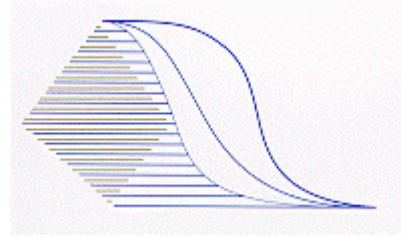


**Centre for Health Services
and Policy Research**



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Physicians to/from Canada**

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*Health Human Resources Unit
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THE UNIVERSITY OF BRITISH COLUMBIA

Immigration and Emigration of Physicians to/from Canada

**Morris L. Barer¹
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Centre for Health Services and Policy Research
The University of British Columbia

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HEALTH HUMAN RESOURCES UNIT

The Health Human Resources Unit (HHRU) was established as a demonstration project by the British Columbia Ministry of Health in 1973. Since that time, the Unit has continued to be funded on an ongoing basis (subject to annual review) as part of the Centre for Health Services and Policy Research. The Unit undertakes a series of research studies that are relevant to health human resources management and to public policy decisions.

The HHRU's research agenda is determined through discussions of key current issues and available resources with the senior staff of the Ministry of Health. Various health care provider groups participate indirectly, through on-going formal and informal communications with Ministry of Health officials and with HHRU researchers. Arminée Kazanjian is the Associate Director and Principal Investigator for the Unit.

Three types of research are included in the Unit's research agenda. In conjunction with professional licensing bodies or associations, the HHRU maintains the Cooperative Health Human Resources Database. The Unit uses these data to produce regular status reports that provide a basis for in-depth studies and for health human resources planning. The Unit undertakes more detailed analyses bearing on particular health human resources policy issues and assesses the impact of specific policy measures, using secondary analyses of data from the Cooperative Database, data from the administrative databases maintained under the HIDU, or primary data collected through surveys. The HHRU also conducts specific projects pertaining to the management of health human resources at local, regional and provincial levels.

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A. Introduction

At the beginning of the 1960s there was approximately one doctor per thousand people in Canada. Beginning in the late 1960s, Canada experienced a major expansion in medical schools (about 50% increase in first year enrolment capacity by the early 1980s). At the same time, until the mid-1970s, there was a relatively open immigration policy for graduates of foreign medical schools. As a result of both these factors, physician supply expanded much more rapidly than the population. Between 1961 and 1989, physician supply grew about 3.7% annually, while population grew at an annual average rate of about 1.5%. By the end of the 1980s, supply was approaching one doctor per five hundred population.

For a variety of reasons, including some medical school enrolment reductions in the 1980s and somewhat increased physician emigration during the 1990s, expansion of physician supply has slowed so that the physician: population ratio has been relatively stable for the past decade. A more recent decision to reduce national first year medical school enrolment by a further 10%, which took effect in 1993, is only just beginning to have an effect on domestic additions to supply. Given the demographic distribution of the physician population and an anticipated high rate of retirement over the next ten to fifteen years, concern is now being expressed about a possible physician shortage and pressure is mounting to expand medical school enrollment (Sullivan, 1999).

About twenty five percent of Canada's physicians received their undergraduate (MD) training outside Canada. The major source of international medical graduates (IMGs) has been the United Kingdom (see Table 1). However, in more recent years, South Africa and India have featured more prominently among IMGs, with India being a notable source of specialists, and South Africa, of general/family practitioners (many of whom are recruited into rural/remote areas). Interestingly, in 1998 only 3.3% of Canadian IMG physicians had been trained in the United States, whereas about 33% were trained in the U.K. The relative importance of Eastern Europe as a source of IMGs has declined over this period, as Western European countries have become a more significant source. Among the 1998 IMGs from the United States, about one-quarter had been trained in California or New York.

In the next section of this paper we describe the distribution of IMGs in Canada, before turning attention in sections C through E to recent trends in immigration and emigration. Sections F and G of the paper contain some discussion of current policy issues and approaches, and we offer some concluding observations in the final section.

B. Specialties and Canadian Destinations for IMGs

There are wide differences in the proportion of foreign-trained doctors in different parts of the country and there is considerable variation among specialties in the proportion of graduates of foreign medical schools. However, the proportion of physicians who are IMGs is very similar in urban and non-urban areas. While it is

commonly assumed that a large proportion of physicians practicing in non-urban areas of the country are IMGs, in fact in 1998 only about 26% of those practicing outside census metropolitan areas were IMGs. This was not appreciably different than the overall ratio of IMGs to all practicing physicians in Canada [personal communication, Lynda Buske, Canadian Medical Association, April 1999].

In Table 2 we show the distribution of IMGs across the country, and split by family medicine and specialists. The relative importance of IMGs varies widely across provinces. For the country as a whole, they represented 23.5% of physician supply in 1998. But they accounted for only 12% of supply in Quebec, and about 50% in Saskatchewan!¹ Other provinces relying heavily on IMGs include Newfoundland (44% of supply), and Manitoba (30% of supply). About 58% of Saskatchewan's family practice physicians were IMGs in 1998. Newfoundland ranked second, at 45%. In Quebec the comparable proportion was under 11%! Among specialists, IMGs were most heavily relied upon in Newfoundland (43%) and Saskatchewan (40%), while 33.5% of British Columbia specialists were IMGs. In Quebec the comparable proportion was 13%.

This dramatic variation in the relative presence of IMGs is portrayed in ratio form in the two right-most columns of Table 2. These columns show the relative importance of IMGs to family practice, and specialist, supply, respectively. For example, the family medicine column indicates that Saskatchewan family medicine IMGs as a share of all Canadian family medicine IMGs was 2.6 times as large as Saskatchewan's proportion of all Canadian family practitioners -- they have a disproportionate share of the family medicine IMGs in the country. Newfoundland clearly stands out as disproportionately dependent on IMGs for both family practice and specialty care, whereas B.C. is a relatively high IMG site only for specialists. Prince Edward Island and Quebec have proportionately fewer IMGs.

In Table 3 we show the CMG/IMG distribution of physicians by specialty for the country as a whole. Overall in 1998, 23.5% of Canadian physicians had earned their MD degrees outside the country. But over one-third of the laboratory specialists (medical biochemistry, medical microbiology, and pathology) were IMGs, along with about one-third of the paediatricians and psychiatrists. In contrast, about 22% of family practitioners, and less than 20% of ophthalmologists, orthopedic surgeons, and various other smaller specialties, were IMGs.

C. Routes to Entry

Physicians receiving their undergraduate (MD) training in other countries end up in Canada for a variety of reasons, and there are a variety of routes through which some of those physicians eventually enter practice with full Canadian licensure (see Figure 1). Some come by choice as immigrants, for financial, professional, personal, or family reasons. Others arrive through the push of being refugees from their own countries or the pull of being recruited to fill hard-to-fill positions in Canada. And still others are

¹ These percentages are arrived at simply by summing the family medicine and specialist IMG columns in the table.

Canadians who have gone abroad for MD training. While the majority of hard-to-fill positions are in rural and remote areas, there has also been recruitment to fill academic and/or tertiary care positions due to mismatches between Canadian production and tertiary care facility requirements for residents, or where specific academic expertise was being sought.

