Canada's Physician Workforce

Occupational Human Resources Data Assessment and Trends Analysis

Executive Summary

February 2005

A Physician Human Resource Strategy for Canada

Une stratégie en matière d'effectifs médicaux pour le Canada

TASK FORCE TWO

GROUPE DE TRAVAIL DEUX

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Executive Summary

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Task Force Two:
A Physician Human Resource Strategy for Canada

February 2005

This project is funded by the Government of Canada. The opinions and interpretations in this publication are those of the author and do not necessarily reflect those of the Government of Canada.

This document is an Executive Summary of the ***Canada's Physician Workforce – Occupational Human Resources Data Assessment and Trends Analysis*** report. The full report can be downloaded from the Task Force Two Web site at **www.physicianhr.ca**

EXECUTIVE SUMMARY

INTRODUCTION

The past decade has seen considerable change in the number of physicians practicing in Canada, the geographic variations in their practice, and the manner in which they deliver care. Many factors have compounded these issues such as demographic changes in the population and the medical profession, major restructuring of health care systems and in particular, reforms in the delivery of primary care.

In 1998, the Canadian Medical Forum (CMF) – a forum of nine national medical organizations for consultation, consensus building, strategy development and joint action – created Task Force One to examine physician human resources. Their report, which was presented to ministers and deputy ministers of health in 1999, prompted an increase in undergraduate positions in medical schools. Building on the work begun by Task Force One, Task Force Two, a partnership of the major health organizations in the country, the Government of Canada, provincial and territorial governments and representatives from other health professions in Canada and the public, was created in 2001.

Task Force Two is mandated to undertake a comprehensive examination of the labour market for physicians, and to develop options for a long-term physician human resource strategy that is sensitive to Canada's provincial and territorial realities. This report is part of the overall activities of Phase Two of Task Force Two's workplan. Building on the literature review and gap analysis that was undertaken in Phase One, the goal of Phase Two is to understand the labour market for physicians in Canada and identify the priority human resource issues facing physicians today and in the future. A second goal of this phase is to identify practice models suited for the future and assess their implications in context of the priorities of the physician occupation. The final phase of the project, Phase Three, will be the development of a human resources strategy(s) for physicians in Canada.

The objectives of the occupational human resources data assessment and trends analysis are to:

1. review and analyze occupational data looking at the physician workforce;
2. identify current and future occupational trends;
3. provide the empirical underpinnings for speculating on future supply and demand issues; and,
4. provide key benchmarks against which to explore the human resource implications of new models of health care delivery.

To attain these objectives, the project research team met eleven *specific research* objectives:

1. to assess physician supply and demand models;
2. to assess methods of measuring shortages of physicians;
3. to describe current approaches to physician compensation, and physician attitudes and preferences towards these approaches;
4. to describe current recruitment and retention strategies;
5. to describe the physician work force and the impact of future trends;
6. to assess approaches to quantifying functional specialty and to test sample data;
7. to identify methods for measuring full time equivalents (FTEs) including those in non fee for service remuneration plans;
8. to identify supply estimates for Canadian-trained and internationally-trained medical graduates (IMGs) working in Canada;
9. to describe work organization and work conditions for physicians in Canada;
10. to identify trends in training and professional development; and,
11. to describe the current capacity for physician mobility in Canada.

Research under these eleven themes was carried out using a variety of methods of both a quantitative and a qualitative nature. This included a review of the relevant Canadian and international literature, analysis of existing data sources (such as the National Physician Survey), focus groups with family physicians, specialists, health administrators, and postgraduate medical residents, and interviews with over fifty key informants representing a broad cross-section of Canadian expertise in areas related to physician human resource planning.

THE CANADIAN PHYSICIAN WORKFORCE

In 2003, there were 60,809 active physicians in Canada. While physician headcounts exceeded population growth by nearly 3% over the past decade, demographic shifts in supply and demand tended to counteract the net increase in supply. An ageing physician and patient population, and the increased number of female physicians who tend to practice less intensively during certain periods of their life, offset the increased headcount.

