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## Common Problems, Different "Solutions": Learning from International Approaches to Improving Medical Services Access for Underserved Populations

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# Articles

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Morris L. Barer  
Laura Wood\*

Common Problems, Different  
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*Canada shares with most OECD countries the problems associated with inequitable geographic access to physician services, and improving the geographic distribution of physicians is a policy preoccupation of all ministries of health in Canada today. Recent court challenges by newly-entering physicians to physician supply controls in B.C. and New Brunswick have brought the issue into sharp relief. The authors explore the degree to which the provinces have adopted common approaches to addressing these problems, and whether Canadian policy-makers have learned from international experience. The recent judgment in the Waldman case in B.C. is analyzed in terms of likely implications for future policies on the geographic distribution of physicians in Canada. The authors conclude that the B.C. and New Brunswick cases may lead to broad changes in health care policy direction by severely limiting the range of narrowly targeted policy options available to ministries of health across Canada.*

*Le Canada partage, avec la plupart des pays de l'OCDE, un problème d'accès géographique inéquitable aux services médicaux. Améliorer la distribution géographique des médecins préoccupe aujourd'hui les divers Ministères de santé à travers le Canada. Les contestations judiciaires récentes mises en oeuvre en Colombie-Britannique et au Nouveau-Brunswick, par des médecins-entrants, mettent en relief le problème de distribution géographique des médecins au Canada. Les auteurs explorent combien les provinces ont eu recours à des approches similaires afin de cerner ce «problème» et, de plus, si les responsables canadiens ont appris des expériences internationales. Le jugement Waldman en Colombie-Britannique est ensuite examiné en termes de ses implications sur la future politique de distribution géographique des médecins au Canada. Les auteurs concluent que l'expérience de la Colombie-Britannique et du Nouveau-Brunswick pourrait provoquer de grands changements en politique de santé en limitant sévèrement les options auxquelles les Ministères de santé pourront avoir*

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*recours afin d'adresser le problème de distribution des effectifs médicaux au Canada.*

### *Introduction*

Canada shares with most OECD countries the problems associated with inequitable geographic access to physician services. Wide variation in the geographic supply of physicians is a problem with a long history and a broad international sweep. It is thus a common feature across a rich and varied mix of organizational and financing arrangements found in modern health care systems,<sup>1</sup> and has persisted despite an equally rich and creative mix of attempts at remediation. In some countries considerable geographic variation persists, despite decades of waiting for the markets to solve the problem. In others, regulatory or financial initiatives intended to improve these situations have had little effect. As a leading example of this intra-country variation, the population per physician in the United States varied in 1991 from about 660-725 in states such as Alaska and Idaho, to 265-280 in Maryland, Massachusetts, and New York.<sup>2</sup>

Many OECD countries see this wide regional variation in physician supply as a significant policy problem.<sup>3</sup> Ironically, the problem co-exists with a problem of aggregate oversupply in most of these countries: there is widespread agreement that there are more than enough physicians to meet the medical care needs of the populations, but some sub-populations (particularly urban) are often considerably oversupplied with physicians,<sup>4</sup> while others (particularly rural) continue to face access problems. A few countries, such as Belgium, Switzerland, and Israel, do not seem to have serious geographic distribution problems, but they are both

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1. Organisation for Economic Co-operation and Development, *The Reform of Health Care Systems: A Review of Seventeen OECD Countries* (Paris: OECD, 1994).

2. Personal communication, Bradley Gray, University of Wisconsin – Madison, January 1997.

3. See, for example, A. Ritsatakis, "Problems Related to Future Medical Demography in the European Community" in H. Viefhues, ed., *Medical Manpower in the European Community* (New York: Springer-Verlag, 1988) at 205; A. Kalandidi & A. Ritsatakis, "Greece" in *ibid.* at 125; L. Malcolm, "The Development of Medical Workforce Policies in New Zealand" in M. Barer & G. Stoddart, *Toward Integrated Medical Resource Policies for Canada: Appendix I*, HPRU Paper 91:7D (Vancouver: Centre for Health Services and Policy Research, University of British Columbia, 1991).

4. "Oversupply" means that there are more physicians than is necessary to meet those clinical needs that can most efficiently be met using individuals with extensive medical training. See, e.g., M. Barer & G. Stoddart, *Toward Integrated Medical Resource Policies for Canada Background Document*, HPRU Paper 91:6D (Vancouver: Centre for Health Services and Policy Research, University of British Columbia, 1991). The effects of such oversupply can include such empirical phenomena as use of services increasing far more rapidly than population growth and aging would suggest might be appropriate; wide variations across small

geographically much smaller than Canada, and preoccupied with the policy implications of serious physician oversupply.

Differential access to physician services is commonly perceived as contributing to deficiencies in the provision of medically necessary services, and thus to geographic variations in population health status. The relative contribution of medical care to population health within developed countries is a matter of considerable debate. Evidence linking access to physician services with the overall health status of a population tends to be derived from studies of disadvantaged groups whose access to medically necessary services is relatively poor, in part as a result of geographic distribution, and in part because of other characteristics of those groups (e.g., race, ethnicity, socio-economic status).<sup>5</sup> The relationship between the availability of physician services and population health status within a wide observable range of physician supply is not transparent, and so policies governing geographic distribution of physician services may not necessarily, or only, be spawned by concerns about the health of the populations served.

Consensus would clearly exist in certain situations that a region is underserved in terms of relatively expeditious access to certain types of clinical care. But how often these situations of restricted access result in documented deleterious health effects is not clear. What does seem indisputable is that the residents of such regions are often seriously inconvenienced, and often have to incur considerable personal costs, to obtain care that urban residents simply take for granted. This should not, however, be taken as *prima facie* evidence that all, or most, claims regarding relative undersupply of physicians in non-urban regions of Canada would stand up to more detailed scrutiny. "Undersupply" seems

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regions in the provision of particular services; widespread increases in the number of different physicians seen by the average patient, no inverse correlation between availability and prices, and so on. Whereas in other economic arenas, excess capacity would be expected to have a dampening effect on prices and on incomes, this is generally not the case in health care, where imprecise relationships between clinical problems, therapeutic decisions, and health effects leave wide bands of discretion to clinicians. Thus there may be an almost infinite amount of clinical care that would be of some (small) benefit to some (small) number of patients, so that despite rapid increases in physician supply per capita, physicians can be kept busy and, in most cases, still be "doing no harm." From a social policy perspective, however, committing scarce public resources to such activity comes with a high "opportunity cost" – there are other activities that would yield greater public benefit, and even greater *health* benefits, than continuing to commit resources to the training and support of additional physicians. On the topic of other determinants of health, see, e.g. R.G. Evans, M.L. Barer & T.R. Marmor, eds., *Why are Some People Healthy and Others Not? The Determinants of Health of Populations* (New York: Aldine de Gruyter, 1994).

5. N.P. Roos et al., *Needs-Based Planning for Manitoba's Generalist Physicians* (Winnipeg: Manitoba Centre for Health Policy and Evaluation, 1996); Evans, Barer & Marmor, *supra* note 4.

often to be used in a ‘relative,’ rather than ‘absolute’ sense — regions with far fewer physicians per capita than large urban centres are “undersupplied” — irrespective of whether there is any evidence suggesting health deficits attributable to such “undersupply,” and whether other care-givers can provide at least some of the necessary care.<sup>6</sup> Whatever the rationales, improving the geographic distribution of physicians is a policy preoccupation of all provincial and territorial departments of health in the country today.

All this leads to two questions. First, have governments adopted common approaches to addressing the ‘problem’? Secondly, has the fact that Canadian policy-makers are not alone in having to address both real and perceived problems with geographic ‘maldistribution’ led them to learn from international experience and evidence? It is these questions that occupy us in this paper. We begin with a short summary of the policy initiatives that one finds across Canada today. We then contrast the domestic experience with a limited selection of some of the more relevant international experiences. We conclude the paper with a brief discussion of the current legal initiatives related to recent Canadian approaches, again tying these to international experience.

### I. *Canadian ‘Solutions’ — a brief overview*

In every province and territory in the country today, one finds a witch’s brew of strategies to entice physicians to rural and remote areas and retain them there. Policy approaches to improving the geographic distribution of physicians may be distinguished according to whether they are primarily regulatory/administrative, educational, financial, or laissez-faire strategies, although these often overlap in practice. For example, many financial incentives are rooted in enabling legislation, and there are a variety of financial incentives tied in one way or another to physician training. A billing numbers policy which restricts the issuance of ‘rights’ to bill a provincial medical plan for services rendered could be viewed as a financial disincentive program in which the disincentive was a 0% fee proration. Nevertheless, most policies seem to fit relatively comfortably within one of the above categories.

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6. Of course for many specialties and sub-specialties there are good and logical reasons for urban supply to be considerably higher than that in other regions. For example, the population required to keep a thoracic or cardiac surgeon fully occupied can easily number in the hundred thousands—in such situations it makes little sense to talk about “equal” access. But similar arguments do not ring true for general/family practice in particular, and some primary care specialties. Here the reverse is often argued—that with the much easier access to specialist services, the urban requirement for primary care practitioners could be, if anything, somewhat less than the non-urban requirements.

By “regulatory/administrative” approaches we mean any public policies with a primary intent of influencing location decisions. These may be ‘codified’ in provincial or federal statutes, or take the form of policies enacted by bodies who have been given self-regulatory powers through acts or regulations, or may be applied through administrative rules. The latter may include restrictions on the issuance of ‘billing numbers,’ without which physicians cannot receive reimbursement from the provincial medical insurance plan, and controls on the recruitment, training and licensing options of ‘foreign medical graduates’ (physicians who received their medical training outside Canada). “Financial” approaches include different methods of paying providers, as well as incentives within a payment system. The latter are perhaps the most familiar and long-standing in Canada, and include northern/isolation allowances or income floors, loan forgiveness, assistance with practice expenses, differential fees (e.g., discounted fees for practitioners locating in areas designated as “amply- or over-supplied”), and the like. Among “educational” initiatives we include a wide range of policies, ranging from high school science enrichment to curricular and clinical exposures provided during medical and post-graduate training.

By “laissez-faire” we mean the approach of “letting ‘the market’ take care of it.” This approach is commonly based on the view that as urban centres become more crowded, there will be a spill-over or ‘trickle-down’ effect which will result in more physicians setting up practice in rural areas. It would also include efforts by communities, regions, or even departments of health, to ‘advertise’ opportunities in, and attractions of, particular locations in need of physicians. Thus we consider initiatives such as “recruitment fairs” or “recruitment tours,” intended to heighten awareness among practising and soon-to-be-practising physicians of opportunities in underserved areas, as components of a “laissez-faire” approach; these are the sorts of promotional activities one would expect to find if the matter of distribution is left to ‘the market.’

