Where Have All the Family Doctors Gone?

Response to the George Panel on Health Professional Human Resources Report

Respectfully submitted to:

The Honourable Tony Clement
Minister of Health and Long Term Care
10th Floor, Hepburn Block
80 Grosvenor Street
Toronto, Ontario M7A 2C4

Contact:

Mrs. M. Janet Kasperski, RN, MHSc, CHE
Executive Director
THE ONTARIO COLLEGE OF FAMILY PHYSICIANS
357 Bay Street, Mezzanine
Toronto, Ontario M5H 2T7
Phone: 416-867-9646  Fax: 416-867-9990
Email: ocfp@cfpc.ca  Website: www.cfpc.ca/ocfp

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Executive Summary

Ontarians are not being well served.

Family Medicine continues to be in crisis in Ontario. This analysis has been prepared by the Ontario College of Family Physicians in response to the George Panel Report on Health Professional Human Resources that was released in May 2001. The George Panel was struck to follow-up on the recommendations in the McKendry Report released in December of 1999. These reports were triggered, in part, by a report from the Ontario College of Family Physicians released in June 1999, identifying solutions to a crisis for patients due to lack of the availability of family doctors.

After two years, there continues to be a deepening problem of physician supply, distribution and mix affecting access to care in our cities, towns and rural areas. Between 1994 and 2000, the ratio of family doctors per 100,000 Ontario citizens has declined by 10.5%. Ontario now runs significantly below the Canadian average. The total number of physicians in Ontario per 100,000 population also remains below the Canadian average and well below the American and European averages in this regard. Ontarians do not expect this relative inadequacy in their healthcare system.

The Ontario College of Family Physicians applauds the Ontario government’s recent commitment to the Ontario Family Health Network. It demonstrates a bold vision to make Ontario a leader in both population health and in cost-effective healthcare services. But the acute shortage of family doctors is placing this plan in jeopardy as more doctors opt out of full service, comprehensive care practices.

In December 1999, Dr. Robert McKendry released his fact-finding report on the supply, mix and distribution of physicians throughout Ontario. Dr. McKendry recommended short-term strategies to deal with immediate needs but also stated that a long-term strategy was needed.

In May 2001, the George Panel Report was released, issuing 30 recommendations on how to build Ontario’s long-term capacity to plan, educate, recruit and retain physicians. But these recommendations failed to pay sufficient attention to Family Medicine. They also perpetuate, rather than relieve, the shortage of family doctors in Ontario. By focusing on a relatively short-term planning horizon (2000 – 2010), they failed to prepare Ontario for the future needs of Ontarians.

The George Panel misunderstood the numbers.

The Ontario College of Family Physicians endorsed the establishment of the George Panel and was prepared to take an active role in supporting its work. But the process used by the panel soon showed us that its members lacked an in-depth understanding of the severity of the crisis in Family Medicine in Ontario.

Using a simple headcount to measure the current supply of physicians, the panel suggested that the crisis in Ontario was the result of a shortage of only 136 family doctors. But data from the Institute of Clinical Evaluative Studies (ICES) indicates that only 70% of the total number of general and family practitioners are actually practicing broad spectrum non-specialized care. The George Panel Report overstated the supply and under-estimated the problem.
Using the Institute of Clinical Evaluative Studies methodology, last year, Ontario was estimated to have had 6,830 family doctors providing comprehensive care, but these physicians were providing the work of 7,436 (full-time equivalent) doctors. The George Panel indicated that 9,907 Family Physicians were needed. According to our calculations the shortfall is 3,077, not 136. By 2010, Ontario will have experienced a shortfall of 4,572 family doctors delivering comprehensive care.

The estimate and the recommendations made by the George Panel have caused us grave concerns. There are hundreds of thousands of people currently without a family doctor. In addition, there is a trend among Family Physicians toward specialization and restricted practices and they face crushing workloads trying to maintain comprehensive care.

The numbers show Ontario’s decline in service.

Since 1995, the number of family doctors per 100,000 population dropped significantly:

· Reports from the Canadian Institute of Health Information (CIHI) demonstrate that Ontario is the only province in the country that is showing a decline in the ratio of physicians per 100,000 population and this decline is a direct result of the decrease in the number of Family Physicians in the province.

· Ontario now has the second lowest ratio of family doctors to 100,000 population in Canada.

· The Ontario ratio is significantly lower than the Canadian average.

· In contrast, the ration of specialists per 100,000 population in Ontario has increased and is one of the highest in the country and above the national average.

· The number of graduates entering general / family practice has dropped from 54% to 38%.

Short-term and long-term solutions are needed.

The George Panel made 30 recommendations to the Ministry of Health & Long Term Care and we applaud the Honourable Minister Tony Clement for following through on many of these recommendations. These include:

· Increasing the size of our medical school classes;

· Allowing International Medical Graduates to attain the necessary assessments and training to achieve certification and licensing in Ontario;

· The creation of a northern medical school; and

· The creation of Rural and Regional Training Networks in Southwestern and Central Ontario.

But in preparing for the future needs of the population, we need to look beyond the current decade (2000 – 2010) which is the timeframe adopted by the George Panel. In the next decade, Ontario will face a major change in population demographics. With an increase in the number of people over 65 years of age, care will need to shift from the management of acute episodic illnesses and injuries in hospitals to the management of complex chronic problems in the community.
The Ontario Family Health Network will address this shift in population needs by restoring comprehensive, full-spectrum care – which includes an increased focus on health promotion and disease prevention, early detection and treatment of disease, increased monitoring and follow-up of patients with chronic disorders, and access on a 24/7 basis. But this supportive infrastructure will not be possible for Ontarians if we do not have the proper supply of Family Physicians to deliver this range of comprehensive care.

Ontario can do better.

A recent Decima poll found that 21% of Ontarians report difficulty in finding a family doctor, with this figure jumping to 26% outside of major urban centres. Failing to address the real number of Family Physicians needed will result in a severe lack of access to care and undue stress and workload on existing physicians, creating a downward spiral where more physicians opt out of comprehensive care and fewer new graduates are attracted to Family Medicine. Inadequate access to Family Physicians compounds challenges in the overall health system. People make more demands on hospitals, prevention practices decline, and the system ultimately costs more to operate.

Family Medicine is the foundation of our Canadian healthcare system and family doctors in Ontario are committed to rebuilding primary care. Their energy and skills can be harnessed if short-term and long-term strategies are developed to address the acute shortage of family doctors in the province. This must be the number one priority for medical human resource planning in Ontario.

The crisis is becoming worse. The time for studies is past and the time for action is now. Ontarians expect and deserve quality Family Medicine. Our province and our people will be better as a result.

The Ontario College of Family Physicians’ major recommendations are as follows:

1. The Ministry of Health & Long Term Care should proceed as expeditiously as possible to remove the barriers to the establishment of Family Health Networks throughout Ontario by making group practices an attractive means for Family Physicians to provide better quality care for their patients.

2. Lack of access to family doctors delivering broad spectrum, comprehensive family medicine services should be the measurement tool used to establish an under-serviced designation in communities throughout Ontario. To determine this measure, patient enrolment with comprehensive family doctors should proceed expeditiously.

3. **At a minimum**, the Ministry of Health & Long Term Care should ensure that the number of graduates from Family Medicine residency programs be increased to equal the number of graduates from the combined graduating classes of the Family Medicine Residency Program and the Rotating Internship Programs in 1992.

4. To reflect the increased reliance on Family Medicine in light of Primary Care, Long Term Care & Mental Health Care Reforms, as well as changing practice patterns in Family Medicine, the Ministry of Health & Long Term Care should consider further increases in the
number of Family Medicine Residency positions to establish a 60/40 ratio between practicing family doctors and specialists by 2010 and beyond.

5. The Ministry of Health & Long Term Care should develop a vision for our future healthcare system and develop a stable, predictable funding environment to support that vision.

5. In addition, our direct responses to the 30 recommendations made by the George Panel are as follows:

Recommendation 1 – Long-Term Planning
The George Panel Report needs to be viewed with caution and treated as the first steps in the development of a long-term plan for Health Professional Human Resources.

Recommendation 2 – Impact of Reform Initiatives
The George Panel recommendations need to be revisited to take into account the impact that Primary Care, Long Term Care & Mental Health Care community-based reforms will have on Family Medicine.

Recommendation 3 – Impact of Shortage on Practice
The George Panel recommendations need to be revisited to address the impact a severe shortage of family doctors is currently having on practice patterns, and the implications on their forecasts of practice patterns in the future.

Recommendation 4 – Impact of Resource Allocations
The Ministry of Health & Long Term Care should commit to a stable funding environment as the first step in Health Professional Human Resource Planning. Funding needs to provide each region of the province with adequate resources to meet the age, sex, burden of illness and rurality requirements of its citizens. The funding formula should include an escalation clause reflecting inflation and changing regional demographics.

Recommendation 5 – Health Human Resource Advisory Panel
The Ministry of Health & Long Term Care should support local, provincial and national planning efforts by strengthening the planning abilities of District Health Councils to monitor health professional requirements within their catchment areas, collating this information provincially and working with provincial, territorial and federal governments to develop a national planning process that includes national standards and effective planning tools. Professional training schools and residency programs should receive funding to produce the number and mix of physicians determined through this process.

Recommendation 6 – Ontario Physician Workforce Database
The funding to develop the Ontario Physician Workforce Database should be used to verify data at the local and provincial level for a National Physician Workforce Database that can be used for inter-provincial and Canada-wide comparisons and planning exercises.

Recommendation 7 – A Northern Medical School
The decision to place the Northern Medical School solely in Sudbury instead of a shared model with Thunder Bay is of concern. The current plan does not go far enough in strengthening the ability of northwestern remote, rural and aboriginal communities to recruit and retain sufficient
numbers and mix of physicians to meet the unique needs of these communities. Planning for a true PAN- northern medical school should proceed as quickly as possible.

**Recommendation 8 – Clinical Education Campuses**

The Ministry of Health & Long Term Care decision to proceed with establishing a clinical education campuses in Windsor, St. Catharines and Collingwood is supported and should be explored for other communities with similar difficulties in accessing physician services if they prove successful in these Central and Southwestern communities.

**Recommendation 9 – Tuition Fees**

Tuition fees need to be made affordable for students most likely to be attracted to practices in underserviced communities.

**Recommendation 10 – Quality of Medical Education**

The Ministry of Health & Long Term Care should review all recommendations regarding the quality of medical education with the College of Family Physicians of Canada and the Royal College of Physicians & Surgeons.

**Recommendation 11 – Northern Medical School and Rural Streams**

The rural curriculum developed by the College of Family Physicians of Canada should be used to meet the unique training needs of medical students and Family Medicine residents in the rural streams and in the PAN- northern medical school.

**Recommendation 12 – Urban Poor and Aboriginal Streams**

Recommendations regarding rural, urban poor and aboriginal streams are supported. However, it is essential that all residents in Family Medicine are exposed to practices in a variety of locations to include remote, rural, suburban, urban and inner city communities. Included in the experiences should be experiences in underserviced communities.

**Recommendation 13 – Care of the Elderly**

Given demographic changes in the near future and the decreased ability of communities to attract physicians to care for frail elderly patients in their homes and in long-term care facilities, the care of the elderly should be a core requirement of curriculum development in the medical school and Family Medicine residency programs.

**Recommendation 14 – Continuing Medical Education**

The Ontario College of Family Physicians should be consulted regarding Continuing Medical Education requirements for practicing Family Physicians, and the work of the Guidelines Advisory Committee / Ontario Guidelines Collaborative should be expanded to include a digital health library. Both groups should be financially supported to meet continuing medical education objectives for the province.

**Recommendation 15 – Data Driven Access Modeling**

Data driven access modeling method used by the George Panel must be viewed with caution given the many planning constraints that are inherent in the model. Because of the tremendous variability in practice patterns of individual physicians, headcount methods should not be used to reflect the availability of family doctors delivering comprehensive Family Medicine services. The
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number of patients per community without a broad spectrum family doctor is the key access measurement in family medicine.

**Recommendation 16 – Critical Shortfall of Family Doctors**
Comprehensive Family Medicine must be made professionally attractive to doctors and financially competitive as a key to resolving the shortage of physicians practicing comprehensive Family Medicine. By making comprehensive family medicine more attractive, the number of active non-specialized physicians should increase.

**Recommendation 17 – Managing the Postgraduate Training System**
The George Panel recommendations regarding the Postgraduate Training System should be supported. However, given the significant challenges facing Family Medicine in this province, 54% of the new medical school placements should be allocated to family medicine residency programs in 2006 (i.e. 86 of 160 medical school placements). A further 64 medical school placements should be added and dedicated to family medicine to ensure 150 new family doctors graduate per year by 2010.

**Recommendation 18 – Retaining New Graduates**
The Professional Association of Internes & Residents of Ontario’s Resident Placement Program should be expanded. The Ontario College of Family Physicians and the Professional Association of Internes & Residents of Ontario should be asked to jointly develop a mentoring program for new graduates. The development of Family Health Networks will facilitate this process.

**Recommendation 19 – Repatriating Canadians**
The Ministry of Health & Long Term Care should develop an effective recruitment program for Canadian health care professionals, especially Canadian-trained physicians, to return home.

**Recommendation 20 – International Medical Graduates**
The Ministry of Health & Long Term Care’s announcements regarding International Medical Graduates are welcomed by the Ontario College of Family Physicians, noting that the long-term goals should be self-sufficiency in Health Professional Human Resource Planning in the future; however, 54% of the positions should be dedicated to family medicine and the rest to general specialists able to function in underserviced communities.

**Recommendation 21 – To Encourage Comprehensive Care**
The Ministry of Health & Long Term Care should assess and provide advice on all factors, not just financial, that have reduced the number of family doctors delivering comprehensive care. Given the gravity of the situation, immediate steps should be taken to make comprehensive care competitive, and hospital-based care attractive and professionally rewarding to family doctors.

**Recommendation 22 – Comprehensive Care**
The Ministry of Health & Long Term Care should consider supporting the Ontario College of Family Physicians to develop shared-care programs and mentoring networks for physicians delivering obstetrical care, anesthesia and emergency services, modeled after OCFP’s Collaborative Mental Healthcare Network.
**Recommendation 23 – Interdisciplinary Teams in Primary Care**

Family Health Networks should be supported in analyzing the needs of their patient population and determining the make-up of the interdisciplinary team needed to address patient healthcare requirements. Population health needs cannot be met with a model that includes physicians and nurse practitioners only. Some network populations would best be served by including social workers, dietitians, pharmacists or other professional services.

**Recommendation 24 – Nurse Practitioners: Education**

The education of Nurse Practitioners should be flexible and broad to meet the nursing care needs in primary care practices in a variety of practice locations (remote, rural, suburban, urban and inner city) as well as high-resource intensive / high-need patients within networks.

**Recommendation 25 – Nurse Practitioners: Research**

The Ontario College of Family Physicians and Registered Nurses Association of Ontario should be funded to conduct research and evaluate the role of Nurse Practitioners and interdisciplinary teams in Family Health Networks in a variety of practice settings. The goal of this research would be to determine the most effective roles, distribution and make-up of interdisciplinary teams.

**Recommendation 26 – Interdisciplinary Team Support**

The Ministry of Health & Long Term Care should provide adequate funding for interdisciplinary teams working in Family Health Networks. Liabilities and overhead issues need to be addressed.

**Recommendation 27 – Midwife Practices**

In the interest of continuity of care for mothers and babies, midwives should be encouraged to establish collaborative relationships with Family Health Networks and the mother’s family doctor.

**Recommendation 28 – Electronic Health Record**

Family Physicians should be financially supported to enroll patients in a Family Health Network, to maintain comprehensive electronic health records and to provide comprehensive services including patient education for self-care.

**Recommendation 29 – Telephone Triage**

The Primary Care Reform integrated telephone triage service should be expanded to include each patient enrolled in a Family Health Network.

