



August 20, 2009

International Medical Graduates in Canada: 1972 to 2007

Executive Summary

Over the past several decades, various trends have been changing in Canada's international medical graduate (IMG) workforce. First, Canada's IMGs have gone from being largely trained in Britain or Ireland to being more evenly distributed among several other countries. The countries currently contributing the largest numbers of IMGs to Canada's physician workforce are South Africa and India. Ireland is no longer one of the top 10 contributors to Canada's physician workforce. Second, IMGs as a proportion of Canada's physician workforce have declined from more than 33% in the 1970s to 22.4% in 2007, largely due to the aging and retirement of the wave of British- and Irish-trained physicians who began practising in earlier decades, as well as smaller numbers of new IMGs setting up practice in Canada. The phenomenon of the decline in the percentage of Canada's physicians who are IMGs is present in all provinces and in the territories.

One characteristic that has hardly changed over time, however, is the likelihood of new IMGsⁱ to cease to practise in Canada: other than those from the United Kingdom or Ireland, IMGs who began practising in Canada in the 1990s were equally likely to leave the physician workforce over the next 10 years as those who began in the 1970s. The lack of change in this characteristic contrasts, however, with a change in interprovincial mobility: IMGs who began to practise in the 1990s were significantly more likely to change province or territory over the next 10 years than those who began in the 1970s. The tendency of some new IMGs to stop practising in Canada leads to the effect that IMGs are a more significant presence among new physicians than among physicians overall: although only 22.4% of Canada's physicians were IMGs in 2007, among new physicians, 31.0% were IMGs in the five most recent data years (2003 to 2007).

Within Canada, the decline in the percent of physicians who are IMGs over the period of the study was present in all provinces, as well as in the territories. For Canada's physicians overall, physicians were slightly more likely to be IMGs in rural than urban areas. This phenomenon is more pronounced among new physicians, who were much more likely to be IMGs in rural than in urban areas. Breaking this down provincially,

i. See the Methodology section for the definition of a new physician.

physicians were more likely to be IMGs in rural areas than in urban ones, for both new physicians and for physicians overall, except in Ontario and Quebec, where physicians in urban areas were more likely to be IMGs.

Introduction

Historically, Canada has relied heavily on IMGs to address gaps and shortages in its physician supply.¹ In 2007, 22.4% of Canada's physicians were graduates of foreign medical schools, compared to a high of 33.1% three decades earlier.² Changes in the number of this source of supply of medical professionals are a critically important component of our understanding of the overall physician supply in Canada, now and into the future. This analysis is based on data from Scott's Medical Database (SMDB) at the Canadian Institute for Health Information (CIHI) and the results of the 2007 National Physician Survey (NPS), and it examines the following important questions about the evolution and behaviour of Canada's IMGs over the past four decades:

- Have IMGs increased or decreased as a proportion of Canada's provincial, territorial and national physician workforces?
- What countries have Canada's IMGs tended to be trained in and have those countries changed over time?
- What portion of IMGs are immigrants and what portion are of Canadian origin who received their medical degrees elsewhere?
- Once in Canada, do IMGs tend to be more mobile than Canadian-trained physicians?
- What is the urban versus rural distribution of IMGs?

Data Sources and Methodology

Data Sources

The SMDB is purchased annually from the Business Information Group and maintained by CIHI. The SMDB includes all individuals in Canada with an MD degree and an active mailing address. In some cases of physicians whose MD degree was obtained outside Canada (international medical graduates), the degree may not be an MD degree, but an equivalent degree with a different title in the country in which it was obtained. For simplicity, these degrees will still be called "MD degrees" in this analysis. Data reported by CIHI includes all active physicians, that is, specialists and family physicians in the Canadian workforce who are not residents, serving in the military, retired or semi-retired. Note that these physicians are included whether they are licensed or not, so although they may be working in some capacity in the Canadian physician workforce, they are not always doing clinical work. The current SMDB data covers the period 1968 to 2007. For a more detailed description of the inclusion and exclusion rules, see the Methodological Notes of the latest *Supply, Distribution and Migration of Canadian Physicians* report available online at www.cihi.ca.

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The NPS contains information provided by the 19,239 physicians who replied to the 2007 National Physician Survey (31.64% response rate). All family/general practitioners and other specialist physicians in Canada were contacted. Since the physicians' response rates varied according to age, sex, province, language and year of MD graduation, a weighting system was applied so that not all physicians' responses were counted equally in the analysis. Instead, each physician's response was weighted so that the relative importance of his or her demographic group in the analysis matched that for his or her group among physicians as a whole. The College of Family Physicians of Canada, the Canadian Medical Association and the Royal College of Physicians and Surgeons of Canada carried out the NPS. Detailed survey information, including methodology, questionnaires and results, is available on the NPS website at www.nationalphysiciansurvey.ca. The survey questions used in this study are those relating to the physician's country of MD graduation and the physician's country of upbringing.

Methodology

The term "IMG" will be used throughout this paper to mean a person living in Canada who has an MD degree that was obtained from an institution outside Canada. IMGs may be currently practising medicine or not. Except in the section Canadian-Origin IMGs below, no distinction can be made between IMGs who are immigrants and physicians who are of Canadian origin who studied and received their medical degrees elsewhere.

The determination of who constitutes an IMG and who is a Canadian-educated medical graduate (CEMG) is made according to the country where individuals attained their MD degrees (as opposed to where their postgraduate residencies were completed). In 2007, there were 63,682 active physicians in the SMDB, 48,775 of whom were CEMGs; 14,051 were IMGs and the country of graduation of 856 was unknown. Those of unknown country of graduation declined steadily over the time period under study, from 16.5% in 1972 to 1.3% in 2007. Throughout this analysis those of unknown country of graduation were excluded.

The term "new physician" (or "new IMG") is used to mean a physician in the year when he or she first appeared as an active family physician or specialist in the SMDB (see Data Sources above for whom this includes). This will not necessarily be the physician's first year of practice, as he or she may have practised outside Canada before becoming active in the SMDB.

The NPS data excludes residents and those who are retired. In order to match as closely as possible the methodology used in analyzing the SMDB data, the semi-retired were excluded as well. The NPS does not identify those physicians serving in the military, so it was not possible to exclude them.