In the table below, we list the main policy approaches taken by provincial and territorial governments during the past twenty-odd years, as revealed through our review of policy documents, and responses to requests (in late 1996 and early 1997) for information from each of the provinces and territories.<sup>7</sup> If a policy was implemented for a time and then

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7. Requests for information were sent to each province’s or territory’s health care representative on the federal/provincial/territorial Advisory Committee on Health Human Resources. We requested information that would describe any current policies that had as a key objective the geographic redistribution of physicians in the province or territory. We also requested information on the history of geographic distribution policies in each jurisdiction. Information

rescinded, it is still identified with a “yes.” Thus, any attempts to manage physician geographic distribution by the methods listed below have been included, in order to illustrate both the intractability of the problem, and the wide and imaginative range of potential solutions that have been applied over the past few decades. It is important to note that the table provides a conservative picture of the policy mix, because provincial respondents tended to be somewhat more thorough in providing a picture of current and recent policies than they were in providing us with a complete historical picture. In other words, the table may reflect a certain amount of under-reporting of past policies no longer in effect.

Table I—Provincial/Territorial Policy Approaches

Policy Approaches	B.C.	Alta.	Sask.	Man.	Ont.	Que.	N.S.	N.B.	P.E.I.	Nfld.	Yuk.	N.W.T.
<b>Regulatory/Administrative</b>												
Billing numbers	✓	×	×	✓	✓	×	✓	✓	×	×	×	×
Foreign medical graduates	✓	×	✓	✓	✓	✓	×	×	×	✓	×	×
<b>Funding/Payment</b>												
Isolation payments	✓	✓	×	✓	✓	✓	×	×	×	✓	×	×
Subsidized income	✓	×	×	✓	✓	✓	✓	✓	×	✓	✓	×
Differential fees	✓	×	×	×	✓	✓	×	✓	✓	✓	✓	×
Undergraduate/post-graduate student loans with return of service	×	✓	✓	✓	✓	✓	×	×	×	✓	×	✓
Undergraduate/ post-graduate student loans without return of service	×	×	×	✓	×	✓	×	×	×	×	×	×
<i>Locum</i> /financial support for additional training, cme*, vacation relief, etc.	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	×	×
<b>Educational</b>												
Rural training/exposure	✓	✓	×	✓	✓	✓	×	×	×	✓	×	×
Special recruitment policies	✓	×	×	×	×	✓	×	×	×	✓	×	×
<b>Market-based Initiatives</b>												
Recruitment fairs/tours	×	✓	×	×	✓	×	×	×	×	×	×	✓

\* continuing medical education

was synthesized from information provided directly by those correspondents or others to whom we were referred, and government and published documents. A complete list of relevant references, and key contacts, is available from the authors.

With the exception of Prince Edward Island and the Yukon territory, provinces and territories have tried and continue to employ combinations of policy approaches that encompass more than one of the generic policy categories. One might infer from the number and range of policy approaches that none has been successful in redressing geographical imbalances, and this is generally supported by the very limited evaluative evidence available from the Canadian experience. While evaluations of the policy approaches have not been undertaken routinely, some evidence has emerged from Alberta, Ontario, and Québec. For example, an evaluation of the Rural Physician Action Plan in Alberta (which provided for rural training, extended skills training, continuing medical education support, student loans with return of service requirements, a physician recruitment fair, and *locum* support) reported data indicating that rural areas had become *less* successful at recruiting and/or retaining physicians after the Plan was implemented.<sup>8</sup> Of course there have been extenuating circumstances in the wider health care policy arena in Alberta,<sup>9</sup> which bring to light the difficulty of policy evaluation in a constantly changing external environment.

The Ontario Underserved Areas Program has been reviewed several times, and opinions differ as to how successful it has been in redressing geographical inequities. An analysis performed in 1990 concluded that the program had not resulted in any significant redistribution,<sup>10</sup> while a later review called it "a qualified success."<sup>11</sup> A key methodological difficulty with evaluating the effectiveness of any of these programs is that it is impossible to ascertain what number of relocations might have taken place in the absence of the programs, and 'control' regions are either not available or are not sufficiently comparable in other key respects.

While Québec has employed a wide range of initiatives to improve its geographic distribution of physicians, a long-standing differential fees program has been at the heart of its approach. A recently published

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8. C.A. MacDonald and Associates, *Evaluation of the Rural Physician Action Plan* (Prepared for Alberta Health, 1996) [unpublished].

9. Particularly important among these "extenuating circumstances" are the recent sharp reductions in the funds available under Alberta's global expenditure cap for medical services; (see M.L. Barer, C. Sanmartin, and J. Lomas), *Physician Expenditure Control in Canada: Reminding our Ps and Qs*, HPRU Paper 95:7D (Vancouver: Centre for Health Services and Policy Research, University of British Columbia, 1995).

10. M. Anderson & M.W. Rosenberg, "Ontario's Underserved Area Program Revisited: An Indirect Analysis" (1990) 30 Soc. Sci. Med. 35.

11. Dreezer and Dreezer, Inc., "Review of the Underserved Area Program for the Health Human Resources Planning Group, Ministry of Health" (draft report, February 1992) [unpublished].



evaluation suggests that the Québec policies have had a considerable effect on the distribution of general practitioners in the province.<sup>12</sup> Indeed, the proportion of new general practitioners who decided to set up practice in a remote or isolated region increased from 11.4% in 1981 to 23.8% in 1988. However, the policies have had no detectable effect on the location decisions (or relative supply) of specialists in the province, despite a rich mix of incentives directed towards specialities like internal medicine, obstetrics, general surgery, and paediatrics, which made it particularly advantageous for specialists to provide services on contract to hospitals in isolated and remote areas.

There have not been any formal evaluations of student loan programs which rely upon return-of-service guarantees to secure service provision for underserved areas. Evidence from Alberta indicated that the student loan remission program had not been especially successful,<sup>13</sup> while outcomes appear not to have been tracked in Saskatchewan, Ontario, or Newfoundland. Manitoba reports that, as of June 1996, about 21% of those receiving forgivable loans with obligatory return-of-service had repaid their loans with interest, and 46% had completed part or all of their return-of-service. In Québec it is known that although there are 90 bursaries with return-of-service obligations available each year, only 50 candidates apply annually, and of those who do begin their return-of-service, about 50% repay the remainder of the loan after one year of service.

Canada's limited experience with regulatory/administrative restrictions on rights to payment (billing numbers) policies has been insufficient to provide any detailed opportunity for evaluation. The first experience, in British Columbia in the mid-1980s, has never been formally evaluated (or, if such evaluation exists, it has never been published). However, some applications for billing numbers were denied during this period, and preliminary data examined at the time suggested some reduction in the issuance of numbers as a result of the policy. However, many of these denied applications showed up as unrestricted *locum tenens*, and so the overall effects are likely never to be known.<sup>14</sup>

More recently, New Brunswick has instituted a similar policy, which has been in place since 1992. Regional hospital corporations are responsible for granting privileges to physicians. Under the current policy, such

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12. D. Bolduc, B. Fortin & M. Fournier, "The Effect of Incentive Policies on the Practice Location of Doctors: A Multinomial Probit Analysis" (1996) 14 J. Lab. Econ. 703.

13. MacDonald and Associates, *supra* note 8.

14. For a description of the history of the policy, and a very limited analysis of its effects, see M. Barer, "Regulating Physician Supply: The Evolution of British Columbia's Bill 41" (1988) 13 J. Health Pol. Policy L. 1.

privileges are granted (in the form of a list of procedures that the particular physician in question is authorized to perform in the hospital in question)<sup>15</sup> according to whether the region in question requires additional physicians of any given specialty in order to meet specialty- and region-specific targets established through an extensive planning process involving the province's Physician Resources Advisory Committee. A physician without privileges could, in theory, practice in the region, but would not have access to the hospital, and would not be issued a billing number. In practice, it seems unlikely that a physician would choose to establish a practice without a billing number.

This policy has been subject to limited review, which seems to indicate that the Plan during its first three years had achieved some success in improving the geographic distribution of physicians in that province.<sup>16</sup> One of the key problems with such approaches is that, if applied in a single province, physicians may choose to migrate to other provinces rather than to set up rural/remote area practices.

In terms of the taxonomy described above, it would seem that financially oriented schemes predominate in past and present efforts to remedy geographic distribution problems in Canada. This is so despite rather widespread evidence that financial considerations tend to be well down the list of preoccupations of those making practice location decisions.<sup>17</sup> Québec appears to be the exception, where the differential fees approach seems to have had some effect on redistribution. It may be that language plays some role in limiting the (perceived) mobility of some segment of the Québec physician population, but this is mere speculation. Some

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15. New Brunswick, "Regional Hospital Corporation Interim By-Laws" (mimeograph, n.d. 1992) [unpublished].

16. See J. Reamy, *Managing Physician Resources: The Effectiveness of the New Brunswick Plan* (Report for New Brunswick Department of Health and Community Services, 1995) [unpublished]; and J. Reamy, "Physician Resource Management in New Brunswick: The First Three Years" (Paper presented at International Health Economics Association Inaugural Conference, Vancouver, May 1996).

17. See, for example, B. Ferrier et al., *The Employed Spouse: Impact on Physicians' Career and Family Decisions*, Working Paper 96-21 (Hamilton, Ont.: McMaster University Centre for Health Economics and Policy Analysis, 1996); Canadian Medical Association, *Report of the Advisory Panel on the Provision of Medical Services in Underserved Regions* (Ottawa: CMA, 1992); A. Kazanjian et al., *Study of Rural Physician Supply: Practice Location Decisions and Problems in Retention*, HPRU 91:2 (Vancouver: Centre for Health Services and Policy Research 1991); D.S. Wright, *Factors Influencing the Location of Practice of Residents and Interns in British Columbia: Implications for Policy Making* (M.Sc. Thesis, Department of Health Care and Epidemiology, University of British Columbia, 1985). This literature makes clear the paramount importance of spousal and other family considerations, and of work environment issues such as practice facilities, on-call and holiday relief, and opportunities for continuing education; and the relatively minor importance given to financial considerations and incentives.

financial approaches operate as practice supports, in that they subsidize continuing education, additional skills training, and *locum* provision. Practice supports have been identified by some rural practitioners as important to retention considerations (although less important for recruitment).

Recruitment has also been addressed through a growing number of educational initiatives. In B.C., the U.B.C. Department of Family Practice now actively seeks graduates who were raised in non-urban environments, and most Canadian medical schools now offer rural exposures as an element of undergraduate and/or post-graduate training. Regulatory/administrative methods have been of two general types—‘billing numbers’ restrictions (the mid-1980s B.C. experience and the current New Brunswick plan being the most obvious examples), and a variety of regulatory or administrative restrictions on the geographic mobility of foreign medical graduates who enter Canada to take up specific rural or remote practices. Finally, the information in Table I would suggest that, in general, Canadian policy-makers have tended not to rely on the (misguided) hope that simply training more physicians would result in an adequate geographic distribution—each province has developed a variety of purposive measures in an attempt to counteract the gravitational pull of large urban centres.

