NOTES FOR AN ADDRESS BY

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ASSOCIATION MÉDICALE CANADIENNE
CANADIAN MEDICAL ASSOCIATION

A healthy population…a vibrant medical profession
Une population en santé…une profession médicale dynamique

ASSOCIATION MÉDICALE CANADIENNE

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Introduction

Good afternoon, as mentioned, I am Dr. Sunil Patel, President of the Canadian Medical Association and a family physician from Gimli Manitoba. With me today, is Mr. William Tholl, Secretary General and CEO of the CMA. I am pleased to be here with you today and as a foreign trained physician I believe that I can provide a personal perspective to your study of credentialing of international graduates in the medical profession.

The Canadian Medical Association (CMA) is the national voice of Canadian physicians. Founded in 1867, the CMA's mission is to serve and unite the physicians of Canada and be the national advocate, in partnership with the people of Canada, for the highest standards of health and health care. The CMA is a voluntary professional organization representing the majority of Canada's physicians and comprising 12 provincial and territorial divisions and 43 affiliated medical organizations.

On behalf of its more than 57,000 members and the Canadian public, CMA performs a wide variety of functions, such as advocating for improved access to quality health care, facilitating change within the medical profession, and providing leadership and guidance to physicians to help them influence, manage and adapt to changes in health care delivery.

I will preface my remarks by emphasizing that in the case of medicine, the recognition of the credentials of internationally trained physicians is only one part of a much larger issue – namely that of Canada's continued inability to be self-sufficient in the production of physicians to meet the needs of our population. While we recognize the important contribution that International Medical Graduates (IMGs) have made, and continue to make to the health care system, we believe that Canada's physician workforce policy must not continue to be one of "beggar thy neighbour".

I want to impress upon Members of the Committee that the CMA does not test, license or discipline physicians, nor is it empowered to act on complaints made by patients — this is the purview of the provincial/territorial licensing bodies. We are not directly involved in provincial or territorial benefit negotiations for physicians – this is the responsibility of our provincial/territorial Divisions. Nor do we control medical school enrolment or conduct medical research.

What we do, is carry out research and advocacy on short, medium and long term health and health care issues to ensure we can meet the current and emergent needs of Canadians.

The CMA was pleased to participate as a member of the Canadian Task Force on the Licensure of International Medical Graduates, and we congratulate Drs. Dale Dauphinee and Rodney Crutcher for their tireless work in co-chairing it. I understand that Dr. Dauphinee tabled with this Committee the Task Force's recent report.

As a matter of principle, the CMA supports the international exchange of teaching, research and practice that the mobility of physicians can provide for the betterment of medical practice, both in Canada and internationally. The Canadian health system has benefited tremendously from the contribution of IMGs and we expect it will continue to do so into the future.

Canada has always relied on IMGs as a significant part of its medical workforce. Even after the addition of four new medical schools in the 1960s, it remains the case to this day that almost one of four practising physicians in Canada is an IMG. Although precise data are not available, our best guess is that some 300-400 IMGs new to Canada are licensed to practise each year.

Boom to Bust

Canada's health workforce planning can aptly be described as a "boom to bust" cycle. In the case of physicians, the number of IMGs arriving in Canada exceeded 1,000 annually in the early 1970s and then diminished with the rising concern about health care costs in the 1980s and the fiscal crunch of the 1990s. In 1992 health Ministers unilaterally imposed a 10% cut in undergraduate medical school enrolment that took effect in 1993. This cut has contributed to smaller entry-to-practice cohorts over the past few years and we now face the prospect of a growing physician shortage – a prospect shared by most industrialized countries. Moreover, as is demonstrated in the attached chart, Canada continues to experience the net loss of some 200 physicians each year, mainly to the United States.

In the past few years Canada has been criticized internationally for "poaching" physicians from countries that can ill afford to lose them, although this is no longer the result of systematic recruitment. We must recognize that Canada is still an attractive destination for many prospective migrants of all occupations.

The CMA played a leadership role in working with the World Medical Association to develop a policy statement on ethical guidelines for the international recruitment of physicians that was adopted by the WMA General Assembly in Helsinki in the Fall, 2003 (copy attached).

Need for a National Planning Process

One thing that distinguishes medicine from other professions, both within and outside the health field, is that according to the Canadian Institute for Health Information, more than 98% of physician professional earnings are publicly-funded; in this regard Canada's physicians are unique among industrialized countries. In an era that calls for greater accountability for public expenditure, this underscores the need for a nationally coordinated plan and planning process that strives to ensure that Canada has enough physicians to meet the needs of its population.

