Maximizing Medical Talent:

How Canada can increase the supply of family doctors by 50% quickly and cost-effectively

The Honourable Stan Kutcher
The Honourable Mohamed-Iqbal Ravalia
The Honourable Ratna Omidvar
Kareem El-Assal

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Executive Summary

Canada is facing a primary care crisis. Currently, 6.5 million people lack access to a family doctor, and that number projected to reach 10 million in the next decade. We lag behind our international counterparts, ranking last among 10 high-income countries in access to primary care.

Canada's family doctor shortage is acute and worsening. Due to a combination of factors including administrative challenges, a rapidly growing but aging population, underfunded residency spots, and fewer medical graduates choosing primary care, Canada will face a shortfall of more than 50,000 family doctors by 2031. Without intervention, this shortage will lead to increased strain on emergency departments, longer wait times, and deteriorating health outcomes, particularly in rural and underserved communities.

The International Medical Graduate (IMG) Opportunity

We use the term IMG broadly to include Canadian citizens and permanent residents who completed their medical training outside Canada and the United States, as well as those who were previously licensed and practicing medicine before moving to Canada (commonly referred to as Internationally Trained Physicians, or ITPs).

Canada already has thousands of doctors with the training to fill this gap, but who are unable to practice due to limited residency spots and Practice Ready Assessments (PRA) capacity. Currently, only 39% of IMGs initially match to residencies, and just 18% do so in the second round. This mismatch represents a major loss for the healthcare system, particularly as many IMGs have extensive clinical experience abroad.

Budgets 2023 and 2024 outline the federal government's plan to invest $200 billion to improve health and workforce planning. This report recommends two additional and immediate federal initiatives that would help alleviate this crisis by efficiently integrating International Medical Graduates (IMGs) into the system while concurrently maintaining Canada's high medical standards:

1. Increase IMG Residency Training

The federal government should directly fund 750 additional residency spots per year for IMGs. These IMGs have already met almost all qualifications for Canadian practice but lack access to the necessary residency spots or a Practice Ready Assessment (PRA). It would take two years for the first cohort of 750 family physicians to be ready for practice. At this pace, this initiative would add 6,000 new practice ready family physicians within a decade. These new family doctors would serve an estimated 1,500 patients each, which works out to over 1.1 million additional Canadians per year for every IMG cohort that exits

residency; and 9 million Canadians within a decade.

2. Expand PRA Programs

The federal government should also fund an additional 500 PRA slots annually, enabling qualified IMGs to practice in Canada more quickly. PRA is a fast, cost-effective alternative to residency, taking just 12 weeks. This initiative would add 1,000 family physicians annually, at a lower cost than residency training.

The proposed initiatives would require only 0.2% of the $52 billion allocated for healthcare transfers in 2024-25. The return on investment is substantial: improved access to care for millions of Canadians, reduced strain on emergency rooms, better retention of doctors in rural areas and economics gains as IMGs contribute to the workforce.

By investing in IMG residency training and expanding the PRA program, the federal government can take immediate steps to address the family doctor shortage while ensuring that millions of Canadians receive the high quality health care they need. These initiatives offer a cost-effective, scalable solution to one of the country's most pressing healthcare issues, positioning Canada to build a more resilient and equitable healthcare system for our current and future generations.

Overview

Canada is facing a family medicine crisis.[1] A 2023 Commonwealth Fund study revealed that Canada ranks last among 10 high-income countries in access to primary care.[2] Currently, 6.5 million Canadians do not currently have a family doctor, a number projected to reach 10 million Canadians within the next decade.[3].[4] This shortage has severe consequences: patients experience worse health outcomes, family doctors face burnout due to overwhelming workloads, and the healthcare system suffers from inefficiency as patients seek care through emergency departments, where costs are three time higher than primary care. [56] The current state of affairs has Canadians feeling pessimistic about the future of healthcare in the country. [7]

The federal government, in partnership with its provincial and territorial partners, has been working to address these issues, but workable solutions with timely impact are lacking.

