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Internationally Trained Physicians of Ontario (ITPO)

Policy Brief

Expanding Pathways to Licensure for Internationally Trained Physicians in Ontario: How to Get There and Why It Matters

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About WES

World Education Services (WES) is a non-profit social enterprise dedicated to helping international students, immigrants, and refugees achieve their educational and career goals in the United States and Canada. For more than 45 years, WES has set the standard of excellence in the field of international academic credential evaluation. Through WES Global Talent Bridge, the organization joins with institutional partners, community-based organizations, and policymakers to help immigrants and refugees who hold international credentials fully utilize their talents and education to achieve their academic and professional goals. Through its grantmaking, impact investing, and partnerships, the WES Mariam Assefa Fund seeks to advance economic and social inclusion for immigrants and refugees

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About ITPO

Internationally Trained Physicians of Ontario (ITPO) aspires to provide internationally trained physicians (ITPs) and international medical graduates (IMGs) opportunities to make a comprehensive contribution to the Canadian Healthcare System. In line with the Canadian principles of equity, diversity, and inclusion, we strive to leverage the skills and expertise of ITPs to ensure access to high standard medical care for all Canadians wherever they live.

Learn more:
https://www.itpo.ca/about

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Executive Summary

The health care system in Ontario is in crisis. More than 1.3 million Ontarians don't have access to a family doctor, leading many people to turn to emergency departments or urgent care clinics for issues that would be better addressed by a primary care provider. At the same time, Internationally Trained Physicians (ITPs) continue to face significant systemic barriers to becoming licensed and returning to medical practice. Practical, proven measures exist that would enable ITPs to contribute their skills and training to the provincial health system.

This policy brief examines the stakeholder commitments, policy changes, and investments required to fully integrate ITPs into the Ontario health care workforce. It also discusses the associated benefits, including better access to care and a more equitable and sustainable health care system.

Required Policy Changes	Expected Benefits
Implementation of Practice-Ready Assessment (PRA) at an appropriate scale	Enhanced equity in healthcare delivery
Equitable expansion of medical residency training to ensure ITPs have access	Improved patient health and well being
Establishment of Clinical Assistants under a defined class of registration with the College of Physicians and Surgeons of Ontario (CPSO)	Better use of health human resources
	Reduction in the underutilization of medical skills
	Health cost savings

Taken together, these policy changes – Practice-Ready Assessments, equitable access to residency training, and establishment of Clinical Assistant as a defined class of registration – have the potential to rapidly increase the physician-to-population ratio and number of physician-extenders throughout Ontario. Investment in these solutions should lead to improvements in health care equity and patient health and well-being. It should also lead to cost savings in training; savings related to improved access to primary care and reduced burdens on emergency rooms; and greater efficiency in the health-human resource system, including increased use of valuable ITP skills.

The issue of insufficient physician supply exists within the wider context of a rapidly deteriorating health care system. Rebuilding the health care system that Ontarians deserve will depend on new forms of collaboration among government, educational institutions, regulatory bodies, physicians (including ITPs), employer organizations, and allied stakeholders. All must commit to implementing lasting solutions at scale so that ITPs' experience and training is utilized to full advantage.

I. Introduction: Physician Shortages, Underutilization of Medical Skills, Potential Solutions

The health care systems in Ontario and across Canada are in crisis, facing an aging population and critical shortages of qualified health professionals to respond to increased demands for care. Nearly a **third** of nurses plan to leave their current position within the next 12 months, and the number of physicians reporting high levels of burnout has nearly **doubled** over the course of the pandemic. Across the country, Canadians lack access to primary care services, emergency departments are being forced to temporarily **close** due to staffing shortages, and a growing number of voices are **calling** for long-term, systemic solutions.

In this context, it is extremely concerning that the **thousands** of physicians who have immigrated to Canada in recent years continue to face significant systemic barriers to professional registration and re-entry. Canada has always relied on both physicians who have gained their medical training domestically and those trained internationally who choose to make Canada their home. However, there are currently too few pathways for ITPs[1] to become licensed in Canada. In a time of crisis, valuable medical education and training are being underutilized.

The number of physicians reporting high levels of burnout has nearly doubled over the course of the pandemic.

Practical, proven measures exist that would enable ITPs to fully contribute their skills and training to Ontario's health care system. This policy brief examines the investments required and the benefits to be gained by implementing three measures that can improve access, equity, and sustainability in Canada's health systems:

- Implementing Practice-Ready Assessment (PRA).
- Equitably expanding access to medical residency training.
- Enabling pathways for ITPs to practice as Clinical Assistants under a defined class of registration with the College of Physicians and Surgeons of Ontario (CPSO). This solution could be designed as a training/laddering program to provide recency of practice and additional training to meet requirements for independent licensure.[2]

1 In Canada, several different terms and acronyms are used to describe individuals with medical education and experience gained internationally, including "International Medical Graduate" (IMG), "Internationally Trained Medical Doctor" (ITMD), and "Internationally Trained Physician" (ITP). This brief uses the acronym "ITP" as a term that more accurately captures both recent medical graduates as well as individuals with extensive postgraduate training and experience.

2 The title "Clinical Assistant" is used in Manitoba and Nova Scotia, "Clinical/Surgical Assistant" is used in Alberta, and British Columbia has introduced a class of registration for "Associate Physicians" who must meet similar entry-to-practice requirements. This role is distinct from that of "Physician Assistant."