More specifically, the routes illustrated in Figure 1 most likely to lead to opportunities to work in some aspect of medicine in Canada include:

- Recruited for practice: perhaps the most high-profile recruiting of IMGs is into rural, remote and isolated communities that often have chronic difficulty attracting, or retaining, Canadian-trained physicians (CMGs). “These IMGs will often not have completed the necessary post-MD training (most jurisdictions require at least one year of post-MD training in Canada for full College registration); as a result they will be granted “conditional registration”, a condition being that they can practice only in certain locations for a specified period of time.” (Barer and Stoddart, 1999). Circumstances under which IMGs can enter the country to take up practice opportunities in rural and remote communities vary considerably across provinces and the territories (for details, see Barer, Wood and Schneider, 1999).
- Academic recruits: enter the country in response to situations where agencies (largely medical schools and affiliated teaching hospitals, or biomedical research institutes) have been able to establish, to the satisfaction of Canada's immigration authorities, that no suitably qualified Canadian is available.
- Recruited into post-MD training: these physicians will be recruited to fill post-MD training positions to which no Canadians have been attracted. Historically, recruitment into post-MD residency training programs was an approach to satisfying non-training-related reasons for maintaining residency capacity. This occurred when post-MD training program capacity exceeded the number of Canadians entering the particular specialty in question, either because the specialty was relatively unpopular, or because training program capacity was driven by teaching hospital service needs. Since the early 1990s, few IMGs are likely to have entered this way, because medical schools have agreed to no longer allow visa trainees to enter ministry-funded positions, and the vast majority of residency positions in the country are publicly funded.
- Clinical fellows: these physicians will generally come to the country to complete non-programmatic additional specialty training (i.e. are for individuals who already have specialty training and are not working toward another specialty or sub-specialty Royal College certification). Many of them end up with educational licenses, and in situations in which they become *de facto* ‘recruited’ visa trainees; some may eventually end up applying for landed immigrant status and entering practice.

Recruited IMGs may enter the country either as landed immigrants or on temporary employment authorizations. Those entering as landed immigrants, because they are landed immigrants, cannot be ‘held’ to the positions to which they were recruited. Those entering on employment authorizations are bound to the positions into which they are recruited (for a specified period of time), unless they receive a release

from the initiating sponsor, employer or organization. Those physicians entering on temporary employment visas can, if the job becomes “permanent” (and generally this will be the intent, both of the IMG and of the sponsor), apply for landed immigrant status. Of course while the position may be permanent, once a physician becomes a landed immigrant, his/her tenure in that position is anything but -- again, the physician is free to seek whatever opportunities any other Canadian physician might arrange.

In addition, there are a variety of routes through which physicians enter Canada, but which are considerably less likely to result in the physicians in question being able to find employment as physicians in Canada:

- Visa trainees supported by external (out of country) sources: these physicians will come to Canada for post-MD training with the financial support of their originating country, and under a contractual arrangement requiring that they return after having completed the training. This is still a common, perhaps increasingly common, arrangement.
- Non-recruited, entering as refugees or under family reunification program: These IMGs have had, and continue to have, difficulty gaining access to practice opportunities in Canada. Most will not meet Canadian requirements for licensure.² These IMGs are eligible for the second iteration of the annual Canadian Resident Matching Service (CaRMS).³ But they are competing in that iteration with ‘current’ CMGs not matched in the first iteration, as well as CMGs, graduates of U.S. schools, and others from earlier years. Nevertheless, this does provide a significant number with entry into post-MD training (in 1998, about 15% of eligible IMGs were placed in the second iteration). In addition, there are some post-MD training spots dedicated as entry portals for these IMGs (e.g. 2 in B.C. and 24 in Ontario annually). Since the early 1990s, a previously available route to practice through post-MD training in the United States has also been largely closed off.⁴ In total, the number of post-MD training opportunities available for this group falls far short of the number of IMGs wishing to take advantage of them. As a result, they are engaged in continuous lobbying of various provincial Ministries of Health, regarding the creation of additional entry opportunities.
- Other non-recruited: immigrate to Canada for personal or business reasons; have to sign a form saying they realize they will not necessarily have the opportunity to practice their profession. Have the same limited number of opportunities to gain the

² In most provinces, at least one year of post-graduate training in Canada, or certification with the College of Family Practitioners of Canada or the Royal College of Physicians and Surgeons of Canada.

³ See [<http://www.carms.ca>] for more information.

⁴ Prior to the change in policy in 1993 many IMGs sought, and gained, J-1 Visas allowing them to go for post-MD training in the U.S. Since such training satisfies the post-MD training requirements for licensure in Canada, this ended up being another route to entry to practice. In 1993 a policy was developed which restricted the issuance of J-1 Visas to physicians who: a) were already in Canadian post-MD training and were seeking additional expertise; b) were already in practice in Canada and were seeking additional training in their field of practice; and c) those who had a pre-arranged, non-fee-for-service, employment contract with a health facility which would employ the physician upon completion of the U.S. post-MD training.

necessary post-MD training as those in the category above (refugees/family reunification).

Conditions governing whether IMGs will be able to practice medicine in Canada have changed over time. The most significant changes were the decision in the mid-1960s to add physicians to the so-called “open list” of ‘priority occupations’ for the purposes of application review by immigration officials, and in the mid-1970s to remove physicians from that list. This latter had the effect of drastically reducing the number of physicians able to immigrate to the country. Between 1967 and 1974, for example, between 1000 and 1200 physicians per year immigrated to Canada. Since 1976, this figure has been consistently below 500 per year, and often less than 400 (see Figure 2). The entire immigration process is apparently under review once more, as this is being written; one current view is that the process will move away from an occupation-based review to one based on educational attainment. If this were to occur, one could expect physicians to find entry to Canada easier, which would likely increase the number of pressure points on post-MD training opportunities. In addition, were it to result in increased numbers of physicians entering the country from the U.S., this would have an immediate, and potentially significant, impact on Canadian supply, as many of these physicians would satisfy Canadian requirements for licensure.

In sum, there are a variety of ways in which IMGs enter the country, and a variety of ways that they can enter or eventually ‘leak into’ practice once they are in the country. And even this is not a complete picture. For example, non-recruited visa trainees who come for post-MD training with the support of their sponsoring country, may indeed get the training and return home. However, if they then return to Canada in the future as an immigrant (through any of the immigration routes), they will have fulfilled the requirements for entry into practice!

D. Quantifying Entry -- Attempting to Paint by Numbers

It is, unfortunately, difficult to develop a comprehensive and accurate statistical picture of the entry of physicians to Canada. This is due to the multiple routes to entry (see above), the various ‘statuses’ with which IMGs arrive, and the multiple, often non-reconcilable, sources of data. For example, some are Canadians who have been abroad for medical school training.⁵ Others are IMGs who have practiced in Canada, then leave Canada, then return. Others are ‘new’ (to Canada) IMGs who arrive as landed immigrants. Some of these latter come to arranged employment (the recruited group), while others arrive indicating medicine as their intended occupation, but without arranged employment. Some arrive with temporary employment authorizations. A physician who enters one province on an employment authorization (work visa) and then takes up a position in a second province, may be counted twice in the employment authorization numbers, even if the individual has not departed Canada between employment situations.

⁵ Canadian students will generally seek medical training abroad either because they were unable to gain entry to a Canadian medical school of their choice, or because they are seeking training in a particular (usually high profile, prestigious) medical school outside Canada.

In addition to these, there are the physicians who arrive for training (visa trainees and clinical fellows).

