Article

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Some Effects of Physician Licensing Requirements on Medical Manpower Flows in Canada

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In this paper the author examines the implications of the licensing regulations of physicians in Canada.

There seems to be general agreement among economists that the medical profession, in most capitalist countries, has managed to effectively monopolize the markets for medical services. [1] In one way or another the profession has managed to limit the number of medical practitioners by control over licensing procedures and regulations. Thus it increases the average income of the remaining practitioners by moving up the demand curve for medical services and also creates an economic climate conducive to the maintenance of the monopoly. Physicians are willing to refrain from competitive behaviour, such as price cutting and advertising, because the profession restricts numbers of practitioners sufficiently to guarantee ample business for all without such behaviour.

Licensure controls can take a variety of forms. A favourite procedure of professions is to require an excessive, and increasing standard of training as time passes, for new entrants to the market. [2] This allows practitioners to obtain an increasing amount of quasi-rent on their educational investment throughout their

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* I would like to thank Professor Jan Adam for comments on the paper. He is, of course, not responsible for remaining errors.

[1] See Reuben A. KESSEL, « Price Determination in Medicine, » *Journal of Law and Economics,* vol. 1 (October, 1958) pp. 20-53 and D.S. LEES, *Economic Consequences of the Professions,* Institute of Economic Affairs, London, 1966 for general discussions of the issue. For further views of this author on the subject see Malcolm C. BROWN, « Medicare and the Medical Monopoly », *The Canadian Forum,* April, 1974, pp. 5-9.

[2] D.A. DODGE, « Occupational Wage Differentials, Occupational Licensing, and Returns to Investment in Education : An Exploratory Analysis », S. OSTRY (ed.) *Canadian Higher Education in the Seventies,* Ottawa, Information Canada, 1972, p. 147.

careers. [3] It also reduces the possibility of new practitioners engaging in competitive practices to attract clients since they are always the highest cost producers in the market. Another procedure is to vary the pass rate on the licensing evaminations according to the need (as defined by the profession) for new practitioners. [4] A final possibility is to engage in discriminatory practices with respect to foreign practitioners — for example, more stringent licensing requirements for foreigners than for locals. Discriminatory policies against immigrants are always relatively easy to defend politically and are therefore attractive to use if economic objectives can be achieved through them. [5]

The Canadian medical profession has appeared to stress the first and last methods of control more than the second. In the postwar years formal educational requirements for Canadian medical students have increased continually, with much of the increase difficult to defend in terms of guaranteeing technical competence. [6] Accompanying the increased training requirements for Canadian trained doctors has been increasingly stringent licensing regulations for immigrant doctors. [7] However, neither the licensing requirements for immigrant doctors, nor changes in them, have been homogeneous across Canada. Because of differing economic conditions the provincial medical associations — responsible for most medical policies including those on licensing [8] — have not been able to come to complete agreement on the standards to be used for evaluating immigrant doctors. The problem is that the licensing standards preferred by an organization like the Ontario Medical Association would create a severe doctor shortage if implemented in Newfoundland. Large sections of the province would have few, or no, practicing physicians with such severe barriers of entry to the market. Consequently Newfound-

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[3] *Ibid.*

[4] See Alex MAURIZI, « Occupational Licensing and the Public Interest », *Journal of Political Economy*, vol. 82, no. 2, March/April, 1974, pp. 399-413 for an analysis of the use of this technique in the United States.

[5] Immigrants have in general no way of bringing discriminatory policies to the public attention. Even if they could it is doubtful that, as a foreign group, they would get much sympathy and support. Thus, controlling supply through limiting the number of immigrant workers is a preferred technique by any occupational monopoly.

[6] D.A. DODGE, *op. cit.*, p. 155.

[7] *Canadian Medical Association Journal*, vol. 108, January 6, 1973, p. 96.

[8] Because the British North America Act makes health a provincial matter all medical policies must be implemented through provincial bodies.

land has adopted lower licensing standards than Ontario. In general, the differences in licensing regulations specified by the provincial medical associations have affected the distribution of immigrant physicians among Canadian provinces.

