The Need for Speed:

Scaling Practice Ready Assessment to Alleviate Canada's Family Doctor Crisis

Toronto Metropolitan University

Global Migration Institute

Executive Summary

Canada has a primary care crisis with 6.5 million Canadians lacking access to a family doctor. Waiting for medical care is reported to cost Canadians $5.2 billion in lost wages annually. Assuming an average load of about 1,500 patients per physician, Canada needs over 4,300 additional family doctors today to immediately address its family doctor shortage.

Addressing the primary care crisis quickly requires the pursuit of multiple solutions simultaneously. One of those solutions is to accelerate the effective integration of Canada's internationally trained physicians (ITPs). Canada is well behind its peers in harnessing the talents of its population of ITPs. For example, half of family physicians in the United Kingdom are ITPs, compared to about one-quarter in Canada. Canada cannot afford to overlook the substantial reservoir of talent represented by ITPs.

The current system wastes resources and human potential by underutilizing ITPs when a fast and cost-effective solution exists. Practice Ready Assessment (PRA) is a proven solution that is faster and more cost-effective than requiring experienced ITPs to redo residency training and compete for limited residency spaces. On average, PRA is approximately ten times quicker and ten times more cost-effective than having ITPs complete a two-year family medicine residency in Canada. The PRA track record demonstrates both feasibility and impact. The potential contribution PRA could make to addressing physician shortages is being dramatically under-leveraged, at tremendous cost to those Canadians unable to access care by a family physician.

PRA enables eligible ITPs to complete a workplace-based competency assessment in a Canadian clinical setting where they are supervised and assessed by an experienced family physician. If the ITP demonstrates they are competent to practice family medicine in Canada safely and effectively, they are then eligible to practice under a form of provisional license. In most provinces they are required to complete a mandatory period of service in a specific underserved community and then can move on to complete requirements for a full license.

Only 1,500 ITPs have become licensed through PRA across Canada between 2018 (when the Medical Council of Canada launched the National Assessment Collaboration PRA framework) and 2025. While the number and capacity of programs have been growing, with the right investments and innovations, the PRA model has the potential to be scaled significantly.

Factors currently limiting the ability to scale and enhance PRA include:

- Barriers to recruiting a sufficient and sustainable supply of qualified assessors and to expanding the number of assessment sites
- Fragmented information and application processes creating access barriers for ITPs and administrative inefficiencies for PRA programs
- Lack of standardized PRA eligibility criteria strongly based in evidence
- Significant barriers preventing ITPs from meeting current recency of practice requirements
- Insufficient post-assessment supports to ensure the successful integration of ITPs

The barriers preventing the scaling of PRA are neither insurmountable nor inevitable. Innovative solutions already exist for scaling and enhancing program efficiency by investing in: exploring new models and adapting current ones to increase assessor supply; centralizing information provision and administrative elements of the application intake process; standardizing and reforming candidate eligibility criteria including recency of practice, based on solid research evidence; and supporting post assessment integration. All of this can be achieved by unlocking federal investment to support scaling up assessment numbers through the establishment of a federal fund to channel resources to provincial programs and pan-Canadian organizations.

Scaling PRA nationally requires political will and strategic investment, coordinated action, and collaboration across federal and provincial governments, regulatory colleges, healthcare authorities, and the ITP community itself. Far exceeding the investment needed to unlock this solution are costs of inaction measured in economic losses, delayed care, and continued physician shortages across Canada.

Recommendations:

1. Increase scale by increasing the supply of assessors and assessment sites

- → Support the development, testing, adaptation/modification, and expansion of models that increase the supply of assessors for PRA programs thus allow programs to increase the number of assessments they are able to complete annually.
- → Support the necessary physical and technological infrastructure and team-based approaches to allow PRA programs to expand.

2. Improve efficiency through a centralized applicant documentation portal

Expand and enhance the MCC's Physicians Apply portal to:

- → Provide a centralized and digitally updated source of information on all PRA programs presented in a comparable and easily navigable format.
- → Direct ITPs to the PRA programs for which they are eligible.
- → Serve as the digital wallet for all required PRA applicant documentation including storage, verification and sharing of all documentation.
- → Collect data on which PRA programs applicants have applied to and been accepted to.

3. Standardize evidence-based eligibility requirements

- → Move towards standardization of evidence-based eligibility requirements for PRA programs across Canada.
- → Undertake collaborative research that would gather evidence across PRA programs in Canada and similar programs internationally to support adoption of standardized evidence-based eligibility criteria.

4. Address Recency of Practice Barriers

- → Undertake collaborative national research to develop evidence to inform appropriate recency requirements. Use this evidence to determine whether recency requirements should be revised or waived for the PRA pathway.
- → Expand the opportunities for ITPs to practice in Canada under supervision to maintain currency.
- → Expand regulated Physician Assistant/Clinical Assistant/Associate Physician roles to jurisdictions where they do not exist, and structure these roles as bridges to PRA.
- → Standardize acceptance of Physician Assistant/Clinical Assistant/Associate Physician experience as eligible recency for PRA.