**Recommendation 30 – Attracting and Retaining Physicians Where They Are Needed**

The Ontario Medical Association / the Ministry of Health & Long Term Care’s Physician Services Committee should be advised to develop attractive funding models for all Family Physicians in the province. The funding models need to be able to compete with specialty compensation packages and non-comprehensive Family Medicine practices. Remote, rural and underserviced incentives should be part of the blended funding models. Infrastructure funding should be a component of the funding model, as well.
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Planning Realities: 1990 - 2020

1990 – 2000
▪ the number of Family Physicians decreased significantly resulting in thousands of “orphaned patients”
▪ the number of Family Physicians delivering comprehensive care has decreased
▪ only 30% of family doctors are accepting new patients
▪ the number of Family Physicians providing specialty services has increased
▪ the number of Specialists in the province has increased, however, the mix and distribution remains problematic
▪ the number of hours physicians are willing to work each week has decreased
▪ workload for Family Physicians has increased due to hospital restructuring (71 hours per week on average for comprehensive care physicians)

2000 – 2010
▪ workload for Family Physicians will further increase due to Primary Care, Long Term Care & Mental Health Care Reforms

2010 – 2020
▪ shortages of currently practicing Family Physicians will increase
▪ rates of retirement will increase
▪ workload will increase further due to population growth and aging as the baby boomer generation begins to make extensive use of the system

RESULT
2000 – 2010 ▪ too few Family Doctors
2010 – 2020 ▪ far too few to address population needs

1.0 INTRODUCTION

In June of 1999, the Ontario College of Family Physicians brought government and media attention to the growing crisis in Family Medicine arising from an acute shortage of family doctors available to deliver comprehensive, broad spectrum Family Medicine Services. We recommended strategies to increase the number of physicians in the province but warned that a supportive infrastructure was needed to assist with the provision of vital primary care services. 1, 2, 3, 4

The Honourable Elizabeth Witmer, former Minister of Health & Long Term Care responded by beginning a process to enhance Primary Care throughout Ontario. Ms. Witmer also appointed Dr. Robert McKendry as a “Fact Finding Commissioner to provide advice on the scope and nature of physician supply, mix and distribution issues.”

Dr. McKendry’s Report 5 was released in December of 1999. Dr. McKendry found that there was a problem with the supply, distribution and mix of physicians in the province. He identified the need to increase the total physician supply by 1,000 physicians (5% increase) to meet current needs and warned that the “demographics of consumers and providers point to an increasingly insufficient supply and inappropriate distribution and mix to meet societal healthcare needs in the next 5 to 10 years if corrective actions are not taken immediately.” Dr. McKendry noted that the medical fields where “consumers appear to have ongoing problems receiving timely care include family medicine, anesthesiology, general surgery, obstetrics/gynecology, psychiatry and orthopedics.” It should be noted that Family Physicians often provide the services of these specialties, especially in rural communities. Many family doctors have specific training in these areas of specialization (GP anesthetists, GP psychotherapists, etc.). Other family doctors develop the procedural skills to perform many of the tasks associated with these specialties to meet the needs of their community. In the absence of specialists, the workload for family doctors increases significantly and this has further compounded the shortage of family doctors in the province.
The McKendry Report recommended short-term strategies, but noted that “Ontario must increase the supply of physicians in a way that addresses the province’s long-term problems with distribution and more recent problems with mix.” Dr. McKendry recommended “a commitment to attracting students who are likely to choose rural practice and to providing the rural medical education experience they need to prepare them for practice.” The report also recommended changes to increase the number of new physicians who enter specialties in short supply.

In accepting Dr. McKendry report, Ms. Witmer announced $11 million in funding to implement short-term recommendations. In addition, Dr. Peter George, President of McMaster University was appointed to lead a Panel to address the “longer term healthcare professional needs of Ontario.” The Ontario College of Family Physicians supported both announcements and was fully prepared to contribute to the George Panel deliberations. Our research and recommendations were submitted to the Minister of Health & Long Term Care and to the George Panel in a report entitled “Where Have All the Family Doctors Gone?”, November 2000.1 (see appendix A)

The Ontario College of Family Physicians’ report contained twenty recommendations to:

- address the urgent shortage of family doctors – now and in the future
- attract family doctors to locations and to populations needing them the most
- retain Family Physicians in comprehensive, continuing care practices
- provide better access for every citizen in the province to Family Medicine services

Our paper reminded the Minister that we need to address the shortage of family doctors in the province and at the same time, develop strategies to encourage family doctors to renew their commitment to comprehensive family medicine. In April of 2001, the Honourable Tony Clement announced the establishment of the Ontario Family Health Network. Family Health Networks are seen as key to the delivery of broad spectrum, comprehensive care; however, the acute shortage of family doctors is placing this plan in jeopardy. The recommendations developed by the George Panel may inadvertently result in a perpetuation of the shortage of family doctors in this province and stall Ontario’s best opportunity to provide the key services that people need and want in a cost-effective manner.

The OCFP believes that the George Panel failed to appreciate the key role that family doctors play in our healthcare and the increasingly complex role they will play as a result of Primary Care, Long Term Care and Mental Healthcare Reforms. The Panel also failed to recognize the unsustainable workload shouldered by family doctors practicing comprehensive care. The 2001 Janus Project’s National Family Physician Workforce Survey (appendix B) reveals that family doctors who carry out regularly scheduled office hours, participate in hospital duties and an after-hours on-call schedule are working on average 71 hours per week. This is not sustainable and is driving physicians out of comprehensive care. Many physicians are no longer accepting new patients. The Janus Survey revealed that only 30% of Canada’s family doctors have fully opened practices and able to accept new patients. In Ontario, conditions are even more serious. Ontario has one of the highest percentages of physicians who are not able to accept any new patients. In addition, many physicians have restricted the range and scope of their practices. These coping strategies have hit Ontario hard and are correlated with the depth of the shortage of family doctors in Ontario.
Canada has experienced a 1.4% increase in family doctors between 1994 & 2000 whereas, Ontario has seen a 3.9% decrease. With the workload for the remaining physicians overwhelming, many have sought relief by emigrating to the United States. Physicians who have left for the United States reveal that the benefit they value most is not increased income but improved working conditions and a better lifestyle. With an increased ratio of physicians to population and better access to other essential services, the pressures of practice compared to those in Ontario are considerably eased.

The lack of sufficient numbers of family doctors delivering comprehensive care represents a crisis in Family Medicine that the George Panel ignored; however, the public has not ignored the shortage. Thousands of residents of Ontario are not able to access the services they need. Many people do not have a family doctor at all and receive only episodic care in walk-in-clinics or emergency departments. Others find that their family doctor has changed his/her practice pattern and no longer offers broad spectrum care. These “orphaned” patients are forced to endure “two-tiered” medicine at its worst. Research demonstrates that 84% of people believe that it is vitally important to have a family doctor that co-ordinates care throughout the system and they are demanding that government address their concerns. Every person in this province deserves the opportunity to develop a trusting relationship with a family doctor and the government has committed to renewing family medicine as the foundation of our healthcare system. The George Panel recommendations fall short in preparing the government to meet this commitment and need to be viewed cautiously.

This paper will discuss the following issues that have impacted upon the practice of family medicine in this province, namely,

- the impact of unstable funding on human resource planning;
- the decision to eliminate the rotating internship program and the subsequent failure to appropriately address the number of family medicine residency positions;
- planning based on “headcount” methodology;
- changing practice patterns amongst family doctors requiring an increased number of physicians to provide same levels of services;
- healthcare reforms (Primary Care, Long Term Care & Mental Health Care) requiring an increased number of physicians to address patient needs.

The George Panel is calling for 160 more medical student placements. If the current ratio of Family Medicine to Specialist residency positions is maintained, Ontario will produce only 61 more family doctors by 2008. The Ontario College of Family Physicians is calling upon government to increase the number of Family Medicine residency positions so that we
begin to graduate at a minimum 150 new family doctors each year by 2010. We are also asking that 54% of International Medical Graduate positions be allocated to Family Medicine (i.e. approximately 50 positions) and the rest to general specialists capable of functioning in underserviced areas (general medicine, general surgery, psychiatry, etc.). This number far exceeds the total number called for by the George Panel; however, it is a realistic estimate of the number needed to address the crisis in Family Medicine. Action is needed now as we grapple with the planning realities of 2010 and beyond.

2.0 LONG TERM HEALTH PROFESSIONAL HUMAN RESOURCE PLANNING

2.1 Overview

The George Panel was asked to develop a plan to address the longer term Health Professional Human Resources needs of Ontario. The George Panel Report notes that past planning efforts were “hampered by the ability to identify and forecast needs or supply accurately, the inflexibility of the medical education system, the inability to access the impact of training, working conditions and other factors on physician practices and the tendency to invest in short-term solutions rather than developing the capacity for ongoing long-term planning. Past decisions have also often been based more on financial imperatives than on population health needs. In fact, past efforts to manage physician resources have often created serious problems.”

The George Panel faced many of the same constraints and its report needs to be reviewed with these constraints in mind. It takes six to ten years to train physicians; therefore, planning needs to take place at least ten years in advance. Health Professional Human Resource Planning is ultimately reliant on knowledge about the current human resource pool, future population needs, the system that will be in place to meet those needs and the financial resources available to support the system. The planning horizon of 2000–2010 adopted by the Panel is of concern given the time it takes to train physicians. As a result, the Report does not prepare Ontario to meet population needs in 2010 and beyond. The impact of system and practice changes were under-estimated and the Report fails to advocate for planning within a sound and stable fiscal environment. By developing recommendations that do not clearly address future needs in 2010 and beyond, the George Panel Report has the potential to perpetuate the current crisis in Family Medicine and undermine Ontario’s planned healthcare reform initiatives.

2.2 Ten Year Planning Cycles

As noted previously, it takes six to ten years to train physicians; therefore, planning for Medical Human Resources needs to be undertaken at least ten years in advance. The George Panel was charged with developing a “longer term plan for Health Professional Human Resources”; therefore, it is disconcerting to see that the Panel’s planning horizon was 2000–2010 (a relatively short-term planning horizon). The Panel used 1990’s fee-for-service data, an unreliable physician headcount methodology and population demographics from the 2000’s to develop strategies which will not provide maximum effect until 2010 and beyond. A planning horizon of 2000–2010 is an inappropriate timeframe for the development of a long-term plan to
meet the medical services needs of Ontario’s population. It is important that the Ministry of Health & Long Term Care begins a process to plan for the Health Professional Human Resources required in 2010 and beyond.

2.3 Self-Sufficiency in Health Professional Human Resource Planning

Traditionally, Canada has relied heavily on International Medical Graduates (IMG’s) to augment the pool of physicians trained in Canada. There is a worldwide shortage of health professional human resources and the shortage will only get worse. As one of the world’s richest countries, we can no longer remain dependent upon other countries to augment our human resources. Planning for 2010 and beyond should begin with an agreement to educate sufficient physicians, nurses and other healthcare professionals to meet our own needs. However, we will never be able to train sufficient numbers if efforts are not made to retain these highly educated and vital healthcare professionals in Ontario. Retention is key to sustainability.

The Ontario College of Family Physicians supports recommendations making it easier for international medical graduates to receive the assessment and training required for certification and licensure to practice; however, we need to develop strategies to train sufficient numbers of doctors and retain them in Ontario, so that, in time, we will be self-sufficient and able to address our own needs.

2.4 Population Needs

Assessing future population needs is fraught with difficulties; however, there are certain variables that we do know about the decade beginning in 2010. In the next decade, Ontario will face a major change in population demographics. With an increase in the number of people over 65 years of age, care will need to shift from the management of acute episodic illnesses and injuries in hospitals to the management of chronic problems in the community. The shift will significantly increase the need for family doctors. With an increase in the number of frail elderly patients requiring supportive care, the specialty services of Geriatric Medicine and Geriatric Psychiatry will be in high demand.

Fee-for-service data from the 1990’s and population demographics from the 2000’s do not reflect population needs in the future (2010 and beyond). The George Panel’s short planning horizon led to a failure to emphasize the key role of family doctors in the next decade and beyond. Without a concerted effort to increase the number of family doctors trained during this decade and beyond, Ontario will experience critical problems with access to care in the period immediately following the George Panel’s planning horizon.

2.5 Changing Patterns of Care

A. Primary Care Renewal

Care Confirms the Importance of Primary Care.” The study demonstrates that 12 times as many people are seen in primary care physicians’ offices in the US than in hospitals. The study makes a strong case for designing and implementing “a first rate primary care system in the United States.”

Table 2

| Event                                      | Percentage |
The successful implementation of Primary Care Reform will shift more services to Family Medicine than ever before including greater access around-the-clock. Family Health Networks will restore comprehensive, full spectrum Family Practice. With an increased focus on health promotion, disease prevention, early detection and effective treatment of disease, increased monitoring and follow-up of patients with chronic disorders and access on a 24/7 basis, the workload of primary care providers may intensify even further. The current workload is overwhelming; any further increases in workload without increases in the number of family doctors and a supportive infrastructure will be unbearable. Planning based on 1990’s fee-for-service billing will prove to be an ineffective tool for capturing the workload implications of Primary Care Renewal. Failure to adequately address workload issues will result in a downward spiral where even fewer new graduates are attracted to Family Medicine.

With only 25% of the physicians providing primary care, 52% of the visits are to a primary care provider. Since primary care is much more advanced in Canada than in USA, this figure is significantly higher in Canada with almost 80% of care delivered by family doctors. In spite of our already heavy reliance on family doctors, every province is moving forward with strategies to further enhance Primary Care in Canada. Thanks to the work of the Ministry of Health & Long Term Care and the Ontario Medical Association, Ontario has provided national leadership in this regard. However, the shortage of family doctors is straining our current system and putting further reforms at risk.

In response to the shortage and to an increased workload due to hospital restructuring, many family doctors have restricted their practices to office-based services only. Primary Care Reform will shift more services to Family Medicine than ever before including greater access around-the-clock. Family Health Networks will restore comprehensive, full spectrum Family Practice. With an increased focus on health promotion, disease prevention, early detection and effective treatment of disease, increased monitoring and follow-up of patients with chronic disorders and access on a 24/7 basis, the workload of primary care providers may intensify even further. The current workload is overwhelming; any further increases in workload without increases in the number of family doctors and a supportive infrastructure will be unbearable. Planning based on 1990’s fee-for-service billing will prove to be an ineffective tool for capturing the workload implications of Primary Care Renewal. Failure to adequately address workload issues will result in a downward spiral where even fewer new graduates are attracted to Family Medicine.
Primary Care Renewal affords an opportunity for patients to formalize their relationship with a chosen family doctor through an enrolment process. The enrolment process should be used as a method to determine the number of patients in each community who are unable to enroll with a family doctor offering comprehensive services and of care. Health Professional Human Resource Planning in Family Medicine should indicate a commitment to ensure that the gap between those patients who are able to enroll and those who are unable to find a family doctor is eliminated.

B. Community-Based Long Term Care & Mental Health Care Reforms

The Ontario Government has initiated major reforms of the healthcare system. These reforms are expected to change healthcare delivery from an institutionally based system to a system with care focused in the community. In essence, this is a switch from hospital / specialty care to community-based / Family Medicine care. The downsizing of the hospital-sector has had a major impact on the workload of family doctors. As our senior population increases, medical management of the elderly in their homes and in long-term care facilities will further increase workload for family doctors. New drugs and new technologies already have resulted in significantly shorter hospital stays. Technology, such as home monitoring devices, will further decrease reliance on inpatient care and allow patients to be cared for more efficiently in their homes. Telehealth will reduce the need to travel to tertiary care centres and allow patients to receive care under the direction of their family doctors in their own communities. These strategies will further increase workload for family doctors.

The delivery of Mental Health services is increasingly community-based. “Shared-Care” programs between Psychiatry and Family Medicine provide consistent, high quality care and the continuity of care so vital to the support of persons with major psychiatric disorders. Shared-Care in Mental Health is being used as a model to develop Shared-Care arrangements with other specialties such as Geriatric Medicine and Geriatric Psychiatry, Obstetrics, Neurology, Oncology and Palliative Care. As more specialties begin to enter into “Shared-Care” arrangements with family doctors, the workload implications for Family Medicine is tremendous and not addressed by the George Panel.

