

“More Doctors. More Care:” A Promise Yet Unfulfilled

**The Canadian Medical Association’s brief to the
House of Commons Standing Committee on Health
concerning health human resources**

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Robert Ouellet, MD, FRCPC
President



A healthy population...a vibrant medical profession
Une population en santé...une profession médicale dynamique

The Canadian Medical Association (CMA) is the national voice of Canadian physicians. Founded in 1867, CMA's mission is to serve and unite the physicians of Canada and be the national advocate, in partnership with the people of Canada, for the highest standards of health and health care.

On behalf of its more than 70,000 members and the Canadian public, CMA performs a wide variety of functions. Key functions include advocating for health promotion and disease/injury prevention policies and strategies, advocating for access to quality health care, facilitating change within the medical profession, and providing leadership and guidance to physicians to help them influence, manage and adapt to changes in health care delivery.

The CMA is a voluntary professional organization representing the majority of Canada's physicians and comprising 12 provincial and territorial divisions and 49 national medical organizations.



Executive Summary

The Canadian Medical Association (CMA) brief submitted to the House of Commons Standing Committee on Health makes 12 practical recommendations within the jurisdiction of the federal government for investing in the capacity needed to expand and retain our practising physician population. These recommendations are a clarion call for pan-Canadian planning and innovative thinking to meet an ever-increasing demand for physician services from the Canadian public. CMA's research on Health Care Transformation has shown that a commitment to ensuring an adequate supply of health human resources (HHR) is a common trait shared by high-performing European health systems. The last federal election campaign saw most political parties pledge to urgently address HHR shortages. Now is the time to keep those election commitments.

A. Capacity

Cuts to medical school enrolment in the 1990s contributed to Canada's significant shortage of physicians. Growing demand for physician services, the aging of the physician population and changing practice styles among younger physicians are further compounding the problem. Seriously addressing HHR shortages is crucial to transforming Canada's health care system into one that is truly patient focused.

Canada should strive for self-sufficiency in physician supply and do more to repatriate Canadians studying and practising medicine abroad. The CMA supports bringing into practice qualified international medical graduates (IMGs) already in Canada. IMGs should be assessed according to the same evaluation standards as Canadian graduates and more should be done to reduce the backlog in assessing IMGs. With recent increases to medical school enrolment, more support must also be given for the capital infrastructure and faculty required to ensure the highest standard of medical education.

B. Retention

Competition for physicians is an issue with both international and inter-provincial/territorial facets. The revised Agreement on Internal Trade (AIT) and bilateral agreements will ease the movement of health professionals across jurisdictions, but may exacerbate retention difficulties in underserved areas. Canada should be active in retaining and repatriating our health care professionals, particularly since the predicted physician shortage in the United States may result in a return to the physician out-migration seen in the 1990s.

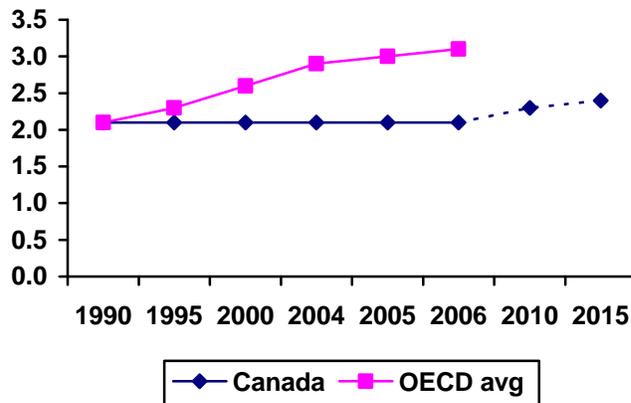
C. Innovation

Canada must do more to encourage innovation within our health care system. Collaborative care — including care delivered with the assistance of Physician Assistants (PAs) — and advances in information technology hold the promise of helping create a more efficient health care system that provides higher quality care.

Introduction

Canada has suffered from a significant physician shortage since the mid-1990s. Nationally, we rank 26th of 30 Organisation for Economic Co-operation and Development (OECD) member countries in physician-to-population ratio. We would need 20,000 new physicians just to meet the OECD average.

Figure 1: Physicians per 1000 population (including residents)



Source: OECD 2008 Health Data; CMA Physician Resources Evaluation Template

During the 2008 federal election campaign, four of the five parties represented in the House of Commons recognized the urgency of this situation and promised measures that would address HHR shortages. Following through on these promises is critical if we are to transform Canada's health care system into one that truly puts the needs of patients first. Research conducted for CMA's Health Care Transformation initiative demonstrates that European countries whose health care systems outperform our own all share a strong commitment to HHR, as demonstrated by their higher physician-to-population rankings.

