Integrating International Medical Graduates into Health Care Delivery in Canada: Attempting to Resolve Years of Discontinuity between Immigration Policy and Implementation Strategies in the Field.

W. Dale Dauphinee, MD, FRCPC
Co-Chair, Task Force on IMG Licensure and Assessment
Ottawa, Ontario, Canada

Definition:

This paper will use the definition of international medical graduates (IMGs) that is commonly used in Canada by national assessment bodies and licensing authorities. It is used by the current Canadian Task Force on Licensure of International Medical Graduates.

'Individuals who received their medical degree from a medical school that is not accredited by the Committee on Accreditation of Canadian Medical Schools (CACMS) or the Liaison Committee on Medical Education (LCME).'

One implication of this definition is that the school of training which confers the medical degree, such as MD or MB, defines who is included as an IMG, rather than country of origin or citizenship. It should be noted that all medical schools currently graduating physicians in Canada are accredited by CACMS and LCME and all American schools are accredited by LCME. Thus, for practical purposes, the vast majority of individual citizens or landed immigrants from Canada who study and obtain their medical degree outside the USA (including Puerto Rico) and Canada will be considered IMGs.

Background: 1965-1999

The nature of medical workforce policy in Canada since the 1980s appears to have been one of self-sufficiency, meaning that Canada's workforce seemed to primarily depend on national production to meet needs, with a minimal contribution of overseas trained physicians, particularly in areas of mal-distribution. Yet in the late 1960s, Canada imported more physicians on a yearly basis than it graduated. That policy changed with the expansion of the number of medical schools and the increase in class size in almost all regions of the country in the late 1960s and early 1970s (Figure 1). The net result has been that the percent of IMGs making up the current medical workforce in Canada has decreased from over 30% in the mid-1970s to roughly 23% (Figure 2). Within that percentage, there were significant variations in the number of IMGs from province to province. For example, in 2000, Newfoundland and Saskatchewan had 46.7 and 55.7% respectively of their practicing MDs as IMGs, as compared to 17.3 and 11.8% in PEI and Quebec (Figure 3).

A second trend indicates that the origin of IMGs coming to Canada over the last twenty-five years has changed from primarily Commonwealth Countries and Ireland to a much wider international community. That change highlights countries in Asia, in addition to

India and Pakistan (the Philippines and Korea), in Eastern Europe, and in the Middle East (i.e. Egypt and Iran). In many of these countries the nature of post-graduate training and licensure is less well known or not as well documented, as in traditional areas from which IMGs were originating in the 1970s. This is an example of a 'disconnect' that has not been solved completely.

Another interesting trend is the percentage of physicians coming to Canada under work permits versus landed immigrant status. An alarming percentage of landed immigrants is located in the larger provinces and large cities in Canada. Ontario and Toronto are prime settlement locations. This contrasts with those coming to Canada on work permits. In that situation, IMGs are more broadly distributed across the country, in particular to areas of traditional need (Figure 3). This pattern of IMGs arriving without identified positions is not new (Figure 4). This implies another disconnect between policy and reality. What is the explanation for this trend? As we will see shortly, based on additional consultations and interviews by the IMG Task Force, these findings confirm that there are two primary pathways to Canada for IMGs: permanent immigration and work permits and the two lead to very different outcomes, with serious socio-political consequences for those in the first category and for governments.

The public impact of these trends is amplified by the notion of too many barriers for IMGs frequently suggested in the public press. Moreover, there is evidence from tracking studies, that contrary to policy views of the 1990's, Canada has a shortage of physicians in both relative terms and absolute in regional terms. The origins are many but the following factors must be considered. On the input side, they are: increasing retirements, loss of physicians to the USA in the 1990s; and recent data suggesting that younger physicians are not willing to work the same number of days and hours as previous cohorts. Further they appear to restrict their practices to more selected areas, such as not undertaking obstetrics or focusing on emergency units (source: Canadian Institute of Health Information). On the output side, the decision to curtail enrollment into Canadian medical schools in the mid-1990s led to a perception that physicians were not needed, and reinforced the decision of many trainees to move elsewhere. Even more importantly, this resulted in fewer graduates in the late 1990s than in the 1980s. Thus the 'yield' of young physicians leaving training programs fell, augmenting the perception of a shortage. Chan has suggested that these perceptions likely reflect reality, again demonstrating a disconnect between policy and reality (B. Chan. 2002. *From Perceived Surplus to Perceived Shortage: What Happened to Canada's Physician Workforce in the 1990s*. Ottawa. Canadian Institute for Health Information.).

An unresolved issue facing workforce policy-making in Canada's provinces/territories remains. What are the actual roles and expected responsibilities of practitioners? A true role definition does not exist in most provincial-territorial health plans. (*Public Symposium. Thirty Years of Evolution: The Public Model of Health Care in Canada. Overcoming the Gridlock – from Solution to Decision to Action.* The McGill Institute for the Study of Canada. Montreal. 16 February 2002).

