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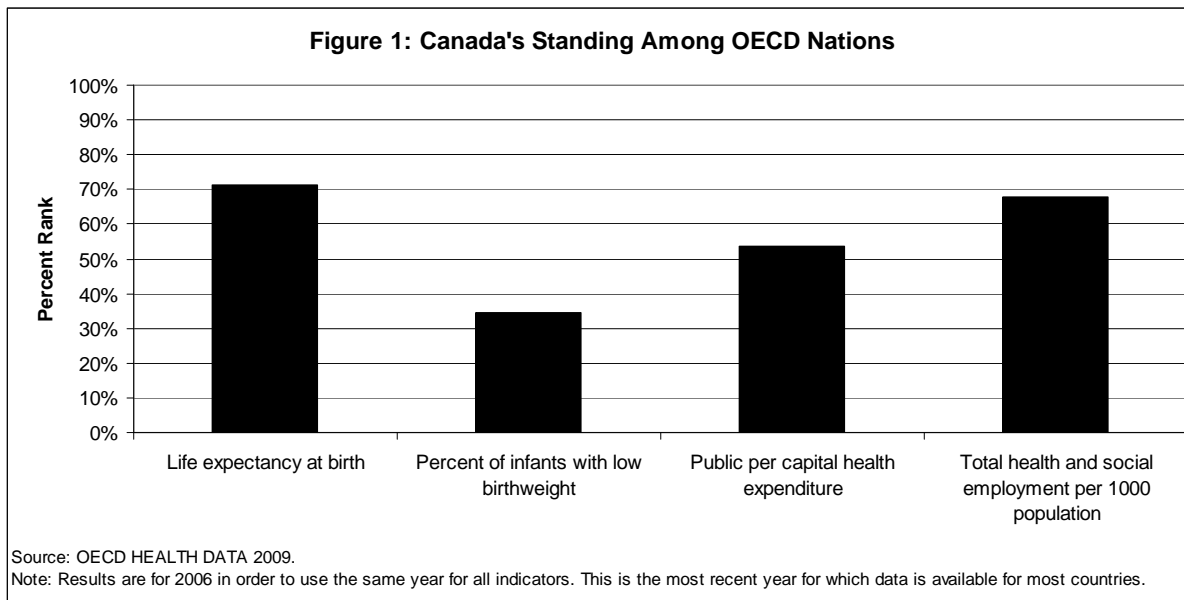
The Association of Faculties of Medicine of Canada
L'Association des facultés de médecine du Canada

Moving the Health Human Resource Agenda Forward

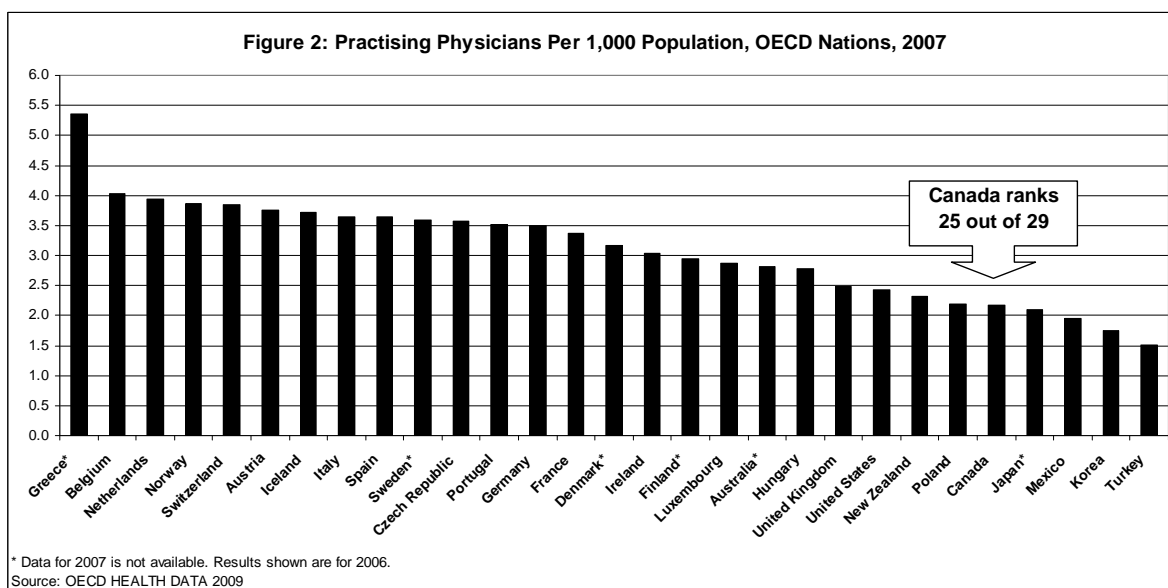
**Submission to the House of Commons Standing Committee on Health
From the Association of Faculties of Medicine of Canada (AFMC)**