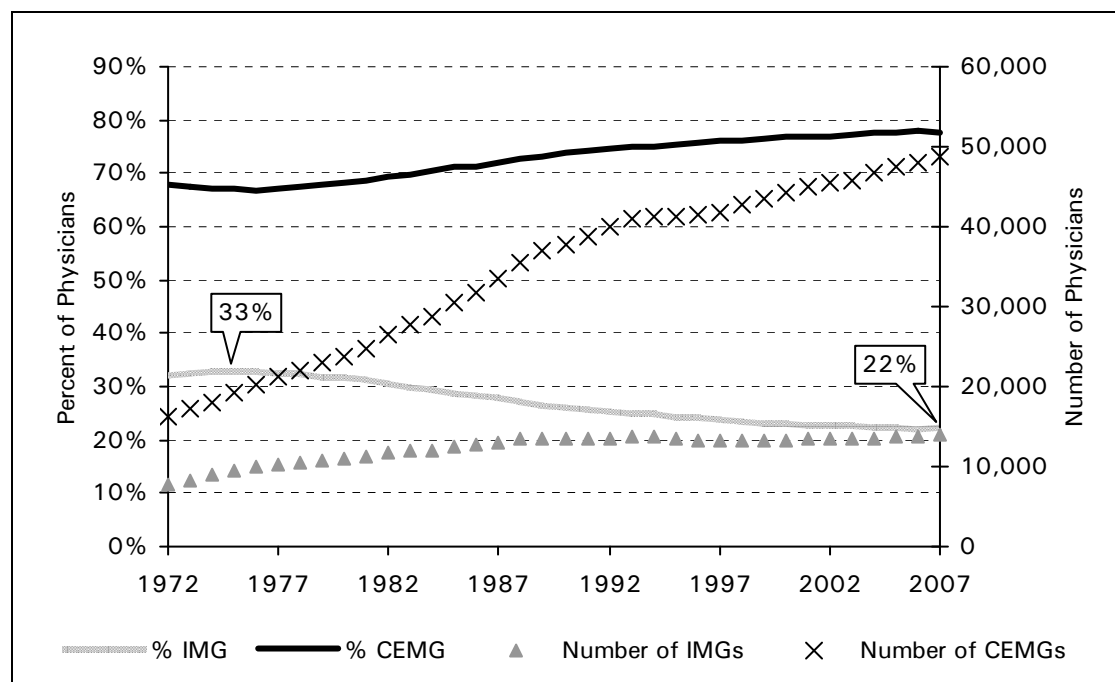
IMGs: How Many and From Where?

In the years following the Second World War, Canadian medical schools were challenged to keep pace with the expanding needs of the post-war population. Between the late 1960s and early 1970s, Canada licensed more IMGs than it graduated physicians domestically.¹

To explore how the proportion of Canadian-trained and foreign-trained physicians changed over time, Figure 1 provides the number (the symbols associated with the right axis) and the percentage (the lines associated with the left axis) of CEMGs and IMGs in Canada from 1972 to 2007. Overall, the number of CEMGs grew steadily throughout this time period, with one brief flat period in the 1990s. This plateau in the mid-1990s has been attributed to several changes during that period that saw an increase in the amount of time physicians spend in postgraduate training, increased physician retirement and medical school enrolment cuts.³

From 1972 to the late 1980s, the number of IMGs increased and has remained at about 13,500 since then. As a percentage of the physician workforce, IMGs peaked at 33.1% in 1976 and have declined since then to 22.4% in 2007.

Figure 1 IMGs Versus CEMGs, Canada, 1972 to 2007



Note

The two series of percentages use the left-hand axis. The two series of numbers use the right-hand axis.

Source

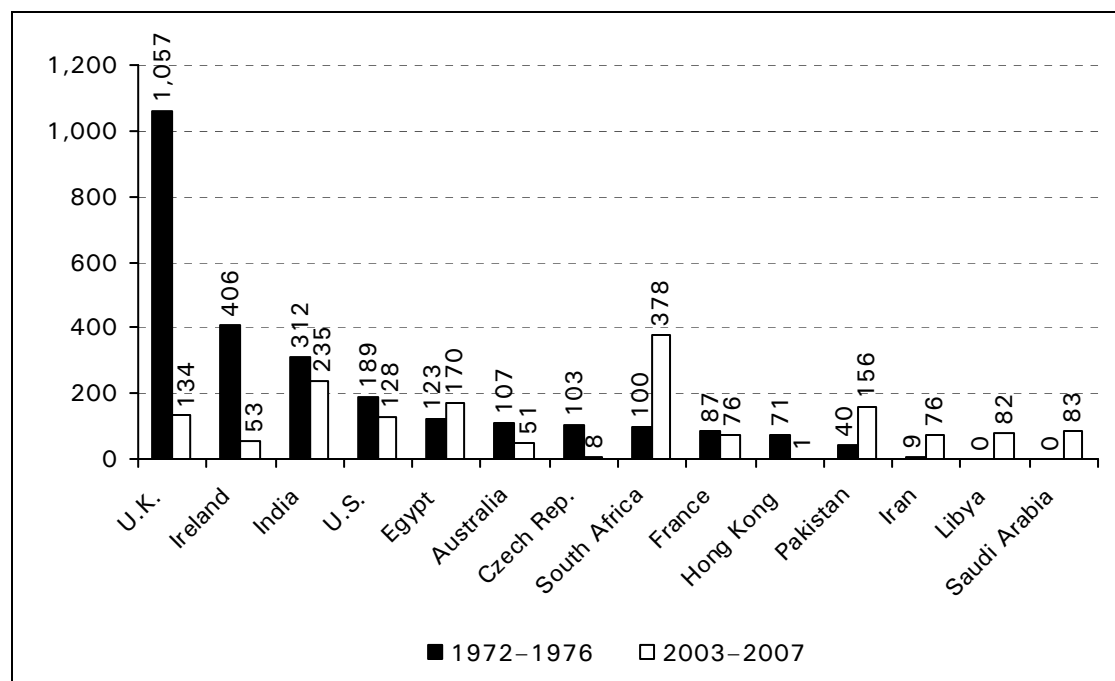
Scott's Medical Database, Canadian Institute for Health Information.

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When discussing changes in the proportion of IMGs in the Canadian physician workforce, it is helpful to examine the countries where IMGs received their MD degrees and how this changed over time. Figure 2 combines data on new IMGs from select countries from two time periods, 1972 to 1976 and 2003 to 2007. Five years of data were combined for each group to provide enough new physicians for a robust sample. In the first five-year period, 1972 to 1976, there were 3,869 new IMGs; in the second period, 2003 to 2007, there were 2,717. The countries were selected either because they were one of the top 10 providers of new IMGs from 1972 to 1976 (the United Kingdom, Ireland, India, the United States, Egypt, Australia, the Czech Republic, South Africa, France and Hong Kong) or because they were one of the top 10 providers of new IMGs from 2003 to 2007 (South Africa, India, Egypt, Pakistan, the U.K., the U.S., Saudi Arabia, Libya, France and Iran).

Figure 2 Number of New IMGs in Canada From Selected Countries, 1972 to 1976 and 2003 to 2007



Note

Although there was no Czech Republic in the 1970s, country of graduation is updated retroactively. Therefore, physicians with MD degrees from Czechoslovakia who practised in Canada in the 1970s have since had their data from that year updated to the Czech Republic or Slovakia, depending on their medical schools.

Source

Scott's Medical Database, Canadian Institute for Health Information.

As can be seen from Figure 2, when comparing the top 10 suppliers of new IMGs to Canada in the period 1972 to 1976 with the period 31 years later, 2003 to 2007, several interesting findings emerge. For example, six countries appear in both periods:

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the U.K., India, the U.S., Egypt, South Africa and France. Also, there has been a shift in the main providers of IMGs from the U.K. and Ireland to South Africa and India. In fact, the U.K. and Ireland have gone from being the major suppliers of new IMGs (1,463 out of 3,869 from 1972 to 1976) to being relatively small players—Ireland is no longer in the top 10 list. And, of the 14 countries (including China's Hong Kong Special Administrative Region and the part of Czechoslovakia that is now the Czech Republic) that appear in Figure 2, 11 of them are countries that have been influenced by the British, American or French administrative systems and therefore have historically had a language in common with Canada. These, among many other factors, may influence how an IMG's credentials will be recognized in Canada and may facilitate the achievement of other requirements to become fully licensed in this country.

