

## **NOTES FOR AN ADDRESS BY**

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President  
Canadian Medical Association

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## **INTERNATIONAL MEDICAL GRADUATES**

Presentation to the Standing Committee on  
Citizenship and Immigration

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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*

Good afternoon, I am Dr. Albert Schumacher, President of the Canadian Medical Association (CMA) and a family physician from Windsor, Ontario. With me today is Dr. Todd Watkins, Director, Office of Professional Services at CMA and also a family physician.

It is estimated that some 4.5 million Canadians have had trouble finding a family doctor, while more than 3 million Canadians do not have regular access to one. Long waiting lists for consultations and specialized diagnostic and therapeutic procedures suggest there is a shortage of specialists.

Including time spent on call, Canada's physicians worked an average of 70 to 80 hours a week. Of the 21,000 physicians surveyed in the recently released National Physicians' Survey, over a quarter said they plan to reduce their work week within the next two years. 60% of family doctors either limit the number of new patients they see or have closed their practices.

At the same time, the average age of physicians in Canada is 48 years with 32% 55 years of age or older. Almost 4000 physicians may retire in the next two years.

There is a "perfect storm" brewing in terms of health human resource in Canada.

The message I hope to leave with you today is that the valuable participation of International Medical Graduates (IMGs) in our medical workforce must be part of a coordinated pan-Canadian plan that strives to address the double imperatives of immigration policies that are fair and policies that in the short, medium and longer term will ensure greater self-sufficiency in the education and training of physicians in Canada.

Today I am going to focus on three things:

Number one: clarify some of the myths about IMGs in Canada;

Number two: stress the need for greater capacity in Canada's medical education and training infrastructure; and

Lastly: emphasize the importance of a national standard for licensure.

## **Myths**

There are a few myths that abound about IMGs in Canada. If you were to believe some of what you read or hear in the media you might gather that it is next to impossible for international medical graduates to enter the practice of medicine in Canada. Nothing could be further from the truth.

As of last month, almost one quarter of the physicians working in our health care system received their medical degree in a country other than Canada. This proportion has declined by only 2% since the 1960s. Estimates peg the number of IMGs arriving in Canada with pre-arranged employment licensed to practice each year at 400. Quite simply, our health care system could not function without the critical contributions of qualified international medical graduates (IMGs).

Also, many IMGs access the postgraduate training system in Canada. As of December 2004 there were 316 IMGs who were either Canadian citizens or permanent residents in their first year of postgraduate residency training – this represents 15% of the total number of first-year trainees.

In the past few years only a few provinces have greatly expanded opportunities for assessing the clinical skills of IMGs and providing supplementary training and practice opportunities.

Just two weekends ago some 550 IMG's participated in the Ontario Provincial IMG Clinical Assessment which was offered at four medical schools across the province. This will lead to some 200 IMGs being licensed to practice in Ontario. Other provinces have similar programs.

I would note that the initiatives of the federal government announced by the Honourable Hedy Fry in March 2004 have been very helpful in communicating information about and raising awareness of the requirements to practice medicine in Canada. Some \$3 million announced at that time was provided to assist provinces and territories in assessing IMGs and will add at least 100 internationally trained physicians into the system.

I am optimistic that her continued collaborative efforts with the medical community will result in positive changes.

So, has Canada closed its borders to IMGs? Hardly. Can more be done to achieve fairness? Absolutely.

### **Capacity**

I can not stress strongly enough the need to increase the capacity of Canada's undergraduate medical education and postgraduate training system.

There are some who think that the fastest and least expensive way of meeting our medical workforce requirements is to simply recruit medical graduates from other countries. In the short term this is a major part of the fix. It is, however, no substitute for a "made in Canada" solution for the long term.

As a long-term policy it fails to recognize the fact that the countries from which we poach these IMGs can ill afford to lose them.

We are simply not pulling our weight as a country in educating and training future physicians. As my predecessor, Dr. Sunil Patel told his Committee last April, in 2002 there were roughly 6.5 first year medical school places per 100,000 population in Canada – just over one-half of the UK's rate of 12.2 per 100,000. The CMA has recommended a 2007 target of 2500 first year medical positions and at the moment we are tracking toward 2300.

Over reliance on IMGs also fails to appreciate the critical role played by Canada's academic health science centres. These institutions have a three-fold mission of teaching, research and the provision of a great deal of patient care and these three components are inextricably linked.

