Internationally Educated Health Professionals Sub-committee
January 26th, 2022 1:00-2:00 EDT

	AGENDA ITEMS	SPONSOR/SPEAKER	ACTION
1:00-1:05	**1. Member Welcome and Roll Call**	Chair: Jake Arbuckle (NB) / Isabelle Duguay Secretariat: Aalia Noorbhai	
1:05-1:10	**2. Approval of Agenda and Record of Decision** Document: a) Agenda b) Record of Decision (December 13th meeting)	chair: Jake Arbuckle(NB) / Isabelle Duguay	Decision
1:10-1:35	**3. WHO's Code of Practice on the International Recruitment of Health Personnel and Canadian Implications** The presentation will focus on WHO Global Code of Practice as well the role Canada's plays.	chair: Jake Arbuckle(NB) / Isabelle Duguay Speaker: Susan Weston (HC)	Discussion
1:35-1:55	**4. Presentation from IRCC on New Labour Market Impact Assessment (LMIA) exemption** The presentation will focus an exemption for certain individuals who are on designated list of HRR occupations with a specific skill set	chair: Jake Arbuckle(NB) / Isabelle Duguay Speaker: IRCC	Discussion
1:55-2:00	**5. Recap and Forward Agenda** Next IEHP Sub-committee Meeting: February 14th, 2023	chair: Jake Arbuckle (NB) / Isabelle Duguay	Decision
2:00	Meeting Adjourned		

Internationally Educated Health Professionals (IEHP) Sub-committee
January 26th, 2022

Record of Decision

Members:
Chair (NB): Jake Arbuckle
Chair (NB): Isabelle Duguay
BC: Laura Heinze
SK: Dastageer Sakhizai
MB : Lori Fontaine
AL : Rosemary Adesanwo
PEI : Brad Ledgerwood
NT: Jessica Jonasson
NU : Christopher Nolan
HC : Leigh Chapman
ESDC : Erin Connell
IRCC: Magali Stretch
IRCC : Annjanette Ridsdale- Weddell
HC : Leigh Chapman

CHW Secretariat:
Aalia Noorbhai
Rain Nourieh

1. Member Welcome and Roll Call

No decision required.

2. Approval of Agenda and Record of Decision

Decisions:

a) The agenda was approved.
b) The Record of Decision from the December 13th meeting was approved.

3. Presentation on WHO's Code of Practice on Professional Recruitment

Heath Canada presented on a deck on WHO's Code of Practice on Professional Recruitment and the Canadian implications. Members were given the opportunity to ask questions and participated in a discussion with guiding questions. Members were asked to submit their written feedback through the CHW Secretariat on questions outlined in the presentation.

Decisions:

- Health Canada to continue to engage the IEHP sub-committee as the work on developing potential framework advances.

4. Presentation from IRCC on Overview of Canada's Temporary Worker Program

IRCC presented a deck on its Temporary Worker Program, and presented for discussion a proposal with respect to an International Mobility Program for health human resources. Members were given an opportunity to ask questions and participated in a discussion with guiding questions. Members were asked to submit any additional feedback/comments through the CHW Secretariat.

No decision required.

5. <u>Recap and Forward Agenda</u>

Next meeting: February 14th, 2023

Health Canada Santé Canada

Canada

The WHO Global Code of Practice on the International Recruitment of Health Personnel – Considerations for the Canadian Context

Presentation to the IEHP Sub-Committee
January 26, 2023

YOUR HEALTH AND SAFETY... OUR PRIORITY.

Purpose

Supporting a discussion on the ethical recruitment of internationally educated health professionals (IEHP):

- Provide an overview of the WHO Global Code of Practice on the International Recruitment of Health Personnel
- Outline key considerations and implications for the Canadian context
- Update on stakeholder proposal for IEHP Ethical Recruitment Framework
- Consider next steps as part of ongoing work related to IEHP in Canada

Context – a global shortage of health personnel poses a threat to health systems internationally

- In 2016, the WHO projected a global shortage of **18 million healthcare workers by 2030** and the COVID-19 pandemic has only exacerbated workforce challenges.

- The current shortage of health personnel constitutes a major threat to the performance of health systems internationally.

- International recruitment is one avenue of increasing the number of health professionals in practice but it can also pose a risk to countries who are experiencing critical workforce shortages.

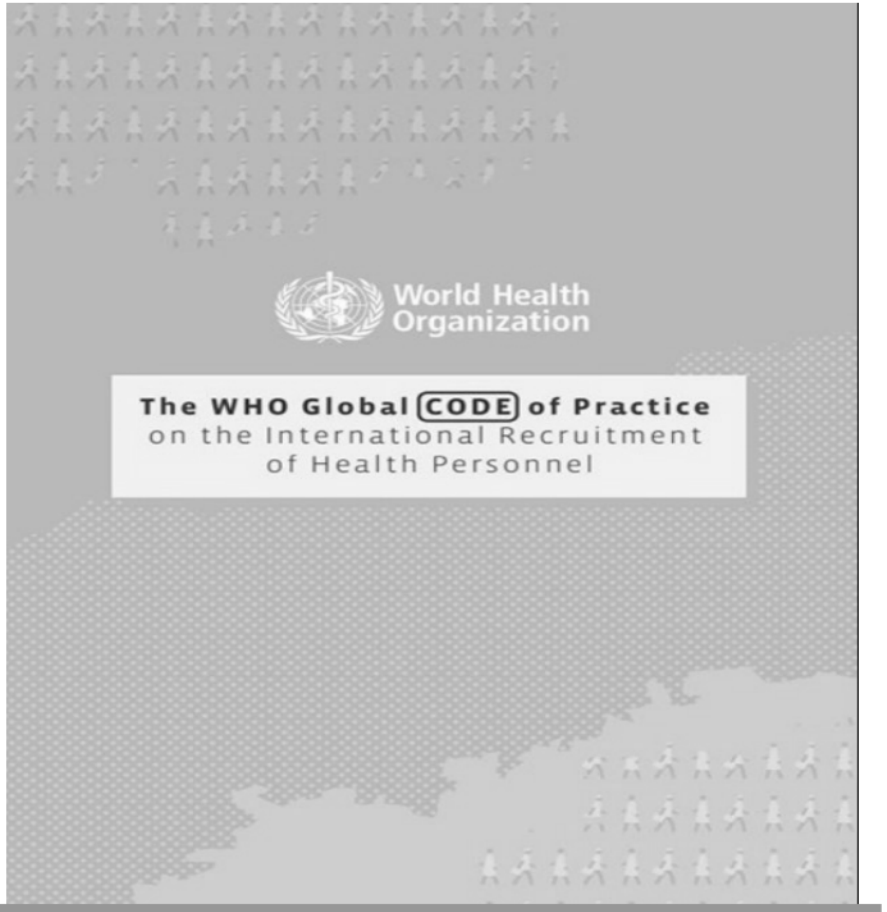
Ethical recruitment refers to the responsibility to not undermine another Country's ability to achieve a secure health system by depleting their health worker resources, while also acknowledging a person's right to mobility.[1]

