Theme 2: Health care system efficiency and the physician workforce: Optimizing the medical workforce through improved system efficiency and physician training

Lead Country: *Canada*

Overview

The following provides a guide to the multi-country authored paper for the session on optimizing the medical workforce.

Approach

Given the bread of this particular theme, the 2010 IMWC conference will dedicate one full day to address some of its key components. The theme will be examined by way of the approach traditionally used at IMWC[1] conferences, led by the UK, and a new method of having one single, multi-country authored paper[2], led by Canada. The UK papers will focus on various dimensions of practice efficiency while the Canadian paper will address various dimensions of system and physician training efficiency.

Background

All developed countries face the demand for higher health care quality while tempering the rate of growth in medical services and expenditures. Efficiency gains in the delivery of medical care might curtail or reduce the growth of medical workforce requirements. Changes in physician training may also contribute to higher efficiencies that lead to lower physician requirements.

Traditionally, attempts to increase physician productivity have primarily been directed towards the goal of greater medical service outputs (e.g., office visits, procedures) per physician through changes in the delivery or practice environment (e.g., greater use of other health professionals or system changes that support physicians in seeing more patients). While these strategies may lead to greater outputs for given inputs within an organization or structure providing care, they often do not improve health care system efficiency on a larger scale such as for a region, or for a specific population such as diabetics.

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[1] Each of the four IMWC partner jurisdictions (US, UK, Canada and Australia/Australasia) have traditionally prepared separate papers addressing a common theme and the lead country is responsible for identifying and supporting a discussant who, among other things, present a brief verbal summary and analysis of the papers, teasing out common themes and differences from the four countries

[2] In addition to the traditional approach, the 2010 IMWC will be piloting a new means to elicit discussion of the issues and potential policy actions by way of a multi-country paper to address a narrower sub-set of issues on the theme at hand. The lead country will also provide an overarching analysis and examine policy levers/solutions that may serve to advance the objective of optimizing the medical workforce and health outcomes of specific or broad populations.

It is important to note, however, that there are a growing number of examples of high performing health care delivery systems (e.g., lower physician labour inputs, high quality and timely care, and comparable or better outcomes and effectiveness of care). Some of these innovations or changes may have occurred by accident rather than design, but they do offer examples of what might be achievable in less efficient locales.

This session will examine the current thinking about health care system efficiency and effectiveness for various populations, with particular attention to the physician workforce and how physicians are trained.

Focus and research questions

The combined, multi-country paper will:

- Present the concept of system efficiency and its relationship to the physician workforce from the perspective of each country.
- Present and discuss country-specific case studies or actual exemplars of system and/or policy innovation(s) (e.g., electronic health record, payment models, task sharing arrangements, interprofessional education, payment models, collaborative care arrangements that use relatively lower physician labour inputs) and their effect on maintaining or improving care and patient outcomes (i.e., "effectiveness"[3]). Case studies or exemplars can be related to one or more "populations"[3] or health care organizations or structures.
- Examine the critical success factors (CSF) and barriers to the successful implementation and generalization of the case studies or exemplars noted in the paper.
- Consider the role of physician workforce planning and training in developing a workforce that provides the maximum benefits per physician labour cost.

Based on the contributions of the various country authors, the Canadian lead author(s) will provide:

- an analysis of common lessons about the Critical Success Factors (CSF) and barriers to successful implementation and generalization of leading/promising innovation in health care delivery as a way of optimizing or tempering physician requirements.
- an overarching recommendations that may serve to inform or influence policy that will optimize physician productivity/efficiency while maintaining or improving quality of care and patient outcomes.

This session would examine some the following questions:

- What are the main gains/benefits to the medical workforce of the identified system innovation(s)/change(s)?
- How could improvements in system efficiency optimize physician requirements in an era when countries face increasing health workforce costs?
- Are there changes in physician training (e.g., inter-professional education; emphasis of training in particular specialties or that promote the acquisition of skills such as in chronic disease management) that could contribute to efficiency gains overall and with regard to physician requirements?
- Does the innovation/change maintain or improve health outcomes?

[3] See "definitions" in the last section

- Has anything been lost by the introduction of the change/innovation (e.g., access by patients, physician autonomy, increased cost), and if so, can there be actions undertaken to redress the loss(es)?
- What system integrative measures are essential to make groupings of doctors more efficient within their practice communities (physical, economic, information, technologic, etc.).
- How important is practice culture?
- What mix of physicians creates best value to a community along primary care/specialty axis? Along hospital-based/community-based axis?
- Do models of medical care that provide patients more responsibility and control improve outcomes and efficiency—if so how does it happen?
- Does direct access to specialists for patients with certain conditions improve clinical outcomes and/or efficiency?
- What can we learn from best practices in each of our countries?
- What are the CSF and barriers to generalizing the identified system change(s)?

Definitions

"Effectiveness" for the care of populations can be defined as:

- maximizing health (e.g., mortality, functional health status)
- maximizing well being (e.g., access, satisfaction with care) of populations per money spent or per resource inputs as measured by capital investments and health labour FTEs
- providing care that achieves optimal health outcomes (e.g., evidence-informed or evidence-based practice)

"Populations" based on different dimensions such as:

- geo-political units: e.g., a province or health region in Canada, a state in the US
- ethno-cultural: e.g., First Nations/Aboriginal
- geographically defined health markets: e.g., Primary Care Trusts in the U.K, a Dartmouth Atlas Hospital Referral Region
- organizational: e.g., hospitals, integrated delivery systems (U.S.), Foundation Trusts (U.K.)
- geographically based: e.g., a province or health region in Canada, urban centres, rural or remote communities
- disease group: e.g., cancer, diabetes, etc.