5. Support post-assessment integration supports

- → Support PRA programs to develop or adapt and implement robust post assessment practice integration programs.

6. Establish a Federal-provincial-territorial (FPT)-mandated fund to support provincial and pan-Canadian efforts to scale and enhance PRA

- → Establish a federal fund for scaling and enhancing Practice Ready Assessment programs, with an FPT mandate to support the scaling of PRA programs across Canada.

Contents

I. PRACTICE READY ASSESSMENT: A KEY PART OF THE SOLUTION TO THE FAMILY PHYSICIAN SHORTAGE 6

II. WHAT IS PRACTICE READY ASSESSMENT? 8

III. BENEFITS OF PRACTICE READY ASSESSMENT: THE CASE FOR EXPANSION..... 10

Cost and Time Effective..... 10

Frees up residency training positions for those who need them 11

Fills shortages in underserved communities 11

IV. SCALING PRA: CHALLENGES AND SOLUTIONS ... 12

Barriers to assessor recruitment: Increasing the supply of assessors and assessment sites 12

Fragmented information and intake: Improving efficiency through a centralized portal for information and applicant intake 15

Evidence-based eligibility: Addressing lack of standard eligibility requirements 17

Removing barriers: Addressing recency of practice 18

Post assessment: Supporting successful integration of PRA candidates into practice 21

Federal Role: Supporting pan-Canadian and provincial PRA efforts with federal funds 22

V. SUMMARY OF RECOMMENDATIONS 23

Bibliography 26


Hair Mineral

I. PRACTICE READY ASSESSMENT: A KEY PART OF THE SOLUTION TO THE FAMILY PHYSICIAN SHORTAGE

Canada has a primary care crisis with 6.5 million Canadians lacking access to a family doctor.[1] Waiting for medical care is reported to cost Canadians $5.2 billion in lost wages annually.[2] Family physician shortages are due to a variety of factors including the aging of Canada's physician workforce and declining interest among physicians and medical students to practice family medicine, which is largely attributed to the administrative burden that family doctors are facing. At the same time our population is aging and patient care needs are increasingly complex.[3]

Many solutions are needed to address the primary care crisis quickly, including increasing the provision of primary care by non-physicians such as pharmacists and nurses, identifying ways to incentivize practice in family medicine such as by reducing administrative strain, and harnessing technology. One major solution to the family physician shortage is to integrate physicians who trained abroad and are already living in Canada, supporting them to obtain licenses to practice here. Canada is well behind its peers in harnessing the talents of its internationally trained physicians. For example, half of family physicians in the United Kingdom are internationally trained, compared to about one-quarter in Canada.[4]

Internationally trained physicians encompass different groups, and it is important to distinguish between them in considering the most efficient pathways to licensure in Canada. There are those who have completed a medical degree abroad but have not completed residency training or practiced independently. This includes both immigrants to Canada who obtained their medical degree abroad and Canadians who went abroad to study medicine. However, there is another large group of physicians trained abroad: those who have done postgraduate residency training, practiced independently abroad, and immigrated to Canada. These Canadian citizens or permanent residents often have significant experience practicing medicine independently overseas. This population of internationally trained physicians (ITPs) is an essential part of the solution to Canada's current family physician shortage and has always played an important role in sustaining Canada's physician workforce.

Because of significant data collection limitations, there is no current and authoritative figure on the number of ITPs in Canada not licensed to practice here, but best estimates suggest the figure is in the thousands.

---

[1]Pham and Kiran, *More than 6.5 million adults in Canada lack access to primary care.*

[2]Moir, *The Private Cost of Public Queues.*

[3]The College of Family Physicians of Canada, *Crisis in Family Medicine*; Richardson and Hussain, *Proof Point: Canada needs more doctors–and fast*; Ontario College of Family Physicians, *More Than Four Million Ontarians Will Be Without a Family Doctor by 2026*; Zhang, *The Doctor Dilemma*; Canadian Federation for Independent Business, Patients before Paperwork.

[4]Zhang, *The Doctor Dilemma*; Medical Council of Canada, *A pan-Canadian milestone*.



Practice Ready Assessment (PRA) is a faster and more cost-effective alternative to medical residencies for eligible ITPs who have completed residency training and practiced independently in another country, while also diverting these ITPs out of the residency training system and freeing up these training spaces for those who require them. However, despite the recent establishment of new PRA programs in provinces that did not previously have them, access to PRA is still extremely limited.

In 2025, the Medical Council of Canada reported that a total of 1,500 ITPs have become licensed through PRA since 2018, when the Medical Council of Canada launched the National Assessment Collaboration (NAC) PRA framework. While the number of PRA programs available across Canada has grown in the past five years, with 338 physicians entering practice through PRA in 2024/2025 (including both family medicine and specialties), this figure is still low considering that Canada needs over 4,300 additional family physicians today to ensure that a family physician is available to all Canadians, assuming the average family physician sees about 1,500 patients per year.