Whatever one's view of these interactions, the accompanying immigration policy from the late 1970s to the mid-1990s was one of moving physicians from a preferred immigration status to restricted one. This policy likely had unintended consequences.

These changes were again reinforced in the early 1990s when an attempt was made to make Canada even more restrictive to the immigration of MDs by actively pressuring assessment bodies to close overseas assessment sites, etc. The net result appears to be that many physicians who entered Canada at that time may have by-passed the restrictive policy and work permit routes by being sponsored by their family or designating themselves as non-physicians. At the same time, many authorities and communities in need were pressing for other physicians from more familiar overseas sources, to come to Canada on work permits. Again this highlights the disconnect between immigration policy and need, and perhaps explains the different settlement patterns between landed immigrants and those of MDs coming on work permits. A recent informal telephone poll of registrars of the medical licensing bodies in Canada indicated that most provinces are licensing a greater percentage of IMGs on work permits than as landed immigrants. In fact, it appears that provincial/territorial employers (or regional authorities) and licensing authorities have no reliable means to locate potential qualified physicians in certain larger Canadian cities as there is no systematic way to identify them or to know their qualifications and clinical experience. Clearly, another disconnect exists that needs solving.

Change in Medical Workforce Direction

In November 1999, the provincial and territorial ministers of health met with the membership of the Canadian Medical Forum, an informal national group made up of all national medical bodies, both assessment and advocacy groups. At that time a paper was presented emphasizing the need for a reconsideration of the decreased first year medical school enrollment policy decision of the early 1990s. Following that meeting, and perhaps influenced by the public perception of shortage, most provinces increased their enrollment over the next 4 years to a level comparable to that seen in the late 1980s.

Along with the public perception of a physician shortage came increased lobbying efforts by IMGs, primarily in Ontario. They questioned certain requirements (and therefore implying unnecessary barriers) to licensure. Since many IMGs were not integrated into the community as practicing physicians, they used the public perception of need, and were able to gain the attention of the Ontario ministry of health, the licensing authority and other stakeholders. Examples of perceived barriers focused largely on national examinations, a practice in North America since the early 1900s, as well as other requirements in the licensing process. Furthermore, many underserved provinces and regions were actively recruiting physicians from other countries while many IMGs in the larger Canadian cities remained mired in non-physician roles, even once they passed their licensing examinations. Accompanying this disconnect was the fact that postgraduate training opportunities via the ministries of health were very tight. The programs were only able to accommodate a small proportion of the waiting IMGs who were in need of or preferred to have supplementary training for specific roles as either primary care physicians or specialists. Many provinces do have specific upgrade programs for IMGs but the capacity of these programs continues to be very limited.

As the issues became more public and better known within the medical community, a conference was organized by individuals within the educational, licensure and assessment

communities trying to resolve these challenges. Health Canada and provincial representatives on the Advisory Committee on Health Human Resources played a key role in funding the conference that was held in Calgary on 1 May 2002 and was attended by one or more people (staff and CEOs) from virtually every organization within the regulatory and assessment communities in Canada. At the conclusion, the meeting unanimously called for solutions, and outlined clearly defined steps that could resolve the issues of IMGs and to better integrate them into health care (*Proceedings: International Medical Graduates National Symposium.* R. Crutcher, editor; University of Calgary. 2002). Building on this concensus, with the assistance of the Federal Government, the Conference of Deputy Ministers of Health responded by appointing a Task Force to tackle these issues in the summer of 2002. While the Task Force's report is not due until December 2003, this paper will conclude with an overview of that Task Force's approach, cite some of its findings to date and present a framework on which to make Recommendations. Its terms of reference were to develop Recommendations to the federal/provincial/territorial Advisory Committee on Health Resources to address:

- integration of qualified foreign trained physicians into physician supply strategies;
- adoption of fair, equitable and transparent processes for the licensure of qualified foreign trained physicians seeking work in Canada; and
- promotion of common guidelines for the assessment of credentials and competences of IMGs seeking medical licensure in Canada.

Under this goal, four strategic objectives were defined:

- build on the outcome of the IMG National Conference to identify a framework to guide the development of a common, fair, unbiased and efficient approach to the assessment of competency of foreign trained physicians seeking medical licensure in Canada;
- identify the strategies and programs of the medical and non-medical key stakeholders currently in place and integrate them in the framework (e.g. colleges, licensure bodies, governments, immigration and settlement, regional health authorities, etc.);
- develop a business and communication plan to support sustainability of the process;
- develop an evaluation strategy to determine the effectiveness of the strategy in addressing the medical human resource needs of the country.

