 Romanow Report and continues to be a national issue.

Primary health care providers working together, also called interprofessional collaboration or team-based care, has been listed by multiple government reports since Romanow as one potential solution to improving the system. Yet, amongst the reports of millions of Canadians without access to primary health care, there are media stories of argument and fighting amongst the very professions whose team-based effort is supposed to fix the problem.

In an effort to explain why interprofessional collaboration in primary health care continues to be the goal rather than the reality in Canada, this report explores the sociology behind the development of professions and the impact it has on the aspirations of team-based care. These investigations reveal that the competition for survival that exists between the health professions overrides any benefits to collaboration, and that the current Canadian health system creates an anti-competitive environment that favours physicians and impedes access.

This report suggests that striving for collaboration will continue to provide little progress towards improving access in primary health care and recommends increasing competition amongst providers in a fair, regulated market.

BACKGROUND

Primary Health Care (PHC), as defined by the World Health Organization, is a "whole-of-society approach" that involves integrated health services, empowers people to take charge of their own health and is necessary for preventative care, early diagnosis and treatment, and community-based care (World Health Organization n.d.). In Canada, PHC services are usually provided by family physicians or general practitioners, but also includes nurse practitioners, nurses, dietitians, physiotherapists and social workers (Canadian Institute for Health Information n.d.). The Canadian PHC system revolves heavily around the profession of medicine due to their historical role and consistently strong presence in policy and politics. Physicians hold autonomy in how they work with the rest of the health care system, a legacy from the implementation of Medicare in the 1960s (M. Leslie et al. 2020). However, the inability for family physicians to keep up with the demand of the growing and aging population has led to access concerns and calls for other health professions to take on a larger role in PHC care.

From a national public engagement survey entitled "OurCare", conducted in Spring 2023, it was determined that more than 6.5 million people living in Canada over the age of 18 do not have access to a regular primary care provider (Martin et al. 2023). This is a global problem; access to PHC has become a greater public health concern on an international scale as the population ages and the burden of chronic diseases grows (Eckera et al. 2020). The COVID -19 pandemic introduced new strains to all levels of healthcare, highlighting the need for improved access and a better approach to the PHC system in Canada (Bell et al. 2023; Martin et al. 2023).

Community-based early intervention that is provided by PHC decreases the number of hospital admissions, shortens hospital stays and reduces the risk of complications for patients (Bell et al. 2023). The inability to access quality PHC causes patients to seek out emergency rooms, either looking for care that could be provided by a primary care provider, or in need of emergency care due to a lack of

primary preventative care. This leads to an overwhelmed acute care system and poor patient outcomes (Martin et al. 2023).

The concept of access in healthcare can be described as having five closely related dimensions: *availability, accessibility, accommodation, affordability, and acceptability* (Penchansky and Thomas 1981). Much of the recent public discussion around PHC access concerns the need to improve the *availability* of primary care practitioners, specifically by increasing the supply of physicians (Herring 2022; Lee 2022) or finding alternatives, such as pharmacy-led walk-in clinics (Stremick 2022). However, *accessibility*, which is the location of health care services, and *accommodation* - how services are organized to meet patient needs - also require the attention of policy makers (Zwick 2022; Smith et al. 2019; Baranek 2005).

Interprofessional collaboration to address availability, accessibility, and accommodation issues has been suggested as one potential solution (Bell et al. 2023). A number of Canadian reports, both provincial and federal, have called for interprofessional collaboration as a means to improve Canadians' access to PHC beginning as early as 2002 with the Romanow report (Regan et al. 2015). There exists a large body of literature supporting interprofessional collaboration as a positive influence on health care system outcomes (Regan et al. 2015). In this context, team based care not only increases the number, and so the availability, of professionals who can provide care, helping solve the primary care shortage (Long et al. 2014), but it adds variety to where that care can be accessed.

Literature studying interprofessional collaboration in PHC suggests that enhancing scopes of practice or creating new provider roles may improve team based care and provide more choice to patients as they access primary care services (Bell et al. 2023; Suter et al. 2017; K. Leslie et al. 2021). In this sense, more choice provides more 'team' and so more availability and accessibility, and therefore increases access to PHC. Interprofessional collaboration would, under these circumstances,

open the 'bottleneck' of physician-centric health care services by increasing the size and location of the health workforce providing PHC.