The *average* Canadian physician is 48 years old (47 years for family physicians, and 49 for specialists). Overall, men outnumber women by more than 2:1, and more so in

older physician cohorts. However, women make up an increasing proportion of younger physicians, and in the youngest age group they slightly outnumber men. If present trends continue, women are projected to make up 40% of the physician workforce by 2015. With the exception of obstetrics and gynecology, the specialties tend to be dominated by males, while female specialists tend to be in clinical rather than in surgical specialties.

The regional supply of physicians differs quite markedly across the country, and there appears to be no consistent pattern in relation to population differences, which suggests other causes for the variation. An uneven distribution of physician human resources, particularly in rural settings, and shortages in certain specialties, are likely to remain problematic.

The physician workforce is ageing and the retirement rate is rising steadily, accounting for a 17% net decline in supply. The retirement rate, based on findings from the National Physician Survey (NPS) data, for the next two years averages out to 3.1% per year, which would amount to a loss of approximately 3,800 physicians by 2005. The retirement issue may be more acute in the case of specialists.

The historical 20% to 30% contribution of internationally-trained medical graduates (IMGs) to the physician pool has varied little over time, but considerably by region. By 2002 IMGs represented 22.7% of physicians – 22.5% of family physicians and 22.8% of specialists. Nevertheless, an extensive untapped pool of IMGs remains with as many as 4,000 IMGs eligible for post-MD training.

The three most frequent first-choice post-graduate programs are family medicine, surgery, and internal medicine. While surgery is dominated by men, family medicine is the major first choice among women, who made up at least 50% of family physician trainees in the past decade. Although internal medicine, psychiatry, and anesthesia are a first choice among about the same numbers of women and men, a greater proportion of women choose obstetrics/gynecology and pediatrics, while a far greater proportion of men make diagnostic radiology their first choice. The most notable divergence between available positions and applicant first choice is in family medicine.

Practice entry has remained relatively stable for laboratory medicine and surgical specialties, fluctuated somewhat for medical specialties, and declined sharply for family medicine in the early 1990s. Overall, nearly as many women as men entered practice in 2003 – 781 versus 789. Women outnumber men as new family physicians by nearly 40%, which, in light of differences in practice intensity, further limits effective supply.

There was a net flow of physicians out of Canada from 1992 to 2002, although the trend has decreased in recent years. Generally, proportionately more specialists than family physicians emigrate, and younger physicians are more likely to leave. Although inter-provincial migration helps physicians to match practice preferences to their life style preferences, and provides health authorities with flexibility in matching demand and supply, some provinces have seen significant net losses in recent years.

Methods of compensation can be a lever to influence not only physician supply and distribution, but also types of practice. **Fee for service** (FFS) — still the dominant form of compensation — tends to encourage high patient volumes and to discourage non-compensated administrative, managerial, education, or communication tasks.

Capitation- and **salary-based** compensation, on the other hand, may help physicians to focus on quality of care by reducing patient volumes, but in both cases there is also a risk that access may be compromised with rising patient volumes. Actual payment schemes can also combine two or three of these methods in a **blended** scheme. There is currently a shift away from FFS as a preferred mode of remuneration, and this is being driven by a number of factors related to the composition of the physician workforce characteristics.

PHYSICIAN HUMAN RESOURCE PLANNING

In general, four approaches have been used to model and forecast physician supply and demand. They are: (i) **supply forecasting**, (ii) **utilization or demand forecasting**, (iii) **needs-based planning**, and (iv) **benchmarking**. There are benefits and limitations to each model. Each of these four successive methods builds greater comprehensiveness into its analytical model; utilization/demand forecasting considers measures of actual physician service delivery capacity, needs-based planning examines population health needs and appropriate models of care, and benchmarking avoids assumptions of stability in the health care system and focuses instead on areas where delivery is perceived to be optimal. However, as the models become more complex and seek to take into consideration a larger number of variables and factors, they can be affected by limitations on the availability of data, and may be informed by judgements that are to some extent normative or by assumptions that may not be stable.