Expanded capacity will work to the benefit of both Canadians aspiring to attain a medical education and IMGs. For example, in 2004 of the 657 IMGs entering second iteration of the residency match, just 87 or 13% were successful.

We need to expand capacity not only within academic health sciences centres themselves, but we need to recruit and support clinical teachers out in the community. This is crucial, especially for the IMG assessment programs now being rolled out.

But most importantly, an enhanced education and training infrastructure will help meet the future health needs of Canadians.

The goal that had been identified in the 2004 First Minister's Agreement, specified \$250 million a year beginning in 2009-10 through 2013-14 "primarily for health human resources" training and hiring. However, Bill C-39, which was recently tabled to implement provisions of the 10-year plan by creating the Wait Times Reduction Fund, falls short of what Canadians deserve and expect. Specifically, it stipulates these dollars may be used for multiple purposes.

This failure to recognize the critical shortage of health care professionals by dedicating specific dollars to the issue now could mean the promised investments may never be made to enhance health human resources. The temptation will be to continue to rely on "beggar thy neighbour" policies. However, Canada can and must do better to pull its own weight.

### **Importance of a National Standard**

As the national organization representing Canada's physicians we have a direct interest in working with government to ensure Canadians have access to health care when they need it.

The CMA has a role in medical and health education in the accreditation of undergraduate medical education and the accreditation of the training programs of some 15 health disciplines.

However, the CMA is not a regulator. We do not grant credentials or license physicians. Regulation of medicine falls under the purview of the provincial and territorial colleges of physicians and credentials are granted by the College of Family Physicians of Canada, the Royal College of Physicians and Surgeons of Canada and the College des Médecins du Québec.

If medicine has a lesson to offer other professions and occupations it is in the value of having a national standard. While health is the constitutional responsibility of the provinces and territories, medicine has been able to realize a national standard for portable eligibility for licensure across Canada. Beginning in 1992 the basis for licensure in all provinces/territories except Quebec has been the successful completion of the two-part Qualifying Examination of the Medical Council of Canada plus certification by either the College of Family Physicians of Canada or the Royal College of Physicians and Surgeons of Canada. The procedures in place in Quebec are very similar.

To be sure there can be interpretation around the application of the standard, but without a doubt it has provided a significant degree of transparency and uniformity about what is required to practice medicine in Canada.

This not only promotes a concordance between the programs offered by our 16 (soon to be 17) medical schools but also provides a basis for the assessment of international programs.

On this latter point, the Institute for International Medical Education has a database that contains information on more than 1,800 medical schools in 165 countries around the world.

## **Conclusion**

During pre-budget hearings last fall, I submitted to the Standing Committee on Finance our plan to address health human resources shortages.

As was the case then, IMGs are a critical part of the CMA plan. A plan that has as its core the belief that Canada must adopt a policy of increased self-sufficiency in the production of physicians in Canada. This involves:

- 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.

This set of imperatives needs to be balanced against a need for fairness. Fairness to ensure those who need to obtain further medical training are able to do so. And, fairness to young Canadians who deserve a chance to pursue a career in medicine.

I appreciate the opportunity of entering into a dialogue with members of the Committee and look forward to your questions. Thank you.

### **CMA's Plan for International Medical Graduates (IMGs)**

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 federal, provincial 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 then 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 were expected to have competed for the 177 positions in the 2nd round match on April 29, 2004. Among the 625 IMGs in the second round of the match in 2003, just under 11% (67) were matched.

Several medical schools have special programs for IMGs. According to the Canadian post-MD registry, while 67 IMGs were matched to postgraduate year one (PGY-1) positions in 2003 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.

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 will need to be forthcoming for the infrastructure costs to medical schools to handle the increased training.

### **Long-Term**

Canadians should be 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 WORLD MEDICAL ASSOCIATION