In short, the largely financially-based approaches, tied to fee-for-service reimbursement (either in the form of differential fees as in Québec or B.C., or in the form of supplementary incentive packages), continue to dominate the geographic distribution policy landscape in Canada, despite two countervailing facts: (a) the research on determinants of locational decision-making seems to suggest that other factors outweigh financial considerations;<sup>18</sup> and (b) with the possible exception of Québec, the evaluative evidence suggests that the financial approaches to date have not been particularly effective. Is Canada alone in taking this approach? Does international experience offer any further insight? Or, put differently, is there experience outside Canada’s borders that would support Canadian policy-makers’ continued preoccupation with fee-based financial incentives?

## II. A (Selective) International Perspective

The two countries to which Canada is most frequently compared in matters of health care policy are the United Kingdom and the United States. Interestingly, these two countries have taken quite different

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18. See *supra* note 17.

approaches to solving problems quite similar to those in Canada, with quite different measures of success. The U.K. versus U.S. comparison is, we believe, particularly illuminating for those addressing the problem in the Canadian context.

The United Kingdom has, since the inception of its National Health Service (NHS), employed regulatory/administrative approaches to geographic distribution, and has enjoyed evident success with those methods. The U.K. has what is referred to as a "negative direction" or negative control regulatory policy affecting the distribution of general practitioners (GPs). A central "Medical Practices Committee" (MPC) must approve all GP applications for practice. This Committee has the power to refuse an application if it considers that the number practising in an area is adequate. Adequacy is determined by the size of patient rosters. "Designated" areas are those with average GP list sizes<sup>19</sup> of 2500 patients and above, "open" areas have average list sizes of 2101-2499, "intermediate" areas have average lists of 1701-2100 patients, and "restricted" areas are those with average lists of 1700 or fewer patients per GP. Applications to practice in designated and open areas are usually granted without question, while those for intermediate and restricted areas are considered on the basis of detailed advice from the appropriate local family practice committee and may be refused.<sup>20</sup> Importantly, the MPC "has absolute discretion in approving or denying any GP location requests."<sup>21</sup> The negative direction policy was evaluated in the mid-1970s, and was found to have some perverse effects. One of the most important is that the areas with the fewest physicians were less likely to be "designated" because of their sparse populations. More recently, its effects have been dampened by the rather liberal list size 'cut points.' For example, there are few "designated" areas remaining in the U.K., and in practice many applications to "intermediate" areas are granted. Nevertheless, overall the policy is widely seen as having provided a reasonably equitable distribution of GP services.<sup>22</sup>

The U.K. has also utilized financial incentives. An initial practice allowance is payable for those setting up practices in designated areas. Those who remain in practice in designated areas for a period of time also receive additional remuneration in the form of a designated area allow-

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19. "List size" refers to the number of patients registered with a physician.

20. R. Haynes, *The Geography of Health Services in Britain* (London: Croom Helm, 1987).

21. D. Taylor, *The Natural Life of Policy Indices: Geographical Problem Areas in the US and UK* (University of Manchester, 1996) [unpublished manuscript].

22. A. Maynard & A. Walker, "The Physician Workforce in the U.K.: Issues, Prospects and Policies" (Background paper prepared for Inaugural Trilateral Conference on Physician Workforce: Washington, D.C., 1-3 November 1996).

ance. The most important incentive was found to be the designated area allowance, though most practitioners regarded it as far too low to affect practice decisions. In addition, the allowances could be counter-productive in that they give established physicians in designated areas an incentive to discourage or refuse newcomers, since the allowance is lost once list sizes drop below the margin, and the MPC membership is dominated by GPs.<sup>23</sup>

With the 1990 NHS GP contract, an additional set of incentives was added. These use an index called the "UPA 8" (which is a weighted average of factors such as percentage of elderly living alone, single parent families, unemployed, unskilled workers) to designate the status of geographically small areas. For areas that are deemed "deprived," a "deprivation payment" is "attached" to all area residents. GPs who have such patients on their lists receive a capitation (per enrolled patient) supplement, as an incentive to serve patients from areas with these characteristics. The annual capitation supplements ranged in 1995/96 from approximately \$15 to \$25 per designated patient.<sup>24</sup> Since these areas tend to be those less coveted by physicians looking to locate practices, this has the effect of creating an incentive to set up practice in relatively less well-served areas.

In addition, a variety of other initiatives are mentioned in the literature, most often with little explanatory detail. A selective list would include an "Inducement Scheme" that provides physicians with "a family-sized house and a surgery for rent ... [plus] 80% of the current agreed average general practitioner earnings ... [and] *locums* for annual and study leave ... paid for by the health authority;"<sup>25</sup> an "Associate Scheme" that provides "salary and expenses, at approximately senior registrar level, for a doctor to work on a shared basis between two or three isolated practices ... at least ten miles apart;"<sup>26</sup> compensation to primary care physicians for "increased time spent travelling when caring for patients in sparsely populated areas;"<sup>27</sup> the "Primary Care Initiative Program" that provides selected assistance to Liverpool practices that require it; and the "London Initiative Zone" that provides a variety of allowances intended to encour-

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23. Haynes, *supra* note 20.

24. Taylor, *supra* note 21.

25. J. Macleod, "Recruitment to rural practice" (1995) 71 (Sept.) *Occ. Papers Royal C. Gen. Practitioners* 43.

26. *Ibid.*

27. United States, House of Representatives, *Primary Care Physicians: Managing Supply in Canada, Germany, Sweden, and the United Kingdom: Report to the Chairman, Committee on Government Operations* (Washington: General Accounting Office, 1994).

age new practice arrangements within the "LIZ."<sup>28</sup> These strategies seem to be secondary to the major U.K. programs.

One might ask why these administrative and financial mechanisms are necessary, if GPs are paid on a capitation basis to start with. "Under a strict capitation system competition for patients (or their associated capitation fees) would produce strong financial incentives to locate in areas of under supply ... , but a large proportion of an average GP's income comes from non-capitation sources."<sup>29</sup> Indeed, while the largely capitation-based method of funding primary care is seen by local students of the U.K. policies as having been quite an effective approach to ensuring reasonable access to primary care services,<sup>30</sup> its effects on geographic distribution have undoubtedly been vitiated somewhat by the array of 'envelopes' through which general practitioners can receive income.<sup>31</sup> On balance, however, the combination of central decision-making through the Medical Practices Committee and funding tied significantly to the number of patients on a GP's practice list, has left the U.K. in a situation where geographic maldistribution of primary care physicians is not currently seen as a problem (although pockets of underservicing do remain).

As for specialist services, most specialists are (at least in part) salaried employees of Hospital Trusts. Funds for specialist services are allocated to regions, and the regional authorities make funds available to hospital trusts on the basis of populations served. Trusts now have some independent latitude in setting "terms and conditions of employment" for specialists, which may facilitate recruitment of specialists to some shortage areas.<sup>32</sup> The regional funding formulae, and the development of independent Hospital Trusts has apparently improved the distribution of specialist services, because it has been possible to steer specialists to the populations in need of those services. Like the capitation-based funding for GP services, the approach of having funding follow populations seems to have reduced problems of geographic maldistribution.

Educational policy approaches do not appear to have played a major role in the U.K.'s methods for managing the distribution of physician

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28. Review Body on Doctors' and Dentists' Remuneration, *Twenty-Fifth Report 1996* (London: HMSO, 1996).

29. S. Birch & A. Maynard, "Medical human resources policy in the UK" Appendix H in M.L. Barer & G.L. Stoddart, *Toward Integrated Medical Resource Policies for Canada: Appendices*, HPRU Paper 91:7D (Vancouver: Centre for Health Services and Policy Research, University of British Columbia, 1991).

30. Maynard & Walker, *supra* note 22.

31. Review Body on Doctors' and Dentists' Remuneration, *supra* note 28, Appendix A at 65-69.

32. Maynard & Walker, *supra* note 22.

services, and there has certainly been limited, if any, reliance on 'market forces.' It could be argued that the market may play a greater role in the distribution of specialists than of GPs, thanks to the persistence of a parallel private health care system from which some specialists receive as much as 40% of their incomes.<sup>33</sup> Areas with higher concentrations of patients with private health insurance would be attractive to such specialists. Since no effort has been taken to manage that aspect of the system, the existence of an alternative source of income in one area would likely be a considerable incentive to a specialist physician making location decisions.

The use of regulatory/administrative approaches in the U.K. and the consequent resolution of many geographic distribution problems is in direct contrast to the general reliance on "laissez-faire" approaches in the U.S. All observers of the U.S. scene agree that there are radical problems with the geographic distribution of physicians, despite continuing increases in supply over the last 25 years. For example, about "20 percent of the U.S. population lives in rural areas while only 9 percent of the nation's physicians practice in rural communities."<sup>34</sup> The difficulty has been exacerbated by the increasing preference of recently-trained physicians to choose non-primary care specialties and sub-specialties. It is well-known that primary care practitioners are much more likely than are secondary and particularly tertiary specialists to end up in non-urban practices. Overall, the U.S. medical associations, medical schools and governments at the state and federal level have relied upon a non-interventionist approach (faith in 'trickle-down'), supplemented by relatively small-scale and rather ad hoc programs which use educational and financial levers, to address distributional issues. Indeed, the U.S. approach has been recently described by an American observer as

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33. While the private sector in the U.K. overall represents less than 5% of total expenditures (Maynard & Walker, *ibid.*), private sector revenues are very unevenly distributed. Arrangements for specialist commitments to the NHS are quite loose (see, e.g., J. Yates, *Private Eye, Heart and Hip: Surgical Consultants, the National Health Service and Private Medicine* (New York: Churchill Livingstone, 1995); and D. Light, *Betrayal by the Surgeons* (1996) 347 *Lancet* 812. For example, in return for relinquishing 1/11 of NHS salary, a specialist can in actual fact spend an unregulated amount of time in private practice. Maynard and Walker suggest that specialists "who progress steadily through the grades of the hospital service will reach a salary of approximately £40,000 in their late thirties and a salary of £52,500 as a consultant in their forties . . . [and] [p]rivate practice, available mainly to surgical specialties and anaesthetics, might add an average of £30,000...."

34. T. Konrad, "The Problem of Shortages of Physicians and Other Health Professionals in Rural Areas: Empirical Evidence and Policy Recommendations" (Report prepared for the Council on Graduate Medical Education (COGME) Workgroup on Health Professions Workforce Policy and Geographic Distribution) (Chapel Hill: North Carolina Rural Health Research Program, University of North Carolina at Chapel Hill, 1996).