1. Walton-Roberts, Margaret. The Ethics of Recruiting Foreign-Trained Healthcare Workers. Healthcare Management Forum, May 31 2022

In 2010 WHO developed a Global Code of Practice on the International Recruitment of Health Personnel to serve as a guide for Member States

- Code is **voluntary and non-binding**; Canada is a signatory along with all other WHO Member States

- Objectives:
  - Establish and promote principles and practices for ethical recruitment, taking into account the rights, obligations and expectations of source countries, destination countries and migrant health personnel
  - Support Member States in the establishment and improvement of frameworks for international recruitment
  - Guide the formulation and implementation of international instruments (e.g. bilateral agreements)
  - Facilitate and promote international discussion and cooperation on ethical international recruitment



The Code does not ban recruitment from the 47 countries on the **WHO Health Workforce Support and Safeguard list** (those with the most pressing health challenges).
Instead, it emphasizes the importance of **mutually beneficial government-to-government agreements.**

Key Elements of the Code

Ethical international recruitment	• The Code discourages the active recruitment of health personnel from developing countries facing critical shortages of health personnel.
Fair treatment	• The Code emphasizes the importance of equal treatment for migrant health workers and the domestically trained health workforce (e.g. professional education, qualifications, career progression, etc.).
Planning and sustainability	• Countries should undertake effective health workforce planning, education, training and retention strategies to sustain a workforce that is appropriate and to reduce the need to recruit migrant health personnel.
International cooperation	• The Code encourages collaboration between destination and source countries so that both can derive benefits from the international migration of health personnel.
Support to developing countries	• Member States are encouraged to provide technical assistance and financial support to developing countries experiencing a critical health workforce shortage.
Data	• Member States are encouraged to strengthen or establish health personnel information systems to collect, analyse and translate data into effective health workforce policies and plans.
Communication	• Each Member State should designate a national authority responsible for the exchange of information regarding health personnel migration and the implementation of the Code.
Monitoring	• Member States should report measures taken, results achieved and lessons learnt to the WHO, who will report on progress and make recommendations to the World Health Assembly.

Obligations as a Signatory to the Code of Practice

- The Code is **voluntary and non-binding** but Member States and other stakeholders are encouraged to take specific actions to support its aims, including efforts to:
  - Publicize the Code
  - Incorporate the Code into law and policy
  - Consult relevant stakeholders
  - Maintain a record of recruiters authorized to operate within jurisdictions
  - Encourage good practice by only using agencies that comply with the Code general principles
  - Observe and assess magnitude of active international recruitment of health personnel from countries facing critical shortages
- Not meant to curtail migration; rather, the Code explicitly states that nothing "*should be interpreted as limiting the freedom of health personnel, in accordance with applicable laws, to migrate to countries that wish to admit and employ them*" (*Art. 3.4*)
- While the Code is global in scope and is intended as a guide for Member States and other actors, it explicitly encourages implementation in accordance with national and subnational responsibilities
  - **It is up to Member States to determine how best to apply the Code for their own domestic contexts.**

Globally, the WHO Code has been interpreted differently and some countries have implemented their own codes or policies

Australia: *Australian Nursing & Midwifery Federation Policy on International Recruitment of Nurses and Midwives*

- Asserts that international recruitment programs must not be used as a primary strategy to overcome nursing and midwifery shortages in Australia, or as an alternative to educational opportunities for existing nurses and midwifery workforce
- Outlines conduct employers wishing to recruit international nurses and midwives must and must not engage in

Scotland: *International Recruitment of Health and Social Care Personnel: Scottish Code of Practice*

- Aims to promote high standards of practice in ethical recruitment and employment of international health and social care personnel, ensuring international recruitment is conducted in accordance with internationally agreed upon principles of transparency and fairness
- Aims to protect and promote the sustainability of health care systems through international cooperation

United Kingdom (UK): *Code of Practice for the International Recruitment of Health and Social Care Personnel*

- Implements the WHO Code of practice through 5 guiding principles and best practice benchmarks
- Includes guidance on how the Code applies to different recruitment models; an Ethical Recruiters List; best practice benchmarks as well as targeted recruitment guidelines, education and language proficiency requirements, and employment laws
- Goal of preventing active recruitment of healthcare workers from developing countries unless a government-to-government agreement to support recruitment exists

United States (US): *Health Care Code for Ethical International Recruitment and Employment Practices*

- A multi-stakeholder effort to promote ethical recruitment practices that maximizes the WHO Global Code of Practice
- Identifies 10 principles (*Annex B*) of ethical conduct for organizations that recruit and employ internationally educated health professionals
- Recruiters and employers certified under this code voluntarily agree to comply with these principles while also complying with laws of foreign countries

Considerations for the Canadian Context

- The Government of Canada **does not actively recruit** health personnel and respects the **right to mobility** as long as immigration criteria are met.
  - Some P/T jurisdictions undertake more active recruitment of health workers

- Canada welcomes a significant number of internationally educated health professionals each year
  - Immigrants accounted for **25%** of Canada's health and social services workforce (2017 labour force data)
  - Immigrants make up approximately 9% of registered nurses, and 19% of physicians licensed to practice in Canada, and approximately 33% of nurse aides/orderlies/patient service associates in Canada[1, 2]

- Canada also experiences an **underutilization** of IEHP
  - For immigrants trained as registered nurses or similar professions, 31% (12,519) were working in an unrelated field; for those trained as licensed practical nurses or vocational nurses, 49% (1,847) were working in a non-health-related field.
  - For IEHP holding a medical degree, 25% (8,480) were working in a non-health related field. For IEHPs trained as health aides or orderlies, 53% (3,331) were working in a non-health related field.[3]

- Ethical recruitment considerations apply not only to bringing health personnel into Canada but also ensuring they are able to **use their skills** and **integrate into health workforce** once they are here
  - E.g. credential evaluation and workplace integration; equal treatment with the domestically trained health workforce (*Art. 4.6*)

1. Canadian Institute for Health Information (2020). Nursing in Canada, 2019: A Lens on Supply and Workforce.
2. Canadian Medical Association (2020). https://www.cma.ca/quick-facts-canadas-physicians
3. 2016 Census Data, Statistics Canada.