Most widely used measures of physician supply still rely on simple head counts, and do not adjust for variations in patterns of medical practice by specialty or for levels of practice intensity among individual physicians. Measuring physician output by the use of **Full Time Equivalents (FTEs)** is an attempt to standardize practice size to a common denominator. The FTE results in a single value for each physician, which quantifies his/her practice relative to what is considered a full load.

Productivity across physicians varies because some physicians may be semi-retired, working part-time, participate in a varying mix of activities within their practice and/or have differing approaches to life style issues. As an alternative to simple head counts there are currently three general approaches used in Canada to calculate physician FTEs. The first, developed by Health Canada, measures physician output/productivity based on fee for service clinical billings. The second uses a variety of methodologies to measure physicians who are remunerated under alternative payment modes to fee for service. The last approach weighs physician counts in relation to hours worked per week.

As the use of alternative and blended funding models becomes more prevalent it is critical that data collection methodologies have the flexibility to collect a variety of activities regardless of the mode of payment. Furthermore, new measures of physician productivity are needed that relate to quality, service and outcomes. Future productivity measures need to account for all that a physician does both in practice and when participating in additional activities that are not easily valued in an objective way.

Functional specialty is the term used to refer to the clinical services and other professional activities actually performed by individual physicians, as opposed to their

certified specialty. Functional specialty looks at the allocation of a physician's time across activities as opposed to categorizing physicians according to their specialty certification. For example, functional specialty analysis would capture the information on certified internists who in fact provide mostly cardiology services. Thus, functional specialty analysis quantifies how much of physicians' work time is devoted to direct patient care and within that, what types of direct patient care they are providing.

Physician workforce management policies in Canada will need to be improved in order to attain a number of key physician HR planning objectives. This will generally entail strengthening the infrastructure for physician human resource planning, including the development of a new integrated physician minimum data set to provide a clearer indication of current supply. This could make it possible to determine appropriate distribution of services, forecast future needs and support research and evaluation activities.

The physician FTE measure is an important indicator that supports health services organization, planning and health human resources deployment. New physician productivity measures must be responsive to and support policy development and assist in facilitating their implementation, monitoring and evaluation. The development of more sensitive measures will also assist in measuring the impact of physician remuneration, incentives, and recruitment and retention policies.

WORK ORGANIZATION AND WORK CONDITIONS FOR PHYSICIANS

In light of recent trends with respect to worklife balance preferences, physician workforce planning must take into consideration a number of issues such as workload, working hours, and flexible working arrangements. As such, a closer examination of the physician work environment in terms of its present state, recent trends, and implications for longer term planning is required.

Physicians' work environments are currently affected by a number of key external factors, including changing demographic trends (such as the ageing of the population), changing patient or consumer needs and expectations, new knowledge and new technologies, and fiscal restraint in the funding of health care.

Physicians exhibit a marked divergence, according to age group, between solo and group practice, as younger doctors are far more likely to practice under the latter, while older doctors have a slight tendency towards the former. Practice networks and other forms of organisation are utilized by relatively few physicians, although there is some evidence to suggest that these numbers may be underreported.

Walk-in clinics have emerged as a somewhat contentious issue. Many physicians are concerned about the quality and continuity of care provided by such clinics. They regard walk-in clinics, which are beginning to address more complex ailments, as providing intermittent, episodic care that is a poor substitute for comprehensive care.

In terms of physician workloads, while gender influences practice and adequacy of supply, the correlation is not straightforward and the relationship is also associated with age and choice of specialty. In particular, male physicians work more hours per week than their

female counterparts across nearly all age and specialty groups, with the exception of family physicians and surgical specialists in the 65+ age group.