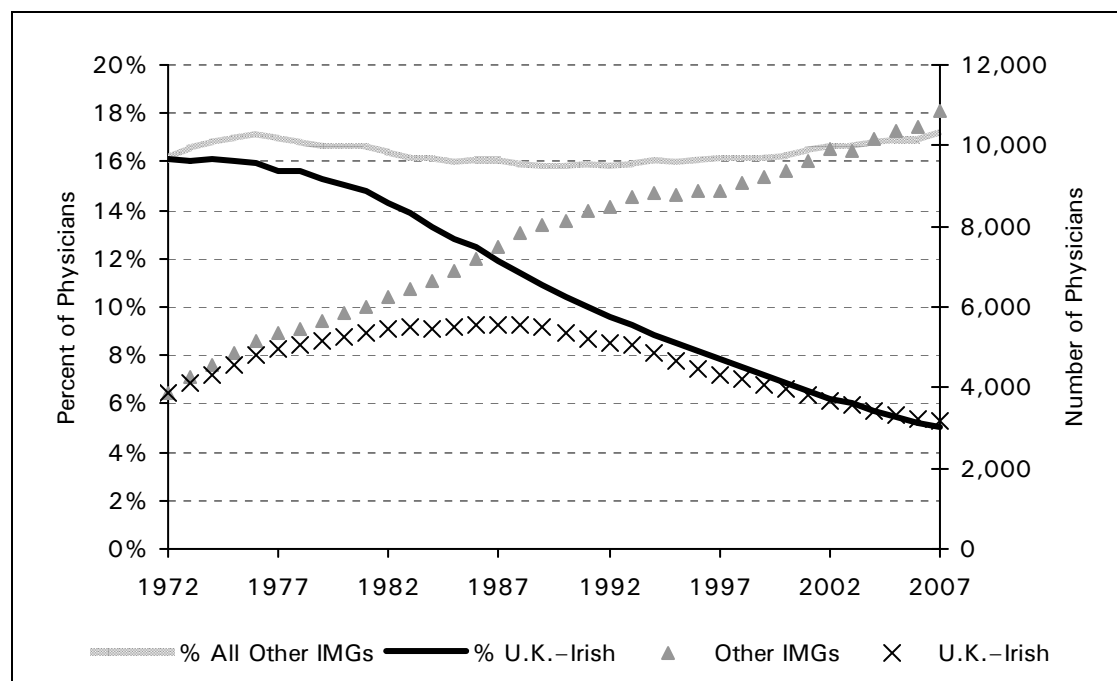
Finally, as illustrated in Figure 2, all member countries of the Organisation for Economic Co-operation and Development (OECD) present (the U.K., Ireland, the U.S., Australia, the Czech Republic and France) have shown declines in the number of new IMGs entering Canada to practise medicine. In contrast, other than India and Hong Kong, all non-OECD countries present have shown increases. This might indicate a shift in Canada's new IMGs training in developed countries to training in developing countries.

Figure 3 further addresses the decline of British and Irish IMGs from the 1970s to the present. This figure takes the number and percent of IMGs in Canada's physician workforce from Figure 1 and separates them into those trained in the U.K. or Ireland and those trained anywhere else.

What is visible from this figure is that IMGs from the U.K. and Ireland represented the majority of Canada's IMGs at the beginning of the 1970s. Both the number and percentage of Canada's physicians who were trained in these countries fell over the subsequent years. IMGs from other countries, however, have been increasing in number over the entire time period. As a percentage of the total physician workforce, they have been roughly constant, ranging from 16.2% to 17.3% over the entire period under study.

From Figure 3, it appears that the decline in the percentage of physicians who are IMGs might be attributed to an effect left over from the end of the years of significant arrival of British and Irish IMGs in the 1970s. While IMGs from countries other than the U.K. or Ireland have been increasing in number, the increase is not enough to compensate for the shrinking numbers of British and Irish physicians who arrived in Canada decades ago and are now leaving the profession. The net result is a long-term decrease in the relative IMG presence in Canada's physician workforce.

Figure 3 U.K.–Irish IMGs Versus IMGs From Other Countries, Canada, 1972 to 2007



Note

The two series of percentages use the left-hand axis. The two series of numbers use the right-hand axis.

Source

Scott’s Medical Database, Canadian Institute for Health Information.

Canadian-Origin IMGs

As part of a discussion of IMGs in Canada, it is important to keep in mind that not all IMGs were born and raised outside Canada. An IMG is someone in the Canadian workforce with an MD degree obtained outside Canada, regardless of country of origin or medical license status. In other words, no distinction is made between physicians who are immigrants to Canada and those who are of Canadian origin who studied and received their medical degrees elsewhere. It is important to analyze information about these Canadian-origin IMGs because their situation may not be comparable to the situation for IMG physician immigrants of non-Canadian origin.

In addition, undergraduate medical students studying abroad represent a potential future supply of physicians as, subject to acceptance into and completion of an accepted postgraduate medical education program, they may be able to practise in Canada. One survey estimates that there are up to 1,500 Canadians currently studying medicine abroad,⁴ but apart from this source, they are difficult to distinguish in the data from other IMGs.

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The SMDB tracks a physician’s country of MD graduation. Using this database, it is not possible to draw a distinction between Canadians who studied medicine outside Canada and immigrants who came to Canada after having completed their MD degrees or equivalent in another country. The 2007 NPS asked physicians about their country of MD graduation and also asked about the province/territory physicians grew up in prior to university (with an option for outside Canada).ⁱⁱ Therefore, it is possible to draw a distinction between IMGs who grew up in Canada (regardless of place of birth) and those who grew up outside Canada.

The 2007 NPS data shows that 19.3% ($\pm 0.5\%$) of Canada’s physicians are IMGs. This is somewhat lower than the 22.4% derived from SMDB data. A factor in this difference may be the difference in the populations of the SMDB and the NPS. For example, the NPS does not include unlicensed physicians, while the SMDB does.

Table 1 gives the breakdown of what percentage of CEMGs and what percentage of IMGs reported their place of upbringing as being in Canada and what percentage did not. Note that, among the IMGs, more than a quarter, 27.3%, were raised in Canada but went to medical school outside Canada. The remaining 72.7% of IMGs neither grew up in nor were medically educated in Canada. These IMGs work out to 14.0% ($\pm 0.8\%$) of Canada’s total physicians (72.7% of 19.3%). In discussions of Canada’s supply and recruitment of foreign physicians, it might be more accurate to refer to this latter 14.0%, since all other IMG physicians had exposure to Canada before beginning to practise medicine, either through education or upbringing.