The variation in provincial licensing standards has apparently been a source of some difficulties for the medical profession. Dr. W.G. McClure, head of a Federation set up by the medical profession to increase uniformity in licensing requirements, has described the situation in the following way :

> This gives rise to a situation where a practitioner may practice for some years in one part of the country but not be eligible for licensure in another. However, prior to the efforts of the Federation in 1969 and 1970, a doctor registered for practice in a province was eligible to write the Medical Council of Canada examinations. With the LMCC, he or she might then apply to another province for registration. This was an embarrassment to some because all the provinces wished to accept the Medical Council's examinations as a Dominion licensing examination, yet some of the licentiates did not fulfil all the provinces' requirements for such things as internship or residency training. [9]

The difficulties appear to relate to the problem of maintaining the discriminatory practices once physicians have become landed immigrants or citizens of Canada. [10] As our later analysis will show, some immigrant doctors manage to overcome the discriminatory practices, initially settling in provinces with easy licensing requirements, and later moving to provinces with difficult entry requirements. In general, the interprovincial migration of foreign trained doctors in Canada appears to be substantially, affected by the licensing requirements across the country.

PROVINCIAL LICENSING REQUIREMENTS

Assessing differences among provinces concerning licensing regulations is difficult because much of the regulation is informal. In the final analysis an immigrant doctor may find his contacts with Canadian medical practitioners and his economic philosophy of as much importance

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[9] W.G. McCLURE, « Physician Licensing Requirements : How the FPMLA is striving for uniformity in Canada, » *Canadian Medical Association Journal*, vol. 106, April 22, 1972, p. 922.

[10] Or perhaps it is more to the point to suggest that there are difficulties in maintaining the discriminatory policies once the immigrants have become members of Canadian medical associations.

in determining his acceptability as his formal medical training. [11] The publication, *Canadian Occupations Entry Requirements, Physicians and Surgeons — CCDO Unit Group 3111,* ends its discussion of licensing requirements with the following comment :

> It should be noted that this assessment of qualifications does not confer the right to practice. Further, the granting of registration and, particularly, the granting of an Enabling Certificate to set the examination of the Medical Council of Canada rests with the provincial regulating body. [12]

Formal licensing requirements appear to be the visible tip of the iceberg. Of necessity it must be assumed that informal and formal licensing requirements are correlated concerning stringency to obtain some notion about differences in effective licensing procedures.

Licensing requirements for Canadian trained doctors have been highly standardized among the provinces, at least partly to facilitate the provincial medical associations discussing and implementing policies of mutual financial and professional interest. In each province a candidate must have his degree and one year of internship in an approved hospital. In most provinces graduates of medical schools must register with the Medical Council of Canada. Often the Medical Council exams, required to become a Licentiate of the Council (LMCC), are integrated into the training programs of the medical schools. Since Canadian trained physicians all have similar formal qualifications they are able to move among the provinces relatively easily. [13]

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[11] Medical associations continually discuss the need to evaluate the integrity, good character, and good professional conduct of potential practitioners but are quite unclear as to what this means. It is known that doctors with « socialistic inclinations » have increased difficulties in practicing medicine in Canada. See Mr. Justine Mervyn WOODS, *The Report of the Honourable Mr. Justice Mervyn Woods on Hospital Staff Appointments,* Regina, Saskatchewan, 1963. It is reasonable to assume that this also has a bearing on the licensing of immigrant doctors.

[12] Department of Manpower and Immigration, *Canadian Occupations Entry Requirements, Physicians and Surgeons — CCDO Unit Group 3111,* Ottawa (Catalogue No. ER31/12), p. 6.

It might be noted that Dr. W.G. McCLURE, *op. cit.,* ends his article with a comment in the same vein.

[13] Movement between Quebec and the rest of Canada is more difficult than other interprovincial movement because of the language problem. Quebec requires graduates from outside the province to be proficient in French. *Canadian Occupations Entry Requirements, op. cit.,* p. 3.

Licensing requirements for immigrant doctors have some similarities among the provinces. With the exception of Quebec, all the provinces prefer medical graduates from the United Kingdom, Eire, South Africa, Australia, New Zealand and the United States. They are preferred, or Category I, candidates because they come from countries with common cultural backgrounds to Canada and comparable standards in the training of doctors. Other, or Category II, candidates are graduates of all other medical schools listed by the World Health Organization. Licensing requirements are always more stringent for Category II candidates than for Category I candidates.