Heavy workload is a factor in fatigue, burnout, and low morale. In a 2001 survey, the Canadian Medical Association (CMA) reported that 65% of physicians indicated that their workload is heavier than they would like; the 32% of respondents who strongly agreed with this statement worked an average of 60 hours and had more than 30 hours on call per week. Moreover, another CMA survey conducted in 2003 of 2,250 physicians indicated that half were unhappy with their chosen profession and 46% appear to be in advanced stages of burnout. The impact of these findings on the overall health system are bound to be considerable, and likely manifest themselves in the form of stress leave, error rates, and attrition – an increase in any of these will only serve to increase the stress levels for physicians who remain in the system.

PHYSICIAN RECRUITMENT AND RETENTION

Historically, physician recruitment and retention in Canada have been undertaken on an ad hoc basis and have relied heavily on financial incentives. Moreover, there has been little coordination across jurisdictions with a number of provinces and communities developing their own strategies and programs.

The factors that influence physicians' decisions about practice location are professional, personal, and financial in nature. Professional factors include worklife balance issues such as: scope of practice, workloads, on call time and scheduling, availability of locums, professional development capacity, and specialist and administrative support. Personal factors consist of those that affect family and life outside of work, or more generally "quality of life." Financial factors are related to the level and stability of income for a physician and his or her family.

Depending on the size and geography of the jurisdiction, physician recruitment and retention efforts in Canada have been focused on rural and remote areas, on jurisdictions as a whole, or on physician specialty areas. The most common recruitment and retention policy initiatives and programs include:

- Recruitment into training, particularly the recruitment of rural students into medicine;
- Financial: premiums, bursaries, debt assistance and other financial incentives to practice in areas deemed to be under serviced and/or to provide specified services (e.g., emergency) in those areas;
- Recruitment campaigns, e.g., provincial/territorial recruitment websites, fairs, campaigns or offices;
- Continuing medical education and professional development;
- Reducing on call and cross coverage responsibilities;
- Other supports aimed at rural doctors and their families.

Hiring **internationally-trained medical graduates (IMGs)** is a common recruitment strategy

in many parts of Canada. In jurisdictions where shortages have been particularly acute, the recruitment of physicians from overseas or other jurisdictions has been quite intense. IMGs are particularly important to provinces that need to fill vacancies in rural and remote regions.

Given these pressures, there is a need for a better way of credentialing IMGs already in Canada so that they can have access to practice with a minimum of barriers. Current practices vary by jurisdiction, and tend to be driven by the degree of reliance on IMGs to address the needs of under serviced areas. The restrictions adopted by some provinces in the early 1990s, which made IMG assessment, accreditation and licensure more difficult from the IMGs' perspective, are now largely being reconsidered. There has been pressure from provincial governments, licensing authorities and the public for credentialing bodies to respond to physician workforce shortages by "fast-tracking" IMG physicians through the assessment process. Several provinces have or are about to introduce programs to assess the skills of graduates in a timelier manner. A number of jurisdictions have also undertaken pilot projects to support IMGs in Canada through educational supports and expedited assessment programs.

MEDICAL EDUCATION AND PHYSICIAN PROFESSIONAL DEVELOPMENT

The medical education system today remains an important focal point of key decisions affecting physician workforce planning. Increased expectations of "social accountability" on the part of the medical education system have placed demands on medical schools and other institutions to respond more effectively to the country's health care needs, including the training of a medical workforce that is able to serve all of Canada's regions — urban, rural or remote.

Medical schools are receptive to these calls to play a greater "social role," but it is not clear how their mandates are to better coordinate with government policy. While funding for medical education comes from provincial departments of education, the key decisions regarding physician supply (of which medical schools are the main source) rest in the hands of provincial departments of health. Because of a lack of intra-governmental and inter-ministerial coordination, medical schools may often find it challenging to coordinate their activities with governments' priorities.

There are, as well, ever-growing expectations that the medical education system respond to the needs of particular populations or geographies and adapt to new and emerging models of care. With respect to the first, medical schools are in the process of moving towards (a) community-based medical education and (b) decentralized or regionalized medical education. Such initiatives are increasingly viewed as important in preparing physicians for practice in settings that address the particular health care needs of all of Canada's communities, including rural and remote communities, inner city areas, Aboriginal communities, and others.