Budgets 2023 and 2024 outline the federal government's plan to invest $200 billion to improve health care for Canadians and to support the recruitment, retention, and planning of the health workforce.[8] However, two additional federal initiatives currently not being adequately addressed, could by themselves, increase Canada's supply of family physicians in a rapid and cost-effective manner. These are: increasing residency positions for International Medical Graduates (IMGs) and expanding the existing Practice Ready Assessment (PRA) framework into a robust national program.

First, the Government of Canada itself can create new family medicine residency spots by providing funding directly to faculties of medicine so that more International Medical Graduates (IMGs)–who have already passed most regulatory steps to demonstrate they are qualified to practice in Canada–can help alleviate the country's primary care crisis. The only hurdle necessary for these IMGs to overcome to practice family medicine in Canada is access to a residency position or a PRA spot.

Second, the federal government can provide direct funding to create a national PRA system and an appropriate number of competency assessment positions using the already existing model of PRA. PRA only

[1] Philpott, Health for All.
[2] The Commonwealth Fund, *Finger on the Pulse.*
[3] OurCare, National Survey Findings; and, Health Canada, Supporting Canada's health workers.
[4] Zhang, Canada has tons of doctors; Glazier, Overview of the primary care crisis.
[5] The College of Family Physicians of Canada, Crisis in Family Medicine.
[6] Zhang, The Doctor Dilemma.
[7] Angus Reid Institute, After a 'decade of decline' in health care.
[8] Health Canada, Supporting Canada's health workers.

takes 12 weeks to complete and provides for fast-tracked competency assessments of IMGs who have practiced medicine abroad and who meet all other regulatory requirements to practice family medicine in Canada safely.

The purpose of this report is to outline the merits of the two proposed initiatives. The report begins by addressing the state and scale of family physician shortages in Canada, with a closer look at how qualified IMGs are falling through the cracks, in large part due to existing barriers that limit their ability to access residency positions or PRA necessary for them to be able to practice medicine in Canada. It then discusses how a modest investment by the federal government can help to increase Canada's supply of family doctors by 50% annually simply by increasing the number of family practice residencies in existing medical schools. We then point out how an even more modest direct investment by the federal government can rapidly promote qualified immigrant doctors (primarily ITPs) into independent medical practice through a properly functioning national PRA program.

Diagnosing Canada's Family Doctor Shortage

Canada's family physician shortage is a function of several major political and administrative miscalculations and demographic factors that have unfolded over time. The practice of family medicine is also currently viewed as increasingly difficult, resulting in doctors ceasing operations[9] and family medicine residencies becoming less attractive to medical school graduates.[10] The share of graduates selecting family medicine as their first choice for residency has declined from 41% in 2014 to 33% in 2023.[11] This lack of attractiveness is explained by "overbearing expectations of family physicians, limited support and resources, antiquated physician compensation, and high clinic operating costs."[12]

On the demographic side, Canada's population is growing rapidly, and the 3.2% population growth rate in 2023 was the highest since 1957.[13] At the same time, Canada's population is aging rapidly, resulting in greater demand for primary care. This is occurring at the time as family

[9] Mulligan, Paperwork burden driving Ontario family doctor to quit.

[10] McKeen, Amid shortages of family doctors; CBC, fewer medical school graduates; Payne, Medical students saying 'no thanks'; Jones, Physicians sound alarm; Zhang, The Doctor Dilemma; Canadian Resident Matching Service, Quota and applications by discipline.

[11] Canadian Resident Matching Service, *Quota and applications by discipline.*

[12] Li et al., Biopsy of Canada's family physician shortage; Jones, Physicians sound alarm; Glazier, Overview of the primary care crisis.

