

2023 Medical Education Day of Action

The Health Human Resource Crisis: Issues in Medical Training and Practice

Overview:

In Canada, health care management and delivery are largely a provincial and territorial responsibility. Universities that provide medical student training are funded by the provincial government, who receive funding from provincial grants and provincial per capita amounts. Provincial ministries of health provide funds to universities and hospitals for a specified number of residents each year. The number of residency spots is decided by the individual provinces as they are responsible for funding residency seats. Although the Ministry of Health and Long-Term Care decides on the overall number of training positions, it plays a much smaller role in determining how these positions are allocated among the various specialties.

To be eligible for certification, Canadian medical graduates must complete a postgraduate training program that has been accredited. This training program, known as residency training, has a different duration for different specialties. Every year, all final-year medical students who wish to pursue post-graduate medical education (PGME) in Canada apply for offered residency positions through the Canadian Residency Matching Service (CaRMS).

During residency, trainees, referred to as residents, are only allowed to practice medicine under supervision and with an educational license. Residency training involves offering direct patient care in various settings, including teaching and non-teaching hospitals, as well as urban academic centers and remote rural communities.

Issues Along the Pipeline - Training to Practice:

For the last 10 years, as the number of medical students has gone up and the number of residency spots has stagnated, more and more Canadian medical graduates have not secured residency spots. Over the past decade, this ratio has steadily decreased to the point where there are now 101 spots for every 100 CMG applicants. When language differences are taken into account, there may be less than 98 spots for every 100 English-speaking applicants due to a greater number of Quebec graduates matching outside of Quebec than vice versa.

Students going unmatched leads to the health care system losing potential physicians who could fill gaps in underserved areas or disciplines. This is highlighted in that, across Canada, 4.6 million people (15% of the population) do not have access to primary care. Although 18% of Canadians live in a rural area, only 8% of Canadian physicians provide care in rural locations.

Additionally, licensing restrictions make it difficult for patients to access care across provincial and territorial borders: after three months in a new jurisdiction, they are no longer covered by their previous province or territory—even virtually. This translates to long waitlists for access to local providers. Extensive wait times and ever increasing patient loads not only

decreases the efficiency of the system, but are also key factors in burnout. In Canada, 53% of physicians report high degrees of burnout, with inflexibilities in the system being a key contributor. Licensure exists as a barrier for practicing physicians as well.

Currently, physicians are required to have individual licenses within each respective province or territory they practice, which limits their mobility across the country. The process for inter-jurisdictional practice is piecemeal with no standardized approach utilizing a database or public registry. Over 95% of physicians and medical trainees support a pan-Canadian license as a means to overcome barriers to care. Overall, pan-Canadian licensure and streamlined workforce planning are key tools to help address regional inequalities in care delivery while supporting cross-border virtual care and enabling physicians to support their colleagues across jurisdictions.

Asks

Increased Training Positions

1. Increase funding for residency training program spots to achieve the optimized 1.2:1 ratio.
2. Allocate residency positions based on population/regional need and employment capacity per specialty.
3. Use the right criteria to determine residency capacity, not institutional (staff or administrator) self-interest.

Incentivizing Primary Care

1. Implement policies and programs that recruit Indigenous and rural students into medical school.
2. Increase the number of rural and remote sites for medical education.
3. Contracts for residents working in rural settings should maximize the rural learning experience and resident autonomy.
4. Support generalist training throughout trainee's medical education.
5. Provide incentives to encourage individuals to join the healthcare workforce such as student debt forgiveness and equitable pay.

Retention of Healthcare Workers

1. Measure, identify and address impact of physician administrative burden
2. Build up an integrated health workforce

National Licensure

1. Create a pan-Canadian national licensing system.
2. Fund a Canadian Digital Registry of health professionals.



National Workforce Planning

1. Increase funding for health workforce research.
2. Establish an organization to amalgamate information collected by provincial and federal initiatives (e.g. CIHI, Health Professions Database in Ontario) and generate a publicly available database.
3. Regular inquiries should be conducted using national databases to identify pay gaps and examine the representation of various groups across different healthcare fields over time.