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Health Human Resources:

An Essential Part of a Sustainable, Accessible and Responsive Healthcare System

Brief to the House of Commons
Standing Committee on Health

April 28, 2009

I Introduction

Thank you for the opportunity to offer the perspective of the Royal College on health human resources to members of the Standing Committee on Health and to contribute to the work of the Standing Committee on this important issue.

The Royal College of Physicians and Surgeons of Canada is a national, nonprofit organization established in 1929 by a special Act of Parliament. The Royal College ensures the highest standards for the training, evaluation and practice of medical and surgical specialists in 61 specialties and subspecialties. The College is dedicated to excellence in specialty medical care, the highest standards in medical education and lifelong learning, and the promotion of sound health policy, including health human resources issues.

The Royal College has played a leadership role in health policy concerning physician resource issues, including Task Force Two[1] and the Canadian Partnership Against Cancer[2] which has brought together leading health professional organizations, in partnership with governments, to identify key issues and propose innovative human resources strategies.

Governments, health planners, health providers and policy-makers have long struggled with health human resources issues, which are a major challenge facing our healthcare system. Appropriate health human resources are an essential part of a sustainable, accessible, responsive and quality healthcare system for all Canadians no matter where they live in Canada.

There have been pan-Canadian HHR initiatives by health professions, including the nursing sector study[3] and Task Force Two, both concluded in 2006. There have also been government efforts, including the 2004 federal/provincial/territorial *10-year Plan to Strengthen Healthcare*[4] and the 2005 *Framework for Collaborative Pan-Canadian Health Human Resources Planning.*[5]

Despite these and other HHR research and planning efforts, maintenance of a stable and sufficient pan-Canadian healthcare provider workforce has proven an elusive goal. As noted by the Health Council of Canada, with the exception of some regional HHR collaboration, "each province and territory does its own planning, without the benefit of pan-Canadian information needed for reliable decision-making. The result is burnout in the workforce and continued competition between jurisdictions for health care providers – and continued public frustration with wait times, uncoordinated care, and finding appropriate providers."[6]

Indeed, as this Committee heard from several witnesses during your 2008 statutory review of the 10-Year Plan, "there are still not a sufficient number of seats in health education programs to produce enough new graduates to replace those who will leave the workforce. In fact, . . . there is a nationwide shortage of health human resources. Information on the extent of these gaps suggests that Canada may even be on the brink of a 'crisis' in health human resources."[7]

We hope our analysis and recommendations concerning the five areas identified by the Committee will assist members in your deliberations to formulate solutions to these HHR challenges.

Issues affecting HHR within specialty medicine are complex and multifaceted. In addition to our brief, we encourage Committee members to consult documentation from a National Specialty Society consultation the Royal College sponsored in November 2008 in which approximately 50

representatives from specialty medicine discussed the HHR problem-set and proposed solutions. This report and companion documents are available on the Royal College website.[8,9]

II. Recruitment and retention: the specialty medical workforce supply

The current situation: While numbers of specialty physicians have increased in recent years, the effective supply and mix of specialty physicians remains inadequate to meet the needs of Canadians in a timely fashion. As such, Canadians are not assured they will receive the specialty care when and where they need it. In times of economic uncertainty, this is especially worrisome given the importance of a healthy workforce to productivity and economic renewal.

Several factors affect specialty physician supply and must be addressed. Aging of the physician workforce will bring within the next 5-15 years significant retirements. Contrasted against this is the fact that younger physicians typically work fewer hours than their older colleagues due to the desire for a different balance in their work and personal lives. Recent federal budget reductions in funding for health and biomedical research place in doubt Canada's ability to recruit and retain leading scholars responsible for leading-edge research and advancements in specialty care. Also, gaps in research and data collection concerning specialty medicine hinder effective HHR research, analysis and planning concerning specialty medicine.