[13] Statistics Canada, Canada's population estimates.

physicians themselves are increasingly aging and entering retirement age.[14] The federal government estimates over 18,000 family physicians will retire by 2031.[15] There is also a scarcity of medical school and family medicine residency spots, which have not kept pace with Canada's population growth.[16] Canada's physician-to-population ratio ranks 29th out of 36 high-income nations.[17]

Based on current caseloads (about 1,500 patients per family physician), over 4,000 additional family doctors are needed immediately to address the shortfall of 6.5 million Canadians presently without access to primary care.[18] The federal government estimates Canada will have a shortage of 78,000 doctors by 2031[19] with family doctors accounting for 72% of the deficit.[20]

The current pipeline of some 1,500 residents completing their family medicine residencies each year[21] is wholly inadequate to address the shortages.[22] In addition, Canada's addition of five new medical schools (bringing the total from 17 to 22) will not be enough.[23] While potentially helpful in the long run, building new medical schools is expensive and will not address the shortage quickly enough. It will take until the early 2030s before the first graduating cohorts of these new medical schools are able to begin practicing family medicine. Furthermore, increasing the number of medical school graduates will not lead to additional family physicians entering practice unless additional residency positions are created for them.

Data shows that 3,618 medical school graduates obtained residency positions in 2024.[24] Compared to 2014, this represents an increase of 12% of graduates who entered residency. However, the shortfall of supply has widened as Canada's population has grown by 15% over the same period and the competing pressures of more aging Canadians seeking primary care and more

[14] Health Canada, Supporting Canada's health workers; Howlett and Sun, One in six family doctors are near retirement age.
[15] Employment and Social Development Canada, Canadian Occupational Projection System (COPS): General practitioners and family physicians (3112) Occupational Outlook.
[16] Li et al., Biopsy of Canada's family physician shortage; Tasker, Meet some of the 6 million Canadians.
[17] Canadian Medical Association, Quick facts on Canada's physicians.
[18] Sanfilippo and Philpott, Addressing the family doctor shortage.
[19] Health Canada, Supporting Canada's health workers.
[20] Richardson and Hussain, Canada needs more doctors—and fast.
[21] Canadian Post-M.D. Education Registry, 2022-2023 Annual Census of Post-M.D. Training.
[22] Zhang, The Doctor Dilemma.
[23] Sanfilippo, This is why you don't have a family doctor.
[24] CaRMS, 2024 R-1 Match Data Snapshot.

aging family doctors nearing retirement.[25] In addition, between 75 and 100 family residency spots have gone unfilled in each of the past four years.[26] The unfilled matches are due to various reasons, including: Quebec having different language and licensing requirements for medical practice than the rest of Canada; mismatches between the medical practice and geographical preferences of applicants and the available residency positions; and concerns about the administrative burden currently faced by family physicians.

The Canadian Resident Matching Service (CaRMS), the national organization that provides matching service for medical training across Canada, holds two matches, called iterations, for the more than 4,800 medical school graduates who apply to residencies at Canada's 17 medical schools each year.[27] The residencies are a crucial step that all Canadian medical graduates need to complete to be able to practice medicine in Canada. The first iteration includes Canadian as well as, American, and international medical school graduates who do not have postgraduate medical training in Canada or the U.S. The second iteration considers applicants who were not matched in the first iteration, applicants with previous Canadian or U.S. postgraduate training, and applicants who did not participate in the first iteration.

A lost opportunity: Thousands of international medical graduates unable to obtain residencies

IMGs seeking to practice medicine in Canada face additional barriers.[28] These Canadian citizens and permanent residents who complete their medical studies at universities outside Canada and the U.S. experience a series of challenges such as increased licensing requirements and Canadian universities giving preference to those who graduate from domestic medical schools when allocating their residencies. This results in much lower residency match rates between Canadian medical graduates (CMGs) and IMGs.

In the first iteration of the 2024 match, for example, 92% of CMGs obtained a residency.[29] Meanwhile, only 39% of first iteration IMG applicants were matched.[30] In the second iteration of the 2024 match, the

[25] Tasker, Meet some of the 6 million Canadians; Statistics Canada, Population estimates, quarterly; Sanfilippo, This is why you don't have a family doctor.