Although policy changes have allowed for the expansion of scope, team-based PHC in Canada has suffered from implementation challenges (Suter et al. 2017). A 2005 report from the Health Council of Canada concluded that overlap in scopes of practice amongst health care professionals allows for flexibility and substitutability, but can make it difficult to optimize the various workers' activities due to role confusion, competition among providers, lost trust between professions, and over or under utilization of certain professions (Baranek 2005). In these observations we can see two opposing effects. On the one hand, legislative changes meant to improve collaboration and access creates new spaces for health care professionals to inhabit as they deliver care. And on the other, these newly created spaces create competition amongst health care professions due to scope of practice overlap and the creation of a 'turf war', in which individual and group self-interest can work against collaboration.

Multiple literature sources state that scope of practice expansion is the key to increase interprofessional collaboration and hence access, while others warn that creating overlapping scopes amongst professionals leads to greater competition between them. Is it possible for PHC professions to work together while also competing against each other? It may be possible, however the dominant focus on collaboration has led to an absence of policy on the competition side of the equation; and it is the inability to compete, not necessarily the lack of collaboration, that holds back reforms to improving access.

COMPETITION AS A PRE-REQUISITE TO PROFESSIONALIZATION

The creation, development and survival of a profession depends on its ability to compete. Abbott (1988) states that "professions both create their work and are created by it" with the link between a profession and its work defined as a jurisdiction. Professions develop when a jurisdiction becomes vacant, either through the creation of a new societal need or if a jurisdiction is left unattended by another profession. For example, psychiatry had a monopoly on the jurisdiction of psychotherapy until the 1970s, at which time they could no longer keep up with demand. This allowed psychologists and social workers to move in and create a legitimate claim to jurisdiction over psychotherapy as a field of practice. This sharing of the jurisdiction persists to this day (Abbott 1988). This example shows that a change in the jurisdiction of one profession affects the jurisdiction of another profession, and this competitive interdependent system forms "an ecology" (Gilbert 1998) that leads to evolution within professions based on the evolution of others. The desire for professions to stay in control of their jurisdiction, and therefore in control of their work, brings the professions into conflict. Professions are, therefore, "bound up with the pursuit of jurisdiction and the besting of rival professions"(Abbott 1988). Professional boundaries are and will be increasingly contested, forcing professions to defend their established jurisdictions, obtain new ones and redefine their status, as jurisdiction is the "central phenomenon of professional life" (Kroezen et al. 2013). Professions live, grow, diminish, and vanish based on their ability to compete with other professions over jurisdiction.

Health professions are created, and their scopes of practice defined by what they can do and what other professions will not let them do (Gilbert 1998). The dominance of medicine in the Canadian health system has been held firm by the professional monopolization of specific services and practices, and that dominant status is dependent on the ability to solely control that jurisdiction. The expansion of other health professionals' scope of practice means a loss of jurisdiction for physicians, and read through Abbott's account, is a threat to medicine's power and status. The expansion of non-

medical profession's scopes of practice starts a 'turf war' as jurisdictions overlap. Jurisdictional change inevitably involves interprofessional contests (Abbott 1988).

Abbott (1988) provides a strong argument for why interprofessional collaboration amongst health professions remains a policy aspiration rather than a practical reality in Canadian PHC. Overlapping scopes and overlapping patient populations put the professions in direct competition with each other. It is a competition to maintain power and influence for some, and the opportunity for others to gain. Under this model it is doubtful that progress towards expanding the scope of various health professions' practices over the past 20 years has emerged from a desire to improve collaboration or advance care. Rather, it seems likely that at least some of the impetus for these changes has been to protect a particular profession's jurisdiction and so it's members' social and financial survival. Indeed, conflicts over power, efforts to determine the ownership of professional turf, and advocacy for one's own profession have all been shown to work against collaboration (Herbert et al. 2007)

Professions that are politically influential, such as physicians, may stop or try to stop other professions from accessing activities that they have traditionally controlled (Lahey and Fierlbeck 2016). It is argued that regulation and organizational policies that restrict scopes of practice are lobbied for in the self-interest of professions protecting themselves, and not based on any evidence for patient safety or care (Frogner et al. 2020). The need to keep political influence and power means that much of the change seen in Canadian PHC remains physician-centric (Suter et al. 2017).

The self-regulating nature of health professions amplifies the competition over jurisdiction and further works against collaboration (Lahey and Fierlbeck 2016). Regulatory colleges are mandated to protect the public interest through enforcement of standards of practice (Regan et al. 2015) and the public has faith in the self-regulatory process because professional members are trusted to act in the

best interest of their patients (Lahey and Fierlbeck 2016). However, if the existence of the Colleges is dependent on the survival of the profession, self-advocacy will also drive the College's actions. In the United States, the US Federal Trade Commission and court rulings have recognized the risk of self-regulation as a means for professional self-protection (K. Leslie et al. 2021).