December 2009

In global terms, Canada's health record shows mixed results. Compared to other member nations of the Organization for Economic Cooperation and Development (OECD), Canada fares relatively well on a variety of health-related measures. For example, approximately 70% of OECD countries rank below Canada in terms of life expectancy and total health and social employment per population. Just over half of OECD countries fall below Canada with respect to per capita public health expenditures. About 1/3 of OECD countries record relatively fewer low birth weight infants than Canada. These are good news stories for Canada, and are illustrated in Figure 1.



In contrast, Canada rates very poorly on the OECD physician supply indicator. In 2007, Canada ranked 25th out of 29 OECD nations with respect to its doctor-to-population ratio (see Figure 2). Moreover, Canada's relative number of doctors changed very little between 1993 and 2007, measuring 2.13 and 2.18 per 1,000 population in each year, respectively. It has been observed that "Canada would need an additional 26,000 doctors to meet the OECD average" doctor-to-population ratio¹.



¹ Canadian Medical Association, 2008. See http://www.cma.ca/index.cfm/ci_id/84950/la_id/1.htm. Cited 3 December 2009.

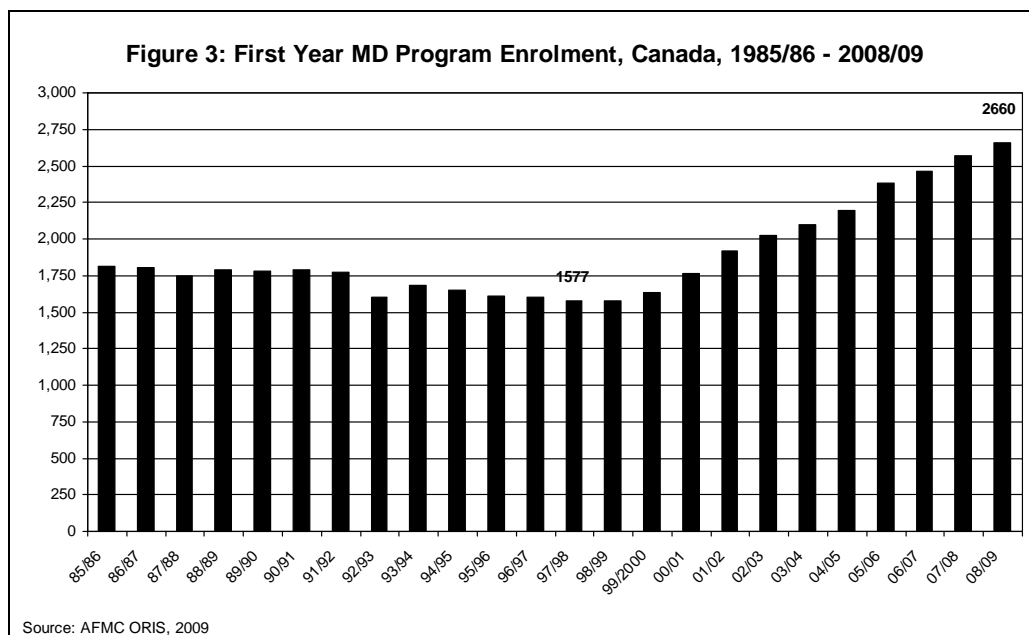
The challenges involved in closing Canada’s physician supply gap are significant and we cannot afford to be complacent. According to Statistics Canada, “in 2008, 84% of Canadians aged 12 or older reported that they had a regular medical doctor, down from 86% in 2003”. Furthermore, “among the 16% of Canadians who did not have a regular doctor, 56% reported that they had not looked for one while 43% reported they could not find a doctor”².

Applying Statistics Canada percentages to our current population (33,739,859³), an estimated 5,398,377 Canadians do not have a regular family doctor. More to the point, an estimated 2,321,302 Canadians have failed to find a regular family doctor in spite of their efforts to do so. As troubling as this figure is in isolation, it is also the case that there are additional Canadians who are struggling to access other medical, surgical and laboratory physician specialists.

There is no question that Canada has seen modest progress in these areas. For example, CIHI recently announced that “the number of practising physicians in Canada increased at a faster rate than the population over the past five years”⁴. Nonetheless, these improvements do nothing to change our global standing on this important measure.