If implemented, these three measures have the potential to rapidly increase the physician-to-population ratio and the number of physician-extenders, leading to:

- **More equity in health care delivery** by diversifying the supply of qualified physicians and enabling more access to culturally appropriate care for diverse population groups in Canada
- **Improved patient health and well-being** by increasing access to health services and reducing wait times for primary and secondary care, enabling earlier detection and management of disease
- **Better use of health human resources** by reducing unnecessary emergency department visits and hospital admissions, reducing the strain on current health care professionals, and thereby lowering the risk of burnout and turnover
- **Less underutilization of medical skills** by allowing ITPs to pursue the most appropriate pathway to licensure while enabling them to practice sooner and at an appropriate level that is commensurate with their training and experience
- **Health cost savings** by more efficiently assessing and licensing qualified ITPs, boosting the supply of health care providers, and expanding access to care; increased access to primary care by efficiently incorporating qualified ITPs can lead to less spending on urgent care in the immediate term and decreases costs of morbidity in the medium and long term

The CMA, the Ontario Medical Association, and the College of Physicians and Surgeons of Ontario have called for measures to boost physician supply in Canada and Ontario by licensing more internationally trained physicians through increased residency spots and a government practice-ready assessment program.

The issue of insufficient physician supply exists within a broader context of health care transformation in Canada. Assessments and restructuring of **payment models** for physicians and interprofessional care teams are **ongoing**. Shifting models of care delivery (including virtual care, or "telehealth") and adapted scopes of practice for health professionals will continue to evolve, with implications for whether new models will rely as heavily on physicians as they currently do. Physician-extender roles, including Clinical Assistants (CAs) and Physician Assistants (PAs), as well as other primary care providers such as Nurse Practitioners (NPs), will continue to play a critical role in expanding available services and supporting patient care.[3] Regulatory modernization, including introducing **new models** of supervised practice and provisional licensure, is ongoing in several provinces and is already impacting pathways to practice and scopes of practice for health care professionals.

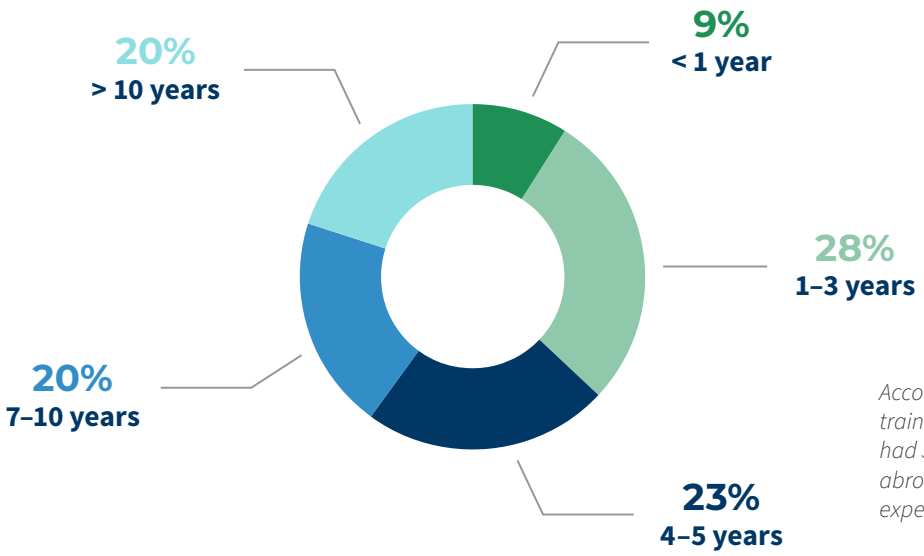
Within this context, as the Canadian Medical Association (CMA) **notes**, "family medicine is the foundation of our health care system." Robust primary care can effectively relieve pressures throughout the system. Stakeholders including the CMA, Ontario Medical Association (OMA), and the College of Physicians and Surgeons of Ontario (CPSO) are calling for measures to boost physician supply in Canada and Ontario by "**licensing** more foreign-trained physicians, through increased residency spots and a government practice-ready assessment program."

3 There is growing demand for these roles; there are only **800** regulated Physician Assistants and **only** a few thousand Nurse Practitioners in Canada.

Underutilization of Internationally Trained Physicians in Canada

While the data are imperfect, it's clear that there is a significant and diverse source of health care talent arriving in Canada through a range of immigration pathways. At least several hundred ITPs arrive in Canada through various immigration pathways every year. Between 2015 and 2021, 2,270 new **permanent residents** in Ontario declared their intended occupation as "primary physician" or "specialist physician," an average of 345 every year. Canada-wide, we know that **more than** 3,600 physicians have become permanent residents through Express Entry and Provincial Nominee Programs[4] since 2015. However, we know that this number represents an undercount. For example, it doesn't include individuals who arrive under temporary immigration pathways, doesn't always account for interprovincial migration, and excludes ITPs who may have declared a different intended occupation.

FIGURE 1
Number of Years of Clinical Experience of ITPO Survey Respondents **(n=324)**



According to a survey of internationally trained physicians in Ontario: 63% had 3+ years of clinical experience abroad; 20% had 10+years; 56% had experience working in family medicine.

