

Two Wings and a Prayer: Should Canada Make It Easier for Canadian Doctors Trained Abroad to Enter Practice Here?

Deux ailes et une prière : le Canada devrait-il faciliter l'entrée en pratique des médecins canadiens formés à l'étranger?

MORRIS L. BARER, PHD

*Professor, Centre for Health Services and Policy Research
University of British Columbia
Vancouver, BC*

ROBERT G. EVANS, PHD

*Faculty, Centre for Health Services and Policy Research
University of British Columbia
Vancouver, BC*

LINDSAY HEDDEN, MSC

*Graduate Student, Centre for Health Services and Policy Research
University of British Columbia
Vancouver, BC*

Abstract

About 3,600 Canadians are currently studying medicine abroad (CSMAs). Most hope to return to practise in Canada. But the road back is not easy. These graduates must complete postgraduate residency training in Canada and alas, there are less openings than there are aspirants. One might have thought, amid the endless rhetoric of “physician shortages,” that an obvious solution would be to increase the number of residency positions. But provincial governments are well aware, even if the media are not, that Canada is in the early stages of a dramatic expansion in physician supply fuelled by increased domestic training capacity. Last time the physician supply outpaced population growth, as it is doing today, governments choked off the entry of international graduates. It could happen again.

Résumé

Environ 3600 Canadiens étudient actuellement la médecine à l'étranger. La plupart d'entre eux espèrent pratiquer la médecine au Canada. Mais le chemin du retour n'est pas facile. Ces diplômés doivent effectuer leur formation en résidence au Canada et, hélas, il n'y a pas assez d'ouvertures. On pourrait penser, avec le discours constant qui rappelle la « pénurie de médecins », qu'une des solutions serait d'accroître le nombre de postes de résidence. Mais les gouvernements provinciaux savent bien, même si les médias l'ignorent, que le Canada en est aux premiers stades d'une expansion importante de l'offre de médecins, nourrie par un accroissement des capacités domestiques de formation. La dernière fois que l'offre de médecins a dépassé la croissance démographique, comme c'est le cas aujourd'hui, les gouvernements ont freiné l'entrée de diplômés provenant de l'étranger. Cela pourrait encore se produire.

HISTORY, IT HAS BEEN SAID, IS THE SCHOOL OF PRINCES. HEGEL, HOWEVER, concluded that the only thing we learn from history is that we learn nothing from history. This would suggest that princes tend to be very poor students. That could be a problem if, indeed, “those who do not remember the past are condemned to repeat it” (Santayana 1905).

In 2010, approximately 700 Canadians obtained medical degrees outside Canada and were seeking entry to practise in Canada (Canadian Resident Matching Service 2010). The number of Canadians studying medicine abroad (CSMAs) has grown rapidly since 2000 (Canadian Resident Matching Service 2014), to the point where behind the current crop of graduates seeking practice opportunities in this country is a large and still-growing group – currently about 3,600 (Canadian Resident Matching Service 2010). The majority of them are studying at schools in English-speaking countries – predominantly the United Kingdom, Australia and New Zealand – but in 2013 there were about 30 different countries hosting CSMAs in around 130 different medical schools (Canadian Resident Matching Service 2014). The 130 schools represent an increase of 50 schools over four years (Canadian Resident Matching Service 2010, 2014). And every year, even more new schools are choosing to offer international students – North Americans in particular – the opportunity to study medicine (Shepperd 2011; Walsh et al. 2011). In part, this trend reflects the fact that a number of countries have realized that establishing a medical school that caters to “Western” standards, or expanding capacity for international students, can be a profitable export industry, a source both of foreign exchange and of high-paying employment for local elites. These schools are becoming more aggressive in their recruitment of Canadian students in particular (Shepperd 2011).

St. Andrews University in Scotland is one excellent example of this phenomenon. The school has launched a medical program that specifically targets Canadians, advertising linkages to the Faculty of Medicine and Dentistry at the University of Alberta and offering dedicated

assistance with preparation for exams and residency matches back in Canada. The program costs in excess of \$250,000 for tuition alone (Queen's University 2013; University of St. Andrews n.d.).

But like the illicit drug trade, the trade in medical school spots requires eager buyers. In 2011/12 there were about 23,800 applications for the approximately 2,900 places in Canadian medical schools (Association of Faculties of Medicine of Canada 2013a). Most (about three-quarters) of CSMA's are among those behind the 88% of unsuccessful applications (Canadian Resident Matching Service 2010). In turn, 90% of them intend to return to Canada for postgraduate training (Canadian Resident Matching Service 2014).