“apiecemeal effort to respond to geographical problem areas ... and not a coherent strategy designed to rationalize the allocation of health resources to improve access.”<sup>35</sup>

If there is a “general approach” in the U.S., it would appear to be to use some sort of index or other method to identify “underserved” or “shortage” areas in absolute terms, and then to make federal or state funds available to those areas, or to individuals prepared to set up practices in those areas. The National Health Service Corps (NHSC) is a financial incentive program rooted in federal legislation, and designed to recruit (and retain) primary care physicians to (and in) rural and underserved areas, including those in metropolitan centres. Developed in 1972, and operating through a combination of incentives and coercion (scholarships and loans, with an obligation of “return-in-service”), it has trained over 20,000 health professionals, the majority of whom have been physicians. A method was developed to identify Health Professional Shortage Areas (HPSA), and NHSC funds are allocated only to such areas. This method involves combining information on the population: physician ratio, and “locally provided information on health need[s] and health facilities.”<sup>36</sup> However, the population: physician ratio appears to be the most important factor, and the ‘cutoff’ ratio appears to be set not on the basis of any research, but rather so as to ensure that about one-quarter of all U.S. counties are eligible for NHSC funds. Thus, it has been a moving target over the life of the program. Since the inception of the NHSC, however, a variety of other financial assistance programs have also adopted the HPSA as the basis on which they allocate funds.<sup>37</sup>

Another financial incentive program has its roots in the *Health Maintenance Organization Act of 1973*.<sup>38</sup> This Act uses a different index, the “Index of Medical Underservice” (based on factors identified by an expert physician panel as being indicators of underservicing) to identify “Medically Underserved Areas” (MUA).<sup>39</sup> The intent of this initiative was to make funds available to underserved areas in order to encourage the development of HMOs in those areas.

Small areas (usually counties) must apply to the federal government for designation either as an MUA or an HPSA, in order to be eligible for funds that can be used for programs intended to improve recruitment or

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35. Taylor, *supra* note 21.

36. *Ibid.*

37. United States, *Health Care Shortage Areas: Designations Not a Useful Tool for Directing Resources to the Underserved* (Washington, D.C.: General Accounting Office 1995).

38. Pub. L. No. 93-222, 87 Stat. 914 (codified as amended at 42 U.S.C.A. § 300).

39. Taylor, *supra* note 21.



retention of health care professionals. Under the HPSA program, counties must re-apply every three years, or they are dropped from the list, and new shortage areas are only added if they actually apply for designation. As a result, one could have changes in the list of HPSAs without accompanying changes in the actual relative supply of health care professionals. Historically, there has been considerable variation in the probability that a shortage area would actually go to the effort of applying, depending largely on whether it perceived that funds would be forthcoming, and whether the host state was aggressive in assisting small areas.<sup>40</sup> In 1994 the NHSC awarded 429 scholarships (189 for physicians) and 536 loan-repayment contracts (217 to physicians).

Evaluation of the NHSC programs has tended to focus on the issue of whether physicians who go through this program end up staying in HPSAs beyond their term of "service repayment." A nine-year follow-up study indicated that between 1984 and 1990, fewer NHSC physicians than non-NHSC physicians remained in the practices in which they worked in 1981, or more generally in practice in a rural county. Long-term (8-year) retention percentages for NHSC and non-NHSC physicians were 12% versus 39%, with 29% versus 52% among non-NHSC physicians remaining in non-metropolitan practices.<sup>41</sup> Problems with retention and satisfaction have since been studied extensively. Factors associated with dissatisfaction include the fact that two-thirds were matched to states where they had not lived or trained, and the sense that the needs of spouses and children and their personal life issues were not dealt with adequately.<sup>42</sup> In addition, it appears that within HPSA-designated areas, there are more and less desirable places to practice. The task of the NHSC is to place practitioners into areas on the basis of relative need, whereas those settling in HPSA areas on their own can choose their locations. As a result, it is likely the case that the NHSC-placed individuals are, on average, in subjectively less desirable areas than are the non-NHSC physicians practising in HPSAs.<sup>43</sup>

A general evaluation of rural HPSA retention was carried out between 1990 and 1992. It found that about 20% of primary care physicians who had located to underserved areas during the period of study had gone

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40. Konrad, *supra* note 34.

41. D.E. Pathman, T.R. Konrad, & T.C. Ricketts, "The Comparative Retention of National Health Service Corps and Other Rural Physicians: Results of a Nine-year Follow-up Study" (1992) 268 J. Am. Med. Assoc. 1552.

42. D.E. Pathman, T.R. Konrad, & T.C. Ricketts, "The National Health Service Corps Experience for Rural Physicians in the Late 1980s" 1994 272 J. Am. Med. Assoc. 1341.

43. Personal communication with Fitzhugh Mullan (Contributing Editor, Health Affairs) (November 1996).

through the NHSC program. Approximately 60% of NHSC physicians and 40% of non-NHSC physicians had left their rural practice setting within four years of arrival. Seventy percent of NHSC physicians intended to leave their assigned practice within 6 years. About 40% of NHSC physicians, in contrast to about two-thirds of the non-NHSC physicians in the same HPSAs, intended to stay for six years in rural practice at the time they began their practices. About 40% of the NHSC participants in HPSAs intended to move to urban areas within the first six years, in marked contrast to less than 10% of the other rural (non-NHSC) physicians surveyed. At least one-third of the NHSC physicians had only a short-term interest in underserved area practice.<sup>44</sup>

“[A]bout one of every four new primary care physicians entering HPSAs in the late 1980s was placed there under the NHSC scholarship or loan repayment programs,” but to argue that “this fact alone boldly illustrates the impact of the program in quantitative terms,”<sup>45</sup> may overstate the case. Indeed, we have no way of knowing whether those same, or other, primary care physicians might have settled in HPSAs in the absence of the NHSC. The evidence from the Pathman and Konrad evaluations suggests that those who chose to settle in HPSAs through their own volition were more committed to rural area practice and more likely to stick with it, than were physicians attracted to such practices through a financial incentive program. However, whether this reflects problems with the program administration, lack of comparability because of failure to adjust for sub-regions within HPSAs, or simply the fact that what attracts physicians to rural areas are not, fundamentally, financial considerations, is impossible to ascertain from the evidence reviewed here.

Of course, the NHSC must be evaluated in the context of other measures intended to encourage rural recruitment and retention. A recent study noted that rural counties in sparsely settled states typically lost three or more physicians for every four new ones they acquired, despite the fact that many of these states have medical schools that encourage matriculation of students from rural backgrounds, place special emphasis on primary care and rural practice, and have well-developed rural-oriented graduate medical education programs.<sup>46</sup>

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44. T.R. Konrad et al., *The Rural HPSA Physician Retention Study*, final report of Grant No. R01 HS 06544-0 (Chapel Hill: University of North Carolina at Chapel Hill, Agency for Health Care Policy and Research, 1993).

45. Konrad, *supra* note 34.

46. T. Konrad & H. Li, “Migrating Docs: Studying Physician Practice Location” (1995) 274 *J. Am. Med. Assoc.* 1914.

Another financial mechanism in the U.S. has been the payment of Medicare bonuses to physicians practising in underserved areas. Beginning in 1989, a 5% bonus payment was made available to rural HPSAs with the most severe physician shortages. This was increased to 10% in 1991 and was extended to all rural and urban HPSA's. This policy was enacted despite the fact that "relevant literature has indicated that physician location and retention decisions are [only] somewhat influenced by financial factors...." The underlying premise was that "payment incentives appear to have greater potential for *retaining* physicians currently located in underserved areas than for *attracting* new physicians...." <sup>47</sup> It is also important to recall that these bonuses are available only for services provided to the Medicare population in the United States which is composed almost entirely of seniors.

In the U.S., educational policy approaches have been used at the state level, with special emphasis on recruitment and rural training. Several medical schools have reported good results with these programs.<sup>48</sup> Unfortunately, federal funding to medical schools appears to have been designed rather perversely, again exposing the ad hoc nature of U.S. physician resource policies. It is well known that general practitioners are over twice as likely to settle in small isolated counties as their specialist counterparts. Yet the amount of federal (particularly National Institute of Health) funding a school receives is inversely related to its propensity to graduate physicians who would likely locate in rural areas. Indeed, Rosenblatt et al. noted four characteristics that are strongly associated with the tendency to produce rural graduates: location of school in a rural state, public ownership, emphasis on family physicians, and *less* NIH funding.<sup>49</sup>

We are aware of only one recent study comparing leading national policies in different countries. Taylor notes that "the National Health Service Corps is one of the most highly visible and probably most evaluated of the responses to geographical problem areas in the U.S. Yet

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47. Physician Payment Review Commission, "Bonus Payments in Health Professional Shortage Areas" in *Annual Report to Congress 1994* (Washington: PPRC, 1994) 429 [emphasis added].

48. A. Roberts, L. Davis & J. Wells, "Where Physicians Practicing in Appalachia in 1978 to 1990 Were Trained and How They Were Distributed in Urban and Rural Appalachia" (1991) 66 *Acad. Med.* 682; T.D. Stratton et al., "Effects of an Expanded Medical Curriculum on the Number of Graduates Practicing in a Rural State" (1991) 66 *Acad. Med.* 101; J.E. Verby et al., "Changing the Medical School Curriculum to Improve Patient Access to Primary Care" (1991) 266 *J. Am. Med. Ass'n* 110; J.B. Lawley, "The Physicians for Rural Areas Assistance Act" (1989) 78 *J. Med. Assoc. Ga.* 689.

49. R.A. Rosenblatt et al., "Which Medical Schools Produce Rural Physicians?" (1992) 268 *J. Am. Med. Assoc.* 1559 [emphasis added].

it is debatable whether the program is a success, or not.... It is a difficult program to evaluate because its purpose is unclear.... NHSC physicians have provided care to those in some of the most deprived parts of the U.S., but few have remained beyond their commitment and many report being dissatisfied from their experience, and potentially less likely to provide care in deprived areas in the future."<sup>50</sup> In contrast, Taylor notes that the MPC in the U.K. "has produced a fairly even distribution of GPs across the U.K. . . . [t]he policy has worked reasonably well, but additional efforts to respond to geographical problem areas became necessary since the MPC does not have the policy scope to compel GPs to particular areas, only to approve or deny requests of GPs to locate in particular areas."<sup>51</sup>

American and British efforts to redress geographic distribution problems operate in radically different contexts. This contaminates any attempt to compare policies in these two countries. In an environment with a national health service, tools are available to give life to MPC-type initiatives. It is difficult to imagine what a comparable structure might look like in the United States, or which level of government would hold the relevant policy levers. It is less difficult to imagine such a mechanism in a Canadian province, or even operating nationally.