Source: Internationally Trained Physicians of Ontario (ITPO),
ITPs - A Diverse, Underutilised, Skilled Health Human Resource, July 2022

4 The **Provincial Nominee Program** (PNP) is a Canadian immigration program that enables provinces and territories to select and invite individuals to immigrate based on their specific skills, education, work experience, and potential to contribute to the economy of the province or territory.

A recent **survey** offers insight into this underutilized resource. Conducted by Internationally Trained Physicians of Ontario (ITPO), a survey with 324 ITP respondents showed that 63 percent of respondents had more than three years of clinical experience abroad, and 20 percent had more than 10 years of clinical experience. The majority, 56 percent of respondents, had experience working in family medicine.

Depending on the province, physicians with international medical education can become independently licensed through several routes, including residency training, **Practice-Ready Assessment** (PRA) programs, **Practice Eligibility Routes** (PER), or Approved Jurisdiction pathways.[5] While many ITPs immigrate to Canada with the hopes of continuing their careers as physicians once they are settled (or have completed qualifying exams), most will not have the opportunity to return to practice. Access to residency positions is extremely limited for individuals who received their training in another country, and pathways to other assessments (such as Practice-Ready Assessment) or to physician-extender roles have not been implemented in all provinces, or at a scale to match demand.

Despite having much-needed medical training and skills, the majority of ITPs do not work as medical practitioners. A **study** using data from 2006 to 2011 showed that only 36.7 percent of ITPs were working as licensed physicians in Canada. In 2022 alone, 1,395 ITPs who applied for residency training positions went unmatched in the Canadian Resident Matching Service (CaRMS) despite having the **required** educational prerequisites; while 115 residency positions, including 99 in family medicine, went **unfilled** that year. The systemic barriers to practice have significant financial, familial, and mental health **impacts** on those ITPs who are unable to return to their chosen profession.

Despite having much-needed medical training and skills, the majority of ITPs do not work as medical practitioners.

5 The "Approved Jurisdiction" route is available to some **specialist** and **family** physicians with training completed in Australia, Hong Kong, Ireland, New Zealand, Singapore, South Africa, Switzerland, the United Kingdom, and the United States; it involves a streamlined process of assessment by either the Royal College of Physicians and Surgeons of Canada (RCPSC) or the College of Family Physicians of Canada (CFPC).

By the Numbers: A Profile of Physician Supply and ITPs in Canada

The Supply	There were 92,173 licensed physicians in Canada in **2020**, roughly half in family practice (50.1 percent) and half in specialty practice (49.2 percent).	25.7 percent of licensed physicians in Canada obtained their medical degrees internationally.	92.4 percent of physicians practice in urban areas; 17.6 percent of Canadians live in rural areas, but only 7.6 percent of physicians practice in these areas.	As of 2021, roughly half of licensed physicians in Canada were registered in Ontario (45,183); of these, just 35,025 were **actively** practicing in the province.
The Inflow	There were 14,020 individuals in postgraduate medical residency training in 2021–22, 5,206 of whom were training in Ontario.[6]	In 2022, 3,557 individuals entered their first year of residency training in Canada.	In 2022, 439 ITPs were matched to residency positions in the Canadian Resident Matching Service (CaRMS).[7]	In 2021, 141 ITPs obtained licensure through the Practice-Ready Assessment (PRA) route.[8]
The Outflow	Roughly 39 percent of physicians in Canada are aged **55 or older**.	27 percent of physicians with 10+ years of experience **intend** to leave or change their job within the next three years. 47.1 percent of physicians with less than five years of experience intend to leave or change their profession.		

6 Barnum, G. & Forward, L. (personal communication, November 30, 2022). Data extracted from Canadian Post-M.D. Education Registry (CAPER) database.

7 Excluding graduates of medical schools in the United States.

8 Data provided by the Medical Council of Canada. Statistics on provincial Practice-Ready Assessment (PRA) programs are collected annually through a program evaluation process for the calendar year period, and the numbers only include programs that participate in the annual data collection process.

Physician Shortages in Ontario: How Many Physicians Do We Need?

More than 1.3 million Ontarians do not have a family doctor, and many people are turning to emergency departments for health issues that would be better addressed through a primary care provider. A **study** focusing on Ontario Health Insurance Plan records estimates that by 2025 that number could jump to more than 3 million. While the **majority** of emergency department visits across Canada are **serious** in nature, 42 percent of Ontarians who visited an emergency room felt they had a condition that could have been treated by a primary care physician if they had access to one. Across the country, there are also significant shortages in some specialty practice areas including infectious disease (10 practitioners per 10,000 people), geriatric medicine (only 304 in the country), and pain medicine (only 18 in the country).[9]

The Conference Board of Canada estimates that the **demand** for additional physicians in Canada will increase from 1,365 annually between 2021 and 2025 to 1,588 annually between 2026 and 2030. There are already urgent needs in **rural** and northern communities. According to the Northern Ontario School of Medicine, **Northern Ontario** needed 325 physicians as of June 2021, of whom 135 must be family physicians.