[26] CaRMS, 2024 R-1 Match Data Snapshot; 2023 R-1 Match Data Snapshot; 2022 R-1 Match Data Snapshot; 2021 R-1 Match Data Snapshot; Pauls, Canada could be training 100 more family doctors this year.

[27] CaRMS, R-1 Main Residency Match.

[28] Li et al., Biopsy of Canada's family physician shortage; Health Canada, Canada is addressing current; Government of Canada, Budget 2024.

[29] CaRMS, 2024 R-1 Match Data Snapshot.

[30] CaRMS, 2024 R-1 Match Data Snapshot.

figure of IMGs being placed in a residency fell to 18%. All told, 786 IMGs were left unmatched following the second iteration in 2024. Estimates suggest there are at least 13,000 IMGs who are currently unable to practice medicine in Canada.[31] It appears the low match rate is resulting in a declining number of IMGs applying for residencies, which is unsurprising given some 90% of unmatched residency applicants are IMGs.[32]

Also notable is the discrepancy in match rates among IMGs by their region of graduation.[33] IMGs who went to medical school in Africa, Asia, Central America and the Caribbean, the Middle East, and South Africa continue to disproportionately struggle to obtain matches. In 2024, 66% of IMGs who graduated from a European medical school were matched, and this has increased in each of the last five years, up from 52% in 2020. IMGs who went to school in Oceania also have higher match rates, likely due to the similarities between Australia and Canada. Many of these individuals who went to medical schools in Europe and Oceania are also Canadians who decided to go abroad for training. Meanwhile, IMGs who graduated from an African (35%), Asian (30%), Central American/Caribbean (35%), Middle Eastern (32%), or South American (45%) medical school had much lower match rates in 2024, and this has been the case over the past five years. This underscores the challenges that many IMGs continue to face in having their education, medical experience, and skills assessed by Canadian medical schools.

Denying IMGs residency spots results in a significant amount of wasted time, money, and resources for IMGs themselves and the entire medical system.[34] Among these individuals are experienced physicians who were licensed and practiced overseas (the internationally trained physicians group), who do not have another pathway to enter the Canadian medical system, such as access to Practice Ready Assessments, and must therefore obtain a residency. A recent survey in Ontario found that over 60% of internationally trained physicians had over three years of clinical experience.[35] These internationally trained professionals are Canadian citizens and permanent residents and while some of them may require additional upgrading for Canadian medical practice (such as completion of a residency training program) others have demonstrated that they can successfully

[31] World Education Services, Internationally Educated Health Professionals; The Suburban, 13,000 foreign-trained doctors; Khan, Foreign doctors ready to help are 'sidelined' by regulation.
[32] Tasker, Canada is short of doctors; Richardson and Hussain, Canada needs more doctors—and fast; CaRMS, 2023 R-1 Main Residency Match – second iteration, Table 65.
[33] CaRMS, 2024 CaRMS Forum.
[34] Medical Council of Canada, Pathways for international medical graduates.
[35] Internationally Trained Physicians of Ontario, *ITPs: A Diverse, Underutilised.*

challenge all Canadian examinations and enter practice after completing a 12 week PRA.

Putting it bluntly, Canada already has thousands of clinically experienced ITPs who would be able to practice medicine in Canada if they could simply access and complete a 12-week PRA. Not providing this cost-effective pathway to practice is both unfair to the ITPs (many who immigrated to Canada with the expectation that they would be given a fair opportunity to enter medical practice) and unfair to the millions of Canadians who already would have access to a primary care physician if this entry pathway was functional.