Yet, on another front, we may be seeing convergence of the U.S. and U.K. systems. As noted above, a key element in the relative success of geographic distribution policy in the U.K. for GPs has been the method of payment. When physicians receive significant components of their income on the basis of the number of patients they enrol in their practices, there is a clear and unmistakable incentive to make oneself available where there are patients in apparent need of physicians. Meanwhile, increasing numbers are becoming patients of practices operating within similarly 'competitive' environments in the U.S., as managed care structured around capitated payments for enrolled populations takes hold. In this context, it is interesting to note that Canadian physicians have thus far successfully resisted any attempts to change the way in which primary care is organized and financed. In so doing, they are keeping at bay an apparently effective tool for improving geographic distribution.

While one could reasonably conclude from any U.S./U.K. comparison that the U.K. has been relatively more successful in solving geographic maldistribution problems, the U.S. evaluation evidence provides some important insights. Most fundamentally, the comparison of NHSC and non-NHSC physicians practicing in MUAs does indicate that physicians who choose to practice in underserved areas because they want to, rather

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50. Taylor, *supra* note 21.

51. *Ibid.*

than because of the availability of financial incentives, seem more likely to stay committed in the long term. This seems consistent with most of the Canadian evidence which indicates that those who accept financial incentives in return for choosing rural or remote practice locations, tend to stay for relatively short periods of time. Retention is not achieved by financial incentives alone.

The New Zealand experience can also inform the Canadian debate. There has been no consistent effort in New Zealand to address geographic distribution problems; that country has relied largely on 'hope and prayer' (*laissez-faire*) approaches which have failed to redress imbalances.<sup>52</sup> For example, between 1981 and 1987, despite large increases in physician supply and medical care utilization, increases in the initially more liberally-supplied parts of Auckland outstripped those in the less well-supplied parts of the city. To the extent that underserved areas had attracted primary care practitioners, these were largely foreign medical graduates. This experience provides yet one more reminder, lest there be any Canadian back-sliding, that letting 'markets' take care of this problem will not take care of the problem.

Until recently Australia lacked any policies whose primary intent was to address geographic maldistribution of physicians, although this was not for lack of a problem.<sup>53</sup> Four mechanisms have recently been introduced, or are under active discussion.<sup>54</sup> A "GP Rural Incentive Scheme" provides financial incentives to attract GPs to more remote locations. The incentives are modest in scope, covering relocation costs, and support for *locums* to make it possible for physicians to take advantage of continuing education opportunities. The size of the incentives is related to the remoteness of the location. A second initiative currently underway involves the establishment of eight small rural health units, with two slated for opening in 1997 and the other six to follow shortly. The units will provide support staff and facilities for physicians willing to locate in these areas. The plan is to second senior specialists to the units on a rotating basis, and to rotate medical students, interns and residents through the units as well. These units are being established by university medical schools. Additionally, the Commonwealth is provid-

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52. Although a short-lived GP contract scheme introduced in 1990 appears to have achieved some success in reducing access barriers in areas of relatively greater need for services; D.P. Matheson & R.S. Hoskins, "The general practice contract scheme: was it targeted?" (1992) 105(127) N.Z. Med. J. 35.

53. Personal communication with Dr. R. Boyce (Research Fellow, Graduate School of Management, The University of Queensland, Australia) (May 1997).

54. Personal communication with J. Richardson (National Centre for Health Program Evaluation, Melbourne, Australia) (October 1996).

ing some funding to selected rural hospitals to assist them with efforts to attract senior specialists for one year 'sabbatical' periods. The hospitals make fellowships available to these specialists.

Given its history of reliance upon *laissez-faire* and funding/payment approaches, it is interesting that Australia was (as of October 1996) about to introduce a *national* billing numbers scheme. The number of Commonwealth Medicare numbers will be limited. Existing physicians will be 'grandfathered,' but the current cohort of interns and residents will be required to apply for a number. Numbers will only be provided to GPs who have completed the Royal Australian College of General Practitioner fellowship exams. Without a number, neither the physician, nor the physician's patients, will be able to seek reimbursement from Medicare. The College restricts the number of places in each year to about 400; the implication is that as many as 800 general practitioners may be ineligible for private practice each year under the new rules. As a result, it is expected that such physicians will be forced to seek hospital positions and, since relatively few are available in urban areas, some physicians are expected to move into rural areas. At present the plan does not involve geographic restrictions, *per se*, although the Commonwealth Minister recently announced a program whereby new medical graduates can be granted temporary provider numbers if they are prepared to undertake *locum* work in rural areas.<sup>55</sup>

Interestingly, while individual states in Australia have the power to register physicians and so could, in principle, restrict access to urban areas or otherwise direct location decisions through legislation, the Australian system embodies inter-state portability. This means that any physician currently practising in any state, has the right to practice anywhere in any other state. If Queensland, for example, were to invoke a policy of excluding its new registrants from setting up practice in Brisbane, this would not stop already registered New South Wales physicians from moving north to, and setting up practices in, Brisbane. Not surprisingly, states have not implemented such policies.

On the education front, at least one Australian medical school has recently responded to the general consensus that continuing to train physicians in large urban tertiary settings does little to increase the likelihood that graduates will be enticed by rural practice opportunities.<sup>56</sup> It opened a rural 'branch plant.' The University of Queensland, based in Brisbane, has established an affiliated North Queensland clinical school,

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55. *Ibid.*

56. See, e.g., M. Kamien & I.H. Buttfield, "Some solutions to the shortage of general practitioners in rural Australia: Part 2. Undergraduate education" (1990) 153 *Med. J. Aust.* 107.

based in Townsville, which will develop curricula and clinical exposures geared to rural area needs and practice conditions. Students from the Brisbane school have been "rostered" to the northern school since 1993.<sup>57</sup> An evaluation of the effects of this initiative is currently underway.<sup>58</sup>

What can we learn from this brief and selective international overview? Perhaps the most obvious 'lessons' come from the U.K./U.S. comparison. The U.K. has clearly been more successful in reducing geographic disparity than has the U.S. This relative success would seem to be tied to a number of key characteristics of the U.K. approach: method of payment and organization of physicians, and an administrative policy that is rather more 'directive' than anything one finds in the U.S. at present. With respect to the former, the fact that GPs (a) receive significant components of their incomes through mechanisms tied to patient roster size and (b) must receive approval of requests to set up practices in particular locations, would seem to have played a significant role in the fact that the U.K. does not currently experience serious geographic distribution problems for GPs. As for specialists, a significant component of their incomes is derived through salaried posts. These tend to be more readily available where there are greater needs. Thus specialist availability in the U.K. seems more tightly linked to population-based considerations related to needs for care than is the case in the U.S. The historical pattern in the U.S. has been that both GPs and specialists physicians can attempt to set up or join practices wherever they wish. Such choices have at times been influenced by the availability of incentives through programs such as the National Health Service Corps. It is also revealing that Australia is now in the process of implementing a national billing numbers policy, presumably because other approaches have failed to rectify the maldistribution situation in that country.

Another important 'lesson' for Canadian policy-makers is that a key characteristic of the U.K. approaches (and the recent Australian billing numbers initiative) is that they have been *national* initiatives employed in an environment where the option for U.K. physicians to move to other countries to practice has not been all that attractive. The implication would seem to be that provincial go-it-alone initiatives, even regulatory/administrative strategies, may fail so long as not all provinces are 'on board;' even then, physicians may choose the U.S. as an alternative place to practice medicine, although recent reforms in that country may make migration south less attractive for Canadian physicians.

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57. P.R. Mudge, "A clinical school for north Queensland" (1993) 159 Med. J. Aust. 501.

58. Personal communication with Dr. Peter Mudge (Clinical Dean, North Queensland Clinical School, The University of Queensland) (May 1997).

In comparison with these four OECD countries, Canadian provinces appear to have employed a remarkably rich and inventive collection of approaches to the problem. While they have been largely dominated by traditional financial incentives tied to reimbursement through fees-for-service, the recent use of educational approaches appears to offer some promise, in light of the research on what factors most influence physicians' location decisions. It seems apparent that laissez-faire methods do not solve distribution problems, even in the long term. Considering what is known about choice of location, the reliance of provincial governments upon financial incentives that subsidize fees-for-service has had rather predictable effects. There is no experience from these other jurisdictions with disincentive schemes such as differential fees. With the possible exception of the Québec experience, the evidence from Canadian provinces suggests that these, too, are unlikely to be particularly effective unless they are unreasonably punitive.

The Yukon, the Northwest Territories, some provinces and the U.S. employ at least two other options for addressing problems with geographic distribution. The territories have implemented a system that makes ample use of non-physician practitioners, such as extended duty nurses and nurse practitioners. In some situations the Territories, along with provinces such as Newfoundland, have developed a variety of salaried and contract arrangements with physicians prepared to locate in, or service, rural or remote regions. The U.S. has been employing non-physician providers (physician assistants, nurse practitioners, midwives, nurse-anaesthetists) for at least 25 years, and the increasing adoption of such practitioners by HMOs as well as in the Medically Underserved Areas may indicate their broader potential in Canada. Alberta and Ontario have recently moved to introduce nurse practitioners, and midwifery has arrived or is coming in Ontario, B.C., Manitoba and Québec. By and large, however, substitution appears to remain a strategy of last resort for provincial governments, in large part, one has to presume, because of continued resistance from the medical profession.

### *III. Recent Legal Challenges to Physician Geographic Distribution Policies*

#### *1. British Columbia*

Physician supply management policies with geographical distribution objectives have been or are currently under challenge in the courts of two Canadian provinces. In British Columbia, the Medical Services Commission (composed of representatives from the B.C. Medical Association, the provincial Ministry of Health, and the public) adopted its "Permanent



Physician Supply Measures” (PSM) in October 1996. These measures consisted of regulatory/administrative financial incentives to encourage physicians to locate in relatively less well-supplied regions of the province. The major incentive within the PSM was a graduated set of differential fees, prorated on a regional and specialty-specific basis.<sup>59</sup> The PSM were rooted in a Physician Supply Plan which determined, on a semi-annual basis, whether each region was “under, adequately, or oversupplied with physicians in each specialty.”<sup>60</sup> Physicians who set up new practices in specialty/region combinations which were considered over-supplied would receive only 50% of the usual negotiated fees; those in adequately served areas would receive 75%. Practices in under-served or isolated regions (which were few and declining)<sup>61</sup> were eligible for at least 100% and up to 120% of negotiated fees, depending on points assigned to the region through the Northern and Isolation Allowance (NIA) program.