But the requirements for Category I candidates vary considerably among the provinces. Newfoundland, Prince Edward Island, Nova Scotia, Manitoba, Saskatchewan and Alberta have had reciprocal agreements with the General Medical Council of Great Britain whereby British doctors can practice in these provinces without any examination. Other Category I candidates are required by these provinces to pass the LMCC exams before being allowed to practice. New Brunswick's requirements are comparable to those just described. While it requires all Category I candidates to obtain the LMCC it grants interim licenses to British doctors awaiting examination. The interim licenses facilitate setting up practice considerably because they allow candidates to work while waiting to write the exams (which are scheduled only once a year) and because they give candidates ample time to assess the nature of the exams. Effectively, the Atlantic and Prairie Provinces can be defined as « easy entry » provinces for immigrant physicians. In contrast Ontario, British Columbia and Quebec are « difficult entry » provinces. None of these provinces has had a reciprocal agreement with any foreign country and each requires Category I candidates to pass the LMCC exams before being allowed to practice. The major differences among them concern their requirements for the Enabling Certificate — which the candidate must have before he can sit the exams. In Ontario a Category I candidate must show that he is licensed to practice in his home country while in British Columbia he must show that he has completed twelve months of rotating internship in a hospital approved by the provincial College of Physicians and Surgeons. Quebec grants the Enabling Certificate only to American graduates who have completed one year of internship in an approved hospital. All other Category I candidates must spend two years of internship in a Quebec hospital to obtain the Certificate. Clearly, Quebec's licensing requirements are more restrictive than those of Ontario and British Columbia.

In general, the reciprocal agreements entered into by six of the provinces facilitate entry to the market by immigrant physicians considerably. In a Brief to the Committee on the Healing Arts the Ontario College of Physicians and Surgeons indicated that Nova Scotia's reciprocity agreement led to the licensing of physicians which « our college would judge to be inferior. » [14]

THE EFFECT OF ECONOMIC CONDITIONS

The licensing requirements concerning foreign physicians are important economically because immigrant doctors constitute approximately half of Canada's annual increase in number of doctors. [15] Of the immigrant doctors about half come from the British Isles. [16] Policies which affect the inflow of doctors, particularly from Great Britain, therefore have a significant impact on Canada's supply of physicians.

Of course, not all provinces have the same relative demand for immigrant doctors. Each province's demand depend upon its own production of doctors and upon its propensity to attract doctors from, or lose doctors to, other parts of Canada. Provinces which produce a large number of doctors and/or which have attractive living conditions will have the least need, relatively, for immigrant physicians.

Producing ones own doctors appears to be a particularly effective way of eliminating the need for immigrant physicians since Canadian born physicians have a high propensity to remain in the region of birth and medical training. Professor Judek found that 87.9 percent of reporting Canadian born physicians in the Atlantic Provinces in 1962 had lived in the region before entering medical school and had remained there during their careers as doctors. [17] The respective figures were 86.4 percent for Quebec, 81.8 percent for Ontario, 77.4 percent for the Prairie Provinces and 38.8 percent for British Columbia. [18]

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[14] J.W. GROVE, *Organized Medicine in Ontario,* A Study for the Committee on the Healing Arts, Toronto, 1969, pp. 141-142.

[15] In 1970 there were 1,054 new graduates from Canadian medical schools and 1,113 immigrant doctors. In 1971 the respective numbers were 1,131 and 987. Health and Welfare Canada, *Canada Health Manpower Inventory 1972,* Ottawa, 1972, p. 63.

[16] Stanislaw JUDEK, *Medical Manpower in Canada,* Royal Commission on Health Services, Ottawa, 1964, p. 39.

[17] *Ibid.,* p. 191.

[18] *Ibid.*

The propensity of Quebec trained physicians to remain in Quebec and the large number of physicians trained in that province helps to explain why it has set up such severe licensing standards for foreign physicians. In 1971 the ratio of M.D.'s granted by Quebec universities to the increase in number of practicing physicians was 134 percent. [19] Quebec produces enough doctors to export them to other parts of Canada and to the rest of the world. [20] Under these circumstances the Quebec medical profession is little interested in having an inflow of immigrant physicians to « glut the market. »

Other than Quebec no province produces enough physicians to be self-sufficient. The ratio of M.D.'s granted to increase in number of practicing physicians in 1971 was 59 percent for Ontario, 40 percent for British Columbia, 65 percent for the Atlantic Provinces and 89 percent for the Prairies. [21] Interestingly enough, the « difficult entry » provinces are less self-sufficient than the « easy entry » provinces. Their stringent licensing requirements reflect not their domestic output of M.D.'s as much as their propensity to attract practicing physicians from the « easy entry » provinces. In turn, the Atlantic Provinces and Prairies must import physicians from outside Canada.

That Ontario and British Columbia should appear relatively attractive to physicians is not surprising. They are the highest income provinces in Canada and the most urbanized. [22]

Furthermore, for many people, they have the most congenial climatic conditions. For these reasons they attract not only physicians from the other provinces but also most other kinds of workers.