The process for IMGs to even submit a CaRMs application to be considered for a residency is already time-consuming and exhaustive. An IMG may be required to complete a language test to demonstrate their proficiency in English or French. Once they pass this exam, they need to verify their foreign medical credentials conform with Canadian standards. They must then pass two more standardized exams that assess their medical knowledge and readiness to enter supervised training in Canada. These exams are equivalent to those taken by Canadian graduates. Only once all of this has been completed can they apply for a residency match. The additional requirement to obtaining a scarce residency position is inefficient and counterproductive.

These applicants have demonstrated that they have met the standard for entry into residency in Canada. However, the long time and high cost that it takes to get through these requirements is wasted if there is no residency position to which the IMG is matched. This entire process results in a lost opportunity for Canada to benefit from the talents of these individuals, while it simultaneously contributes to the widening need for primary care physicians throughout Canada.

What the federal government can do to increase access to residencies for IMGs

In light of Canada's residency positions not keeping up with demand, and the small number of residencies made available to IMGs, the federal government can intervene to significantly increase the supply of new family physicians entering the country's health care system. The federal government can provide funding directly to medical schools that would be used specifically for allocation to IMGs. While this proposed solution is fairly novel, it has a historical parallel. The federal government already does this for the military.

The Medical Officer Training Plan (MOTP) is available to those committed to serve in the

Canadian Armed Forces (CAF).[36] In return for their military service, CAF pays for tuition, books, instruments, salary, medical and dental care, and vacation. An even stronger parallel is the MOTP Surge, which is a collaborative initiative between CAF and participating medical schools. The MOTP Surge is available to medical students who remain unmatched after the first iteration of CaRMS to apply for a family medicine residency position subsidized by the CAF in exchange for a requirement to complete military service.[37] Although the MOTP Surge has not been held since the pandemic due to operational challenges,[38] it serves as an example of how the federal government can act to directly increase Canada's residency capacity in that the country's medical schools can add residency spots if they are properly funded. Further underscoring the importance of funding is Canada's approach to welcoming visa trainees.

Increase in Canada's visa trainees suggests more funding can rapidly increase residency capacity

Visa trainees are internationally-sponsored medical graduates who are not Canadian citizens or permanent residents, and whose tuition and salary are funded by their sponsoring country. They are sent to Canada due to the country's health care research and education system being held in high regard globally. Upon completion of their training, they return to their country of origin. Their country of origin directly pays medical schools for their "residency slot" plus it pays for their salary and benefits during the time of their residency.

In 2022, Canada welcomed 148 new visa trainees in residency, compared to 117 in 2015.[39] All told, Canada hosted 2,972 visa trainees in 2022, of whom, 76% are fellows. Fellows are registered with Canadian universities to pursue clinical or research training which will not be evaluated by supervising faculty for the purpose of a Canadian license or certificate.

They are beneficial to Canadian medical schools due to the significant amount of short-term revenue they generate, and in addition, they provide additional capacity to the Canadian medical system, including in specialized areas of medicine, in which they overwhelmingly complete their residencies.[40] They offer expertise of their own as well as knowledge sharing among the Canadian medical community.

[36] Canadian Armed Forces, Paid Education: Specialty Programs.
[37] CaRMS, Who is eligible to apply to an MOTP Surge program?
[38] Canadian Federation of Medical Students, Medical Officer Training Plan – Canadian Armed Forces.
[39] CAPER, The National IMG Database Report 2023; CAPER, The National IMG Database Report 2017.
[40] CAPER, The National IMG Database Report 2023.

At the same time, there are some drawbacks to hosting them, such as that they tend to have an obligation to return to their home country following their Canadian residencies, which means their benefit to the Canadian medical system is time-limited, unlike Canadian citizens and permanent residents who are able to serve the country's health care system for decades.

In addition, the hosting of visa trainees raises fiscal questions on whether it is in the Canadian taxpayers' best interests to provide residency training for foreign nationals at the expense of IMGs who are unable to obtain residencies due to a purported lack of capacity. However, rather than debating the merits of hosting visa trainees, their very existence in Canadian residency programs at a time when IMGs are being left unmatched from residencies stresses the importance of the federal government earmarking primary care residency funding to grow capacity to meet the health care needs of Canadians.