There is growing interest in preparing physicians for work in integrated and collaborative settings through a pedagogical model known as *interdisciplinary education for collaborative patient-centred practice*, or IECPCP. There are high expectations that IECPCP – as a future standard for health care delivery – will help to provide better health care at a more

reasonable cost. IECPCP is still in its infancy, and pedagogical approaches to teaching it are not yet clearly defined. Medical schools face significant challenges in implementing it, although it appears that the current generation of future physicians is receptive to the idea of working and learning in collaborative environments.

With the emerging demands that are being placed on the medical education system, many stakeholders warn of actual and potential shortages of clinical faculty in Canada, due in part to an ageing academic physician community. Current difficulties in recruiting academic clinicians may become more severe. At the same time, the teaching and research duties of active academic clinicians increasingly must compete with clinical duties. Stakeholders within the medical education community believe there is not enough data on the scope and severity of these problems.

Undergraduate enrolments have rebounded from a low of 1,577 seats in 1997 to 2,096 seats in the 2003/2004 academic year. Schools may be challenged to increase capacity by an additional 300–500 seats, which raises significant questions about the overall capacity and infrastructure required of the system to expand enrolments. On the post-graduate side, the ratio of applicants to residency positions for 2004 was the tightest in recent memory. This may have left many residents unable to find appropriate matches for their field of interest, and also raises significant questions about the availability of residency slots for re-entering physicians and IMGs.

Family medicine has suffered a decline in popularity as a first choice for medical graduates entering residency. This is a worrisome trend given current preoccupations with improving primary care in Canada. There appears to be an equally pressing problem with the current state of what one may call the “generalist-specialist” disciplines. The increasing trend toward increasing subspecialization in post-graduate medical training has occurred at the expense of not only family medicine but generalist specialties (e.g., general surgery, pediatrics).

Questions about the accessibility of medical education persist, and there is widespread concern about high tuition fees, high student debt loads and potential financial barriers to access for persons from socioeconomically disadvantaged backgrounds. However, the relationship between high educational costs and low income family background is not necessarily well understood, and further research in this area could help in the development of financial supports that could help attract a more representative cross-section of Canadian society to the medical profession.

Amid increasing public concerns about patient safety and quality of care, the ability of physicians to maintain and increase their competencies through Continuing Medical Education (CME) and Continuing Professional Development (CPD) is highly relevant to physician HR planning issues in a socially accountable system of care delivery. CME/CPD learning is now mandatory for “maintenance of certification” in both the Royal College of Physicians and Surgeons of Canada (RCPSC) and the College of Family Physicians of Canada (CFPC), while the potential implementation of mandatory re-licensure in several provinces will make CME/CPD ever more crucial to physicians who wish to practice in Canada. Meanwhile, CME/CPD continues to evolve as physicians take on new roles, adapt to new learning methods, and are introduced to new learning technologies.

NEW MODELS OF CARE

Traditional models of health care delivery have been under increasing pressure over the past decade as a result of regionalization, fiscal constraints, changes in the organization of health care delivery, as well as imbalances and shortages in health human resources. These pressures have prompted a search for new models which can provide high quality services and increased access to health care while optimizing the deployment of a variety of health care professionals. In addition, new models of practice have been developed to address the above while also helping health care professionals to achieve a more balanced and healthy lifestyle.

Many of these models are based on the deployment of health professionals into groups, teams or networks. In many cases these models can offer patients access to a broader array of services and after hours care than a single physician could provide. While most of these groups or teams involve family physicians, nurses, nurse practitioners, and other health professionals, many also consist of networks of solo physicians or smaller groups who are linked with others to share the provision of services. In some cases the focus is on teams to provide improved management for patients with specific complex high intensity needs.

Currently there are several health care professions that work with physicians in providing care to Canadians. Faced with physician shortages in some areas (both geographic and professional) researchers and policymakers are examining possibilities for other health care professionals to provide services that have so far been largely provided by physicians. There is agreement that one of the key aspects to new models of care will be the delivery of care through physician group practices involving inter-professional teams. These teams include family physicians, specialists, registered nurses (RNs), nurse practitioners (NPs) as core members as well as other health care providers such as physiotherapists, pharmacists, social workers, and dieticians.