A. Capacity

First-year medical school enrolment was already in decline when health ministers imposed a further 10% cut resulting in a low of 1,577 places in 1997. While there have been substantial increases since then, it took a decade to rebound. In 2007, first-year enrolment stood at 2,569 – 63% higher than a decade earlier. If we had left our domestic production unchanged, we would have almost 1,300 more physicians than we have today.

Canada remains well behind other industrialized countries in the education and training of physicians. In 2005, Canada graduated 5.8 physicians per 100,000 population, 40% below the 9.6 average for the OECD.

Currently, between 4 and 5 million Canadians do not have a family physician. Over one-third of all Canadian physicians are over the age of 55. Many will either retire soon or reduce their practice workload. Most are not accepting new patients.

Ironically, advances in medicine and lifestyle that are helping Canadians live better and longer also mean increased demand for health care professionals. An aging population with high expectations of the health care system is increasing pressure on health care providers to ensure they maintain a high quality of life through their elder years. A growing culture of ‘health consumerism,’ facilitated by the Internet has resulted in a very knowledgeable patient population that expects top quality care delivered in a timely manner by the appropriate health professional.

Advances in medical diagnostics and technology, new and evolving diseases and increasingly complex protocols and guidelines for medical care all increase the demand for physician services. Declining mortality rates for patients with diseases such as cancer have increased treatment of what have become ‘chronic’ diseases. In a collaborative care setting, physicians often take responsibility for the most complex patients.

There is evidence of a cultural change among physicians to place greater importance on their home life by working less. This trend may have a positive effect on the health of the profession but it means Canada will need more physicians to provide the same volume of services.

Greater coordination among jurisdictions is needed to facilitate HHR planning on a national scale. Canada’s doctors and other health professions are ready to assist policy-makers in their planning and coordination to better meet the health care needs of Canadians.

During the 2008 federal election campaign, most political parties recognized the urgency of addressing HHR shortages. The Conservative Party, specifically, promised to fund 50 new residency positions to increase supply of physicians in areas of priority need.

***Recommendation 1:** The federal government should fulfill its promise to fund 50 new residency positions at a cost of \$10 million per year for four years.*

Support for IMGs

The CMA fully supports bringing into practice qualified IMGs already in Canada. Canada has historically benefited from a steady flow of IMGs to our country. In fact, close to one quarter of all physicians in Canada and over 50% of doctors in Saskatchewan are IMGs. Many areas in Canada would have no physicians if not for the contribution of these practitioners.

While IMGs are a boon to Canada, actively recruiting from developing countries is not an acceptable solution to our physician shortage. Canada must strive for greater self-sufficiency in the education and training of physicians. In fact, self-sufficiency is a key principle of the government’s Advisory Committee on Health Delivery and Human Resources’ Framework for Collaborative Pan-Canadian Health Human Resources Planning.

CMA supports online assessment tools and websites that provide information to foreign-trained physicians so they know what standards they must meet once they arrive in Canada. In 2006, over 1700 people used the online assessment tool established by the Medical Council of Canada (MCC). CMA also supports applying the same evaluation standards to international graduates as it does to graduates of Canadian medical schools.

Despite a four-fold increase in the number of IMGs in ministry-funded postgraduate training programs over the last decade, there is still a backlog of IMGs awaiting entry into these programs. About 1300 IMGs applied for a postgraduate training position last year but only 350 (27%) were successful. CMA recommends that funding be made available to provinces for use in mentoring IMGs towards licensure. This could lower costs for the IMGs, pay the community preceptors, cover operational costs and defray other expenses.

It is estimated that up to 1500 Canadians are studying medicine abroad. Two-thirds of these IMGs want to come home to complete their postgraduate training. Canada turns away four good applicants for every student accepted into medical school. Increased training opportunities for all groups of IMGs will ensure that Canada fully utilizes the skills and knowledge of its citizens who have studied medicine.

Recommendation 2: *The federal government should make \$5 million (over five years), available to provinces/territories to address the backlog of IMGs through community preceptorship programs that mentor and assess IMGs for integration into the physician community.*

Recommendation 3: *The federal government should take concrete steps to ensure Canada becomes self-sufficient when it comes to the supply of health care professionals.*

Recommendation 4: *The federal government should continue to fund information tools such as the IMG-Canada website to better inform offshore physicians.*

Infrastructure and faculty

Canada's teaching centres have had to absorb increases in operational and infrastructure costs to accommodate increased enrolment. This includes instructors, space, overhead and supplies. While it appears that the number of faculty members has kept pace with the increased number of medical students, part-time faculty now make up a much larger proportion of the total than 10 years ago.ⁱ

In addition to the traditional academic centres, much of the training of doctors now occurs in a community environment. Mentoring is provided by physicians who may have less experience or resources than do those in the larger centres. Those who teach often experience lost productivity in their practice and receive little or no remuneration. This deficiency must be addressed to achieve a sustainable educational workforce.