Accordingly, the answers to the question, “How many physicians entered Canada from abroad in [choose a year]?”, will invariably be “It depends” or, “There’s no way of getting an accurate figure”. Of necessity, then, what follows is a cobbling together of bits and pieces of available information. At the end of that process, however, it is not possible to know how comprehensive we have been in our painting. In Table 4 we show the number of Canadian physicians returning from abroad, disaggregated into CMGs and IMGs, the number of landed immigrants arriving in Canada with and without arranged employment, and the number of temporary employment authorizations issued to “foreign workers”, for the period 1970 -- 1998.⁶

The number of physicians returning annually has moved within a range of about 200 -- 360 for almost 25 years, the exceptions being 1978 and 1979. Between 15% and 30% of these have been IMGs, although there does not seem to be any policy-related pattern to the mix of physicians (IMGs/CMGs) returning. The number of returning physicians peaked in 1987 and 1988, hit a relative low period in 1996 and 1997, but in the most recent year (1998) the number of returns was near the historical peak.

The second category of physicians entering Canada is the landed immigrants (the total data in Table 4 form the basis for Figure 1 above). The number of landed immigrant physicians arriving with arranged employment was relatively stable between 1977 and 1993. Between 1994 and 1997 the numbers declined sharply, but they were up again in 1998. However, one cannot view these in isolation from the temporary employment authorizations, since in many (perhaps most) instances these seem to be alternate equally available routes of entry. The numbers entering with temporary employment authorizations has increased sharply since 1995, with entries in 1996 and 1997 exceeding the numbers in any previous year for which data are available.

The number of landed immigrants (stating that their occupation is “physician”) arriving annually without arranged employment (refugees; family reunification; other reasons) has ranged between 130 and 365 but here again there is no obvious way to interpret this series because the motivations for immigration will vary with events that would be difficult, if not impossible, to document. Furthermore, at least at present, most of this group does not represent potential new entries to practice, although they do represent an ongoing policy issue (see below).

If one were prepared to set aside qualms about the consistency and quality of the data, and simply sum the three sources of entry (Canadians returning from abroad,

⁶ Data are available for varying periods. For example, prior to 1977, data on landed immigrants were not disaggregated on the basis of whether or not employment was arranged, because in the early 1970s it was much easier for IMGs to immigrate to Canada and practice medicine. In other words, in the earlier years, the distinction was less important. Employment authorizations include only “first issues”, not “extensions”, since the latter will already have entered the country, but nevertheless may double count physicians whose authorization is in a province different from the province where they end up practising. As of the time of writing, complete figures on 1998 temporary employment authorizations were not available.

immigrants with arranged employment, and temporary employment authorizations), one would find that between 1980 and 1990 the total ranged between 525 and 735 annually. Between 1991 and 1993 this total increased to about 850, then fell again to as low as 550 in 1995. In the most recent year for which data are available (1997), close to 1100 physicians eligible to practice medicine entered the country. This represents a significant increase over any other year since 1980; it will be interesting to observe whether this is the beginning of a new trend or plateau reflecting increased reliance on temporary employment authorizations to fill hard-to-fill positions.

E. Emigration

There is a general understanding that most of Canada's emigration of physicians is to the United States, although no reliable sources of data on destinations of departing physicians exist. Active recruitment of various types of physicians from Canada may take place to fill particular needs in geographic or specialty areas. For example, emigration to the United States was believed to be (in historical perspective) relatively high, for example, around the years of the Clinton reform initiative. The trends in Figure 3 are at least consistent with this view.

Physicians migrate for many of the same reasons as people in the general population. They may move to what they see as a more attractive political or social climate or health care system. They may move for personal reasons such as proximity to family members, opportunities for their children or increased income. They may move for professional reasons including style of practice, professional autonomy, or access to facilities and equipment, or they may be recruited. Factors influencing emigration from Canada to the US are well summarized by McKendry et al. (1996). Some of these factors are amenable to public policy decisions directed at encouraging the retention or relocation of physicians (see discussion below).

In Table 5 we report some of the data assembled by the Canadian Institute for Health Information on physician emigration.⁷ These figures do not include physicians who complete training and then move directly abroad without first establishing an address in Canada that is picked up in the database. Physicians whose address abroad is unknown are “removed” from the source database, which may result in a further undercount of the number of physicians “moving abroad”.

Despite these data quality-related caveats, one can be relatively comfortable about examining trends, even if not putting a huge amount of faith in absolute numbers. This is because the processes and definitions used to assemble the data have remained largely unchanged over the time period shown. A number of interesting trends are evident in these data. First, absolute numbers of physicians moving abroad have varied

⁷ The database from which these figures are taken classifies each physician in each year as “active”, “abroad”, in the “USA”, or “removed”. But there are a number of sources of slippage. For example, some physicians who move to the U.S. may, nevertheless, be classified as “abroad” if U.S. destination information is not captured. By the same token, some “abroad” may, in fact, be in the U.S. As a result, we do not report a USA/Abroad split in this table.

considerably over the years, with a local peak in the late 1970s, and another, apparently, in the mid-1990s. But of course because the supply of physicians in Canada grew dramatically over those twenty years, the departures as a proportion of overall supply were higher in the mid-1970s (reaching a peak of almost 1.9% of supply in 1978) than in the more recent period (where the peak appears to have been in 1994 at 1.4%) (see Figure 3).

Second, despite much sound and fury about mass migrations south, the total number of physicians departing Canada has declined in the most recent two years for which data are currently available. But, third, CMGs have become an increasingly prominent component of departing physicians in recent years. IMGs represent about one-quarter of all Canadian physicians. Between 1986 and 1994, between 27% and 31 % of physicians moving abroad were IMGs. However, since 1994 this proportion has declined so that, in the latest year, the CMG/IMG proportions moving abroad reflected the CMG/IMG distribution in overall supply.

Fourth, between 1982 and 1993, the number of specialists moving abroad exceeded the number of general/family practitioners by a considerable margin in virtually all years. This trend appears to have changed in 1994, with departures of general/family practitioners exceeding those of specialists in recent years. The 1998 figure suggests the possibility of a return to the earlier pattern, although one year makes a short trend.

In Figure 3 we show the proportion of all “active civilian physicians” who departed in each year, by broad specialty. A number of observations seem of interest. First, the gp/fp and specialist trends move roughly in tandem. For example, during periods such as 1975-78, when the proportion of gp/fps leaving the country was increasing, the same was true for specialists. Second, this general parallelism in trends notwithstanding, an obvious gap opened up in 1982 and was sustained through to 1995. Throughout this period, a greater proportion of specialists, than of gp/fps, was departing Canada, and the differences were often substantial. This mirrors the absolute differences noted above. For example, from 1988 to 1991 the proportion of specialists leaving was about double that of gp/fps.

Third, from 1994 to 1997, the proportion of gp/fps moving abroad increased markedly from the pattern over the previous 12 years. Arguably, this may be where the ‘Clinton plan’ side-effects are reflected in the patterns of Canadian physician movement. In that regard, however, it is interesting to note that the out-migration of gp/fps in those years was considerably less than in the 1977-1979 period. And finally, since 1995, the gp/fp and specialist patterns have closely tracked one-another, and in general, movement abroad seems to be trending down as a proportion of overall physician supply.

F. Net Migration

Setting aside **new** IMGs entering the country for a moment, it is clear from Tables 4 and 5 above that Canada experiences a permanent annual net loss of **Canadian** physicians. The number of physicians (CMG and IMG) returning to Canada has varied

within a relatively narrow range of 200-360 since 1980. It dropped to just above 200 in 1996, but has increased in the most recent two years. On the other side of the ledger, the number of departing physicians has, in historical terms, been relatively high since about 1992, although those numbers seem to be declining again in the most recent two years. The net effect, however, has been that there has been an increase in net outflow of Canadian physicians, at least between 1992 and 1997, relative to the pattern during the 1980s and early 1990s. For example, in 1996 the number of Canadian physicians departing exceeded the number of returning Canadian physicians by over 500. The comparable figure in 1998 was about 250. While even a net loss as high as 500 represents less than 1% of overall supply, these losses become a significant political issue when they come from already hard to service (e.g. rural and remote) areas or from key, high profile disciplines such as neurosurgery or radiation oncology.