In March 2022, the Ontario government **announced** the addition of 450 medical education seats (undergraduate and postgraduate) through a budget allocation of "$42.5 million over two years to support expansion of medical education and training." However, of the 295 postgraduate positions, only 20 percent will be available to international medical graduates (IMGs),[10] a majority of whom are likely to be Canadians who studied medicine abroad, leaving little space for physicians who have immigrated to Canada. (NOTE: The allocation of positions for internationally trained individuals will be at the discretion of each university.) Many more physicians and allied health professionals will be needed in the coming decade, but existing processes limit supply. Neither Ontario nor Canada as a whole is training and licensing Canadian-born physicians at a rate necessary to match the growing need for health care, **particularly** in elder care or long-term care.

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TABLE 1

Projected Annual Demand for Physicians in Canada (2017–2030) (Average Number of Physicians Needed Annually)

	All Physicians	Family / Primary Care	All Specialists	Emergency	Orthopaedics
2017–20	1,365	707	658	14	27
2021–25	1,468	761	708	15	29
2026–30	1,588	823	765	17	32

Source: Conference Board of Canada calculations based on custom simulations and CMA data, 2016

9 Specialists will often advise other physicians as consultants, multiplying their effectiveness.

10 Statistic was provided through correspondence with the Ontario Ministry of Health.

II. Solutions to Underutilization: Expanding Pathways to Licensure

Three practical measures can enable many more qualified ITPs to practice either independently or under supervision in Ontario. Some measures have already been implemented successfully in other provinces, and some have interjurisdictional or pan-Canadian implications.

A. Bring Practice-Ready Assessment to Ontario

About PRA: The **Practice-Ready Assessment** (PRA) model developed by the Medical Council of Canada's National Assessment Collaboration (NAC) provides an expeditious route to licensure for ITPs who have already completed residency and practiced independently in another jurisdiction abroad. PRA candidates' competence in appropriate clinical skills and knowledge is assessed over a period of 12 weeks. Once licensed, candidates fulfill a Return of Service (RoS) of two to four years in an underserved community of the province. The NAC's PRA model is currently available in British Columbia, Alberta, Saskatchewan, Manitoba, Quebec, Newfoundland and Labrador, and Nova Scotia. It is not available in Ontario.

In 2021, only 124 ITPs obtained licensure through the PRA process across Canada.[11] In order to maximize the skills and training of ITPs licensed through PRA, the model needs to be implemented at an appropriate scale to match demand. That, in turn, requires government funding commitments and support to ensure a corresponding number of experienced preceptors to assess and supervise candidates.

Three practical measures can enable many more qualified ITPs to practice either independently or under supervision in Ontario.

HUMAN RIGHTS CONSIDERATIONS

There are human rights and equity issues that need to be addressed when implementing the recommendations in this paper. For example, the differential application of incentives and Return-of-Service agreements for internationally trained versus Canadian-trained physicians has been raised as a human rights violation. In 2020 five immigrant physicians filed a **human rights complaint** in British Columbia alleging systemic discrimination against many ITPs. At the time of publication, this case was ongoing. Similar concerns have been raised in other provinces.

How to make this model work: All NAC PRA programs operate under a cost-recovery model that accounts for different provincial funding models, including government funding and candidate fees. Programs can be funded through Ministries of Health spending or other provincial programs, or indirectly through provincial international medical graduate (IMG) programs, through regional health authorities, or through individual or group practices. In Alberta, the cost per applicant is a maximum of $34,470 (see Appendix A); in Manitoba, the cost per applicant ranges from roughly $30,000 for family practice

11 Source: Correspondence with Medical Council of Canada, 2022.

applicants to $40,000 for specialty practice applicants.[12] Fees for assessment are paid by the sponsor; however, applicants may be responsible for paying some or all of the fees, depending on their employer and the details of the sponsorship.

A **pilot** to implement PRA in Ontario was developed in 2016, but never launched. In December 2022, the province acknowledged that plans were underway to develop a PRA program. However, at the time of publication, the scale and operational details had not yet been made public.

Supervision and assessment of incoming candidates is a time- and resource-intensive process, and there are few incentives for supervising physicians to take on this added responsibility if it comes at the expense of practice efficiency. To overcome this, the provincial government could structure or subsidize the sponsorship agreements to incentivize sponsors to participate in supervised assessment of ITP candidates. In its August 2022 **letter** to the Ontario Government, the CPSO noted that "a program could be implemented immediately and begin injecting a new supply of [ITPs] into the system as early as spring 2023 and onwards." Government investment towards implementing PRA at an appropriate scale in Ontario has the potential to substantially increase physician supply in the short term.

B. Establish Clinical Assistant as a Regulated Profession in Ontario and Create a Pathway from CA to Independent Licensure

About the Clinical Assistant role: The Clinical Assistant (CA) role is a growing profession in Canada. CAs provide supportive patient care and act as "physician-extenders." The Winnipeg Regional Health Authority **distinguishes** between Physician Assistants (PAs) and CAs as "distinct roles with many overlapping functions,"

PHYSICIAN EXTENDERS & THE ONTARIO HEALTH CARE SYSTEM

The term "physician extender" lacks a common definition, but is generally understood to include roles such as Clinical Assistant / Clinical Surgical Assistant, Physician Assistant, and Associate Physician. These roles can add significant short- and long-term capacity to the Ontario health care system, ensuring that Ontarians have better access to care and alleviating pressures that lead to burn-out among health care workers.

and the roles have distinct entry-to-practice and educational requirements. In provinces where PAs are regulated, becoming licensed requires a four-year **PA degree** from one of only three accredited institutions in Canada. The PA educational pathway is distinct from medicine and is not an appropriate option for ITPs who already have a medical degree, postgraduate training abroad, and often extensive experience.