Table 1 Percent of IMGs and CEMGs, by Country of Upbringing

	CEMG	IMG
Grew Up in Canada	93.8%, $\pm 0.4\%$	27.3%, $\pm 1.3\%$
Grew Up Outside Canada	6.2%, $\pm 0.4\%$	72.7%, $\pm 1.3\%$
Total	100%	100%

Notes

Figures in the text may differ from those arrived at using these numbers due to rounding. The uncertainty is quoted to 95% confidence intervals.

Sources

National Physician Survey Database, 2007, College of Family Physicians of Canada, Canadian Medical Association and Royal College of Physicians and Surgeons of Canada.

ii. NPS question wording was “In which province(s)/territory(ies) did you grow up prior to university?” with a box for “Outside of Canada.”

IMG Stability

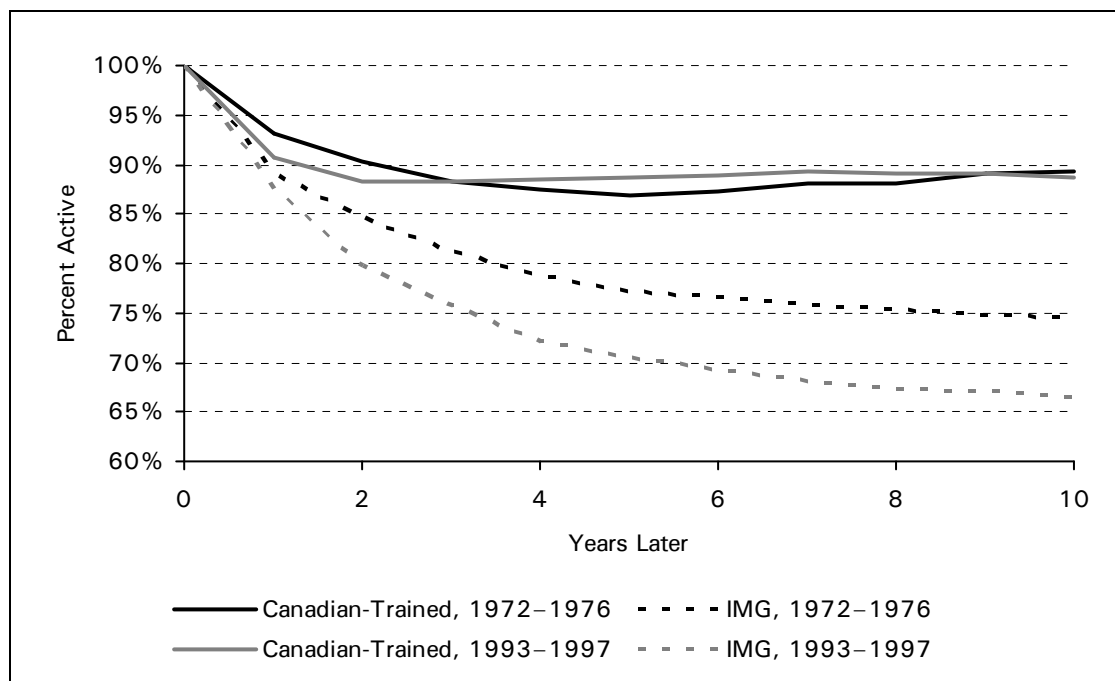
Over the years, policy-makers and health human resource planners have been concerned with the loss of Canadian physicians to emigration.^{5, 6} The number of physicians moving abroad peaked in the late 1970s and from 1992 to 2002.⁷ Previous work has shown that among CEMGs who left Canada, 80% went to the United States while, for IMGs, the most likely destination was their country of training or a neighbouring country with no medical school (43%).⁸

It is worthwhile investigating the relative stability of Canadian-trained physicians versus IMGs in the Canadian physician workforce. One measure of stability is to see whether IMGs are less, more or equally likely to stay active as physicians in Canada compared to Canadian-trained physicians.

Figure 4 shows the proportion of new physiciansⁱⁱⁱ who first appear in the data during two time periods (1972 to 1976 and 1993 to 1997) and who are still active in the database (that is, still active as physicians in Canada) in the 10 years following their initial appearance. The purpose of this analysis is to focus on physicians whose main reason for not still being in the database is that they have left the country or changed careers. Among older physicians, a physician will be more likely to no longer be active in the database due to retirement or death. To reduce this effect, physicians who were age 45 or older the first year they were active in the SMDB were not included. Although it is expected that the main reason a physician age 45 or younger wouldn't be in the database 10 years later would be due to leaving the country or the physician profession, it is always possible that some of those who left the Canadian physician workforce will have died or retired early.

iii. "New physicians" refers to those who appear as active (not residents, military physicians, retired or semi-retired) family physicians or specialists in the SMDB for the first time.

Figure 4 Comparison of Change in Proportion of New IMGs and New CEMGs Still Active Over 10 Years, Canada, Newly Active 1972 to 1976 Versus Newly Active 1993 to 1997



Note

The drop and subsequent rise in the percent of physicians still active could be due to physicians temporarily withdrawing from the SMDB and then returning.⁹

Source

Scott’s Medical Database, Canadian Institute for Health Information.

As can be seen from Figure 4, there has been no significant change in the status of Canadian-trained physicians over this time period. For the cohort first active from 1972 to 1976, there is an initial drop in the percentage of active physicians, with the proportion of active physicians levelling off at just less than 90%, where it remains at the 10-year mark. The behaviour of the 1993-to-1997 cohort is virtually identical. The initial drop followed by a slight rise in the percent still active can possibly be explained by some physicians either temporarily leaving Canada or returning for more training (in 2006–2007, there were 107 re-entries of Canadian MD graduates to postgraduate training positions).⁹

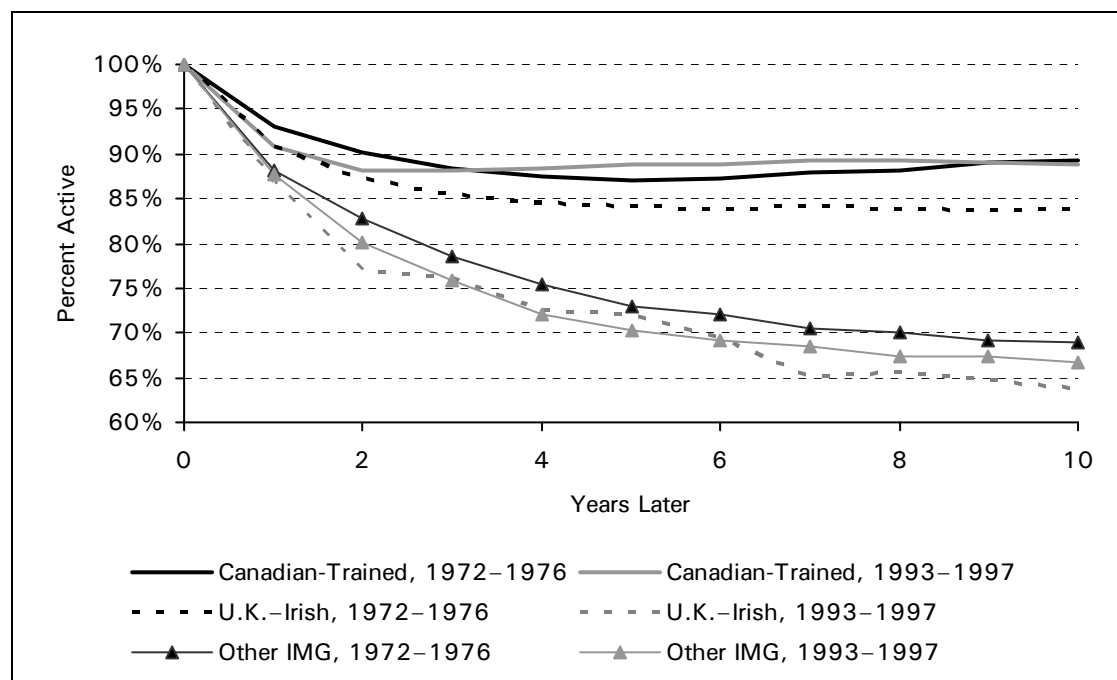
There are some interesting differences between the migration patterns of the 1972-to-1976 and 1993-to-1997 cohorts of IMGs. Both cohorts see a steady decline in the percentages that are still active in Canada; however, the rate of decline differs. Approximately three-quarters of physicians from the 1972-to-1976 cohort were still active after 10 years, while only about two-thirds of the 1993-to-1997 cohort were still active.

