Matching the supply of doctors with Alberta's needs.

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The Edinburgh Declaration of Medical Education 1988

How many doctors does Alberta need?

Is there an unmet health need that arises because a suitable doctor is not available in Alberta?

What can we learn from looking at comprehensive surveys of unmet health need in EU countries?

Eurostat 2013	Cost barriers	Travel barriers	Waiting time barriers	Non health system factors	Total unmet need (% of total pop.)
Sweden	0.5	0.2	1.2	11.7	**13.6**
France	2.1	0.1	0.5	3.5	**6.2**
Germany	0.6	0.1	0.8	4.5	**6**
UK	0.1	0.1	1.4	1.5	**3.1**
Switzerland	1	0	0.1	1.2	**2.3**
Netherland	0.1	0.1	0.3	1.1	**1.6**

Eurostat 2013	Non health system factors	Total unmet need (% of total pop.)
Sweden	11.7	**13.6**
France	3.5	**6.2**
Germany	4.5	**6**
UK	1.5	**3.1**
Switzerland	1.2	**2.3**
Netherlands	1.1	**1.6**

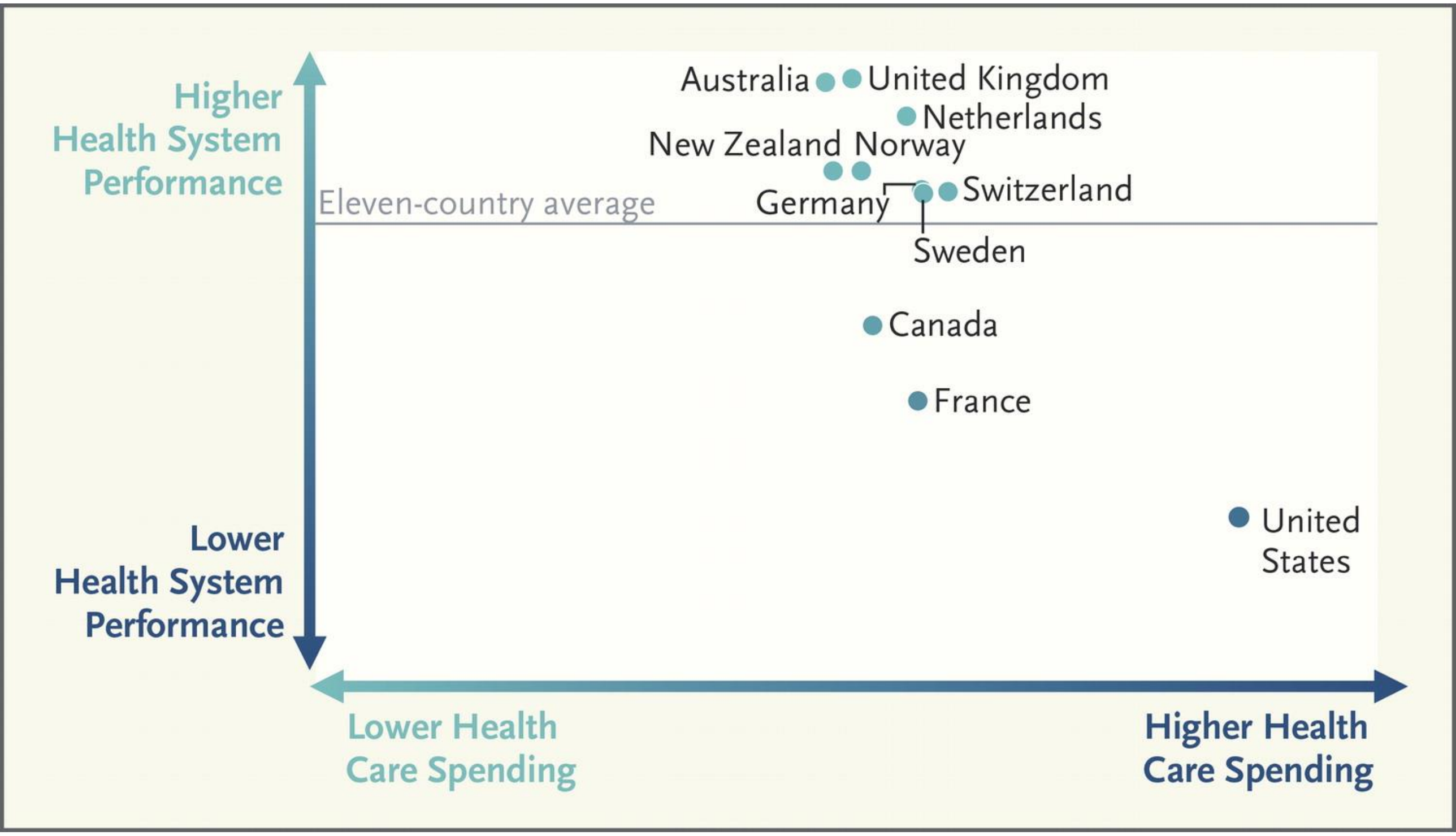
What conclusions can you draw about health care in comparison to other service industries in the context of these data?