In **Manitoba**, **Nova Scotia**, and **Alberta**, the CA occupation is a regulated profession under the provincial medical regulatory colleges, and entry-to-practice requirements are designed to target individuals with a medical degree from a medical school listed in the World Directory of Medical Schools (see Appendix B). In Ontario, ITPs employed as CAs are leveraging the position as an entry point and orientation to the Canadian health care system; as a means of forming networks; and as a potential stepping-stone to securing residency or PRA positions. However, ITPs employed as CAs in Ontario face significant issues related to scope of practice

12 Source: Correspondence with University of Manitoba Faculty of Medicine, 2022.

and job quality, leading to skills underutilization in a highly unregulated setting. Many hope that the position can become a formally recognized, regulated, and funded role that can serve as a stepping-stone to independent licensure.

How to make this model work: The CA role is unregulated in Ontario, and currently no dedicated mechanism exists to fund or integrate ITPs as CAs in health care settings. Best-practice models of CA regulation and workforce integration in other Canadian jurisdictions can inform how Ontario might approach this process. Following a delegation model under the Regulated Health Professions Act, ITPs could be empowered to extend physician services more effectively by practicing as regulated CAs.

Licensing of ITPs as CAs should be structured as a stepping-stone to full licensure. Nova Scotia is one example of a province with a laddered licensing process that includes CA licensing, and provisional ("defined") **licensing** that includes supervised practice for a period of 6 to 24 months, enabling long-term licensing based on an assessment of competence. Aspects of this process parallel the College of Nurses of Ontario's (CNO) **Temporary Class** of licensing, which allows internationally educated nurses to practice while working towards full registration.

Ontario should consider the introduction of additional classes of registration that align with best practices in other Canadian provinces. Increased uptake of provisional or limited classes of licensure should be done in combination with other long-term measures that ensure fair pathways to licensure and commensurate employment.

The Government of Ontario has implemented the **Physician Assistant (PA) Career Start Program**, which provides grants of $46,000 to employers who are committed to integrating and supporting PAs on a long-term basis in emergency departments, primary care, and internal medicine. This model has the potential to be replicated to support the integration of ITPs as CAs, using registration criteria aligned with other jurisdictions where the role is regulated.[13] Hundreds of ITPs in Ontario stand to immediately benefit from investments towards regulation and integration of CAs in health settings, and Ontario's health care system stands to benefit from rapid integration of medical skills and training.

C. Expand ITP Access to Canadian Medical Residency Training

About medical residency training: The required length of residency training for family medicine is a base of 2 years; general practitioners in family medicine may then choose to do an additional year of training in a subspecialty (a total of 3 years). For specialty practice, the length of residency training ranges between 3–8 years. In all streams, the pool of positions open to ITPs is much smaller than it is to Canadian-trained physicians. Depending on the **province**, ITPs apply to residency positions either in the same stream as Canadian medical graduates ("competitively") or to a separate stream (in "parallel"). In 2022, only 23.9 percent of international medical graduates (including Canadians who studied abroad) were matched to residency in the Main Residency Match through CaRMS, as compared with a match rate of 92 percent for graduates of Canadian medical schools.

In 2022, only 23.9 percent of international medical graduates (including Canadians who studied abroad) were matched to residency in the Main Residency Match through CaRMS, as compared to a match rate of 92 percent for graduates of Canadian medical schools.

13 The CPSCB also recently introduced an **"Associate Physician"** class of registration, which has comparable entry-to-practice requirements and scope of practice as Clinical Assistants in other provinces.

Since 2018, more than seven times as many graduates of Canadian medical schools have entered **residency** training for family and specialty practice through the CaRMS Main Residency Match than graduates of international medical schools (14,615 as compared to 2,056), and evidence suggests that a **majority** of IMG residents are Canadians who studied medicine abroad but had not yet received postgraduate training or been licensed to practice in another jurisdiction. There is clearly a need to ensure that pathways to practice through residency training are equitable, that decisions concerning access are made through an assessment of competence, and that access is not limited based on the location of training.[14]

How to make this model work: The number of different stakeholders involved in the governance and implementation of medical education and residency training in Canada adds complexity to a discussion of simply "expanding the number of residency seats for ITPs." These stakeholders include provincial ministries of health, regulatory bodies, faculties of medicine, the Association of Faculties of Medicine of Canada (AFMC), and the Canadian Residency Match Service (CaRMS). Provincial ministries of health are responsible for designating an "appropriate" number of positions for international medical graduates within the province, as well as for mandating RoS requirements associated with residency training for ITPs. However, they do so in collaboration with faculties of medicine and the AFMC.

Provincial ministries of health are the primary funder of postgraduate medical residency positions in each province. As with PRA (and with the exception of Alberta and Quebec), RoS agreements are a requirement for ITPs to become licensed through Ministry-funded residency training in Canada. In Ontario, the RoS **requirement** for Ministry-funded residency positions is five years of service. In Ontario, all residency positions must be funded by either the Ontario Ministry of Health - Clinical Education Budget (CEB), other Ontario Government agencies, or provincially or federally sponsored foundations or agencies. Foreign-sponsored governments, agencies, or foundations (for example, the Kuwaiti Government, Aramco, and the World Health Organization) also coordinate and fund postgraduate training at medical schools in Ontario. For example, a scholarship **program** set up by the Saudi Arabian Cultural Bureau pays roughly $100,000 per trainee per year. **CAPER** data show that in 2021–22, there were 715 visa trainees studying as medical residents in Canada, including 280 in Ontario.