- *The aging of the specialty medical workforce:*
  - The Canadian Institute for Health Information confirms that the specialist physician workforce in Canada is aging: the average age of specialty physicians increased from 48.5 years in 1997[10] to 50.5 in 2007[11].
  - CIHI data also shows that in 2007 more than half of the medical specialty workforce (51.3%) was fifty years of age or older, [12] up 9.3% since 2000[13].
- *Younger physicians are seeking a different balance in their work and personal lives:*
  - The aging workforce is not the only factor contributing to looming retirements for specialty physicians. Comparable data from the 2004 and 2007 National Physician Surveys show that specialty physicians reduced their mean number of work hours devoted to direct patient care[14,15] excluding on-call. Furthermore, in 2007, 35.6% of specialty physicians indicated that they planned to reduce their weekly hours of work (excluding on-call), while only 7.2% of specialists stated that they planned to increase their weekly hours of work.[16]
  - As the effects of an aging workforce are taken into account, we must also recognize that, typically, younger physicians are seeking a different balance in their work and personal lives than previous generations. Data from the 2007 NPS shows that physicians under age 45 reported working fewer hours per week (excluding on-call) than their colleagues between the ages of 45 and 65.[17] In addition, 87.4% of 2nd year specialty medical residents noted the ability to achieve balance between work life and personal life as an important factor in having a satisfying and successful medical practice.[18]
- *Loss of human capital in research:*
  - Specialists are integral to evidence-based research and advances concerning medical care and those who have received support from CIHR and other granting organizations have completed leading edge research resulting from this support.
  - While we commend new funding within the 2009 budget of $35 million for postgraduate scholarships funded through our granting councils, we are concerned that the proposed reduction of $147 million (5.5%) over three years to Canadian granting councils (NSERC, SSHRC and CIHR) will not only threaten the sustainability of Canada's research enterprise,

but also this nation's ability to recruit and retain leading scholars and scientists. This is particularly worrisome given that other countries such as the US and the UK are enhancing their investments in research.[19,20] and such contrasting policies may result in the return of the "brain drain" effect Canada suffered during the 1990s.

To address current and upcoming recruitment and retention challenges, the Royal College recommends that:

1. **The federal government invest in the training and education of medical and other health professionals, including fulfilling the 2008 Conservative federal election campaign commitment to invest $10 million per year over four years to fund 50 new residency spots in teaching hospitals,[21] and extend it by 10 years; and**
2. **The federal government expand and sustain Canada's investment in biomedical, health system and psychosocial research to improve both Canada's health care system and its ability to recruit and retain leading health, scientific and biomedical researchers.**

III. Collaborative team-based healthcare

The current situation: The benefits of collaborative patient-centred care are increasingly understood, accepted and implemented. In medicine, 94% of medical and surgical specialists responding to the 2007 NPS felt that collaboration with other health professionals not only enhanced the care they can deliver to their patients, but also improved the care their patients receive.[22] The federal government has made interprofessional education for collaborative patient-centred practice[23] a focus of its HHR Strategy. Federal/provincial/territorial governments affirmed their commitment to interprofessional practice though the Framework for Collaborative Pan-Canadian Health Human Resources Planning Action Plan.[24] Under the 10-Year Plan, governments committed to 50% of Canadians having 24/7 access to primary care through multidisciplinary teams by 2011.[25]

While we commend government action concerning collaboration within primary care, efforts toward this end cannot stop there. Interprofessional collaborative care must be implemented across the continuum of care. Systematic attention and investment for other components of the continuum of care, including chronic and acute care, are equally deserved since the ongoing wellbeing—even survival of some Canadians—are at stake. Indeed, as was noted to this Committee by witnesses during your statutory review of the 10-Year Plan, other aspects of the continuum such as home care and long term care should be seamlessly coordinated with primary care,[26] and this must include interprofessional, collaborative HHR.