An important feature of the PSM was that new physicians would accumulate points in proportion to their fee-for-service billings (20 points per year for a full-time-equivalent practice) and once a physician had accumulated 100 points, (s)he would no longer be subjected to the fee proration, regardless of where, or in what specialty, (s)he chose to practice. Physicians already in practice in 1994,<sup>62</sup> as well as U.B.C. medical students and interns and residents who were in training (or accepted into training) as of June 30, 1995, were exempted from the provisions of the Plan. Also, physicians taking up *locum tenens* arrangements with “grandfathered” physicians were able to amass the 20 points per year, while practising in non-prorated regions.

In September 1996, adjustments were made to the PSM which had the effect of requiring any physician wishing to move to a NIA-eligible community first to receive “written confirmation of community support” in order to gain a 100% billing number and eligibility for the NIA bonus. “Community support” was defined as either the existence of a hospital physician workforce plan, which would presumably indicate whether the additional physician was needed, or “[s]upport of senior local govern-

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59. B.C. Medical Association, *British Columbia Physician Supply Plan* (Victoria: Medical Services Commission of British Columbia, 1996).

60. See B.C. Medical Services Commission, *Minute 96-0015* (Victoria: Medical Services Commission of British Columbia, 1996) at 10.

61. By 1996, there were no regions in the province in which a new physician not trained in B.C. and wishing to undertake general or family practice, would have been eligible for 100% fees.

62. At which point the predecessor “Interim Physician Supply Measures” took effect.

ment official [sic] *and local physicians*.”<sup>63</sup> This seemed curious at the time, since the NIA program is intended to attract physicians to relatively underserved areas, whereas these adjustments appeared to undermine that process. If a community is “underserved,” on what grounds might such a community not support a new physician? It appeared to be a thinly veiled attempt to permit physicians already in those areas to balance their needs for necessary support and relief, against their “need” for NIA-points-eligibility.<sup>64</sup>

In August 1995, an action was brought against the B.C. Medical Services Commission and the Attorney General’s Office of B.C. by a young female physician (Deborah Waldman) and two others who had been affected by the policy. The Professional Association of Residents — B.C. (PAR-BC) intervened on behalf of the petitioners, while the B.C. Medical Association intervened in support of the respondents.

The petitioners sought judicial review of the PSM and future scheduled modifications. They alleged that:

1. The PSM exceeded the jurisdiction of the Medical Services Commission under B.C.’s *Medicare Protection Act*,<sup>65</sup>
2. The PSM violated certain conditions of the *Canada Health Act*,<sup>66</sup> specifically the requirement that any provincial medical insurance program must “provide for reasonable compensation for all insured health services rendered by medical practitioners.”
3. The PSM infringed their rights as guaranteed under the *Canadian Charter of Rights and Freedoms*, and more specifically the rights described in s. 6 (mobility rights); s. 7 (rights to life, liberty and security of the person); and s. 15 (equality rights).
4. Any such infringements were not “reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society,” as required under s. 1 of the *Charter*;

The case of *Waldman v. British Columbia (Medical Services Commission)*<sup>67</sup> was heard in 1996, and a decision was filed in the Supreme Court of B.C. on June 30, 1997. This decision may have important conse-

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63. See British Columbia, *British Columbia Physician Supply Plan* (31 October 1996) (Unpublished, appears as Exhibit “R” of Affidavit of Dr. Lorne Verhulst in Supreme Court of B.C. (*Waldman v. British Columbia (Medical Services Commission)*) (1997), 150 D.L.R. (4th) 405) [hereinafter *Waldman*], Appendix A at 5 [emphasis added].

64. R. Hanvelt & D. Schneider, *Comment on the Implementation of the British Columbia Permanent Physician Supply Measures* (December 1996) [unpublished].

65. S.B.C. 1992, c. 76; now R.S.B.C. 1996, c. 286.

66. R.S.C. 1985, c. c-6.

67. *Supra* note 63.

quences for the future range of Canadian provincial policy options in this arena, and possibly for the policy currently under legal challenge in New Brunswick.

In her decision, Madame Justice Levine first considered whether the PSM exceeded the administrative jurisdiction provided to the Medical Services Commission (MSC) through the province's *Medicare Protection Act*.<sup>68</sup> The petitioners argued that the central role played by the B.C. Medical Association in the development of the PSM revealed that the true intent of the PSM was to protect the incomes of already-practising physicians in the province. If such had been found to be the case, this would have constituted an improper purpose beyond the powers of the MSC under the Act. The respondents countered that the intent of the PSM was clearly set out in the preamble to Commission Minute 96-0015, viz "to ensure more equitable access to medical services and more equitable distribution of physician resources based on population needs and to assist in the better management of the provincial health care budget."<sup>69</sup> The respondents argued that this purpose was clearly within the powers granted to the Commission through the Act. The Court agreed with the respondents' characterization of the intent of the PSM, and affirmed that their purpose did not fall outside the ambit of the Act. Briefly, the measures were found not to prevent the petitioners from practising medicine in the province (which would, the petitioners argued, have exceeded the powers granted under the Act). Furthermore, the establishment of different categories of practitioners<sup>70</sup> for the purposes of creating different rates of remuneration was found to be within the authority given to the Commission under the Act.

While Levine J. determined that the PSM discriminate in an administrative sense "between resident and non-resident physicians,"<sup>71</sup> she concluded that the *Medicare Protection Act*<sup>72</sup> provides the necessary authority to do so.<sup>73</sup> But it did not provide, in her view, the explicit authority to discriminate in this manner retroactively. The necessary authority to discriminate is embodied in s. 4(1)(r.1) of the Act, which was added to the *Medicare Protection Act* through an amendment passed into

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68. *Supra* note 65.

69. As cited in *Waldman*, *supra* note 63 at 437.

70. There were 13 categories set out in *Minute 96-0015*, *supra* note 60. For example, any physician active in B.C. as of February 1994 fell into a "grandfathered" category 3.10; those "new billers" who chose to practice in areas designated as "oversupplied," category 3.3, were to be granted 50% billing numbers; and various other categories provided for exemptions to 50% and 75% billing number designations.

71. *Waldman*, *supra* note 63 at 446 & 448.

72. R.S.B.C. 1996, c. 286.

73. *Waldman*, *supra* note 63 at 450.

law on July 14, 1995.<sup>74</sup> Since the section contains nothing explicit about retroactivity, and since the petitioners had all applied for, and been denied, 100% billing numbers prior to that date, Levine J. concluded that the statute did not provide the authority for the Commission to establish different categories of petitioners with “retroactive effect.”<sup>75</sup> This was sufficient to render the PSM “invalid,” both with respect to the applications of the three petitioners specifically, and with respect to any practitioners who had been affected by what were, in effect, retroactive decisions of this nature.

Levine J.’s decision could have ended there, as this was sufficient to dispose of the case before her. However, in light of the fact that both parties had asked her to consider the full range of issues “in the expectation that my decision may be reviewed on appeal and that the court of appeal may disagree with my decision thus far,”<sup>76</sup> she provided a comprehensive analysis and series of obiter remarks on matters arising from challenges based on the *Canada Health Act* and the *Canadian Charter of Rights and Freedoms*.<sup>77</sup> We do not intend to precis the entire judgment. Rather, we focus primarily on the other components of the petitioners’ claims that were supported in the judgment. It is these that hold the key to future policy options, assuming they survive any appeal process.

The petitioners claimed that the PSM violated s. 12(1)(c) of the *Canada Health Act*, specifically the requirement that the Medical Services Plan “provide for reasonable compensation for all insured health services rendered by medical practitioners.” The issues here were (a) whether 50% fees could be considered “reasonable compensation;” and (b) whether the PSM violated the Act if the petitioners were not, in fact, restricted to situations involving 50% fees.<sup>78</sup> On the former matter, Levine J. used evidence provided by a private accounting firm, which indicated that standard practice overhead costs ranged from 42-44% of gross, to conclude that 50% (gross) fees could not in any way be

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74. *Health Statutes Amendment Act, 1995*, S.B.C. 1995, c. 52.

75. *Waldman*, *supra* note 63 at 456. The key here was that other parts of the Act were explicit about retroactivity. For example, s. 21(5) states that “The Commission may act retroactively under this section to....” Since the power to discriminate was embodied in s. 4(1)(r.1), and since that section was *not* explicit about retroactivity, Levine J. concluded that retroactivity was not intended, or rather that this section could not be construed as providing the authority to the Commission to act retroactively in this respect.

76. *Ibid.* at 458.

77. Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11.

78. Indeed, at the time, none of the petitioners was actually working for 50% fees. One had a 100% fee hospital post; the other two were in *locum tenens* situations in urban centres.

considered “reasonable compensation.”<sup>79</sup> She also found that the Master and Working Agreements between the BCMA and the MSC violated s.12(2) of the *Canada Health Act*.<sup>80</sup> On the latter issue, she regarded the respondents’ claim that the intent is to provide reasonable compensation for all medically necessary services, but not necessarily for all medical practitioners as “strain[ing] the purpose and the words of the Act beyond any sensible meaning.”<sup>81</sup> Because s. 4(2) of the *Medicare Protection Act* requires that the Commission’s actions be governed by the criteria set out in the *Canada Health Act*, she concluded that the Commission had exceeded its jurisdiction by failing to provide reasonable compensation under the Plan.<sup>82</sup>

With respect to the *Charter* challenges, the petitioners claimed that the PSM violated their rights under ss. 6, 7 and 15 of the *Charter*. Section 6(2)(b) of the *Charter* guarantees that “[e]very citizen of Canada and every person who has the status of a permanent resident of Canada has the right to pursue the gaining of a livelihood in any province.” Levine J. determined that the PSM violated this section insofar as “restrictions to earning their livelihood imposed on physicians coming into the province from other provinces ... *prima facie* violate their rights under section 6(2)(b).”<sup>83</sup> In particular, the PSM provided explicit exemptions to “new billers” trained or in training in B.C. at a specified point in time during 1995, thereby disadvantaging “new billers” from outside B.C. relative to “new billers” in B.C.<sup>84</sup>

The exemptions provided by the MSC’s permanent measures applied to residents in training in B.C. at a particular point in time, or individuals who were about to enter medical school in the province as of a particular point in time. Eventually there would no longer be anyone left in those

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79. It is interesting that elsewhere in her judgment, Levine J. notes that one of the petitioners (Waldman) was in a *locum* situation where she was receiving 60% of gross fees. If overhead costs are indeed 42-44%, it is difficult to understand why a practitioner would hire a *locum tenens* under a 60% arrangement, since simple arithmetic would suggest that the practitioner who owns the practice would be losing money in such circumstances. There is considerable dispute among ‘students’ of physician overhead costs, about what constitutes reasonable and necessary practice overhead. It is quite possible that 42-44% overstates true overhead, perhaps by a substantial amount. Nevertheless, it still seems defensible to these observers to conclude that 50% fees are not “reasonable compensation.”