But the road back is long and highly uncertain. A degree from an accredited medical school abroad grants a Canadian nothing more than an opportunity to go to the next step in the process – attempting to pass two entrance exams (compared to the single exam required for graduates of Canadian medical schools). The first of the two examinations, the MCCEE – Medical Council of Canada Evaluating Exam – is an assessment of an international medical graduate's (IMG) general medical knowledge that is designed to assess skills required at the level of entry into a Canadian residency postgraduate program (Medical Council of Canada 2014a). The MCCEE is a prerequisite for the second exam, required by all graduates, international or Canadian, seeking residency training, the MCCQE – Medical Council of Canada Qualifying Exam (Part I). The MCCQE tests knowledge, clinical skills and attributes for entry into supervised clinical practice within a postgraduate training program (Medical Council of Canada 2014b).

Those who successfully jump these hurdles must then compete for a spot in a minimum two-year (length depending on the choice of specialty) residency training program in Canada, the final requirement for securing a licence to practise here. Opportunities for IMGs, whether CSMA's or not, are limited. In the most recent year for which statistics are available, there were approximately 3,280 first-year residency positions funded in Canada. But the majority of these (around 2,900) are intended to ensure that all graduates of Canadian medical schools are able to complete their pre-licensure training. There is a "dedicated quota" for IMGs (which includes CSMA's), but this typically amounts to less than 10% of available slots (Canadian Resident Matching Service 2012). The highly restricted number of residency positions reserved for IMGs represents a real and present choke point for CSMA's (and other IMGs) who have Canadian practice aspirations. And CSMA's are increasing rapidly in numbers and also increasingly displacing non-Canadian IMGs in these sought-after R-1 postgraduate training spots (Walsh et al. 2011).

Why are there so few residency positions available to CSMA's? After all, is there not a serious and enduring shortage of physicians in Canada? The media keep up a steady drumbeat of such claims, studded with personal stories of people who cannot find a doctor and those whose doctor is leaving the country, changing communities or retiring. Stories of shortages in particular specialties, resulting in long waits for surgery or other services, also abound. The overall picture conveyed is of "shortage, shortage, shortage!"

Two Wings and a Prayer: Should Canada Make It Easier for Canadian Doctors Trained Abroad to Enter Practice Here?

And do CSMAAs not represent an inexpensive solution to these problems? They are, after all, Canadian talent trained at someone else's expense (usually their own). This particular medical workforce "policy" seems patently absurd. Of course, there is no single policy at play here. The current situation is the outcome of a myriad of provincial residency position funding decisions. And residencies cost money. But that explanation is too simple by far, and everyone involved in the process understands this apparent paradox. It is not a result of people being stupid, ignorant or malicious.

An increase in residency positions sufficient to satisfy external "demand" would increase significantly the rate of growth of the Canadian medical workforce. The 3,600 current CSMAAs implies an increase in the neighbourhood of about 900 additional entrants to practice per year. But of course, if one were truly to open the spigot to all interested graduates, then we might expect the number of CSMAAs to balloon (recall the number of Canadians coveting a career in medicine who do not get into Canadian medical schools, the increasing availability of international medical training opportunities and the specific marketing of that capacity to frustrated Canadians).

Conspicuously scarce in the media coverage is recognition that Canada is in the process of a major expansion in physician supply from domestic sources, the effects of which are just now starting to be felt, but which will grow and be with us for decades. This is a consequence of decisions taken 20 years ago. Between 1997/98 and 2012/13, first-year enrolment in Canadian medical schools increased about 85%, from 1,577 to 2,913. This implies about 2,900+ new entrants to practice each year, until or unless the size of the domestic class changes. At the other end of the working life, for the next two decades, there will be, on average, 1,500 to 1,800 physicians retiring each year. The arithmetic is not complex; the consequences are beginning to be transparent. Over the last five years, Canadian physician supply increased 4.1% per year, which was three times faster than the growth of the population (CIHI 2012). Only those who have had their heads in the sand will be surprised by now-emerging early reports of new Canadian graduates having trouble establishing practices. This increase is not inconsistent with localized or specialty-specific shortages, but the overall numbers and trends are what they are, and what they will continue to be.

But surely there are other things going on. First, the emergence of un- or underemployed physicians appears, at this point, to be clustering in specialties such as surgery that require public investment in complementary capacity (staffed and funded operating suites) (Branswell 2013; Dempsey 2012). Second, the increasing feminization of the physician workforce means less effective physician supply because of fewer hours of work per physician (Crossley et al. 2009; Watson et al. 2006). Third, an aging population will need more doctors – and the population is certainly aging. Lastly, IMGs have always been an efficient solution to our chronic undersupply problems in rural and remote areas.