Development of a Canadian Ethical Recruitment Framework

- Canada does not currently have a document to guide the implementation of the WHO Code of Practice in Canada

- Stakeholders have proposed creating a **Canadian ethical recruitment implementation framework** to provide relevant organizations with context-specific guidance on how to engage in ethical recruitment in Canada. This would:
  - Ensure Canada's commitments to ethical recruitment of IEHP are clear, aligned to the WHO Global Code of Practice and contextualized to the Canadian IEHP recruiting landscape
  - Provide practical guidance on how to engage in ethical recruitment

- Would involve broad consultation (PTs, IEHP, regulators, ethicists, recruiters, employers, government representatives from source countries, etc.) to understand key challenges and opportunities related to ethical recruitment across Canada, and to inform the development of a possible Framework and its implementation.

- Actors involved in the IEHP journey in Canada would be expected to use the Framework to guide their actions

- Implementation options could include endorsement by HMM

Next Steps

- Exploratory discussions within the federal family with implicated departments (e.g. IRCC)

- Inviting PT views on benefits / parameters / proposed approach to a possible Ethical Recruitment Framework

Discussion

- What does 'ethical recruitment' of international health professionals mean to you/in your jurisdiction?

- What international recruitment initiatives are underway in your jurisdiction? What tools or resources would be helpful to you when considering the ethical recruitment of international recruitment of health personnel?

- How would you see an Ethical Recruitment Framework being useful in your jurisdiction? Are there specific activities or tools that would be helpful? What type of actors should be targeted through this framework?

Thank you

ANNEX A – 2020 Health Workforce Support and Safeguards List

Angola	Congo	Gambia	Malawi	Sierra Leone	Djibouti	Kiribati
Benin	Cote d'Ivoire	Ghana	Mali	South Sudan	Pakistan	Micronesia (Federated States of)
Burkina Faso	Democratic Republic of the Congo	Guinea	Mauritania	Togo	Somalia	Papua New Guinea
Burundi	Equatorial Guinea	Guinea-Bissau	Mozambique	Uganda	Sudan	Solomon Islands
Cameroon	Eritrea	Lesotho	Niger	United Republic of Tanzania	Yemen	Vanuatu
Central African Republic	Ethiopia	Liberia	Nigeria	Haiti	Bangladesh	
Chad	Gabon	Madagascar	Senegal	Afghanistan	Nepal	

Countries on the Safeguard List have a Universal Health Coverage (UHC) Index lower than 50, and a density of doctors, nurses and midwives that is below the global median (i.e. 48.6 per 100,000 population). The list was last updated in 2020 and is updated every three years by the WHO.

ANNEX B – Example from the U.S: Health Care Code for Ethical International Recruitment and Employment Practices

10 Principles of Ethical Conduct

1. Recruiter and employer accountability
2. Migrant rights and responsibilities
3. Freedom from discrimination and retaliation
4. Right to know
5. Right to receive a contract with fair terms and to give informed consent
6. Right to move freely without economic coercion
7. Right to access justice
8. Right to freedom of association and collective bargaining
9. Right to receive support for clinical and cultural integration
10. Respect for sending countries

Internationally Educated Health Professionals Working Group

March 29, 2023

Mandate of the Sub-Committee/Working Group

In 2022, the FPT Committee on Health Workforce created a working group focused on providing strategic, and technical advice and recommendations on issues related to Internationally Educated Health Professionals.

Key objective is to leverage Internationally Educated Health Professionals and allow for faster and more efficient accreditation processes and pathways for IEHPs with a focus on:

- Study impact of labour mobility on internationally educated health professionals vs Canadian trained.
- Ensure jurisdictions maximize IEHPs to bolster health workforce.
- Expand collaborative approaches with regulators focused on identifying barriers and innovative approaches to ensure quality, safety and efficient processes to accreditation to other regulators of other professions, including physicians.
- Language proficiency training for IEHPs to better understand pan-Canadian needs
- Examine interplay of competency-based approaches and credential standards

2022/2023 Work Plan – Status Update

Key Work Plan Deliverables	Status Update
Study with Statistics Canada on numbers of IEHPS in Canada, and whether they are working in health care (including disaggregation of data by jurisdiction and other equity factors)	✓ HC-Statistics Canada Memorandum of Understanding put in place. ✓ HC working with Stats Can to review the data report from 2021 census ❑ Initial results to be presented at the IEHP Sub-Committee in April 2023
Undertake Needs Assessment for language proficiency training for IEHPs	✓ On-going discussion on effective models for language training (e.g., Quebec Model; Red River College) ✓ Statement of work developed to undertake needs assessment ✓ Contractor identified to undertake the work (Laval U) ❑ Draft recommendation on addressing language related challenges to be presented to IEHP subcommittee in June 2023 ❑ Provide recommendation to CHW on potential measures to minimize language related barriers (e.g., alignment in testing levels and requirements)
Immigration Barriers and Pathways	✓ To support on-going discussion immigration barriers and pathways; IRCC and ESDCs are now members of the IEHP Sub-Committee ✓ Provided advice to IRCC on new physicians measures, challenges with pathways for healthcare workers; and barriers related to settlements. ✓ Provided advice on proposed health workforce related stream under International Mobility Program ✓ Gained understanding of Canada's commitment under WHO's Code on Ethical Recruitment

Examine interplay between competency-based approaches and credential standards (i.e. entry-to-practice) within Canada and internationally for specific types of care	• On Hold –
	  • Prioritized other IEHP work underway (e.g., IEHP Blueprint; ESDC call-out for FCR proposals);
	  • IHEP Blueprint developed and presented to FPT CDM members. FPT members provided input on the blueprint including initiatives of interest.
	  • ESDC provided update on Foreign Credential Recognition Program (FCRP) at IEHP sub-committee meeting to seek subcommittee's advice on roadblocks and path forward

Establish IEHP Matchmaking Initiative that facilitates direct connections between PTs seeking IEHPs and immigrant settlement organizations	• On Hold – Members noted need to better understand language requirements prior to establishing any matchmaking initiative. Additionally, various PTs are currently working on specific navigational supports for IEHPs.