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[19] *Canada Health Manpower Inventory 1972, op. cit.*, pp. 61, 69.

[20] McGill accounts for most of the export of doctors from Quebec. Laval, Sherbrooke and Montreal, which train about 70 percent of the M.D.'s trained in Quebec, get more of their students from the province and train them in the expectation that they will practice there. *Medical Manpower in Canada, op. cit.*, p. 70.

[21] *Canada Health Manpower Inventory 1972, op. cit.*

[22] Personal income per capita in 1971 was $3,960 in Ontario, $3,713 in British Columbia, $3,403 in Alberta, $3,200 in Manitoba, $3,025 in Quebec, $2,775 in Saskatchewan, $2,608 in Nova Scotia, $2,469 in New Brunswick, $2,207 in Newfoundland and $2,188 in Prince Edward Island.

In 1970 British Columbia had 59.4 percent of its population in urban centers over 100,000 in size, Ontario had 59.4 percent, Manitoba had 53.1 percent, Quebec had 52.4 percent, Alberta had 51.6 percent, Saskatchewan had 26.0 percent and the Atlantic Provinces had 21.6 percent.

Because of the interprovincial migration of physicians Ontario and British Columbia, along with Quebec, have fewer residents per physician than any other province. In 1970 British Columbia had 613 residents per active physician while Ontario had 637 and Quebec had 681.[23] The « easy entry » provinces all had more. Manitoba had 702, Alberta had 707, Nova Scotia had 758, Saskatchewan had 817, New Brunswick had 1,104, Newfoundland had 1,109 and Prince Edward Island had 1,134.[24] Ontario, British Columbia and Quebec have stringent licensing requirements for immigrant physicians because, compared to the other provinces, they have an abundant supply of doctors .

The more stringent licensing standards of Ontario, British Columbia and Quebec may also exist because the potential for monopoly gain is greater. The expenditure on personal health care as a percent of personal income is lower in these provinces than in most others. In 1970 the ratio was 6.17 percent for British Columbia, 6.37 percent for Ontario, 6.77 percent for Manitoba, 6.88 percent for Quebec, 7.05 percent for Alberta and New Brunswick, 7.08 percent for Prince Edward Island, 7.40 percent for Nova Scotia, 7.51 percent for Saskatchewan and 7.64 percent for Newfoundland.[25] Assuming the price elasticity of demand for health care varies positively with the percent of income allocated to these services, the « difficult entry » provinces allow the medical associations more benefit from raising prices than do most of the other provinces.[26]

The data suggest that the « easy entry » provinces are not a homogeneous group anymore than are the « difficult entry » provinces. In particular, Alberta and Manitoba differ significantly from Saskatchewan and the Atlantic Provinces. They have higher incomes per capita, they are more urbanized, they have lower population to doctor ratios and they spend smaller percents of their incomes on personal health care.

The above considerations and the data on interprovincial migration of practicing physicians (Table 1) suggest the following groupings of

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23 *Canada Health Manpower Inventory 1972, op. cit.*, p. 62.

24 *Ibid.*

25 Health and Welfare Canada, *Expenditure on Personal Health Care in Canada, 1960-1971,* Ottawa, 1972, pp. 10-19.

26 For the argument to be valid under the medicare system it would have to be assumed that the provinces resist price increases, in a variety of ways, more vigorously as the percent of national output allocated to health care increases.

Canadian provinces. Quebec (I), a net exporter of practicing physicians to all other parts of Canada, is the most « difficult entry » province for immigrant physicians. Ontario and British Columbia (II), net importers of practicing physicians from all other parts of Canada, are « difficult entry » provinces for immigrant physicians. Manitoba and Alberta (III), net importers of practicing physicians from Quebec, Saskatchewan and the Atlantic Provinces but net exporters to Ontario and British Columbia, are « easy entry » provinces, at least partly because their exports exceed their imports. Finally, Saskatchewan and the Atlantic Provinces (IV), net exporters of practicing physicians to all other parts of Canada except Quebec, are « easy entry » provinces that have the greatest need for immigrant physicians. These groupings will be used in subsequent analysis.

TABLE 1

Net Migrations of Practicing Physicians, January 1, 1970 to December 30, 1972

Outflow / *Inflow*	*I*	*II*	*III*	*IV*	*Total*
I	0	297	23	50	370
II	−297	0	−140	−154	−591
III	−23	140	0	−36	81
IV	−50	154	36	0	140
Total	−370	591	−81	−140	0

SOURCE : Health and Welfare Canada, *Year to Year Mobility of Physicians Resident in Canada by Activity Status and Province of Residence, 1969-1972*, Ottawa, 1973.