Access to health care is a core Canadian value. It is imperative that we work together to meet the needs of Canadians who cannot access appropriate physician care.

Canada’s poor international standing on physician supply and the large number of people without family doctors are, in part, a legacy of our past. In the late 1980’s and early 1990’s, it was thought by many that Canada was facing a pending oversupply of physicians. As a result, entry level medical school class sizes were scaled back. In 1997, 1,577 students entered medical school compared to 1,812 in 1985 - a 13% reduction. Recognizing that in fact, Canada would quickly be in need of more physicians, these reductions were reversed; since 1997, entry level class sizes have increased 69%. In 2008, 2,660 students entered medical school. These trends are illustrated in Figure 3 below.



² Statistics Canada. Canadian Community Health Survey. The Daily, Friday, June 26, 2009.

³ Statistics Canada. Canada’s Population Estimates. The Daily, Tuesday, September 29, 2009.

⁴ Canadian Institute for Health Information. http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=media_20091126_e. Cited December 8, 2009.

Over the past decade, faculties of medicine and provincial-territorial governments have taken great strides to close Canada's physician supply gap. Increased MD program class sizes have resulted in 5,938 more students entering medical school. This is in addition to the number that would have entered if the 1997 entry figure remained in effect. In total, 23,285 medical students have entered Canada's faculties of medicine since 1997.

During the 2008 federal election, all major political parties recognized the need to respond to Canada's doctor shortage. More specifically, the Conservative Party of Canada promised to "fund 50 new residency spots in teaching hospitals across the country, and create a \$5-million incentive fund to encourage Canadian physicians practicing abroad to return to Canada"⁵. In light of Canada's enduring doctor shortage, it is essential that this commitment be implemented.

Alterations to admission levels in our faculties of medicine, either at the undergraduate or postgraduate levels, cannot be achieved by decree alone; the first step to achieving the goals of increased cohorts of learners is to engage with Canada's faculties of medicine. With respect to adding postgraduate positions in Canada, Postgraduate Deans and program directors must be engaged in discussions around how best to achieve desired goals.

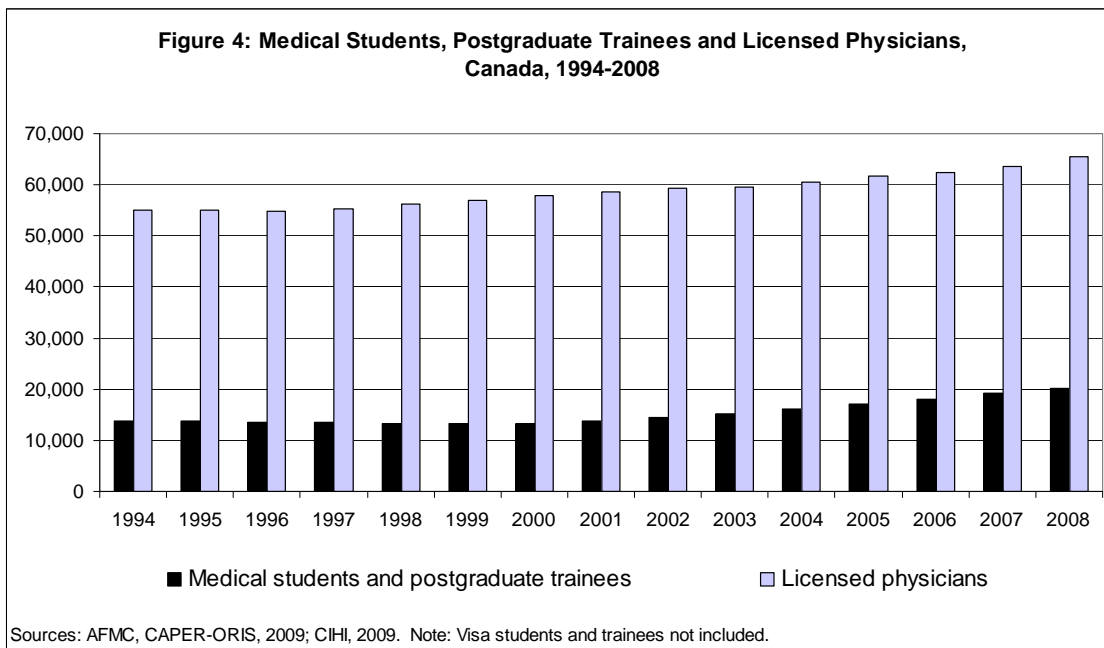
Canada's community of medical educators can shape and implement strategies that are feasible, strategic, and take into account the inherent capacity and resource constraints that exist in many faculties. As one option for fulfilling the promise of 50 new residency positions, the AFMC has proposed a model that makes modest reductions to visa trainee positions, such that the goal is met without placing additional financial or teaching demands on faculties of medicine⁶. Medical residency planning rests with postgraduate leaders and their respective provincial and territorial government partners. The AFMC strongly supports continued dialogue with faculties of medicine to develop and implement new residency training opportunities.