Stakeholders, including the Ontario Medical Association and Canadian Medical Association are calling for an expansion of residency seats for ITPs.

Stakeholders, including the Ontario Medical Association and Canadian Medical Association, are calling for an expansion of residency seats for ITPs. The appropriate scale of expansion should be determined collaboratively with all involved stakeholders based on need, potential supply (of both domestically and internationally trained medical graduates), and capacity of faculties of medicine and preceptors.

14 In British Columbia (BC), the BC Human Rights Tribunal is considering a case that **alleges** that the separate and differential pathways to residency training constitute a human rights violation for ITPs.

III. Why It Matters: Social and Economic Benefits of Expanding Pathways to Licensure

Government health spending continues to rise in Ontario and Canada, and interventions aimed at increasing physician supply by expanding pathways to licensure for ITPs should aim to maximize cost-effectiveness. In 2021, **total** health spending in Canada amounted to $308 billion, or $8,019 per Canadian, representing 12.7 percent of Canada's GDP. Hospitals (25 percent), drugs (14 percent), and physicians (13 percent) are expected to continue to make up the largest share of health spending; in 2019–2020, total gross **payments** to physicians stood at $29.4 billion, an increase of 4.3 percent from the previous year.

The 2022 federal **budget** allocated $45.2 billion to the provinces through the Canada Health Transfer (CHT) for 2022-2023 (including a $2 billion top up to the provinces to "continue to address immediate pressures including backlogs in surgeries and procedures"); in 2022 Ontario received a health care transfer of **$755.5 million**. Stakeholders in the province, including the **Ontario Medical Association**, along with **premiers** across the country, are calling on the federal government to increase spending through the Canada Health Transfer, from 22 percent to 35 percent, to account for increases in provincial health spending. This would amount to $28 billion in additional health care transfer spending.

In Ontario, health spending accounts for 39 percent of total government program **spending**. The Ministry of Health was projected to spend $74.1 billion in FY 2021–2022, an increase of $0.9 billion (1.3 percent) from FY 2020–2021. Health care costs are expected to continue to **increase** as a proportion of provincial government spending in coming years. In May 2021, the Financial Accountability Office of Ontario estimated it would cost the province **$1.3 billion** just to address the backlog of surgical and diagnostic procedures caused by the pandemic,

Urgent pressures in the Ontario health care system need to be addressed in cost-effective ways. Implementing more efficient and effective assessment and licensing of ITPs is one way to support this goal.

and that annual savings of $3.7 billion would be needed by FY 2023–2024 if the province is to meet its targets for health sector spending. Urgent pressures in the system, including the backlog of surgical and diagnostic procedures and critical staffing shortages, need to be addressed in cost-effective ways. Implementing more efficient and effective assessment and licensing of ITPs is one way to support this goal.

A Caveat: Acknowledging the Complexity of Measuring Costs and Benefits of Increasing Physician Supply

For several reasons it is difficult to predict the various social, economic, and health outcome returns of boosting the supply of physicians in Canada. For instance, investments in training and licensing one family physician does not translate to one family physician practicing full-time. Some physicians work part-time (for example, they may be semi-retired, teaching, or in clinical research). A 2016 **study** from the Auditor General of Ontario found that, on average, family physicians in the province work an equivalent of 3.5 days per week.

Interprovincial migration means that not all physicians will remain in the city or province in which they complete their residency training

or postgraduate medical education. Hence, investments in medical education in one province may not benefit the same province in the long term. Some mechanisms, like RoS agreements, support retention in the short term, but there is a lack of evidence supporting RoS agreements' **effectiveness** on long-term retention in underserved communities.[15]

Certain factors, including fee structures, also have the effect of **disincentivizing** physicians from entering family practice. Under Canada's system of public health care, a majority of health care services provided by physicians are covered under publicly funded **insurance**, and physicians are independent service providers, not government employees. Family physicians in Canada are responsible for a range of costs associated with running a medical practice. On average, family physicians earn roughly **half** of what specialist physicians do, and factors like work-life balance and prestige have also been **shown** to impact the ratio of primary care providers to specialists.

As **noted in an analysis** by Globe and Mail health reporter André Picard, increasing physician supply addresses one piece of the problem. In the long term, stakeholders will be required to think critically about what incentives (including remuneration) will lead more physicians to practice in the specialties and areas where they are most needed.

Benefits of Expanding Pathways to Licensure

Evidence suggests that investments in ITP integration can bring significant benefits. Assuming that licensing and credentialing processes ensure that ITPs are as or more qualified than Canadian-born and -educated medical graduates, and that they are able to practice at rates of Canadian-born and -educated medical graduates, we can expect a number of positive social, economic, and health care outcomes from expanding models of assessment and pathways to commensurate employment.