LICENSING AND MIGRATION OF FOREIGN TRAINED DOCTORS

The provincial licensing regulations have affected the migration of immigrant physicians to Canada. In general, the less stringent the licensing requirements the more immigrant physicians relative to other immigrants a province gets (Table 2). Thus Ontario and British Columbia get relatively small inflows of immigrant physicians while Manitoba, the Atlantic Provinces and Saskatchewan get relatively large inflows. Quebec and Alberta are exceptions to this tendency (Table 2) but the former province's situation is easily explained. Quebec is the only low income and French speaking « difficult entry » province. Thus it attracts relatively fewer immigrants of all kinds than does Ontario or British Co-

lumbia.[27] In effect, while physician inflows are small for the province so are other immigrant inflows. The relatively small inflows of immigrant physicians to Alberta is the only migration pattern specified in Table 2 that is difficult to explain. Our previous analysis would lead us to predict that Alberta's relative inflow of immigrant physicians would be comparable to Manitoba's, although this is clearly not the case.[28]

TABLE 2

Immigration to Canada by Province of Destination, 1972 (Per Cent)

Province	*Physicians*	*Total Immigration*	*Difference*
I Quebec	15.8	15.2	0.6
II Ontario	44.9	52.3	−7.4
British Columbia	8.5	16.9	−8.4
III Manitoba	7.9	4.3	3.6
Alberta	6.6	6.9	−0.3
IV Atlantic Provinces	10.5	3.2	7.3
Saskatchewan	5.8	1.2	4.6
Total	100.0	100.0	0.0

SOURCE : Manpower and Immigration, *1972 Immigration Statistics,* Information Canada, Ottawa, 1974, Catalogue No. MP22-1/1972, pp. 8-9.

To be effective the licensing regulations must affect not only the destinations of immigrant physicians but also their subsequent movements. Table 3 indicates that they have, in some measure, been successful in achieving this latter objective. Areas III and IV import from the rest of Canada relatively more foreign trained physicians than Canadian trained physicians, the situation being more accentuated for IV than for III.[29] On the other hand, I and II import relatively fewer foreign trained physicians, the situation being more accentuated for I than for II. The

[27] In 1972 Quebec's immigration as a percent of its population was 0.31. The respective rates for Ontario and British Columbia were 0.82 and 0.90.

[28] In 1972 Alberta's immigration as a percent of its population was 0.51 while Manitoba's immigration was 0.53. In contrast, Saskatchewan's immigration was 0.17 percent and the Atlantic Provinces' was 0.19 percent.

[29] Positive entries in Table 3, reading by column, implies a relatively larger gross inflow of foreign trained physicians than Canadian trained physicians. A negative entry implies the reverse.

proportion of foreign trained doctors migrating to an area declines as the licensing standards become more stringent. [30]

TABLE 3

Variation in Migration Pattern Between Foreign Trained Physicians and Canadian Trained Physicians in Canada January 1, 1970 to December 30, 1972 (Per Cent)

Outflow / *Inflow*	*I*	*II*	*III*	*IV*	*Total*
I	0.00	−11.46*	−0.91	−0.77	−13.14
II	−4.94	0.00	−1.75	3.42	−3.27
III	−0.16	−5.37	0.00	3.80	−1.72
IV	0.24	14.07	3.82	0.00	18.14
Total	−4.86	−2.76	1.16	6.46	0.00

SOURCE : Health and Welfare Canada, *Year to Year Mobility of Physicians Resident in Canada by Activity Status and Province of Residence, 1969-1972*. Ottawa, 1973.

* From 1970 to 1972 14.68 percent of the total inter-area migration of foreign trained practicing physicians was from I to II. The respective figure for Canadian trained physicians is 26.14. The difference is −11.46.

Not only is it difficult for foreign trained physicians to enter Quebec, Ontario and British Columbia but it is also difficult for them to move among these provinces. Interprovincial migration between any two of these provinces is always relatively smaller for foreign trained physicians than it is for Canadian trained physicians. [31]

The data on gross outward migrations of physicians (the rows in Table III) bear on the licensing issue as well, although not as directly as the data on inward migration. The propensity of foreign trained physicians to leave an area relative to that of Canadian trained physicians varies inversely with the stringency of the licensing restrictions of the

[30] From 1970 to 1972 the gross inflow of foreign trained physicians as a percent of inflow of all physicians from the other 3 areas was 33.67 for I, 40.16 for II, 43.02 for III and 47.48 for IV.