Each of these claims is found wanting when viewed through an evidence lens. Thirty years of research has consistently shown that population aging, in and of itself, will raise the need for and use of physician services by about 0.5% per year well into the future (Evans et al.

2001). Physician supply is growing far faster than that. That supply will not be overwhelmed by the coming wave of grey (though other sectors of the healthcare system – long-term and continuing care, and mental health, for example – will see dramatically increased demands).

While Canada has relied heavily on IMGs to provide medical services to rural and remote communities, physicians from abroad have, in fact, never been a sufficiently reliable and stable supply chain to represent a “permanent” solution, and only the delusional would believe that it can become so using just CSMAAs. Solutions such as this for addressing the problems of attracting and retaining physicians in smaller communities in a vast geography turn out to be compelling, simple and wrong (Canadian Foundation for Healthcare Improvement 2013).

The composition of the physician workforce has, indeed, become more female. First-year entrants to medical schools in Canada are now about 56% female, and have been since 1999 (Association of Faculties of Medicine of Canada 2013c). But the more important trend here is a secular decline in physicians’ hours of direct patient care over time (Crossley et al. 2009), which would seem to reinforce the claim that more physicians are needed. The inconvenient truth, however, is that even as hours of work are falling, (fee-adjusted) billings per doctor are increasing (McGrail et al.). This implies either a steady increase in activity per physician, fee creep (average fees rising faster than is reflected in the official fee increases) or both. To the extent that it reflects the first possibility, reconciliation with the claims of ever-worsening shortages will remain challenging.

As for the emerging employment problems faced by certain specialties, this is a natural consequence of different rates of growth in interconnected parts of a system. But that problem will grow more severe, and it will spread to other specialties unless provincial/territorial governments are planning to increase hospital and other components of ministry/department of health budgets sufficiently to keep up with the consequences of their decisions two decades ago on physician training capacity. And if they do not, the pressure to relax restrictions on private delivery and payment will increase apace (Fayerman 2014).

Whatever is going on, what seems incontestable is that (a) physician supply continues to grow much faster than the population; (b) physician expenditures continue to grow faster than physician supply; (c) these trends show no signs of abating; and (d) the trends are, or will be soon, a significant headache for ministers of health everywhere. From 2002 to 2007, per capita inflation-adjusted expenditures on physician services in Canada increased 18.5%. From 2007 to 2012, the increase was 17.4% (CIHI 2013). Balancing fiscal imperatives against the forces unleashed with the decisions about medical school capacity promises to be one of the most vexing challenges for healthcare policy makers over the coming decade.

It is difficult to reconcile these trends with the often-reported patient experiences in gaining timely access to some physician services. One possible explanation can be found in recent analyses from British Columbia showing a significantly increased share of physician expenditure being accounted for by dramatic growth in diagnostic services provided to the elderly, and particularly the very elderly (McGrail et al. 2011). This increase is not accounted for by increases in the numbers of seniors or in their average age.

Two Wings and a Prayer: Should Canada Make It Easier for Canadian Doctors Trained Abroad to Enter Practice Here?

Given these circumstances, it is difficult to imagine provincial ministers of health high-fiving the notion of opening up more residency slots for physicians trained abroad, whether or not they happen to be CSMAAs. Indeed, we might do well to recall some not-so-ancient local history. We have been here before.

In 1964 the Hall Commission report projected a significant shortage of physicians (Royal Commission on Health Services 1964). That projection was based on assumptions that the baby boom would continue, and that “medicare” would result in both a dramatic increase in patient demand and significant migration south of Canadian physicians. The policy response was a significant increase in Canadian medical school enrolment: 970 first-year medical students at Canadian medical schools in 1960 increased to over 1,800 by 1975 (Association of Faculties of Medicine of Canada, personal communication, March 30, 2014). It is now well known that the population explosion failed to arrive and patient demand did not explode (and there was a war in Vietnam) – but the medical school expansion continued apace. As a result, physician supply per capita began to increase dramatically, and policy makers, scrambling to adjust, clamped down hard on the entry of foreign medical graduates in the mid-1970s (Evans 1976). They also tried, but failed miserably, to moderate the flow of domestic production. Not until 1989 did population growth finally catch up with the two-decades-earlier increase in medical school enrolment.