Addressing the challenges limiting the potential of PRA to scale to its full potential is a crucial element in meeting Canada's family physician and primary healthcare needs. This report will explore why PRA for experienced internationally trained physicians as a licensure pathway to family medicine is currently limited and will offer recommendations to address the challenges that are constraining Canada's ability to increase the licensure of ITPs through PRA. While expanding PRA for specialists is equally important given the extreme shortages in many key specialties, this report focuses specifically on PRA for family medicine and does not address PRA for specialists.

To understand the limitations hindering the scaling of PRA for family medicine, an extensive literature review was completed and complemented by insights shared by 18 key stakeholders in interviews conducted in 2025/26. Respondents are from organizations in Nova Scotia, Quebec, Ontario, Saskatchewan, Alberta, Manitoba, and British Columbia as well as national organizations. They include licensed physicians with experience supervising PRA, ITPs themselves, licensing bodies, researchers, and associations that support ITPs.

II. WHAT IS PRACTICE READY ASSESSMENT?

There are two paths for physicians trained abroad to become licensed to practice family medicine in Canada: family medicine residency training and practice ready assessment.

For those international medical graduates who have not completed post graduate residency training abroad and practiced medicine independently outside of Canada, completing a two-year family medicine residency program in Canada remains the standard, and often the only, pathway towards becoming a family physician in Canada. Upon completing Medical Council of Canada exams, demonstrating language proficiency and meeting recent practice experience requirements, many of those pursuing family medicine training apply through the Canadian Residency Matching Service (CaRMS) process to obtain one of the limited number of residencies specifically available to international graduates.

Obtaining a residency is challenging for a variety of reasons. Principal among these is the fact that the number of candidates exceeds the number of spots available to internationally trained physicians. For those who don't obtain a spot, this is usually where their medical licensing process comes to a halt.

For ITPs who have already completed residency training and practiced medicine independently abroad, the training process is largely redundant. For these experienced ITPs, a second, less common option exists – Practice Ready Assessment (PRA). This path enables eligible ITPs who have already undertaken residency training abroad, and have independent practice experience in other jurisdictions, to undergo a workplace-based clinical competency assessment, generally lasting 12 weeks, though there is some variation in duration among provinces. During this period, candidates practice under the direct supervision of a trained PRA assessor - an experienced physician who evaluates their clinical competence using a standardized pan-Canadian assessment framework to ensure they meet the rigorous safety and quality standards required to practice medicine independently in Canada.

Once the ITP successfully passes the PRA, demonstrating that they are competent to practice family medicine in Canada safely and effectively, they are then eligible to practice under a form of provisional license. In most provinces they have a pathway to full licensure. Processes vary between provinces in terms of the pathway to a full independent license, involving completing a mandatory period of service in a specific community or workplace under a Return of Service Agreement or sponsored employment contract, and meeting other certification requirements of the provincial medical regulatory college.

PRA has been available in various forms since the 1970s in Quebec, since 2002 in Alberta, and became available in Nova Scotia, Saskatchewan, Manitoba, and British Columbia, between 2009 and 2015. The introduction of the National Assessment Collaborative (NAC) framework in 2018 was a significant milestone in standardizing the assessment methodology of PRA across Canada, to ensure the consistent application of assessment while maintaining high standards for patient safety. PRA was introduced in Ontario, New Brunswick and Newfoundland & Labrador in 2023 and is now available in every jurisdiction except for Prince Edward Island and the three territories.

There is wide variation in the numbers of ITPs assessed each year in each program. For example, Nova Scotia aims to assess approximately 45 ITPs a year through its newly established model of a single dedicated central assessment clinic, while Ontario's PRA pilot aims to assess 100 in its first 2 years. In Alberta's model ITPs apply to jobs sponsored by all types of health delivery providers across the province, with numbers varying year to year depending on the number of sponsored positions available.

In 2025, 159 full PRAs were initiated in Alberta.[5] The New Brunswick PRA launched in 2023 aims to conduct 14 assessments annually.[6] There is currently no centralized database of PRA candidates, making tracking of numbers challenging. Accurate numbers are difficult to obtain from publicly available data.

As each program has evolved differently across Canada in response to provincial mandates and circumstances, there is significant variation in the way programs are governed, managed and delivered, as well as in their eligibility requirements. This creates both opportunities and challenges for considering how best to scale PRA nationally.

Core to all PRA programs is workplace-based clinical assessment based on the National Assessment Collaborative's PRA methodological framework, based on a 12-week guideline.[7] As well, in all provinces except Alberta where ITPs obtain sponsored employment positions, successful PRA candidates are required to complete a mandatory Return of Service (ROS), agreeing to practice for a specified period, typically 3 years, in a high-need or rural community.