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Further analysis of the data reveals that the change in IMG behaviour might be less significant than it first appears. Figure 5 splits IMGs from each cohort into two groups—from the U.K. and Ireland and from anywhere else.

Figure 5 Comparison of Change in Proportion of New U.K.- or Irish-Trained IMGs, Other IMGs and Canadian-Trained Physicians Still Active Over 10 Years, Canada, Newly Active 1972 to 1976 Versus Newly Active 1993 to 1997



Note

The drop and subsequent rise in the percent of physicians still active could be due to physicians temporarily withdrawing from the SMDB and then returning.⁹

Source

Scott's Medical Database, Canadian Institute for Health Information.

Similar to results for CEMGs, among IMGs from countries other than the U.K. or Ireland there was very little change in status between the cohort from the early 1970s and the cohort from the early 1990s. Approximately 70% of the early 1970s cohort was still active in Canada 10 years later, while the 1990s cohort's likelihood of still being active was only slightly lower.

The difference in IMG behaviour over the two time periods appears to be primarily due to a change in the percent still active from the U.K. and Ireland, as well as their smaller representation in the data. The proportion of British- and Irish-trained IMGs who first appear in the 1972-to-1976 period and are still active 10 years later, at just less than 85%, is consistent with that of Canadian-trained physicians during the same period. However, the proportion of British- and Irish-trained IMGs from the 1990s cohort that is still active 10 years later, at less than 65%, resembles that of other IMGs.

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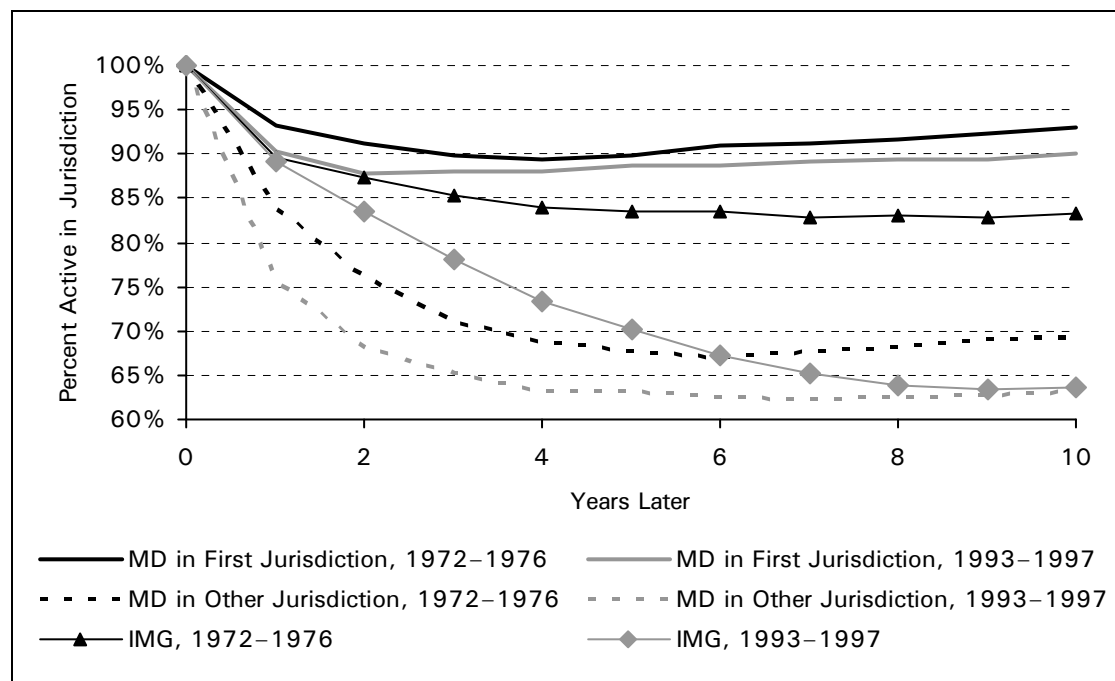
Thus, the likelihood of new Canadian-trained physicians and IMGs from countries other than the U.K. or Ireland remaining active in Canada after 10 years has not changed significantly from the 1970s. However, IMGs from the U.K. and Ireland have gone from behaving like Canadian-trained graduates to behaving like other IMGs, in terms of their likelihood of still being active 10 years later.

IMG Interjurisdictional Mobility

When considering the impact of IMGs on physician supply, it is useful to examine the migration of IMGs between provinces and territories. For example, are physicians who start working in the same province they trained in (there are no medical schools in Prince Edward Island, New Brunswick or the territories) more likely to continue working in this province than other physicians? And, for those who began practising in a province where they didn't get their MD degree, does it matter whether they were trained in Canada or not? Analysis done elsewhere has shown that, although immigrants to Canada are less likely to move from one province to another, this difference disappears once one corrects for factors such as education, age and family size.¹⁰

To explore these questions, SMDB data was used to divide physicians entering practice (new physicians) in Canada into three groups: those who got their MD degree in the province where they first practised, those who got their MD degree in a Canadian province other than the province or territory where they first practised and IMGs. Figure 6 shows, for those who were new physicians from 1972 to 1976 and from 1993 to 1997, the percent of those new physicians who were still active in their first jurisdiction of practice over their first 10 years in the profession. Only those physicians who were still active in Canada 10 years later were included in this analysis.

Figure 6 Percent of New Physicians (1972 to 1976 or 1993 to 1997) Active in Their First Canadian Jurisdiction of Practice, After 10 Years, by Place of MD Graduation



Source
 Scott's Medical Database, Canadian Institute for Health Information.