Areas of Focus for 2023-2024

Carry Forward from 2022-2023 Work Plan	Potential Deliverable	Desired Outcome
IEHP Data: Undertake study with StatsCan on numbers of IEHPS in Canada, and whether they are working in a) health care, and b) in their area of training, c) with additional elements as feasible (e.g., length of time from start of credential recognition process to registration; whether partners are experiencing professional barriers)	• Stats Can to provide update to IEHP sub-committee, and based on the results, planning for future studies to better understand the drivers behind these numbers.	• Quantify number of IEHPs to support policy priorities and decisions to accelerate integration of IEHPs into Canadian health system
Language Requirements: Understanding language assessment requirements	• Results of current contract (due June) on environmental scan of language assessment and training opportunities with reporting back to CHW on what has been learned and a path forward.	• Identify and address language related barriers faced by IEHPs and enablers/best practices and evolving approaches

Areas of Focus for 2023-2024

Proposed New Priorities	Potential Deliverable	Desired Outcome
Mentorship and Bridging Programs: Undertake cross jurisdictional environmental scan of mentorship, bridging programs and pathways available to IEHPs	• Contracted study that outlines effective mentorship, bridging programs and pathways for IEHPs; principles of best practice; and preparing newcomers for practice (professional culture and new health system)	• Better availability and improved uptake of supportive programs for IEHPs
Navigation Support: Develop a public-facing compendium of navigation support available for IEHPs	• A single portal (e.g., webpage) with links to critical information available from various jurisdictions. • Identify best practices (including metrics) for creation of PT navigational portals where they do not exist	• Ensure IEHPs can easily connect with jurisdictionally available support systems to accelerate integration into Canadian health system
Ethical Recruitment: Provide advice and input on the development of the ethical recruitment framework.	• Ethical Recruitment Framework that reflects PT perspectives and is endorsed by FPT members.	• Shared understanding of ethical recruitment practices
Accelerated pathways for Internationally Educated Nurses (starting with Registered Nurses) – List of Countries ****In collaboration with PNATF****	• Share assessment processes for including a specific country on list of accelerated pathways • Compilation of countries that are included on lists for streamlined pathways	• Enhanced understanding of various assessment processes with opportunity to leverage/adopt assessment results • Potential to have a harmonized list of countries for IENs
On-Going Information Sharing and Advice: Provide advice on barriers and issues impacting IEHPs (identification of bottlenecks, immigration pathways, credential recognition, etc.)	• Identify specific immigration related bottlenecks • Effective advancement of policy priorities under the IEHP Blueprint, and ensuring actions reflect FPT perspectives	

Considerations

- Significant FPT efforts are currently underway to support IEHPs focusing on wide range of areas (e.g., recruitment campaigns, navigation support, streamlined approach to licensing, incentives)

- IEHPs sub-committee's role in sharing best practices and approaches to support IEHPs remains critical

- It is critical to ensure that the proposed priorities are aligned with priorities established by FPT Health Ministers and FPT Conference of Deputy Ministers

- Given's IEHP Sub-Committee's expertise, FPT CHW needs to consider which specific recommendations and/or initiatives will help accelerate integration of IEHPs into Canadian health system

July 23 Morning Sitting - Page 20-21

PAUL – this first one is concerned with the specific condition of Myalgic Encephalomyelitis and any training physicians may have received in it. I included the lead in question for context, but the key question is at the bottom of the second column. I'm unsure if this is directly in our purview, but any update we can find would be helpful.

N. Letnick	Again, the light of hope is put out there for another group. Thank you. We'll switch now to ME and CFS. During estimates last year, Minister, we covered the topic of ME and CFS. By the last count I have, there are about 77,000 British Columbians who live with the disease. Seventy-five percent of people living with ME are unable to work, and 25 percent are housebound or bed-bound. They are among the most severely disabled in our community. Last year I asked if the government would agree to develop a provincial strategy to address unmet health care needs for British Columbians living with ME. I also asked: would the government commit to timely implementation of diagnostic and billing codes for ME? I've been asked to ask the same questions again. So those two questions and one more, if I may. Would the minister agree to launch an educational ME campaign for doctors?	Thank you very much to the member for his question. As he may be aware, subsequent to that, there have been meetings by the ME/FM Society and the Ministry of Health on some of the questions they've raised, and that process continues. As he will know, there are no specific tests confirming diagnosis at this time for ME or chronic fatigue syndrome. The symptoms for these conditions are similar to many other illnesses, and diagnosis is determined from a medical exam by the patient's doctor or health care provider. The absence of other identifiable diagnoses responsible for patient symptoms often results in this diagnosis, and it's a significant condition facing people in B.C. I would say with respect to…. We continue to work on these questions. The complex chronic diseases program, a program of the Provincial Health Services Authority, is a provincial referral centre providing comprehensive and evidence-based care for adults with complex chronic diseases such as…. I would say on the question of billing codes, the member may know that they're developed for medical services or procedures and not for conditions. Existing billing codes are available to doctors to support diagnosis and care to patients with these conditions, but it's unlikely that we would develop a specific billing code, principally because that's not how the system works. The member will also know that we've had some meetings, and we're going to continue to have a process of engagement with the society. On the issue of education, the member will know — he may even be interested in this himself — that in August, the International Association for Chronic Fatigue Syndrome and ME is providing a virtual research conference for all biomedical and behavioural professionals, including clinicians, researchers and educators with an interest in ME/CFS and	HSD

		its associated co-morbidities. Continuing medical education credits for physicians and nurses will also be provided. People affected by ME/CFS and their supporters are also welcome to participate in this process. I would note that in June, 2019 the guidelines and protocols advisory committee added a new partner guideline on identification and symptom management of ME/CFS to detect key symptoms and manage these symptoms over the long term. And of course, the government of Canada is currently and actively engaged, through Health Canada and the Canadian Institutes of Health Research, to support the work of the national network to improve the quality of life of people living with ME. There's a significant amount of research, engagement and education happening right now. That engagement is available to doctors and nurses in the B.C. health care system.	
N. Letnick	Is there any way to identify how many physicians have taken up the professional education piece that's going to happen in August around ME(Myalgic Encephalomyelitis)?	I'll endeavour to find an answer to that for the member. Also, I'll endeavour to send, to him and other members of the opposition and the government side here who might be interested, more information about that process.	HSD / HSWBSD

July 23 Afternoon Sitting

PAUL – This looks like our work directly and I trust we can update for recent statistics. Note that there are multiple follow up questions

N. Letnick	Now we'll transition to another issue, one of physician shortages in British Columbia. This is both in terms of GPs as well as specialists. I know that the government is continuing on the primary care plan that was consulted through and developed. I think it was 2015 when the current deputy minister put out the white papers. You know, government is to be congratulated with moving forward with all of the things that we were trying to do as a government to make sure that we have more access to physicians, especially in primary care.	I'm happy to respond to that, and I will in a second. I wanted to just point out, and I think that it's important to do so…. I will not spend any more time than this saying that we've dramatically increased nurse practitioners. We've added nursing spaces, including nurs spaces all over the province, most recently th new spaces in Fort St. John and the new hea sciences professional positions in Prince Ge We're building team-based care. This is the model of health care that resident doctors, th model of health care that people in medical school are learning and are embracing.	HSWBSD s.13