As the national voice of Canadian faculties of medicine, the AFMC calls for the federal government to engage with faculties of medicine to plan and implement support for 50 new residency training opportunities. Federal commitment of \$86M over the next 5 years will create 250 new postgraduate training positions, adding up to 250 new physicians to Canada's workforce targeting Canada's healthcare priorities. This strategy is consistent with promises made during the 2008 federal election and, more importantly, it responds to the needs of Canadians.

To truly address our physician resource challenges, we must first gain a better understanding of them. Improved research and data analysis will help prevent crises before they happen. While some physicians enter Canada fully trained and are directly licensed by regulatory authorities, the primary pathway to medical practice continues to be through the Canadian medical education system. To illustrate, Figure 4 shows that growth in the number of practicing doctors is, in fact, paralleled by increased undergraduate and postgraduate medical enrolment. Our health human resource planning record will improve if we truly appreciate that changes made to our health education system have the potential to dramatically influence physician supply in Canada.

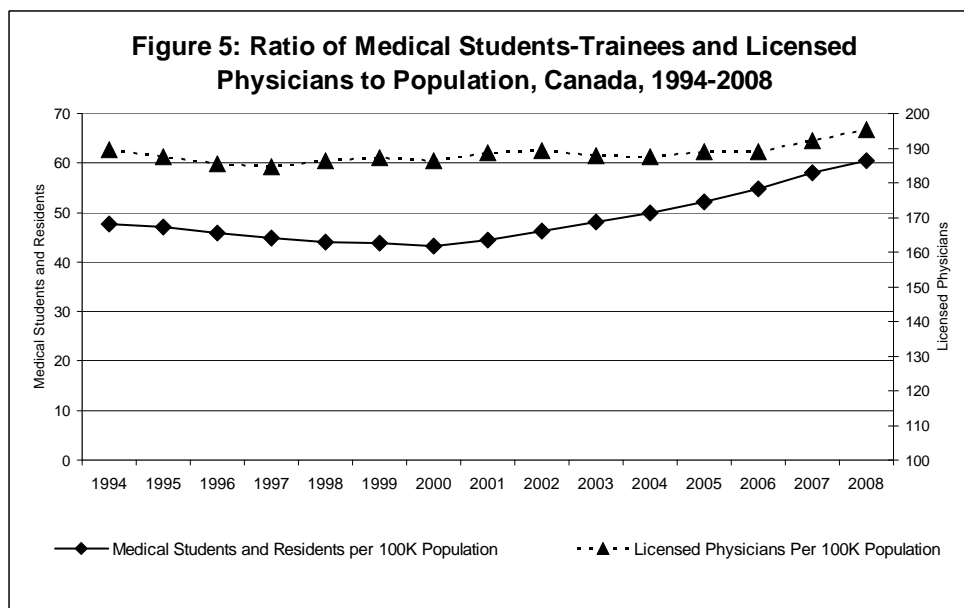
⁵ CANWEST News Service. Harper blasts opposition 'panic and pessimism'. 8 October 2008.

⁶ Association of Faculties of Medicine of Canada. Smart Spending in Difficult Times: Investing in our Future. <http://www.afmc.ca/pdf/financebrief2009-10.pdf>. Cited 4 December 2009.



