Commentaire/Commentary

Why more doctors won't solve the health care system's problems

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The Canadian province of British Columbia (BC) has nearly one million citizens who do not have established access to primary care. My profession, Family physicians, loudly declaims that it is because there are not enough doctors, or because we are not paid enough. I do not think that is the real problem, and neither do most observers of the health care scene who are not physicians, or who have a broad view of the current situation. So I write this commentary with a mixture of wonder and sadness, and hope for a better future for health care in this part of the world.

On May 10, 2022, BC's Minister of Health, Adrian Dix, spoke in the Legislature about restructuring the health care system to address the nearly 1 million persons who have no primary care practitioner.[1] He "dared" to say, at one point, that sometimes (not all the time, but sometimes) Nurse Practitioners did a better job than doctors, in large part because they spent more time with their patients.

The immediate uproar over this remark (just one of many he made in his speech) has been intense — embarrassingly so. The Doctors of BC, the lobby group/union for doctors in the province, as well as a whole bevy of family physicians and some politicians, have loudly denounced this remark; physicians have promised to be "more strident" in their demands for ramping up the supply of family physicians, identified by many as the singular and only valid response to the presence of "unattached" people (those without an identified family doctor of their own).

The reason I called the uproar "embarrassing" is because it is based on such a limited interpretation of a complicated problem, as well as being rather obviously self-serving.

Here's why I think this way

First, the number of family doctors graduating from

universities in Canada has been increasing for decades. At the University of British Columbia alone, the graduating class now numbers 288 students; when I was in attendance in the 1970s, it was 60. That is a 480% increase. During the same time, BC's population has roughly doubled. So there are more doctors available — but the number of people without a family doctor has still increased significantly.

Furthermore, and more importantly, the number of doctors per 1000 population is not directly related to health outcomes. In Canada and around the world, good or poor health is far more directly connected to basic income, to the state of a country's food supply, to opportunities for employment, to overall climate patterns (an increasing concern), to the presence or absence of violence and conflict, and to the general level of equity. Examples of equity include: having a health care system that supplies publicly funded health services to all citizens; living in a country where differences in income are not extreme; having widespread access to affordable housing; or having a social safety net available to everyone. These and other similar factors all increase health outcomes more than the number of available doctors.

Strong evidence suggests that a shortage of family doctors is not the real reason there are so many "unattached" persons. The problem is a structural one: how the primary care system works.

Primary care means care given to someone who seeks care right away for a problem that has not yet been characterized. It is healthcare at a generic rather than specialized level, and for people who initially approach a physician, nurse or other care provider for treatment.

"Basic" does not mean "simple". It is actually more complicated to figure out a problem from scratch than one that has already been defined and categorized. Working in primary care is a very demanding occupation — in many respects, far more demanding than specialty care, where much of what is done is routine and predictable.

The way doctors practice in BC, however, has changed radically over the last 30-40 years. Family doctors have become less and less accessible to their patients. Outside regular office hours, the only options for most people in BC are either a walk-in clinic (colloquially called "McMedicine") or an Emergency Room (ER). Interestingly, Canadians use ERs well above the average for developed countries. In BC, a fair number of family doctors limit almost all appointments to 10 minutes, often insisting on addressing only one health problem per visit; some have even posted signs saying this is how their practice is structured. In addition, office hours during which doctors see patients are now generally much shorter — typically 10:00 am till 4:00 pm.

Many doctors do not take phone calls. I am not referring to phone visits implemented during the response to COVID-19; I am talking about calls by patients asking for test results, posing a quick question, or seeking to re-order medication. Instead, patients are expected to make a formal appointment to come to the office for such reasons, thus filling up (and burdening) the doctor's schedule with minor visits for which Medicare is charged.

There are some important underlying reasons for these day-to-day structural problems

Medical school used to be subsidized by public funds, so that students paid very little, if anything at all, for their courses. It was assumed that their role in society was important enough that paying for them to study and train was a public good. Now universities get less public money, and so function more like businesses; they engage in what is called "cost recovery", which is a polite term for billing students for almost the full cost of their training.

And medical school is expensive. When I graduated in the 1970's, I had a student debt of about $1500 — acquired before I went into medical school. I had no further debt when I completed my training, including my residency in family medicine. My wife worked part-time, and so did I when I was able, and we lived modestly. But costs of training were low. Today students pay for most of their schooling; it is not uncommon for medical students to leave their training program with $300,000 owed to the bank. Unsurprisingly, banks loan money to doctors with unabashed enthusiasm. They do so because they know that the payment system for doctors is so incredibly secure that it is almost guaranteed that they will be fully paid back.