## POLICY

### THE WORLD MEDICAL ASSOCIATION STATEMENT ON ETHICAL GUIDELINES FOR THE INTERNATIONAL RECRUITMENT OF PHYSICIANS

Initiated: May 2003

Adopted by the WMA General Assembly, Helsinki 2003

#### A. PREAMBLE

1. The WMA acknowledges that temporary stays of physicians in other countries help both the receiving and the sending countries to exchange medical knowledge, skills and attitudes. The exchange of medical professionals is therefore beneficial for the development of medicine and healthcare systems and in general deserves the support of national medical associations as well as governments.
2. The WMA Statement on Medical Manpower - 1 (1983, 1986) called upon all National Medical Associations to work with their governments towards solutions to the emerging problems related to the medical workforce.
3. The WMA Resolution on the Medical Workforce (1998) identified the major components of the medical workforce situation that need to be taken into account when developing a national workforce policy.
4. For several decades many governments, employers and medical associations have misinterpreted demographical data regarding the number of physicians that are required. Young people seeing employment as physicians have often been seriously affected by poor medical workforce planning.
5. In many countries, including the wealthiest ones, there is a shortage of physicians. A major reason for the shortage is a failure to educate enough physicians to meet the needs of the country. Other reasons for the net loss of physicians are the recruitment of physicians to other professions, early retirement and emigration, and the problems of combining professional and family responsibilities, all of which are often due to poor working conditions for physicians.
6. Some countries have traditionally solved their need for physicians by recruiting medical graduates from other countries. This practice continues today.
7. The flow of international migration of physicians is generally from poorer to wealthier countries. The poorer countries bear the expense of educating the migrating physicians and receive no recompense when they enter other countries. The receiving countries gain a valuable resource without paying for it, and in the process they save the cost of educating their own physicians.

8. Physicians do have valid reasons for migrating, for example, to seek better career opportunities and to escape poor working and living conditions.
9. There is considerable international activity underway at present to determine the nature and extent of physician migration and related medical workforce issues. The World Medical Association recognizes that there is an important ethical dimension to these issues and has developed this statement to guide national medical associations and policy makers in their efforts to find solutions to these issues.

## **B. RELEVANT ETHICAL PRINCIPLES**

10. **Justice** - Distributive justice requires an equitable allocation of resources among individuals and groups. Corrective justice requires action to address inequities. Procedural justice requires that efforts to achieve equity respect the rights of all who are involved.
11. **Co-operation** - Problems that affect two or more groups, including nations, should be resolved by working together, either bilaterally or through multilateral organizations such as the World Medical Association.
12. **Autonomy** - An individual's right to determine his or her own destiny should be respected as long as it does not interfere with the corresponding right of others, in which case a fair process for resolving conflicts should be implemented.

## **C. RECOMMENDATIONS**

13. National medical associations, governments and employers should exercise utmost care in utilizing demographic data to make projections about future requirements for physicians and in communicating these projections to young people contemplating a medical career.
14. Every country should do its utmost to educate an adequate number of physicians, taking into account its needs and resources. A country should not rely on immigration from other countries to meet its need for physicians.
15. Every country should do its utmost to retain its physicians in the profession as well as in the country by providing them with the support they need to meet their personal and professional goals, taking into account the country's needs and resources.
16. Countries that wish to recruit physicians from another country should only do so in terms of and in accordance with the provisions of a Memorandum of Understanding entered into between the countries.
17. Physicians should not be prevented from leaving their home or adopted country to pursue career opportunities in another country.

18. Countries that recruit physicians from other countries should ensure that recruiters provide full and accurate information to potential recruits on the nature and requirements of the position to be filled, on immigration, administrative and contractual requirements, and on the legal and regulatory conditions for the practice of medicine in the recruiting country.
19. Physicians who are working, either permanently or temporarily, in a country other than their home country should be treated fairly in relation to other physicians in that country (for example, equal opportunity career options and equal payment for the same work).
20. Nothing should prevent countries from entering into bilateral agreements and agreements of understanding, as provided for in international law and with due cognisance of international human rights law, so as to effect meaningful co-operation on health care delivery, including the exchange of physicians.

17.9.2003

# PHYSICIAN WORKFORCE

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## Backgrounder

February, 2005

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

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CANADIAN  
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The Canadian Medical Association (CMA) is the national voice of Canadian physicians. Founded in 1867, 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.

On behalf of its more than 59,000 members and the Canadian public, CMA performs a wide variety of functions, such as advocating health promotion and disease/injury prevention policies and strategies, advocating for 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.

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.

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## Canadian Physician Workforce

### Highlights

- There are currently close to 60,000 active physicians in Canada, 52% of which are family physicians and 48% are specialists.
- There is 1.87 physicians per 1000 population or 1 physician for every 534 people. This is down from the 1993 peak of 1.91. There has been a 5% decrease in the “real” physician to population ratio when adjustments are made for age/sex of physicians and patients.
- Canada continues to lag behind other industrialized countries with respect to physician numbers. The OECD average (2.9 per 1000 population) is 38% higher than Canada’s comparable number of 2.1 (includes residents).
- Physicians average 51 hours per week plus are on-call for an additional 20-30 hours per week. Over a quarter of physicians plan to reduce their workweek within the next two years.
- The average age of physicians is 48 years. 32% are 55 or older.
- Almost 4000 physicians may retire in the next two years, based on indications of a recent survey.