IMG Task Force: Process and Findings

The Task Force made three operational decisions: i. to create four working groups around four main problems identified in the Terms of Reference and reflected by the Calgary Conference findings: Regulation; Competency Assessment; Orientation and Settlement; and Roadmap; ii. to handle the development of solutions for other deliverables by subcontracting with known and respected national experts; and iii. to establish a consultative process within each province by conjointly meeting with regulatory, educational bodies and ministries of health, as well as meeting with all national bodies and federal and provincial/territorial departments involved in physicians'

assessment for licensure and for immigration and settlement respectively. Those consultations took four months but proved to be most useful. In many instances misunderstandings on roles, responsibilities and current activities were dealt with in a face-to-face manner simultaneously, thus improving mutual perception and understanding, often a challenge in a decentralized federal system.

As reports from the working groups and outsourced contractors have appeared, and the findings of the consultative processes have been collated, certain issues have become rapidly apparent. While not wanting to anticipate the final recommendations that are currently under consideration, these issues will be grouped under two headings. First, it must be noted that Canada is internationally perceived as a major leader and innovator in the assessment of physician competency and education, and Canadian licensure authorities are viewed as leaders in thinking about maintenance of competence, and the certifying bodies are also seen as international leaders. Yet disconnects such as lack of coordination is apparent, implying that new mechanisms must be found to better harmonize these natural strengths and to facilitate integration of IMGs into Canada. Secondly, within the government communities, the lack of appreciation for unintended consequences of earlier policies have lead to a number of administrative and policy disconnects. That having been said, the primary findings, in the view of this author are:

1. an alarming 'disconnect' between immigration policy regarding landed immigrants and areas of need identified by the primary employers of physicians in Canada, the provincial/territorial health plans. This has resulted in two conditions:
   - a backlog of an unknown number of IMGs, currently residing within Canada, who immigrated without prior competency assessment or prior offer of a position, and who are not practicing or able to upgrade their skills; and,
   - a number of IMGs currently in Canada who have been inactive or who have only partial training in primary care or a specialty, are unable to seek remediation or upgrading due to the lack of opportunities for IMGs;
2. the lack of an integrated system for the process of verifying existing credentials, leading to delays and applications to multiple bodies, and a lack of a common credentials registry;
3. the lack of a data base on IMGs currently residing within Canada with partial qualifications who immigrated without prior competency assessment, or qualified IMGs who immigrated without a prior offer of a position, which provincial/territorial health plans could utilize in recruiting physicians for further training or to fill practice vacancies respectively;
4. the lack of accurate and integrated information processes, readily available, to guide IMGs in their immigration decisions prior to arrival or prior to applying to come to Canada;
5. the need to develop an integrated assessment strategy across all assessment and licensure bodies to deal with performance based assessment of IMGs already in Canada, whose qualifications are in doubt or inaccessible to verification by assessment/certifying bodies in Canada;
6. the need to define a standard set of requirements and processes for all IMGs wishing to immigrate to Canada permanently or temporarily. That approach should permit them to self assess their knowledge AND require them to

ultimately demonstrate their competencies through existing examination processes before entry into Canada. This would avoid these disconnects by clarifying Canadian expectations and requirements prior to entry, particularly as up-grading knowledge and skills without the support of the primary employers in Canada is not possible. This is in contrast to the well functioning processes existing for those who wish to come to Canada for study under sponsorship of international bodies or countries contracting with Canadian medical education institutions, and.

7. the need for an overall framework to guide solutions, followed by an assessment of outcomes from these revised and better coordinated processes.

Inherent in these observations, is the fact that Canada, through its constitutional realities has created significant challenges for itself. Better coordination is needed within its decentralized federation and within its various agencies. There are disconnects between immigration practices around landed immigrants and permanent settlers that have led to unemployed physicians who cannot meet standards required of Canadian trainees and who require upgrading. The connections must be made with both the employers (predominantly provincial and territorial health plans) and provincial and territorial licensing authorities (who have flexibility to accommodate community needs), and the agencies able to assist the licensing authorities in the assessment of IMGs. The Canadian assessment community has been seen as an international leader in almost all of the identified problem areas and has the collective capability to deliver solutions, if requested. This first requires that Canada think of enablers and not barriers, and that all parties see how the 'disconnects' are both conceptual, at the policy level, and operational. The Task Force is now considering its recommendations in the context of mutual cooperation between all agencies and bodies, with a view to using our existing talents and capacities as enablers and facilitators in a coordinated manner. Secondly, steps must be taken to prevent the experience of the past many years from continuing. The past includes: a lack of accurate information, a lack of coordination, an inability to identify role requirements, and a lack of the required skills and knowledge prior to coming to Canada, etc. Can it be done? Yes. The Faculties of Medicine in Canada have been doing that for many years when contracting with other countries to train their specialists, in a coordinated manner, with stated academic and clinical requirements, and with linkage of visa processes to training sites. Any Canadian physician who has undertaken post-graduate studies in the USA is familiar as to how this should operate. Why should we do any less well for IMGs who seek to live in our country?