Such a plan has eluded Canada thus far. Indeed Canada's health workforce policy might be described as one of "beggar thy neighbour", both within Canada – between provinces/territories and communities - and internationally.

In terms of how IMGs might be factored into such a plan, the CMA would recommend short, medium and longer-term approaches.

A critical first step in moving ahead on such a plan would be to convene a table along the lines of the recent IMG Task Force that would tackle the full breadth of workforce issues with representation from the national medical organizations and the provincial, federal and territorial governments.

Short-Term

At present, IMGs are able to access postgraduate medical (post-MD) training by successfully completing the Medical Council of Canada Evaluating Exam (MCCEE) and than applying to the second iteration of the match conducted each year by the Canadian Resident Matching Service (CaRMS) or by applying to one of the special programs for IMGs that are offered at some Canadian medical schools.

In the short-term the CMA would recommend that the federal government provide sufficient funding to provide additional training positions for a number of the some 700+ IMGs who would be eligible to begin a post-MD residency training immediately. Such funding could also provide for the comprehensive assessments of IMGs that have been developed in several jurisdictions. The CMA also strongly supports the initiative of the Medical Council of Canada (MCC) in developing a pilot for the off-shore electronic administration of the MCCEE. The March 1, 2004 announcement by Dr. Hedy Fry of $4 million in support of the Task Force recommendations is very welcome, but it is just a first installment on what is required.

Medium-Term

The CMA and other national medical organizations believe that the size of the postgraduate medical training system is a bottleneck, both for Canadian medical graduates and IMGs alike. The number of post-MD training positions funded by provincial governments has been flat-lined since the early 1990s, and is only barely sufficient for the graduating cohort, thus leaving virtually no room for either IMGs or for practising Canadian graduates wishing to retrain.

Over the past few years the number of IMGs applying in the second iteration of the CaRMS match has more than doubled, rising from 294 in 2000 to the forecast 758 who will compete for the 177 positions in the 2nd round match on April 29th of this year. Among the 625 IMGs in the second round of the match in 2003 just under 11% (67) were matched.

I would be remiss however in not acknowledging that several medical schools have special programs for IMGs. While 67 IMGs were matched to postgraduate year one (PGY-1) positions in 2003, according to the Canadian post-MD registry there were a total of 213 IMGs in PGY-1 as of November 2003.

The CMA and other national medical organizations have been advocating for a minimum of 120 PGY-1 training positions for every 100 graduates. Action on this recommendation will become crucial in the next few years when the expanded undergraduate cohort (post-1999) graduates.

More generally, we believe that the following components must be explicitly factored into the planning for the capacity of the post-MD training system:

- all new graduates of Canadian medical schools who are permanent residents (including opportunities to switch training programs);
- re-entry into postgraduate training among physicians in practice in Canada;
- IMGs who are permanent residents or citizens of Canada; and
- non-resident IMGs wishing to pursue postgraduate training in Canada as visa trainees.

I would add that increased efforts and resources will be required to recruit additional community-based teachers to participate in both undergraduate medical education and post-MD training, and to support and retain those who are already doing so. As well, government funding for the infrastructure costs to medical schools as a result increased training will need to be forthcoming.

Long-Term

First, I am aware from reading the proceedings of earlier sessions that concerns have been raised about the multiplicity of licensing and credentialing standards among the provinces and territories. This is one area where I can think that medicine can be justifiably proud as, since 1992 there has been a national standard for portable eligibility for licensure – that is, successful completion of the two-part Qualifying Examination of the Medical Council of Canada plus certification either by the College of Family Physicians of Canada, Royal College of Physicians and Surgeons of Canada or the Collège des Médecins du Québec. The regulatory authorities have flexibility in the application of this standard so that IMGs can receive provisional licensure to practise and ultimately attain full licensure. There are also a variety of means through which practising IMGs can achieve certification.

This is something that the CMA strongly supports – that Canadians are served by a uniform standard for medical practice that applies both to Canadian medical graduates and IMGs alike. This national standard must continue to be the cornerstone of a long-term vision and plan for Canada's physician workforce.

In moving toward such a plan, the CMA believes Canada should adopt a policy of increased self-sufficiency in the production of physicians in Canada, that includes:

- increased opportunities for Canadians to pursue medical education in Canada;
- enhanced opportunities for practising physicians to return for additional training;
- strategies to retain physicians in practice and in Canada; and
- increased opportunities for IMGs who are permanent residents or citizens of Canada to access post-MD training leading to licensure/certification and the practice of medicine in Canada.