Self-regulation allows professions to determine how they interact with other health professions. This means that any expectations of interprofessional collaboration must be shared by, and enforced by, regulatory colleges (Lahey and Fierlbeck 2016). Leaving it to the Colleges to advocate for collaboration as a means to improve access requires them to ignore the competition for turf that exists between them. For example, Ontario's Health System Improvement Act (SO 2007) enacts collaboration as a requirement of health professions, by making collaboration part of the statutory mandate of each regulatory college (Lahey and Fierlbeck 2016). The province also introduced the *Regulated Health Professions Statues Law Amendment Act* in 2009 which mandated that in situations where controlled acts overlapped, regulators must work together to develop standards (K. Leslie et al. 2021). Regan et al. (2015) looked at the effectiveness of these pieces of legislation. From the point of view of interviewed representatives of the regulatory Colleges, the barriers to implementation and interprofessional collaboration were to be found in: practice protection, conflicting legislation, and lack of knowledge of other professions. Interviewees stated that if the legislation expected Colleges with overlapping scopes to work together on joint standards of practice, it would not happen (Regan et al. 2015).

This introduces the complication of defining what "collaboration" is in the context of self-regulated health professions. Herbert et al. (2007) states collaborative practice involves two or more professionals, and the patient, working towards a common health goal. It is unclear who has the authority to dictate the methods for reaching that goal, or who initiates interventions along the way.

Physician groups that support scope-of-practice restrictions also support team based care that is *led by* medical doctors, where physicians delegate care to other members of the team (McCleery et al. 2014). The College of Family Physicians of Canada states that they believe in collaboration, but stress that care cannot be "easily substituted" and that collaboration should happen on very specific, physician-led terms (The College of Family Physicians of Canada 2023). Again, self-regulation allows each profession's College to define what collaboration means for their membership always with the benefit of that same membership in mind.

In this sense, competition is inherent to professions, while collaboration is not. Within the current PHC environment physicians hold professional dominance; the ability to control their own work but also define the work or limits of other groups' work (Gilbert 1998). This inhibits other professions' capacities to compete and practice to their full potential. This lack of full and fair competition in turn prevents improvements in access.

THE ANTI COMPETITIVE ENVIRONMENT OF PRIMARY HEALTH CARE

Subordination has been an important tactic used by physicians to hold dominance over jurisdiction and other professions. The profession of medicine has used hierarchical workplaces and physician-centric policies to create an environment that does not allow other professions to compete by limiting their ability to practice. Scopes of practice for health professions in Canada have been defined more by history and politics than by evidence of knowledge or abilities, and the dominant position held by physicians in the health care system is reflected by the many controlled acts – restricted activities assigned to specific health professions - they have retained a monopoly over (K. Leslie et al. 2021).

CASE STUDY: NON-MEDICAL PRESCRIBING

Authorizing non-medical prescribing is becoming a popular method to achieve greater access. Ninety-nine countries worldwide have some level of non-medical prescribing in place, ranging from legislation in progress, emergency-only prescribing to full prescribing authority (Eckera et al. 2020). There is increasing interest globally in the roles of independent prescribing by nurse practitioners and pharmacists as these health professionals working in traditionally medical scopes of practice are seen as an opportunity to improve accessibility, patient experience and quality of care (Officer, Cumming, and McBride-Henry 2019). A Cochrane Systematic Review concluded that non-medical prescribing was as effective as usual care medical prescribers, leading to comparable disease management outcomes and patient satisfaction ratings (Weeks et al. 2016). Non-medical prescribing can alleviate strain on physicians, especially in areas of low physician to population ratios (Eckera et al. 2020).

Medicine did not share the jurisdiction of prescribing willingly. Physicians continue to try to maintain exclusive jurisdiction over prescribing, while other professions are working to create their own claims. Kroezen (2013) studied the "negotiating of professional boundaries by the nursing and medical professions when it comes to the task of prescribing medicines" in the Netherlands. Both professions made a case for their exclusive knowledge claims over the jurisdiction of prescribing (Kroezen et al. 2013). Both nursing and medicine actively tried to influence the public and policy makers in the years leading up to Nurse Practitioner (NP) prescribing. As the fight over jurisdiction continued, the medical profession altered its claims; over time the profession of medicine determined it would be "wise to put its energy into arranging nurse prescribing in such a way that the outcomes would be as beneficial as possible for itself" instead of outright resisting NP prescribing, which had not been effective (Kroezen et al. 2013). The medical profession changed their focus to having a say on the regulation of NP prescribing, attempting to preserve an element of intellectual or advisory jurisdiction.