Programs across the country are managed under a variety of partnership or collaborative structures, usually involving some combination of the provincial medical regulatory college, medical educators, provincial health ministries/health authorities, professional associations and sponsoring organizations.

[5] College of Physicians and Surgeons of Alberta Annual Report 2025

[6] College of Physicians and Surgeons of Alberta, CPSAs *Accelerated Route to Registration* CBC News; New Model for Licensing International Docs; Government of New Brunswick, *More Internationally Trained Physicians Providing*

[7] In Alberta, PRA for ITPs from approved jurisdictions is 12 weeks, with an additional 12 weeks for those from unapproved jurisdictions. (respondent interview). In the Nova Scotia PACE model, candidates may complete demonstration of the required competencies, or be exited unsuccessfully from the assessment, in fewer than 12 weeks. (respondent interview)

III. BENEFITS OF PRACTICE READY ASSESSMENT: THE CASE FOR EXPANSION

The business case for PRA is clear. It is a highly efficient, affordable means for quickly integrating qualified internationally trained physicians into our family physician workforce. The return on investment is almost immediate, shrinking the number of Canadians without access to a physician, and creating positive social and economic impact in their communities. Fully scaling PRA by increasing its capacity and enhancing its delivery also leverages the reality that, as a country of immigration, ITPs are now, have always been, and will continue to be a key element of Canada's physician workforce.

Cost and Time Effective

PRA programs utilize a cost-recovery model supported by a combination of government funding and candidate fees.[8] In Alberta, for instance, the cost per candidate is approximately $35,000, and in Manitoba, it is roughly $30,000.[9] By way of comparison, it costs an estimated $340,000 per two-year medical residency with training costs and the salaries of residents factored in.[10] In other words, it is ten-times faster and ten-times more cost-effective for an ITP to undergo a family medicine Practice Ready Assessment than to complete family medicine residency training in Canada. This means that PRA has the potential to significantly increase the supply of ITPs independently licensed in Canada while decreasing licensing costs that Canadian taxpayers currently subsidize through medical residencies.

PRA has other financial benefits to ITPs and to the public purse. Consider that the average income for a family physician is $324,000 per year compared with about $70,000 per year for a medical resident.[11] PRA allows ITPs to earn a physician's salary more quickly, contributing to the economy as a purchaser and a taxpayer. There are also significant fiscal benefits of providing Canadians with more primary and preventative care as well as alleviating the financial costs Canadians experience due to excessive wait times. The overall benefit to the local economy of being able to provide healthcare to its residents is also key. The lack of access to healthcare in many underserved communities has a significant impact on their ability to remain viable and to attract new residents and businesses.

---

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

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

[10] Kutcher et. al, *Maximizing Medical Talent*.

[11] Canadian Institute for Health Information, *A profile of physicians in Canada*; Canadian Resident Matching Service, *Salary*.



Frees up residency training positions for those who need them

Another major benefit of PRA is that it diverts those ITPs who do not require additional training out of the residency training system. It addresses the redundancy of requiring an ITP to complete a Canadian medical residency when they have already graduated from a medical residency overseas. This creates the additional advantage of increasing access to medical residencies for both Canadian and international medical graduates who do require residency training. In 2025, nearly 5,000 Canadian-trained and internationally trained candidates submitted residency applications and nearly 3,900 were matched with a residency,[12] leaving some 1,100 candidates – the majority of whom are internationally trained – without a training position.

Fills shortages in underserved communities

PRA is increasing the supply of family physicians in smaller and rural communities across Canada that are currently underserved, as ITPs who successfully complete a PRA (in all provinces except Alberta) are required to work in communities designated as underserved through an RoS agreement. British Columbia's PRA, for instance, has placed over 360 family physicians in 78 underserved communities across the province since 2015.[13] As of 2024, Saskatchewan had 307 doctors practicing in the province through their PRA program, 74 per cent of whom were practicing in rural communities.[14]

---

[12] Canadian Resident Matching Service, *2025 Annual Report; 2025 CaRMS Forum.*

[13] Practice Ready Assessment - British Columbia.