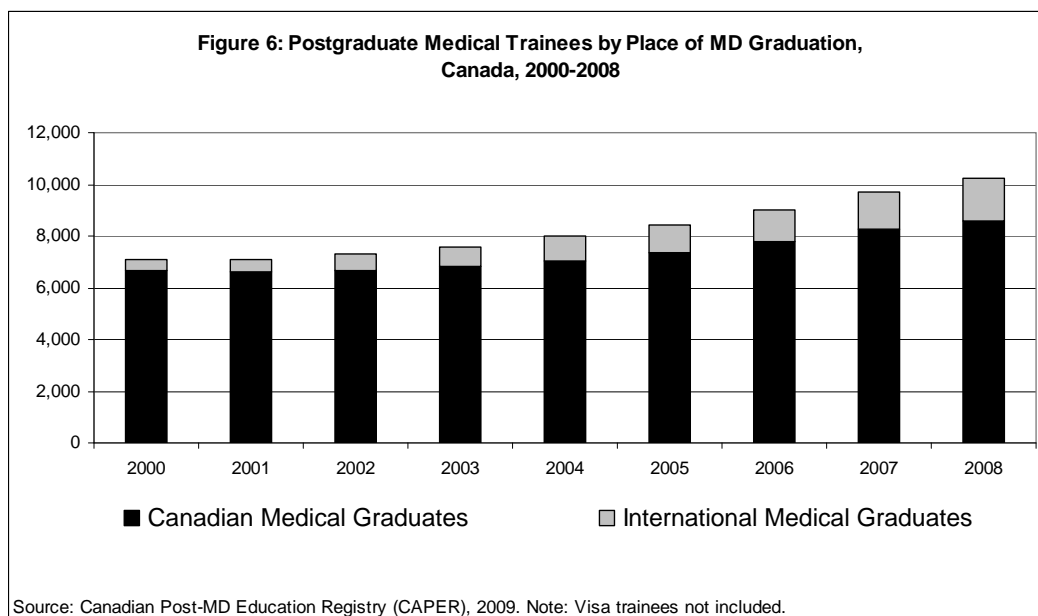
With respect to the physician workforce, early indicators of future supply come from within Canada's faculties of medicine. In general, it takes at least six years to complete undergraduate and postgraduate medical training in family medicine. For medical, surgical and laboratory specialists' completion of undergraduate and postgraduate medical education typically takes 8-10 years.

With these timelines in mind, Figure 6 illustrates how medical education trends forecast future physician supply. The ratio of medical students and residents to population took an upward turn in 2001 and the trend line has continued upward ever since. However, the ratio of licensed physicians (i.e., physicians who have completed undergraduate and postgraduate education) to population remained relatively flat between 2001 and 2006. In the past two years, 2007 and 2008, the relative supply of licensed physicians has shifted upward. This upward movement corresponds with increased medical school enrolment six years earlier. **In a very literal sense, when it comes to physician supply we must look at where we've been in order to gauge where we're going.**



More so than ever Canada’s faculties of medicine are bridging the gap between population and physician workforce growth. According to the Canadian Institute for Health Information, “in 2007, 22.4% of Canada's physicians were graduates of foreign medical schools, compared to a high of 33.1% three decades earlier”⁷. While their percentages may have dropped, international medical graduates (IMGs) contribute significantly to the care of Canadians, be it in meeting health care needs in underserved areas or bringing in new knowledge or reflecting the diversity of this nation.

While some IMGs are “practice ready” when they arrive in Canada, a growing number – and percentage – undertake postgraduate medical training in Canada. In 2008-09, 1,628 postgraduate medical trainees were IMGs. This figure represents a four-fold increase over the 411 IMGs enrolled in postgraduate training in 2000. Between 2000-01 and 2008-09, IMGs have increased from 6% to 16% of all postgraduate medical trainees (see Figure 6). Faculties of medicine are not only working to produce “home grown” physicians. Increasingly, they provide the final stages of training for those who started their medical education outside of Canada.



Canada’s medical education databases offer an important window on the future physician workforce. For example, Figures 7a and 7b illustrate how the gender demographic has changed within broad medical specialties over the last four years. Between 2004 and 2008, the percentage of male family medicine trainees dropped to below 40%. Similarly, males represent a decreasing proportion of trainees in other medical, surgical and laboratory specialties. These demographic shifts may be viewed in light of data telling us that female family physicians spend fewer hours per week on direct patient care compared to men, but they are also more likely to care for pregnant women, delivery babies and provide infant care⁸.

⁷ Canadian Institute for Health Information. International Medical Graduates in Canada: 1972 to 2007. CIHI, August 20, 2009.

⁸ 2007 National Physician Survey. The College of Family Physicians of Canada, Canadian Medical Association, The Royal College of Physicians and Surgeons of Canada. http://www.nationalphysiciansurvey.ca/nps/2007_Survey/Results/physician2-e.asp.