Offsetting this net loss of Canadians is a supply of non-Canadian IMGs which has ranged over the past decade from about 300 to over 800 physicians. In Figure 4 we bring three series together: net movement of Canadian physicians; new landed immigrants with arranged employment; and temporary employment authorizations. This Figure suggests that the current decade has been quite different than the previous, at least in terms of the patterns for Canadian physicians and IMGs arriving with temporary employment authorizations. It also makes clear that, with the exception of 1994 and 1995, the number of IMGs entering Canada has, at least over this period, exceeded the net loss of CMGs.

G. Current Policy Issues

The problems for which IMGs are seen as a(n at least temporary) solution, and the dilemmas they pose once in the country, are not unique to Canada, and have been with us for a very long time (Barer, Wood and Schneider, 1999; Evans, 1976). To understand why the problems exist, and persist, it is useful to recall the basic architecture of the system within which Canadian physicians work, and through which they are funded. Medical services are largely funded from provincial government budgets. There are a few other sources of income for some physicians, for example workers' compensation work, care related to insurance claims, or services not covered by provincial plans because they are deemed not medically necessary. With the exception of the non-medically necessary services (e.g. cosmetic surgery), in general, patients do not pay directly for any portion of the costs of their medical care.

Historically, physicians have been free to choose the specialty and location of their practice (the former within the limits of available residency positions). Most provinces have, over the years, employed a variety of approaches to attempt to improve the geographic distribution of physicians. The great distances, and sparse population, that characterize much of the country, have always posed significant problems for this effort. The most common approaches have been a variety of financial incentives, either to encourage physicians in practice to move to, or stay in, less well-supplied areas, or to encourage medical students, and post-graduate trainees, to consider establishing practices in such areas (Barer, Wood and Schneider, 1999). A number of provinces have also attempted to restrict where physicians could establish practices, but these attempts have

run afoul of the Canadian Charter of Rights and Freedoms (Barer and Wood, 1997). Another approach has been to try to encourage more physicians to work under non-fee-for-service arrangements, through contracts or salary. These approaches have been resisted by the medical profession, and funding has been scarce for such alternatives because most of the funding for medical services tends to be locked up in negotiated fee-for-service 'pools' that provincial medical associations consider 'off limits' (Barer, Lomas and Sanmartin, 1996). As a result, non-fee-for-service payments continue to be a relatively small fraction of total remuneration for medical services.

Because of the limited success of these 'domestic' policy approaches, overseas recruitment has a long history as a reliable approach to providing services to hard to service areas. The primary incentive for the physicians involved has been the opportunity to immigrate to Canada. A major drawback with this approach has always been that, once these IMGs enter Canada, and gain landed immigrant status, provinces are no more able to control where they practice, than they have been with native Canadian physicians. We are aware of no evidence suggesting that the IMGs are more likely to remain in the hard to service areas than are Canadian graduates. Jurisdictions which have chronic difficulties attracting or retaining physicians see a steady stream of IMGs as about the only reliable solution to their problems; areas perceived to be oversupplied regard this source as a "leak" in the system, resulting over time in ever-increasing supply in specialties and locations which do not necessarily require them.

But this 'leakage' problem is not the only current policy issue with which Canadian health policy-makers struggle. An overarching issue has always been, and continues to be, the fact that there is more than one policy jurisdiction involved in decisions which ultimately have effects well beyond those contemplated at key decision points. Decisions around immigration into Canada must take into consideration a host of factors, many of which have nothing at all to do with health care policy. Physicians who enter the country as refugees, or under the family reunification program, do so without regard to whether the country has, or will have, a need for the skills and experience they bring. Once in the country, these physicians run head-on into a quite hostile health care policy environment, and few get the opportunity to enter medical practice in Canada. Even decisions by immigration officials regarding whether "physician" is to be an occupation on or off the "open list" may not be adequately coordinated with those responsible for provincial health care policy. Currently under consideration is a change in immigration policy which would move away from "designated occupations", and toward an assessment based on education, language, skills and similar criteria. If such a change is implemented, it is likely to increase considerably the number of physicians entering the country through the non-recruited immigration route. This can only increase the pressure on post-MD training, and licensing bodies.⁸

Similarly, decisions to make Canadian training resources available to foreign post-graduates, may be part foreign aid, part local pragmatism, but rarely take account of the Canadian physician supply/requirements calculus (such as it is). An unknown

⁸ And, in the case of physicians from the U.S., on provincially negotiated global physician expenditure budgets (since most of these physicians would be able to enter practice without further post-MD training).

number of these trainees, having completed some post-MD training in Canada, are likely to ‘leak’ back into supply through unrelated immigration routes.

Another chronic policy issue is the fact that the United States has always been, and will always be, a magnet for some small segment of physicians trained in Canada. A greater range of opportunities, perceptions of greater availability of high tech facilities and equipment, and a perception of a more ‘private’ health care system, continue to attract some physicians. However, this phenomenon is no different in health care than in virtually every walk of life. The extent of the Canadian ‘brain drain’ is an ongoing source of conflict and debate in political and policy circles.

Earlier this decade, the alleged mass migration south of family practitioners in response to aggressive Clinton-reform-related primary care recruiting, became a significant policy issue. Many of the disgruntled physicians who were attracted south allegedly came from rural and remote areas in Canada, exacerbating already difficult retention situations.⁹ The data we have been able to assemble for this paper, limited though they may be, suggest that there has been very little change in net migration of physicians to the United States, when viewed over multiple decades. However, it takes only a periodic high profile departure from an esoteric academic sub-specialty, or the departure of sufficient specialists to force the discontinuation of a service in a particular area, or a few departures of physicians from single physician rural communities, to keep this issue on the front pages of the newspapers.

In addition to these over-arching policy issues, there are specific issues pertaining to each immigration stream portrayed in Figure 1 above. IMGs recruited to practice seem to be entering ever more frequently on temporary work visas. This is presumably because this route is a path of less bureaucratic ‘drag’ or resistance, although in practice the routes tend to be similar. “Temporary” is a tag of convenience -- it is understood by the IMG and the sponsor, employer or organization doing the recruiting that the physician is being brought into a situation with the understanding that (s)he can stay in the position as long as both parties are happy. But again, these individual decisions are made in an uncoordinated fashion, perhaps on the basis of business rather than considerations of medical need and, as noted above, many of these temporary workers will eventually gain landed immigrant status and migrate to larger urban centres.

Academic recruiting brings its own set of policy issues. Positions must first be advertised to suitably qualified Canadian citizens or landed immigrants. For academic posts this may be a problem where the immigration authorities look at basic qualifications but the recruiting institution is looking for special background and skills. In general, both federal and provincial approval is required when recruiting foreign-trained physicians. Licensure may be a problem at the provincial level when foreign credentials are being considered and specialty qualifications may not be accepted as the equivalent of Canadian qualification. While an individual may be allowed to practice, they may not be allowed to bill the medical plan as a specialist. This is likely to reduce their income earning

⁹ Although we are unaware of any detailed empirical analysis of the nature or extent of this out-migration from rural/remote areas.

capacity, and so may make recruitment more difficult. Each of these individual policies has its own rationale but, again, there is no overall coordination of policies affecting IMGs and collectively they may inhibit rational planning.