By remaining silent on the workload implications of Primary Care, Long Term Care and Mental Health Care Reforms, the George Panel Report under-estimated the number of family doctors needed in a reformed healthcare system.

2.6 Changing Practice Patterns

A. 1990’s Planning Decisions

Decisions made in the 1990’s changed the medical human resource landscape. Health planners noted that the annual per cent increase in the number of physicians holding licences to practice in Canada was greater than increases in the population. Decisions were made to cut medical school enrolments by 10% to correct the assumed “over-supply” of physicians. The elimination of the rotating
internship program without increases in family medicine residency program protected specialty residency programs but reduced the number of combined General Practitioners and Family Physicians eligible for licensure by 31%. In 1992, Canada was licensing 945 General and Family Practitioners. Two years later, only 650 family doctors were eligible for licensure. By 1998, the percentage of General / Family Practice Graduates across Canada had fallen from 54% (in 1992) to 44%. In Ontario, the ratio has fallen to 38% of the residency positions. The George Panel methodology assumes this ratio should be maintained. The Ontario College of Family Physicians recommends restoring the number of residency positions in Family Medicine to the 1992 number from the combined graduating classes of the rotating internship and the Family Medicine Residency Programs – as a minimum.

Table 3
Field of Training of Canadian Medical Graduates at Exit from Canadian Postgraduate Programs (1990 – 1998)

<table>
<thead>
<tr>
<th>Year of Exit</th>
<th>Rotating Internship</th>
<th>Family Medicine</th>
<th>Total (rotating internship &amp; family medicine) N (%)</th>
<th>Specialties N (%)</th>
<th>Total N</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990</td>
<td>383</td>
<td>537</td>
<td>920 (51%)</td>
<td>878 (49%)</td>
<td>1,798</td>
</tr>
<tr>
<td>1991</td>
<td>399</td>
<td>539</td>
<td>938 (53%)</td>
<td>828 (47%)</td>
<td>1,766</td>
</tr>
<tr>
<td>1992</td>
<td>348</td>
<td>597</td>
<td>945 (54%)</td>
<td>805 (46%)</td>
<td>1,750</td>
</tr>
<tr>
<td>1993</td>
<td>284</td>
<td>606</td>
<td>890 (51%)</td>
<td>872 (49%)</td>
<td>1,762</td>
</tr>
<tr>
<td>1994</td>
<td>28</td>
<td>622</td>
<td>650 (45%)</td>
<td>781 (55%)</td>
<td>1,431</td>
</tr>
<tr>
<td>1995</td>
<td>—</td>
<td>654</td>
<td>654 (45%)</td>
<td>784 (55%)</td>
<td>1,438</td>
</tr>
<tr>
<td>1996</td>
<td>—</td>
<td>692</td>
<td>692 (47%)</td>
<td>789 (53%)</td>
<td>1,481</td>
</tr>
<tr>
<td>1997</td>
<td>—</td>
<td>682</td>
<td>682 (43%)</td>
<td>901 (57%)</td>
<td>1,583</td>
</tr>
<tr>
<td>1998</td>
<td>—</td>
<td>694</td>
<td>694 (44%)</td>
<td>886 (56%)</td>
<td>1,580</td>
</tr>
</tbody>
</table>

(Taken from Thurber & Busing, "Decreasing the Supply of Family Physicians & General Practitioners: Serious Implication for the Future.")

B. Attrition

The absolute reduction in the number of graduates entering general practices was accompanied by an increase in migration and other sources of attrition such as death, retirement or leaving medicine altogether. Ontario’s newly graduated family doctors are highly valued in the United States and actively recruited to practice south of the border. The decreased number of new family doctors due to the elimination of the rotating internship program was accompanied by a dramatic increase in the number of physicians migrating to the United States. The reason for this migration is two-fold; firstly, Ontario developed coercive policies intended to drive physicians to underserviced areas of the province at the same time that for-profit American insurance companies discovered how very cost-effective our Family Physicians were in managing patient care. During the period between 1994 and 2000, Ontario has seen a 4% decrease in the number of family doctors holding a
licence to practice in Ontario. This was accompanied by a 9% increase in the number of specialists in the province.
Table 4

Percentage Decline in the Number of Family Physicians in Ontario

<table>
<thead>
<tr>
<th>FAMILY DOCTORS*</th>
<th>SPECIALISTS</th>
<th>TOTAL NUMBER OF PHYSICIANS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ontario</td>
<td>10,359</td>
<td>9,974</td>
</tr>
<tr>
<td>Canada</td>
<td>28,719</td>
<td>29,113</td>
</tr>
</tbody>
</table>

Source: CIHI  * Family Medicine includes all physicians holding a license to practice who do not have specialty designation with the Royal College of Physicians & Surgeons.

Due to an absolute decrease in the number of Family Physicians at the same time that the population has been increasing, the ratio of family doctors to the population has decreased from 95 per 100,000 population to 85 per 100,000 (a 10.5% decrease). International research would indicate that 98 family doctors per 100,000 is required to provide adequate care for the population.

Table 5

Percentage Decline in Family Physicians per 100,000 Population in Ontario

<table>
<thead>
<tr>
<th>FAMILY DOCTORS</th>
<th>SPECIALISTS</th>
<th>TOTAL NUMBER OF PHYSICIANS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ontario</td>
<td>95</td>
<td>85</td>
</tr>
<tr>
<td>Canada</td>
<td>98</td>
<td>94</td>
</tr>
</tbody>
</table>

It should be noted that the Canadian Institute of Health Information (CIHI) data used a “headcount” method. The data includes physicians who are no longer practicing in the province but maintain their licenses to practice. It also reflects Family Physicians who practice on a part-time basis or providing specialized services only rather than comprehensive Family Medicine. As such, the data inflates the number of Family Physicians available to provide Family Medicine services. Caution is needed in interpreting data based on medical licence holders only.

The data reveals a shift to americanized, specialized medicine in Ontario. In the United States approximately 25% of practitioners provide primary care and only 12% are family doctors. Canada has traditionally maintained a 50/50 ratio. In 1994, the ratio of family doctors to specialists in Ontario was 50/50. By 2000, the ratio had shifted to a 47/53 in favour of specialists. This flies in the face of reform efforts to strengthen community-based primary health care.

Table 6

Ratio of Family Doctors to Specialists

<table>
<thead>
<tr>
<th></th>
<th>1994</th>
<th>2000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ontario</td>
<td>50 / 50</td>
<td>47 / 53</td>
</tr>
<tr>
<td>Canada</td>
<td>52 / 48</td>
<td>50 / 50</td>
</tr>
</tbody>
</table>
Ontario had established a policy to move towards a 55/45 ratio between family doctors and specialists in keeping with the reform agenda. This policy, if adhered to, would have moved Ontario in the direction being taken by other countries who are moving towards a 60/40 or 70/30 ratio as they enhance their primary care systems. Ontario’s failure to implement strategies in the 1990’s to move towards the 55/45 ratio paved the way for the current crisis in Family Medicine. The George Panel’s failure to develop recommendations to move from a 47/53 to 55/45 through increases in Family Medicine residency positions in the 2000’s means that Ontario will face unmanageable shortages in 2010 and beyond. If Ontario is to move towards the 55/45 ratio as planned, the number of specialists would need to remain constant and the number of family doctors would need to increase by over 3,000 doctors (33%).

C. Hours Worked / Services Provided

The George Panel used a simple headcount method to measure the current supply of physicians; however, a headcount is an unreliable measurement tool. Headcounts assume that every physician with a licence actively practices in the province, works the same number of hours and provides the same services. In essence, headcounts assume that a doctor is a doctor and as alike as paving stones in a driveway. To understand the “supply side” of medical human resources, it is important to know the number of physicians who are in active practice. The medical databases include physicians who do not practice in the province, physicians who work part-time hours only and physicians who work excessive number of hours that may not be sustainable over time. The data needs to be converted to “full-time equivalent” to provide a better understanding of the current supply. The George Panel fell into the trap of using the headcount method.

In addition, it is important to understand the scope of practice and the services that each physician is providing. The databases include in the General / Family Practice pool physicians who are highly specialized and do not practice comprehensive, broad spectrum care. Documentation of the supply of comprehensive family doctors needs to identify these specialized physicians so that they can be included within the ranks of the Specialists rather than Family Medicine.

Projecting variability in the hours currently worked vs. hours to be worked in the future is an essential planning task that was not undertaken in sufficient detail by the George Panel methodology. As more and more physicians seek balance in their lives and wish to engage in healthy living, they are no longer interested in the long hours that have traditionally been associated with being a physician. The era of 70–80 hour workweeks is over. Moreover, 60% of Family Medicine residents are women. By 2020, half of the family doctors in the province will be women. The professional activities of female doctors are greatly influenced by family life cycles. Research demonstrates that female physicians spend an additional 40-45 hours per week in the home in addition to professional hours during child rearing years, whereas their male counterpart’s hours spent in the home remain constant and significantly lower. With more family doctors choosing to work fewer hours, we will need 20–25% more family doctors to provide the same level of services.
With workload expected to increase in Family Medicine, 30–35% more family doctors than we currently have will be needed to establish a sustainable workload for family doctors in the very near future.

Woodward et al\textsuperscript{11} recently examined changes in preferred hours of working and actual professional working hours over time. The study found that the gap is a good predictor of future reductions in hours worked. Their survey work indicates that the gap between how many hours family doctors wish to work and the hours they are currently working is growing. We can expect reductions in the hours worked by family doctors in the near future. Woodward suggests that more family doctors in the near future will be needed to deliver current levels of services.

\section*{D. Specialization in Family Medicine}

Woodward et al\textsuperscript{12} also demonstrated that receiving certification in Family Medicine does not guarantee that physicians will remain in broad spectrum Family Practice. Losses from Family Practice to specialization were found to be greater than losses from migration. Of the cohort examined, nearly 39\% had very restricted practices, had become specialized or were considering a change of field. Another 1\% were contemplating (or had left) medicine entirely.

The headcount method demonstrates the reduction in the number of physicians licensed to practice in the province as a family doctor or general practitioner. The Woodward findings demonstrate the need to look beyond mere headcounts.

Family Medicine is losing practicing physicians due to the following reasons:

- Attrition
  - migration
  - retirements
  - withdrawal from medical practice
  - death

- Specialization
  - re-entry into specialty residency program
  - re-training as a GP Specialist (e.g., Psychotherapy, Emergency Medicine, Anaesthesiology, Sports Medicine, Palliative Care, Long Term Care, etc.)

- Reduced Hours of Work
  - academics with emphasis on teaching and research
  - female physicians
  - balanced / healthy lifestyles

The Institute for Clinical Evaluation Sciences \textsuperscript{12} has demonstrated the significant error rate that occurs when a simple headcount method is used to identify the number of family doctors in the province. By failing to identify physicians with an active practice who have specialized practices, the headcount method over-estimates the number of family doctors providing full spectrum care by 30\%. This is the same thing as saying to orthopedic surgeons that the depth of the shortage in their discipline is not as deep as they are portraying because the overall number of consultants is adequate.
Table 7

Non-Specialist FP / GPs Providing Family Medicine Services in 1997

<table>
<thead>
<tr>
<th>Headcount</th>
<th>Active</th>
<th>FTE</th>
<th>Non-Specialized Active</th>
<th>Non-Specialized FTE</th>
<th>% Active Specialized</th>
</tr>
</thead>
<tbody>
<tr>
<td>10,386</td>
<td>8,811</td>
<td>9,445</td>
<td>7,257</td>
<td>7,903</td>
<td>17.6%</td>
</tr>
</tbody>
</table>

*Institute for Clinical Evaluation Sciences* \(^{12}\)

*Table 6* indicates that only 8,811 physicians of the 10,386 in the headcount were actively practicing in the province in 1997. These active physicians were performing the work of 9,445 full-time equivalent (FTE) physicians. As Woodward has pointed out, this level of workload is not sustainable over time. Moreover, only 7,257 (71%) of the table were in general, non-specialized practices. The headcount method would lead to the conclusion that we have 10,386 family doctors in the province. In essence, we have only 7,257 physicians practicing, comprehensive broad spectrum care. 3,129 others are either not practicing in the province or practicing highly specialized forms of medicine.

The workload for these physicians is crushing. This level of workload is driving physicians to increasingly restricted practices, to positions as hospitalists, full time Emergency Physicians, Walk-in-Clinics and locum physicians and to specialization. Workload implications and uncertainty due to primary care reform are decreasing the likelihood that young doctors will choose comprehensive Family Medicine as a career. A recent US study by Williams et al\(^{13}\) found strikingly similar figures to those published by Woodward. The study relates physician work patterns to levels of job satisfaction. It is tempting to extrapolate that reductions in work stress may have the potential to reduce the loss of trained Family Physicians from broad spectrum clinical practices. The George Panel is silent on effective retention strategies and workload issues in Family Medicine. OCFP is not. We need to develop effective strategies to address the workload issues in family medicine and make comprehensive care medicine competitive financially and professionally.

### 2.7 Implications of Planning Based on Fiscal Imperatives

#### A. Stop and Go Funding

As the George Panel Report points out, previous Health Professional Human Resource planning efforts have been hampered by investments in short-term solutions based on fiscal imperatives. The George Panel recommends the development of capacity for ongoing long-term planning. Ultimately, long-term planning is a function of future population needs and the resources allocated to meet those needs. Dr. McKendry recommended “access modeling” to determine population needs. Access to services is a function of the availability of Health Professional Human Resources to provide needed services and the available funding envelope to train and support the work of our healthcare professionals. Both the McKendry and the George Panel are silent on the need for predictable and reliable funding allocations as a key requirement for long-term health
services planning and the Health Professional Human Resources needed to meet population requirements.

Our healthcare system is very labour intensive and the vast majority of our healthcare dollars are spent on human resources. In a period of “Stop Funding,” it is very easy to deplete our Health Professional Human Resources; in a time of “Go Funding,” it is extremely difficult and costly to replenish our reserves. It is for this reason that Health Professional Human Resource Planning in a “Stop and Go” funding environment becomes an impossible task. Our brightest and best simply do not choose professional careers fraught with uncertainty and instability.

In early 1990s, short-term fiscal imperatives drove decisions to limit the number of individuals obtaining medical licences and their accompanying billing numbers. Physicians were considered to be cost-centres and the control of their numbers was seen as a way to help control costs. The strategy was unsuccessful and the climate created by this decision has seriously affected the supply of family doctors in this province. Ontario produces some of the most highly trained healthcare professionals in the world, family doctors are seen as especially valuable assets and are under constant pressure from recruiters to move to the United States or to other provinces. The political climate in Ontario was such that these recruiting strategies were increasingly successful. Once physicians migrate and have established roots, it is very difficult to bring them home. The cost of encouraging these physicians to return to Ontario includes addressing the issues that drove them away in the first place – lack of respect and increasing workload. While financial remuneration may have played a part, uncertainty, heavy workload and decreasing morale are the more important variables.

At the same time that the government was implementing policies to reduce the number of physicians in the province and to penalize new physicians setting up practices in “over-serviced” areas, other healthcare reforms were also being initiated. Restrictive funding in the hospital sector resulted in lay-offs in the hospital-base workforce, bed closures and program reductions. This shifted care to the community-based services; however, this shift was not accompanied by adequate resources to meet needs. Neither system was adequate to meet the needs of the people of this province and the effects were felt in every Emergency Department and Family Physician office in the province. The emotional toll that comes from trying without success to advocate for services on behalf of patients has weighed heavily on physicians.