	I don't want to talk about that piece. The minister might want to, but in consequence of time, I'd just like to focus on one small piece of the whole puzzle, because we can spend days, as the minister knows, on this whole piece of access, whether it be for foreign-trained doctors or students who have gone abroad or you name it. There are all kinds of things — bringing in nurse practitioners, etc. I just want to focus on the one piece, and that is the piece of educating our own British Columbians to become physicians. From 2017 to 2020, the doctors in family practice received an increase of 99. So 6,267 up to 6,366. From 2001 to 2017, the number of doctoral training seats doubled to 288 and expanded training so that it was across the province. But 288 grads no longer cover what we need, especially with retirements, departures from B.C. or physicians focusing on specializations instead of general practice. If the minister would indulge me to focus on the issue of doctor training here, my questions are…. I'll start with the first one. Does the minister know how many doctors B.C. has graduated in each of the years since 2016?	It's important to understand professional shortages. We often focus on doctors. Sometimes we focus on nurses. But there are significant shortages with the health sciences profession. The second point I'd say is that if you look at Canada, the province with the most doctors per capita is Nova Scotia. In second place is Newfoundland, and third place is British Columbia. So in relative terms, we're doing well, and why wouldn't we be doing well? This is, of course, the best place in the whole country to live and to work in health care, especially with all the good things happening in our public health care system, so all of that's understandable. The third point I'd make is that we are significantly recruiting more doctors net of retirements. I think this is important to understand. Just to put it in context, since I became Minister of Health, net of retirement we have 1,000 more doctors, which is significant. It doesn't mean that we're necessarily meeting demand or not, because as the member said, the focus of care may be different and we may not be successfully meeting the need, but we're doing a pretty good job. This government, and the previous government, have certainly focused some of that need, in terms of residencies, on family practice, with great success. Here, I want to say, as we get to the questions, I think it has also been a success for the distributed model, which was put in place, to a great extent, under the previous government. We'll get to this, I think, in some of the questions the member may ask. One of the most important factors, and this has guided our decisions in other health professions, is to regionalize training, from health care workers and care aides right up to nurses and health sciences professions — to regionalize training, as we have, very aggressively in recent times. It's had a positive effect. We'll get to that in a second, in particular to the doctor shortage and the percentage of doctors who train in regions outside of Metro Vancouver who stay in those regions to work. It shows, I think, the effectiveness of that model. That model, as the member has noted and I wouldn't expect him to	• The World Health Organization Global Code of Practice on the International Recruitment of Health Personnel promotes voluntary practices for ethical international recruitment such as discouraging the active recruitment from developing countries facing critical shortages of health personnel. At the same time, we must respect the individual freedom of health personnel to migrate to countries that wish to employ them. s.13 s.13 •

		fail to note, was put into place under the previous government. Essentially, per year, in terms of UBC post-graduate residency positions: the first-year seats, we have 288 positions, as the member will know, for Canadian medical graduates, and we have 58 positions for international medical graduates, for a total in those programs of 346. We continue to have, in all four of those years, 288 positions in the UBC school.	
	Follow up Question #1: Just to clarify, is the minister saying that we have graduated 288 physicians in each of the years since 2016?	**Follow up Response #1:** Well, the number of graduates through residencies has been 346, and they're in residency programs. While there is some falloff in terms of numbers — not everyone makes their way through the program — it's pretty close to 346, in terms of post-graduate residency work. As the member notes, the entry points are at 288.	
	Follow up Question #2: The minister mentioned a net number of 1,000 new physicians have come into British Columbia. Can the minister expand a little bit as to the source of those 1,000 new physicians?	**Follow up Response #2:** I think we do have a detailed analysis. I don't have that here, but I'd be happy to provide that to the member. What I would say is this. I think we're increasingly successful at keeping our own graduates at home. Obviously, British Columbia is a place where people want to come. I think the distributed model has assisted us in that regard. So even though we have significant retirements and we're going to expect significant retirements, we're seeing a significant number of net new physicians across British Columbia, and that data is readily available from the College of Physicians and Surgeons. Just to say what it is, because this is active registrants: 13,257 in 2020 — that's what I'm referring to — and back to 2017, which was 12,187. So in that time, from the end of fiscal year 2017 essentially through the end of fiscal year 2020, we've added, well, more than a thousand doctors to that.	
	Follow up Question #3: Yes, I would appreciate the breakdown. My concern here is…. Are we taking away physicians from other provinces or other countries that are in desperate need of keeping their own physicians in their countries or in their provinces? It would be nice to know if we are, indeed, doing that, I guess as an ethical question more than anything else. The other piece to this is if we can afford to train our own British Columbians…. I wouldn't always say "youth," because by the time people graduate from med school	**Follow up Response #3:** I could give that in writing, but I'll just give you an example, the most recent example, to assist the member, and then…. There may be limited utility in going back year after year on this, but what I asked staff to do, and what they prepared, was to	

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July 24 – Morning Sitting

NONE

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s.13; s.17

N. Letnick	Thank you to the minister for expanding on his vision and the role of chiropractors moving forward — in particular, on the team-based care piece. I understand that maybe what he's saying is not today, but	The member will know that we've significantly increased the role of nurse practitioners in our health care system. That was an innovation, initially, of Ministers of Health at the time of Mr. Hansen and Mr. Abbott, who brought	HSWBSD • s.13; s.17

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N. Letnick	In the meantime, "What's needed next?" is the question for physician assistants. I don't believe they are licensed in British Columbia, if I can clarify that with the minister. Are they actually licensed to practise, to work, in British Columbia, and if they're not, what would they require to do so?	I was just checking on the professional process. They're not licensed in B.C. now, so what you would have to do is probably find a current health care professional college. What would be critical, of course, is a decision to fund the positions, ultimately, because it's not a question of being able to work that's significant. It would be important to them to have that work paid for. So there's that element. You'd have to have a policy that drove the implementation of physician assistants in the system, and then you'd probably have to have one of the existing colleges take up the regulation and start the regulation of physician assistants in the system. Probably, in that case, the likely model under the current health professional model — there are others to consider, and the member is as expert in this now as I am to provide advice on that — would be the College of Physicians and Surgeons. The member will know that certified dental assistants, which is a very different category of workers — I'm not comparing them as jobs — don't have their own college but are regulated, I believe, under the College of Dental Surgeons now. That's sometimes an issue for them because it reintroduces into the college	HSWBS