Nurse practitioners (NPs) are considered key in new models of care involving multidisciplinary teams, skill substitution, health prevention and promotion. Core competencies for NPs are fairly consistent across Canada, although a lack of regulation, training and certification may impede the more intensive use of this professional group. In collaborative settings, the relationship between physician and NPs is critical, but perceptions which categorize NPs as ‘doctor assistants’ or as being unsuitable to serve as the primary provider of health services persist. These perceptions can be detrimental as they demonstrate a lack of understanding of the NP’s role and do not recognize the NP’s legal scope of practice.

Midwives are the primary care provider for approximately 5% of births in jurisdictions where midwifery is regulated, and the proportion of hospital births attended by midwives is rising. As there is continued concern about current and future shortages of obstetricians (mainly due to retirement) and family physicians who include prenatal care and delivering babies as part of their practice, the increased use of midwives (and an expanded role for this profession) in providing maternity services in Canada requires a closer look. Midwifery is a regulated profession in five jurisdictions, with significant variation in terms of where midwives practice, how they are paid, how their services are funded and their

scope of practice. Regulatory guidelines dictate when midwives must consult or transfer care for the woman or newborn to a physician.

Physician Assistants (PAs) are health care professionals trained to provide medical care under the supervision of a physician. There is currently only one PA training program in Canada, affiliated with the Canadian Armed Forces, but creating PA training programs is under discussion in at least three jurisdictions. Being a young profession in Canada, there are as yet few licensing options. Currently, Manitoba is the only province with legislation to regulate Clinical Assistants (as they are termed). A common question surrounding the future of PAs in Canada is how their role would compare with that of Nurse Practitioners, as there are practical and philosophical differences in how PAs and NPs train and work. Physician Assistants may, in the future, play a major role in the Canadian health care system, although further study is required to assess their potential roles and contributions. As with nurse practitioners, midwives and other health care professionals, the issues of liability and funding still need to be resolved.

CONCLUSIONS

This report brings together and addresses a vast array of information sources and analysis that contribute to our understanding of the complexities of physician human resource planning. While both quantitative and qualitative sources of information on physician resources are improving, much work still remains in terms of data gathering and analysis. Planning-model sophistication is far greater than in past decades, but as models incorporate an increasing number of relevant factors, the recommendations that stem from them become increasingly contingent on developments and circumstances outside of the parameters of traditional human resource planning.

The Current State of the Physician Workforce

The degree of present instability in the physician workforce stems from a variety of factors, including: attrition from increased retirement rates as the workforce ages, growing trend to retire at an earlier age, increasing vacancy and turnover rates, increasing inter-provincial mobility, inter-provincial competition for physician resources and declining numbers of physicians. Important gender and generational differences are also present, and they touch on a range of issues including shifting practice patterns, practice intensity, and compensation.

While data and analysis can always be improved, any benefits from a more complete analysis are likely outweighed significantly by the costs of further delay in planning and action. Still, new instruments such as the National Physician Survey are a rich source of data that will be highly relevant in terms of monitoring some of the trends discussed in this study.

Trends in the Practice Environment

It is important to take into consideration emerging trends in physician attitudes and behaviour in order to assess future HR requirements and strategic directions. At the same

time, actions must be tempered with the recognition that the context in which physicians practice continues to be somewhat fluid and that trends can wax and wane over time.

Issues around enrolment, recruitment, and more importantly retention of all health professionals, including physicians, may well become increasingly critical to the sustainability of the system. As such, the demographics of other health care providers who support physicians are important to understanding the physician's workplace environment.

Shifting scopes of practice, as well as new licensure requirements for physicians and other health professionals also need to be taken into account. These include issues such as an increasing trend toward subspecialization and a concurrent lack of general specialty coverage, a tendency of many physicians approaching retirement to teaching within faculties of medicine and teaching hospitals, and a growing interest in and willingness to develop collaborative (team-based or inter- and multidisciplinary) practices that coincides with policymakers' interests in placing a greater emphasis on the continuum of care with more attention to primary health care and home care.