The shortage of family doctors resulted in thousands of people experiencing first hand two-tiered medicine as “orphaned patients” without a family doctor to deliver their care. Communities entered into competition with one another for scarce Family Medicine resources with one community’s gain being another’s loss. In addition, with an increased volume of office-based services, many family doctors withdrew from broad spectrum care. By restricting their practices to office-based services only, they left their patients orphaned – often at times of greatest need – when they required more care than could be provided during an office visit.
Hospitals faired poorly, as well. “Stop Funding” resulted in termination packages that wiped out any potential savings. Deficits accrued as hospitals began to provide service incentives for physicians to provide essential clinical services that were previously offered as a condition of hospital privileges. These new expenditures further compromised the ability of hospitals to deliver services and promoted models of care that result in fragmented care for patients. As an example, in a northern Ontario community, 23 of the 52 family doctors (44%) in town are now full-time employees of the hospital providing care as emergency physicians, hospitalists and as hospital-based walk-in clinic doctors. With almost half the physicians no longer providing comprehensive care, most patients are “orphaned” and receive fragmented, episodic care through the hospital. It is not hard to conclude that efforts to support family doctors in returning to comprehensive practices and sharing in the delivery of hospital-based services would serve the public better.

As a result of the problems that people are experiencing in accessing care, healthcare has become the number one priority for the public, and the government seemed committed to strengthening the system and restoring stability. “Go Funding” was provided for hospitals and for long-term care facilities. As more positions opened up in the institutional sectors, community-based home care providers found it increasingly difficult to retain staff within their limited budgets and the effects on our most vulnerable people continues to be felt. The balance in the system was not achieved and Family Medicine continued to experience difficulties in obtaining necessary care for their patients. At the heart of Family Medicine is the trusting patient-physician relationship. Family doctors establish a covenant with their patients to do whatever is necessary to address their needs. It is emotionally draining to advocate for excellent care on behalf of patients and to find that the needed care is not available, delayed or substandard.

The 2001 Throne Speech and the subsequent budget announcements indicating that the government was intending to launch another “Stop” cycle was particularly disheartening. These announcements included projections of the impact of healthcare spending on spending in the future if current rates of annual increases continue. These projections were used to question the long term sustainability of the system; however, these projects were based on straight-line projections during an extreme “Go” period as the government tried to stabilize the system after years of “Stop” funding. This is clearly a methodology that is fraught with error. Using projections based on straight-line projections has been shown to result in a high error rate. Using projections based on unusual rates of spending will always result in the wrong answer. Khaw demonstrated the errors that accrue using straight-line projects. Based on 1976 data, the UK would have planned for over 300,000 people over the age of 65 who would be unable to function independently in 2036.
Table 8

<table>
<thead>
<tr>
<th>Year of estimate</th>
<th>No (thousands)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1976</td>
<td>500</td>
</tr>
<tr>
<td>1980</td>
<td>1500</td>
</tr>
<tr>
<td>1985</td>
<td>2000</td>
</tr>
<tr>
<td>1991</td>
<td>2500</td>
</tr>
</tbody>
</table>


Based on 1996 data, planning for 2030 would have included only 70,000 people. In addition to developing better systems for estimating trends, we have the ability to decide how much we can afford to spend based on usual rates of spending and thereby, effectively manage fiscal realities. The key is to develop a stable, predictable funding formula based on solid research and effective planning.

Recent government announcements caused confusion in an industry that was just begin to recover from the effects of past planning efforts based on fiscal imperatives, not population needs. The lack of commitment to a vision for our healthcare system and lack of a stable funding envelope to support that vision will make recruitment and retention very difficult, if not impossible.

The George Panel was handicapped by lack of knowledge about the planned directions for the healthcare system and government spending priorities. The Romanow Commission nationally, and the provincial-based consultation process, should provide the vitally-needed vision for our healthcare system in 2010 and beyond. In the meantime, a stable funding envelope to restore confidence in the system and provide buy-in for the future vision is needed.

**B. Too Little? Too Much?**

The Spring Throne Speech and budget announcements suggested that Ontario is currently spending too much on healthcare. The problems being experienced in the system would suggest that we are paying too little. This dichotomy between government and healthcare providers reflects a major flaw in the planning cycle in the 1990s. In preparing for the needs of the population in 2010 and beyond, the government needs to develop stronger primary care and community based systems; however, the need to meet current population requirements must be addressed during the transition period. Instead of investing in the new systems while maintaining the current system, planners tried to direct funding from the current system. The lack of resources jeopardized the reform initiatives and destabilized the system as reported previously. In announcing concerns about healthcare spending in the budget, it was noted that the government was spending
44% of its “program” budget on healthcare. This does not reflect spending capacity and may indicate decreases in spending on other programs rather than inappropriate levels of spending on healthcare. Most provinces and countries review their spending capacity using two readily available measurement tools:

- Percentage of the Gross Domestic Product (GDP)
- Per Capita Healthcare Spending

These two measures indicate that Ontario was spending less than the Canadian average during the “Stop” between 1990 and 1998.

Table 9
Public Expenditures in Canada as a Percentage of the GDP

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Ontario</td>
<td>4.8%</td>
<td>6.2%</td>
<td>6.6%</td>
<td>5.9%</td>
</tr>
<tr>
<td>BC</td>
<td>5.6%</td>
<td>6.9%</td>
<td>7.1%</td>
<td>7.3%</td>
</tr>
<tr>
<td>Alberta</td>
<td>3.9%</td>
<td>6.4%</td>
<td>5.5%</td>
<td>5.0%</td>
</tr>
<tr>
<td>Quebec</td>
<td>6.6%</td>
<td>6.9%</td>
<td>7.2%</td>
<td>7.2%</td>
</tr>
<tr>
<td>Canada</td>
<td>5.5%</td>
<td>6.8%</td>
<td>6.9%</td>
<td>6.5%</td>
</tr>
</tbody>
</table>


As one of Canada’s wealthiest provinces, Ontario spends less of its GDP on healthcare than many of the other provinces across Canada. The percentage of the GDP spent in Ontario between 1990 and 1998 on healthcare fell from 6.2% to 5.9%; whereas, the Canada-wide average fell from 6.8% to 6.5% – higher than the Ontario average prior to the implementation of cost-containment strategies. Compared with other countries, the percentage of the GDP spent on public healthcare does not seem alarming. The Organization for Economic Co-operation & Development average of public healthcare expenditures as a percentage of the GDP was 5.8% in 1998.

Table 10
Public Expenditures in Developed Countries as a Percentage of the GDP

<table>
<thead>
<tr>
<th></th>
<th>1993</th>
<th>1995</th>
<th>1998</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ontario</td>
<td>6.3%</td>
<td>6.5%</td>
<td>5.9%</td>
</tr>
<tr>
<td>Canada</td>
<td>7.3%</td>
<td>6.7%</td>
<td>6.5%</td>
</tr>
<tr>
<td>U S</td>
<td>6.1%</td>
<td>6.5%</td>
<td>6.1%</td>
</tr>
<tr>
<td>U K</td>
<td>5.8%</td>
<td>5.8%</td>
<td>5.6%</td>
</tr>
<tr>
<td>Denmark</td>
<td>7.2%</td>
<td>6.8%</td>
<td>6.8%</td>
</tr>
</tbody>
</table>

As an example, the United States provides 55% of its healthcare through the public purse and spends a higher portion of their GDP (6.1%) doing so. In contrast, Ontario provides 68% of our healthcare needs through our publicly-funded system and yet we spent a lower portion of our GDP (5.9%). The percentage of the GDP spent on healthcare is obviously influenced by the rate of increase in the GDP itself. Canada saw a 19.8% increase in the GDP during the past ten years. With more funding available, increases in the per capita expenditure should be comfortably accommodated; however, the per cent increases in the period between 1990–1998 were well below the rate of inflation.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Ontario</td>
<td>1,685</td>
<td>1,819</td>
<td>1,919</td>
<td>12.2%</td>
<td>1.5%</td>
</tr>
<tr>
<td>Canada</td>
<td>1,644</td>
<td>1,805</td>
<td>1,946</td>
<td>15.5%</td>
<td>1.9%</td>
</tr>
<tr>
<td>B C</td>
<td>1,641</td>
<td>2,003</td>
<td>2,073</td>
<td>20.8%</td>
<td>2.6%</td>
</tr>
<tr>
<td>Alberta</td>
<td>1,701</td>
<td>1,578</td>
<td>1,837</td>
<td>7.4%</td>
<td>0.9%</td>
</tr>
<tr>
<td>Quebec</td>
<td>1,547</td>
<td>1,756</td>
<td>1,897</td>
<td>18.5%</td>
<td>2.3%</td>
</tr>
</tbody>
</table>


On a per capita basis, Ontario’s increase was 12.2% (1.5% per annum) on average; whereas, the Canada-wide increase was 15.5% (1.9% per annum). In 1998, Ontario was spending $27 less per capita than the Canadian average. This equates to more than $3 billion less than would have been spent if Ontario’s spending was at the Canadian average. Given the access problems that occurred, it appears that the funding was inadequate to meet current needs and to reform the system. The government seems committed to moving forward with reforms; however, investments in the system will be needed to complete the reform processes. Measures to further rein-in spending during this period of change will merely perpetuate the problems being experienced in the system. Provision of an appropriate level of funding, as well as funding for investments in system changes are needed as a pre-requisite for Health Professional Human Resource Planning. We have much to learn from the business sector. Banks installed ATMs before closing branches; the healthcare system was asked to do the opposite and it failed.

The George Panel failed to address the impact of funding issues on their data driven access modeling. Human Professional Resource Planning becomes a guessing game in the absence of clear directions regarding the system and the funding envelope to support the system. By relying on activity levels during a period of upheaval caused by “Stop and Go” funding, the report fails to reflect Health Professional Human Resource requirements in the post-reform period. As can be seen in the 1990s, “Stop & Go” funding results in an unstable system. The ability to recruit and retain healthcare professionals is seriously handicapped.
when our brightest and most capable perceive that their careers will be subject to sudden “Stop’s & Go’s”. The healthcare system needs a steady state as a prerequisite to planning.

C. Funding Requirement of Underserviced Areas

Both the McKendry and George Panel reports indicate the need to address underserviced areas of the province. The George Panel promotes the theory that providing medical education in underserviced regions of the province will be sufficient to address the needs of these communities. Recruiting individuals from these communities and training them close to home is an important strategy; however, we need to retain them over the long haul. Physicians working in these areas tend to be “ground down” by their efforts to gain access to services for their patients. The lack of appropriate distribution of healthcare resources throughout the province places “have not” regions of the province at risk from a retention perspective. The Ontario College of Family Physicians agrees with the need to move medical education to the areas of greatest need in the province as a recruiting strategy, but the failure to properly fund healthcare services for these areas of the provinces will render the educational strategy meaningless. The lack of investment in services will make it very difficult to retain physicians to practice in areas where there is a constant struggle to access needed services. Funding formulas are needed to ensure that each region of the province is adequately funded to meet population needs. Serving the needs of remote, rural, urban poor, aboriginal populations, frail elderly, mentally ill and HIV+/AIDs population is very resource intensive. The George Panel Report is silent on the need to strengthen “service delivery” for under-funded and resource intensive populations as a key recruitment and retention strategy.

RECOMMENDATIONS IN RESPONSE TO THE REVIEW OF THE GEORGE PANEL REPORT

Recommendation 1 – Long-Term Planning

The George Panel Report needs to be viewed with caution and treated as the first steps in the development of a long-term plan for Health Professional Human Resources.

Recommendation 2 – Impact of Reform Initiatives

The George Panel recommendations need to be revisited to take into account the impact that Primary Care, Long Term Care & Mental Health Care community-based reforms will have on Family Medicine.

Recommendation 3 – Impact of Shortage on Practice

The George Panel recommendations need to be revisited to address the impact a severe shortage of family doctors is currently having on practice patterns, and the implications on their forecasts of practice patterns in the future.

Recommendation 4 – Impact of Resource Allocations
The Ministry of Health & Long Term Care should commit to a stable funding environment as the first step in Health Professional Human Resource Planning. Funding needs to provide each region of the province with adequate resources to meet the age, sex, burden of illness and rurality requirements of its citizens. The funding formula should include an escalation clause reflecting inflation and changing regional demographics.

### 3.0 REVIEW OF THE GEORGE PANEL RECOMMENDATIONS

#### 3.1 Plan Services to Meet Needs

**A. Health Human Resource Advisory Panel**

The George Panel recommends the establishment of a permanent Health Human Resource Advisory Panel; however, the model seems to be “top down”, and may be duplicating work that could be more effectively performed at the local and national level. Health Professional Human Resource Planning in such a diverse province should reflect the need for local population health planning and monitoring of health professional human resources to meet local needs. Health Professional Human Resource Planning should not occur in an “ivory tower” at the provincial level; it needs to be tied to a community-based planning through a strengthened role of the District Health Councils. The assessments and recommendations of the DHCs should be collated and coordinated at the provincial level. The Health Human Resource Advisory Panel should be carefully organized to reduce duplication of effort by the District Health Councils, by Ministry of Health & Long Term Care’s disease-specific planning bodies and by national organizations. Ontario-trained physicians can obtain a licence to practice in any other province. For this reason Health Professional Human Resource Planning needs to have a national component. Much of the research used by the Panel should be undertaken at the national level by a joint provincial-territorial-federal panel that is formally linked to provincial panels and supports their work.

Decisions regarding the number of medical school placements, international medical graduates, re-entry positions and the mix of residency position should be based on regional, provincial and national research into population needs and the impact of changes in the system. Universities should be contracted to provide the identified numbers and mix. The impact on serviced provision at major teaching hospitals will need to be addressed as we move towards a system of meeting province-wide needs.

**Recommendation 5 – Health Human Resource Advisory Panel**

The Ministry of Health & Long Term Care should support local, provincial and national planning efforts by strengthening the planning abilities of District Health Councils to monitor health professional requirements within their catchment areas, collating this information provincially and working with provincial, territorial and federal governments to develop a national planning process that includes national standards and effective planning tools. Professional training schools and residency programs should receive funding to produce the number and mix of physicians determined through this process.
B. Ontario Physician Workforce Database

The report recommends that the Ministry of Health & Long Term Care, Institute for Clinical Evaluative Sciences and Ontario Physician Human Resources Data Centre (OPHRDC) continue to develop “a new more robust master physician database called the Ontario Physician Workforce Database.” The ability to plan for future medical human resource requirements begins with an accurate assessment of the current number of physicians, the services they are providing and the level of public access to those services deemed vital and necessary. Between the McKendry and the George Panel Reports, six different provincial and national databases are referenced that are used to determine the number of physicians in current practice in Ontario. Dr. McKendry, in referring to four of the databases, demonstrated the high degree of variability amongst the databases. The George Panel chose to use two Ontario-based databases and this is somewhat surprising since the chosen two have been the most divergent over time. The Ontario Physician Human Resources Data Centre and the Institute for Clinical Evaluative Sciences have consistently projected the lowest and highest number of physicians respectively, using the simple headcount method. The report is unclear how the collapsing of these two databases was used to create one “robust” database that overcomes the unreliability found previously in national and provincial databases.

Moreover, as discussed previously, the Institute for Clinical Evaluative Sciences demonstrated how significant the rate of error is when a simple headcount method is used to count the number of family doctors in the province. The headcount method includes physicians who are retired, no longer practicing in Ontario, practicing in a different part of the province, practicing part-time or providing restricted services or practicing in a different discipline. Given the landmark work of the Institute for Clinical Evaluative Sciences in developing the “active non-specialized” designation to identify Family Physicians delivering comprehensive Family Medicine services, it was disconcerting to note that the “robust” database was used to under-estimate the supply of comprehensive family doctors by reverting to the headcount method.

Moreover, an Ontario specific database cannot be used for inter-provincial and Canada-wide planning exercises. The Ministry of Health & Long Term Care
should take a lead role in working with its provincial and federal counterparts to
develop a national database that is verified locally and provincially for reliability
and capable of delivering accurate Canada-wide information to each province.
An Ontario specific database is seen as duplication of effort and a backward step
in Canada-wide Health Professional Human Resource Planning.

