Dire need for medical officers of health

Public health issues have surged to the forefront in recent years, what with the tainted water tragedy in Walkerton, Ont., the SARS outbreak and, now, almost daily reports of the global threat of a flu pandemic. Along with the emerging health threats is a growing awareness that Canada's public health system remains understaffed for handling such challenges.

"There are shortages [of community medicine specialists] right across the country," says Dr. Gerry Predy, Edmonton's Medical Officer of Health (MOH) and president of the National Specialty Society for Community Medicine (NSSCM).

There are about 400 practising physicians who have received community medicine certification and roughly 150 local or associate MOHs. Just how many are needed will be assessed over the coming year by the Public Health Agency of Canada (PHAC) and the provincial and territorial governments. A report is due late in 2006.

Underlying the shortage is the fact that there aren't enough community medicine specialists being trained. There are 16 residency slots available annually for the 5 years of training required to qualify as a community medicine specialist. Only 10 were filled in 2005. All told, there are now 73 residencies across the country.

That's hardly enough to replace people who are expected to retire in the next few years — let alone address demand for expansion of the public health system, says Dr. David Mowat, deputy chief public health officer for the PHAC.

"There's a consensus that we have to expand the community medicine residencies," Mowat says, adding that the number of available slots has fluctuated over the past decade, first dropping when medical schools moved to dissuade practising physicians from re-entering the system for specialty train-

Canapress

SARS, Walkerton and now the threat of a flu pandemic are compelling reasons to bolster Canada's public health staffing.

ing but then slowly climbing back as the policy was partly reversed.

"We already had a significant problem attracting people directly from medical school. And when there was this movement to do away with [residency] re-entry, it really significantly impacted on community medicine's ability to fill the slots. In some cases, the universities then took away the unfilled slots."

PHAC plans to financially support 2 new residency spots next year, bringing the total to 18, and 2 medical schools are contemplating adding programs. But the overall number of slots could justifiably be doubled, Mowat says. "That would be an enormous step toward addressing some of these issues."

But only a step, argues University of Toronto resident Vinita Dubey, a representative on the NSSCM. Unless pay levels are hiked, many newly minted but debt-ridden graduates will continue to seek clinical, academic, consulting or international opportunities

as an alternative to lower-paid jobs in the public health system. Some community medicine specialists earn around \$110 000 a year.

Equally problematic is that the system doesn't have enough instructors to readily double the number of available residencies, says Predy. "When you have a shortage in the specialty in practice, it's hard to get people to teach because they are too busy doing their work. It's a bit of a Catch-22."

The problem is reportedly playing out across Canada, although only Ontario has recently released information. A November report from the Ontario Medical Association (OMA) indicates that about one-third of the province's 36 district health units are violating a regulatory requirement to hire a full-time MOH.

This poses an enormous threat to all Canadians, as a single dysfunctional health unit could incubate a national epidemic, says Dr. Ted Boadway, the OMA's executive director of health policy. "We're all dependent one upon another in a

community. I'm as dependent here in Toronto on Ottawa, as Ottawa is on me and, in fact, I'm actually quite dependent on how they do it in Winnipeg as well."

The OMA and Ontario's Chief MOH Dr. Sheela Basrur attributes the province's woes to a chronic shortage of community medicine specialists, inadequate pay and difficult working conditions, plus an often-incoherent governance structure with confusing lines of authority and 50–50 cost-sharing (to be elevated to 75–25 in 2007) of public health between the provincial government and municipalities.

The financial load has prompted several municipalities to use a loophole in the province's Health Protection and Promotion Act to fill vacant local MOH posts with "part-time, acting" appointees, who often lack proper training to oversee disease outbreaks but are willing to toil for lower pay.

Basrur says existing regulations governing minimum educational credentials for local MOHs are so weak that someone with 1 year of postgraduate training in epidemiology, quantitative methods, administration, and disease prevention is eligible for appointment. "But I can tell you that to do anything close to the basic training in those 4 areas would take more than a year."

"Yet even with that minimum, we have trouble getting candidates," Basrur adds. — Wayne Kondro, Ottawa

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Diabetes plan considered

Health Canada is reviewing a proposal by the Canadian Diabetes Association (CDA) for a "catastrophic drug plan" to help Canadians with diabetes "relieve the overwhelming personal out-of-pocket costs for medications, supplies and devices."

More than 2 million Canadians live with diabetes and bear out-of-pocket expenses ranging from \$250 a year in the Yukon to around \$3600 in Newfoundland, according to the CDA's *Diabetes Report 2005*. With a price tag estimated at \$500 million a year, the proposed national drug plan could

eliminate this burden, in addition to helping with other chronic diseases.

Chris Williams, a communications officer for Health Canada, says a catastrophic drug plan is a key component in discussions around a National Pharmaceutical Strategy being developed by federal, territorial and provincial governments. Health Ministers will report on progress by June 30.

The CDA argues that a national plan would substantially reduce the financial burden of diabetes; the condition and its complications cost Canada's health care system \$13.2 billion annually. — Andréa Ventimiglia, Ottawa

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Provinces lure physicians from one another

Provinces and territories are continuing to compete for physicians in the absence of a national or provincially coordinated recruitment plan, says the Health Council of Canada.

In the 5-year period, 1999–2003, Newfoundland and Labrador, Quebec and Saskatchewan lost the greatest number of physicians, at 269, 263 and 263 respectively. British Columbia, Ontario and Alberta attracted the largest

number of physicians, at 466, 345 and 241 respectively (see Fig. 1).

The report, *Modernizing the Management of Health Human Resources in Canada*, sets 2–5 year targets for human resource planning for governments, professional associations, regulatory bodies, employers, unions and educators. It also recommends that initiatives be "properly resourced" and based on population health needs integrated across jurisdictions.

"The Council's emphasis is not on seeing this as a physician supply problem, but on seeing this as an organization of care problem," says Michael Decter, chair of the Council.

If a hospital loses a physician to another province, at least the organization can conduct a search to replace the doctor, Decter says. It's a much tougher problem in the community, where losing a family physician can mean the service disappears.

Creating strong organizations, such as group practices, at the primary care level means that, if a physician leaves, the organization can still look after patients and can recruit, says Decter.

Evidence suggests that the team approach to health also produces better health outcomes for patients, particularly those with chronic conditions such as diabetes, Decter says.

The Ontario Medical Association recently issued its own recommendations concerning physician shortages.

Fig. 1: Number of physicians gained or lost (Canada, 1999–2003).
Source: Canadian Institute for Health Information