Auntie’s story and the comparison of virtual services in banking versus the uptake of virtual healthcare

What impact would a widespread take up of virtual healthcare, and particularly in community settings, have on the need for doctors?

Eurostat 2013	Cost barriers	*Annual health spend per capita in USD*	Total unmet need (% of total pop.)
Sweden	0.5	3,925	**13.6**
France	2.1	4,118	**6.2**
Germany	0.6	4,495	**6**
UK	0.1	3,905	**3.1**
Switzerland	1	5,643	**2.3**
Netherlands	0.1	5,099	**1.6**

	% GDP health spend	CF Ranking
UK	9.9	1
Australia	9.0	2
Netherlands	10.9	3
New Zealand	9.4	4
Norway	9.3	
Sweden	11.2	6
Switzerland	11.4	
Germany	11.0	8
Canada	10.0	9
France	11.1	10
USA	16.6	11



Schneider & Squires N Engl J Med 2017; 377 (10): 1-4

Eurostat 2013	Waiting time barriers	Doctors per 1,000 pop. (ratio of OECD mean)	Total unmet need (% of total pop.)
Sweden	1.2	1.1	**13.6**
France	0.5	1.1	**6.2**
Germany	0.8	1.1	**6**
UK	1.4	0.7	**3.1**
Switzerland	0.1	1.2	**2.3**
Netherlands	0.3	1.2	**1.6**

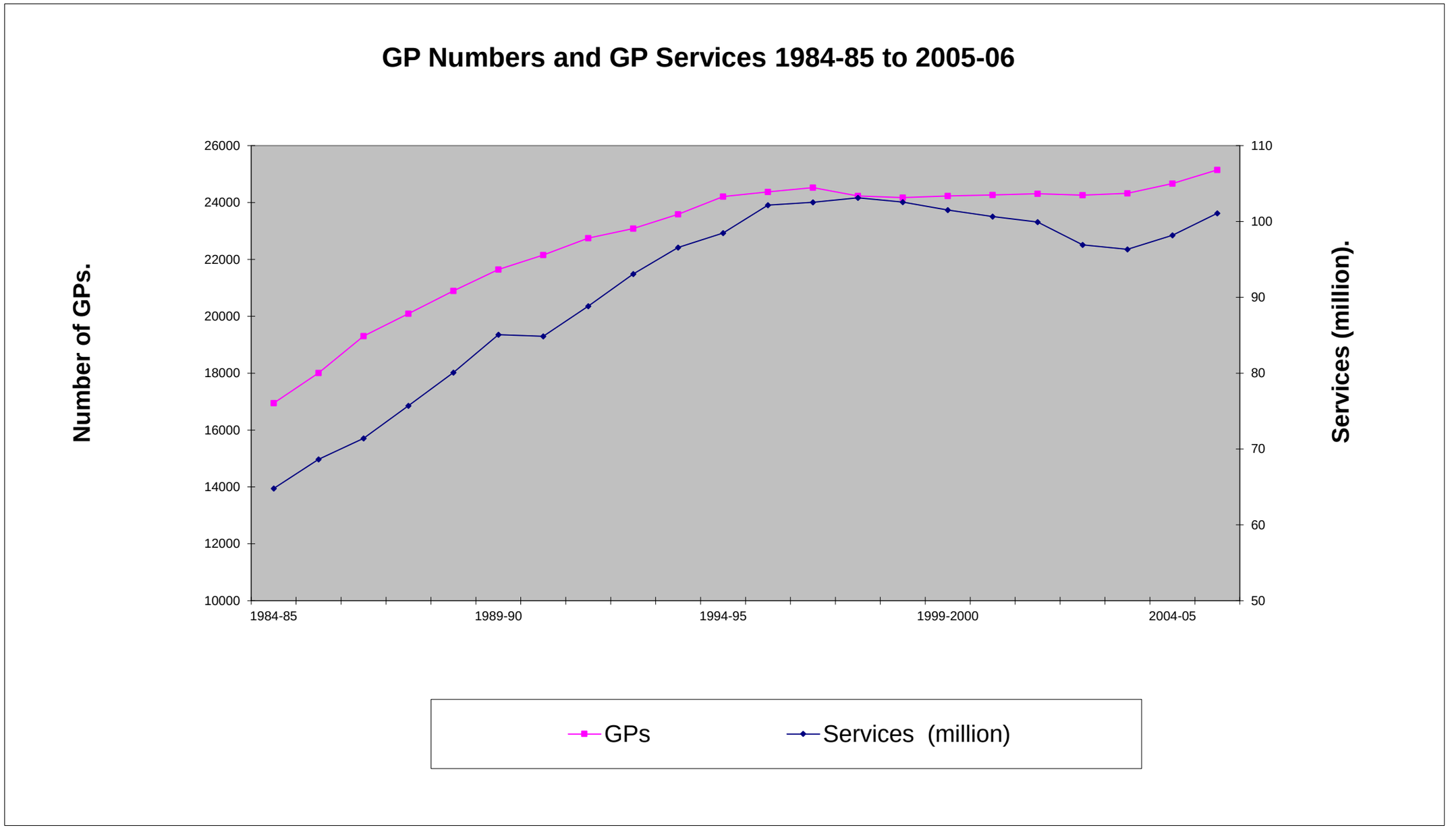
Based on these data, increasing the number of doctors or health funding, in isolation, would predictably have little impact on the level of unmet health need in these EU countries.