Health care equity: While both graduates of Canadian medical schools and ITPs are ethno-culturally diverse and can broaden access to culturally appropriate care, a survey of 324 ITPs showed that respondents arrived from 59 countries and 47 percent of respondents spoke three, four, five, or six languages. This cultural and linguistic diversity is critical to reducing barriers and supporting an increasingly diverse Canadian population; evidence **suggests** that individuals achieve better health outcomes when their physician speaks their first language. Conducted by Internationally Trained Physicians

THE MULTIDIMENSIONAL COSTS OF SKILLS UNDERUTILIZATION

The underutilization of ITP skills has a multiplicity of costs. The first is to Canada's overall economic health: A Royal Bank of Canada report from 2019 estimates that the Canadian economy loses as much as $50 billion per year (~2.5 percent of GDP) because of wage gaps stemming from skills underutilization of immigrants. A second is to ITPs themselves: There are profound social, psychological, and economic costs of prolonged de-skilling, downward mobility, and underemployment. A third is to Canada's international reputation: concerns have been raised about the **ethics** of recruiting internationally educated health professionals without also ensuring viable pathways to their integration into the health care system.

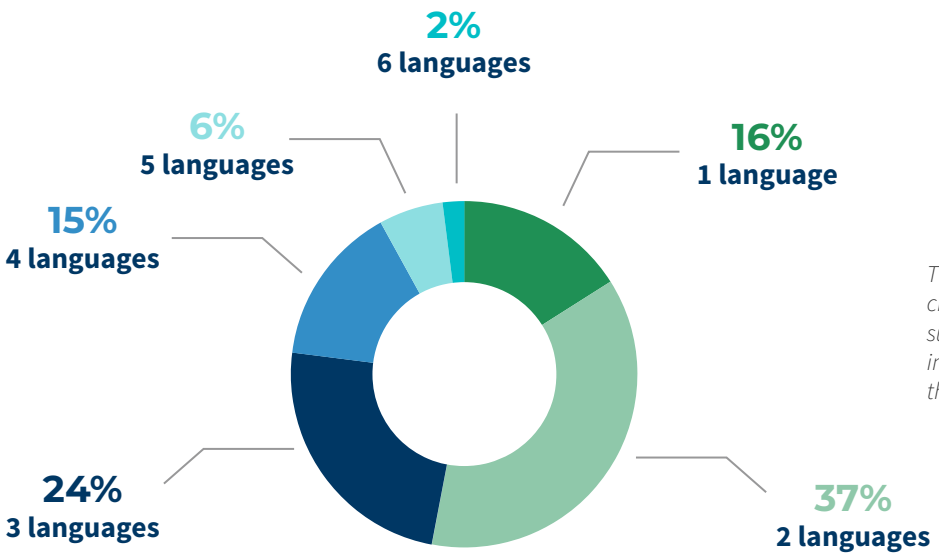
15 This dimension is linked to the **call** from the CMA and other stakeholders for a national licensure model to facilitate health care workforce planning at the national level.

of Ontario (ITPO), the survey also showed that nearly 90 percent of ITP respondents were willing to relocate to northern or rural communities in Canada in order to work in the health care sector, demonstrating the huge potential of this untapped resource to serve in areas where access to care is a significant issue.

Added capacity, reduced burnout: Burnout is a growing problem for physicians working in an overstrained system. In 2021, more than half of physicians and medical students in Canada reported "high levels of burnout," compared with just 30 percent in 2017, and **54 percent** of Ontario family physicians describe their job as extremely or very stressful. In both the short and long term, ITPs employed as Clinical Assistants, residents, or fully licensed physicians have the potential to play a vital role in increasing supply and thereby reducing burnout of health care providers and overall strain on the system. ITPs practicing in these roles provide an immediate contribution to the health care workforce by helping to absorb a percentage of patient volume on wards or in clinics.

Skills use improvement: A significant proportion of ITPs have many years of experience as independently practicing physicians; according to the ITPO survey, some ITPs had up to 30 years of experience abroad. Compared to the time and costs associated with putting an individual through medical school and postgraduate residency training, implementing PRA and models of supervised practice (Clinical Assistants) can be an efficient way to license ITPs who meet requirements and to rapidly apply their skills at a commensurate level. Alberta and Manitoba have developed competency-based assessment models for licensing Clinical Assistants. These models can be replicated in other jurisdictions. Key here is establishing systems that allow efficient and effective assessment and triage of ITPs' existing

FIGURE 2
Number of Languages Spoken by Internationally Trained Physicians **(n=324)**



The linguistic skills of ITPs are critical to health equity: Evidence suggests that health outcomes are improved when physicians speak their patients' first language.

Source: Internationally Trained Physicians of Ontario (ITPO), **ITPs - A Diverse, Underutilised, Skilled Health Human Resource, July 2022**

competencies, streamline professional re-entry, and reduce skills underutilization.

Improved patient outcomes: A major concern, and a significant contributor to the strain on emergency departments, is the fact that patients are coming in sicker. This problem is further compounded by increasing wait times to see a specialist after being referred by a primary care provider; only a **third** of patients in Ontario reported that they were able to see a specialist within 30 days of referral, and more than two-thirds (70 percent) went **unseen** for more than five months. Boosting the supply of ITPs licensed as Clinical Assistants or physicians has the potential to both immediately add capacity to primary care and decrease wait times for specialist referrals. With greater access to health care providers and specialists, patient health outcomes can be improved.