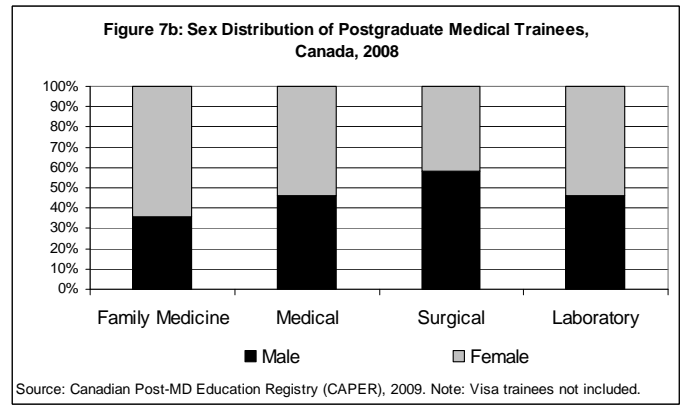
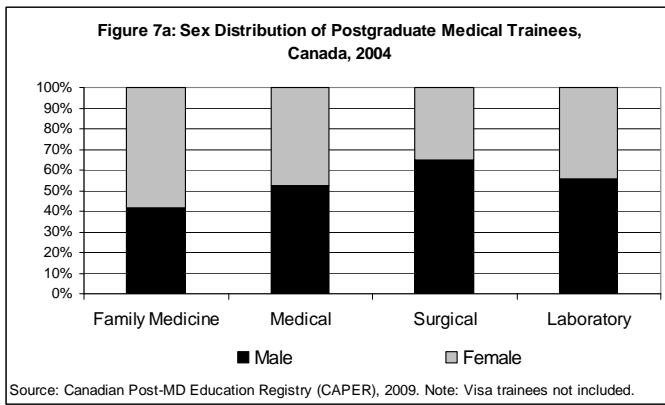
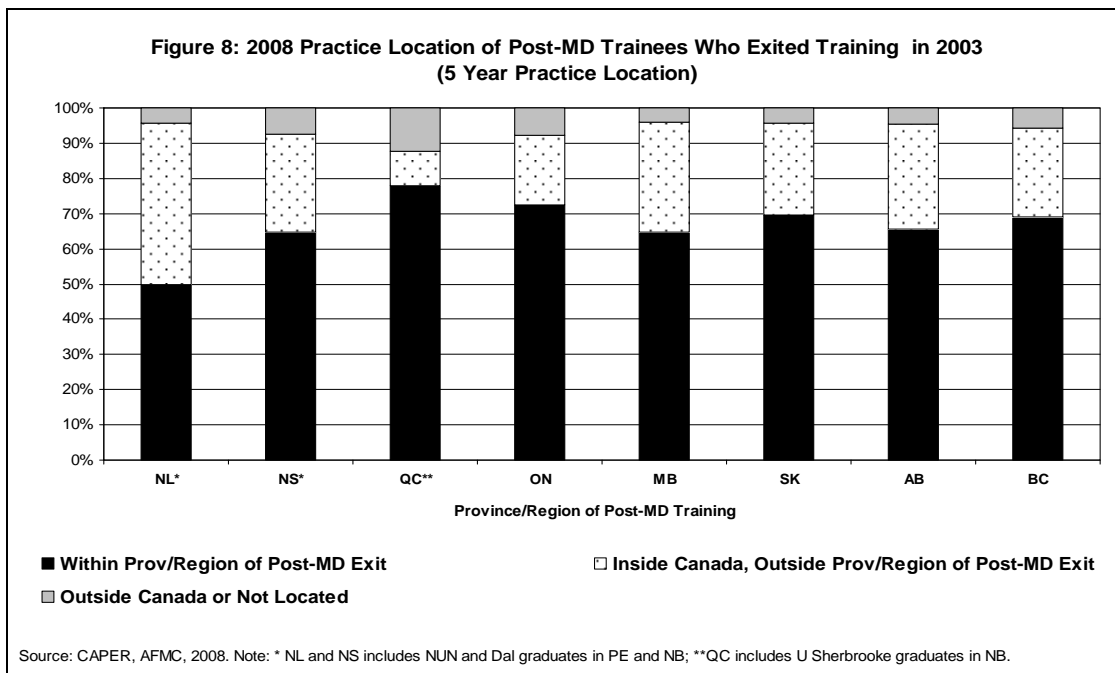


Figure 8 shows that physicians do not always practice in the province or region where they complete their postgraduate medical training. Half (50%) of physicians who completed their postgraduate medical training at the Memorial University of Newfoundland in 2003 were practicing in the province five years later, in 2008. In contrast, more than three-quarters (78%) of physicians who completed their postgraduate medical training in Quebec in 2003 were practicing in the province five years later. From a physician resource planning perspective, it is important to bear in mind that, in Canada, medical residents may move across jurisdictions to acquire the knowledge and skills that will aid their future practice. While faculties of medicine are mandated to impart these skills, the future physician may go on to practice outside of the jurisdiction where he or she trained.