80. The s. 12(2) violations related to such matters as the absence of a mechanism for binding arbitration, and the fact that the section requires a mechanism for “settlement of disputes through conciliation or binding arbitration by a panel....”, whereas in the current B.C. agreements, a single arbitrator is specified.

81. *Waldman*, *supra* note 63 at 467.

82. *Ibid.*

83. *Ibid.* at 470.

84. *Ibid.* at 421.

exemption categories, which left open the question of whether, at that point, the PSM would still violate s. 6(2)(b) of the *Charter*. Levine J. concluded that they would still do so, because new non-B.C. physicians would still not have the same opportunities to gain a livelihood as at least some B.C. physicians.

Levine J.'s reasoning appears to get a bit tangled through reference to the fact that a majority of "new billers" would be from outside B.C.<sup>85</sup> This seems to imply that had B.C. (like Ontario) been a net exporter of "new billers," the PSM would not violate s. 6(2)(b) after the grandfathering of B.C.-trained "new billers" had expired. This seems inconsistent with the idea that the key matter to be considered is not whether there is equal treatment of resident and non-resident "new billers" (which there would be), but rather whether there is equal treatment of all residents and non-residents (which there would not be, since all non-new-biller residents are grandfathered).

The problem becomes even more complicated, since s. 6(2)(b) of the *Charter* can be overridden under s. 6(3)(a) by laws of the province, so long as such laws do not "discriminate among persons primarily on the basis of province of present or previous residence." In concluding that the permanent PSM violate s. 6(3)(a), Levine J. noted that the measures "will nevertheless continue to distinguish principally on the basis of province of present or previous residence,"<sup>86</sup> because most new billers wishing to set up practice in B.C. will be non-residents of B.C. Extending this logic, one might conclude that the constitutionality of a policy such as the PSM depends on whether physicians from outside a province attempt to set up practice in the province. This could vary from province to province, and from year to year, and seems a rather fragile basis for determining that this section of the *Charter* is violated by such a policy. In particular, were this policy to have been enacted in Ontario or Québec, where the majority of "new billers" would presumably be Ontario or Québec residents, on this interpretation s. 6(3)(a) would not be violated. Surely this is not what was intended. Either the *Charter* s. 6 requires that residents and non-residents be treated equally, or it does not. If it does, then why would it matter whether there was 1, or a majority of, new billers coming from outside a given province?

Levine J. found that the PSM did not violate the petitioners' rights under s. 7 of the *Charter* (life, liberty and security of the person). Briefly stated, Levine J. considered herself bound by jurisprudence subsequent

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85. *Ibid.* at 471.

86. *Ibid.* at 473.

and contrary to the 1980's B.C. judgments in the *Mia*<sup>87</sup> and *Wilson*<sup>88</sup> cases. In particular, the Supreme Court of Canada's decision in the "Soliciting Reference"<sup>89</sup> led Levine J. to conclude that "section 7 does not protect the right of a person to practise a profession."<sup>90</sup> Once that conclusion was reached, it became unnecessary to further consider s. 7, since the petitioners' claims of violation of "liberty" pertained only to the alleged right to practice their profession.

The claims with respect to s. 15 (equality rights) were that the PSM discriminated on the basis of age and province of previous residence (in the case of all petitioners), and sex and religion in the case of Waldman. Levine J. found against the petitioners on the age, sex and religion grounds, but in their favour on grounds of previous residence,<sup>91</sup> which she concluded was "an analogous ground" under s.15.<sup>92</sup>

The remainder of the judgment dealt with whether the violations of ss.6 and 15 could be construed as "reasonable limits demonstrably justified in a free and democratic society" under s. 1 of the *Charter*. The key considerations in attempting to satisfy this test are whether the limits were imposed in the pursuit of objectives of "sufficient importance" bearing on a "pressing and substantial concern," and whether the means chosen (in this case the PSM) were "proportional and appropriate to the ends."<sup>93</sup> Levine J. found that the objectives (maintaining or improving the

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87. *Mia v. British Columbia (Medical Services Commission)* (1985), 17 D.L.R. (4th) 385 (B.C.S.C.).

88. *Wilson v. British Columbia (Medical Services Commission)* (1988) 53 D.L.R. (4th) 171 (B.C.C.A.).

89. *Reference re: ss. 193 and 195.1(1)(c) of the Criminal Code*, [1990] 1 S.C.R. 1123.

90. *Waldman*, *supra* note 63 at 481.

91. *Ibid.* at 490.

92. *Ibid.* at 493. Again this conclusion, like that on s. 6(3)(a), appears to be based largely on the fact of the distribution of source of new physicians in B.C. Had B.C. been a province that imported no new physicians from other provinces or countries, it seems possible, on the reasoning here, that Levine J. would have found no violation of s. 15. She states, at 494: "In this case, the Commission clearly had in mind the effect of the measures on out-of-province physicians and enacted the measures with the intention of limiting their entry into the medical care system for B.C." But what if a province has no medical school, in which case *any* new biller would be from out of province if one equates location of training with location of residence? And what of provinces most of whose new physicians are trained 'at home'? The implication seems to be, again, that an identical policy, enacted in different provinces, could be evaluated differently with respect to s. 15. Our interpretation is that the s. 6 and 15 violations are synonymous, in the sense that if Levine J. had found in favour of the respondents on s. 6, she would have similarly found in favour on s. 15, and vice versa. The grounds on which the PSM were found to violate each section are likely, in the end, to be indistinguishable to most observers outside the legal profession, despite the fact that in the former case the issue was "mobility" and in the latter it was "equality." In both cases, it came down to whether all physicians had 'equal mobility.'

93. This test was originally formulated in *R. v. Oakes*, [1986] 1 S.C.R. 103.

quality of health care provided to the residents of B.C., and managing or controlling health care sector costs) were “pressing and substantial.”<sup>94</sup> However, she was persuaded by the analysis of economist Robin Hanvelt, in which he argued that the PSM were unlikely to reduce supply, improve geographic distribution, or help control health care costs.<sup>95</sup> Particularly significant were the facts that most physicians confronted with the PSM choice were opting for *locums*, and that there were no regions where new general practitioners could be granted 100% billing numbers. This seemed rather likely to vitiate any effects of the PSM on geographic distribution, or on overall costs. Also troublesome was the apparent contradiction between identifying regions with established needs, and entitling existing physicians in those regions to determine whether a new physician would be accepted.<sup>96</sup> Indeed, Levine J. was rather explicit about this: “The measures are in fact contradictory to the stated objective.”<sup>97</sup> In addition, she determined that the infringement of the petitioners’ mobility and equality rights did not meet the minimal impairment standard under s. 1. Thus, the PSM failed the proportionality branch of the “*Oakes test*.”

In summary, Levine J. found that the PSM exceeded the jurisdiction of the MSC under the *Medicare Protection Act*, went beyond the province’s authority because the measures conflicted with the federal *Canada Health Act*, and also violated petitioners’ rights under ss. 6 and 15 of the *Charter* in ways that were not justifiable under s.1 of the *Charter*.

## 2. *New Brunswick*

The other recent challenge to a provincial regime was brought against New Brunswick’s “Physician Resource Management Plan” (the Plan). The Plan was established in 1992, and one of its key objectives was to attempt to encourage physicians establishing new practices in the province to do so in regions with relatively greater needs for physicians. The Plan established target population: physician ratios for each specialty (and for general practitioners) for the year 2000-2001, and assigned to regional hospital corporations the responsibility of ensuring that new physicians were permitted to establish practices only if doing so would

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94. *Waldman*, *supra* note 63 at 497.

95. R. Hanvelt, “A Review of the British Columbia Medical Services Commission’s Permanent Physician Supply Measures,” expert report prepared for the petitioners in *Waldman*.

96. R. Hanvelt and D. Schneider, 1996.

97. *Waldman*, *supra* note 63 at 501.



keep the region within the full-time-equivalent interim supply target for the year, region, and specialty in question.<sup>98</sup>

Unlike the situation in British Columbia, where physicians *could* establish practices wherever they wished if they were prepared to work for 50% or 75% fees, New Brunswick physicians who are not granted privileges by the regional hospital corporations cannot establish practices (or rather can establish practices only if they are prepared to receive 0% fees from the provincial medical plan and practice without hospital privileges).<sup>99</sup> Furthermore, any corporation that permits the addition of physicians not approved by the Department of Health faces quite punitive disincentives: a corporation that grants unauthorized privileges to a physician, where doing so has the effect of taking the region over target for the specialty, is responsible for bearing the cost of that physician's fee-for-service billings to the Medicare Branch.<sup>100</sup>

The action in this case was brought by four physicians and the Professional Association of Residents and Interns – Maritime Provinces. The petitioners claim that the restriction of billing numbers, the placement of regional and specialty quotas on full-time-equivalent physicians, combined with restrictions on the privileges hospital corporations may grant, and the refusal to reimburse for services delivered by a physician without a billing number, violate the *Charter's* freedom of association (s.2), the right to pursue the gaining of a livelihood in the province of New Brunswick (s. 6), rights to liberty and security of person (s. 7), and sex equality (s. 15). The equality argument is based on the fact that the current supply of physicians in urban centres is male-dominated, and the Plan has the effect (if not the intent) of perpetuating that situation just as the supply of new physicians entering practice has become more 'gender-balanced.'

While our interpretation of the litigation is that it is firmly rooted in the above alleged *Charter* violations, the plaintiffs are also claiming that the Plan violates the "comprehensiveness" and "accessibility" provisions of the *Canada Health Act*.<sup>101</sup> This case is scheduled to be before the courts some time in 1998. Various experts, the plaintiffs, and Department of Health officials have been examined during the past two years.<sup>102</sup>

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98. New Brunswick, *Physician Resource Management: A Plan for New Brunswick* (Fredericton: Department of Health and Community Services, 1992).

99. The patient who received services from such a physician would also not be eligible for reimbursement of out-of-pocket expenses.

100. New Brunswick, *Policy and Procedures: Physician Resource Management*, rev. ed. (Fredericton: Department of Health and Community Services, 1994).

101. R.S.C. 1985, c. c-6.

102. One of us (M.L.B.) served as a consultant to the New Brunswick Department of Health in this respect.

#### IV. *Implications and Options*

These B.C. and New Brunswick cases are interesting in a number of respects. The *Waldman* judgment would appear to pose significant challenges for the respondents in the current New Brunswick action. The policies are not identical, but there would appear to be some significant similarities. If the New Brunswick courts also find in favour of the petitioners, it is likely to send a clear signal about the range of potential policy interventions that will be tolerated by Canadian courts. This in turn will limit the potential of Canadian policy makers to take advantage of international experience.