The non-recruited IMGs continue to be a major policy issue for the country. As noted above, these physicians enter for reasons completely divorced from health care policy considerations. Nevertheless, once in the country, and despite any 'agreements' or understandings they may have been signatories to on entry, collectively this pool of IMGs represents an ongoing source of pressure on provincial Ministries of Health and licensing authorities. They are interested, quite naturally, in portals of entry, either into post-MD training, or into temporary (and eventually permanent) practice situations through changes in licensure restrictions/requirements. To date, the general perception of an overall surplus of physicians has led to a tight rein on such opportunities. Whether this will be 'loosened' in future, as the wave of Canadian baby boom physicians who took up all those new medical school training opportunities in the 1970s approaches retirement, remains an unanswered political question. We see a major area of future conflict, between advocates of ramping up medical schools again, and those who believe we should provide the necessary post-MD training opportunities to the large and growing pool of Canadian physicians who are being denied access to opportunities to demonstrate their capabilities.¹⁰

Policies related to examinations necessary for licensure in Canada arguably contribute to the creation of this pool of IMGs with no routes to practice, and again reflect the lack of coordination in IMG policy. The Medical Council of Canada (MCC) continues to make it possible for IMGs to sit the MCC Qualifying Examination (MCCQE; the first of two exams necessary for licensure for IMGs) at a variety of sites around the world. It is perhaps not surprising that IMGs see this as a fast track into Canadian practice -- after all, if this were not the case, why on earth would the MCC go to the expense and inconvenience of making it possible to write their exam in faraway places?¹¹ Another example of this lack of coordination is recent changes to the Royal College of Physicians and Surgeons of Canada requirements; IMGs must have Canadian or accredited U.S. post-MD training to be eligible to write the specialty certification exam.

As noted earlier, restrictions on entry into Ministry-funded posts has resulted in a decline of visa trainees entering these posts by about two-thirds over the past five years, as the number of funded positions has been brought more into line with the number of positions necessary to provide post-MD training opportunities for Canadian graduates. But the overall number of post-MD training positions in the country continues to increase -- the number funded by foreign countries has increased (Canadian Post-M.D. Education Registry (CAPER), 1999). As noted earlier, the expectation, and the understanding, is that the vast majority of these latter do, in fact, come to Canada for training and then return to their native country. However, we are unaware of any data that could be used to

¹⁰ Of course these are not complete substitutes for each other, as the age profile of the non-recruited landed immigrants may be quite similar to the current crop of CMGs in practice.

¹¹ One might speculate that, rather than being an expense, it is in fact a source of revenue for the MCC.

confirm this. There is nothing preventing such an IMG from coming to the country, marrying a Canadian for example, and then staying and entering practice. Furthermore, as noted earlier, once an IMG has received Canadian post-MD training, should the IMG eventually wish, or find a way, to immigrate to Canada, in most cases the necessary post-MD training requirements for licensure would have been satisfied.

The “clinical fellow” route also leads to unintended increases in Canadian supply, and an increasing number of these are being funded by non-provincial government sources. There is considerable controversy around whether many of these individuals truly come to Canada for educational purposes, or because they are recruited into service situations using an educational license. Again, once in the country, there are a variety of routes through which these individuals can enter practice, and they generally do not come under the same conditions as IMG visa trainees (i.e. under an agreement that they will return to the originating country).

And finally, there are the Canadian IMGs, who go elsewhere for their MD degrees with mixed signals. Following the 1993 reductions in domestic medical school enrolment, provinces agreed not to provide student loans for students who wished to study medicine outside the country. Virtually none of the provinces followed through on this agreement, meaning that we are in the most curious position of providing student loans for students to train in an area where, once trained, they will be given virtually no opportunity within Canada to complete the post-MD training necessary to practice. Again, the larger the pool of such physicians one creates, the greater the source of political pressure.

H. Looking Ahead

There are two major factors that inhibit the development of coordinated physician immigration policies. The first is the difficulty in developing national approaches that meet the needs of the regions and provinces. In the real world, each province, and often each community, develops its own plans to the extent that they exist, and the national ‘plan’ is the aggregate of these. Since there is very little effective control of inter-provincial migration, and no control of intra-provincial movement, policies often end up being in conflict, with doctors being recruited to under serviced provinces or regions and then resettling in already adequately serviced areas. Policies, which suit the needs of one area, may be antithetical to other areas. As noted earlier, it is difficult if not impossible to develop policies that restrict inter-provincial migration, and imposing restrictions on intra-provincial mobility using traditional approaches continues to test the minds of some provincial policy-makers and lawyers. Furthermore, policies which are directed at discouraging doctors from locating in particularly desirable areas may also foster emigration.

The debates over immigration, in particular, are carried out in front of a backdrop of uncertainty about how many physicians, of what types, we need where, to provide appropriate services. Some are now forecasting a reduction in the Canadian physician/population ratio over the coming decades, as the baby boom bulge of

physicians trained in the era of medical school capacity expansion moves through to retirement. The policy response to this, if it turns out to be accurate, will depend to a considerable extent on perspective on past events and the current situation. For those who believe that the current supply of physicians in the country is ‘about right’, or even in deficit, any reduction in the ratio will be a cause for alarm. For those who believe the country dramatically overshot in its training capacity a few decades back, that same reduction may be seen as some welcome relief, or as a spur to long-needed fundamental structural reform.

These opposing views are likely, in turn, to lead to quite different views on immigration policy. If one assumes that any reduction in the current ratio represents a deficit that will need to be covered, in the short run this could only be done by encouraging more immigration and easing access to practice for those who do immigrate, or have already immigrated (for example, by increasing the availability of post-MD training opportunities for these IMGs who are already landed immigrants or Canadian citizens). On the other hand, a view that the system can easily absorb some reduction in that ratio if steps are taken to align needs and supply more closely, might lead to a rather more restrictive, and selective, approach to immigration policy. At the moment, this is a political rather than a research debate.

In many respects, policy with respect to migration will depend on where the political pressures focus at a particular time. As a general proposition, Canada has moved strongly in the direction of the pre-eminence of individual rights as determined by the courts. This significantly constrains efforts to legislate on issues of within-country mobility. Politicians are regularly under strong pressure to deal with “hot spot” issues, such as loss of a local family practitioner, by taking *ad hoc* action such as providing additional funding or resources. Nevertheless, we may be seeing the beginnings of a more systematic approach to the organization and financing of primary care, which should, if effective, help address access in underserved areas. The pace of these initiatives seems likely to increase. Notwithstanding this, it is likely that Canada will continue to receive and in some settings, depend on, a flow of immigrant physicians for the foreseeable future.

There is no current evidence of the emergence of a more coordinated federal/provincial/territorial/regional approach to issues related to immigration. “Where should we go?” “That depends on where we want to get to”. Unfortunately there are no signs of an emerging consensus on this latter.