The number of doctors that any jurisdiction needs depends upon what the doctors do.

The Soweto Story

The number of doctors that are apparently needed to meet need will also depend upon how they are recognised, remunerated and rewarded.

Relationship between GP numbers and services in the Australian fee-for-service health system
Dr Ian McRae (Australian National University)



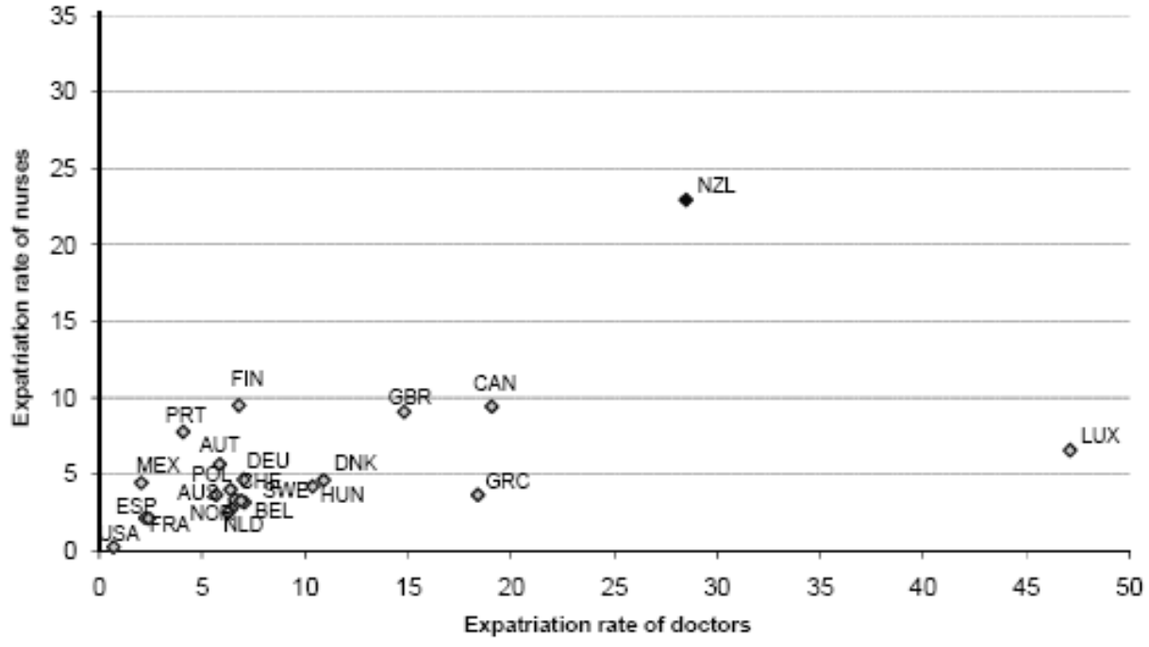
TLT commissioning, informed consumer driven health spend and an evolutionary approach to workforce development