Physician Resource Planning

This report identifies the benefits and limitations of current modelling approaches. It recognizes that expectations of physician resource planning are becoming increasingly sophisticated with multiple models undergoing continual development and refinement that are increasingly sensitive to both the exogenous and endogenous variables affecting the demand and supply of physicians.

Physician workforce management policies need to be improved for more effective recruiting and retention, better accommodation of changing practice patterns, development of succession strategies, and accommodation of planning flexibility for the most efficient mix of physicians and other health professionals. However, policy development in this area also faces a number of challenges, including weak coordination at and among the various jurisdictional levels of the health care system, data quality issues, rapid changes in the structure of health care delivery, insufficient understanding of the impact of incentives or recruitment/retention policies, insufficient study on how data and planning models accommodate the complexities and limitations of a wide range of fee negotiation environments, and differing perspectives on shorter-term returns versus longer-term health outcomes.

Better overall integration of planning would address many problem areas and help anticipate and better manage potential broad swings in Physician Human Resource supply versus demand. In addition to the limited understanding of the impact of particular policy decisions, there are other policy challenges, including how best to use strategic HR investments, how to align the activities of educational institutions with the needs of a health care system in transition, and how best to foster collaboration, communication, and coordination between key stakeholders on matters such as policy design, implementation, and evaluation.

Physician Recruitment and Retention

Physician recruitment and retention strategies must account for a range of professional, personal and remuneration challenges. Most government policy in this area has focused on financial incentives to adjust geographic distribution, especially for rural and remote locations – which tends to result in success for recruitment, but not retention. Governments need to rethink short-term approaches, and develop longer-term strategies that effectively manage professional, stakeholder, and public expectations, and provide balanced investment for a stable, sufficient and sustainable workforce.

Remuneration is integral to any recruitment and retention strategy. Currently compensation trends are shifting, as fewer physicians rely solely on the fee for service system, and some demonstrate a willingness to participate in alternative payment. An understanding of at least the direction of the impact of these policy and remuneration changes is necessary to develop compensation strategies and incentives to maintain an optimal workforce. At the same time, physicians are increasingly influenced by factors other than professional and remuneration considerations in their choice of practice and location. Other considerations, such as quality of life, spousal preferences, level and type of support, etc. are taking precedence. Lifestyle issues are emerging in the forefront as a key concern for younger recruits entering practice, while older physicians are increasingly concerned with workload issues.

In Canada, there is an increased focus on recruiting IMGs. The assessment and licensure of IMGs is inconsistent across the country, although there does appear to be a strong commitment to harmonization of processes for the integration of IMGs across jurisdictions. At the same time, there is increased worldwide competition to recruit IMGs into many of the health professions, and Canada will have to confront the ethical and moral issues of attracting health professionals from developing countries where training costs are a greater drain on limited public resources and where needs are more critical.

Medical Education and Physician Professional Development

The face of medical education is changing. At the same time, growing evidence indicates that many physician human resource planning policies are developed without due consideration of the changes such policy choices may entail for physician education. And yet medical education at all levels – undergraduate, graduate and continuing professional development – is expected to adapt to these changes in terms of not only human resource strategies, but also, and perhaps just as profoundly, the overall organization and delivery of quality services. What becomes readily apparent is that health reform generally, and physician human resources planning specifically, must be understood and coordinated with physician education at all levels.

With widespread acknowledgement of the need for better integration of medical education with physician HR planning to address supply and demand problems, a host of other issues also require resolution. These include: training greater numbers of Aboriginal physicians and, more generally, a physician workforce that is more representative of the increasing diversity of the Canadian population; addressing the lack of interest in family medicine and some generalist specialties; addressing the lack of interest in rural and remote practice;

and coming up with solutions to the mounting costs of education, including the increasing debt load of recent graduates.