This situation does several harmful things to health care

First, it means doctors are focussed intensely on repaying their debts for the first few years of practice — often being drawn to "McMedicine" (walk-ins) or other fast money situations in order to get their finances in order.

Second, it means that unless he or she has wealthy parents or an independent source of income, a student who has an aptitude for medicine will nevertheless steer clear of it because he or she cannot afford it.

But third, and most unhelpful, medical students are not given a clear sense that society wants them. At the beginning of the training program, they are told they are special and unique and important. But then they are confronted with a mounting barrage of significant costs, for which they are personally

responsible. They acquire a feeling that they are on their own and getting through medical school is a personal financial ordeal – the antithesis of a signal that society as a whole values their services (even if it does).

For medical students, any altruistic feelings that might have initially inspired them to go into medicine can be severely challenged by a crushing burden of debt, and replaced by a more pragmatic sense that one might as well look after oneself, and seek maximum recompense for every professional act. It is actually remarkable that a fair number of medical students still graduate with some sense of idealism and a desire to be helpful.

When students finish their training, they are then brought face-to-face with the standard system for paying doctors for their work. This system is called "fee-for-service": every time a doctor sees a patient he or she receives a flat fee for whatever is done. An ordinary visit fee is about $40.

A telephone call "visit", since the COVID-19 pandemic began, pays the same. For many years before that, there was no fee for any telephone call with a patient; consequently most doctors rarely called their patients. Now that there is a fee for doing so, telephone visits have become routine. In fact, they have sometimes become too routine, replacing in-person visits to a great extent or even completely. Phone appointments facilitate short, narrowly focussed visits, because it's easier for a physician to control the flow of the visit and terminate it when it suits him or her. Yet short visits pay the same as longer, more detailed exchanges. This has resulted in a downward pressure on content, and an upward pressure on brevity.

Interestingly, a lot of new doctors are not happy with the fee-for-service system and would prefer to be paid a salary (or something similar), so that they can take more time with a given patient and concentrate on quality rather than quantity of visits.[2] But more established doctors are resistant to this change, just as they are resistant to handing over control of their practice venue to anyone else.

There is one other element in this picture that deserves mention. When students enter medical school, they are still told that they are #1 (this was already the case in the 1970s, much to my personal annoyance!). They are still told that, as doctors, they are utterly special and critically important. In a world where we are all struggling towards accepting the value of every person and their role and station in life, where acknowledging "diversity" is what characterizes our best collective aspirations, being indoctrinated with the notion that one is part of a rarefied stratosphere of superiority is decidedly old-fashioned and out of touch. It creates unnecessary expectations that are not met in real life – and especially so when it comes to the student-borne cost of training.

In Cuba, by contrast, all education is publicly financed up to the post-doctoral level. Not surprisingly, Cuban doctors have become famous for their astonishing altruism, both in Cuba and around the world. There is something powerful that arises from the notion that your community values what you do enough that it will cover the cost of your entire training experience.

Experiments with a "universal living wage", by the way, have shown the same thing

Research has also shown that in almost all countries, a health care system where care is delivered in coordinated teams, in which preventive activities are coordinated with direct clinical care, produces better outcomes than one that is fragmented into separate "silos". Costa Rica, for example, has a system that works like this, and that country's health statistics are very good, despite having a national GDP per person that is 1/4 that of Canada.[3]

In BC, there are many elements of the health care system that can be changed to make it work better. Nurse practitioners in particular — the place of controversy where I started this commentary — have been part of the Canadian health care scene for over a hundred years, primarily working in remote settings where doctors were not always willing to practice. Now they are becoming more mainstream, and more visible, with organized and sophisticated training programs. And for the first time, they are practicing in urban centres where doctors also provide care. My profession, especially in BC, has been both prideful and also overly sensitive, for reasons noted above, to any suggestion that they are not the single most important and valuable part of the health care team.

We doctors have to be more balanced and open to solutions to resolving the problems that beset health care in this part of the world. I think we must recognize that working in multi-disciplinary groups, establishing more detailed and intimate understanding of our patients, and accepting the value of other kinds of practitioners will help make finding solutions — and improving health outcomes — that much easier.

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