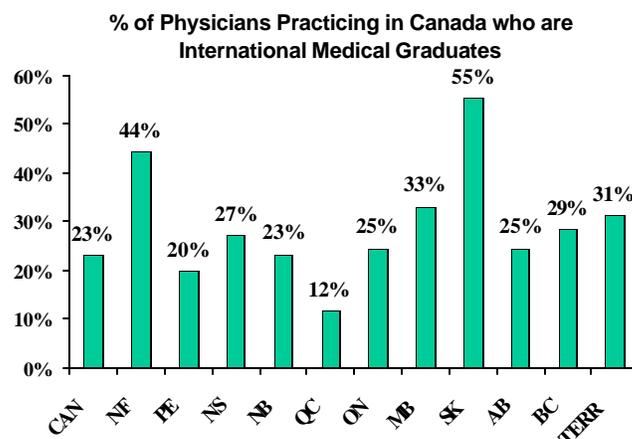
### Toward a National Strategy

**National Self-Sufficiency** – The key element of national strategy for the physician workforce must be to strive for national self-sufficiency in the production of physicians. This will require continued progress in increasing undergraduate enrolment, to at least 2500 per year - based on what we know now the level will be 2200 by the fall 2005. In addition there needs to be sufficient capacity added to the post-MD training system to allow for re-entry training and international graduates – a target of 120 first year residency positions for 100 graduates is recommended.

Part of the strategy of self-sufficiency is to make the best use of the providers that we have. Toward this end the government has made a promising start by co-funding six workforce sector studies in the health field. A needed next step is the formation of a health sector roundtable.

### **Fast-Track Assessment of International Medical Graduates**

– While the CMA does not believe that Canada should systematically recruit medical graduates from lesser economically advantaged countries, we must recognize that Canada is an attractive destination for many prospective migrants of all occupations. In concert with the Medical Council of Canada, the CMA has proposed an international on-line program that could be used by international graduates to determine their suitability and eligibility for completion of post-MD training that could lead to their entry to the practice.



Source: Canadian Medical Association Masterfile, January 2004

**Rapid Expansion of the Post-MD System** – At the present time there are several hundred International Medical Graduates in Canada who have been determined eligible to take post-MD training in Canada – however there is insufficient capacity in the post-MD system to accommodate them. The federal government could ameliorate this situation by providing funding to increase the number of first year residency training positions to a level of 120% of the graduates of Canadian medical schools. An additional contingent of 500 positions at a cost of \$30,000 per resident per year (exclusive of salaries) would cost \$15 million in the first year, reaching \$60 million within four years.

## Canadian Physician Workforce

The Canadian Medical Association (CMA) has been encouraged by significant movement towards the implementation of the 1999 recommendations of the Canadian Medical Forum calling for an increase in undergraduate and post-graduate medical training positions. There has been an increase of close to 40% in the number of first year Canadian medical students since 1998/99 for a total of 2193 in 2004/05

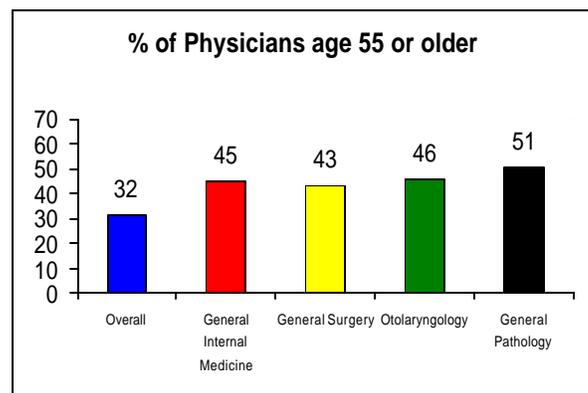
But clearly these initiatives will not solve the immediate difficulty Canadians have in accessing physician services. A survey by the College of Family Physicians of Canada estimates that 4.5 million people had trouble finding a family doctor in 2001 and in July 2002, Statistics Canada found that 12.3% of Canadians (or more than 3 million Canadians) did not have access to a regular family doctor. Long waiting lists for consultations and specialized diagnostic and therapeutic procedures suggest that there is also a shortage of specialist physicians.