To help optimize the contribution of all members of collaborative team-based care, the Royal College recommends that:

3. **The federal government provide national coordination and financial support to enhance supply, deployment and evaluation of other health professionals, such as physician assistants, advanced clinical nurses (including nurse practitioners and clinical nurse specialists), whose work ensure that Canadians can access more and better specialty care.**

IV. Foreign-trained professionals

The current situation: Canada has historically included International Medical Graduates (IMG), who have comprised approximately 20-30 per cent of the physician workforce,[27] While the overall total of IMGs for Canada in 2007 was 22%, there were considerable variations across jurisdictions, with NL, SK, MB and YK including a greater proportion of IMGs within their respective workforces.[28] As recommended by Task Force Two, The Royal College advocates that "Canada should achieve self-sufficiency by ensuring an adequate domestic production, together with the integration of ethical immigration policies to meet the evolving needs of society."[29]

Table 2: Canadian-trained medical graduates and international medical graduates, Canada, 2007*[30]

P/T	NL	PEI	NS	NB	QC	ON	MB	SK	AB	BC	YT	NWT	NU	CAN
All MDs														
• CN	65%	86%	72%	78%	89%	76%	70%	51%	72%	72%	69%	71%	89%	78%
• IMG	35%	14%	28%	22%	11%	24%	30%	49%	28%	28%	31%	29%	11%	22%
FamMed														
• CN	66%	85%	73%	84%	88%	78%	58%	45%	64%	71%	69%	66%	88%	77%
• IMG	34%	15%	27%	16%	12%	22%	42%	55%	36%	29%	31%	34%	13%	23%
Specialists														
• CN	63%	88%	70%	72%	90%	74%	81%	59%	82%	73%	71%	85%	100%	79%
• IMG	37%	13%	30%	28%	10%	26%	19%	41%	18%	27%	29%	15%	0%	21%

*Note: percentages may not equal 100% due to rounding.

IMGs and other Internationally Educated Health Professionals are essential to meeting the healthcare needs of Canadians. Having said this, they must meet Canadian standards to enter practice. Canada, therefore, must have the capacity to examine their credentials, measuring their abilities and at the same time, allowing them to seamlessly integrate into the Canadian medical system. We commend the work accomplished through the Canadian Task Force on Licensure of International Medical Graduates and accompanying initiatives by FPT governments in evaluating and providing for IMGs and other IEHPs.

To respond to societal healthcare needs and address specialist physician shortages in Canada, the Royal College has developed routes to certification to enable qualified specialist physicians, including IMGs, to attain full Royal College certification. We are committed to enhancements over time for our certification process in keeping with evolutions in medical education and training, while maintaining standards to ensure that patients receive quality, safe care.

Since 2007, IMGs providers can participate in the first round of the Canadian Resident Matching Service matching process.[31] Due to differences in training and education of some IMGs, not all are eligible for certification, and some provincial alternatives are being developed. For example, HealthForceOntario's Physician Assistant Initiative is aimed at recruiting IMGs as Physician Assistants, some of whom face challenges to practice without complete retraining.[32] While such measures are helpful, more must be done to meet the healthcare needs of Canadians while ensuring the provision of high-quality, safe care.

- *Additional measures concerning IMGs should ensure that Canada's medical education and training system has the capacity to:*
  - Train properly qualified IMGs for practice in Canada.
  - Enable Canadian trainees returning from abroad to complete their residency training.

– Accomplish both of the above while not curtailing opportunities for Canadians who wish to pursue post-MD training in Canada.

To expedite Canada's intake of International Medical Graduates – both landed immigrants and Canadians studying abroad – into the Canadian medical workforce and educational systems, the Royal College recommends that:

4. **The federal government establish targeted and sustained funding to expand medical school capacity, including the number of residency positions, and to develop assessment systems and tools for IMGs.**

V. Rural and remote needs

The current situation: Accessing physician care (and other healthcare services) in rural and remote areas is a chronic problem in health service planning. [33] Underlying this is the problem of physician maldistribution. "Between 1991 and 1996, the proportion of physicians working in Canada's small towns and rural areas declined from 14.9% to 9.8% while the population in those areas increased from 19.2% to 22.2% of the total population; physicians and hospitals are increasingly concentrated in urban and urban fringe areas."[34]