Once finalized, the Task Force Report will identify the strengths and weaknesses, as well as the 'disconnects', so that the existing strengths in Canada can be better used and inter-connected to serve its medical workforce needs. Thus the Task Force will make Recommendations through which Canada and the provincial/territorial health plans can hope to facilitate the integration of appropriately qualified IMGs into Canadian society and culture and into the Canadian health care system where they are needed.

Figures

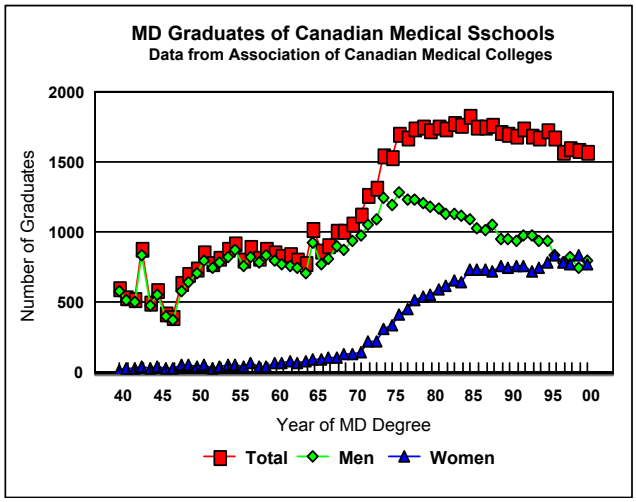

Figure 1. MD Graduates of Canadian Schools

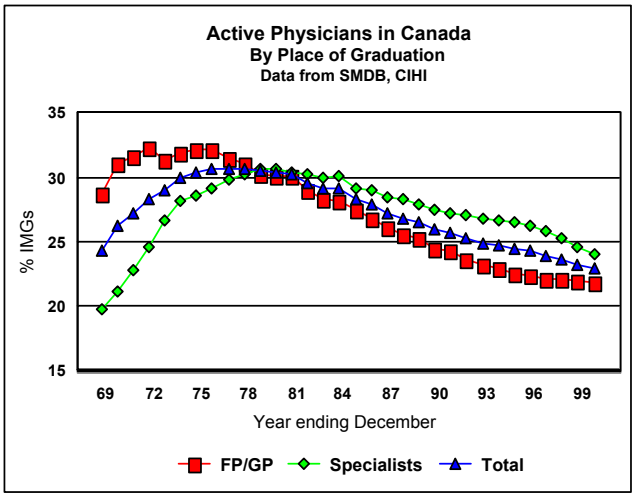

Figure 2. Active MDs: Percent IMGs

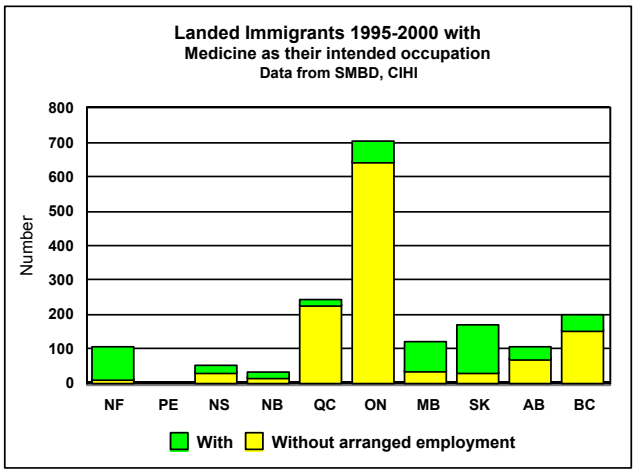

Figure 3. Number of MD Immigrants

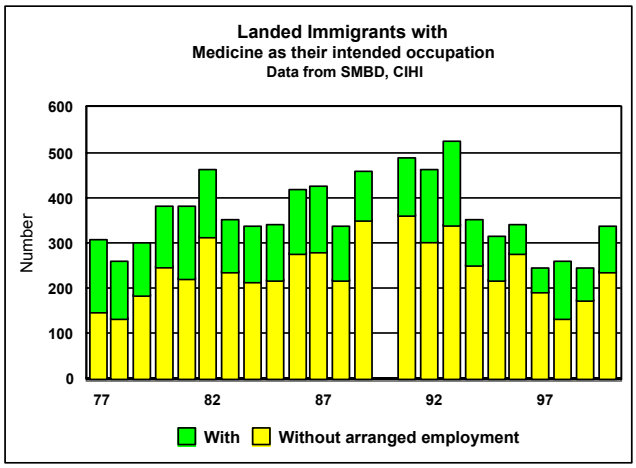

Figure 4. IMGs without positions: trends