This stabilization of physician supply per capita in the early 1990s provided a breathing space during which some fundamental changes might have been made in how medical services are funded and delivered (Barer and Stoddart 1991). Two examples: significant changes could have been made in the way that diagnostic services are organized and paid for (Bayne 2003; British Columbia Royal Commission on Health Care and Costs 1991); more nurse practitioners could have been trained, and more flexible use (as substitutes, not complements) could have been made of them. Myriad other policy options were available to anyone serious about taking advantage of evidence available at the time.

Alas, instead, policy makers embraced new opportunities for old mistakes. They were convinced by medical school leadership that a surplus that most of them acknowledged was about to flip over, and that drastic measures needed to be taken, now. Virtually overnight, a surplus became a shortage in the common rhetoric, and beginning in about 1998, a second wave of dramatic domestic medical school expansion got underway. Hegel was right yet again.

If past history is a guide, there will not be any cuts to medical schools in Canada in the foreseeable future; and Canadian provinces’ past experiences with other blunt attempts to control costs are not encouraging (Barer et al. 1996). Therefore, the only lever that beleaguered provincial ministers of health may have to constrain this whole process is to further tighten the noose around the necks of IMGs, and that will include CSMAAs.

This approach is likely to be politically much more difficult this time, because a much larger proportion of those IMGs are CSMAAs. They are politically organized, and they have a built-in local constituency.

So who loses this time? CSMA's stranded abroad? Taxpayers? Or does this become the proverbial straw that breaks the back of medicare?

Stay tuned, and hold on tight.

Correspondence may be directed to: Morris L. Barer, PhD, Centre for Health Services and Policy Research, University of British Columbia, 201 – 2206 East Mall, Vancouver, BC V6T 1Z3; e-mail: mbarer@chspr.ubc.ca.

References

- Association of Faculties of Medicine of Canada. 2013a. *Admission Requirements of Canadian Faculties of Medicine: Admission in 2013*. Retrieved April 14, 2014. <https://www.afmc.ca/pdf/2013_ad_bk.pdf>.
- Association of Faculties of Medicine of Canada. 2013b. *Canadian Medical Education Statistics*. Retrieved April 14, 2014. <<http://www.afmc.ca/publications-statistics-e.php>>.
- Association of Faculties of Medicine of Canada. 2013c. "Enrolment in Canadian Faculties of Medicine by Sex, 1968/69–2012/13." Table 8 in *Canadian Medical Education Statistics*. Retrieved April 14, 2014. <<http://www.afmc.ca/publications-statistics-e.php>>.
- Barer, M., J. Lomas and C. Sanmartin. 1996. "Re-minding Our Ps and Qs: Medical Cost Controls in Canada." *Health Affairs* 15(2): 216–34. Retrieved April 14, 2014. <<http://content.healthaffairs.org/content/15/2/216.short>>.
- Barer, M.L. and G.L. Stoddart. 1991. *Toward Integrated Medical Resource Policies for Canada*. Report Prepared for the Federal/Provincial/Territorial Conference of Deputy Ministers of Health.
- Bayne, L. 2003. *BC Laboratory Services Review*. Victoria: British Columbia Ministry of Health.
- Branswell, H. 2013 (October 10). "One in Six Newly Graduated Medical Specialists Can't Find Work: Report." *The Globe and Mail*. Retrieved April 14, 2014. <<http://www.theglobeandmail.com/news/national/one-in-six-newly-graduated-medical-specialists-cant-find-work-report/article14794764/>>.
- British Columbia Royal Commission on Health Care and Costs. 1991. *Closer to Home: The Report of the Royal Commission on Health Care and Costs*. Victoria: Queen's Printer.
- Canadian Foundation for Healthcare Improvement. 2013. "Myth: International Medical Graduates Are the Solution to the Doctor Shortage in Underserved Areas." *Mythbusters*. Retrieved April 14, 2014. <<http://www.cfhi-fcass.ca/PublicationsAndResources/Mythbusters/ArticleView/2013/05/14/e628dec0-3dd1-4572-999c-456c54ef0f06.aspx>>.
- Canadian Institute for Health Information (CIHI). 2012. *Supply, Distribution and Migration of Canadian Physicians*. Retrieved April 14, 2014. <<https://secure.cihi.ca/estore/productSeries.htm?pc=PCC34>>.
- Canadian Institute for Health Information (CIHI). 2013. *National Health Expenditure Trends, 1975 to 2013. Spending and Health Workforce*. Retrieved April 14, 2014. <<http://www.cihi.ca/CIHI-ext-portal/internet/EN/subtheme/spending+and+health+workforce/spending/cihi015954>>.
- Canadian Resident Matching Service. 2010. *Canadian Students Studying Medicine Abroad*. Retrieved April 14, 2014. <https://www.carms.ca/pdfs/2010_CSA_Report/CaRMS_2010_CSA_Report.pdf>.
- Canadian Resident Matching Service. 2012. *R-1 Match Reports, 2012*. Retrieved April 14, 2014. <<https://www.carms.ca/en/fm-em-match-reports-2012>>.
- Canadian Resident Matching Service. 2014. "Returning to Canada." Retrieved April 14, 2014. <<https://www.carms.ca/en/returning-to-canada>>.
- Crossley, T.F., J. Hurley and S.-H. Jeon. 2009. "Physician Labour Supply in Canada: A Cohort Analysis." *Health Economics* 18(4): 437–56. doi: 10.1002/hec.1378.