[31] This observation is documented in a general way by the negative entries between I and II in Table 3. It can be documented in greater detail by developing a Table in which all 10 provinces are specified separately.

area. This would be consistent with the following explanation. Foreign trained doctors in the « easy entry » provinces are often there because of expediency. They therefore move often and into the « difficult entry » provinces whenever they are able to. In contrast, foreign doctors in the « difficult entry » provinces cannot move easily within the area and do not want to migrate to the « easy entry » provinces. They therefore move across provincial boundaries relatively little.

IMPLICATIONS FOR POLICY

In one sense the results of this paper are easy to summarize. The medical profession has implemented licensing regulations designed to affect the provincial location of foreign trained physicians. They have induced a large number of immigrant physicians to locate, and remain, in the Atlantic Provinces and in the Prairie Provinces, thus helping to alleviate the doctor shortages in these areas.

Of course, the licensing policy has not completely restricted the movement of foreign trained practicing physicians in Canada. From 1970 to 1972 Ontario gained, on net, 128 foreign trained physicians from other provinces, constituting 5.8 percent of its original supply. [32] Similarly, British Columbia gained 10.9 percent. [33] In contrast, the « easy entry » provinces lost foreign trained physicians. Over the three year period the Atlantic Provinces lost, on net, 3.9 percent of its foreign trained practicing physicians, Manitoba lost 3.7 percent and Saskatchewan lost 20.4 percent. [34] The leakage of foreign trained physicians from the Atlantic Provinces and the Prairies to Ontario and British Columbia accounts for the medical profession's continued interest in licensing regulations concerning foreign doctors. Recently the provincial medical association have been able to agree that provincial registration will no longer carry with it the right to take the exams of the Medical Council of Canada. [35] The effect of this agreement is to restrict even more the interprovincial movement of foreign trained practicing physicians.

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[32] Health and Welfare Canada, *Year to Year Mobility of Physicians Resident in Canada by Activity Status and Province of Residence, 1969-1972,* Ottawa, 1973, pp. 11-13.

[33] *Ibid.*

[34] *Ibid.*

[35] W.G. McCLURE, « Physician Licensing Requirements : How the FPMLA is striving for uniformity in Canada, » *op. cit.*, p. 922.

The implications of the licensing regulations are not so easy to summarize. Given present institutional arrangements they undoubtedly lead to a better geographic distribution of doctors than would a situation where all provinces adopt similar licensing regulations. However, they do not get at the basic problem, which is one of inadequate numbers of doctors in rural areas. Currently, only Ontario and British Columbia appear to have sufficient numbers of full time physicians [36] serving the population outside centers of 100,000 or more (which we will define as rural). [37] As of 1970 Ontario had 1 physician for every 1,109 urban residents and 1 physician for every 1,135 rural residents. [38] The respective numbers for British Columbia were 837 and 1,301. [39] While the other provinces had adequate numbers of physicians for their urban residents (compared to Ontario) they did not have adequate numbers for their rural residents. The Atlantic Provinces had 1 doctor to 1,036 residents in urban centers but only 1 doctor to 2,062 residents in rural centers. [40] Respective numbers for Quebec were 1,284 and 1,926, for Manitoba they were 1,025 and 2,000, for Saskatchewan they were 871 and 2,252 and for Alberta they were 952 and 1,663. [41] In most parts of Canada rural areas have over 1,500 residents per active physician, and this despite the discriminatory licensing practices which currently exist for foreign physicians. [42]

The problem of inadequate numbers of physicians in rural areas will only be resolved if it is tackled more directly than through provincial licensing regulations. Two obvious ways of dealing with the problem come to mind. The first would be to manipulate the fee schedule such that physicians in urban areas get paid less than those in rural areas. [43] The

[36] A full time physician is defined as one who makes $15,000 or more in a year from his fees-for-service.

[37] Admittedly, the definition of rural is inadequate since towns between 5,000 and 100,000 in size do not have the same difficulties attracting doctors as do areas that are truly rural. The definition is dependent on data availability.

[38] Health and Welfare Canada, *Earnings of Physicians in Canada, 1960-1970*, Ottawa, 1972, pp. 31, 34.

[39] *Ibid.*

[40] *Ibid.*

[41] *Ibid.*

[42] Of course, it must be remembered that the medical profession has never maintained that its licensing regulations are for the purpose of affecting the geographic distribution of physicians.

