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BACKGROUNDER

Canada's Doctor Shortage

COMPARING CANADA WITH THE WORLD

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Canada versus the World: Average physicians per 1,000 people

According to the latest figures from the Organisation for Economic Co-operation and Development (OECD), Canada ranks 23rd out of 30 countries (tied with New Zealand) for doctors per 1,000 people. In 2005, the last year available, Canada had just 2.2 doctors per 1,000 people, barely higher than in 1990 when Canada had 2.1 physicians per 1,000 people (OECD, 2007).

In contrast, in 2005, Greece, Belgium, Switzerland, Spain, Italy, the Netherlands, Norway, Iceland, Denmark, the Czech Republic, Austria, France, Germany, Portugal, Sweden, the Slovak Republic, Hungary, Ireland, Australia, Luxembourg, Finland, the United States and the United Kingdom *all had more physicians per 1,000 people*.

The number of physicians per 1,000 in these countries was 2.4 in the United Kingdom; 3.8 in Spain, Switzerland and Italy; 4.0 in Belgium; and 4.9 in Greece. When Canadians fall ill, they should hope they are on vacation in the Swiss Alps or on a beach in Spain, Italy or Greece.[1] The OECD average is 3.0 physicians per 1,000 people.

1. Some might argue that an age-adjusted comparison for doctor-people ratios would show Canada in a more favourable light. This assertion is incorrect. In a 2004 age-adjustment, the Fraser Institute found that Canada ranked 24th out of 28 countries for doctors per 1,000 people. (Esmail and Walker, 2007)

Canada is losing ground compared to other countries

Since 1990, 24 other countries increased their physician-people ratio by 10 per cent or more. Since 1990, the doctor-people ratio increased 16 per cent in New Zealand; 18 per cent in Japan; 20 per cent in Finland; 21 per cent in Belgium, Germany, and Portugal; 23 per cent in Australia; 24 per cent in Denmark; 27 per cent in Switzerland; and 32 per cent in Iceland. The ratio increased 40 per cent in Ireland, 48 per cent in the Netherlands, 50 per cent in the United Kingdom and 59 per cent in Austria.

In comparison, Canada's ratio of doctors to people (2.2 per 1,000 in 2005, up from 2.1 per 1,000 in 1990) increased only 5 per cent. Besides Canada, only Hungary, Italy and Poland failed to increase their physician supply ratio by 10 per cent or more.

It should be noted that two of these countries – Hungary and Italy – already had significantly higher doctor-people ratios than Canada in 1990. Hungary's ratio was 2.8 doctors and Italy's was 3.8 doctors per 1,000.

The doctor shortage in Canada is but one example of a healthcare system that is inadequate and in need of reform.

Table 1: Practising physicians per 1,000 people*

Country	Physicians per 1,000 People	Country	Physicians per 1,000 People
Greece	4.9	Slovak Republic	3.1
Belgium	4.0	Hungary	3.0
Switzerland	3.8	Ireland	2.8
Spain	3.8	Australia	2.7
Italy	3.8	Luxembourg	2.5
Netherlands	3.7	Finland	2.4
Norway	3.7	United States	2.4
Iceland	3.7	United Kingdom	2.4
Denmark	3.6	New Zealand	2.2
Czech Republic	3.6	**CANADA**	**2.2**
Austria	3.5	Poland	2.1
France	3.4	Japan	2.0
Germany	3.4	Mexico	1.8
Portugal	3.4	Korea	1.8
Sweden	3.4	Turkey	1.5

Source: OECD 2007. * For most countries, the most recent data available are from 2005.

Table 2:
Increase in physicians per 1,000 people 1990-2005

Increases of 10% or more: 24 countries

Australia, Austria, Belgium, Czech Republic, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Japan, Korea, Luxembourg, Mexico, Netherlands, New Zealand, Norway, Portugal, Spain, Switzerland, Turkey, United Kingdom, United States

Increases of 0 - <10%: 4 countries

CANADA, Hungary, Italy, Poland

Source: OECD 2007. The Slovak Republic did not exist in 1990 and was part of Czechoslovakia. No 1990 figures are available for Spain.

Table 3:
Percentage increase in physicians by country 1990-2005

	Practising physicians per 1,000 population			
	2005	1990	2005 increase over 1990	
Australia	2.7	2.2	23	%
Austria	3.5	2.2	59	%
Belgium	4.0	3.3	21	%
CANADA	**2.2**	**2.1**	**5**	**%**
Czech Republic	3.6	2.7	33	%
Denmark	3.6	2.9	24	%
Finland	2.4	2.0	20	%
France	3.4	3.1	10	%
Germany	3.4	2.8	21	%
Greece	4.9	3.4	44	%
Hungary	**3.0**	**2.8**	**7**	**%**
Iceland	3.7	2.8	32	%
Ireland	2.8	2.0	40	%
Italy	**3.8**	**3.8**	**0**	**%**
Japan	2.0	1.7	18	%
Korea	1.6	0.8	100	%
Luxembourg	2.5	2.0	25	%
Mexico	1.8	1.0	80	%
Netherlands	3.7	2.5	48	%
New Zealand	2.2	1.9	16	%
Norway	3.7	2.6	42	%
Poland	**2.1**	**2.1**	**0**	**%**
Portugal	3.4	2.8	21	%
Slovak Republic	3.1	---	na	
Spain	3.8	---	na	
Sweden	3.4	2.9	17	%
Switzerland	3.8	3.0	27	%
Turkey	1.5	0.9	67	%
United Kingdom	2.4	1.6	50	%
United States	2.4	2.1	14	%

Source: OECD 2007.

Policy Options and Proposals for Reform

Monopolies are problematic and inefficient.