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Table 1 Distribution of Active Civilian IMG Physicians, by Place of M.D. Graduation and Physician Type, 1980, 1990 and 1998

		Percent Distribution			Counts			
		Family Medicine	Specialist	All Physicians	Family Medicine	Specialist	All Physicians	
1980	United Kingdom	46.87	38.91	42.94	2,901	2,344	5,245	
	Scandinavia	0.15	0.18	0.16	9	11	20	
	Western Europe	4.91	4.90	4.90	304	295	599	
	Eastern Europe	12.04	12.13	12.08	745	731	1,476	
	United Arab Republics	0.97	2.94	1.94	60	177	237	
	India	5.38	7.44	6.39	333	448	781	
	South Africa	1.76	2.69	2.22	109	162	271	
	Australia and New Zealand	1.71	2.52	2.11	106	152	258	
	Central America	2.76	4.81	3.77	171	290	461	
	United States	2.13	2.91	2.51	132	175	307	
	Other	9.48	11.69	10.57	587	704	1,291	
	Unknown	11.84	8.88	10.38	733	535	1,268	
	All Places of Foreign Grad		100.00	100.00	100.00	6,190	6,024	12,214
	1990	United Kingdom	43.12	36.42	39.74	2,882	2,485	5,367
Scandinavia		0.16	0.29	0.23	11	20	31	
Western Europe		7.96	5.80	6.87	532	396	928	
Eastern Europe		10.86	11.20	11.03	726	764	1,490	
United Arab Republics		1.60	3.47	2.55	107	237	344	
India		7.83	9.59	8.71	523	654	1,177	
South Africa		6.27	3.99	5.12	419	272	691	
Australia and New Zealand		1.62	2.86	2.24	108	195	303	
Central America		4.25	6.71	5.49	284	458	742	
United States		2.51	4.05	3.29	168	276	444	
Other		13.80	15.61	14.71	922	1,065	1,987	
Unknown		0.01	0.01	0.01	1	1	2	
All Places of Foreign Grad		100.00	100.00	100.00	6,683	6,823	13,506	
1998		United Kingdom	34.36	29.86	31.99	2,148	2,086	4,234
	Scandinavia	0.19	0.24	0.22	12	17	29	
	Western Europe	9.36	7.26	8.25	585	507	1,092	
	Eastern Europe	8.22	8.85	8.55	514	618	1,132	
	United Arab Republics	2.38	4.09	3.29	149	286	435	
	India	8.13	10.91	9.60	508	762	1,270	
	South Africa	13.13	6.71	9.75	821	469	1,290	
	Australia and New Zealand	1.66	2.55	2.13	104	178	282	
	Central America	4.50	6.80	5.71	281	475	756	
	United States	2.37	4.08	3.27	148	285	433	
	Other	15.69	18.64	17.25	981	1,302	2,283	
	Unknown	0.00	0.00	0.00	0	0	0	
	All Places of Foreign Grad		100.00	100.00	100.00	6,251	6,985	13,236

Source: SMDB, CIHI

Note: Excludes interns and residents.

Data as of December of given year.

Table 2 **Distribution of IMGs by province and broad specialty, 1998**

Province/Territory	Total Physicians	Family Medicine		Specialists		% fam med IMGs/% fam med docs	% spec. IMGs % spec docs
		CMG	IMG	CMG	IMG		
Nfld	926	33.37%	27.11%	22.35%	17.17%	2.05	1.72
PEI	175	49.71%	7.43%	33.71%	9.14%	0.59	0.84
N.S.	1830	38.96%	12.79%	33.66%	14.59%	1.13	1.20
N.B.	1152	45.83%	12.76%	31.16%	10.24%	0.99	0.98
Que.	15481	44.32%	5.32%	43.67%	6.69%	0.49	0.53
Ont.	20469	37.75%	10.14%	36.67%	15.45%	0.97	1.17
Man.	2018	31.07%	19.03%	38.11%	11.79%	1.73	0.94
Sask.	1530	24.77%	33.79%	24.71%	16.73%	2.63	1.60
Alta	4762	36.35%	16.48%	35.47%	11.70%	1.42	0.98
B.C.	7762	41.99%	12.93%	29.86%	15.09%	1.08	1.33
Terr.	108	64.81%	15.74%	14.81%	4.63%	0.89	0.94
CANADA	56203	39.66%	11.12%	36.79%	12.43%	1.00	1.00

Source: Adapted from Canadian Institute for Health Information, 1999, "Supply Distribution and Migration of Canadian Physicians, 1998", Table 4, p. 14

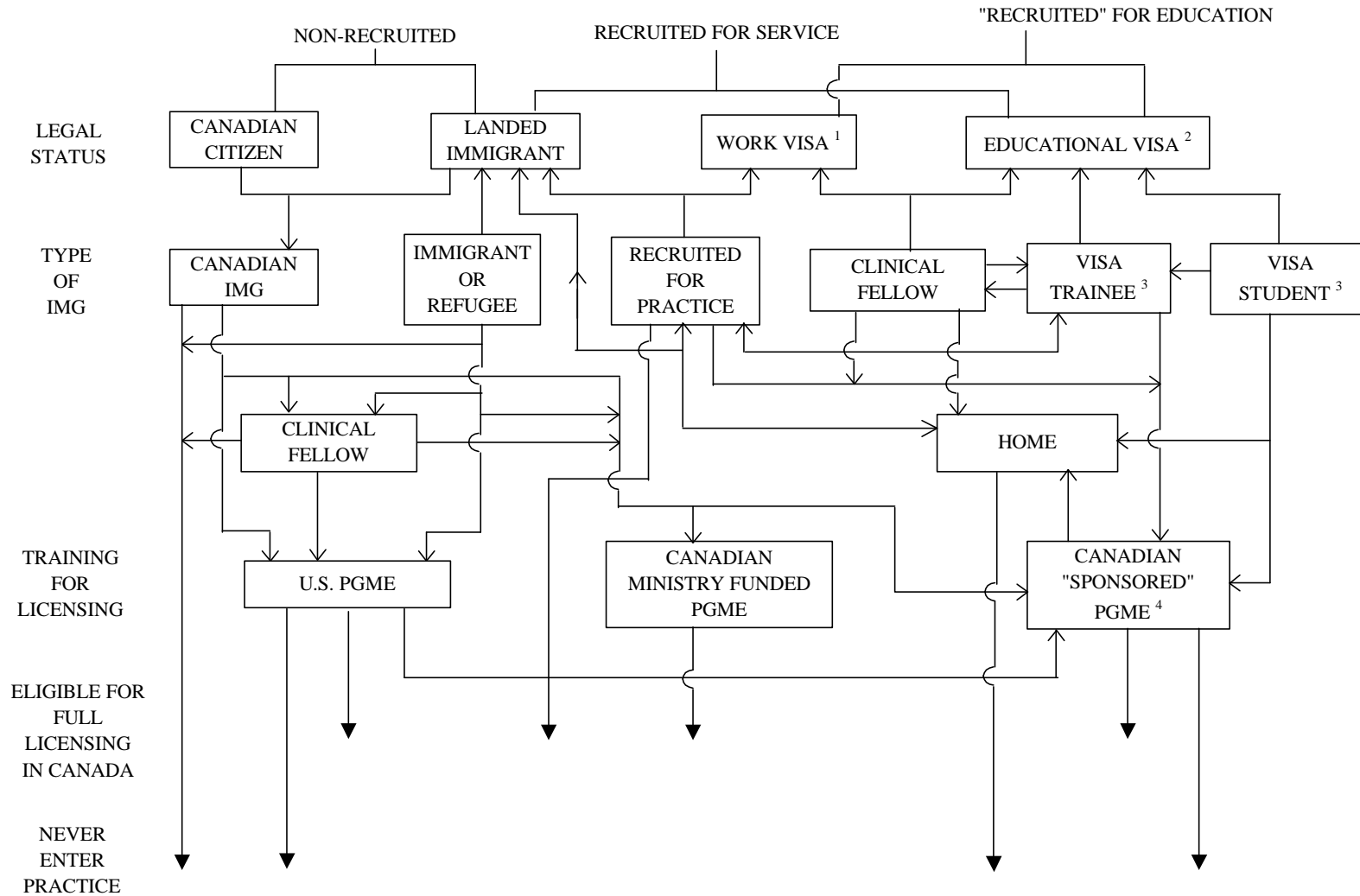
Table 3 Distribution of Canadian physicians by specialty and place of graduation