How much money is needed to increase residency capacity for IMGs?

The average salary over a two-year residency varies by province, but it ranges between about $60,000 - $70,000 annually.[41] It is estimated that sponsoring countries pay some $100,000 annually per visa trainee hosted in Canada.[42] These figures provide us with a ballpark amount of about $170,000 per new IMG residency spot the federal government could fund. This means it would cost some $127.5 million annually to fund 750 new family physician residencies for IMGs, which would represent a 50% increase on some 1,500 doctors who exit family medicine residencies each year. These 750 new family doctors would be able to serve an estimated 1,500 patients each, which works out to an equivalent of over 1.1 million Canadians annually.

This spend would represent only 0.2% of the over $52 billion the federal government is earmarking to the provinces and territories in the 2024-25 fiscal year through the Canada Health Transfer.[43] The return on this investment would be 6,000 new family physicians over the course of a decade, who could serve the equivalent of 9 million Canadians.

[41] CaRMS, See salaries and benefits for postgraduate training, by province.

[42] Canadian Medical Association Journal, Saudi medical trainees may keep posts in Canada.

[43] Finance Canada, Major federal transfers.

Greater access to primary care would enhance the quality of life of Canadians. Increased physician capacity would also alleviate pressures on existing family doctors, reducing the likelihood of them burning out or exiting family medicine altogether. There are ways this initiative could help increase the distribution of family physicians in smaller communities across Canada. Some 87% of surveyed internationally trained physicians indicate a willingness to move to rural and remote parts of Canada to practice medicine.[44] This shows that creating pathways to practice medicine in Canada for IMGs can help to alleviate healthcare workforce strain in smaller jurisdictions across the country.

Increased capacity can also help diversify IMGs who obtain residencies, so that more IMGs from regions around the world can serve ethnic communities across Canada in their native languages and in culturally sensitive manners.

On the economic and fiscal side, better access to primary care would help Canadians avoid missing time away from work due to avoidable illnesses or because of time wasted in waiting or emergency rooms. Moreover, preventative medicine helps save health care system costs down the line such as public spending on more serious medical procedures that could have been avoided had the patient had easier access to primary care.

There would also be significant economic benefits of having these IMGs consume goods and services in Canada and pay taxes off an average salary of about $300,000 per year.[45] The economic and fiscal benefits to Canada of an IMG earning this salary over the course of decades-long careers would be greater than the estimated $170,000 outlay per federally-funded residency.

Can't we increase capacity by building more medical schools?

Our proposal will likely raise legitimate questions about capacity. The forthcoming addition of five new Canadian medical schools is welcome, but it will take a long time for the first cohorts of medical students to eventually complete their schooling and residencies before they become practice ready. An entrant in the fall of 2025 will not be able to enter the workforce as a family doctor until the early 2030s, and only if there were enough new family practice residencies developed to support this increased output. Hence, immediately increasing residency capacity through additional federal funding will offer

[44] Internationally Trained Physicians of Ontario, *ITPs: A Diverse, Underutilised.*

[45] Canadian Institute for Health Information, *A profile of physicians in Canada.*

a much quicker and much less expensive solution.

It may also be argued that the medical system does not currently have enough capacity to add 750 more family medicine residency spots per year. Medical school faculty already feel stressed, overwhelmed, and underpaid. This underscores the importance of the federal government collaborating closely with faculties of medicine to ensure enough support is provided to ensure the feasibility of our proposal. For example, the federal government can work with the medical schools to gradually ramp up capacity over an agreed upon number of years until the additional 750 residency spots are added. In addition, the five new medical schools coming online will help to gradually increase residency capacity.