Cost savings: A 2007 **study** showed that investments in competency-based assessments that lead to professional registration of ITPs in Canada (such as PRA) can generate rates of return between 9 percent and 13 percent by streamlining professional re-entry. In Canada, the cost of medical education and residency training for one individual may reach hundreds of thousands of dollars; for some ITPs who have already completed their training and have extensive experience practicing abroad, this expenditure may not be necessary.[16]

Expanding access to primary care providers, and thus reducing the strain on hospitals caused by unnecessary emergency department visits, can also lead to cost savings. The average cost associated with an emergency department visit in Canada (excluding physician compensation) is $304. In Ontario, there are approximately **453** visits per 1,000 population per year, at a cost of $137,712 per 1,000 population. Although a **majority** of emergency department costs are due to urgent health issues, about 25 percent represent less serious or non-urgent conditions that could be better served by expanded access to primary care services.

Ensuring that ITPs are able to practice as primary care providers and physician extenders can help to alleviate the pressure on our emergency rooms, and minimize unnecessary costs.

Some ITPs have decades of experience practicing as physicians and can quickly become licensed through the PRA model. Others with training gaps could be directed towards expanded residency seats, while others who meet entry-to-practice requirements for a regulated Clinical Assistant role could enter the system immediately and work towards full licensure. PRA and defined licensing models also have the potential to serve as an opportunity for assessment of prior learning, meaning that any learning gaps, including an orientation to the culture of medicine in Canada, can be identified and addressed.

Ensuring that ITPs are able to practice as primary care providers and physician extenders can help to minimize wait times, alleviate pressure on our emergency rooms, minimize unnecessary costs, and improve patient health outcomes.

16 Provinces and territories must of course abide by principles of ethical recruitment and Canada's international commitments, including the **WHO's Global Code of Practice on the International Recruitment of Health Personnel**.

Conclusion

In response to an extreme shortage of health care providers, stakeholders in Ontario and nation-wide are actively seeking sustainable solutions to ensure that our health care system has the workforce it needs for the long-term. ITPs — both those already living in Ontario and those who will choose to settle in the province in the future — represent a key piece of the solution. Individuals with medical education and training should be directed into the pathway that most efficiently moves them into the system in roles that are commensurate with their knowledge, skills and experience. This brief outlines three policy changes required to achieve that goal.

Required Policy Changes

Implementation of Practice-Ready Assessment (PRA) at an appropriate scale

Equitable expansion of medical residency training to ensure ITPs have access

Establishment of Clinical Assistants under a defined class of registration with the College of Physicians and Surgeons of Ontario (CPSO)

Effective implementation of these policy changes depends on several key actions:

- **Stakeholder collaboration:** Government, educational institutions, regulatory bodies, physicians (including ITPs), health care employers, and allied stakeholders must collaborate effectively.
- **A multi-pronged approach:** Stakeholders must establish a coherent set of pathways to ensure the quick, effective, and ethical integration of ITPs with varying levels of experience and training into Ontario's health care system.
- **Sufficient investment:** Government must commit to investing at an appropriate scale to ensure systemwide transformation.

The measures outlined in this brief are proven and achievable. They will, if implemented sustainably and at appropriate scale, pay dividends in both the short and the long term. What is required is the collective will to act.

Appendices

Appendix A: Cost Structure for Practice-Ready Assessment (PRA) in Alberta

Expense	Description	2022
Administrative fees	A portion of admin fees goes to NAC-PRA, the Medical Council of Canada program that oversees PRA assessments across Canada. This fee is set to increase to $7,955 by December 2023.	$7,470
Preliminary Clinical Assessment (PCA) Assessor fee	Paid to a CPSA-approved assessor (licensed physician) who reviews clinical competence, chart management, and professionalism over a 3-month period of direct observation.	$2,000 per week; max 12 weeks (max $24,000)
Supervised Practice Assessment (SPA) Supervisor fee	—	$200 per hour; max 15 hours (max $3,000)
Travel expenses	Costs incurred in driving to and from assessment location(s)	$0.59/km for first 5,000 km driven; $0.53 for any additional km driven
Total cost (not including expenses)	—	max of $34,470 per applicant

Source: CPSA

Appendix B: Percentage of health care workers intending to leave or change jobs in the next three years:* Statistics Canada Survey percent

	Less than 5 years experience	5–10 years experience	Over 10 years experience
All health care workers	39.6	25.9	34.6
Physicians	47.1	25.9	27.0
Nurses	43.1	25.4	31.5
Personal Support Workers (PSWs) or Care Aides	37.8	33.6	28.6
Others	31.4	20.7	47.9

* Percent according to experience and occupation, Canada, September to November 2021. Does not include health care workers intending to retire.

Source: **Statistics Canada**

Appendix C: Registration Criteria for Clinical Assistants (Alberta)

- Medical degree from a school listed in the World Directory of Medical Schools.
- Postgraduate training (minimum of one year).
- Must be hospital-based training in clinical services providing direct patient care interaction in an acute care setting. Medical or clinical research, full-time administrative activity, and instruction in aspects of medicine not contributing to direct patient care do not qualify.
- Medical Council of Canada's Qualifying Exam Part 1 (MCCQE1)
- Proof of English language proficiency if trained in a country where English is not the first and native language (even if English was the language of instruction).
- Letter of offer from Alberta Health Services.
- Successful completion of Alberta Health Services Clinical or Surgical Assistant orientation programme.

Source: **CPSA**

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