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COLLABORATIVE HEALTHCARE DEFINED

COLLABORATIVE HEALTHCARE is an international transformative movement in primary health care. The World Health Organization, in 1993, defined the goals of primary care as follows:

“The ultimate goal of primary health care is better health for all. WHO has identified five key elements to achieving that goal:
1) reducing exclusion and social disparities in health (universal coverage reforms);
2) organizing health services around people’s needs and expectations (service delivery reforms);
3) integrating health into all sectors (public policy reforms);
4) pursuing collaborative models of policy dialogue (leadership reforms); and
5) increasing stakeholder participation.”

Collaborative health care subsumes this definition, but it is much more. It also defines a way of working together to reach these goals. Various levels of collaborative care practices are underway in the United Kingdom, United States, Europe and Australia. Canada and our province are just a few of the many countries and provinces to pursue collaborative primary care. Canada joined in transforming its understanding of primary health care system needs, beginning in 2003, with a federally funded initiative for collaborative care.

Our province accepts all the elements within the World Health Organization’s (WHO) Goal statement. There is, further, a recognition that the patient has been removed from the hub of the care model and that this error must be corrected. Still the patient care piece is only one piece of collaborative health care.

In BC, we have become a province where specialists are involved in diagnosis first and foremost, albeit after usually too long wait times. Treatment, including psychological treatment, unless it is

1 WHO site: tp://www.who.int/topics/primary_health_care/en/
on an emergency basis, is short term or non-existent for the mental illnesses that accompany chronic illnesses.

Our province has gone much further in its transformation beyond what we usually think about as practitioners and patient care. It is in the midst of creating transformation, through dialogue, about new ways of addressing:

• exclusion from care,
• needed service delivery reforms,
• public policy reform, leadership reform and
• stakeholder participation

This comprehensive shift in policy reform, in patient service, in delivery reform and, most of all, in dialogue rather than confrontation defines the hoped for collaborative health care system.

THE ENORMITY OF OUR HEALTH CARE CHALLENGES

Since 2005, the BC government has been studying discussing, listening and transforming its primary care models and frameworks with others outside government. There is a commitment to change. Much of the first part of the work was in gathering and analyzing data about population health. Our government and the BCMA then set about forming the first collaborative physician’s agreement, now signed.

Very briefly, their analysis became more and more focused on chronic illness and its costs now and into the future, as they studied. We must, as psychologists, understand the data on which these transformations are based.

HOW MANY BRITISH COLUMBIANS LIVE WITH CHRONIC ILLNESS?

Population by health status, BC, 2005-2006

This 34% of BC citizens with known chronic illness consume 80% of the health care budget (MSP, Pharma Care and Acute Care). The government estimates that, by 2020, there will be an increase to 59% of British Columbians living with one or more chronic illnesses and their cost of consumption of healthcare services will rise by 79%.

Based on a careful analysis, during and after these collaborative discussions, of both population and health statistics, along with the existing challenges and strengths, the BC government established the following seven priorities:

1. Improved access to primary health care
2. Increased access to primary maternity care
3. Increased chronic disease prevention
4. Enhanced management of chronic diseases
5. Improved coordination and management of co-morbidities
6. Improved care for the frail elderly
7. Enhanced end-of-life care

We face a challenge that is all of ours, both government and taxpayers. It is an economic challenge and it is an opportunity for psychology to enter fully into the public sector of helping. Our knowledge and contributions are known. BC, like other provinces, faces the ballooning economic costs of non-collaborative care as the population mean age moves upward.

Obesity and smoking and all their societal and psychological causes including decreased exercise through sedentary work have had impacts as the

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2 B.C. Ministry of Health, Medical Services Division. Chronic Disease Registers, 2005/06.
population ages. Within aging and vulnerable populations, we see these epidemic levels of chronic illnesses developed and still developing. Diabetes, cardio-vascular illnesses, kidney disease, high blood pressure and COPD, to name a few, are the consequences of the past decades of an excess and over-consumerism. The epidemic sized illnesses are costing individuals and society both in terms of its health and in terms of our government’s ability to pay. Clearly transformation of the system is the right call.

As a professional association, it is our time to begin collaborating.

These disorders are ones to which psychology brings knowledge about motivation, proven treatment methods for complicated depression and anxiety and our ability to act as primary care practitioners. We are uniquely qualified.

Through discussions framed as collaboration, not confrontation or moral suasion, our government and BCMA colleagues have moved from conversations to a charter agreement and a new way of providing health care that allows for more personalized care and enhanced patient management. The physician and patient are to be at the hub of a new planning process. The intent of the charter is that equally collaborative discussions can take place with other primary health care professionals.

It is now the time for psychology to be at the planning table, not as second sisters, but as collaborators. The only thing that may be in our way is our own attitude that there is only one model of providing treatment. A public practice model needs to be added to our possibilities.

I have seen a few decades now in British Columbia and I have watched changes in our profession. During the 1980s, a government cut off all contractual arrangements with sessional psychologists. I saw my profession reel and then recover as colleagues made their way into the private sector. This was painful for many. I watched as we learned to quit competing about methods and begin speaking in one voice about what we do. CBT describes a range of approaches and tools and we are finding a way to bring the domain of affect and emotions into the ways we speak about our work. Mostly importantly, we are configuring these additions as additions that make CBT even more effective. We are finding ways to incorporate meditation and mindfulness practices into a concern about relapse prevention—a concern for our patients continuing health.

Our efforts of the past two decades about the importance of evidence preceding treatment selection has served our patients and our colleagues well. Now is the time for discussion about collaborative primary psychological care. Just as we help our patients leave their pasts behind, it is time for us to move ahead without blame and rancor for past decisions made at government levels.

Now, with collaborative healthcare and with our newly developed classes of membership within the College, I see an opening happening for psychology to collaborate as full partners in developing primary psychological care within the public sector. Our colleague physicians know how our work complements theirs. They are ready to refer in much greater numbers if only we can set our minds to a new way of doing practice. There is a general understanding that illness always carries physical and psychological components, an acceptance that CBT is the proven treatment of choice.

**THE CHALLENGE TO PSYCHOLOGY**

Can we set aside our hurt pride, our desire to be paid in an old model? Can we sit down with government, collaborate with them with open heartedness and open mind? Can we put patients at the centre of our services hub and our thoughts? I expect we can, look at all we have done previously when we thought we had to change…we are quite good at it. Aren’t we?

A thorough reading of the Primary Health Care Charter: A collaborative Agreement (www.health.gov.bc.ca/library/publications/year/2007/phc_charter.pdf) is essential for all of us who view ourselves as primary care providers. This is the Ministry of Health’s guiding document as it looks to future collaboration and as it makes its serious attempts to provide health care to British Columbians living with chronic illness.