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N. Letnick	To the minister, I understand through the professional regulations that, from what he said, the College of Physicians and Surgeons might be the correct place for them to speak with to provide them with an opportunity to become regulated in the province of B.C. Assuming they do, what I also understand from my conversations with them — and I must admit, it's been a year and a half, I think, since I last spoke with them — was that some of them were looking to work in remote parts of the province, paid for by the private sector. It would not require any public dollars. For instance, in an oil rig kind of scenario or maybe an LNG plant or something, where they would be of use in those kinds of industrial settings, is where they actually said they were looking to work — at least to get a foothold in the province to prove out their capacity. I guess it's more of just a rhetorical piece rather than a question, because I'm not asking the minister if he would approve of them working on an LNG plant. Just so the minister understands, it's not all about them getting public dollars, at least not the ones that I spoke to over a year and a half ago. If he wants to respond, sure.	I assume what would be required is probably a direction to the college from the ministry, in this case, to consider the issue. I think that's what would be required. It's not something that they would necessarily generate on their own. I think it's true of many professions that they operate outside of the public system, either in health or elsewhere. But I think if you're going to make the argument that they're essential value, one has to make that argument. But if the argument is that we should just create a whole new regulatory structure for them to be used in only occasional places, I'm not sure that would be the right way to proceed. I think the right way to proceed in this area, and to consider, would be some form of…. It would require direction. That would cause a lot of time and effort. And to do that in health care when they're talking about people who work with physicians and without a role in the public system, I don't think it would make a great deal of sense. There may be exceptions to that, but I don't think you would develop a whole new regulatory system to deal with those exceptions. We'd have to make the decision that this is where we want to go. I think almost certainly…. This is what we d have either in B.C.: training within B.C. for physician assistants. There is no training at a here. The member talked about other health professions yesterday coming into the provi and the need to train people here. But witho infrastructure in place…. That is an issue, anyway, for the development of physician assistants in Canada, because, essentially, yo would be depending on the relatively small number of other institutions that provide suc training in other jurisdictions in the country.	HSWBSD

From: Lorenz, Tanya HLTH:EX
To: Bringsli, Eric C HLTH:EX; Clarke, Paul HLTH:EX
Cc: Ghesquiere, Breanne J HLTH:EX
Subject: RE: Hansard
Date: April 16, 2021 8:53:44 AM
Attachments: image001.png
Hansard_TL edits.docx

Good morning all,

I've connected with Health Match regarding this question:

Are we taking away physicians from other provinces or other countries that are in desperate need of keeping their own physicians in their countries or in their provinces? s.13	s.13

s.13

–

- s.13

- The World Health Organization Global Code of Practice on the International Recruitment of Health Personnel promotes voluntary practices for ethical international recruitment such as discouraging the active recruitment from developing countries facing critical shortages of health personnel. At the same time, we must respect the individual freedom of health personnel to migrate to countries that wish to employ them.[s.13]
- s.13

Additionally, I've added a comment that HWPI branch may have additional edits or information to contribute to this section given their key role in health workforce planning.

Thanks!

Tanya

Tanya Lorenz, BScN, MScHQ | Senior Policy Analyst, Physician Workforce Development
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July 23 Morning Sitting - Page 20-21

PAUL – this first one is concerned with the specific condition of Myalgic Encephalomyelitis and any training physicians may have received in it. I included the lead in question for context, but the key question is at the bottom of the second column. I'm unsure if this is directly in our purview, but any update we can find would be helpful.

N. Letnick	Again, the light of hope is put out there for another group. Thank you. We'll switch now to ME and CFS. During estimates last year, Minister, we covered the topic of ME and CFS. By the last count I have, there are about 77,000 British Columbians who live with the disease. Seventy-five percent of people living with ME are unable to work, and 25 percent are housebound or bed-bound. They are among the most severely disabled in our community. Last year I asked if the government would agree to develop a provincial strategy to address unmet health care needs for British Columbians living with ME. I also asked: would the government commit to timely implementation of diagnostic and billing codes for ME? I've been asked to ask the same questions again. So those two questions and one more, if I may. Would the minister agree to launch an educational ME campaign for doctors?	Thank you very much to the member for his question. As he may be aware, subsequent to that, there have been meetings by the ME/FM Society and the Ministry of Health on some of the questions they've raised, and that process continues. As he will know, there are no specific tests confirming diagnosis at this time for ME or chronic fatigue syndrome. The symptoms for these conditions are similar to many other illnesses, and diagnosis is determined from a medical exam by the patient's doctor or health care provider. The absence of other identifiable diagnoses responsible for patient symptoms often results in this diagnosis, and it's a significant condition facing people in B.C. I would say with respect to…. We continue to work on these questions. The complex chronic diseases program, a program of the Provincial Health Services Authority, is a provincial referral centre providing comprehensive and evidence-based care for adults with complex chronic diseases such as…. I would say on the question of billing codes, the member may know that they're developed for medical services or procedures and not for conditions. Existing billing codes are available to doctors to support diagnosis and care to patients with these conditions, but it's unlikely that we would develop a specific billing code, principally because that's not how the system works. The member will also know that we've had some meetings, and we're going to continue to have a process of engagement with the society. On the issue of education, the member will know — he may even be interested in this himself — that in August, the International Association for Chronic Fatigue Syndrome and ME is providing a virtual research conference for all biomedical and behavioural professionals, including clinicians, researchers and educators with an interest in ME/CFS and	HSD

		its associated co-morbidities. Continuing medical education credits for physicians and nurses will also be provided. People affected by ME/CFS and their supporters are also welcome to participate in this process. I would note that in June, 2019 the guidelines and protocols advisory committee added a new partner guideline on identification and symptom management of ME/CFS to detect key symptoms and manage these symptoms over the long term. And of course, the government of Canada is currently and actively engaged, through Health Canada and the Canadian Institutes of Health Research, to support the work of the national network to improve the quality of life of people living with ME. There's a significant amount of research, engagement and education happening right now. That engagement is available to doctors and nurses in the B.C. health care system.	
N. Letnick	Is there any way to identify how many physicians have taken up the professional education piece that's going to happen in August around ME(Myalgic Encephalomyelitis)?	I'll endeavour to find an answer to that for the member. Also, I'll endeavour to send, to him and other members of the opposition and the government side here who might be interested, more information about that process.	HSD / HSWBSD

July 23 Afternoon Sitting

PAUL – This looks like our work directly and I trust we can update for recent statistics. Note that there are multiple follow up questions

N. Letnick	Now we'll transition to another issue, one of physician shortages in British Columbia. This is both in terms of GPs as well as specialists. I know that the government is continuing on the primary care plan that was consulted through and developed. I think it was 2015 when the current deputy minister put out the white papers. You know, government is to be congratulated with moving forward with all of the things that we were trying to do as a government to make sure that we have more access to physicians, especially in primary care.	I'm happy to respond to that, and I will in a second. I wanted to just point out, and I think that it's important to do so…. I will not spend any more time than this saying that we've dramatically increased nurse practitioners. We've added nursing spaces, including nurs spaces all over the province, most recently th new spaces in Fort St. John and the new heal sciences professional positions in Prince Ge We're building team-based care. This is the model of health care that resident doctors, th model of health care that people in medical school are learning and are embracing.	HSWBSD s.13