[14] Government of Saskatchewan, *More Doctors Recruited to Rural Saskatchewan*

IV. SCALING PRA: CHALLENGES AND SOLUTIONS

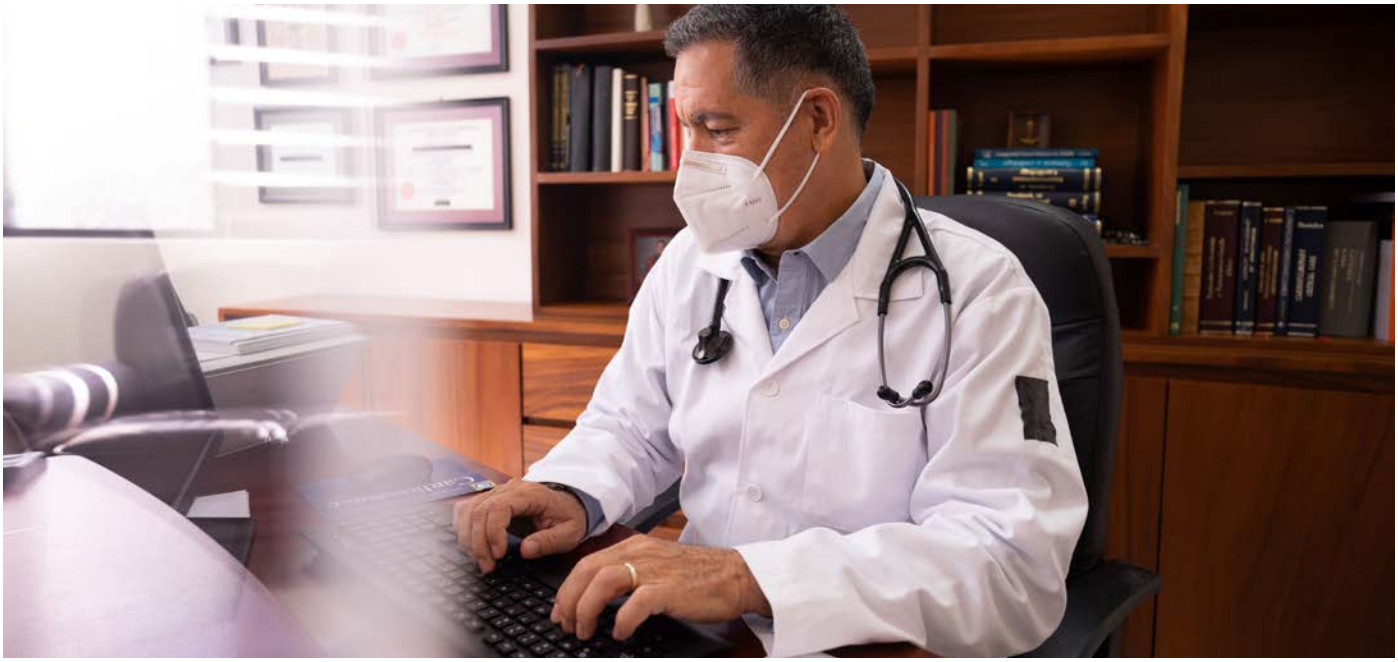
A number of challenges that impact both the ability to scale and the overall efficiency and equity of PRA were identified by interviewees, and a range of potential solutions emerged. Some of the solutions would directly increase the ability to scale, while others could contribute significantly to efficiency, evidence-based policies, and equity. The following section explores these challenges and solutions and presents recommendations.

Barriers to assessor recruitment: Increasing the supply of assessors and assessment sites

Providing an assessment space requires resources. At a minimum it requires a qualified assessor and the resources to compensate them; access to adequate physical clinic space to accommodate patients, assessors and candidates; and administrative and technological supports to run the PRA program and to support the assessors.

A major bottleneck in scaling PRA nationally is the challenge of recruiting a sufficient number of qualified, willing, and available assessors. Each PRA space requires a trained and qualified assessor – a licensed physician who is currently seeing patients with whom the candidate can be assessed. This shortage of assessors is constraining the capacity of PRA programs.

According to interviewees, most current PRA models are struggling with assessor recruitment and retention because the work of assessment creates additional responsibilities for family physicians who are already balancing demanding clinical practices, heavy administrative workloads, and in some cases, are already supervising medical residency trainees. According to some interviewees, the incentives, compensation and supports offered to physicians to serve as assessors are often not sufficient to offset the considerable time commitment for assessor training and assessment tasks, as well as the added legal responsibility assessors assume as the supervising physician.



Increasing the Supply of Assessors: adapting what's working

Delivery models for PRA vary considerably across provinces depending on provincial regulatory requirements, funding contexts, geography, and the unique goals defined by government and other stakeholders. Each model presents unique challenges and potential benefits in terms of recruiting assessors and increasing the number of sites. Exploring the models of several provinces can offer insights into what's working and can potentially be adapted across jurisdictions.

A number of promising practices have emerged to address the challenges of assessor recruitment - solutions that with adequate investment and support could be modified and adapted to other jurisdictions.

One example is the Physician Assessment Center of Excellence (PACE) model launched in 2025 in Nova Scotia. This centralized assessment clinic located in Halifax was developed in response to the challenge of assessor recruitment and includes a number of innovations that have increased assessor supply. PACE is a functioning primary care clinic that is a purpose-designed assessment facility. As a purpose designed clinic, PACE can provide a robust range of supports including administration, technological tools, and a system where assessment tasks are distributed among assessors. This creates a supportive community of practice for assessors while providing direct patient care. The model also allows for continuous intake, expediting the number of ITPs who can be assessed.