Again, faculties of medicine play a foundational role in rejuvenating Canada's physician workforce and meeting the health care needs of Canadians. Figure 4, 5 and 6 above illustrate this in terms of the raw numbers of students and residents flowing through our medical education system. Looking beyond simple head counts, our postgraduate medical education system is poised to address specific health care priorities. For example, family medicine programs support our ability to respond to the 2.3 million Canadians who cannot find a regular family doctor. In a similar vein, oncology, radiology and surgical specialists play a variety of key roles in providing timely referral to cancer care. It is not difficult to see the relationships that connect the health care needs of Canadians to the medical education environment.

The AFMC is home to a wealth of data and information that can better inform physician resource planning. For example, we collect data that tells us how many students enter medical school – a factor that predicts how many physicians will eventually enter practice. We also track the types of doctors being trained – family doctors, general surgeons, radiologists, geriatricians and others. We also track where physicians go on to practice as well as their ongoing patterns of mobility. These are but three examples of the kinds of data we currently house.

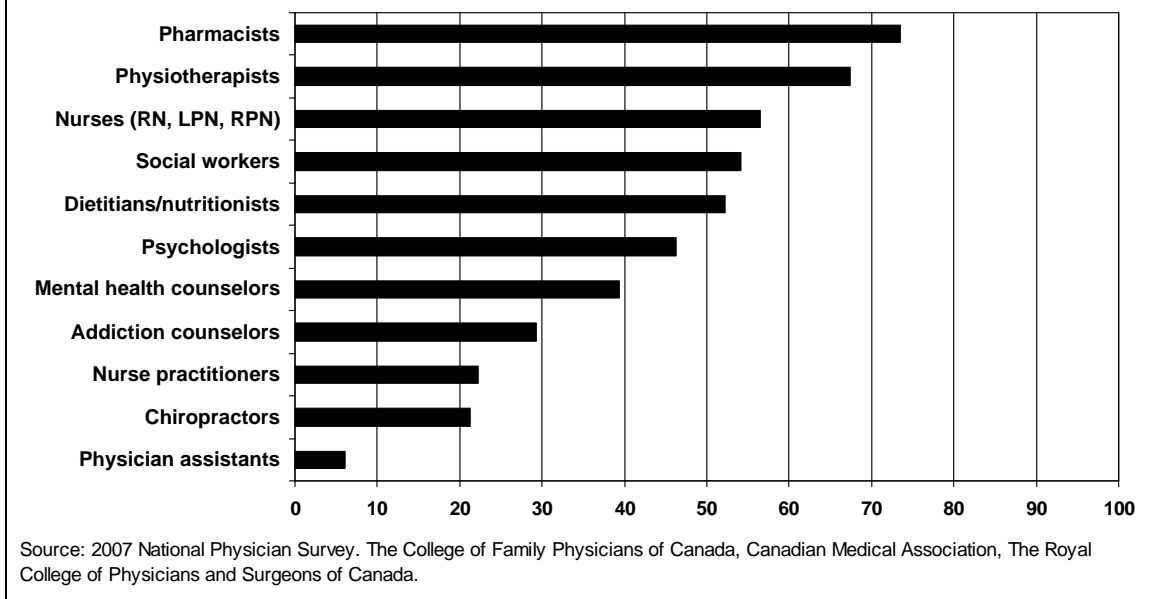
Canada's medical education databases were founded more than a quarter century ago. The AFMC Office of Research and Information Services compiles data that extends back to the 1940's. The Canadian Post-MD Education Registry (CAPER) contains electronic data dating back to 1989. While this longitudinal data holds great potential for improved health human resource planning, the underlying databases are, themselves, dated. Resources are needed to renew these databases with a view to providing improved online access to timely information for decision makers.

While AFMC data is longstanding and highly relevant, investment is needed to modernize our databases with a view to providing improved access to timely, policy-relevant information. We need to integrate our data and provide new information services that meet the needs of today's health system planners and decision-makers. Support is needed to train clients how to access information through a secure online portal. The AFMC calls for a \$1.5 million investment to deliver this plan over the two-year period, 2010/11 – 2011/12. This investment is needed to put in place a physician resource planning approach that is proactive and preventive, rather than reactive and focused on crisis management.