	I don't want to talk about that piece. The minister might want to, but in consequence of time, I'd just like to focus on one small piece of the whole puzzle, because we can spend days, as the minister knows, on this whole piece of access, whether it be for foreign-trained doctors or students who have gone abroad or you name it. There are all kinds of things — bringing in nurse practitioners, etc. I just want to focus on the one piece, and that is the piece of educating our own British Columbians to become physicians. From 2017 to 2020, the doctors in family practice received an increase of 99. So 6,267 up to 6,366. From 2001 to 2017, the number of doctoral training seats doubled to 288 and expanded training so that it was across the province. But 288 grads no longer cover what we need, especially with retirements, departures from B.C. or physicians focusing on specializations instead of general practice. If the minister would indulge me to focus on the issue of doctor training here, my questions are…. I'll start with the first one. Does the minister know how many doctors B.C. has graduated in each of the years since 2016?	It's important to understand professional shortages. We often focus on doctors. Sometimes we focus on nurses. But there are significant shortages with the health sciences profession. The second point I'd say is that if you look at Canada, the province with the most doctors per capita is Nova Scotia. In second place is Newfoundland, and third place is British Columbia. So in relative terms, we're doing well, and why wouldn't we be doing well? This is, of course, the best place in the whole country to live and to work in health care, especially with all the good things happening in our public health care system, so all of that's understandable. The third point I'd make is that we are significantly recruiting more doctors net of retirements. I think this is important to understand. Just to put it in context, since I became Minister of Health, net of retirement we have 1,000 more doctors, which is significant. It doesn't mean that we're necessarily meeting demand or not, because as the member said, the focus of care may be different and we may not be successfully meeting the need, but we're doing a pretty good job. This government, and the previous government, have certainly focused some of that need, in terms of residencies, on family practice, with great success. Here, I want to say, as we get to the questions, I think it has also been a success for the distributed model, which was put in place, to a great extent, under the previous government. We'll get to this, I think, in some of the questions the member may ask. One of the most important factors, and this has guided our decisions in other health professions, is to regionalize training, from health care workers and care aides right up to nurses and health sciences professions — to regionalize training, as we have, very aggressively in recent times. It's had a positive effect. We'll get to that in a second, in particular to the doctor shortage and the percentage of doctors who train in regions outside of Metro Vancouver who stay in those regions to work. It shows, I think, the effectiveness of that model. That model, as the member has noted and I wouldn't expect him to	s.13

		fail to note, was put into place under the previous government. Essentially, per year, in terms of UBC post-graduate residency positions: the first-year seats, we have 288 positions, as the member will know, for Canadian medical graduates, and we have 58 positions for international medical graduates, for a total in those programs of 346. We continue to have, in all four of those years, 288 positions in the UBC school.	
	Follow up Question #1: Just to clarify, is the minister saying that we have graduated 288 physicians in each of the years since 2016?	**Follow up Response #1:** Well, the number of graduates through residencies has been 346, and they're in residency programs. While there is some falloff in terms of numbers — not everyone makes their way through the program — it's pretty close to 346, in terms of post-graduate residency work. As the member notes, the entry points are at 288.	
	Follow up Question #2: The minister mentioned a net number of 1,000 new physicians have come into British Columbia. Can the minister expand a little bit as to the source of those 1,000 new physicians?	**Follow up Response #2:** I think we do have a detailed analysis. I don't have that here, but I'd be happy to provide that to the member. What I would say is this. I think we're increasingly successful at keeping our own graduates at home. Obviously, British Columbia is a place where people want to come. I think the distributed model has assisted us in that regard. So even though we have significant retirements and we're going to expect significant retirements, we're seeing a significant number of net new physicians across British Columbia, and that data is readily available from the College of Physicians and Surgeons. Just to say what it is, because this is active registrants: 13,257 in 2020 — that's what I'm referring to — and back to 2017, which was 12,187. So in that time, from the end of fiscal year 2017 essentially through the end of fiscal year 2020, we've added, well, more than a thousand doctors to that.	
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Commented [LTH1]: See bullets above. HWPI branch may have additional edits/input given their key role in health workforce planning.

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s.13; s.17

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Commented [LTH2]: Perhaps Profession Regulation Branch would be best positioned to provide any additional input re: regulation?

		framework the hierarchy that exists in workplaces, for example. You would probably seek out, just if he's asking for technical things…. You'd have to find a college that would take on that work, and then, as well, you'd obviously have to find the means and the policy that would provide funding for those positions in addition to all the other expansion of primary care and other care that we're doing.	
N. Letnick	To the minister, I understand through the professional regulations that, from what he said, the College of Physicians and Surgeons might be the correct place for them to speak with to provide them with an opportunity to become regulated in the province of B.C. Assuming they do, what I also understand from my conversations with them — and I must admit, it's been a year and a half, I think, since I last spoke with them — was that some of them were looking to work in remote parts of the province, paid for by the private sector. It would not require any public dollars. For instance, in an oil rig kind of scenario or maybe an LNG plant or something, where they would be of use in those kinds of industrial settings, is where they actually said they were looking to work — at least to get a foothold in the province to prove out their capacity. I guess it's more of just a rhetorical piece rather than a question, because I'm not asking the minister if he would approve of them working on an LNG plant. Just so the minister understands, it's not all about them getting public dollars, at least not the ones that I spoke to over a year and a half ago. If he wants to respond, sure.	I assume what would be required is probably a direction to the college from the ministry, in this case, to consider the issue. I think that's what would be required. It's not something that they would necessarily generate on their own. I think it's true of many professions that they operate outside of the public system, either in health or elsewhere. But I think if you're going to make the argument that they're essential value, one has to make that argument. But if the argument is that we should just create a whole new regulatory structure for them to be used in only occasional places, I'm not sure that would be the right way to proceed. I think the right way to proceed in this area, and to consider, would be some form of…. It would require direction. That would cause a lot of time and effort. And to do that in health care when they're talking about people who work with physicians and without a role in the public system, I don't think it would make a great deal of sense. There may be exceptions to that, but I don't think you would develop a whole new regulatory system to deal with those exceptions. We'd have to make the decision that this is where we want to go. I think almost certainly…. This is what we d have either in B.C.: training within B.C. for physician assistants. There is no training at a here. The member talked about other health professions yesterday coming into the provin and the need to train people here. But withou infrastructure in place…. That is an issue, anyway, for the development of physician assistants in Canada, because, essentially, yo would be depending on the relatively small number of other institutions that provide suc training in other jurisdictions in the country.	HSWBSD

Commented [LTH3]: Same comment as above re: Pro Reg Branch for any additional input re: regulation.

