Analysis

Those "in the know" should lay the parameters for human resource planning

Whether we consider the highly centralized National Health Service in the UK, the largely market-driven nonsystem of health care in the United States, or the predominantly publicly funded "universal coverage" model in Canada, a single theme unites them: in the medium to long term, they are fundamentally unsustainable.

This somewhat less-than-optimistic view of the future formed a substantial part of the messages conveyed by 50 opinion leaders from Canada, the United Kingdom and the United States at the 7th Trilateral Conference held in Vancouver, BC, Oct. 15–17.

Of critical importance to sustainability is the pressing problem of obtaining and maintaining adequate health human resources (HHR). This year's Trilateral focused on the complex issue of HHR planning, weighing the relative merits of centrally controlled regimes versus market-driven systems in determining the appropriate number of health care professionals needed by national health care systems.

Keynote speaker Dr. Penny Ballem, professor of medicine at the University of British Columbia and, until recently, BC's Deputy Minister of Health, concluded the HHR choices that must be made are so tough, they may be unpalatable for politicians and bureaucrats; the profession(s) and academic health centres must therefore lead. Production of health care professionals must meet the public's needs, as opposed to its wants.

Ballem's point is well taken. Canadians have repeatedly affirmed that medicare is their most important public enterprise, their defining national institution. Furthermore, access to physicians and medical services are key elements: witness the attention given to wait times. Heaven help the politician or bureaucrat who would tamper seriously with the system! Those in government, elected or otherwise, have a very narrow window of opportunity for action, nonetheless.

To meet the public need in this climate of limited resources, it may well be that only those who actually staff and manage our health and education systems can successfully adapt them. Winston Churchill once said that "Experts should be on tap, not on top" — but when the challenge of war loomed, he entrusted and empowered those same experts, the scientists. The outcome was Britain's leadership in the development of radar.

"Breaking up the concrete" is not going to be painless, or popular with all interests; there are no simple solutions in a federation such as Canada. Yet, it must be done. Those who work in health and education know the problems and most of the solutions, and have their hands on the levers of change.

Current political mechanisms for resolving HHR issues have not been particularly effective, as Ballem argued at the 2006 Trilateral Conference. This conference series began 15 years ago, when leaders from the health care and academic sectors from the 3 countries decided that a forum for the exchange of ideas on issues of mutual interest could be of value. By consensus, a single topic is chosen as the focus for each meeting, initially held every 4 years, but every 2 years for the past 8. Each country hosts in turn. Numbers of attendees are kept small (15–20 per delegation) and discussions are meant to be informal, frank and free-wheeling. Topics have included medical-school curricula, globalization and health, health and the economy, and health and foreign policy.

Unsurprisingly, individual national traits, cultural peculiarities and systems of governance, which have invariably become evident in discussions past, resurfaced when the discussions turned to sustainability and HHR planning. As common solutions were sought, "think globally" rapidly became "act locally" — or, "How will it play in Brighton, Baton Rouge and Bonavista?"

The sustainability issue was illustrated dramatically by Ballem. If trends in BC's revenues and expenditures continue at 2004–2005 levels, in 2017–2018 health's share of the provincial budget will have increased from 42% to 72%; education will remain flat at 27%; and all other government spending will "tank" from 28% to about zero.

In each country, health care costs are increasing year by year at a rate exceeding the GDP — often by multiples, not just fractions. HHR are a major element in the nonsustainability equation. Furthermore, the HHR deficit is a global one; regardless of the ethical issues, plundering less-developed nations would not serve up a solution. Pressures on government are enormous, and the risk exists, particularly in the face of a growing HHR deficit, of their throwing even more money at the problem to get the same product. As Ballem said, "Value for money is critical."

Daniel Rahn, president of the Medical College of Georgia, noted that health professionals represent 11% of the US workforce and that 8 of the 20 most rapidly growing professions are in health care. In the United States, nurses, physicians, dentists, allied health professionals, pharmacists, and public and mental health professionals are all projected to be in short supply. The absence of a true health care system and the failure to define health care priorities has, according to Steven Wartman, president of the US Association of Academic Health Centers, seriously undermined efforts at national HHR planning. The concept of national self-sufficiency therefore cannot be adequately tackled.

In a somewhat different view, James Buchan of the UK described how a substantial overshoot in HHR there — despite the best central planning — has resulted in a virtual shutdown of HHR immigration. The reality of unemployed UK-trained physicians has created a

DOI:10.1503/cmaj.061539

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huge fuss. The apparent overshoot is now attributed to significantly increased enrolments (12.9 medical-school entry positions per 100 000 population v. 7.1 for Canada and the United States) and to robust recruiting efforts offshore. Many delegates expressed skepticism that this relative abundance of HHR would be sustained in the long term.

At the other end of the spectrum from centrally controlled planning lies the US market-driven system, where health care is seen more as a commodity than a social good. Norman Edelman, former dean of medicine and now professor at Stony Brook University, NY, illustrated one consequence of this: a dramatic increase in the number of allied health care professionals. While a minority of them seek an extension of their scopes of practice, far more are seeking independent practice, autonomy and the title "doctor," despite the larger investment of time and money required to achieve these goals. He opined that this trend would continue and actually increase because the market will drive it, particularly with the present and projected physician shortage.

How can British–Canadian–American opinion leaders in health care and health education predict all this with such certainty? The answer lies in a large number of trends that emerged during formal and informal discussion at the Trilateral, all of which are negative. They include the demographic aging of the population, with its attendant exponential increase in demand for health services; the aging of the health care workforce; increasingly expensive new technologies and therapies; the relatively poor productivity of the workforce; a perceived unattractiveness of health care careers to today's youth, often coupled with lifestyle issues; the public demand for "Mercedes/Cadillac" health care; the education of health professionals in rigid silos (interprofessional education is still much less than a reality); "credentials creep" and its attendant prolongation of the educational process; and sub- and superspecialization. While these realities are both global and national, their consequences will be felt most deeply in rural, remote and currently underserviced areas.

An old Icelandic sage observed, "He was the wisest man in all Iceland without the gift of foresight." This is not what we want on our tombstones, so perhaps the time has indeed come to break up the concrete.

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Competing interests: None declared.

Leadership

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