Recommendation 5: *The federal government should implement a Health Human Resources Infrastructure Fund in the amount of \$1 billion over 5 years to expand health professional education and training capacity by providing funding to support the:*

- *Direct costs of training providers;*
- *Indirect or infrastructure costs associated with the educational enterprise; and*
- *Resources that improve Canada's data collection and management capacity in the area of health human resources.*

B. Retention of Canadian Physicians

Competition for physicians is both an international and an inter-jurisdictional challenge. The new Agreement on Internal Trade within Canada and numerous bilateral agreements will no doubt ease the movement of health professionals. This may exacerbate the already difficult task of retaining physicians in underserved areas. On the positive side, it is hoped this will facilitate the movement of physicians who provide short-term relief for physicians needing time off for continued professional development and vacation (i.e., locum tenens).

Repatriation

As the political situation and health care plans evolve south of our border, Canada should remain active in the quest to retain the health professionals we have educated and trained and make it easier for those who have emigrated to return to practice in Canada. The Conservative Party committed in the 2008 election campaign to create a repatriation fund for Canadian physicians practising abroad. The federal government should keep this important commitment.

Migration to the United States peaked in the late 1990s when Canada lost between 600 and 700 physicians per year. While some physicians returned to Canada each year, our net losses for this period were over 400 per year. Today we are enjoying small net gains each year but this may not last given the predicted shortages in the U.S. of between 80,000 and 100,000 physicians in the years ahead. We can expect U.S. recruiters to ramp up activities in Canada in the near future.

***Recommendation 6:** The federal government should fulfill its election promise to establish a fund of \$5 million per year over four years to help Canadian physicians living abroad who wish to relocate to Canada. It is thought this initiative could bring back as many as 300 Canadian physicians over four years.*

***Recommendation 7:** The federal government should establish a Health Professional Repatriation Program in the amount of \$30 million over 3 years that would include the following:*

- *A secretariat within Health Canada that would include a clearinghouse function on issues associated with health care workers returning to practise in Canada.*
- *An ad campaign in the United States.*
- *A program of one-time relocation grants for returning health professionals.*

Physician Health and Well Being

Ultimately, we hope that healthier physicians will create a more vibrant profession. Hopefully these healthier physicians will in turn create a more healthful professional environment that will support their ability to provide patient care of the highest quality.

Through programs and conferences, the CMA has contributed to growing efforts to reduce the stigma surrounding physician ill-health and to support a new, healthier culture for the profession. Given the myriad other issues that contribute to our doctor shortage, it is clear that Canada cannot afford to lose a single physician to ill health.

Our research shows that the most stressful aspect of the medical profession is being on call after hours. Physicians average 50 hours a week in the usual settings of office, hospital or clinic but then 70% are on call for another 30 hours per week. In small communities, physicians are often on call all the time. A quarter of all physicians face some form of mental health challenge that makes their work difficult. This is higher than the 1 in 5 Canadians that will face a mental illness over their lifetime.ⁱⁱ

The ongoing pressures experienced by overworked physicians can result in stress related disorders and burn-out and are frequently a precursor to more significant physical and mental health problems. If not addressed early, these conditions can lead to physicians taking prolonged periods of time off work, changing their practice patterns or leaving the practice of medicine altogether.

Prevention programs are the key to assisting physicians before they are at significant risk. The CMA visited such a program in Norway which has been shown to significantly reduce burn-out and reduce the subsequent time-off work related to stressⁱⁱⁱ. A program to enhance physician resiliency and prevent stress related disorders, based on the Norway model, could be expanded to include services for all health professionals. The potential impact would be improved provider health and morale, reduced sick days and fewer long-term leaves.

Recommendation 8: *The federal government should invest in research directed at assessing the quality of work life among health workers through an interprofessional survey at a cost of \$1.5 million.*

Recommendation 9: *The federal government should explore the feasibility of developing a ‘made in Canada’ Resiliency Program for Health Professionals that would include the development of a feasibility study, including a business case, and a pilot curriculum, at a cost of \$500,000.*

C. Innovation

While Canada must do more to increase both our supply and retention of HHR, we must also encourage innovation within our health care system to make better use of our existing health resources. Collaborative models of interprofessional care and advances in information technology hold the promise of helping create a more efficient health care system that provides higher quality care.