For Canada to retain and attract physicians, compensation will have to be increased. The question is how to do this with a minimum of new public resources – there are plenty of calls on government budgets, be it for healthcare, infrastructure, the need for competitive tax regimes and environmental initiatives to name a few.

One option is to re-examine the existing provincial government healthcare and redirect spending. Here are three brief policy proposals to that end.

Reform 1: Keep health care universal and increase choice in health care in order to prevent monopoly control by the public sector

Monopolies are problematic and inefficient whether in the private or the government sector. Policymakers and the public should be reminded that the *Canada Health Act* allows provincial governments to tap into the non-profit and private sectors for service delivery in health care. For example, most doctors' offices are private and governments "contract" with such providers through fee-for-service arrangements. More delivery should be allowed through this type of arrangement, through private and non-profit providers (be they private clinics, religiously-owned health institutions, Chinese benevolent societies, or veterans' organizations, for example). Instead, governments too often contract with public sector unions in a monopolistic fashion for much of their healthcare service delivery. Current practice is akin to a provincial government contracting with one grocery store chain to provide food to all welfare recipients.

This creates potential and real bottlenecks. For example, when most hospitals are served and controlled by the public sector, innovation, flexibility, efficiency and merit are discouraged. In addition, the public is held hostage in the event of a strike. In British Columbia in 2004, the Hospital Employees' Union (which provides custodial and laundry service to hospitals) went on strike. Here are some of the cancellations that resulted in just *one* week.

Almost 4,200 surgeries were cancelled including the following:

- heart surgery for a nine-year-old Campbell River boy,
- breast cancer surgery for two Kelowna women,
- surgery at BC Children's Hospital in Vancouver to remove a growth from a three-year old boy who waited months to have it done and
- surgery for another 79 children at the same facility.

Thousands of diagnostic tests were cancelled including the following:

- 514 MRIs and
- 1,852 CT scans.

Other medical and public health services were cancelled including the following:

- 450-650 mammograms per day,
- at least 11,500 medically necessary laboratory tests,
- over 11,000 ambulatory care procedures including diabetes education, cast clinics to remove casts, wound care, epilepsy management clinics, occupational and physical therapy sessions and Holter monitoring for heart disease,
- respite services for seniors and family members were reduced or cancelled and
- public health services such as youth sexual health services, sexual health education, prenatal classes, hearing and speech difficulty assessments.

Compare the monopoly provision in healthcare to that which takes place in the provision of food. In the case of a grocery store, if one union at one grocery chain goes on strike, customers can and will shop elsewhere. No union has ever been able to monopolize every grocery store and strike at all stores simultaneously; the delivery of a basic need is not imperiled by a monopoly chokehold in the system *because there is no monopoly provider for food and food delivery.* Thus, to funnel extra money to where it is needed (instead of having it captured by existing interests) and to avoid monopoly chokeholds in the system, a variety of service providers are critical.

To avoid monopoly chokeholds in the system, a variety of service providers are critical.

Reform 2: Increase the supply of physicians by increasing the amount of money allowed into the health-care system from other sectors

There is a lose-lose scenario being played out among provincial governments in Canada: Governments are reluctant to pay for more doctors, as that would increase billings beyond what the governments, and by extension, the taxpayers are willing to pay. Taxpayers are reluctant to finance additional healthcare costs, as they suspect governments are not the most efficient providers.

Thus, doctor shortages are endemic and becoming worse. It is another queue approach to controlling health-care costs. Critics of healthcare reform note the shortage of doctors as a reason private practices, clinics and hospitals cannot be expanded. Private delivery is thus held off because of the fear that physician time will be decreased by private sector siphoning. The result of the above is a system in sclerosis where experimentation does not occur because of fear.

Governments cannot allot unlimited amounts to healthcare, as it is one of many budget items paid for through taxation. This is the reality. However, they can allow others to insert extra financing into the system.

Part of this financing will occur naturally when the private and non-profit sectors own and manage the hospitals. The release of public money that was previously spent on capital infrastructure would allow more physician-training spaces to open up and with other reforms would allow doctors to practice their craft with higher compensation than is currently permitted by provincial government budgets. This in turn would lead to a growing supply of physicians that would rebalance the health-care system and improve the ratio of doctors per 1,000 people.

Cities and towns should consider topping up provincial fees.

Reform 3: Encourage cities and towns to top up physician compensation

Canadians in rural areas fear a loss of doctors under any reform. This fear is understandable, but without reform, more doctors will leave and there will be pressure on the remaining doctors to leave, because of the increasing demands on ever-fewer doctors.

Rural areas will never possess the type and variety of healthcare services that are available in major cities – population densities will always prevent that – but the chance to attract and retain doctors will be greater if more physicians are allowed into the healthcare system. Bluntly, this will require money. To attract physicians, cities and towns should consider topping up provincial fees with an annual stipend.

This ad hoc approach would allow cities and towns to decide how much of their budgets they are willing to spend to attract needed services. This is preferable to allowing a far-away bureaucracy and government to perform that calculation. Municipal top-ups would help expand the amount of money available to attract physicians and at the same time help focus healthcare budgets on the priorities desired by citizens in a particular locale.

Summary of Reforms

Reform 1:

Keep health care universal and increase choice in healthcare in order to prevent existing monopoly control by the public sector.

Reform 2:

Increase the supply of physicians by increasing the amount of money allowed into the healthcare system by other sectors.

Reform 3:

Encourage cities and towns to top up physician compensation.

Sources

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More Frontier Backgrounders on Healthcare

More Private Healthcare in Canada?
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The Catalan Health Care Model
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Euro-Canada Health Consumer Index 2008
January 2008

Universal Medical Savings Accounts
June 2000

For more on health policy see the Healthcare Frontiers Project at

www.fcpp.org

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