To date, this centralized clinic model is proving highly effective in attracting assessors. The clinic is largely staffed by assessors who are not in full-time family practice but rather have part-time roles in other settings and work as assessors at PACE from one to four days a week.

While Nova Scotia does not face the issues of large provinces with vast distances and large numbers of remote communities, there are aspects of the centralized assessment clinic model that could potentially be adapted to meet unique needs and goals of other provinces.

By contrast, the new Ontario PRA program, serving a large province with many rural and remote underserved communities, is a cohort-based program which prioritizes assessing candidates in communities and practice settings similar in nature and resources to the underserved communities where the successful ITP candidates will practice while fulfilling their return of service obligations. Assessing candidates in the types of communities where they will practice is core to the model in Ontario and several other provinces. The challenge of recruiting family physicians under this model is that they are often sole practitioners running clinics in small communities and find it difficult to take on additional assessment responsibilities in their overburdened practices. The recruitment benefits of the PACE model could potentially be adapted to other provinces dealing with large distances and more remote communities by establishing a hub and spoke model with dedicated assessment clinics in regional hub communities linked to the smaller/rural underserved communities and practices where successful ITPs will practice during their return of service period.

The Alberta PRA runs on an entirely different model where ITPs first apply for medical positions sponsored by employers. Once selected by an employer, the ITP is referred to the College of Physicians and Surgeons of Alberta which runs the province's PRA program. The Alberta PRA assesses family medicine & all specialties for rural and urban placements for a range of scope and practice types.

From 2015-2024, sponsored positions were only available through the regional health authority. In 2024, the model was expanded to extend sponsorship opportunities beyond the health authority, allowing individuals, organizations, corporations, and others to apply to sponsor a physician position in any community, including in urban areas. This has led to an expansion in both the number of positions available and the number of potential assessors in sponsoring organizations willing to assess candidates who will be employed by other sponsors. Assessors are also incentivized with attractive compensation as well as continuing medical education credits. This expansion, along with the incentive package, has largely eliminated previous challenges in assessor recruitment. Alberta's PRA model has allowed it to initiate over 150 assessments in 2025. While this model operates significantly differently from other provinces, there may be aspects that can be adapted to help scale programs in other provinces.

Several interviewees also suggested exploring the potential of engaging physicians nearing retirement or recently retired. Models could potentially be developed to allow late-career physicians to integrate temporarily into existing practice settings to serve as assessors, or to transfer patients to a specialized assessment clinic as part of a practice wind-down strategy. Incentives for these assessors could include waiving medical registration fees, supporting insurance and other costs, and offering competitive compensation. Government could invest in pilots to develop recruitment, training and support models specifically designed for physicians in the wind-down phases of their careers. Another important source of assessors is ITPs who are now practicing and ready to support the program to help bring other colleagues into practice. These relatively untapped sources of assessors have the potential to significantly increase the capacity of PRA programs.

Recommendations:

→ Support the development, testing, adaptation/modification, and expansion of models that increase the supply of assessors for PRA programs thus allowing programs to increase the number of assessments they can complete annually.

→ Support the necessary physical and technological infrastructure and team-based approaches to allow PRA programs to expand.

Fragmented information and intake: Improving efficiency through a centralized portal for information and applicant intake

Documentation and information

Some elements of PRA, such as assessment guidelines, clinical assessment tools and assessor training are provided to all PRA programs through the National Assessment Collaboration (NAC) PRA Framework administered by the MCC. However, while they operate from a shared assessment framework, Canada's nine PRA programs operate separately and uniquely. Each program has different eligibility requirements, rules, and processes for ITPs to navigate. Each program independently verifies and assesses a candidate's eligibility documentation. This completely decentralized approach creates a substantial burden for applicants and considerable duplication of administrative effort when an applicant applies to programs in more than one province.

Equally challenging for ITPs, information about PRA programs is not centralized. ITPs must access and parse information from nine different PRA program websites, each presenting information in different formats with different update cycles. This creates confusion and slows down the application process for ITPs. Federal dollars have already been invested in a number of tools, housed with different organizations, to help internationally trained physicians navigate the licensure process. These should be fully leveraged and integrated wherever possible to maximize these investments and their impact.

Overall, these challenges around documentation and information provision create inefficiencies for PRA programs across Canada. They reduce accessibility and add application barriers for ITPs, and they create additional administrative burden for PRA programs.

National Data

The absence of a national PRA database means there is no centralized list of all available PRA opportunities nationally and no ability to track unique candidates and which programs they are applying to. This reduces the opportunity to track PRA nationally, and to better align requirements and timelines to both maximize ITP opportunities and ensure that candidates not accommodated in one province can be redirected to another, ensuring that all available PRA positions across jurisdictions are efficiently filled.