Thus far, this brief has focused on medical education and the physician workforce. This is by no means meant to understate the interdisciplinary and inter-professional nature of health care delivery in Canada. In fact, the AFMC is an active member and serves as secretariat to the Accreditation of Interprofessional Health Education (AIPHE) initiative. AIPHE is a 20-month partnership of eight national organizations that accredit pre-licensure education for six health professions in Canada. The goal of this collaboration is to create and support the use of core joint principles and guidelines in formulating standards for interprofessional education.

There is no question that, in Canada, health care delivery is a multidisciplinary and interprofessional enterprise. For example, Ontario has established family health teams, Quebec has implemented the Groupe de médecine familiale, and Alberta and BC both have pilot and permanent group practice models in place. As illustration, Figure 9 shows that most family physicians collaborate regularly with pharmacists, physiotherapists, nurses, social workers and dietitians/nutritionists. In fact, the list of providers with whom physicians share patient care is more extensive and includes midwives, nurse practitioners, audiologists, alternative medicine practitioners and others.

Figure 9: Percent of family physicians who collaborate regularly with other health care providers, 2007



Health care delivery is not only collaborative, it is also constantly changing. New providers and delivery models emerge regularly. In terms of new providers, for example, the University of Manitoba, McMaster University and, starting in 2010, the University of Toronto and Northern Ontario School of Medicine offer physician assistant training programs. As an example of changing practice scopes, pharmacists now exercise certain prescribing privileges in many jurisdictions. Embracing the evolutionary nature of health care delivery, the AFMCs forthcoming report on the Future of Medical Education in Canada recommends that,

To improve collaborative, patient-centred care, MD education must reflect ongoing changes in scopes of practice and healthcare delivery. Faculties of Medicine must equip MD education learners with the competencies that will enable them to function effectively as part of inter- and intra-professional teams.

As health system planners and managers we must accept that the optimal health care delivery model in one setting is not necessarily the optimal model in another setting. For example, health workers in remote areas may arrive at different, yet entirely appropriate, solutions than collaborative networks in large urban centres. Communities may have unique needs that prompt health care providers to find new ways of working together. Legislative, administrative and regulatory frameworks can induce health care providers to practice in new ways. Collaboration and coordination is essential in such a complex system.

It is perhaps because of this complexity that health human resource (HHR) issues have come to the forefront of so many national, provincial-territorial, regional and local agendas. At the national level, important messages were delivered through the comprehensive health system reviews carried out by Mr Romanow and Senator Kirby.

Numerous federal bodies play important roles in HHR planning, including Health Canada's HHR Strategies Division. Agencies like Statistics Canada and the Canadian Institute for Health Information work diligently to deliver timely, relevant health data. Federal, provincial and territorial governments endeavor to coordinate their health care planning efforts through bodies like the Advisory Committee on

Health Delivery and Human Resources. Professional medical organizations do likewise through the Canadian Medical Forum.

The Health Council of Council has taken on the important mission of assessing progress in improving the quality, effectiveness and sustainability of the health care system. Similar health quality agencies have been established in a number of Canadian jurisdictions. Moreover, provincial governments have established regional and local health authorities in an effort to have communities manage health care delivery in a way that meets their unique and immediate needs.

Many health human resource conferences are held in Canada each year. A variety of organizations host important HHR conferences that promote knowledge exchange. These conferences foster improved understanding of issues as wide-ranging as aboriginal health care, recruitment and retention and healthy work places.

Reflecting on the collaborative nature of health care delivery, we must ask ourselves if our health human resource planning efforts have been equally coordinated. Unfortunately, one is left with the impression that our efforts are fragmented. Our common goals and objectives appear divided.

Without undervaluing the important HHR planning efforts that are underway in Canada, the Association of Faculties of Medicine of Canada calls for the establishment of a Health Human Resource Observatory for Canada. The Observatory would provide a formal structure for the collection and analysis of Canada's disparate data sets, the collection of data where needed, and would serve as a resource to governments, federal and provincial, in matters of health human resources. The Observatory would be broadly constituted and representative of federal, provincial and territorial governments, the public, a wide range of health care provider groups as well as health system managers and researchers.

As a first step in the realization of this project, AFMC is requesting \$600,000 to establish a secretariat and hold a series of national, regional and provincial consultations which would culminate in an actionable and fully-costed business plan for the Observatory.

The multiplicity of HHR planning activities in Canada underscores the pressing need to coordinate our efforts. To date, our fragmented HHR planning efforts are analogous to a body of appendages that lacks a coordinating brain function. At the ground level – and more so than ever – diverse health care providers work together to care for patients. Canada's HHR Observatory must bring together care givers, patients, governments, managers, researchers and other stakeholders to analyze data, make evidence-based recommendations and build consensus around forward-looking strategies.