The New Zealand approach

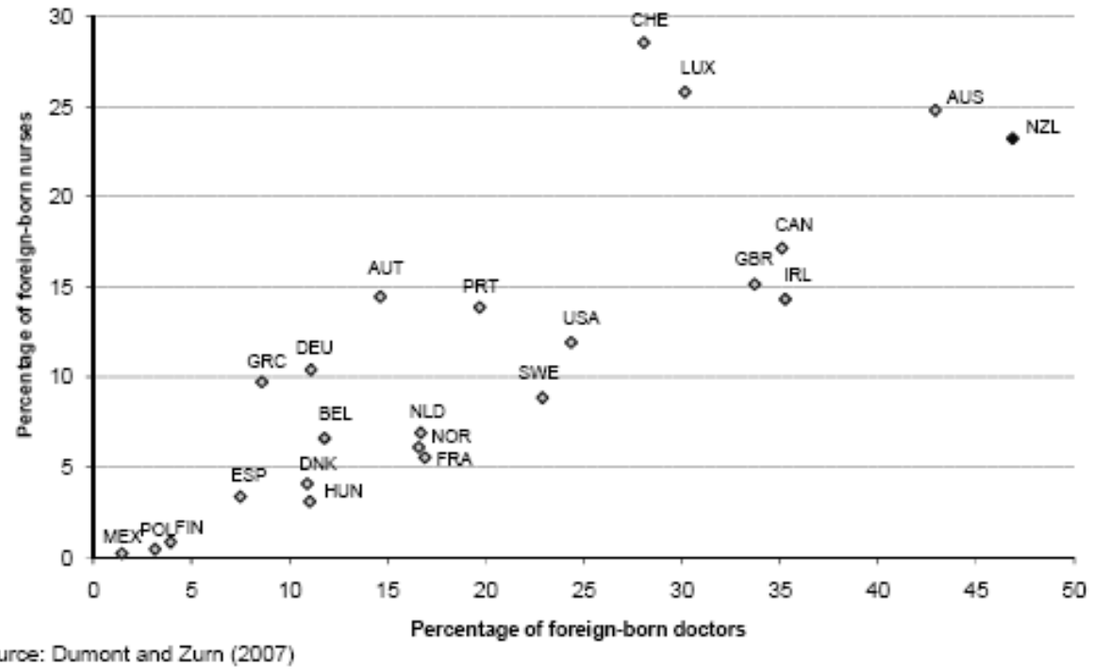
Zurn P, Dumont J-C. Health workforce and international migration: can New Zealand compete? WHO DELSA/HEA/WD/HWP (2008)3

Country or Region	Ratio of doctors per 1,000 in 2004
All OECD nations	3.1
Australia	2.5
New Zealand	2.2
Canada	2.05

Chart 7. Expatriation rates and percentages of foreign-born doctors and nurses, selected OECD countries, circa 2000



Source: Dumont and Zurn (2007)



Source: Dumont and Zurn (2007)

We need to test the basic premises of these WHO assumptions.

On what basis is a ratio of 3.1 doctors/1,000 population a meaningful statement of anything?

Australia and Canada's workforce planning was driven by provider to population ratios as compared to critical analyses of unmet health.

Fréchette, D., et alia, Findings from the Royal College's employment study. Ottawa, Ontario: The Royal College of Physicians and Surgeons of Canada. © 2013 Royal College of Physicians and Surgeons of Canada

Australia is graduating 1,000 more doctors than there are vocational training positions.

Advantages of an over-supplied medical labour market:

(1) more competitive markets for procedures and interventions that will lower costs if managed properly;

(2) the displacement of doctors to under-served areas and disciplines;

(3) behaviourally sound recognition, reward and remuneration schema for doctors.