Physicians who started working in a particular jurisdiction within Canada were more likely to stay if they were trained there—more than 90% stayed after 10 years in both periods. The drop and subsequent rise in the percent of these physicians still active can probably be explained by a combination of physicians temporarily leaving the province, temporarily leaving the country or returning for more training (in 2006–2007, there were 107 re-entries of Canadian MD graduates to postgraduate training positions).⁹ Of physicians who were trained in another Canadian jurisdiction than the one they became active in, only 69.2% of them were still active in their first jurisdiction after 10 years in the earlier period (1972 to 1976), and 63.2% stayed after 10 years in the later period (1993 to 1997).

The proportion of IMGs that was still practising in the same jurisdiction after 10 years varies between the two cohorts. IMGs that started practising in the early 1970s (83.0%) were much more likely than those from the early 1990s (65.0%) to still be practising in the same jurisdiction.

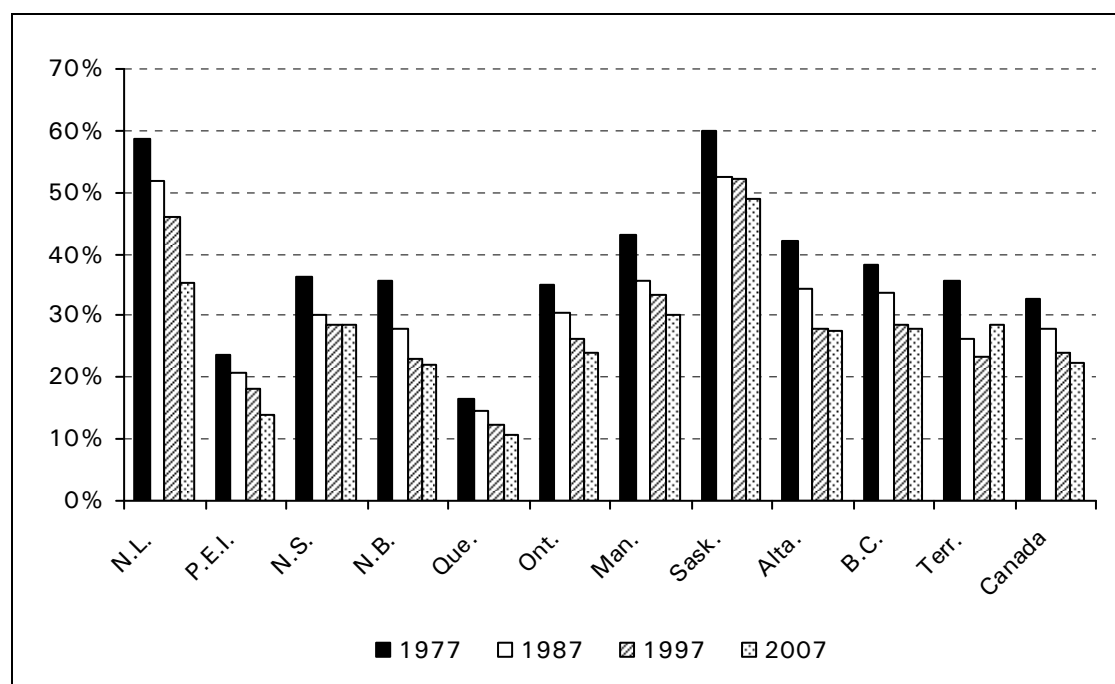
Finally, all three groups were less likely to still be practising in their first jurisdiction of practise after 10 years if they began to practise in the early to mid-1990s than in the early to mid-1970s. This contrasts with the Canadian population in general, which had lower rates of interprovincial migration in the 1990s and 2000s than in the 1970s and 1980s.¹¹

Distribution of IMGs Within Canada

This paper has focused exclusively on the national portrait of the IMG workforce in Canada. It is worthwhile, however, examining the relative differences in the IMG presence among Canada’s jurisdictions and their evolution over time.

Figure 7 shows the percent of Canada’s active physicians who were IMGs by province/territory. SMDB data was used to produce these percentages for four years, each 10 years apart: 1977, 1987, 1997 and 2007. Over the entire time period, Quebec and Prince Edward Island had the smallest proportion of IMGs in their workforces and Saskatchewan and Newfoundland and Labrador had the largest. In addition, despite a recent bump in the territories, the percentage of physicians who received their MD degrees outside of Canada decreased in all jurisdictions from 1977 to 2007.

Figure 7 Percent of Physicians in Canada Who Are IMGs, by Province and Territory, 1977, 1987, 1997, 2007



Note

Due to the small number of physicians in the territories, the numbers have been combined.

Source

Scott’s Medical Database, Canadian Institute for Health Information.

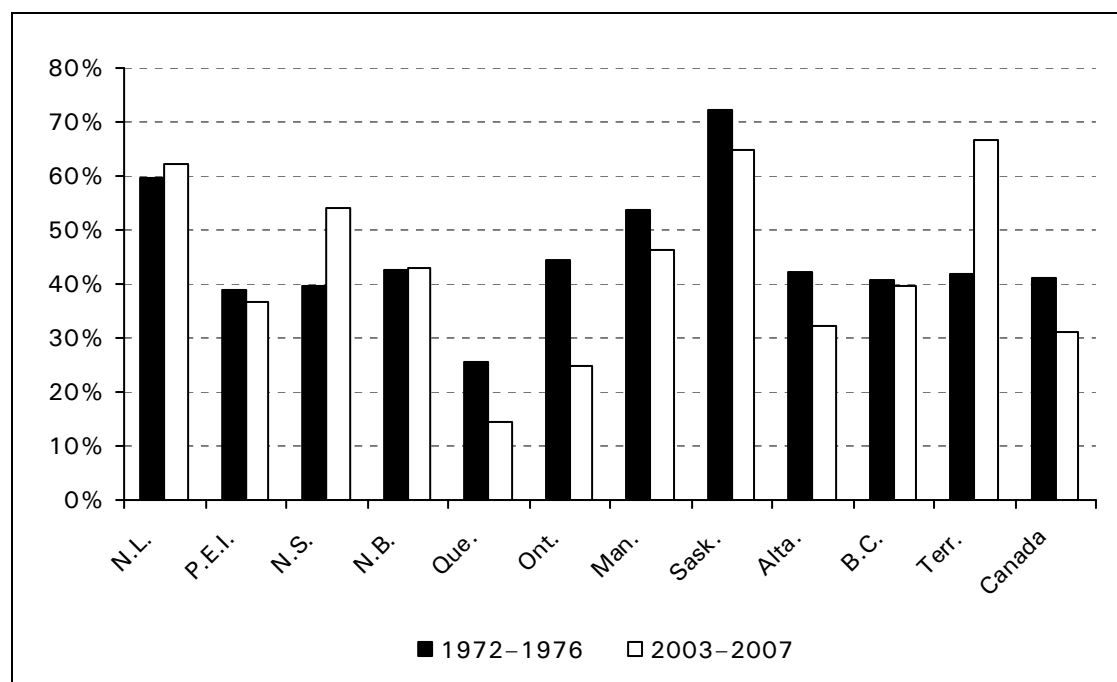
In addition to the question of what proportion of physicians are IMGs, it is also worthwhile asking what proportion of *new* physicians are IMGs. Figure 8 provides the proportion of new physicians who are IMGs. As before, the definition of a new physician is one who appears as an active family physician or specialist in the SMDB

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for the first time. Also as before, two groups will be examined: those who were new physicians at some point from 1972 to 1976, and those who were new physicians at some point from 2003 to 2007.