In 2009, there was strong opposition from the medical community to Nurse Practitioner prescribing in Canada (The Canadian Press 2009). It was of the opinion of physicians at the time that non-physician prescribing would lead to a loss of control in care and medical training was the only training appropriate for prescribing (Desroches 2009). A position paper from The College of Family Physicians of Canada outlined 10 recommendations on how to control the prescribing of non-physicians (The College of Family Physicians of Canada 2010).

Family physicians who practice in Alberta's Primary Care Networks (PCNs) use their position in politics and health policy development to hold Nurse Practitioners (NPs) in a subordinate role by blocking direct public funding for NPs. This first happened in 2012 when the physicians were successful in stopping the implementation of NP-led Family Care Clinics (M. Leslie et al. 2020), and continues to this day through the Nurse Practitioners Support Program (NPSP). Funding for NPs through the NPSP flows through physician-controlled PCNs, giving physicians the power to determine if NPs practice or not, as the NPs rely on physicians to be hired and paid (Black, Fadaak, and Leslie 2020). This arrangement allows physicians to continue their dominance over NPs, who are seen as a threat to physicians due to their overlapping scope of practice (Black, Fadaak, and Leslie 2020). This competition for dominance over jurisdiction and the lack of funding not linked to PCNs has led to a lack of integration of NPs into Alberta PHC (Zwick 2022; Goulet 2021). Suter (2017) compared policies for team-based care in primary care settings in Alberta, British Columbia and Saskatchewan. Across all three provinces there was concern regarding the "distribution and control of funding streams" holding back the development of team-based practice (Suter et al. 2017).

Pharmacist prescribing has also faced critique and pushback. In Alberta, interviewed family physicians did not accept pharmacists' ability to initiate new prescriptions and stated that they did not have sufficient contact with community pharmacists to evaluate each individual pharmacist's

proficiency in prescribing (Faruquee, Khera, and Guirguis 2020). In the development of Ontario's legislation to allow limited pharmacist prescribing, physicians were at the table providing input into the legislation and publicly voiced concerns about the implications of the legislation (Nakhla and Shiamptanis 2021; Abdulla and Schurter 2022). Pharmacists have expressed apprehension around prescribing due to negative attitudes from doctors and the professional rivalry that exists between the two professions (Raiche et al. 2020; Mills, Patel, and Ryan 2021).

As the case study illustrates, the benefits of non-medical prescribing are going unrealized as the medical profession continues to dominate the policy and clinical practice environments of PHC. The expansion of scope to include prescribing for nurse practitioners and pharmacists did not lead to better collaboration, as was earlier suggested, but to jurisdictional conflict that has led the profession of medicine to stand firm and effectively deploy subordinating tactics to maintain turf.

If expanding the scope of practice of non-medical professionals on an uneven playing field does not lead to interprofessional collaboration, might enhancing competition by levelling the field be more effective? Put another way, might abandoning talk of collaboration in favour of policy supporting competition achieve greater access to PHC for patients? Literature exists that suggests more competition can improve PHC in general, but the environment of such competition must be fair and regulated.

JUSTIFICATION FOR A COMPETITIVE MARKET FOR PRIMARY HEALTH CARE

Acknowledging the existing conflict between the health professions in PHC is the first step to utilizing it to the advantage of increasing access to care. Step two is the removal of barriers that uphold

the anti-competitive environment that favours physicians and create an environment that allows other professions to compete, practice to full scope and provide patient choice.

A report written by the U.S. Departments of Health and Human Services, Labor and the Treasury and published in 2019 concluded that increased competition in health care is needed to reform the American PHC system (Azar, Mnuchin, and Acosta 2019). It calls for changes in federal and state law, regulation, guidance and polices to impact patient choice and competition in health markets (Azar, Mnuchin, and Acosta 2019). Canadians' culturally conditioned reactions to the introduction of ideas from the American health system tend to include outright and total rejection. However, these ideas could possibly be adapted and applied to the universal, public payer system in Canada. The report states governments restrict competition when they do now make a way for health professionals to practice at their full scope and state restrictions are often not in response to safety concerns or protection of patients, but rather the influence of a healthcare profession with overlapping scopes of practice who wants to use the restrictions to remove competition: "Extremely rigid collaborative practice agreements and other burdensome forms of physician and dentist supervision are generally not justified by legitimate health and safety concerns" (Azar, Mnuchin, and Acosta 2019). Increasing competition amongst healthcare providers can be done by removing restrictions for non-physicians on services they can provide and expand the scope of other providers. The U.S. report concludes that scope-of-practice regulations need to allow all providers to be able to bill and be paid independently, leading to increased quality and lower costs due to more competition and consumer choice in healthcare (Potera 2019). In March 2014, the Federal Trade Commission argued that the need for physician involvement in advanced practice nurses in practice in the Veterans Affairs system could lead to decreased access to health services by restricting competition (McCleery et al. 2014). Advocates for a national system of scope definition that would superseded state laws argue this would

increase access to primary care by reducing costs and increasing availability (McCleery et al. 2014) and that overarching standardization should be evidenced-based minimum scopes of practice for health professions (Frogner et al. 2020).

