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## Modeling urology when primary care is universal

Stop me if you've heard this one before: there is a primary care crisis in Canada, with great swaths — more than 20% — of the population unattached to a family doctor or team.<sup>1</sup> Pretty dusty to call a healthcare system *universal* under these circumstances. The typical tropes when discussing these facts are that a) solvable and preventable health issues in these patients are neither solved nor prevented; b) pressure rises on emergency rooms and hospitals as the consequence of unmanaged risk manifests in sickness; and c) care costs balloon in a fixed-price system.

Something obvious but less-stated occurs to me: the undersubscription of Canadians to primary care is *baked in* to the practice phenotype of specialists like Canadian urologists. Our own ballooning waits for referral and surgery exist within a system in which we don't have to contend with six million Canadians unable to be referred into the brimming hopper. It follows then that a repair of the primary care infrastructure — that is, universal access — would open a huge new cohort to the matrix of visits, referrals, and surgical indication, and that specialist societies and governments had best attend to this possibility in step.

The seeds of improved primary care access are being planted. This is obviously a good thing! In Ontario, the Primary Care Action Plan aims for universal access by 2029, with several winning pilots already established.<sup>2</sup> British Columbia family docs have seen a \$135K remuneration bump, a huge incentive towards choosing the specialty.<sup>3</sup> Queen's University opened a satellite medical campus at Lakeridge Health dedicated to family medicine training, already in its second year.<sup>4</sup> CaRMS 2025 family medicine match numbers were the highest ever at 1740 through the two rounds.<sup>5</sup> Nurse practitioner-led clinics, or extension of family health teams, expands the pool of skilled caregivers.

So what happens in, say, five years — the length of a single urology training program — if

the available population to specialist care increases by 25%? What compounding occurs when this happens at a time when the army of baby boomers are all in their 80s and take up low orbit around doctors' offices?

The simplest expectation would be this: assuming the currently unattached cohort are of average health and healthcare needs, specialist referrals would rise predictably as the same rate of referral is applied to a larger denominator. This has been the abiding "we'll need more X" paradigm we've been hearing for decades as we "prepare" for the baby boomer glut (and WWII ended 80 years ago, so...). This feels like poor predicting to me, and too simple a model. I am certainly no soothsayer in this space, but I think a riff on how we *might* model expectations could help thinking on what a "response" might look like, and inform the policy aces' armamentarium.

The first contention I'll make is that our clinical and surgical practices are derived from overlapping but quite different sources. In the clinic, we see all of the non-surgical urology, of course, comprising LUTS, sexual dysfunction, pain and infection, screening and surveillance, and all the other patients we follow without any clear trajectory toward the OR. Many of these folks do distill into surgical cases — TURPs and TVTs and the like. Additionally, there are many clean referral → consultation → operation cases, like screen- or cysto-detected and incidental cancers, penoscrotal sorrows, and such. In the future state of universal primary care, clinical and operative resource needs for these cases would rise in proportion to the population.

Where the simple model slips is the fact that lots of operative urology comes from sources outside primary care. Stones, retention, dramatic hematuria, and the like find their way to the operating theatre irrespective of a patient's primary care coverage. In an updated model, the increase in primary care coverage *disproportionately increases clinical urology*, and somewhat less

so operative urology, a sting for the “urologic surgery” scrub cap set but a logical expectation. In HR planning, hospital planning, and “what is urology” terms, this matters. If someone wants to study what proportions of surgical urology originate from what sources, or drop a “Urology 2035” white paper, loop me in as a co-author :)

Surgical cases will still rise, and significantly, when more patients have a venue to articulate their problematic LUTS, to undertake screening, and to have imaging for all of the other indications that discover renal masses, hydronephrosis, time-bomb asymptomatic stones, etc. If you hadn't noticed, there is not a ton of wiggle room to access more OR resources in Canada, and no turn-key or rapidly deployable model to ratchet up access. ORs are still mostly in strained hospitals, anesthesiologists are not hatched on demand, and OR nursing is not a seller's market. Keep in mind the fact that more family docs and NPs means more arthritis and bum shoulders and hernias and bariatrics and biliary colic and spinal stenosis and carpal tunnel and fibroids finding their way onto operative waitlists as well. There ought to be red flags waving from hospitals astride every welcome improvement in primary care access.

It is reasonable to wonder if a sudden change in enrolment would change the *quality* of referrals. Will fresh MDs trained in new models approach referral differently? Do NPs really overuse testing and referral (I can't find a good reference to validate this cliché)? Will the newly rostered appear on the cusp of a dozen crises and clog urologists' offices with four separate issues? Will our specialist colleagues, who will also be seeing more GI, endocrine, nephro, and other patients, send marginal referrals from their encounters with new patients taking the opportunity to unload a raft of issues on review of systems?

On the counter side, perhaps faced with a sudden rush of clinic substrate, urologists may flex appropriate triage and dispense with unnecessary-but-lucrative followup visits.<sup>6</sup> New opportunities to partner with more comprehensive “health homes” in primary care could mean urologists practicing closer to the top of our scope. Perhaps a more fulsome e-consult environment or simplified out-of-clinic communication with patients is waiting for the crisis of a demographic explosion?<sup>6</sup>

How might we envision urology then, in this “recalculation” of urologic care needs? Will more urol-

ogy spots in residency be the simple unidimensional answer? In that case, we'll have some explaining to do if urologic practice shifts increasingly toward clinical urology. “First of all, I want to be a surgeon” would lower somewhat in status as a necessary hoop for candidates. Is that desirable? Can we envision training cleaved or altered to allow clinical specialists to graduate into less OR-intensive practice, while others crystallize into more operative urology (maybe another hot-take editorial some time on this). Perhaps a novel “men's health” or “urologic health” +1 year after family medicine comes to pass, decanting much of this care away from surgical specialists, if such a thing is really desired by FRCSC urologists. Perhaps urologists will themselves link to primary care hubs as liaisons between the family clinics and the hospitals. Perhaps centralized referral, such as that outlined in an Ontario Medical Association policy proposal, will come to pass and smooth regional bulges in waits and access.<sup>7</sup> It's an open book for now, but an interesting and soon important space in which to think.

This has been an attempt at articulating the variables in a model of future urologic care needs. Of course, the degrees of freedom and ranges are high, so there are no point estimates to be made. The primary care crisis persists, despite the green shoots noted above. It seems clear that something other than “the same but more” is likely on the horizon, and the policy-interested ought to be running the numbers. With some luck, we'll contend with the model in real life soon.

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