[43] Not only a two price system, but a three price or four price system, or more could be considered if economic conditions warranted it.

second would be to implement a clinic system, something like that described in the Hastings Report or the Castonguay-Nepveu Report. [44] The clinic system would automatically establish the number of physician position in each area. The clinics would then have to fill these positions, perhaps by bidding against each other for physicians in the job market. But the choice of method is beyond the scope of this paper since it would depend on the complete set of goals that are specified for health policy.

Quelques effets des règlements sur la pratique de la médecine dans la répartition des praticiens au Canada

Les économistes sont d'accord pour reconnaître que, dans la plupart des pays capitalistes, la profession médicale a agi de manière à exercer un monopole sur les marchés des services médicaux. D'une façon ou d'une autre, les membres de la profession ont cherché à limiter le nombre des praticiens en contrôlant les conditions et les règlements d'accessibilité à l'exercice de la médecine.

Le contrôle de l'autorisation de pratiquer peut revêtir plusieurs formes dont on peut retenir les trois suivantes. Une des méthodes favorites pour y arriver consiste à exiger des candidats un niveau de formation exagéré, ce qui a pour effet d'assurer aux praticiens une valorisation accrue de leurs brevets, d'empêcher les aspirants d'accéder à la pratique et de se tailler une clientèle. La deuxième méthode vise à doser la sévérité des examens en fonction des besoins. Enfin, par une troisième méthode, on discriminera les sujets étrangers par rapport aux autochtones, ce qui se défend assez bien auprès de l'opinion publique.

La profession médicale canadienne a eu tendance à recourir à la première et à la troisième méthode plutôt qu'à la seconde.

Depuis l'après-guerre, on s'est montré de plus en plus exigeant relativement à la formation scolaire des candidats à l'étude de la médecine. On a resserré les exigences requises des médecins immigrés, même si elles ne sont pas homogènes d'un bout à l'autre du pays. À cause de conditions économiques différentes, les associations provinciales de médecins n'ont pas pu s'entendre sur les critères destinés à évaluer les médecins immigrés. Par exemple, si on appliquait à Terre-Neuve les normes du Collège des médecins de l'Ontario, il s'ensuivrait une grave pénurie de médecins dans la province insulaire et d'immenses régions de la province seraient privées de praticiens. Conséquemment, les exigences sont moindres à Terre-Neuve.

Les variations de ces normes constituent une source d'embêtements pour la profession médicale. Certains médecins immigrés s'arrangent pour contourner ces

[44] « Report of the Community Health Centre Project to the Conference of Health Ministers », Ottawa, 1972. « Report of the Commission of Inquiry on Health and Social Welfare », vol. 14, *Health*, Quebec, 1970.

pratiques discriminatoires. Il s'installent d'abord dans les provinces où les exigences sont moindres et déménagent ensuite là où les règlements sont plus rigoureux.

Il est difficile de se faire une idée exacte des différences qui existent dans les normes parce que celles-ci revêtent souvent un caractère informel, la réglementation ne représentant que la pointe de l'iceberg. La conception que le médecin immigré se fait de la vie médicale pèse autant sinon plus que sa formation professionnelle. Il est certain que les médecins à tendance socialiste ont plus de difficultés que les autres à se faire admettre à la pratique.

Les conditions requises pour obtenir l'autorisation de pratiquer ont été uniformisées de façon à faciliter la mise en place de politiques d'intérêt professionnel. Dans chacune des provinces l'aspirant doit détenir une licence en médecine et avoir fait une année d'internat dans un hôpital agréé. De même, les écoles de médecine doivent être agréées par le Conseil médical du Canada. Par conséquent, étant donné que les médecins formés au Canada possèdent des qualifications similaires, ils peuvent facilement passer d'une province à l'autre.

Les exigences requises des médecins immigrés sont à peu près les mêmes dans les différentes provinces et, à l'exception du Québec, toutes les provinces préfèrent les médecins originaires du Royaume-Uni, de l'Irlande, de l'Afrique du Sud, de l'Australie, de la Nouvelle-Zélande et des États-Unis. La rigueur des exigences varie considérablement selon les provinces mais c'est au Québec que les restrictions sont le plus marquées.