Specialty	Total physicians	1998	
		% CMG	% IMG
Family Medicine	28542	78.10%	21.90%
Internal Medicine	5759	77.70%	22.30%
Paediatrics	2082	66.19%	33.81%
Psychiatry	3722	66.85%	33.15%
Anaesthesia	2283	73.81%	26.19%
Radiology	2158	77.85%	22.15%
Lab Specialists	1420	62.89%	37.11%
General Surgery	1845	75.61%	24.39%
Obstetrics/Gyne	1582	71.93%	28.07%
Ophthalmology	1084	81.55%	18.45%
Orthopedic Surg.	1094	81.17%	18.83%
Other	4632	81.43%	18.57%
TOTAL	56203	76.45%	23.55%

Source: Canadian Institute for Health Information (1999), "Supply Distribution and Migration of Canadian Physicians, 1998", Adapted from Tables 3.0 and 3.1, pp. 54-5

Note: An unknown number of the IMGs will have received their specialty training in Canada.

Figure 1



¹ Provisions under the Immigration Act or its regulations state that IMGs on a Work Visa are restricted to practice in a given location for a certain 'employer' and are prohibited from "attending any university, college or other institution and against taking any academic, professional, or vocational training course at any university, college or other institution".

² Provisions under the Immigration Act or its regulations state that IMGs on an Educational Visa are not allowed to take employment except "on campus", but can work for one year after their education is finished.

³ Visa Trainees and Visa Students include those 'recruited' by Medical Faculties developing contracts with foreign governments to train their nationals who will return home on completion of their training.

⁴ Canadian "Sponsored" PGME includes Visa Trainees coming under foreign government contracts, Canadian IMGs, Immigrants/Refugees, or Clinical Fellows "sponsored" by community groups, health authorities, Faculty of Medicine Divisions or Residency Programs, and may include individual Visa Trainees who are recruited directly from off-shore.

Figure 2: Landed Immigrants Stating Medicine As Their Intended Occupation by Year of Entry to Canada, 1967 - 1995

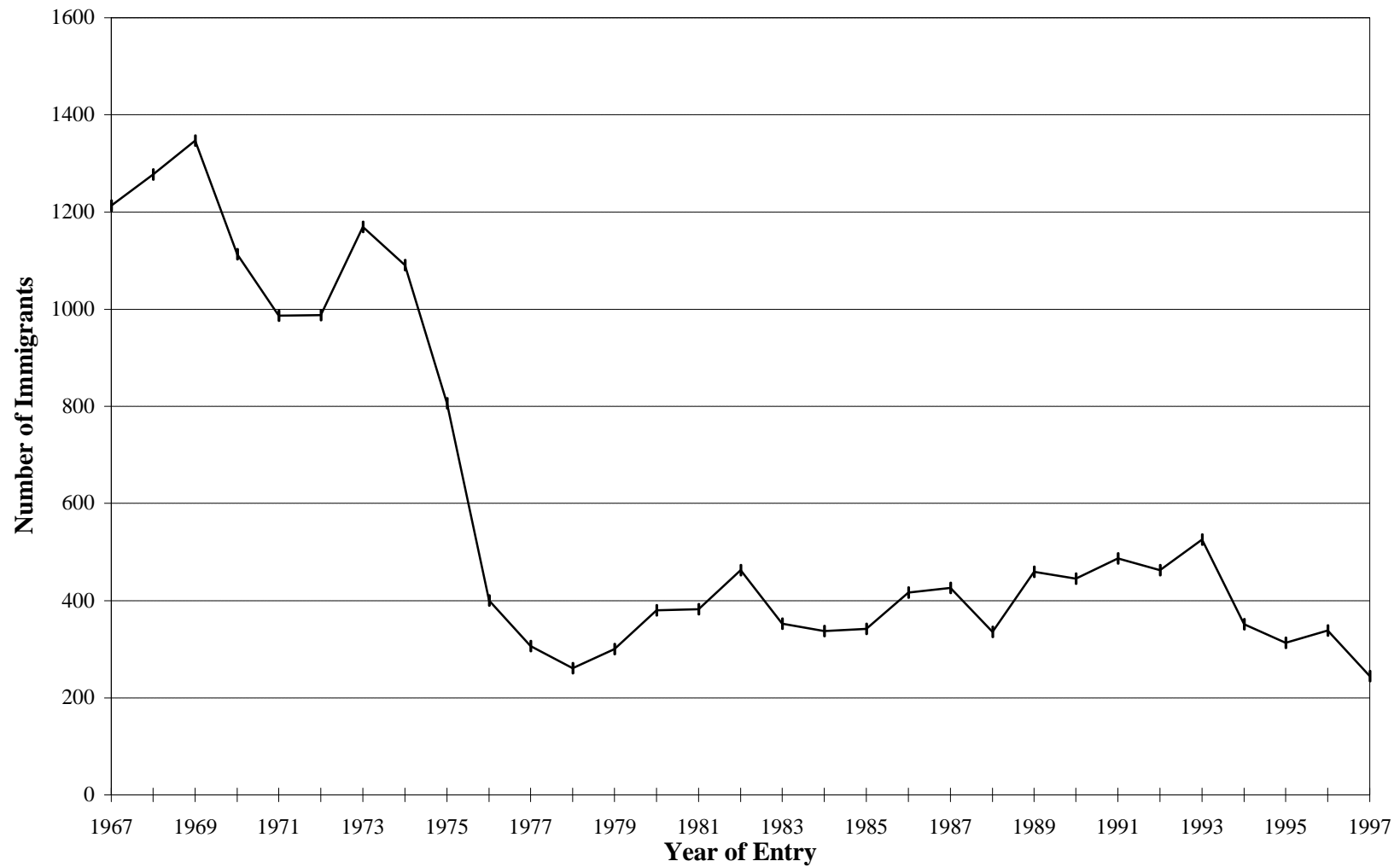


Table 4: Physicians Entering or Returning to Canada by Year and Status

Year	CMGs returning	IMGs returning	CMG/IMG? returning	Total returns	Landed Immigrants With Intended Occ. Physician/Surgeon			Temporary Employment Authorizations
					w. arranged empl.	w/out arranged emp.	Total	
1970	104	9	7	120			1113	
1971	123	25	3	151			987	
1972	98	18	5	121			988	
1973	125	36	9	170			1170	
1974	141	47	12	200			1090	
1975	152	53	7	212			806	
1976	145	53	11	209			401	
1977	145	67	9	221	158	149	307	
1978	105	46	11	162	127	134	261	
1979	117	57	10	184	113	187	300	
1980	166	71	6	243	133	247	380	259
1981	161	71	10	242	160	222	382	222
1982	193	77	12	282	148	314	462	192
1983	161	64	4	229	113	239	352	181
1984	194	54	5	253	121	216	337	192
1985	208	68	2	278	124	218	342	260
1986	216	61		277	140	277	417	278
1987	257	79		336	144	282	426	227
1988	301	59		360	116	219	335	260
1989	203	46		249	106	353	459	335
1990	209	54		263			445	427
1991	205	51		256	123	364	487	473
1992	212	47		259	158	304	462	432
1993	221	57		278	184	341	525	388
1994	220	76		296	98	253	351	270
1995	192	64		256	93	220	313	202
1996	164	54		218	61	278	339	582
1997	189	38		227	57	215	272	790
1998	251	70		321	125	133	258	n/a

Sources: **Returning from Abroad:** 1970-1995, from Table 26, CIHI (1997a);
1996-1998, from Tables 18.1 and 18.2, or 17.1 and 17.2 (1998 data), CIHI (1997b, 1998, 1999)

Landed Immigrants: Table 28, CIHI (1997a); Table 20, CIHI(1997b);
1997 and 1998: personal communication, CIHI

Temporary Employment Authorizations: Citizenship and Immigration Canada
Prepared by Health System Division, Strategies and Systems for Health Directorate,
Health Promotion and Programs Branch, Health Canada, August 20, 1998

Note: Data do not include interns and residents; thus they exclude visa trainees and clinical fellows, some of whom may eventually enter practice in Canada.