Physician Assistants

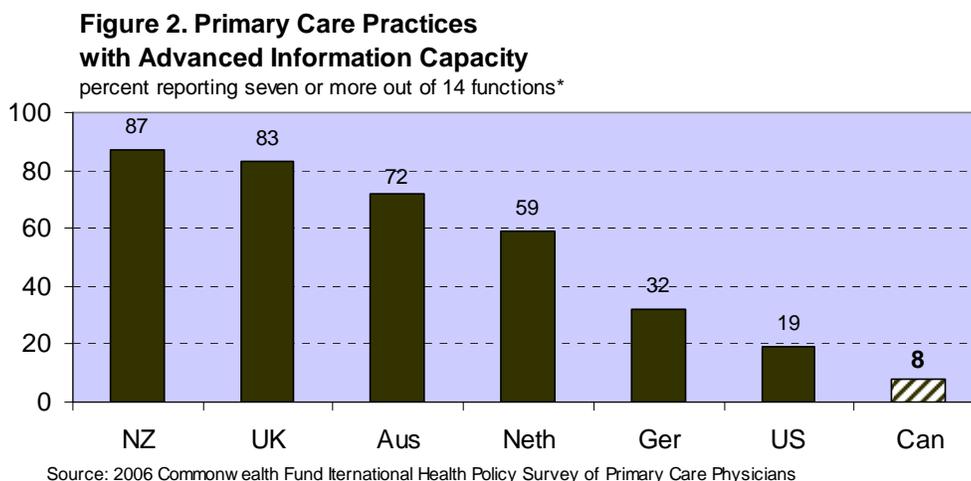
Increasingly physicians are working in interprofessional teams that may include professions that are relatively new to Canada’s health workforce such as physician assistants (PAs). The CMA accredits PA curricula and has held two conferences to promote the use of PAs in all levels of care.

Recommendation 10: *The federal government should fund a study to evaluate the impact of physician assistants on access to health care and to determine their cost effectiveness relative to other providers at cost of \$150,000.*

Technology to Support Health Care Delivery

Information technology will continue to create a more efficient and effective health care system. It will lead to more patient safety, more Canadians finding a physician, better care, cost avoidance such as eliminating duplicate tests and the establishment of collaborative interprofessional health care teams.

Canada's adoption of electronic medical records lags behind other OECD countries. We only spend a third of the OECD average on information technology in our hospitals. The adoption of EMRs in community settings (primary care, home care and long-term care facilities) also trails most other countries (Figure 2^{iv}). This is not due to any general resistance by providers, but rather a combination of: a lack of evidence on how best to use electronic records to improve care delivery; a need to improve the return on investment for physicians by providing value-added solutions such as greater connectivity to lab results, drug data and colleagues; the time it takes to implement a new electronic record capability and a lack of funds to acquire new technology.



Recent investments in Canada Health Infoway (CHI) will help address some of these issues but it is estimated that for Canada to have a fully automated health care delivery system we need to invest \$ 10 to \$12 billion^v. An overall investment of \$2 billion is required to fully IT enable the community-based health care delivery sector. While Budget 2009 provided \$500 million to CHI for EMRs, more is still required.

Recommendation 11: *The federal government should provide a further investment of \$500 million for new technology to fully enable all points of care in the community settings and an enhanced change management program to speed up EMR adoption.*

Recommendation 12: *The federal government should create a \$10-million fund to establish an applied research program for the next five years that will provide evidence on how best to integrate information technology into the health care delivery system.*

D. Conclusion

Canada's doctors believe that we can build a health care system where all Canadians can get timely access to quality health care services regardless of their ability to pay. Developing a comprehensive HHR strategy that assures an adequate supply of all health care providers, including physicians, is a pillar of achieving timely access to high quality care. Building such a system requires that we shift our attitude and move to implement new strategies, new ideas and new thinking. That new thinking must begin with a commitment to act now to address Canada's physician shortage. A promise made must be a promise fulfilled.

References

ⁱ Canada's Health Care Providers 2007, Ottawa: CIHI, 2007

ⁱⁱ Frank E. Canadian physicians healthy – national survey finds. A report from the 2008 International Conference on Physician Health. London, UK Nov 2008.

ⁱⁱⁱ Isaksson Ro, K et al. Counselling for burnout in Norwegian doctors : One year cohort study. *BMJ*. November 2008. Vol 337, 1146-9.

^{iv} * Count of 14: EMR, EMR access other doctors, outside office, patient; routine use electronic ordering tests, prescriptions, access test results, access hospital records; computer for reminders, Rx alerts, prompt test results; easy to list diagnosis; medications, patients due for care.

^v Vision 2015 - Advancing Canada's Next Generation of Healthcare, Canada Health Infoway, 2008