Potential solutions

The Medical Council of Canada (MCC)'s existing portal, Physiciansapply.ca, provides a central place for medical students and IMGs/ITPs to apply for MCC examinations, access and share exam results, have their medical credentials source verified, and share their credentials with Canadian medical regulatory authorities and other organizations. Several interviewees recommended that this portal be expanded to verify and facilitate sharing of other required PRA eligibility documentation directly to the programs the ITP is applying to. This could include documentation of language testing results, immigration status, residency training, reference letters, and other required documentation.

Physicians Apply could also potentially be enhanced to direct ITPs to the information and application processes for the specific PRA programs they meet core eligibility criteria for and allow them to share their documentation directly to those programs. This could significantly reduce the time and effort required on the part of ITPs to identify their PRA options and manage their documentation, as well as significantly streamlining and reducing the administrative burden on programs.

This portal could also be enhanced to serve as a national PRA database, allowing for effective data collection and tracking across the country. The success of this enhanced portal would require the engagement of all PRA jurisdictions and of ITP applicants to ensure it meets their needs and accommodates different program models.

Recommendations:

Expand and enhance the MCC's Physicians Apply portal to:

→ Provide a centralized and digitally updated source of information on all PRA programs presented in a comparable and easily navigable format.

→ Direct ITPs to the PRA programs for which they are eligible.

→ Serve as a centralized portal for storage, verification and sharing of all required PRA applicant documentation.

→ Collect data on which PRA programs applicants have applied to and been accepted to.

Evidence-based eligibility: Addressing lack of standard eligibility requirements

Lack of consistency in PRA eligibility

While there is understandable variation in delivery models across provinces due to different provincial contexts, it would be reasonable to expect a significant degree of standardization of eligibility requirements for undergoing a PRA based on solid research evidence. However, there is significant variation in eligibility criteria and requirements across Canada's nine PRA programs. Some provinces require MCC Qualifying exams and/or the National Assessment Collaboration (NAC) Objective Structured Clinical Examination (OSCE). In contrast, the Nova Scotia PRA program does not require either of these assessments as these are not designed for mid-career physicians. Recency of practice, residency training, and independent practice experience eligibility requirements also vary.

As several interviewees pointed out, even in this moment of federal priority on interprovincial labour mobility, PRA eligibility requirements have moved towards increasing variation rather than harmonization. Variations in requirements reflect both the degree to which provinces are competing for physicians, and the lack of a strong evidence base for which requirements predict success in PRA assessments. Both scaling PRA so that there are spots available for all who qualify and improving research evidence on appropriate requirements would help to remove obstacles to increased harmonization of PRA requirements across the country.

While recognizing that provinces wish to maintain flexibility in their PRA delivery models, moving towards clearly justifiable, evidence-based and standardized eligibility criteria remains an important goal. There is a clear need for collaborative national research that would support a common evidence base for eligibility requirements. National standardization of eligibility should encompass all the core requirements. A standardization process could be managed through the National Assessment Collaborative coordinated by the MCC and supported with federal resources as required.

Recommendations:

→ Move towards standardization of evidence-based eligibility requirements for PRA programs across Canada.

→ Undertake collaborative research to gather evidence across PRA programs in Canada and similar programs internationally to support adoption of standardized evidence-based eligibility criteria.



Removing barriers: Addressing recency of practice

Recency of practice requirements deserve particular attention as they create a unique barrier for ITPs, as most are unable to maintain recency once they have settled in Canada.

Currency of practice requirements exist to ensure that physicians maintain current clinical competency and have not experienced prolonged gaps in practice that could compromise patient safety. This applies to Canadian-trained physicians returning to practice as well as newcomers entering mid-career practice in Canada after being away from clinical practice while immigrating and settling in Canada and working towards accessing a licensure pathway. Each provincial regulator has its own recency requirements, with the general criteria being evidence of a minimum number of years of independent medical practice within the last three to five years. Canadian-trained physicians who fall out of currency are generally required to undertake an assessment and remediation program.

The variation in currency requirements across provinces and PRA programs reflects the lack of consensus in the research evidence in relation to the appropriate period of elapsed time before which an assessment is required for any physician (domestically or internationally trained) in any setting who has had a gap in practice, as well as how best to take into consideration years of experience and other factors for a given physician. A systematic research review published in 2023 found that there is no consensus in the research evidence on the length of time away from practice after which a competency assessment should be completed. The study concludes that "factors that need to be taken into consideration in developing ROP standards include length of time away from practice, previous experience, age and the complexity of the intervention, however, there is a need for further research in this area."[15]

Meeting currency criteria is challenging for most ITPs, as time typically elapses in the period following their immigration to Canada, while they and their families are settling and they undertake the exams and other steps required to begin the medical licensure process here. It is common for this transition period to result in ITPs no longer meeting practice currency requirements. There are currently almost no opportunities available for ITPs to maintain recent clinical practice as physicians in Canada, limiting the number of ITPs who can meet this PRA eligibility requirement and reducing the pool of potential PRA candidates. It leaves many ITPs facing the difficult decision to either give up on practicing medicine in Canada or to leave Canada temporarily to practice medicine abroad to meet this criterion – a decision which can result in not only financial hardship, but also family hardship for ITPs leaving their family behind in Canada.