Table 5: Physicians Moving Abroad, 1970 - 1998

Year	CMGs		IMGs		Unknown		IMGs/All	Total		Total
	gp/fp	specialist	gp/fp	specialist	gp/fp	specialist		gp/fp	specialist	
1970	15	46	4	29	21	6		40	81	121
1971	10	59	8	47	32	17		50	123	173
1972	17	61	15	61	26	28		58	150	208
1973	27	70	17	41	49	32		93	143	236
1974	51	72	32	41	68	18		151	131	282
1975	46	51	24	35	60	26		130	112	242
1976	54	87	33	67	96	26		183	180	363
1977	109	132	34	101	135	38		278	271	549
1978	138	187	45	119	127	47		310	353	663
1979	147	161	48	116	96	38		291	315	606
1980	108	119	48	83	47	23		203	225	428
1981	102	110	47	69	32	12		181	191	372
1982	92	150	54	103	32	19		178	272	450
1983	92	137	34	81	20	8		146	226	372
1984	88	169	59	78	20	4		167	251	418
1985	97	152	48	74	11	5		156	231	387
1986	99	123	44	44	4	0	0.28	147	167	314
1987	103	161	42	74	4	3	0.31	149	238	387
1988	90	184	38	64	1	0	0.27	129	248	377
1989	96	165	46	77	0	0	0.32	142	242	384
1990	131	213	53	81	0	0	0.28	184	294	478
1991	118	214	55	92	0	0	0.31	173	306	479
1992	172	324	78	115	0	0	0.28	250	439	689
1993	178	284	84	89	0	0	0.27	262	373	635
1994	259	292	108	118	0	0	0.29	367	410	777
1995	280	218	82	94	0	0	0.26	362	312	674
1996	292	257	79	102			0.25	371	359	730
1997	250	238	81	90			0.26	331	328	659
1998	215	221	38	95			0.23	253	316	569

Source: CIHI 1997. Supply and Distribution of Physicians, Canada, Selected Years, 1961 to 1995, Tables 15.1, 17.1 and 17.3

CIHI 1997, International and Interprovincial Migration of Physicians, Canada 1970 to 1995

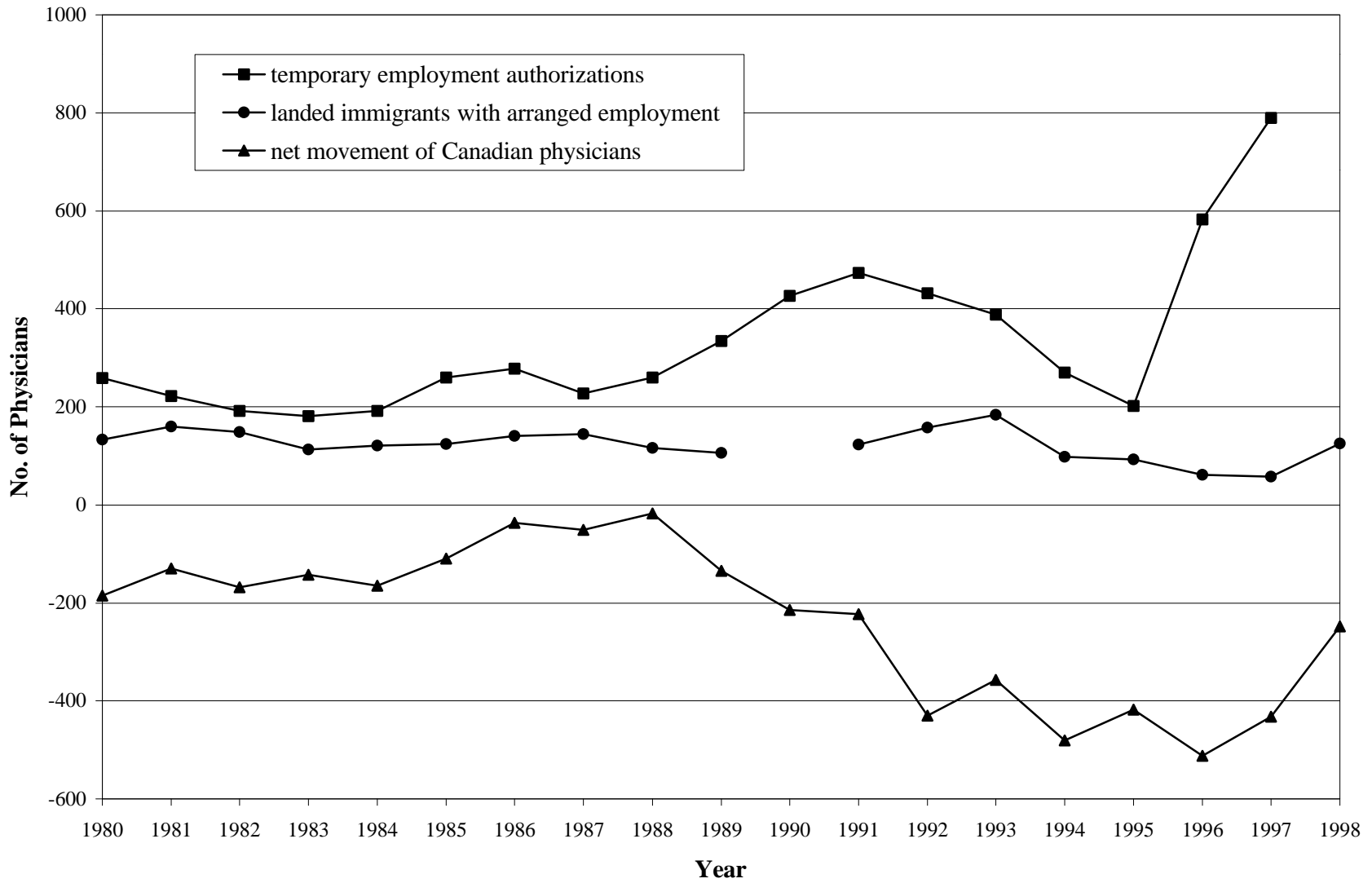
CIHI 1997-1999. Supply, Distribution and Migration of Canadian Physicians, 1996, 1997, 1998 Tables 14.1 and 14.2 or 15.1 and 15.2

Figures do not include interns and residents.

Figure 3: Physicians Moving Abroad as Proportion of Active Civilian Physicians



Figure 4: Net movement of Physicians to/from Canada, 1980-1997



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