**Recommendation 6 – Ontario Physician Workforce Database**

The funding to develop the Ontario Physician Workforce Database should be
used to verify data at the local and provincial level for a National Physician
Workforce Database that can be used for inter-provincial and Canada-wide
comparisons and planning exercises.

### 3.2 Provide Appropriate Education

**A. Decentralizing and Streaming Medical Education**

The George Panel Report identifies some of the factors that lead to effective
recruitment of physicians to rural, remote and underserviced areas. As a result of
these findings, the report recommends building on existing relationships and
infrastructures to create clinical education campuses in Thunder Bay, Sudbury
and Windsor to deliver decentralized medical education. Physicians tend to settle
in the regions surrounding their medical school. This is due to the development
of supportive personal and professional relationships that develop during their
training. The decentralized model reflects the need to train individuals in the area
in which they are needed to facilitate the establishment of lifelong relationships
that are at the heart of retention. The Ontario College of Family Physicians would
recommend that the Ministry revisit the decision to establish a Northern Medical
School in Sudbury and a Clinical Education Campus in Thunder Bay. For people
living in the remote northern and northwestern areas of the province, Sudbury
remains a “southern” community. First Nation people, in particular, will
experience linguistic and cultural barriers in a model that uses a “southern”
community as the hub for undergraduate education. The likelihood of recruiting
medical students from remote northern communities and especially from
aboriginal communities may be jeopardized by the proposed model. The model
of a true PAN- Northern Medical School envisioned by these northern
communities remains the preferred model for better serving the remote northern
and northwestern portions of the province.

For many people in the north, especially the northwest, the decision has been a
blow that may reduce the likelihood that a truly innovative and creative medical
school will be established to meet the unique needs of remote, rural, northern
communities that for far too long have experienced first-hand the effects of two-
tiered medicine.

The students most likely to be retained in underserviced parts of the province are
from families living in underserviced regions of the province or from
underserviced communities. The current provincial medical school tuition rates
are a major deterrent for these families. Families should not have to go into debt
to support students from underserviced communities accessing educational opportunities that promote retention to underservice areas.

**Recommendation 7 – A Northern Medical School**

The decision to place the Northern Medical School solely in Sudbury instead of a shared model with Thunder Bay is of concern. The current plan does not go far enough in strengthening the ability of northwestern remote, rural and aboriginal communities to recruit and retain sufficient numbers and mix of physicians to meet the unique needs of these communities. Planning for a true PAN-northern medical school should proceed as quickly as possible.

**Recommendation 8 – Clinical Education Campuses**

The Ministry of Health & Long Term Care decision to proceed with establishing a clinical education campuses in Windsor, St. Catharines and Collingwood is supported and should be explored for other communities with similar difficulties in accessing physician services if they prove successful in these Central and Southwestern communities.

**Recommendation 9 – Tuition Fees**

Tuition fees need to be made affordable for students most likely to be attracted to practices in underserviced communities.

**B. Ensure Quality**

Ontario’s medical schools do not operate in a vacuum. Residency programs are part of national programs organized under the auspices of the College of Family Physicians of Canada and the Royal College of Physicians and Surgeons. These two organizations are responsible for setting standards of practice and education of residents and practicing physicians. Both Colleges provide an accreditation process for each residency program, set examinations leading to certification that drive curriculum content and provide an accreditation process for continuing medical education for practicing physicians (MAINPRO<sup>®</sup>-M1 and MAINPRO<sup>®</sup>-C programs). Consultations with both Colleges should proceed prior to investments affecting the quality of medical education including common curriculum and evaluation tools. The George Panel report advises the use of current curriculum for the Northern Medical School and this is not in keeping with the directions of the College of Family Physicians of Canada in regards to rural medicine. It should be noted that the College of Family Physicians of Canada has developed a curriculum specific to rural Family Medicine residency programs. This curriculum was developed in recognition of the fact that the current curriculum used in our medical schools does not reflect the needs of physicians choosing to practice in rural areas. From pre-clerkship forward, students at the Northern Universities and in rural streams should be exposed to the unique rural curriculum developed by the College of Family Physicians of Canada rather than the traditional curriculum currently in place in our universities. In addition, the current curriculum is weak in preparing students to meet the unique needs of our Aboriginal / First Nations people. A new curriculum is needed that addresses this issue including spirituality and cultural aspects of health.
The report also refers to southern universities choosing to continue rural streams and / or to develop specific streams for chronically underserviced populations such as urban poor and First Nation people. These recommendations are supported; however, it is noted that every resident in a Family Medicine Program should be exposed to practice in a variety of settings including remote, rural, suburban, urban and inner city locations. These experiences should be designed to specifically include underserviced populations. In light of changing demographics and our decreased ability to find physicians interested in supporting frail elderly populations in their homes or in long-term care facilities, care of the elderly should be considered core to learning in all Family Medicine residency programs.

The mandate of the Ontario College of Family Physicians includes excellence in continuing medical education for practicing Family Physicians in the province; the Ontario College of Family Physicians should be consulted regarding the continuing medical education needs of family doctors, and financially supported to meet those needs.

The Ministry of Health & Long Term Care has been supporting the work of the Guideline Advisory Committee and the Ontario Guideline Collaborative. The Ontario Guideline Collaborative’s membership was specifically chosen to lend province-wide credibility to a process for disseminating evidence-based information to practicing physicians. The website under development to disseminate peer-reviewed guidelines should be funded to form the basis of the digital health library and linked to other sites to reduce duplication of efforts and costs.

**Recommendation 10 – Quality of Medical Education**

The Ministry of Health & Long Term Care should review all recommendations regarding the quality of medical education with the College of Family Physicians of Canada and the Royal College of Physicians & Surgeons.

**Recommendation 11 – Northern Medical School and Rural Streams**

The rural curriculum developed by the College of Family Physicians of Canada should be used to meet the unique training needs of medical students and Family Medicine residents in the rural streams and in the PAN- northern medical school.

**Recommendation 12 – Urban Poor and Aboriginal Streams**

Recommendations regarding rural, urban poor and aboriginal streams are supported. However, it is essential that all residents in Family Medicine are exposed to practices in a variety of locations to include remote, rural, suburban, urban and inner city communities. Included in the experiences should be experiences in underserviced communities.

**Recommendation 13 – Care of the Elderly**

Given demographic changes in the near future and the decreased ability of communities to attract physicians to care for frail elderly patients in their homes and in long-term care facilities, the care of the elderly should be a core
requirement of curriculum development in the medical school and Family Medicine residency programs.
Recommendation 14 – Continuing Medical Education

The Ontario College of Family Physicians should be consulted regarding Continuing Medical Education requirements for practicing Family Physicians, and the work of the Guidelines Advisory Committee / Ontario Guidelines Collaborative should be expanded to include a digital health library. Both groups should be financially supported to meet continuing medical education objectives for the province.

3.3 Producing the Right Supply and Mix of Physician Services

A. Data Driven Modeling Approach for Planning Physician Services

Dr. McKendry recommended “Access Modeling” as the basis for measuring healthcare needs to determine the most appropriate mix, number and distribution of healthcare providers. Access modeling was described in 1996 by the Provincial Coordinating Committee on Community and Academic Health Science Centre Relations’ Expert Panel in Physician Resources. Access modeling has been effectively used by the Cardiac Care Network in Ontario, by Radiation Oncology in British Columbia and as a triage tool for Emergency Patients in Ontario.

Access modeling is based on having an Expert Panel:

· identify the key services or procedures used frequently (core services) in a given specialty
· specify the minimum accepted level of access to these services or procedures for each condition
· develop a template for minimum access standards

The Provincial Coordinating Committee on Community and Academic Health Science Centre Relations model requires the various specialties to measure their current levels of access to care for core services against pre-defined standards that vary depending upon activity, location (urban, rural, remote) and other factors. Communities that fail to meet standards would then identify the reasons for the deficiency. The method has a decided advantage over anecdotal evidence or crude measurements such as the number of physicians per capita; however, the main drawback to the model is the length of time between the identification of an access problem and the ability to resolve the problem given the lead time needed to produce sufficient supplies of physicians.

The members of the George Panel were presented with a “data-driven” modeling approach that deviated significantly from the methodology that has already proven useful in Ontario and in British Columbia. Unlike the Provincial Coordinating Committee on Community and Academic Health Science Centre Relations, access modeling that involves physicians in identifying core services and specifying the minimum accepted level of access to these services, the model is computer-based and invalidated. The results of the modeling indicate that Ontario was short only 136 family doctors in the year 2000. A survey conducted by Decima in December 2000, found that one in five people had trouble finding a
family doctor during that year. The ratio increased to 26% of people in rural communities. It is hard to accept that the critical shortage of family doctors of this magnitude could be solved by adding a mere 136 family doctors to the system.

The physician per capita data would indicate that the shortfall is much greater than the George Panel methodology would indicate. CIHI recently demonstrated a 4.2% decrease in number of family doctors per 100,000 population; however, two years previously the ratio was considerably higher at 95 per 100,000. Compared with 2000 data, this is a drop of 10.5%. Most provinces experienced an increase and it is startling to find such a decrease in Ontario’s family doctors. This ratio is significantly lower than the Canada-wide average of 94 per 100,000. Only Prince Edward Island and two of the territories have lower ratios. The drop in the ratio of family doctors to population has been accompanied by reports of thousands of people unable to access family doctors and increased workload for the remaining physicians. These factors are not being picked up by the methodology used by the George Panel.

### Table 13

<table>
<thead>
<tr>
<th>Province</th>
<th>Family Medicine</th>
<th>Specialists</th>
<th>Total Physicians</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nfld</td>
<td>101 103 103 106 106</td>
<td>64 66 67 68 66</td>
<td>166 169 170 171 172</td>
</tr>
<tr>
<td>PEI</td>
<td>99 99 101 101 101</td>
<td>52 51 55 56 52</td>
<td>125 121 127 130 128</td>
</tr>
<tr>
<td>NS</td>
<td>88 87 90 91 90</td>
<td>88 90 94 97 100</td>
<td>187 188 195 199 201</td>
</tr>
<tr>
<td>NB</td>
<td>104 103 105 105 106</td>
<td>105 106 106 106 108</td>
<td>209 209 211 212 214</td>
</tr>
<tr>
<td>Ont</td>
<td>89 86 86 85 85</td>
<td>99 92 93 94 95</td>
<td>181 179 179 179 180</td>
</tr>
<tr>
<td>Man</td>
<td>86 85 86 92 91</td>
<td>86 89 88 88 89</td>
<td>144 144 149 153 154</td>
</tr>
<tr>
<td>Sask</td>
<td>86 88 87 92 91</td>
<td>58 59 62 61 62</td>
<td>148 157 182 135 138</td>
</tr>
<tr>
<td>Alta</td>
<td>85 83 86 86 86</td>
<td>74 74 77 79 80</td>
<td>159 157 162 167 166</td>
</tr>
<tr>
<td>BC</td>
<td>106 105 106 105 106</td>
<td>86 86 87 88 88</td>
<td>191 191 193 193 195</td>
</tr>
<tr>
<td>YT</td>
<td>125 135 125 114 116</td>
<td>22 22 19 20 20</td>
<td>146 157 145 133 136</td>
</tr>
<tr>
<td>NWT</td>
<td>73 77 69 84 69</td>
<td>18 21 22 43 43</td>
<td>90 98 92 127 112</td>
</tr>
<tr>
<td>Nun</td>
<td>88 87 90 91 90</td>
<td>37 21 21 4 4</td>
<td>40 25 5</td>
</tr>
</tbody>
</table>

**Notes:**
- Physician per 100,000 ratios for 2000 are revised from previous years' figures due to updated population estimates. Therefore figures may differ from past publications.
- Excludes residents and physicians who are not licensed to provide clinical practice and have requested to the Southam Medical Group that their data not be published.
- Data as of December 31 of given year.
- Includes physicians in clinical and/or non-clinical practice, including research, teaching or administration.

(Taken from Southam Medical Database, Canadian Institute for Health Information)
Table 14

ICES Estimates of the Number of Family Doctors in 2000

<table>
<thead>
<tr>
<th>Headcount</th>
<th>Active</th>
<th>FTE</th>
<th>Non-Specialized Active</th>
<th>Non-Specialized FTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>9,771</td>
<td>8,295</td>
<td>9,882</td>
<td>6,830</td>
<td>7,436</td>
</tr>
</tbody>
</table>

Source: ICES: Primary Medical Care in Toronto

If estimates of the number of family doctors is based on the active non-specialized designation developed by the Institute for Clinical Evaluative Sciences rather than the headcount method, the magnitude of the shortage of comprehensive family doctors over time can be seen. The following tables illustrate how this shortage in comprehensive family doctors would be applied to the scenarios in the George Panel Report.

Table 15

Estimates of the Number of Family Doctors Needed Using the Active Non-Specialized Designation

Scenario 1

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>Total Produced</td>
<td>6,830</td>
<td>6,831</td>
<td>6,846</td>
<td>6,864</td>
<td>6,901</td>
</tr>
<tr>
<td>B.</td>
<td>Total Needed</td>
<td>9,907</td>
<td>10,227</td>
<td>10,549</td>
<td>10,866</td>
<td>11,188</td>
</tr>
<tr>
<td>D.</td>
<td>George Panel Shortfall</td>
<td>(136)</td>
<td>(455)</td>
<td>(755)</td>
<td>(1,046)</td>
<td>(1,315)</td>
</tr>
</tbody>
</table>

A. Estimated number of Family Doctors providing comprehensive care based on ICES formula for determining active non-specialized physicians.
B. Total needed based on George Panel data
C. B-A = Shortfall in comprehensive family doctors
D. Shortfall according to George Panel report

By 2010, Ontario will experience a shortfall of 4,572 Comprehensive family doctors compared with the George Panel estimate of 1,582. Even using the most aggressive scenario of replacing family doctors with nurse practitioners and midwives in ratios that research and the public will not support, the shortfall is pervasive and significant.

Table 16

Estimates of the Number of Family Doctors Needed Using the Active Non-Specialized Designation

Scenario 3

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>Total Produced</td>
<td>6,830</td>
<td>6,962</td>
<td>7,089</td>
<td>7,199</td>
<td>7,313</td>
</tr>
<tr>
<td>B.</td>
<td>Total Needed</td>
<td>9,865</td>
<td>10,104</td>
<td>10,350</td>
<td>10,511</td>
<td>10,687</td>
</tr>
<tr>
<td>C.</td>
<td>Shortfall</td>
<td>(3,035)</td>
<td>(3,142)</td>
<td>(3,261)</td>
<td>(3,312)</td>
<td>(3,368)</td>
</tr>
<tr>
<td>D.</td>
<td>George Panel Shortfall</td>
<td>(94)</td>
<td>(144)</td>
<td>(207)</td>
<td>(211)</td>
<td>(225)</td>
</tr>
</tbody>
</table>
A. Estimated number of Family Doctors providing comprehensive care based on ICES formula for determining active non-specialized physicians.
B. Total needed based on George Panel data
C. B-A = Shortfall in comprehensive family doctors
D. Shortfall according to the George Panel report

The headcount method clearly over-estimates the number of physicians available to deliver comprehensive Family Medicine services and fails to capture the changes that were taking place in physician practices during the 1990s. The use of data from the 1990s represents unsustainable workload for comprehensive family doctors and the under-servicing of individual patients who were denied access to comprehensive services and continuity of care. Underservicing was driven home through the OMA/MOHLTC negotiation process that revealed the capitation rate for physicians with high volume case loads to be approximately $40-$60 versus physicians with lower volume case loads of $160 to $200 per patient per year. As primary care, community-based long-term care and mental healthcare service delivery systems expand, the role of the family doctor will be even more prominent than it is today. Computer-based modeling using head counts and historical fee-for-service data during a particularly chaotic period of time for Family Medicine, are unreliable tools for projecting the magnitude of the shortage of family doctors in the province. The key access measurement tool for family medicine is the number of patients per community who do not have a family doctor.

