Steven Lewis: The health care fix too obvious to implement

The solution to Canada's primary care access gap is for communities to grow their own roster of nurse practitioners (NPs).

Steven Lewis ***The Star-Phoenix***

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You're sick of reading and I'm tired of writing that Canada's primary care access crisis dooms prospects for fixing the health-care system.

One in five adults has no regular source of care. Few clinics provide the inter-professional team-based care essential to an aging population and other higher-needs patients. Many get referred to specialists, creating backlogs, long waits, and avoidable health breakdown that lands them in hospitals and nursing homes, straining capacity and driving up costs.

No one disputes this. There is also an unfortunate consensus on what to do about it: Pay family doctors more, open new medical schools, license more international medical graduates. It is unfortunate because these solutions are reruns that merely double down on the errors of logic and history.

There is a solution — not the solution to everything, but the only credible path to a primary care home for all who want one. It is not as elusive as the Higgs

Boson, the “god particle” proposed in 1964 and found 48 years later. It is a practical, ready-for-prime-time solution with a half-century track record of success.

The solution is for communities to grow their own roster of nurse practitioners (NPs) to fill the primary care capacity gap. NPs are trained across Canada, typically in two-year master’s degree programs open to registered nurses (RNs) with a minimum of three years of experience. Most offer distance education and local preceptorships that allow students to train mainly in place.

Here’s how it might work:

Provinces would identify unmet need for primary care by geographic area, develop a funding model for NP-intensive clinics, negotiate NP scope of practice and contracts, and supply any new required infrastructure. Communities would sign onto the care model, define their service populations, and recruit RNs from their local areas to take NP training.

To make the transition attractive, pay trainees $60,000 a year for the two years of study and waive tuition. In return the recruits — already with roots in their communities — would make multi-year commitments to local primary care practice. Currently NPs earn at least 30 per cent to 50 per cent more than RNs. The transition will be attractive to many.

There are more than 300,000 RNs in Canada. Say the program aimed to recruit 1 per cent of them (3,000) a year, for at least three years, to take NP training. In four years there would be 9,000 new primary care NPs. At a modest 800 patients each, that’s added capacity for 7.2 million — more than the 6.5 million now without a regular source of care.

If added annual training costs are $25,000 per student, the total cost per graduate would be $170,000 — a fraction of the cost of training a family doctor. Total costs over four years would be $1.53 billion, about $400 million a year.

Ottawa currently sends over $45 billion annually to the provinces. A potentially groundbreaking solution that costs one per cent of that amount is a rare bargain.

It might take a year or two to expand educational programs and practicum capacity for 3,000 new candidates. Some jurisdictions and communities might

be more enthusiastic than others. It could be four or five years before the public sees a big impact. That's a lot faster than never.

Most doctors view the NP option the way the Catholic church views the ordination of women: an existential threat to sacred turf. The threat wouldn't exist had family doctors years ago embraced inter-professional care, and not abandoned rural Canada.

The existential threat that matters is to medicare, imperilled by an access crisis that grew out of control on governments' and doctors' watch.

Family medicine's problem isn't NPs; it is its own declining value proposition. Its future lies in evolving to occupy a central and unique role in the system. It should willingly cede practice terrain to NPs — and other capable professionals — and focus on higher complexity patients repatriated from specialists.

The NP option is not only a big win for the public. It should catapult family medicine to a long-overdue renewal that makes it a rewarding and irreplaceable profession. In the words of the late Sinead O'Connor, family doctors should fight the real enemy: the chilling prospect of their looming obsolescence.

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I'm told that because NP's are government employees, they can be required to work more hours and days than doctors, private contractors, often will. I suspect a part of our "doctor shortage" is that many ageing doctors, much as we need them, take up positions but work only 2-3 days a week seeing patients.

We all have a doctor or two we love, even as our faith in medical methods sinks. But M.D.s are not going to lead us out of this mess; much as the ethic of service is sincere—they put up with so much nonsense from us often expected to do the impossible—yet they inevitably settle into looking out for their own interests first, feeling they have been taken advantage of for too long (with pastures ever greener somewhere else). And let's not forget, doctors resisted Medicare fiercely when it was introduced; many would not regret seeing it go.

I'm told on good authority that, peculiarly, there is resistance to NP expansion within Saskatchewan Union of Nurses (SUN) ranks. As well, there is the old division between RN's and LPN's. SUN may be lauded for publicizing (at its own expense) the health care crisis, but if even nurses cannot come together and mobilize in their own interests, to serve ours, we really are doomed. TJB