Disadvantages of an over-supplied medical labour market:
(1) doctor unemployment and consequent poor returns on training investment;
(2) social disruption for displaced doctors;
(3) reversion of innovative models to previously disrupted practices to employ more doctors.

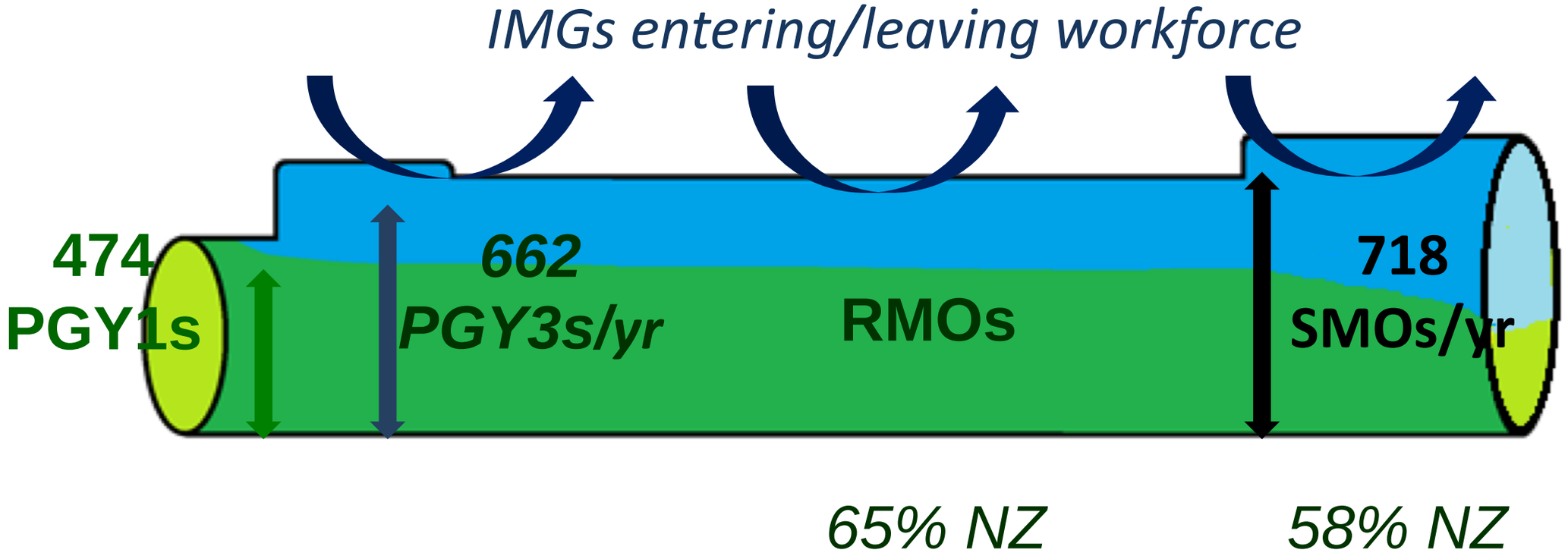
The Zealand Approach – the OECD nations on average have 40% too many doctors!

Given the structural flaws in and perverse funding of the New Zealand health system, the usual high-quality clinical outcomes must be due to the quality of the health workforce.

It follows that whatever investments you make in workforce development, the quality of the clinical training experience should never be compromised.

200 additional medical students in 2008 based on system capacity to accommodate learners without compromise.

The second question is whether a reliance on IMGs is sustainable?



Besides not considering them as a homogeneous group, the need is to consider IMGs as an asset to be managed carefully and not as a problem.

Approaches to determining doctor supply:

(1) Traditional 'linear' modeling based on projected provider ratios;

(2) Qualitative forecasting based on health need;

(3) Combined quantitative and qualitative approaches;

(4) Agnostic evolutionary approaches.

OECD nations are probably over-supplied with doctors, but health data suggest those doctors are not well distributed to meet need.

What works in aligning the medical workforce to better meet health need?

Selection processes
Undergraduate pedagogy
Immediate PG exposure
Sound behavioural economics
Targeted vocational training
Career factor attention
Social engineering

The quality of healthcare in Alberta is probably largely dependent on the quality of the health workforce such that …