Moreover, additional initiatives, some of which are already underway, can be promoted. For example, we can establish additional residency spots in medical practices located in rural communities and smaller cities. We can also deliver more medical training via technology. Further, we can look to welcome more IMGs who now practice medicine in Canada to serve as preceptors–their experience in particular can provide invaluable by sharing their learnings with IMGs who are also looking to practice family medicine in Canada.

Allocate more federal funding to Practice Ready Assessments and the Development of a National Practice Ready Assessment Program

Another major opportunity–our second proposed initiative–is to increase access to PRA for internationally trained physicians with clinical experience. After clearing the requirements of credential verification, language tests, the Medical Council of Canada Qualifying Exam and the National Assessment Collaboration Objective Structured Clinical Examination, there are two possible final steps on the pathway to licensure for this group of IMGs. Postgraduate residency training, as already outlined, is the first and indeed the only pathway for IMGs without residency training from abroad and with limited clinical experience. For IMGs who have post-graduate training and who also possess a level of professional experience, there is a second potential route to licensure which is even more time and cost-effective than residency training, known as PRA.

PRA provides the opportunity for an IMG to undergo a clinical workplace-based assessment of their competencies over a period of about 12 weeks. During this time, the IMG candidate works under supervision of a PRA assessor and is evaluated on their skills and competencies to ensure they are

able to practice medicine properly, safely and at the same high standard of care as other physicians must meet in a Canadian healthcare setting. There are currently only a few PRA programs available nationally, across nine provinces. All of these PRA programs adhere to a Pan-Canadian framework for PRA and use the common guidelines, tools and materials developed by the National Assessment Collaboration (NAC) of the Medical Council of Canada.[46]

Although following common principles, entry to the nine existing programs, each run by the provincial college or regulatory body, requires a separate application process without a common intake point, no matching of applicants to geographic need and no established annual intake. For an IMG seeking licensure anywhere in Canada, the numerous applications and procedures make this enormously time-consuming, confusing and inefficient. Access to PRA is often a complicated dance orchestrated by an employer (hospital, community clinic or health authority), university faculty of medicine (various departments) and the provincial regulatory body. The time it takes to organize a PRA is frustrating for all parties and may come to a grinding halt due to requirements for currency of practice.

For PRA to provide an accelerated route to licensure for experienced immigrant physicians, access must and can be improved and the PRA assessment position numbers need to significantly increase. Since 2018, only some 1,000 IMGs have graduated from a PRA program to enter family practice in Canada,[47] primarily because of a lack of positions.

Hence, we recommend federal funding be allocated to support the development, implementation, and operation of a centralized system for accessing PRA along the lines of the physiciansapply.ca portal[48] and the CaRMS match. This would enable an appropriately qualified IMG to apply for PRA and be matched with a region or health authority in a timely manner. Similarly, a region or health authority seeking physicians in a particular field, and prepared to set up a PRA in an expeditious fashion would benefit from the same system. PRA activity could be monitored and increased, success could be tracked, best practices highlighted and provinces with sluggish participation could be encouraged to increase their numbers.

A centralized system with an entry to PRA portal and sufficient PRA slots distributed across the country could go a long way toward putting this final piece of the puzzle

[46] Medical Council of Canada, *Practice-Ready Assessment.*

[47] Medical Council of Canada, 2022-2023 Annual Report; 2023-2024 Annual Report.

[48] Medical Council of Canada, Your services portal: physiciansapply.ca.

in place and federal funding could make this happen. If a national PRA program is put into place with only 500 positions annually dedicated to IMGs, at a graduation rate of two physicians per position per year, 1,000 practice ready primary care physicians can be added to Canada's pool of family physicians annually.

In terms of expense, PRA operate on a cost-recovery model that accounts for government funding and candidate fees.[49] In Alberta, for example, the maximum cost per candidate is about $35,000 while it costs some $30,000 in Manitoba.[50] It stands to reason that a PRA position which only lasts 12 weeks is less costly for the federal government to fund than a residency position which lasts two years. Furthermore, the costs associated with a PRA assessment do not include the additional educational and administrative costs associated with residency training. Therefore, the PRA route, which can be readily accessed by qualified IMGs is likely to be both rapid and cost-effective in its delivery of physician graduates who have demonstrated the high degree of competencies needed for Canadian medical practice.

