The Amyot* Lecture: “Medicare and Wellness - The Odd Couple”

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We are at a crossroads. The health care system that has enjoyed such success and popular backing is struggling. Public confidence is at record lows following years of restructuring but the support for the health care system and its founding principles remains high. The issue is not one of whether or not it continues but rather how it should reconfigure; what changes should be made; and what new directions must be taken? We must reflect on our fundamental values both as individual citizens and collectively as people. We must strive to regain “the moral centre of a common understanding,” as Dr. Nuala Kenny phrased it.

It is timely to be reflecting on and learning anew from our visionary forebears; what they teach us of the past and its meaning for the future. Dr. John A. Amyot, the namesake for this lecture series, was a giant – a visionary physician – who among his achievements introduced filtration and chlorination of water and pasteurization of milk to Canada. He also was a pioneer investigator (1912-13) of pollution in the Great Lakes. More recently, the principles enunciated by Emmett Hall in 1964 of comprehensiveness, universality, portability and public administration¹ are timeless. There is also enduring truth to the insights lent by the justifiably renowned *Lalonde Report*² of 1974. The report stands as a foundation for building the health system of the future.

Definitions

Medicare is the provision of “medically necessary acts”³ as identified in the

Medical Care Act of 1966. It is the basis of the publicly funded health care system.

“Wellness” is a relatively new word and appears irregularly in dictionaries. The most suitable definition is (drawing on the statement in the World Health Organization’s Constitution on health) “a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity.”⁴

Two solitudes

“Wellness” and “Medicare” currently exist as ‘two solitudes’⁵ or as an *odd couple*. Given that the goals of the two overlap, it is indeed odd that they represent two such differing perspectives.

Medicare is often characterized as a “repair shop,” or the “disease-centered model.” More often than not these descriptors are used as labels to identify what is wrong with the health care system. At its worst, the health care system fulfills this stereotyping. At its best, however, it is much more. Medicare is part of the Canadian sense of identity.

For its part, wellness is inextricably linked with the precepts and principles of population health which are key to progress. However, it has been characterized by its critics as a mere abstraction and a philosophical nicety detached from the real world of patients and their needs.

Whatever the perceived shortcomings of either Medicare or the wellness agenda, stereotyping is unhelpful because it is apt to polarize the discussion. Polarization is not what is needed. Integration is.

There is a pathway between Medicare and wellness that commands our attention. Our success in mapping and understanding this pathway will form the necessary trajectory for the future. Fortunately, there is a growing volume of knowledge and evidence to guide us. For example, the *Ottawa*

Charter of 1986 included calls to action for ecosystem health, for healthy public policy and for fostering greater equity.⁶ It also spoke of the need for “enabling people to increase control over and to improve their health.”⁶ It is a unifying vision, a metaphorical bed that both members of the odd couple could comfortably lie in.

“Bridging the gap”

There will always be support for a health care system that respects the principles of the *Canada Health Act*; that is accountable and transparent; and promotes innovation. Similarly, there will be a place for wellness and the population health perspective if they become more fully integrated into the health system of the future. This integration could result in “healthy public policy” – public policy that is sensitive to its health impacts – to date, it remains an elusive goal.

There is a significant gap between what we are doing and what could be done. Our central task is to explore, define and understand the connection between the health of an individual and of a population. What are the mechanisms, or the biological pathways of the determinants of health? Can we mitigate the ill-effects and enhance the positive? These questions have been posed before. The time has come to seek the answers and bridge the gap between the two solitudes.

Patient-centered medicine

The concept of Patient-Centered Medicine (PCM) is not new. PCM focusses on the person, the nature of their lives within their social, physical and economic environment, and the meaning of a health compromise in that context.⁷ At minimum, the goals of care are to empathize, communicate and find common ground between patient and physician. The treatment plan includes the patient as partner to the full extent that s/he is able. The engagement is continuing (not episodic)

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and, ideally, primary care and PCM would be maintained throughout the life cycle.