We offer some brief thoughts here on the applicability of the approach taken in *Waldman* to the New Brunswick action.<sup>103</sup> With respect to the *Canada Health Act*, there would seem to be a key difference in the two situations. Under the B.C. PSM, physicians were faced with being reimbursed at 50% fees if they chose to practice in over-supplied areas. In such a situation, they would be providing “medically necessary” services as defined under that Act, but would not be receiving reasonable compensation. Under the New Brunswick policy, positions are simply not available in certain regions and specialties, so arguably no “medically necessary” services would be provided by physicians who choose not to practice in regions with available positions.<sup>104</sup> Under such circumstances, it may be that the court will determine that the issue of “reasonable compensation” simply does not arise, particularly if there are other regions in which the practitioners in question *could* receive hospital, and therefore billing, privileges.<sup>105</sup>

The *Charter* issues seem more problematic, although again there are some key, perhaps determinative, differences between the two policies. The B.C. PSM created a clear distinction between new billers and already-practising physicians. The latter were free to move without restriction within the province for the purposes of practising medicine.

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103. Bearing in mind that neither of the authors claims any legal expertise, and that if past experience is any guide, one would not wish to bet too heavily on the judgment in *Waldman* guiding the judgment in the New Brunswick case.

104. Presumably a physician could choose to practise outside the provincial plan and so without access to hospital services. In such a case patients would presumably offer reasonable compensation, or else the services would likely not be provided. But see note 105.

105. One might speculate that the petitioners will argue that what they are being offered in those situations is 0% fees (because they would not be eligible for compensation from the New Brunswick medical care plan, and they would be unlikely to find patients willing to pay out of pocket, particularly in light of the fact that these will be regions which are already deemed oversupplied). However, if no services are being, or are likely to be, provided by new billers in the regions in question, then it seems unlikely that a “reasonable compensation” argument under the *Canada Health Act* could be sustained.

The New Brunswick Plan, in contrast, applies restrictions equally to all physicians, in the sense that established physicians practising in one region of New Brunswick are not free to take up and re-establish their practice in other areas, unless those areas are under their physician: population target ratios for the specialty in question at the time of application. In this important sense, the Plan makes no distinction by province of residence in the application of the policies and procedures.

Even under the New Brunswick Plan the playing field is not level, however, because older physicians will have had prior access to the more desirable practice locations. While all new entrants, in any field, face restricted opportunities relative to those with already established jobs or practices, the petitioners will undoubtedly argue that they should be afforded equal opportunity to provide services wherever they feel they can establish a successful practice, because they are independent practitioners and not employees of the state.

With respect to mobility rights, New Brunswick has no medical school; all new entrants will be non-residents as defined by Madame Justice Levine. Although all physicians face a restricted range of potential practice settings under the Plan, those already in practice in New Brunswick will have included in their restricted range the locations in which they already practice (many of which may not be available to the new entrants). Therefore, new entrants will experience more restricted choices than resident physicians. In light of the *Waldman* judgment, it seems possible that the New Brunswick court could find that the Plan violates mobility rights of new entrants, even though all physicians, residents and non-residents alike, are faced with the same rules. Or, put another way, were Levine J. to be presiding over the New Brunswick case, we do not believe that she would rule differently on s. 6 in New Brunswick than she did in B.C. But of course the judge, the petitioners, the respondents, and the details, will all be different, and there seems little to be gained from this sort of speculation.

As for equality rights guaranteed under s. 15, the key here will be the specific bases on which the petitioners allege discrimination. To the best of our knowledge, the only specified ground at this time is "sex," the argument being that new entrants are, relative to established practitioners, disproportionately female, and so new female entrants are being denied equal access to desirable practice locations. In light of the very similar circumstances in front of Levine J., it seems unlikely that the Plan would be found to violate the petitioners' rights on the basis of sex. If the New Brunswick court is asked to determine whether the Plan discriminates on the "analogous ground" of province of residence, the situation will be one in which *all* new billers will, by definition, be coming from

outside New Brunswick and so be deemed non-residents. If the same line of argument as was used by Levine J. were then to be followed by the New Brunswick courts, again it seems conceivable that the Plan could be found to violate the petitioners' rights under s. 15 of the *Charter*.

It is well beyond the scope of this paper to speculate on the likely outcome of any attempted s. 1 justification for any alleged *Charter* violations. The challenges for the province of New Brunswick, as in B.C., will be to demonstrate the importance of the objectives, and then that the Plan passes the test of proportionality. Key to this would be a demonstration that the Plan (which will have had a number of years to run) is meeting those objectives. If it is not, then it may well fail to show the requisite rational connection between the means and the objective. Even if a rational connection is proved, it will still be up to the province to demonstrate that other, less intrusive, means of achieving those same ends could not have been developed.

What does seem beyond debate is that any provincial or territorial policy that can be seen as restricting any aspect of free choice of practice location will be subject to challenge until, or unless, the legal landscape is brought into sharper focus. The recent B.C. judgment begins to provide some clarity; the New Brunswick case promises to elucidate matters even further.

This leaves open the issue of what options for improving geographic distribution might remain. Leaving aside a divergent outcome from the New Brunswick action, our analysis above suggests that, were B.C. to wish to take another run at a regulatory/administrative approach, it would need to satisfy, *inter alia*, the following conditions:

1. either the policies should not be applied retroactively, or the *Medicare Protection Act* would need to be amended to make explicit the retroactive scope of the intended measures;
2. unless the gradations are much finer (e.g., 90%, 80%) a differential fees approach is likely to run afoul of the *Canada Health Act* (although, interestingly, the 70% fees in Québec have been in place for years). Depending on the outcome of the New Brunswick action, it may be more productive to develop another true billing numbers policy in which billing numbers either are, or are not, available;
3. any new initiative must not discriminate against new entrants from outside the province and must be less overtly protective of members of the BCMA. The fact that the PSM policy had the effect (even if Levine J. was satisfied that it was not the primary intent of the MSC) of protecting the incomes of established physicians at the

expense of new entrants, left it clearly vulnerable to s. 6 and s.15 challenges.

In the end it may simply not be worth taking this route. Indeed, if the New Brunswick government also comes out on the losing end of that action, we would be left in a situation where

1. the courts inside our borders seem disinclined to permit any regulatory/administrative intervention that has the effect of disadvantaging new entrants on the basis of their province of residence;
2. evidence from outside our borders suggests that the policies that have been found to be most effective embody some restrictions in choice for new entrants, and/or different (non-fee-for-service) approaches to paying for physician services;
3. evidence from within our borders suggests that policies based largely on financial incentives tacked onto fee-for-service reimbursement are relatively ineffective (the Québec differential fees evidence notwithstanding);
4. evidence from provinces such as Alberta suggests that even complex and comprehensive mixes of policies which attempt to span the physician life-cycle have, to date, not achieved the results that their architects might have hoped;<sup>106</sup>
5. most provincial medical associations continue to resist fundamental changes to the way the services of physicians are organized and reimbursed; and
6. most physicians resist inroads into their 'scopes of practice' by fully-qualified alternative personnel.

Decisions such as *Waldman* would then appear to leave policy-makers caught firmly between the proverbial rock and hard place. For example, if the New Brunswick policy is overturned, could one infer that the courts would also not allow a province to attempt to solve the geographic distribution problem by doing away with fees-for-service, replacing them with salaried posts, and making those posts available only where there are established needs? In such a situation, one could argue that new entrants (all non-residents) would be disadvantaged relative to physicians already in place unless one adopted a "zero base" approach in which everyone, new and experienced physicians alike, had to apply for the new positions. Did the *Charter* intend to imply that one must disrupt long-established

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106. For a description of the policy scope across the life-cycle, see G.L. Stoddart & M.L. Barer, "Toward integrated medical resource policies for Canada: 3. Analytic framework for policy development" (1992) 146 Can. Med. Assoc. J. 1173; the comprehensive Alberta approach is described in C.A. MacDonald and Associates, "Evaluation of the Rural Physician Action Plan" (Prepared for Alberta Health, February 1996) [unpublished].

professional practices and financial, personal, and patient commitments already in place, in order to be found not in violation of inter-provincial mobility rights? Any other approach to this problem necessarily involves some measure of grandfathering, and in many provinces the "grandfathered" physicians will be residents and the new entrants will be disproportionately non-residents.<sup>107</sup>

The two policies (B.C. and New Brunswick) differentially affect new physicians attempting to establish practices, although in so doing, they do not create situations much different than those that are faced by most new job-market entrants in most other fields of endeavour. If both ultimately fail to pass judicial scrutiny, the big 'losers' may be the "grandfathered" members of the profession. If policy levers such as differential fees and billing number restrictions are found to violate *Charter* rights, and cannot be saved under s.1, provincial departments of health are likely to move more forcefully and swiftly toward broader, more sweeping, organizational and financial reform. Initiatives under such circumstances might include the revamping of primary care organization and payment, more liberal regulations governing the scopes of practice of non-physician providers such as nurse practitioners, and even the embodiment of budgets for medical care within regional funding structures in an effort to have funding for medical care follow patients rather than providers. Some observers (ourselves included) would suggest that such reforms are long overdue in any case.<sup>108</sup> If this comes to pass, then some of the international approaches reviewed earlier in this paper, as well as others, may yet offer important insights.

If the New Brunswick action is unsuccessful and that province's Plan stands, we would expect to see more provinces (including British Colum-

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107. Indeed, physicians with already-established practices would find themselves at a clear advantage relative to new entrants even under a scheme that adopted the capitation-based payment aspect of the U.K. approach to primary care funding. The difference, in the eyes of the courts, would presumably be that new entrants are not barred from attempting to establish practices. But the effects, on the ground, might be not that much different, and so one could even speculate, hard as it may be to believe, that the effects in the courts might also not be that much different!

108. A detailed description of what these options entail is well beyond the scope or intent of the present paper. Discussion of some of these ideas can be found in the recent report of the National Forum on Health (National Forum on Health, *Canada Health Action: Building on the Legacy*, vols I & II (Ottawa: National Forum on Health, 1997)), and one possible model for primary care reform is described in Federal/Provincial/Territorial Advisory Committee on Health Services, *The Victoria Report on Physician Remuneration: A model for the reorganization of primary care and the introduction of population-based funding: A discussion document* (Victoria: The Committee, 1995).

bia) attempt to design policies with similar features for improving access to physician services for rural, remote and other underserved populations, in part because they would require less immediate and direct conflict with the established members of the medical profession than would the more fundamental reforms noted above. Indeed, it would then not be beyond the realm of possibility that we might see a pan-provincial/territorial policy, such as that recently established in Australia, emerge from the chaos. Whether such initiatives would improve access for those populations truly in need and would do so more efficiently and equitably than the other more fundamental reforms noted above, remains a critical outstanding question, and one unlikely to be answered any time soon.