Numerous factors influence the provision of physician services in rural and remote areas and must be addressed. Many underserviced areas rely upon IMGs to provide care, but, like their Canadian-trained counterparts, significant numbers leave upon achieving full medical licensure for more urban areas. There are concerns that the newly amended Agreement on Internal Trade may exacerbate physician shortages in these areas since mobility rules are set to apply to both fully licensed as well as provisionally licensed physicians. Where physicians receive their training also influences where they decide to practice, and retention of local graduates is higher than those who come from further away to receive their medical training. Social and economic factors also influence recruitment and retention of physicians in these areas.

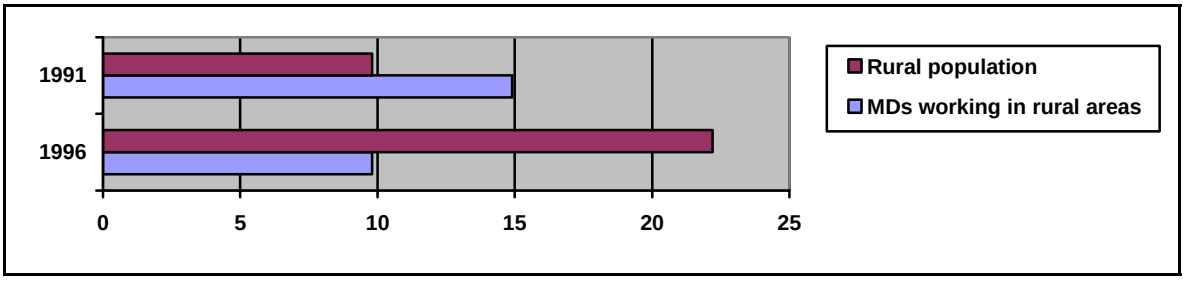

Figure 1: Changes in rural population and MDs working in rural areas, 1991-1996

- *Reliance upon provisionally licensed IMGs for physician care in underserviced areas:*
  – Rural and remote regions of Canada in particular have relied upon IMGs to meet the healthcare needs of Canadians living in these areas. Traditionally it has been difficult to attract Canadian-trained physicians to these areas,[35] and thus IMGs account for 26.9% of family physicians in rural areas, compared with 22.6% in urban areas.[36] Provisionally licensed physicians (physicians whose ability to practice is restricted in some way), most commonly IMGs, can practice medicine without passing some or all of the required Medical Council of Canada (MCC) exams and subsequent Canadian postgraduate medical training.[37] Provisionally licensed IMGs employed in underserviced areas usually must agree to work for a specific

period before qualifying for a full license. Following the acquisition of their full license, IMGs may locate anywhere in Canada. Similar to Canadian-trained physicians, many IMGs gravitate to urban centres upon achieving a full license.[38] This costs smaller, less wealthy jurisdictions within Canada more to recruit physicians from abroad[39] and train them.[40]

- *Potential implications regarding physician maldistribution under the amended AIT:*
  - The recent amendment concerning labour mobility provisions under the AIT as currently written has the potential to worsen physician maldistribution by exacerbating the movement of physicians away from certain provinces and territories given that these amendments will apply to both fully licensed as well as provisionally licensed physicians. The College has produced a discussion paper[41] on this issue and communicated our concerns in a letter to FPT Ministers of Health and Labour;[42] both documents are available on our website.
- *Influence of location of medical training:*
  - Where residents receive their training influences where they decide to practice. For example, a recent study by Memorial University found that, in contrast to both IMGs and Canadian-trained graduates from outside NL, "Memorial University medical graduates are more likely to remain in the province than IMGs or doctors trained elsewhere in Canada. Efforts to improve recruitment of local graduates may help stabilize the province's supply of doctors."[43]
- *Other influences concerning provision of physician services in rural and remote areas:*
  - Other influences affecting where residents decide to practice include quality of life, income, job satisfaction, professional opportunities, workload, work/home-life balance, and team environment.[44] Given the complexity of recruitment and retention in underserviced areas, in concert with a pan-Canadian body to support HHR planning**,** Task Force Two also recommended the development of "special recruitment and retention measures to address the needs of groups where health inequities are evident such as for Aboriginal peoples, people living in rural, remote, northern and isolated communities, and where shortages of providers are predicted."[45]