PCM brings the determinants of health to the individual patient encounter; results in higher patient satisfaction, fewer diagnostic tests, fewer referrals, higher adherence to treatment plans and better physiological outcomes; takes no longer than traditional approaches; and is an excellent foundation for pursuing the goals of disease prevention, health promotion and evidence-based care.⁷

Although PCM is not a panacea, it does achieve some integration of the aspirations of the wellness agenda, the goals of population health, and the need for effective care for the individual.

A case study – The changing workplace

The linkages between the determinants of health and wellness are seldom more apparent than in the workplace. As a practicing physician, my ability to treat and manage the work-related ailments of my patients is far more limited than I would like. This observation, of course, is anecdotal as is the sense I have that the situation is becoming worse.

According to the Institute of Work and Health (IWH) and the Canadian Policy Research Network (CPRN), over the past decade, there have been profound changes in the workplace.⁸⁻¹⁰ There has been a shift from blue collar to white collar work reducing physical risks but increasing workplace stress and pace. According to the IWH, in 1997, the number of work-days lost in Canada was 66 million or 6.2 days per employee.¹¹ What is most revealing, however, is that among the one third who had work-related health conditions, 60% were attributed to mental and/or emotional stress.¹¹

As one contemplates these findings, it is not hard to imagine why medical treatment struggles to provide definitive relief. As much insight as a practitioner may have in regard to the work-related problems of stress or of tenosynovitis or carpal tunnel syndrome, the prospects of therapeutic success are dim in the absence of a change in the circumstances of work.

The case study of the workplace is a good example of the need for linkages between the two solitudes. The changes identified at the level of the population of workers

informs the individual encounter. In addition, the phenomenon of determinants of health being adversely influenced by the workplace and its negative impact on health care delivery is important information. It is of value to the development of labour and health policy as well as being of interest to employers, unions and others.

Proposals

In contemplating the “odd couple” and the resulting isolation of the Medicare and the wellness agendas, some strategies to create integration of the two are in order. The following is a starting point and not an exhaustive list of proposals.

Primary care reform

Family practitioners, who make up almost 50% of physicians, will be important partners in any primary care reform initiatives. Family practitioners are more likely to have a community perspective of care; engage in collaborative practice; consider alternative payment schemes; and engage with people longitudinally. The foregoing is a formidable list of assets when contemplating change in delivery models. Across Canada, there are a number of practice settings that are characterized by collaborative, multi-disciplinary care and alternative payment approaches. If there were policy initiatives that supported further development and the principles of PCM, significant progress would be possible.

Literacy

Increased investment in literacy – at all ages – is a priority. According to the International Adult Literacy Survey (1994), only 22% of Canadian adults were in the top two levels of the five-level scale. Furthermore, over 50% of seniors (over 65 years old) were in the lowest level.¹² Literacy is as important in the context of health and health care as it is in the workplace for virtually all coping skills and a meaningful life itself. In the future, literacy should be part of any primary care reform initiative.

Conclusion

Progress is possible if it is based on the evergreen principles of Hall. Enactment of the other requirements in the health care system of the future involves an integration

of PCM, issues of literacy and effective evaluation. All can be woven into a coherent whole of primary care reform.

The whole would be characterized by a connectivity that would join the two solitudes, enriching both. The outcome would be a more robust health care system for the future, and a positive contribution to the health status of Canadians.

The task is daunting. It will require the efforts of, at a minimum, the political and governmental sector, the health professions and, certainly, the public.

The evolving opportunity deriving from the historical federal investment in research with the Canadian Institutes of Health Research must not be missed. The integration of research themes envisioned by the CIHR mandate is entirely congruent with these proposals and the bringing together of the odd couple.

The rewards are potentially great. There is a lot at stake including not only the future of Medicare, but of Canada itself. It is a time when wise choices are imperative.

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