More solutions are needed to improve Canadian healthcare

Our proposals to provide more federal funding for residency spots and PRA are not a panacea, and we acknowledge there is much more that can be done to improve the state of Canadian primary health care. For instance, it is important for the medical community to identify how to improve incentives so that more medical school graduates decide to pursue family medicine and how to move beyond single physician practice into forms of association that include the skills of various primary care providers. A key area is identifying how to reduce the administrative burden so family doctors can be more productive spending time with patients.[51] It is estimated Canadian physicians spend 18.5 million hours per year (the equivalent of 55.6 million patient visits annually) on unnecessary paperwork or administrative tasks that could be completed by someone that does not require clinical expertise or eliminated altogether.[52] Striving to reduce just 10% of this extra administrative work could save physicians the equivalent of 5.5 million patient visits per year.[53] It is also worthwhile reviewing global best practices

[49] World Education Services, Expanding Pathways to Licensure for Internationally Trained Physicians in Ontario.

[50] College of Physicians and Surgeons of Alberta, Physician Fees; World Education Services, Expanding Pathways to Licensure for Internationally Trained Physicians in Ontario.

[51] Zhang, The Doctor Dilemma.

[52] Canadian Federation for Independent Business, *Patients before Paperwork.*

[53] Canadian Federation for Independent Business, *Patients before Paperwork.*

on payment models for physicians to ensure Canada is keeping up with the times.

Harnessing technology, such as the use of telehealth can also help to improve access to care. We can also leverage existing health professionals such as nurse practitioners and pharmacists who can help to provide primary care access and give family physicians more time to treat patients who require their level of competency.[54]

Providing more education and support to IMGs about pursuing alternative career pathways is also necessary to help them pursue a dignified career in Canada's health care sector sooner, rather than stringing them along for years until they fail to practice medicine in Canada due to unnecessary access to licensure barriers.

It is also incumbent we rapidly reduce barriers for IMGs and immigrant health professionals to obtain licensure and employment in Canada. Here, we can also learn from peer nations. The United Kingdom, for example, has an IMG share of some 50%, compared to about one-third of Canada's family physicians being internationally-trained.[55] We wish to stress once again that many of the IMGs in Canada are already experienced medical professionals with years of overseas clinical experience under their belts who simply need a fair opportunity to enter the Canadian medical system after completing the licensing steps required to demonstrate they meet Canadian medical standards.

Conclusion

Canada's primary care system is at a critical juncture. With 6.5 million Canadians currently without access to a family physician – a number projected to rise to 10 million within the next decade – immediate and decisive action is required. While current government investments are an important step, they do not sufficiently address the immediate and long-term challenges posed by this growing shortage of family doctors.

This report proposes two targeted initiatives that can be initiated by the federal government that would quickly and significantly increase the supply of family physicians. These both provide for much better integration of IMGs into the healthcare system. By funding 750 additional residency spots annually and expanding the PRA program, Canada has the opportunity to add more than 6000 new family doctors over the next decade. These initiatives could come at a modest cost of 0.2% of the healthcare transfer budget, delivering substantial benefits to both the health and economic sectors.

[54] Zhang, The Doctor Dilemma.

[55] Zhang, The Doctor Dilemma.

Implementing these solutions would not only improve access to care for millions of Canadians but also relieve the growing pressure on emergency rooms, reduce physician burnout, and help ensure a more equitable distribution of healthcare professionals across the country. The economic impact of fully utilizing the skills of IMGs – through increased employment, tax revenue and contributions to the healthcare system – would be considerable.

With strong federal leadership and the implementation of these initiatives, Canada can work to address its family doctor shortage, improve healthcare outcomes and build a more resilient system for future generations.

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