**Canada continues to lag behind other industrialized countries with respect to physician numbers.** The most recent OECD data show Canada at 2.1 physicians (including residents) per 1000 population compared to the OECD average of 2.9. A study from the Canadian Institute for Health Information estimates that there was a 5% decrease in the “real” physician to population ratio. This ratio takes into account the age/sex distribution of both the physicians and their patients.

**Heavy workloads are contributing to fatigue, burnout and low morale.** In 2001, 65% of physicians surveyed by the CMA reported that their workload is heavier than they would like. Those who strongly agreed (32% of all physicians) averaged 60 hours per week plus over 30 hours on-call. Responses to a 2003 CMA survey indicated that 46% of physicians appear to be in advanced stages of burnout.

It is not surprising, with statistics like these, that the profession as a whole is losing appeal. A recent Medical Post survey showed that over half of family physicians in Canada would not choose the same career if they had it to do all over again. Another indicator of decreasing popularity is the decline in the proportion of medical school graduates selecting family medicine as a first choice discipline. The percentage fell from 38% in 1993 to 26% in 2004.

**The average age of a physician in Canada is 48 years.** Physician careers already span a great number of years. The average age of retirement is 66. Even if physicians continue to work long careers, there will be significant decreases in service provision as the boomer physicians begin winding down (or closing) their practices over the next decade.



Physicians have aged significantly over the last decade and are now on average 48 years old. Currently 32% of the active physician population is 55 or older.

**This has serious implications for service provision not only now but in the future.** According to CMA survey research, physicians in the older age groups, especially those over the age of 65, tend to work fewer hours per week than younger physicians. This translates into fewer services provided per year. When these large cohorts of physicians actually retire from clinical practice in the not too distant future, there will be a large gap in service provision that would have to be filled by younger physicians working harder than the 53 hours per week they are currently averaging. And this excludes the additional 20-30 hours per week that physicians are on-call.

Recent increases in medical school enrolment have resulted in much more positive projections of overall supply (although the starting point does not take into account current vacancies). The more crucial issue will be the number of full-time equivalents. It is estimated that females will represent 44% of the physician population by the year 2020 and past research has clearly shown that women work, on average 7 fewer hours per week than their male colleagues. We are also facing increasing numbers of retiring physicians over the next decade.

A more highly educated population and the widespread use of information sources such as the Internet are contributing to a heightened sense of patient empowerment, higher expectations and consumerism. These factors will increase pressure for high-quality health services. Although we encourage patients to be informed, we must be prepared for the added demands on the health system that this enhanced knowledge will create, especially in terms of the supply of health human resources. As well we have not only an aging population but an environment where thanks to medical advances, there is an increase in chronic conditions that require ongoing monitoring and treatment by health professionals.

**There is an urgent need in Canada for an integrated approach to health human resource planning that is based on the current and future needs of the population.** This would facilitate a dynamic approach to planning to meet the challenges of demographic changes of both the population and provider groups. As well, planning in this fashion would enable the system to react appropriately and quickly to unexpected shortages, system reform, innovation in technology, new diseases, etc.

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## Health Resources Education and Training

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The necessary increases in undergraduate enrolment in medicine needed to address this situation require funding not only for the positions themselves, but also for the infrastructure (human and physical resources) needed to ensure high-quality training that meets North American accreditation standards. In addition, capacity must be sufficient to provide training to international medical graduates and allow currently practising physicians the opportunity to return to school to obtain postgraduate training in new skill areas.

As well, the CMA remains very concerned about high and rapidly escalating increases in medical school tuition fees across Canada. According to data from the Association of Canadian Medical Colleges (ACMC), between 1996 and 2001 average first-year medical school tuition fees increased 100%. In Ontario, they went up by 223% over the same period. Student financial support through loans and scholarships has simply not kept pace with this rapid escalation in tuition fees.

Findings from recent research show that high tuition fees and fear of high debt loads create barriers that discourage people to apply to medical school and potentially threaten the socio-economic diversity of future physicians serving the public. They may also exacerbate the “brain drain” of physicians to the United States where newly graduated physicians can pay down their large student debts much more quickly. In addition, high debt loads may influence physicians’ choice of specialty and practice location.

**The Federal Government can show a commitment to ensuring self-sufficiency** by taking action to increase the current supply of physicians. CMA recommends the establishment of a **\$1-billion, five-year Health Resources Education and Training Fund** and increasing targeted funding to post-secondary institutions to alleviate some of the pressures driving up in tuition fees. This could include the provision of enhanced direct financial support to students, in particular, through bursaries and scholarships.