To ensure that Canadians do not go without necessary health services because of a lack of health workers or other resources, the Royal College recommends that:

5. The federal government study the feasibility of creating a special federal infrastructure fund to provide exceptional relief and assistance to rural and remote communities lacking adequate health services.

VI. Aboriginal peoples and other federal groups

The current situation: First Nations, Inuit and Métis peoples comprise approximately 3.8% of the total population of Canada, or almost 1.2 million people.[46] It is well known that First Nations, Inuit and Métis peoples report poorer health than non-Aboriginal Canadians.

Health conditions affecting First Nations, Inuit and Métis Canadians:

- A shorter life expectancy of 7.4 years less, for First Nations men and 5.2 years less for First Nations women respectively.[47]
- Three to five times the rate of diabetes.[48]
- Rates of cancer that are rising faster than in the non-Aboriginal population.[49]
- Eight to ten times the rate of tuberculosis.[50]

We commend the investments made to Aboriginal health within the 2009 federal budget, as well as investments to facilitate broadband infrastructure, which should improve the provision of telehealth services to Canadians who live in rural and remote communities, many of whom are Aboriginal. Given the health challenges facing Aboriginal Canadians, we also urge the federal government to enhance its commitments to improve Aboriginal health and healthcare.

The Royal College has collaborated with the Indigenous Physicians Association of Canada to develop core competencies within a Curriculum Framework for Postgraduate Medical Education in order to provide safe, cultural appropriate care to Aboriginal people within the domains of family medicine, psychiatry and obstetrics and gynecology. This is a tangible demonstration of our commitment to improving the health of First Nations, Inuit and Métis populations. We are proud of this initiative and grateful for the support of Health Canada. The Curriculum was unveiled with the participation of the Minister of Health in March of this year, and we encourage Committee members to consult the document on our website.[51]

We recognize and support the need for culturally appropriate care for all Aboriginal people from all physicians. We also recognize the need to encourage diversity in the physician workforce and support those Aboriginal people who wish a career in medicine, which will require strong leadership in medical education and medical workforce development. We commend federal involvement in such efforts through the Aboriginal Health Human Resources Initiative.

To meet the health care challenges of First National, Inuit and Metis the Royal College recommends that :

6. **The federal government establish a special targeted fund to:**
   - i) **integrate within medical education curricula across Canada the Framework on Aboriginal Core Competencies developed by the Indigenous Physician Association of Canada and the Royal College;**
   - ii) **establish scholarship and mentioning programs throughout the medical education continuum;**
   - iii) **recruit and place First Nations, Inuit and Métis health professionals in professional practice.**

VII. Conclusion

In its 2008 report on health reform, the Health Council of Canada noted that "Canada is a long way from having a system where patients routinely receive coordinated and comprehensive care from interprofessional teams."[52] The Council advocated a pan-Canadian vision of health and healthcare and mechanisms to achieve this vision while respecting provincial/territorial delivery of healthcare.[53] This is similar to the call by Task Force Two for "a body or mechanism to support and facilitate coordinating mechanisms in developing and establishing future pan-Canadian HHR plans to ensure Canada has the right number of physicians, working in the right places and in an optimal way to meet the needs of Canadians."[54]

To improve Canada's ability to properly plan and deploy its HHR, the Royal College recommends that:

7. **The federal government establish and fund a pan-Canadian HHR observatory or institute to:**
   i) **address gaps and deficiencies in data, research and analysis; and**
   ii) **disseminate knowledge particularly about health outcomes relating to HHR shortages, developments with respect to new models of collaborative service delivery, and evaluate the impact of the amended Agreement on Internal Trade on migration and distribution of health professionals.**

Real and sustained progress across Canada on HHR challenges confronting our healthcare system is urgently needed to realize the vision underlying the *Framework for Collaborative Pan-Canadian Health Human Resources Planning*. Our recommendations are offered for your consideration to achieve this end. Canadians, regardless of where they live, deserve no less.