Figure 8 Percent of New Physicians in Canada Who Are IMGs, by Province and Territory, 1972 to 1976 and 2003 to 2007



Source
Scott's Medical Database, Canadian Institute for Health Information.

Figure 8 shows results that differ markedly from those of Figure 7. Most notably, the percent of new physicians who are IMGs is much higher than with all physicians: in 2007, 22.4% of active physicians in Canada were IMGs, but 31.0% of new physicians from 2003 to 2007 were. This finding is consistent across all jurisdictions. The explanation for this phenomenon can probably be found in earlier findings from this paper which indicated that new IMGs are less likely to stay active in Canada's physician workforce than Canadian-trained physicians.

Although all parts of Canada saw declines in the percentage of physicians who are IMGs from the 1970s to the beginning of this decade, the same trend does not hold for new physicians. The representation of IMGs in the new physician workforce actually increased in three of the Atlantic Canadian provinces as well as in the territories. This has still not prevented the overall IMG workforce from declining, probably due to the same migration trends as noted above.

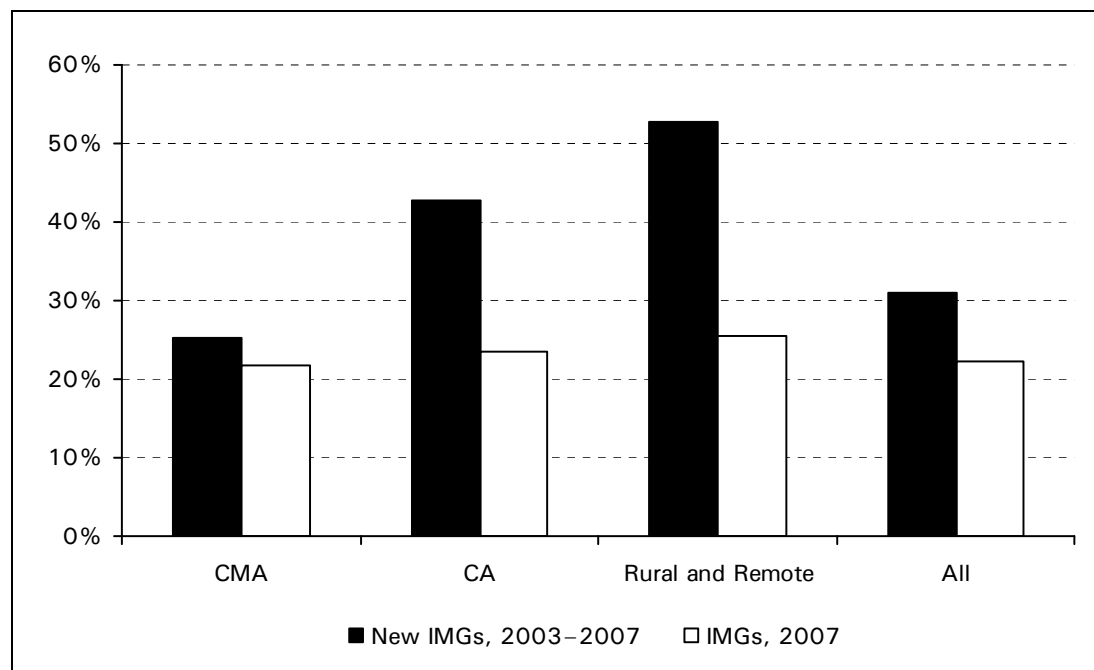
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Figure 9 shows the percentage of new physicians in census metropolitan areas (CMAs), census agglomerations (CAs)^{iv} and rural or remote areas who are IMGs, as well as the percentage of physicians overall who are IMGs.^v Here, those not located in CMAs or CAs will be referred to as being in rural or remote locations.

Both new physicians and physicians overall are more likely to be IMGs in less urban areas. The less urban the area, the higher the percent of doctors whose MD degrees were obtained outside Canada. This trend is much more pronounced among new physicians than among physicians overall. While IMGs make up 52.8% of new physicians in rural or remote areas, 42.7% in CAs and 25.2% in CMAs, IMGs represent approximately one-quarter of physicians overall (25.6%) in rural or remote areas, 23.5% in CAs and 21.8% in CMAs. This would suggest that newly practising IMGs have a tendency to begin practice in rural areas and then migrate over time to larger communities, not necessarily in the province they became active in or in Canada. This is a tendency that has been reported elsewhere¹² and is consistent with the practice of provinces offering provisional licenses to IMGs, typically for a period of two years, under the agreement that they work in a rural or remote location.¹³

Figure 9 Percentage of Physicians in Canada Who Are IMGs, by Community Size (CMA, CA or Rural and Remote), Newly Active Physicians From 2003 to 2007 and Overall Physicians in 2007



Source
Scott's Medical Database, Canadian Institute for Health Information.

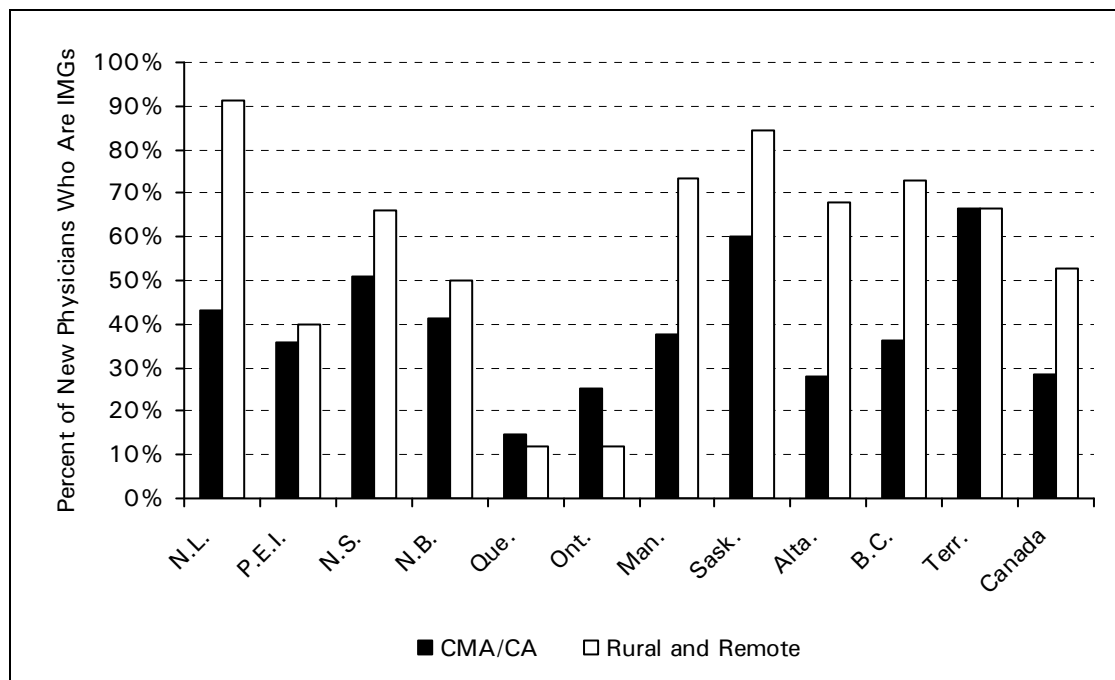
- iv. Census metropolitan area (CMA), population of 100,000 or more; census agglomeration (CA), population of 10,000 to 100,000; rural or remote (smaller community, rural area or the territories).
- v. New physicians were taken from the cohort of those who first became active from 2003 to 2007, and their first address of practice is used. For the percentage of physicians overall who are IMGs, the 2007 data is used.