The CMA believes that there are too few opportunities for Canadians to pursue medicine as a career in Canada. For example, in 2002 there were roughly 6.5 first year medical school places per 100,000 population – just over one-half of the comparable level of 12.2 per 100,000 for England. This shortfall is exacerbating the current situation by creating a new category of international graduates, namely the growing numbers of Canadians who are pursuing an international medical education as a result of the shortage of medical school places in Canada. The CMA has recommended a 2007 target of 2,500 first year medical positions. At best we are tracking toward 2,200 at present.

Impact Assessment

We would urge this committee to call on the government to conduct a detailed impact assessment of the Immigration and Refugee Protection Act. For example, at this point we have simply no idea if the numbers of qualified foreign workers arriving in Canada with medical credentials and without arranged employment agreements have increased or not, and we suspect that this may be true for other professionals and occupations.

Conclusion

In conclusion, as regards the medical profession, we believe it is crucial that the federal, provincial and territorial governments must make the high level policy commitment to a nationally coordinated plan for the physician workforce that I have outlined above. Such a commitment is long overdue.

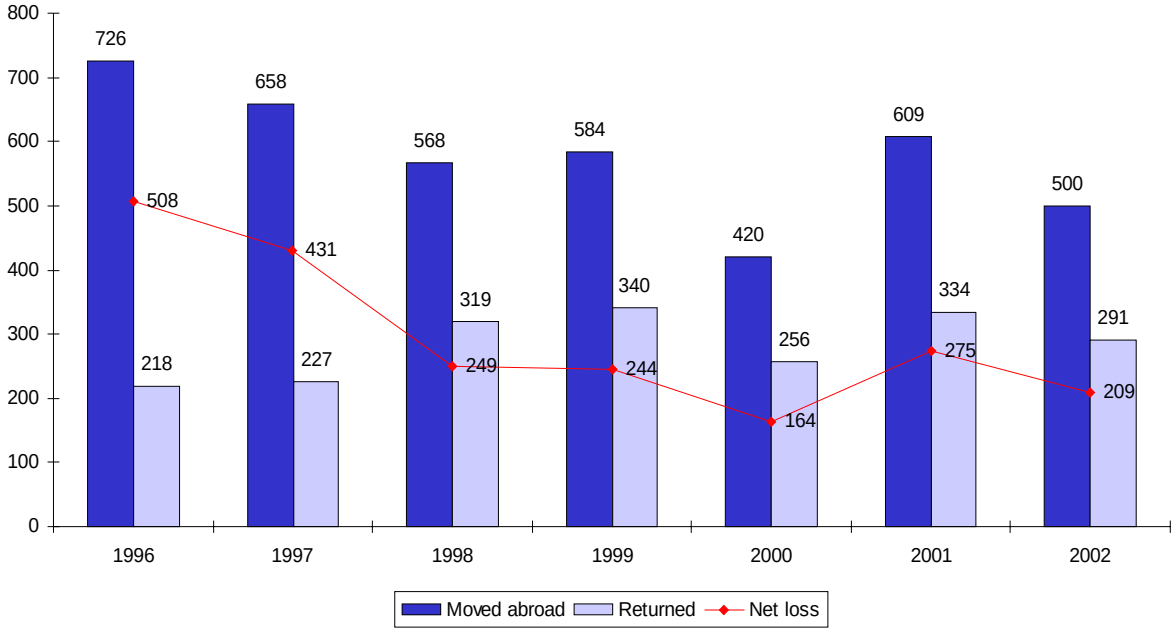
In the context of such a plan, in the short-term we believe that implementation of the recommendations of the Canadian Task Force on the Licensure of IMGs will contribute significantly and moreover will add a measure of transparency and fairness, particularly for those IMGs who are residents of Canada and who have not been able to access the post-MD system.

For our part, the CMA is addressing Task Force recommendation 5b, which called for a recruitment database that will permit IMGs to post curricula vitae and employers to access this information. We have implemented a module on our national online career forum MedConnexions.ca that provides IMGs with electronic tools to create an online resume and to search and apply to medical and health-related employment opportunities.

While we must increase our efforts to promote the integration of IMGs in the Canadian health care system it is imperative that this be done in the context of a national action plan to achieve a greater level of self-sufficiency than we have in the past.

I look forward to your questions and I thank you for your attention.

Migration of Canadian Physicians



Source: Supply, Distribution and Migration of Canadian Physicians, CIHI