Two Wings and a Prayer: Should Canada Make It Easier for Canadian Doctors Trained Abroad to Enter Practice Here?

- Dempsey, A. 2012. "Health-Care Checkup: Why Can't Newly Graduated Specialist Doctors in Canada Find Jobs?" *Toronto Star*. Retrieved April 14, 2014. <http://www.thestar.com/news/gta/2012/11/15/healthcare_checkup_why_cant_newly_graduated_specialist_doctors_in_canada_find_jobs.html>.
- Evans, R.G. 1976. "Does Canada Have Too Many Doctors? Why Nobody Loves an Immigrant Physician." *Canadian Public Policy* 2(2): 147–60.
- Evans, R.G., K.M. McGrail, S.G. Morgan, M.L. Barer and C. Hertzman. 2001. "APOCALYPSE NO: Population Aging and the Future of Health Care Systems." *Canadian Journal on Aging* 20(S1): 160–91. doi: 10.1017/S0714980800015282.
- Fayerman, P. 2014. "Dr. Brian Day vs. the BC Government and Anti-Privatization Foes: Legal Case Twists, Turns." *The Vancouver Sun*. Retrieved April 14, 2014. <<http://blogs.vancouversun.com/2014/03/10/dr-brian-day-vs-the-bc-government-and-anti-privatization-foes-legal-case-twists-turns/>>.
- McGrail, K., R. Evans and M.L. Barer. 2011. "Diagnosing Senescence: Contributions to Physician Expenditure Increases in British Columbia, 1996/97 to 2005/06." *Healthcare Policy* 7(1): 41–54. Retrieved April 14, 2014. <<https://www.longwoods.com/content/22527>>.
- Medical Council of Canada. 2014a. "Medical Council of Canada Evaluating Examination." Retrieved April 14, 2014. <<http://mcc.ca/examinations/mccee/>>.
- Medical Council of Canada. 2014b. "Medical Council of Canada Qualifying Examination Part I." Retrieved April 14, 2014. <<http://mcc.ca/examinations/mccqe-part-i/>>.
- Queen's University. 2013. "The Land of Opportunity for Canadian Medical Student Wannabes: Scotland?" Department of Medicine blog. Retrieved April 14, 2014. <<http://deptmed.queensu.ca/blog/?p=266>>.
- Royal Commission on Health Services. 1964. *Report of the Royal Commission on Health Services: 1964*. Volumes I and II. Ottawa: Queen's Printer.
- Santayana, G. 1905. *Life of Reason, Reason in Common Sense*. New York: Charles Scribner's Sons.
- Shepperd, M. 2011. "Too Many Canadians Studying Medicine Overseas." CBC News. Retrieved April 14, 2014. <<http://www.cbc.ca/news/health/too-many-canadians-studying-medicine-overseas-1.993980>>.
- University of St. Andrews. n.d. "St. Andrews/Edinburgh/Alberta Medical Programme." Retrieved April 14, 2014. <<http://medicine.st-andrews.ac.uk/pro/alberta/>>.
- Walsh, A., S. Banner, I. Schaborn, H. Armson, I. Bowmer and B. Granata. 2011. "International Medical Graduates – Current Issues." Members of the FMCC PG Consortium. Retrieved April 14, 2014. <https://www.afmc.ca/pdf/fmcc/05_Walsh_IMG%20Current%20Issues.pdf>.
- Watson, D.E., S. Slade, L. Buske and J. Tepper. 2006. "Intergenerational Differences in Workloads among Primary Care Physicians: A Ten-Year, Population-Based Study." *Health Affairs (Millwood)* 25(6): 1620–28.