Interdisciplinary medical education efforts appear stymied by a combination of institutional resistance and a catch-22 situation whereby the uncertain future of primary care reform efforts inhibits changes to curricula, which continues to produce physicians unsure about how to work in interdisciplinary collaborative practice settings. An effective interdisciplinary teaching model is needed, but it must be achieved without abandoning the things that medical schools do well, and without placing unrealistic burdens on existing infrastructure.

New Models of Care

Efforts to improve comprehensiveness of care are largely dependent on identification of precise resource requirements for new delivery models, for which detailed work is underway for nurses and nurse practitioners. Detailed information is lacking, however, for many allied health professionals with a potential role in health care reform. Much of the data needed for long-term monitoring and evaluation of new models of care and new health policy currently does not exist. Identification and development of critical minimum data sets with expanded supply-side information is a high priority.

In addition to family physician shortages, communities are experiencing difficulties with the integration of primary and specialty care, and with the integration of community and hospital care. Consideration must be given to community-based integration models, adequately funded and supported by appropriate infrastructure, that are intended to align family physicians with other health care providers and their requisite resources.

It is recognized that there are both limits and opportunities for inter-professional collaboration. The sharing of common assumptions, however, about concerns such as the range of future health policies and roles of health professionals will at least enhance the overall consistency and compatibility of planning models developed by different professional groups. While work has been done on the skills needs of multidisciplinary teams, issues still persist around scopes of practice, regulation and licensure, fee negotiations and the accountability for interventions, outcomes, indemnification and responsibility.

Setting Realistic Benchmarks to Monitor Change

Movement on any of the recommendations made in this report will require greater levels of collaboration between governments, professional and regulatory bodies within the medical profession and, increasingly, between health care professions. As such there needs to be a greater flow of information from governments to professional and regulatory bodies regarding the work they are doing in the area of physician planning and how their plans relate to the overall changes foreseen for the system.

One of the key benchmarks for planning models will be to make progress on recognizing that physician planning has to be linked to other health care professions’ planning efforts

and to linkages with the structural/institutional and financial aspects of the health reform agenda. The development of more integrative planning models is likely to be most beneficial at the local/regional level and it is here where progress should be expected – and resources dedicated – in the coming years. It is also incumbent on governments and stakeholders to understand the HR implications of *other* health reform initiatives.

It will therefore be necessary to develop broad indicators and goals to measure both the trends identified in this report and the success of the recommendations made. These must be based on key physician human resource policy targets, such as:

- a more optimal physician supply;
- a better distribution of physician resources with improved patient access;
- more flexibility in physician deployment and planning;
- a more integrated and stable physician workforce that meets both the needs of the system and the expectations of physicians;
- greater service efficiency;
- increased effectiveness and quality of care; and,
- greater overall accountability and responsiveness of the physician workforce.

More specifically, there is a need for benchmarks that can assist in understanding:

- The extent to which the data gaps noted in this report are being filled;
- Shifts in the medical education system towards interprofessional training;
- The development of common processes for the assessment of IMGs;
- The level of physician job satisfaction across various categories;
- The extent to which alternative payment plans are becoming institutionalized and their impact on how physicians practice;
- The ability of models to accurately reflect the changing context/landscape of health care delivery; and,
- The identification of appropriate outcomes for evaluations.

What all actors within the health care system share is a commitment to ensuring that the quality of care for patients remains high. Change must not come at the expense of providing quality health care to Canadians. Thus, any changes and new initiatives must be undertaken with a clear understanding of how those changes will affect the quality of care patients receive.

Given the limited resources of the health care system, it will be critical to have a balanced investment strategy in physician human resources which includes supply, education, recruitment and retention, deployment, utilization, accountability and management. To invest solely in one or two of those factors may waste resources and not bring desired results but may also exacerbate the situation and in doing so reduce the quality of care Canadians expect and to which actors within the system are dedicated.

A Physician Human Resource Strategy for Canada
TASK FORCE TWO

Une stratégie en matière d'effectifs médicaux pour le Canada
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