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The general trend of new IMGs to be most present outside urban areas is not present in all jurisdictions. To illustrate this point, Figure 10 shows the percentage of new physicians who are IMGs in urban areas (CAs or CMAs) and rural or remote areas. Figure 10 shows that the percentage of new physicians who are IMGs is actually higher in urban than in rural areas in Quebec and Ontario. For active physicians overall, the same general tendency is observed, in that Quebec and Ontario don't match the national trend of physicians in rural areas being more likely to be IMGs (Figure 11).

Figure 10 Percent of New Physicians in Canada Who Are IMGs by Community Size (CMA/CA or Rural and Remote) by Province and Territory, From 2003 to 2007



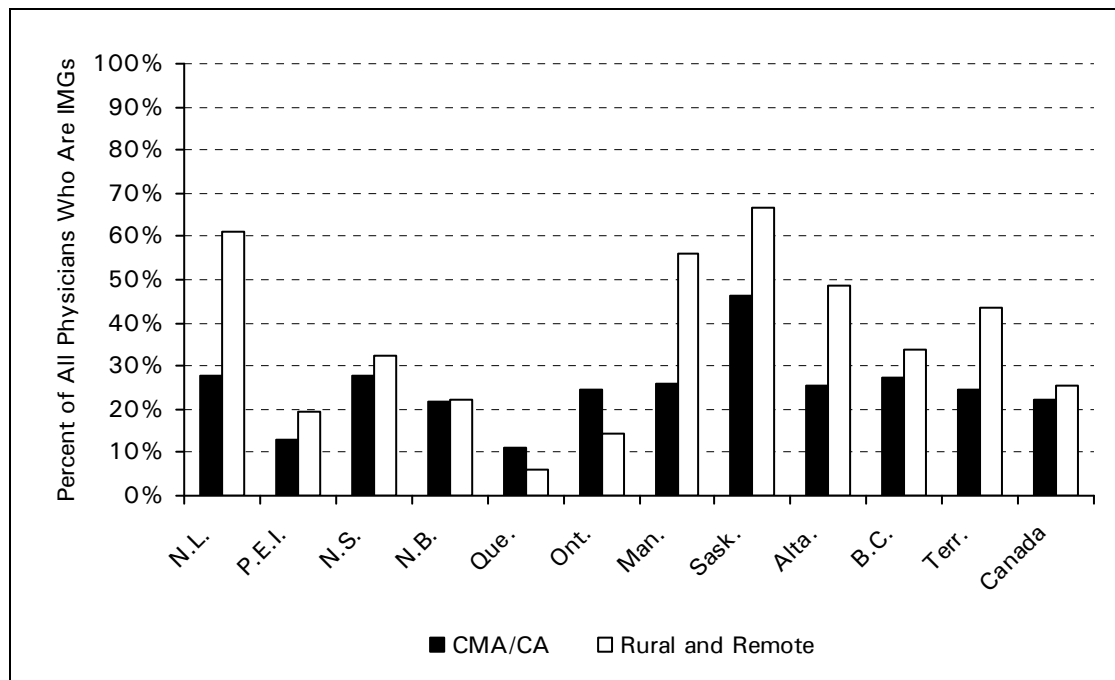
Source

Scott's Medical Database, Canadian Institute for Health Information.

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Figure 11 Percent of All Physicians in Canada Who Are IMGs by Community Size (CMA/CA or Rural and Remote) by Province, 2007



Source

Scott's Medical Database, Canadian Institute for Health Information.

Conclusion

The past several decades have seen changes in Canada's IMG workforce. IMGs have become an ever-smaller presence in Canada's physician supply, while also changing in character from a mostly British- and Irish-trained population to one trained in a more diverse group of countries. This non-British Isles trained group has been remarkably consistent over time, however, in its likelihood to continue practising in Canada once established here. This consistency in international mobility contrasts sharply with a large increase in interprovincial/territorial mobility.

As for where IMGs practise, they tend to be a larger proportion of physicians outside of urban centres than within them, although this is much more pronounced when they are beginning to practise than it is later on. Ontario and Quebec oppose this trend, however.

Finally, since approximately one IMG in four is someone who, despite having an MD degree or equivalent obtained outside Canada, was actually raised in Canada, caution must be exercised when equating IMGs with "foreign doctors."

There are some unanswered questions from this analysis worthy of further inquiry. For example, it was noted here that, consistently over time, countries that are sources of IMGs tend to be former members of the British, American or French administrative systems with similar education and credentialing systems and a common language. Do these factors tend to ease the difficulties physicians from these countries experience for their credentials to be recognized in Canada? Another point worth examining is why are new IMGs more likely to change provinces than in the past, despite there being little change in their tendency to leave Canada? This willingness to move among IMGs contrasts with that of new Canadian-trained physicians, who have had no significant change in either type of migration.

Acknowledgements

The study described in this paper was conducted utilizing original data collected for the College of Family Physicians of Canada, the Canadian Medical Association and the Royal College of Physicians and Surgeons of Canada's National Physician Survey Database. The study was also supported by the Canadian Institute for Health Information (CIHI). The study and all of the data contained therein and the copyright-protected works of the College of Family Physicians of Canada, the Canadian Medical Association and the Royal College of Physicians and Surgeons of Canada cannot be copied or reproduced in whole or in part without permission of the College of Family Physicians of Canada, the Canadian Medical Association and the Royal College of Physicians and Surgeons of Canada.

CIHI wishes to acknowledge and thank the following individuals for their contribution to *International Medical Graduates in Canada: 1972 to 2007*:

- John David Stanway, Senior Analyst, Health Human Resources, CIHI
- Deborah McCartney, Senior Analyst, Health Human Resources, CIHI
- Geoff Ballinger, Manager, Health Human Resources, CIHI
- Sarah Wibberly, Program Consultant, Health Human Resources, CIHI

CIHI would also like to thank the National Physician Survey Technical Advisory Committee for its invaluable advice.

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The Canadian Institute for Health Information (CIHI) collects and analyzes information on health and health care in Canada and makes it publicly available. Canada's federal, provincial and territorial governments created CIHI as a not-for-profit, independent organization dedicated to forging a common approach to Canadian health information. CIHI's goal: to provide timely, accurate and comparable information. CIHI's data and reports inform health policies, support the effective delivery of health services and raise awareness among Canadians of the factors that contribute to good health.

Production of this analysis is made possible by financial contributions from Health Canada and provincial and territorial governments. The views expressed herein do not necessarily represent the views of Health Canada or any provincial or territorial government.

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