Solving the primary care crisis—A proposed strategy for physician allocation

Here we outline a suggestion for a policy designed to ensure nationwide access to physician services while ensuring the highest standards of medical trainee selection. At the same time, we recognize the increasing burden of health care costs on the Canadian economy and aim to reduce costs by increasing efficiency.

Peter J. Nicholson,
Nimrod Levy

The current physician shortage has highlighted the fact that provincial governments are unable to provide access to physician services for many of their citizens. The most worrisome shortfalls are in primary care. Due to demographic pressures, in particular an aging population and an aging physician pool, the situation will worsen before it eases. The shortage of physicians is only part of the problem. The other part is the distribution of physicians. Under the current system, the existence of a physician surplus would not guarantee service nationwide.[1,2]

Currently, there is no way to guarantee a supply of physicians for any given locality. Individual localities are left to compete in order to attract physicians. Canadian journals are filled with advertisements meant to attract physicians to the various administrative regions, which are forced to spend public money at cross-purposes. It is a colorful manifestation of the feudal, patchwork nature of the current system. When positions cannot be filled, the unfortunate administrative unit must resort to improvisation. Most often the burden is taken up by remaining physicians. Consequently, physicians who elect to work in underserviced areas often face unpredictable and punishing workloads. Occasionally, the need cannot be met by remaining doctors (who may even quit) and a disruption in service results.[3] In the case of a disruption, nearby units are faced with an unexpected demand in a domino effect.

Generally speaking, ad hoc operations are more costly, more stressful for personnel and patients, and less effective than routine operations. Efficient and cost-effective heath care administration is hardly possible without a guaranteed supply of physicians that may be allocated where needed.

The problem of personnel allocation is not unique to medical services. Large-scale private enterprises (e.g., the Canadian Pacific Railway, the petroleum industry) routinely face the same challenge. Workers are often required to live where the company dictates as a condition of employment.

In the public sector, the RCMP must administer essential services across Canada. Ever since the late 1980s, the RCMP has had its recruits sign a cadet's agreement. Under this agreement, cadets must be willing to serve anywhere in Canada that suits the needs of the force. The result is that less desirable posts are filled by junior staff. As recruits gain seniority, they are able to transfer to more desirable posts.[4]

An agreement signed before entering medical school would stipulate that, following graduation and for a period of 2 or possibly 3 years, all junior doctors would serve where needed by the health administration.

The same principle could well be applied to medical trainees. Their mandate would be to perform primary care duties. Graduated postings would place junior doctors in increasingly isolated and responsible roles. Academic material may be delivered by telecommunications in the same way that it often is today. After this period they would receive a qualification akin to the general practitioner licence of past years and would be eligible to practise where they wish or pursue

Peter Nicholson and Nimrod Levy are senior medical students at the University of British Columbia.

(now abbreviated by at least 1 year) specialist training.

To compensate trainees for this commitment of service, medical education should be free for all candidates. Most physicians, in the interest of advancing the profession, and certainly the public, out of concern for their personal health and safety, would agree that medical studies should be undertaken by intellectual elite, not social elite.

Recent increases in post-secondary tuition have made medical school less accessible to poorer members of the intellectual elite. Medical candidates can expect to incur approximately $120 000 of debt during their medical training (not including debt acquired in pursuit of an undergraduate degree, which is at least 66% as much).[5] We submit that this is a significant deterrent for those without considerable personal or familial means. Even with the promise of substantial earnings at the completion of 9 or more years of training, the possibility of illness causing disability, or some other unforeseen circumstance, means that this debt cannot be undertaken lightly by the majority of potential candidates. Financial aid as administered today is inadequate and does not safeguard against crushing debt in the case of being unable to complete the course of studies. Additionally, beginning one's career with debt is damaging to morale. Perhaps justifiably, it deadens enthusiasm for public service and fosters a preoccupation with earning money quickly.

We submit that providing free medical education in this manner would prove cost-effective. It is obviously cheaper to pay a junior doctor a salary (equivalent to a resident's salary) than to employ a fully trained physician. Further savings would come from the administrative regularity enabled by a flexible, guaranteed physician workforce.

The current distribution of residents leads to an oversupply in urban areas, where junior trainees are sometimes considered a nuisance. Specialized instruction is only strictly necessary for senior/specialist trainees.

Broader distribution of junior trainees would help to create a culture of teaching in smaller centres and thereby strengthen the tradition of teaching within the profession as a whole.

Changes in primary health care delivery could be more easily implemented if a large force of recent graduates were distributed nationwide. Their influence could be used to bring about a shift toward prevention-based care, which could lead to more cost savings.

Competing interests

None declared.

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