From: Bringsli, Eric C HLTH:EX <Eric.Bringsli@gov.bc.ca>
Sent: April 14, 2021 1:45 PM
To: Clarke, Paul HLTH:EX <Paul.Clarke@gov.bc.ca>
Cc: Lorenz, Tanya HLTH:EX <Tanya.Lorenz@gov.bc.ca>; Ghesquiere, Breanne J HLTH:EX <Breanne.Ghesquiere@gov.bc.ca>
Subject: RE: Hansard

Thanks Paul,

The same info is going around to all Directors so if we don't have the answer to this question, it doesn't mean that others aren't trying to answer it as, like me, they've read through the whole transcript. I noted a couple of things in the table below in ALL CAPS though I didn't mean to shout, only differentiate.

Eric

From: Clarke, Paul HLTH:EX <Paul.Clarke@gov.bc.ca>
Sent: April 14, 2021 12:39 PM
To: Bringsli, Eric C HLTH:EX <Eric.Bringsli@gov.bc.ca>
Cc: Lorenz, Tanya HLTH:EX <Tanya.Lorenz@gov.bc.ca>; Ghesquiere, Breanne J HLTH:EX <Breanne.Ghesquiere@gov.bc.ca>; Clarke, Paul HLTH:EX <Paul.Clarke@gov.bc.ca>
Subject: RE: Hansard

Hi Eric

Bre and I connected this morning, and so we are providing these initial brief thoughts/comments just to better define our approach forward.

We have highlighted where I think we may be able to revise/update (green), and also the questions that should likely be addressed outside 'Medical Educations and Partnership' (red).

Happy to chat anytime, especially if you feel that we should be contributing more to one of the 'red' questions.

Best regards,
Paul

Last year I asked if the government would agree to develop a provincial strategy to address unmet health care needs for British Columbians living with ME. I also asked: would the government commit to timely implementation of diagnostic and billing codes for ME? I've been asked to ask the same questions again. So those two questions and one more, if I may. Would the minister agree to launch an educational ME campaign for doctors?	s.13
Is there any way to identify how many physicians have taken up the professional education piece that's going to happen in August around ME(Myalgic Encephalomyelitis)?	s.13
physician shortages in British Columbia. This is both in terms of GPs as well as specialists. I DON'T THINK I SAW THIS AS A SPECIFIC QUESTION SO NOTHING MORE NEEDED HERE	s.13
Does the minister know how many doctors B.C. has graduated in each of the years since 2016?	s.13

	s.13
is the minister saying that we have graduated 288 physicians in each of the years since 2016?	Yes, 288 UGMEs graduate (MD degree is conferred) from UBC each year s.13 s.13
Can the minister expand a little bit as to the source of those 1,000 new physicians? THANKS, WE'LL SEE IF THEY CATCH THAT ONE	s.13
Are we taking away physicians from other provinces or other countries that are in desperate need of keeping their own physicians in their countries or in their provinces? TANYA – THOUGHTS ON THIS?	s.13
How many people enter residency programs at B.C. hospitals by year and by health authority?	s.13
Will the minister fund, whether directly or through Advanced Education, I would assume, additional physician training seats in B.C. so that we can get beyond the 288?	s.13

	have messaging from AEST, but will check to see if it has been revised since we last check

From: Bringsli, Eric C HLTH:EX <Eric.Bringsli@gov.bc.ca>
Sent: April 13, 2021 10:47 AM
To: Clarke, Paul HLTH:EX <Paul.Clarke@gov.bc.ca>; Lorenz, Tanya HLTH:EX <Tanya.Lorenz@gov.bc.ca>
Subject: Hansard

Hi Paul and Tanya,

We have been asked to review and update the answers to the questions posed during Estimates in 2020. I've gone through the whole transcript and severed the ones pertaining to us in the attached document. I will note which ones I'd like each of you to lead with your teams (shaded in blue at the top of the question). Can you please edit and keep tracked changes on? This will then be merged with the whole transcript. Note that the highlighting in the document is not mine. It came that way presumably to focus on the ultimate question asked. Fortunately we have only have a few but we do have a tight turnaround. Can you please return by end of Friday?

Instructions from the DMO:
Please have program staff provide updates, if any, in the last column. If there are no updates, please indicate this in RED font in the updates column.

Please let me know if you have further questions

Thanks

Eric

From: Lorenz, Tanya HLTH:EX
To: "Audra Fediurek"; Elizabeth Williams
Subject: s.13
Date: April 15, 2021 10:13:21 AM
Attachments: image001.png

Hi Audra and Liz,

Thank you kindly for your quick responses and s.13
s.13

Thank you again for your support!

Best regards,

Tanya

Tanya Lorenz, BScN, MScHQ | Senior Policy Analyst, Physician Workforce Development
Physician Services Branch | Health Sector Workforce and Beneficiary Services Division | Ministry of Health
PO Box 9649 STN PROV GOVT | Victoria BC V8W 9P4
E: Tanya.Lorenz@gov.bc.ca P: 236-478-1298

From: Audra Fediurek <Audra.Fediurek@heabc.bc.ca>
Sent: April 15, 2021 9:25 AM
To: Elizabeth Williams <Elizabethw@healthmatchbc.org>; Lorenz, Tanya HLTH:EX <Tanya.Lorenz@gov.bc.ca>
Subject: s.13

Hi Liz and Tanya,

s.13

s.13

There is literature available through the World Health Organization related to a code of practice on the international recruitment of health professionals. The key takeaways are that we have a responsibility to those countries that are particularly vulnerable to health workforce shortages. At the same time, we must respect the individual freedom of health personnel to migrate to countries that wish to employ them.

s.13

Hope this is helpful.

Audra

From: Elizabeth Williams
Sent: April 15, 2021 8:59 AM
To: Lorenz, Tanya HLTH:EX <Tanya.Lorenz@gov.bc.ca>
Cc: Audra Fediurek <Audra.Fediurek@heabc.bc.ca>
Subject: Re: s.13

Hi Tanya

s.13

s.13

Thanks
Liz

Elizabeth Williams
Program Manager, Recruitment Services
Health Match BC

On Apr 15, 2021, at 8:38 AM, Lorenz, Tanya HLTH:EX <Tanya.Lorenz@gov.bc.ca> wrote:

Good morning Liz,

s.13

With many thanks,

Tanya

Tanya Lorenz, BScN, MScHQ | Senior Policy Analyst, Physician Workforce Development
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