A report from the European Commission's Expert Panel on Effective Ways of Investing in Health concluded that competition amongst health care providers can improve access to health care (Barros et al. 2016). The requirements for a market of health professionals would include having several providers offering "more or less" substitutable services, with freedom over relevant aspects of their practice and they would compete amongst each other for patients. Patients would need to have free choice of provider and the payment to providers needs to be based on patients treated (Barros et al. 2016). There must be a properly functioning market and enforcement of competition rules for such a system to work.

A POTENTIAL EVOLUTION OF PRIMARY HEALTH CARE IN CANADA

Gilbert (1998) described the interdependent system of professions as "an ecology" where professions evolve due to the external pressures forced upon them by other professions. This evolution holds out the possibility that professional jurisdictions can be redefined, and in the context of PHC, the possibility that control of its policy and clinical environments might be redistributed. Creating a market of health professionals in a freely competitive environment would allow this access-supportive evolution to happen much more rapidly and more effectively than what is experienced today. Professionals would evolve to inhabit new jurisdictions, maybe creating new jurisdictions or vacancies along the way. Completely new professions may come into existence. A new 'system' for delivering care and how patient's experience that care is possible.

A potential PHC System, with policies and governance structures separate from the acute care system, could oversee compliance with competition rules and quality assurance expectations, working in tandem with regulatory Colleges. Under such a system, independent practitioners would practice to full scope and competency, and bill the public payer system for services provided. In short, they would have the full and fair capacity to compete for patients. Patients, who would be well informed through engaging educational campaigns, would know who can provide which services and would be free to see the PHC provider of their choice. Competing to meet the needs of patients means that patient choice would, alongside the quality assurance enforcement of the system's regulators, drive professional jurisdictional evolution. This same public pressure would also lead to improvements in the patient experience. No profession would have an elevated status or voice in health care policy or politics. The ability to meet the access crisis – by providing services that are available, accessible, and accommodating – would determine each profession's ability to compete.

Creating a fair, regulated market for health care professionals will require legislative and cultural changes and also more research and experimentation. Health care professional markets are imperfect and most research looking into competition focuses on insurers and hospitals, not individual practitioners (Currie, Li, and Schnell 2023). Competition in health policy must be used strategically and reevaluated as it could be helpful or harmful, or both, and the lack of evidence in practice requires judicious use (Barros et al. 2016).

Built upon a foundation of competition, is collaboration possible amongst health care professionals in the PHC system imagined here? If competition and collaboration truly are two sides of the same coin, co-existence should be attainable. Would a mutual respect between professions develop within the levelled playing field, kindling a recognition that working together improves patient outcomes? Is it possible that collaboration becomes an essential part of the care patients expect, giving

those who collaborate a competitive edge? More research is needed before trying to determine what form collaboration may take in a competitive PHC System. It would also be short-sighted not to acknowledge that other factors, such as Fee-For-Service or other funding models, will have an impact on how professions interact with one another and should be the focus of future research.

RECOMMENDATIONS & CONCLUSION

Although past calls for PHC reform through interprofessional collaboration were not wrong, they neglected a vital element in the relationship that exists between healthcare professionals. Pushing for team-based care while ignoring the competition and unfair advantage of physicians has led to very little improvement in access to PHC. This capstone concludes that PHC policy needs to focus on, and utilize, this competition to the benefit of patients.

Reforming PHC into a competitive market system that allows all health care professionals to work independently, practice to full scope and provide patients with choices will increase access. Such a system has the potential to shift professions and their jurisdictions based on patient need, further expanding access. The possibility of true interprofessional collaboration will still be alive, but what form it will take is yet to be determined.

Urgent attention is needed to address the PHC access crisis in Canada and policy makers need to recognize that without changes to the current anti-competitive system in which health care professionals currently operate, those same health care professionals will remain part of the problem. Bold reform focused on the long-neglected competitive aspect of interprofessional work is required before policy attention can turn to creating the conditions for true collaboration, and a stronger PHC system, to emerge.

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