

“An Honest Tale Speeds Best, Being Plainly Told”: Another Look at Health Spending and the Supply of Physicians

« Une parole honnête fait impression quand elle est dite simplement » : un regard différent sur les dépenses en santé et sur la disponibilité de médecins



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Abstract

Claims that the current physician resource shortage is due to the reduced work effort of physicians are misleading and ignore important trends, namely the demographic changes within the profession, the growth in non-physician spending that has out-paced spending on physicians and the relative decline in spending on physician services over the past 20 years. Such data make it difficult to support Evans's and McGrail's

(2008) assertions, which distract from more fruitful policy discussions about eliminating the current shortage of physicians, integrating non-physician health providers into medical practice and otherwise meeting the growing demand for health services.

Résumé

Les allégations à l'effet que la pénurie actuelle de médecins est imputable à une réduction de l'effort de leur part sont trompeuses et ne tiennent pas compte des principales tendances, c'est-à-dire les changements démographiques au sein de la profession, la croissance des dépenses pour les non médecins qui ont dépassé celles pour les médecins et le déclin relatif des dépenses pour les services médicaux au cours des 20 dernières années. De telles données ne permettent pas d'appuyer les assertions de Evans et McGrail (2008), lesquelles font obstacle à des débats politiques plus fructueux qui visent à remédier à la pénurie de médecins en intégrant les fournisseurs de santé non médecins dans la pratique médicale, répondant ainsi à la demande grandissante pour les services de santé.

“An honest tale speeds best, being plainly told.”

– William Shakespeare, *Richard III*, Act IV, Scene IV

IN “RICHARD III, BARER-STODDART AND THE DAUGHTER OF TIME,” EVANS and McGrail (2008) lament the vilification of Barer and Stoddart (1992, 1999) as perpetrators of cuts to medical school enrolment. They go on to state that the current physician resource shortage is due not to a lack of capable bodies, but rather reduced work effort, noting that Canadians are now paying “more for less” for their (at least somewhat unnecessary) medical care. We detect an alternative agenda.

Clearly, past decisions for medical school cuts cannot be laid at the feet of Barer and Stoddart. Those choices were the purview of governments and, in any case, were well underway prior to publication of their report. But neither can they avoid all responsibility (nor do we think they would want to); their participation in that policy debate in the preceding years is a matter of record. Their very public report provided a validation for government action, so it should be no surprise that it was the focal point for contrary reaction: flag bearers are always prime targets.

Assigning or avoiding blame is a fool's exercise that impedes future progress. The more important question is “Where to go from here?” As Evans and McGrail correctly note, the actual physician head count has been growing, albeit due to a greater reliance on foreign-trained physicians, something that Barer and Stoddart counselled against. Evans and McGrail also point out that, notwithstanding the increase in head count,

individual physicians, on average, now seek to work fewer hours per week owing to a variety of lifestyle issues. Much of this impact is explained by demographic changes, including the increasing number of female physicians, who tend to work less than their male counterparts (National Physician Survey 2007). This is not surprising. Nor should it be portrayed in an unsavoury manner à la “paying physicians more to work less.” The fact that average physician remuneration is increasing in this environment is a conscious societal decision achieved largely through negotiation led by governments that presumably know what they are doing.

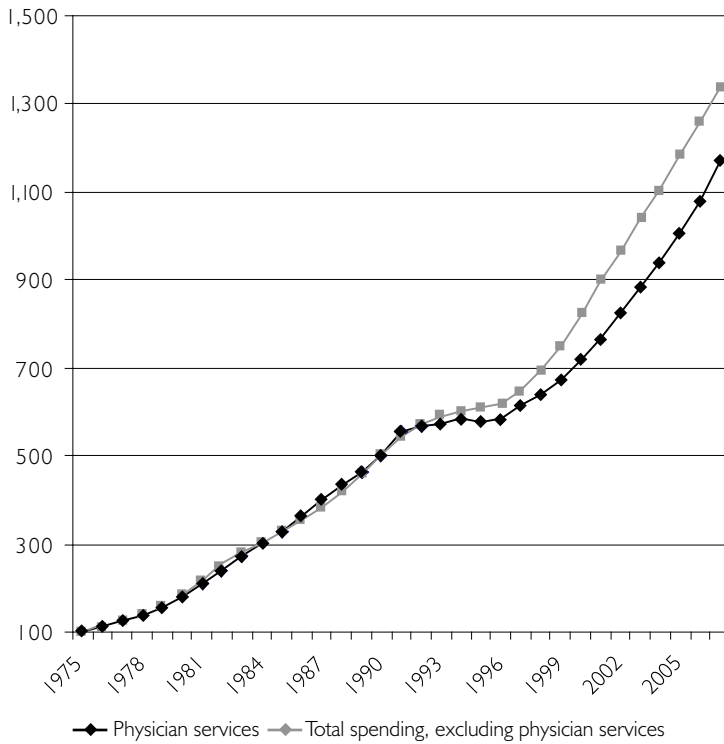
Furthermore, the authors’ analysis neglects the consistent trend of growing expenditures across all areas of healthcare, not just physician services. Indeed, spending on hospitals, non-physician health professionals, prescription drugs, administration and public health has increased more rapidly than for physician services (Figure 1). Since 1976, annual growth of non-physician expenditures has averaged 8.5%, compared to 8.0% for physicians. In the last 10 years, the figures are 7.5% and 6.6%, respectively. Moreover, when spending on physician services is examined as a percentage of total healthcare spending (Figure 2), one sees a declining trend over the past 20 years, from a high of 15.7% in 1988 to just over 13% in 2006 (National Health Expenditure Trends 2006). Such data not only make it difficult to support the authors’ assertions that increased spending on physicians uniquely “threatens serious fiscal trouble over the next two decades, and is likely to pre-empt any significant system reform,” but also call into question their motivation for singling out physician services from among any other area of healthcare spending.