Ontario will not be able to address a problem of this magnitude through physician substitution models, minor increases in Family Medicine residency class sizes or increased reliance on International Medical Graduates. We need to address the factors that have led to a 30% reduction in the number of physicians actually practicing in the discipline for which they were trained. William et al recently published a very relevant study in the US. Their work focused on a sample population of clinically active physicians, mostly generalists in the fields of family medicine, internal medicine and paediatrics. The authors found that there was a significant minority of physicians (25%) who perceived a moderate or greater likelihood of leaving their current practice situation within two years. And more significantly, more than 40% planned to decrease their work hours within five years. Almost 20% indicated a moderate or greater likelihood of leaving direct patient care altogether. In this group, it was clear that increased perception of job stress, decreased levels of job satisfaction, and increased mental health problems such as anxiety and depression were related to greater intention to decrease work hours, change specialty, and quit direct patient care entirely. In this study, physicians with increased levels of depression and anxiety were most likely to quit direct patient care altogether rather than just decrease work hours or commitments. The Janus Survey 2001 indicates that 17.3% of family doctors in Ontario are planning changes that will affect the supply of family doctor. To address the problems we have in Ontario with recruitment and retention of comprehensive care physicians, a substantive effort to make comprehensive Family Medicine attractive to family doctors is needed. While we need to increase the number of family doctors we are producing to meet societal needs,
we also need to address the workload issues by developing supportive infrastructures to support their work. The key to addressing the problem is making Family Medicine professionally attractive to physicians and financially competitive with other professional non-comprehensive work Family Physicians could do.

**Recommendation 15 – Data Driven Access Modeling**

Data driven access modeling method used by the George Panel must be viewed with caution given the many planning constraints that are inherent in the model. Because of the tremendous variability in practice patterns of individual physicians, headcount methods should not be used to reflect the availability of family doctors delivering comprehensive Family Medicine services. The number of patients per community without a broad spectrum family doctor is the key access measurement in family medicine.

**Recommendation 16 – Critical Shortfall of Family Doctors**

Comprehensive Family Medicine must be made professionally attractive to doctors and financially competitive as a key to resolving the shortage of physicians practicing comprehensive Family Medicine. By making comprehensive family medicine more attractive, the number of active non-specialized physicians should increase.

**B. Managing the Postgraduate Training System**

The George Panel recommends using the postgraduate training system to shape the mix of physician skills in Ontario. The report recognizes the trend towards sub-specialist medicine and the negative impact this is having on non-academic health science centre communities in meeting population needs. The majority of these communities cannot support sub-specialist care and rely on family doctors, as well as specialists trained as generalists to meet local requirements. The Ontario College of Family Physicians supports the George Panel recommendations aimed at better meeting the needs of people throughout the province. The implementation of recommendations to address the mix of physicians in the province are needed and welcomed.

The George Panel report, however, is silent on the need to use the Postgraduate Training System to restore balance in the number of Family Physicians being produced. While planning is needed to increase the number of general specialists and to meet the needs of priority programs such as cardiac surgery, oncology, geriatric medicine and public health, the need to produce an adequate number of Family Physicians each year is acute and should be seen as a priority in assigning residency positions at each of the universities. Given their key role in rural and underserviced communities, Family Physicians should be a priority with Health Human Resources Advisory Panel and the Council of the Faculty of Medicine.

In responding to the George Panel recommendations, Mr. Clement has announced 160 new medical school placements by 2002. If the current ratio of Family Medicine residency positions to Specialists residency positions is
maintained, this will result in only 61 (160 × 38% = 61) new graduates in Family Medicine entering practice in 2008.
The following table based on George Panel & ICES data emphasizes the fact that the crisis in comprehensive Family Medicine will not be relieved by an increase of only 61 Family Medicine residents:

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Needed</th>
<th>Total Active Non-Specialized FPs</th>
<th>B + 61 FPs Graduates by 2008</th>
<th>Number Required from Other Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>9,907</td>
<td>6,830</td>
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<td>10,227</td>
<td>6,831</td>
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<td>10,549</td>
<td>6,846</td>
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<td>3,703</td>
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<td>2006</td>
<td>10,866</td>
<td>6,864</td>
<td>6,864</td>
<td>4,002</td>
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<tr>
<td>2008</td>
<td>11,188</td>
<td>6,901</td>
<td>6,963 *</td>
<td>4,226</td>
</tr>
<tr>
<td>2010</td>
<td>11,517</td>
<td>6,945</td>
<td>7,128</td>
<td>4,389</td>
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</table>

A = total needed according to the George Panel methodology
B = total estimated comprehensive Family Physicians using the Institute for Clinical Evaluation Sciences methodology to identify active non-specialized Family Physicians
C = total active non-specialized Family Physicians plus 61 more Family Medicine graduates beginning in 2008 *
D = A – C (other sources = IMGs, repatriation and return to comprehensive care)

According to the George Panel, 11,517 comprehensive family doctors will be needed by 2010. Institute of Clinical Evaluative Studies (ICES) data indicates that we will have an estimated 6,945 physicians delivering comprehensive Family Medicine services. If only 61 more physicians graduate from Family Medicine residency program in 2008, 2009 and 2010, then 4,389 more comprehensive family doctors will need to come from the three other sources (international medical graduates, repatriation of Canadian physicians, and conversion of family doctors who are currently specialized Family Physicians into comprehensive family doctors). This seems unlikely. Any methodology that relies on a simple headcount will result in the wrong answer. We must enroll patients with family doctors committed to comprehensive care practice, and document community-by-community those patients who are unable to enroll as the key “access” measurement. Using a crude measurement tool (i.e. approximately 1500 patients per family doctor), Ontario’s population in 2001 of almost 12,000,000 needs to access approximately 8000 full time equivalent family doctors but we have only 6830 comprehensive care physicians, many of whom provide only part-time services. At a minimum, we would need 1170 more full-time equivalents. If the ratio of family doctors to specialist residency placements remains constant at 38% (i.e. 61 new family medicine residency placements of the 160 new medical school and 34 IMGs from the 90 new positions, it will take until 2020 to achieve the required number of family doctors that we need now and this assumes that every graduate sets up a full-time comprehensive care practice - highly unlikely in today’s climate. The recommended number of family medicine residency positions in the George Report is clearly inadequate to prepare us for the future. It is for this reason that OCFP is requesting that 54% of the 160 medical school placements be allocated to family medicine by 2006 (i.e. 86 positions). A further 46 medical school placements dedicated to family medicine residency will be needed to ensure
that Ontario graduates a minimum of 150 new family doctors each year from 2010 and beyond.
Recommendation 17 – Managing the Postgraduate Training System
The George Panel recommendations regarding the Postgraduate Training System should be supported. However, given the significant challenges facing Family Medicine in this province, 54% of the new medical school placements should be allocated to family medicine residency programs in 2006 (i.e. 86 of 160 medical school placements). A further 64 medical school placements should be added and dedicated to family medicine to ensure 150 new family doctors graduate per year by 2010.

C. Making More Effective Use of Existing Resources

I. RETAIN NEW GRADUATES

The Ontario College of Family Physicians fully supports enhancements to the Professional Association of Internes & Residents of Ontario’s Resident Placement Program; however, we believe that the program could be further enhanced by establishing a formal mentoring program between established practicing Family Physicians in each community and new graduates. The mentors would provide guidance and support to these new physicians. The Ontario College of Family Physicians would be happy to work with the Professional Association of Internes & Residents of Ontario to develop the mentoring program.

Recommendation 18 – Retaining New Graduates

The Professional Association of Internes & Residents of Ontario’s Resident Placement Program should be expanded. The Ontario College of Family Physicians and the Professional Association of Internes & Residents of Ontario should be asked to jointly develop a mentoring program for new graduates. The development of Family Health Networks will facilitate this process.

II. RECRUIT QUALIFIED INTERNATIONAL MEDICAL GRADUATES

The Ontario College of Family Physicians fully supports training opportunities for landed International Medical Graduates and shares the George Panel’s concerns that Canada not be perceived as “poaching” scarce health human resources from other countries. The aim of the program should be to recruit Canadians, especially Canadian trained physicians, to return to Canada and to make it easier for International Medical Graduates to receive the assessment and training they need to practice at the same level of competence as our well-trained Canadian Doctors. In the long term, Canada should be training sufficient numbers of Canadians to address our own future Health Human Resource needs.

Recommendation 19 – Repatriating Canadians

The Ministry of Health & Long Term Care should develop an effective recruitment program for Canadian health care professionals, especially Canadian-trained physicians, to return home.
Recommendation 20 – International Medical Graduates

The Ministry of Health & Long Term Care’s announcements regarding International Medical Graduates are welcomed by the Ontario College of Family Physicians, noting that the long-term goals should be self-sufficiency in Health Professional Human Resource Planning in the future; however, 54% of the positions should be dedicated to family medicine and the rest to general specialists able to function in underserviced communities.

III. ENCOURAGE PHYSICIANS TO PROVIDE MORE COMPREHENSIVE CARE

The George Panel assumed that the trend towards a decreased number of Family Physicians providing psychiatric care, obstetrics, emergency services or anesthesiology could be easily reversed. The George Panel recommends removing financial barriers as the key to restoring the relative proportion of generalists to specialists providing certain service levels. While sessional fees and addressing the “exorbitant cost of liability insurance” will be helpful, the present trend towards exclusive office-based practice for family doctors is multi-factorial and, in many cases, funding is not the main issue. Workload in the community has increased significantly in recent years and many physicians are overwhelmed by this workload. In many communities, hospitals are perceived to be “hostile” environments for Family Medicine. Family doctors have been replaced by full-time Emergency Physicians and Hospitalists. Increasingly, hospitals are operating walk-in clinics and post-discharge clinics to meet the needs of orphaned patients. This leads to fragmented care. The trend needs to be reversed; however, until workload issues are addressed in the community and hospitals become more respectful of the role of family doctors, many of the issues that are driving family doctors away from hospital-based care will continue to reduce the likelihood that family doctors will return to comprehensive care. Financial incentives alone will not restore the balance between generalists and specialists that was in place in 1995.

System-wide support for Family Health Networks as a method to promote quality comprehensive services and continuity of care is needed. Competitive funding arrangements for family doctors need to be built into the Family Health Network model; however, the key variable is restoration of respect and appreciation for the role of comprehensive family doctors and a recognition of the need to address overall workload issues in Family Medicine. Shared Care models and collaborative mentoring networks should be organized to provide family doctors with specialty support and guidance in these identified areas of concern. Re-entry programs to encourage family doctors to enter specialist programs or to function in specialty roles should be organized in conjunction with step-by-step increases in family medicine residency positions so that the pool of comprehensive family doctors is not negatively affected by the re-entry programs.
Recommendation 21 – To Encourage Comprehensive Care
The Ministry of Health & Long Term Care should assess and provide advice on all factors, not just financial, that have reduced the number of family doctors delivering comprehensive care. Given the gravity of the situation, immediate steps should be taken to make comprehensive care competitive, and hospital-based care attractive and professionally rewarding to family doctors.

Recommendation 22 – Comprehensive Care
The Ministry of Health & Long Term Care should consider supporting the Ontario College of Family Physicians to develop shared-care programs and mentoring networks for physicians delivering obstetrical care, anesthesia and emergency services, modeled after OCFP’s Collaborative Mental Healthcare Network.

IV. PROMOTE COLLABORATIVE PHYSICIAN / NURSE PRACTITIONER PRACTICE
The Ontario College of Family Physicians supports interdisciplinary teamwork in Primary Care. Primary Care Renewal places greater emphasis on population health. The enrolment process, with the assistance of computerized information systems, provides the basis for groups of physicians to begin to identify the unique health profiles of the group practice population. With this information, an interdisciplinary team can be established with the knowledge and skills to address the needs of the practice population. The model of care is based on research of the University of Ottawa and captured in the Ontario College of Family Physicians’ paper “Collaboration in Primary Care – Family Doctors and Nurse Practitioners Delivering Shared Care.”

The George Panel Report indicates that its members see Nurse Practitioners as “cost-saving physician substitutes” rather than as members of an interdisciplinary team specifically struck to improve the quality and comprehensive care delivered within primary care systems. By presenting Nurse Practitioners as vehicles for increasing patient volumes in practice rather than practitioners who will further improve the quality of the care provided, the George Panel demonstrated its lack of respect for the emerging roles of Nurse Practitioners. The George Panel Report contends that its review of the literature and its own unpublished research demonstrates that a collaborative physician / nurse practitioner practice can provide primary care for 25–50% more patients than a traditional physician practice. The Ontario-based experiences of the Primary Care Reform Pilot Sites would seem to dispute this claim. Of the eleven established Primary Care Networks in Ontario, five have Nurse Practitioners. Those networks with an NP have an average physician-to-patient ratio of 1,340. In the six Primary Care Networks that do not have a Nurse Practitioner, the average ratio is 1,576. The three Primary Care Networks with the highest physician-to-patient ratio do not have Nurse Practitioners.
Table 18

**Physician-to-Patient Ratio in Ontario Primary Care Networks**

<table>
<thead>
<tr>
<th>Network</th>
<th>Ratio without Nurse Practitioners</th>
<th>Ratio with Nurse Practitioners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hamilton Stoney Creek / Mountain</td>
<td>2,245</td>
<td></td>
</tr>
<tr>
<td>Hamilton Intramed</td>
<td>2,077</td>
<td></td>
</tr>
<tr>
<td>Hamilton Escarpment</td>
<td>1,871</td>
<td>1,509 (1 NP)</td>
</tr>
<tr>
<td>Hamilton Innovations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chatham</td>
<td>1,495</td>
<td></td>
</tr>
<tr>
<td>Hamilton Core</td>
<td></td>
<td>1,467 (1 NP)</td>
</tr>
<tr>
<td>Paris</td>
<td>1,338</td>
<td>1,465 (1 NP)</td>
</tr>
<tr>
<td>Hamilton Carlisle</td>
<td></td>
<td>1,338</td>
</tr>
<tr>
<td>Kingston Rural</td>
<td></td>
<td>1,203 (2 NPs)</td>
</tr>
<tr>
<td>Hamilton Community Health Centre</td>
<td></td>
<td>1,056 (2 NPs)</td>
</tr>
<tr>
<td>Hamilton McMaster</td>
<td>430</td>
<td></td>
</tr>
<tr>
<td>Primary Care Networks Average</td>
<td>1,576</td>
<td>1,340</td>
</tr>
</tbody>
</table>

The Primary Care Network’s Collaborative Physician / Nurse Practitioner Practices have not demonstrated their ability to increase the number of patients in a practice. The evaluation of the Primary Care Reform Pilot Sites indicates that the key to successful introduction of Nurse Practitioners to Family Physician practices is the emphasis on meeting the need of the practice population. While media reports tend to emphasize the training of Nurse Practitioners to address minor problems and thereby freeing physicians to deal with complicated cases, physicians report that the nurses are needed to take on more sophisticated roles providing care for the management of complex and complicated patients. The training of Nurse Practitioners to meet diverse practice needs requires review. Given the critical problems facing Family Medicine in the province, both patients and physicians alike are receptive to collaboration between physicians, nurses and other healthcare professionals; however, we need to organize Family Health Networks first, enroll patients and assess practice population needs. The make-up of the interdisciplinary team and the role of nurse practitioners within each network will be determined by the needs of the population, the geographic realities facing the Network and the skills and interests of the team members.

Respect for Nurse Practitioners should be driven by their potential to improve quality of care and comprehensive care. Every person in the province needs a trusting relationship with a family doctor. The models that are developed to support interdisciplinary team work needs to be carefully implemented to ensure that the trusting patient-physician relationship is maintained and enhanced.17
Funding, liability and practice overhead issues must be addressed to facilitate the development of interdisciplinary team practice and collaboration between nurse practitioners and family doctors. Education of nurse practitioners needs to address the variety of roles and practice locations of nurse practitioners. A “one size fits all” training mentality will not meet the needs of Primary Care in this diverse province.