Dans un autre ordre d'idées, les conditions exigées des médecins étrangers ont des conséquences économiques importantes parce que ceux-ci comptent pour à peu près la moitié dans l'augmentation du nombre de praticiens au Canada, et c'est la Grande-Bretagne qui fournit cinquante pour cent de cet effectif. Par ailleurs, la demande n'est pas répartie également entre les provinces. Tout dépend du nombre de sujets que les écoles de médecine sont en mesure de former. Les provinces les mieux nanties et celles qui peuvent assurer un meilleur niveau de vie aux praticiens ont un moindre besoin de médecins immigrés. Ainsi, en 1962, dans les provinces de l'Atlantique, 87.9 pour cent des médecins autochtones avaient vécu dans la région avant de s'inscrire en médecine et y faisaient carrière. Dans les autres provinces, le pourcentage était de 86.4 au Québec, de 81.8 en Ontario, de 77.4 dans les Prairies et de 38.8 en Colombie Britannique. La tendance des médecins du Québec à y demeurer et la grande quantité des médecins qui y sont formés expliquent que les conditions d'accessibilité à la pratique des médecins étrangers y soient plus strictes. En fait, le Québec exporte des médecins. Il n'en est pas ainsi dans le reste du pays. L'Ontario et la Colombie attirent les médecins parce que les revenus y sont plus élevés, que l'urbanisation est plus avancée, que les conditions climatiques sont moins rigoureuses. C'est pourquoi elles n'attirent pas que les médecins des autres provinces, mais aussi d'autres catégories de travailleurs.

À cause de la migration d'une province à l'autre, l'Ontario, la Colombie Britannique et le Québec ont moins d'habitants par médecin que les autres provinces. Pour la Colombie Britannique, l'Ontario et le Québec, les chiffres étaient respectivement de 613, 637 et 681, tandis que le nombre grimpe à 702 au Manitoba, 707 en Alberta, 758 en Nouvelle-Écosse, 817 en Saskatchewan, 1,104 au Nouveau-

Brunswick, 1,109 à Terre-Neuve et 1,134 dans l'Ile du Prince-Édouard. Ainsi, comparée à ces dernières provinces, les règlements relatifs à l'autorisation de pratiquer sont-ils plus rigoureux au Québec, en Ontario et en Colombie Britannique.

Par ailleurs, étant donné que l'élasticité des prix pour la demande des soins médicaux varie suivant le pourcentage du revenu qui leur est consacré, il est possible que les médecins des provinces où les normes sont plus sévères veuillent ainsi tirer avantage des hausses de prix. De fait, le pourcentage du revenu consacré aux services médicaux est, plus bas qu'ailleurs en Colombie, en Ontario, au Manitoba et au Québec.

En résumé, on peut noter ceci : le Québec qui est la province qui fournit le plus de médecins ailleurs au Canada, est celle qui freine le plus l'entrée des médecins immigrants ; l'Ontario et la Colombie Britannique qui importent des médecins des autres parties du Canada ont aussi une réglementation rigoureuse. Le Manitoba et l'Alberta qui reçoivent des praticiens du Québec, de la Saskatchewan et des provinces de l'Atlantique et dont les conditions d'admission à la pratique sont plus souples, voient leurs médecins immigrer en Ontario et en Colombie Britannique. Enfin, les médecins de la Saskatchewan et des provinces de l'Atlantique, provinces où les règlements d'admission sont conciliants, vont s'établir partout au Canada à l'exception du Québec.

De ce qui précède, force est de conclure que les règlements d'accessibilité à la pratique exercent une influence sur la migration d'une province à l'autre au Canada des médecins étrangers. Pour être efficace, la réglementation devrait non seulement porter sur la destination des médecins immigrants mais aussi sur leurs déplacements ultérieurs. En conséquence, non seulement est-il difficile pour les médecins étrangers de s'établir au Québec, en Ontario et en Colombie Britannique, mais il leur est aussi difficile de passer de l'une de ces provinces à l'autre.

Les conclusions de cette étude sont faciles à tirer. La profession médicale a mis en oeuvre des règlements qui ont une influence sur l'établissement des médecins immigrants. Ils ont incité beaucoup de ceux-ci à se fixer dans les provinces des Prairies et de l'Atlantique contribuant ainsi à alléger la pénurie de praticiens dans ces régions. La réglementation actuelle a permis d'assurer une meilleure répartition géographique des médecins, mais elle n'a pas réglé le problème du manque de médecins dans les campagnes. L'Ontario et la Colombie Britannique ont un nombre suffisant de praticiens dans les régions rurales alors que, dans les autres provinces, s'il y en a assez dans les villes, la situation est tout autre dans les campagnes. Aussi, le problème de la pénurie de médecins en milieu rural ne peut être réglé que par l'établissement de taux de rémunération supérieurs dans les campagnes ou par la mise en oeuvre d'une recommandation des rapports Hastings ou Castonguay-Nepveu qui consisterait à fixer le nombre de médecins pour chaque région.