Finally, the case is not helped by the authors’ rather oblique inference that the medical community somehow sees an economic advantage to ramping up the supply of doctors, thus keeping any attempt to introduce alternative providers at bay, without affecting their own incomes (back to the supplier-induced demand theory). Aside from contradicting a previous assertion that the medical community limits the supply of doctors to maintain incomes (Evans 1984), such Machiavellian thinking seems out of place for a Shakespearian theme. Perhaps m’lord gives too much credit!

Do we need more doctors? Certainly. The ongoing reduction in physicians’ weekly work hours (National Physician Survey 2004, 2007), increasing global competition for well-trained physicians and increasing demand for services in the face of technological advances and decreased mortality of chronic diseases will only exacerbate the existing shortage, currently estimated at 4,000 physicians in Canada (CMA 2008). Do we need more Canadian training slots? For sure. In the global market for physician services, Canada cannot continue to rely so heavily on foreign-trained physicians. Should we be prudent with respect to what types of physicians we train and where we train them? Without doubt. However, until we can establish a plan for what we need, this goal will be difficult to achieve.

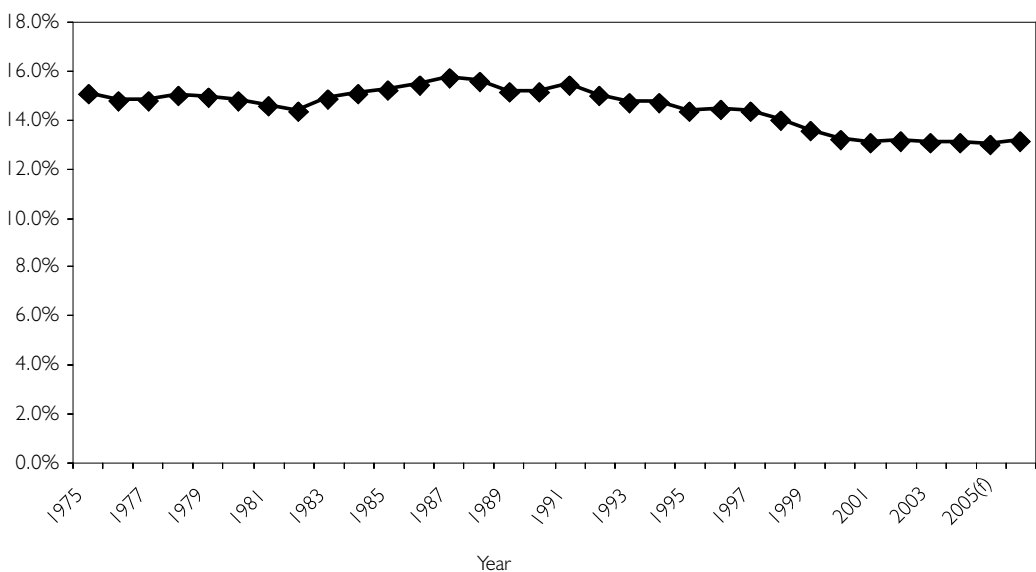
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FIGURE 1. Index of increase in health expenditures by use of funds, Canada, 1975–2007 (1975 = 100)



Source: National Health Expenditure Database 2007. “Total spending” includes spending on hospitals, other institutions, non-physician professionals, drugs, capital, public health and administration.

FIGURE 2. Spending on physician services as a percentage of total healthcare spending, Canada, 1975–2006



Source: National Health Expenditure Trends, 1975–2006.

Can we do a better job of integrating non-medical personnel into the equation? Absolutely. It is not a question of whether we should do it but how we do it. Scope-of-practice expansion for alternative care providers plays a role, but it is hardly less expensive; a comparison of rates of pay for midwives in British Columbia and cost-effectiveness studies on nurse practitioners (DeAngelis 1994; Venning et al. 2000) does not support an economic argument. Thus, integration must be carefully managed.

Physicians' desire to work alongside other healthcare professionals has been amply shown by any number of demonstration projects, and potential wider-scale physician interest has been made clear (National Physician Survey 2007). Yet, golden opportunities to make significant progress have been lost over the past 30 years, stymied by a variety of ideological considerations introduced by government policy makers (Hutchison et al. 2001). Most notable among those was a lemming-like pursuit of non-fee-for-service payment modalities as the price of admission. This decades-long refusal to accept fee-for-service as compatible with multidisciplinary care has needlessly set integrated practice initiatives back a generation. Only recently, and amidst continued detractors, has the possibility of a more pluralistic payment approach rekindled physicians' interest.

Could we use a little less finger pointing and a lot more collaboration? Most assuredly.

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