Recommendation 23 – Interdisciplinary Teams in Primary Care
Family Health Networks should be supported in analyzing the needs of their patient population and determining the make-up of the interdisciplinary team needed to address patient healthcare requirements. Population health needs cannot be met with a model that includes physicians and nurse practitioners only. Some network populations would best be served by including social workers, dietitians, pharmacists or other professional services.

Recommendation 24 – Nurse Practitioners: Education
The education of Nurse Practitioners should be flexible and broad to meet the nursing care needs in primary care practices in a variety of practice locations (remote, rural, suburban, urban and inner city) as well as high-resource intensive / high-need patients within networks.

Recommendation 25 – Nurse Practitioners: Research
The Ontario College of Family Physicians and Registered Nurses Association of Ontario should be funded to conduct research and evaluate the role of Nurse Practitioners and interdisciplinary teams in Family Health Networks in a variety of practice settings. The goal of this research would be to determine the most effective roles, distribution and make-up of interdisciplinary teams.

Recommendation 26 – Interdisciplinary Team Support
The Ministry of Health & Long Term Care should provide adequate funding for interdisciplinary teams working in Family Health Networks. Liabilities and overhead issues need to be addressed.

V. REMOVE ADMINISTRATION BARRIER TO MIDWIFE PRACTICES
The George Panel’s focus was on removing hospital-based barriers to midwife practices. The Ontario College of Family Physicians believes that the development of Family Health Networks presents an opportunity for midwives to move from an independent practice model to collaborative relationships with Family Health Networks.

Recommendation 27 – Midwife Practices
In the interest of continuity of care for mothers and babies, midwives should be encouraged to establish collaborative relationships with Family Health Networks and the mother’s family doctor.
D.  Managing Demand

The George Panel advised the Ministry of Health & Long Term Care to develop initiatives to reduce inappropriate use of health services by educating the public regarding the appropriate time to see a physician or other healthcare providers. The Ministry of Health & Long Term Care has invested in an integrated telephone triage system for the Primary Care Reform Pilot Sites that is effectively triaging patients to self-care and the Family Practice offices, thus, reducing unnecessary use of more costly Emergency Departments. The system requires enrolment of patients with family doctors. In conjunction with telephone triage systems, enrolled patients should be provided with reference material for self care as seen in the British Columbia project and through peer-reviewed patient education tools and websites.

**Recommendation 28 – Electronic Health Record**

Family Physicians should be financially supported to enroll patients in a Family Health Network, to maintain comprehensive electronic health records and to provide comprehensive services including patient education for self-care.

**Recommendation 29 – Telephone Triage**

The Primary Care Reform integrated telephone triage service should be expanded to include each patient enrolled in a Family Health Network.

3.4 Attract and Retain Physicians Where They are Needed

The Ontario College of Family Physicians supports efforts to make comprehensive Family Medicine competitive. The playing field needs to be equalized to attract physicians away from restricted practices to comprehensive Family Medicine. In spite of the growing emphasis on Family Medicine, medical students are not as attracted to Family Medicine as previously. In addition, it is becoming more difficult to retain physicians in comprehensive care, largely due to overwhelming workload and lack of financial incentives for practitioners of broad spectrum care.

While financial incentives based on a rurality index are vitally needed to make underserviced areas competitive, funding models need to address the fact that Family Medicine in general can no longer compete with specialty practices and non-comprehensive Family Practices. In addition, financial incentives in the lieu of strategies to address the overwhelming workload and responsibilities associated with Family Medicine will not begin to address the problems facing communities throughout Ontario.

We need to train more Family Physicians to meet increased demand, provide an effective infrastructure to support their work, and recognize the value of the role through proper compensation packages that support the contributions of Family Medicine to quality patient care and a sustainable healthcare system. The menu of incentives recommended by the George Panel should be expanded to include Family Physicians in suburban and urban practices that work in Family Health Networks especially those that address the needs of urban poor and other hard-to-serve / high
resource intensity population. The recently announced $100 million for Primary Care and $20 million to help retain doctors in northern Ontario is a great initial step forward in this regard.

**Recommendation 30 – Attracting and Retaining Physicians Where They Are Needed**

The Ontario Medical Association / the Ministry of Health & Long Term Care’s Physician Services Committee should be advised to develop attractive funding models for all Family Physicians in the province. The funding models need to be able to compete with specialty compensation packages and non-comprehensive Family Medicine practices. Remote, rural and underserviced incentives should be part of the blended funding models. Infrastructure funding should be a component of the funding model, as well.

**4.0 SUMMARY**

Health Professional Human Resource Planning cannot take place in isolation of healthcare system planning. Effective planning for the system and the human resources to provide professional services within the system, must be clearly anchored in processes to accurately assess the needs of the population. For planning to be effective, governments need to develop a vision of the healthcare system that will meet those needs and commit to appropriate and stable funding to make the vision a reality. Health Professional Human Resource Planning could then proceed on the basis of known conditions. The George Panel was hampered by too many unknowns. As we move forward to implement recommendations to address critical shortages, stakeholder and public consultation provincially and nationally will make next stages in Health Professional Human Resource Planning much more straightforward.

The Ontario College of Family Physicians intends to add its voice in support of the Minister’s decision to conduct consultation regarding the long-term sustainability. Our focus will be, as always, the central role of family doctors in meeting the needs of the people of this province.
5.0 BIBLIOGRAPHY

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6. “Shaping Ontario’s Physician Workforce: Building Ontario’s Capacity to Plan,
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11. Eric Williams et al. “Understanding Physicians Intentions to Withdraw from Practice:
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12. “Postgraduate Education for Rural Family Practice Vision and Recommendations for

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14. “A Shared Care Network: Enhancing Mental Health Services in Ontario” Ontario
    College of Family Physicians, September 2000.


Where Have All the Family Doctors Gone?

A Discussion Document

Contact:

Ms. M. Janet Kasperski, RN, MHSc, CHE
Executive Director
THE ONTARIO COLLEGE OF FAMILY PHYSICIANS
357 Bay Street, Mezzanine Level, Toronto, Ontario  M5H 2T7
Phone: (416) 867-9646  Fax: (416) 867-9990
Email: ocfp@cfpc.ca  Website: www.cfpc.ca/ocfp

February 2001
EXECUTIVE SUMMARY

With 2001 fast approaching, Family Medicine is still operating in an atmosphere of uncertainty and crisis management. Family doctors are the public’s most important interface with the healthcare system. In addition to delivering necessary care, they play a key role in determining the level of confidence that the public has in the system. With patients across the province finding it increasingly difficult to find a trusted physician delivering comprehensive continuity care, access to services has become compromised and confidence in the system is at an all time low.

Ontario citizens are convinced that the need is urgent and the time to implement solutions is now in the era of unheralded prosperity. Taxpayers, patients, and physicians alike are looking for an end to uncertainty and seeking solutions from the Ministry of Health & Long Term Care.

The Ontario College of Family Physicians has sounded alarms on behalf of patients and the Family Physicians of this province. We have fully documented the critical shortages of care, the lack of continuity of care and the gaps in the system across the province that are widening into unbridgeable crevices. We have described the downward spiral of overwork and burnout that has resulted in fewer Family Physicians providing comprehensive care and unhealthy workloads for the remaining doctors. Our concern at this point is that the crisis is in fact becoming the status quo. It is for this reason that many of Ontario’s Family Physicians are withdrawing services, planning early retirements, refusing to set up practice or simply moving away. The practice of Family Medicine has become untenable and the effect on physician morale is corrosive. Each week that this vicious cycle continues endangers the health of Ontario citizens.

However, the Ontario College of Family Physicians believes that adherence to models of practice rooted in the 1950s is not an option. Five years into the crisis, we are convinced that the Government of Ontario is at a historic turning point and can lead the nation in creating a healthcare system for the new millennium. Family Medicine is the fulcrum. Indeed, it must be so because only Family Physicians have the mandate and the flexibility to deliver comprehensive primary healthcare to every citizen in the province. As the only discipline that can coordinate care throughout this increasingly complex healthcare system, Family Medicine is the key to an integrated healthcare system.

The Ontario College of Family Physicians offers the following twenty recommendations in the certainty that implementing them is vital. These ideas are updates to our previous papers and reflect broad consultation. They demonstrate how to:

• Address urgent supply needs, now and for the future
• Attract Family Physicians to the locations that need them the most
• Retain those physicians in practice
• Provide access to “24/7” care for every citizen in the province

The key proposal is the establishment of Family Health Networks, anchored by Family Physicians. Solutions to issues such as urgent care around the clock, workload, cost-effective use of healthcare professionals, continuity of care across the system, flow from this practical, workable, cost-effective and empowering vision.

We are confident that the solutions for Family Medicine are at hand. The time to implement the Family Medicine model for the future can never be better than it is right now. All the pieces are
in place and we look forward to working with the Ministry of Health & Long Term Care to build the future together.
**Recommendations**

The Ontario College of Family Physicians recognizes that the Ministry of Health & Long Term Care has laid important groundwork toward the goal of ensuring optimal, cost-effective primary care to all Ontario citizens. The Ontario College of Family Physicians respectfully advises that in moving toward that end, the Ministry will carefully consider the following as necessary policy commitments and next steps:

1. **Develop strategies to provide every citizen with access to their own Family Physician.**
   - To utilize national and international research and consensus regarding the fundamental importance of Family Physicians as the cornerstone of our health system.

2. **Move quickly to support the development of Family Health Networks offering alternative funding models.**
   - To counter the increasing number of patients that are having difficulty finding Family Physicians to provide the care they need.
   - To counter the negative impact of uncertainty surrounding “Primary Care Reform” across Ontario.

3. **Implement the Patient Choice Registration System as soon as possible.**
   - To introduce the only method that can accurately determine the number of Family Physicians needed to deliver primary care across the province.

4. **Conduct a community-based physician human resource planning exercise in each community, for cumulative use in province-wide planning.**
   - To replace current ineffective, inaccurate, and obsolete methods of human resource planning.

5. **Factor manageable workloads and on-call schedules into the Professional Human Resource planning process.**
   - To recognize that without realistic workload and on-call estimates, the decline in Family Physicians will continue across Ontario.

6. **Establish a permanent Healthcare Human Resource authority to oversee the ongoing process of evaluating and planning Professional Human Resources.**
   - To review the changing demographics, patterns of practice, databases, and tabulations that must be taken into account to ensure that the future supply of Family Physicians is equal to the need for Family Physicians.

7. **Review the need for an increased number of family doctors.**
   - To reflect increased workload with shift from hospital to community.
8. Immediately increase the number of medical school placements to 1992 levels, as a necessary minimum.
   • To meet the impact of demographic, technological, and system changes that will require an increased number of physicians in virtually all medical disciplines.

9. To establish a sixth medical school whose mission would be to train physicians for northern and rural practice, and that would place a special emphasis on recruiting from northern, aboriginal, remote and rural communities.
   • To rectify the long-standing and serious deficits in both recruiting and retaining Family Physicians to serve rural, northern and aboriginal communities.

10. Increase the number of Family Medicine Residency positions, to ensure at a minimum that the number of new licences issued each year to Family Physicians is equal to the number granted to the 1992 graduates in the combined Family Medicine and Rotating Internship Programs (945 Family Medicine Residency positions)
    • To address the decline in medical students training for Family Medicine.

11. Develop strategies to restore the optimal policy ratio of Family Medicine to Specialist Medicine, and review the policy in light of evidence supporting the strengths of Family Medicine.
    • To address the fact that the Ministry’s own policy of a 55/45 ratio of Family Medicine to Specialists has not been adhered to in recent years (i.e., currently 47/53 in favour of Specialists, or 38/62 using the Full-time Equivalent (FTE) Non-Specialist method).

12. Increase both the number of General Specialists in training and the number of third-year residency positions in advanced Family Medicine skills (Family Physician anaesthesia, obstetrics, care for the elderly, mental health, surgical procedures, palliative care and emergency medicine, etc.).
    • To address shortfalls in supply of General Internist, General Surgeons, Anaesthesiologists, Pediatricians, and Psychiatrists, which are compromising care in most communities across Ontario.

13. Create 120 post-graduate slots for every 100 medical student placements, thereby allowing for re-entry and career change, as well as providing opportunities for Family Medicine Residents, International Medical Graduates, and practicing physicians to expand their skill base.
    • To offer an alternative to the common first-year internship model, which would add expense without value.

14. Provide medical students with practical experiences in each practice setting (remote, rural, suburban, urban, inner-city) in Ontario, reflecting the actual diversity of practice in Ontario.
    • To implement a key recruiting strategy for our most seriously underserviced areas of the province – on-site, realistic experience and exposure to Family Medicine.
15. Make medical school tuition affordable.

- To ensure that medical school tuition is not a barrier to recruitment for some socioeconomic groups across the province, including rural, aboriginal, and inner-city students – i.e., the very students who are most likely to choose these practice settings upon graduation.


- To cease the morally questionable practice of recruiting Healthcare Professionals from the disadvantaged countries that invested in their training and need their services.
- To provide qualified Canadian youth with access to the professional training of their choice.

17. Streamline the assessment process for International Medical Graduates, with an assessment protocol designed to maintain Canada’s high standards of training and practice.

- To clarify a current situation that does a disservice both to current Ontario residents who are qualified International Medical Graduates, and to our communities urgently in need of Family Physicians.

18. Empower Family Physicians to enter into collaborative Family Health Networks with health professionals such as nurses, nurse practitioners, social workers, dietitians, pharmacists, physiotherapists, and others.

- To give Family Physicians in communities across Ontario the resources and power to meet the actual needs of their local patient population.

19. Develop Shared Care Programs and Managed Waiting Lists to ease access to all major specialty and subspecialty services, and strengthen community-based systems.

- To address the compromised access to care in hospitals and communities across the province.
- To build on the success of Cardiac Care Network and Shared Care as models for maximizing access.
- To reflect technological changes allowing for effective delivery of care in the home or community (non in-patient setting).

20. Including the Ontario College of Family Physicians in future planning of changes that impact upon the education of our members and the practice of Family Medicine.

- To utilize the expertise of the Ontario College of Family Physicians in all matters relating to the training and practice of Family Medicine – including accreditation of Family Medicine residency programs, maintenance of certification and continuous medical education of Family Physicians, and recruitment, retention and repatriation strategies for Family Medicine.
- To acknowledge the Ontario College of Family Physicians as the voice of more than 6,000 Family Physicians in Ontario.
Fact Sheet

1.0 1.1 Family Medicine is the cornerstone of our Canadian Healthcare System and Family Physicians are the major providers of primary care. According to Dr. Barbara Starfield,6,7 “a wealth of evidence documents the benefits of characteristics associated with primary care performance.” Of the seven countries (including Canada) with the top average ranking for sixteen health indicators, five have strong primary care infrastructures. Although better access to care is widely considered to be the solution, there is evidence that the major benefit of better access to care accrues only when it facilitates receipt of primary care.11 (see Appendix A) Planning needs to ensure that every person in the province has their own family doctor providing comprehensive services and continuity of care.

1.2 Family In any given month, less than 0.1% of the people of Ontario require services in a tertiary care setting where Family Physicians provide few services. In the remainder of medical care settings (private offices, community hospitals, long-term care facilities and patient homes), the majority of the required care is provided by family doctors. Due to the current shortage and increased workload, more family doctors are needed.

2.0 Current databases are unreliable as planning tools and should be replaced by a Patient Choice registration process and a community-based planning exercise that can be used cumulatively for provincial planning of medical resources. (see Appendix C)

2.1 The estimates of Medical Human Resources requirements vary considerably from organization to organization. It is clear that we do not know how many practicing physicians there are in Ontario and have failed to properly plan for future needs.

**Estimate of Number of MDs Needed in Ontario**

<table>
<thead>
<tr>
<th>Source</th>
<th>Number of MDs Needed</th>
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<tbody>
<tr>
<td>Dr. R. McKendry's Report</td>
<td>1,000 MDs needed</td>
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<tr>
<td>Canadian Medical Association</td>
<td>700 MDs needed</td>
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<tr>
<td>Ministry of Health &amp; Long Term Care</td>
<td>570 MDs needed</td>
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</tbody>
</table>

2.2 The lack of a single reliable database and methodology has hampered planning activities. Each database produces different head counts.