VIII. List of Recommendations

To address current and upcoming recruitment and retention challenges, the Royal College recommends that:

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2. **The federal government expand and sustain Canada's investment in biomedical, health system and psychosocial research to improve both Canada's health care system and its ability to recruit and retain leading health, scientific and biomedical researchers.**

To help optimize the contribution of all members of collaborative team-based care, the Royal College recommends that:

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Endnotes

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[12] CIHI (2008), op.cit, Table 1.2 Specialist Physicians by Sex, Age Group, Province/Territory and Canada, 2007, 65. Physicians age 50-59: 8,620; age 60-64: 3,161; age 65-69: 2,149; age 70-74: 1,251; 75-79: 568; age 80+: 193.
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[29] Task Force Two, op.cit., 12.

[30] Adapted from "Table 20.0 Number and Proportion of Physicians Receiving Their MD Graduation From Canadian and Foreign Universities by Specialty, Province/Territory and Canada, 2007," op.cit.

[31] In 2008, 353 of 1299 IMGs (27%) were matched into programs, an increase of 87 out of 657 (13.2%) matched in 2004. Fifty percent of IMGs chose family medicine as their stream in 2008. CaRMS matching statistics from 1995-2008 are available at http://www.carms.ca/eng/operations_R1reports_08_e.shtml.

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[37] See Royal College of Physicians and Surgeons (January 2009). "Appendix 4, Table 5: Provincial/Territorial forms of provisional medical assessment, licensure and registration," One Step Forward – Two Steps Back? A Discussion Paper on Physician Mobility in Canada, 23-27, retrieved from http://rcpsc.medical.org/publicpolicy/Physician%20Mobility%20Paper_e_fe.pdf.

[38] "Improving Access to Needed Medical Services in Rural and Remote Canadian Communities: Recruitment and Retention Revisited," op.cit, 15.

[39] "Recruiting a new physician, particularly from abroad, is expensive. If regional health authorities are required to replace physicians every two years (which is typically the amount of time necessary to obtain a full license), this means a considerable outlay of financial resources that would be more efficiently spent on the actual provision of healthcare." Rick Audas, Amanda Ross and David Vardy. "The Role of International Medical Graduates in the Provision of Physician Services in Atlantic Canada," op.cit, 15.

[40] " . . . (i) the correlation between provincial net migration and graduation rates is negative (-0.41) and significant, [and] (ii) the correlation between net migration and the share of IMGs is also negative and significant (-0.39). In other words, it seems that provinces that train less benefit more from interprovincial migration and those that lose more through interprovincial migration recruit more internationally." Jean-Christophe Dumont, Pascal Zurn, Jody

Church and Christine Le Thi. World Health Organization. (2008). International Mobility of Health Professionals and Health Workforce Management in Canada: Myths and Realities. OECD Health Working Papers #40, 32, retrieved from http://www.oecd.org/dataoecd/7/59/41590427.pdf.

[41] One Step Forward – two Steps Back?, op.cit.

[42] See http://rcpsc.medical.org/news/documents/AIT_letter_e.pdf.

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[45] Task Force Two, op.cit., 22.

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[50] Royal Commission on Aboriginal People at 10 Years: a Report Card, 2003, op.cit.

[51] Indigenous Physicians of Canada, Royal College. First Nations, Inuit, Métis Health: Core Competencies - A Curriculum Framework for Postgraduate Medical Education, March 2009, retrieved from http://rcpsc.medical.org/residency/FirstNations/CC_IPAC_PGME_e.pdf.

[52] Rekindling Reform, op.cit.,16.

[53] Ibid, 36.

[54] Task Force Two, op.cit., 8.

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