**Number of GPs / FPs in Ontario (1995)**

<p>| | |</p>
<table>
<thead>
<tr>
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<tr>
<td>9,433</td>
<td>Full-Time Equivalent</td>
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<td>9,869</td>
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</tbody>
</table>

2.3 The appropriate physician-to-population ratio is unknown; however, Canada’s ratio is lower than the rest of developed countries and Ontario’s ratio is even lower.
Where Have All the Family Doctors Gone?

Response to the George Panel on Health Professional Human Resources Report

October 22, 2001

**Physicians per 100,000 Population**

<table>
<thead>
<tr>
<th></th>
<th>Ontario</th>
<th>Canada</th>
<th>US</th>
<th>OECD *</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>178</td>
<td>186</td>
<td>230</td>
<td>260</td>
</tr>
</tbody>
</table>

* Organization for Economic Co-operation & Development

2.4 The Full-time Equivalent (FTE) Non-Specialist method is the preferred method for identifying the number of practicing Family Physicians in the province since it has the potential for identifying physicians who are delivering comprehensive Family Medicine services. Head count methods include non Royal College certified specialists and Family Medicine specialists. These physicians perform valuable services but are not practicing comprehensive Family Medicine.

**General / Family Practice Physician Head Count 1997 / 98**

<table>
<thead>
<tr>
<th>Area</th>
<th>Raw</th>
<th>Active</th>
<th>FTE</th>
<th>Non-specialized Active</th>
<th>Non-specialized FTE</th>
<th>% FTEs Specialized</th>
</tr>
</thead>
<tbody>
<tr>
<td>Toronto</td>
<td>2,843</td>
<td>2,472</td>
<td>2,692</td>
<td>2,001</td>
<td>2,210</td>
<td>18%</td>
</tr>
<tr>
<td>Kingston</td>
<td>177</td>
<td>136</td>
<td>123</td>
<td>109</td>
<td>101</td>
<td>18%</td>
</tr>
<tr>
<td>London</td>
<td>377</td>
<td>326</td>
<td>325</td>
<td>269</td>
<td>276</td>
<td>15%</td>
</tr>
<tr>
<td>Ottawa</td>
<td>526</td>
<td>406</td>
<td>371</td>
<td>313</td>
<td>291</td>
<td>22%</td>
</tr>
<tr>
<td>Sault Ste. Marie</td>
<td>71</td>
<td>49</td>
<td>49</td>
<td>33</td>
<td>36</td>
<td>26%</td>
</tr>
<tr>
<td>Sudbury</td>
<td>129</td>
<td>116</td>
<td>135</td>
<td>87</td>
<td>105</td>
<td>22%</td>
</tr>
<tr>
<td>Windsor</td>
<td>157</td>
<td>137</td>
<td>170</td>
<td>116</td>
<td>149</td>
<td>12%</td>
</tr>
<tr>
<td>Rest of Ontario*</td>
<td>6,106</td>
<td>5,169</td>
<td>5,580</td>
<td>4,329</td>
<td>4,734</td>
<td>15%</td>
</tr>
<tr>
<td>All Ontario</td>
<td>10,386</td>
<td>8,811</td>
<td>9,445</td>
<td>7,257</td>
<td>7,903</td>
<td>16%</td>
</tr>
</tbody>
</table>

*Rest of Ontario = all of Ontario minus the above named communities

(Taken from Primary Medical Care in Toronto: Strengthening the Foundation, Building the System, Toronto District Health Council, June 2000, Page 7.)

2.5 A simple head count physician / population measure fails to take into account factors such as use of resources of people from outside the catchment area. Formulas using population statistics fail to account a further 13.7% population who use Toronto’s family doctors but reside elsewhere.

**Population per Family Physician Ratio 1997 / 98**

<table>
<thead>
<tr>
<th>Area</th>
<th>Raw</th>
<th>Active</th>
<th>FTE</th>
<th>Non-specialized Active</th>
<th>Non-specialized FTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Toronto</td>
<td>880</td>
<td>1,012</td>
<td>929</td>
<td>1,250</td>
<td>1,132</td>
</tr>
<tr>
<td>Kingston</td>
<td>837</td>
<td>1,089</td>
<td>1,202</td>
<td>1,359</td>
<td>1,460</td>
</tr>
<tr>
<td>London</td>
<td>902</td>
<td>1,043</td>
<td>1,047</td>
<td>1,264</td>
<td>1,231</td>
</tr>
<tr>
<td>Ottawa</td>
<td>689</td>
<td>892</td>
<td>977</td>
<td>1,157</td>
<td>1,245</td>
</tr>
<tr>
<td>Sault Ste. Marie</td>
<td>864</td>
<td>1,252</td>
<td>1,248</td>
<td>1,860</td>
<td>1,692</td>
</tr>
<tr>
<td>Sudbury</td>
<td>1,410</td>
<td>1,568</td>
<td>1,352</td>
<td>2,091</td>
<td>1,735</td>
</tr>
<tr>
<td>Windsor</td>
<td>1,402</td>
<td>1,606</td>
<td>1,296</td>
<td>1,897</td>
<td>1,477</td>
</tr>
<tr>
<td>Rest of Ontario</td>
<td>1,136</td>
<td>1,342</td>
<td>1,243</td>
<td>1,603</td>
<td>1,466</td>
</tr>
<tr>
<td>All Ontario</td>
<td>1,035</td>
<td>1,220</td>
<td>1,139</td>
<td>1,482</td>
<td>1,361</td>
</tr>
<tr>
<td>Toronto + 13.7</td>
<td>1,001</td>
<td>1,151</td>
<td>1,057</td>
<td>1,422</td>
<td>1,287</td>
</tr>
</tbody>
</table>

(Taken from Primary Medical Care in Toronto: Strengthening the Foundation, Building the System, Toronto District Health Council, June 2000, Page 8.)
None of the methodologies identify physician needs related to complexity of care for the target population or variation in the provision of secondary and tertiary care by Family Physicians in communities throughout Ontario.

### 3.0 A Significant Shortage of Family Doctors in Ontario

Since 1995, Family Medicine has seen a decrease in numbers of Physicians per 100,000 population. The number of Specialists in the province has increased.

3.1 Family Medicine has experienced a decrease in absolute numbers (4.1%) and in the Family Physicians / population ratio (8.6%). Ontario and Northwest Territories recorded the greatest declines in the number of Family Physicians per 100,000 population between 1995 to 1999. Only Prince Edward Island and the Northwest Territories have lower Family Physicians per 100,000 population rates than Ontario.

#### Number of Physicians by Physician Type and Province / Territory, Canada (1995 – 1999)

<table>
<thead>
<tr>
<th>Province</th>
<th>Family Medicine</th>
<th>Specialists</th>
<th>Total Physicians</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nfld</td>
<td>606</td>
<td>569</td>
<td>569</td>
</tr>
<tr>
<td>PEI</td>
<td>100</td>
<td>99</td>
<td>95</td>
</tr>
<tr>
<td>NS</td>
<td>931</td>
<td>924</td>
<td>934</td>
</tr>
<tr>
<td>NB</td>
<td>660</td>
<td>662</td>
<td>657</td>
</tr>
<tr>
<td>Que</td>
<td>7,528</td>
<td>7,561</td>
<td>7,559</td>
</tr>
<tr>
<td>Ont</td>
<td>10,230</td>
<td>9,903</td>
<td>9,773</td>
</tr>
<tr>
<td>BC</td>
<td>4,080</td>
<td>4,144</td>
<td>4,189</td>
</tr>
<tr>
<td>PEI</td>
<td>39</td>
<td>40</td>
<td>43</td>
</tr>
<tr>
<td>NWT</td>
<td>48</td>
<td>49</td>
<td>52</td>
</tr>
</tbody>
</table>

**Notes:** Excludes interns and residents. Data as of December 31 of given year. Includes physicians in clinical and/or non-clinical practice.

(Taken from Southam Medical Database: Supply, Distribution and Migration of Canadian Physicians, 1999, Canadian Institute for Health Information, 2000, Page 10.)

#### Physicians per 100,000 Population by Physician Type and Province / Territory, Canada (1995 – 1999)

<table>
<thead>
<tr>
<th>Province</th>
<th>Family Medicine</th>
<th>Specialists</th>
<th>Total Physicians</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nfld</td>
<td>107</td>
<td>102</td>
<td>103</td>
</tr>
<tr>
<td>PEI</td>
<td>74</td>
<td>73</td>
<td>69</td>
</tr>
<tr>
<td>NS</td>
<td>100</td>
<td>99</td>
<td>101</td>
</tr>
<tr>
<td>NB</td>
<td>88</td>
<td>88</td>
<td>87</td>
</tr>
<tr>
<td>Que</td>
<td>104</td>
<td>103</td>
<td>103</td>
</tr>
<tr>
<td>Ont</td>
<td>93</td>
<td>89</td>
<td>86</td>
</tr>
<tr>
<td>BC</td>
<td>106</td>
<td>106</td>
<td>105</td>
</tr>
<tr>
<td>PEI</td>
<td>124</td>
<td>125</td>
<td>135</td>
</tr>
<tr>
<td>NWT</td>
<td>72</td>
<td>73</td>
<td>77</td>
</tr>
</tbody>
</table>

**Notes:** Physician per 100,000 ratios for 1999 are revised from previous years’ figures due to updated population estimates. Therefore figures may differ from past publications. Excludes interns and residents. Data as of December 31 of given year. Includes physicians in clinical and/or non-clinical practice.

(Taken from Southam Medical Database: Supply, Distribution and Migration of Canadian Physicians, 1999, Canadian Institute for Health Information, 2000, Page 11.)
3.2 A significant factor in this decrease is due to the loss of Rotating Interns who became General Practitioners after graduation.

Field of Training of Canadian Medical Graduates at Exit from Canadian Postgraduate Programs (1990 – 1998)

<table>
<thead>
<tr>
<th>Year of Exit</th>
<th>Rotating Internship</th>
<th>Family Medicine</th>
<th>Total (rotating internship &amp; family medicine) N (%)</th>
<th>Specialties N (%)</th>
<th>Total N</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990</td>
<td>383</td>
<td>537</td>
<td>920 (51%)</td>
<td>878 (49%)</td>
<td>1,798</td>
</tr>
<tr>
<td>1991</td>
<td>399</td>
<td>539</td>
<td>938 (53%)</td>
<td>828 (47%)</td>
<td>1,766</td>
</tr>
<tr>
<td>1992</td>
<td>348</td>
<td>597</td>
<td>945 (54%)</td>
<td>805 (46%)</td>
<td>1,750</td>
</tr>
<tr>
<td>1993</td>
<td>284</td>
<td>606</td>
<td>890 (51%)</td>
<td>872 (49%)</td>
<td>1,762</td>
</tr>
<tr>
<td>1994</td>
<td>28</td>
<td>622</td>
<td>650 (45%)</td>
<td>781 (55%)</td>
<td>1,431</td>
</tr>
<tr>
<td>1995</td>
<td>—</td>
<td>654</td>
<td>654 (45%)</td>
<td>784 (55%)</td>
<td>1,438</td>
</tr>
<tr>
<td>1996</td>
<td>—</td>
<td>692</td>
<td>692 (47%)</td>
<td>789 (53%)</td>
<td>1,481</td>
</tr>
<tr>
<td>1997</td>
<td>—</td>
<td>682</td>
<td>682 (43%)</td>
<td>901 (57%)</td>
<td>1,583</td>
</tr>
<tr>
<td>1998</td>
<td>—</td>
<td>694</td>
<td>694 (44%)</td>
<td>886 (56%)</td>
<td>1,580</td>
</tr>
</tbody>
</table>

(Taken from Thurber & Busing, “Decreasing the Supply of Family Physicians & General Practitioners: Serious Implication for the Future.”)\(^{13}\)

3.3 Most countries are moving towards a higher ratio of family doctors to specialists (70/30 or 60/40 compared with Canada’s traditional 50/50 split). Ontario has reversed the trend and the family doctor-to-specialist ratio has been reduced to 47/53. With an emphasis on Primary Care and Community-based Care, this reversal from previous policy needs to be addressed.

### CIHI Number of Physicians by Type

<table>
<thead>
<tr>
<th></th>
<th>Family Medicine</th>
<th>Specialists</th>
<th>Total Physicians</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ontario</td>
<td>10,230</td>
<td>9,811</td>
<td>(4.1%)</td>
</tr>
<tr>
<td>Canada</td>
<td>28,619</td>
<td>28,838</td>
<td>0.8%</td>
</tr>
</tbody>
</table>

### Current Ratio

- 47 / 53 ratio in Ontario
- 51 / 49 ratio in Canada

### Ratio according to Policy

- 55 / 45 in Ontario
- 50 / 50 in Canada

If the Full-time Equivalent Non-Specialist method is used, the Ontario ratio for eligible Family Physicians available to deliver comprehensive care is 38/62. Thousands of people in Ontario are without a family doctor because of this trend which needs to be reversed.
4.0 Other Facts

4.1 None of the planning for Medical Human Resources took into account the increased workload for family doctors produced by Healthcare restructuring which is moving resources from hospitals to the community and from Specialists to family doctors.

4.2 None of the planning for Medical Human Resources took into account the growth and aging of the population or changes in the practice patterns of Family Physicians (early retirements, reduced hours of work, locums and walk-in clinics rather than Family Medicine practices). The average age of Family Physicians in Ontario is significantly higher than the Canada-wide average (46.7 vs. 45.8). The average age for Specialists is comparable (48.9 vs. 48.8). The early retirement of Canada’s Family Physicians will hit Ontario first.

4.3 Primary Care Reform models that propose replacing Family Physicians with Nurse Practitioners to save money are misguided. The narrow scope of Nurse Practitioner practice requires the backup of Family Physicians. This fragmented approach to care disrupts the patient-physician relationship which is at the heart of Family Medicine and the strength of Primary Care systems. Nurse Practitioners need to be in collaborative practice with family doctors and should be viewed as an added cost to the system; however, given the improvements in care and potential downstream savings, it is money well spent (see Appendix E).

4.4 The Primary Healthcare Team needs to reflect the needs of the practice population. Planning for Professional Human Resources has not taken into account the need for each Group Practice Network to gather demographic information regarding the population to be served and based on that data, make decisions regarding the best staffing complement. As an example, an aboriginal community may need a diabetes educator and an inner-city population may need mental health workers and social workers. The composition of the team needs to be flexible and based on patient needs.

4.5 Policies requiring International Medical Graduates to serve a short period of time in an underserviced area in exchange for a licence to practice have not worked in the past. For example, of the 25 International Medical Graduates recruited to provide psychiatric services in Northern Ontario, 24 were practicing in Toronto within two years. Rural medicine requires a higher level of expertise than Family Medicine practiced in communities with easy access to specialists. Rural communities require stable group practices committed to long-term service to the community. Planning based on short-term obligations to practice in underserviced areas fail to address the need for committed rural experts in Family Medicine. Recruiting of International Medical Graduates is morally unacceptable.
4.6 The maldistribution of specialists is of grave concern. Of particular concern is the maldistribution of Psychiatrists:

**Ratio of Psychiatrists to Population**

<table>
<thead>
<tr>
<th>Location</th>
<th>Psychiatrists per Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ottawa</td>
<td>1 Psychiatrist per 3,000 people</td>
</tr>
<tr>
<td>Northeastern Ontario</td>
<td>1 Psychiatrist per 20,000</td>
</tr>
</tbody>
</table>

Other specialists are always inappropriately distributed but not to the same degree.

4.7 The vast majority of communities cannot support subspecialists. The number of General Surgeons, General Internists, community-based Paediatricians, Psychiatrists and Anaesthesiologists residency position needs to be increased to meet community needs.
APPENDIX – B

Initial Data Release of the 2001 National Family Physician Workforce Survey