Three types of solutions were proposed by interviewees to address the recency barrier that many ITPs face: waive or revise the recency criteria; create clear and accessible opportunities for ITPs to maintain currency after arriving in Canada; and provide temporary work permits to mITPs who have not yet immigrated so they can undertake a PRA before immigrating.

[15] Main and Anderson, *Evidence for recency of practice.*

Waiving recency for the PRA pathway

One potential way of addressing currency of practice barriers is by seeking a consensus among provincial regulators to waive the recency requirement for ITPs going through the PRA pathway. The argument for this rests on the fact that currency of practice requirements are meant to ensure safe practice following a period of interruption of practice. Some interviewees argue that the recency requirement is redundant in the case of PRA because the workplace-based evaluation the programs conduct is, by definition, a competency-based assessment designed to determine whether an experienced ITP who has practiced in another jurisdiction is currently competent to practice medicine safely in Canada. It is arguably redundant therefore to include recency as an eligibility criterion for the PRA pathway. Given the absence of opportunities for physicians who have immigrated to Canada to maintain recent clinical practice here, and the fact that the ITPs going through PRA will, by definition, be assessed for current competency, some interviewees have argued that recency requirements are not appropriate for this licensure pathway.

Others however, argued that there is some evidence for the value of recency in predicting which candidates will successfully demonstrate competency in an assessment. Suggestions to reform recency requirements in line with the research included considering the total years/hours of clinical experience in combination with the time elapsed since practice. This would address the current more arbitrary criteria requiring that clinical experience must have been obtained in a continuous period or within the preceding 3-5 year period, regardless of the number of years of experience the ITP has, or other evidence-based factors identified in the research.

Creating opportunities for ITPs living in Canada to maintain currency:

There are several potential ways to make it possible for ITPs to maintain currency. One is to create opportunities for them to practice for periods of time under provisional/supervised licenses. There is precedent for this type of approach in nursing. Ontario, for example, has established the Supervised Practice Experience Program through which internationally educated nurses who have met all other licensure requirements are given the opportunity to meet recent/safe practice hours requirements through paid supervised clinical placements.

Regulators and medical educators could also consider ways in which regulated clinical assistant or associate physician roles and other forms of supervised experience in clinical settings could be formally structured to bridge toward fulfilling the recency requirements. Several PRA programs already accept this experience in support of recency of practice eligibility requirements and this could be standardized across programs.

Recommendations:

→ Undertake collaborative national research to develop evidence to inform appropriate recency requirements. Use this evidence to determine whether recency should be revised or waived for the PRA pathway.

→ Expand the opportunities for ITPs to practice in Canada under supervision to maintain currency.

→ Expand regulated Physician Assistant/Clinical Assistant/Associate Physician roles to jurisdictions where they do not exist, and structure these roles as bridges to PRA.

→ Standardize acceptance of Physician Assistant/Clinical Assistant/Associate Physician experience as eligible recency for PRA.



Post assessment: Supporting successful integration of PRA candidates into practice

Many interviewees pointed to the need to fund, develop and scale the proven integration supports that help ITPs to be successful in the communities they will practice in following their assessment. These interventions include: mentorship; peer support networks: continuing education; integration supports for the physician's family; and diversity, inclusion and anti-racism initiatives in the receiving community. Interviewees pointed to the Saskatchewan PRA as a strong model for post assessment supports. While not directly related to scaling PRA, many argued that these supports are essential to the success of PRA candidates, and to the potential for retaining them in communities following their mandatory return of service or sponsored employment. Attraction and retention of physicians in rural and remote underserved communities is a problem that cannot ultimately be solved by mandatory return of service, and many have challenged the equity of requiring it only of ITPs, but supporting ITPs to succeed in underserved communities may increase the likelihood that they will stay.

Recommendations:

→ Support PRA programs to develop or adapt and implement robust post assessment practice integration programs.



Federal Role: Supporting pan-Canadian and provincial PRA efforts with federal funds

Provincial governments in nine provinces across Canada have funded and supported the establishment of PRA programs, each developing innovative approaches to their unique contexts. Solving the challenges PRA programs and ITP candidates face and fully leveraging the opportunities for scaling PRA requires funding, collaboration, coordination and leadership. As a 2025 report by a group of Canadian Senators argued,[16] there is a clear role for the federal government to play in supporting provinces and national medical organizations to continue to develop, test, adapt, and scale the implementation of solutions to fully leverage the potential of PRA to help solve our family physician shortages across Canada.

The integration of immigrant physicians into Canada's physician workforce crosses the mandates of several federal departments including Health Canada, ESDC, IRCC, and Labour. Federal-provincial-territorial (FPT) tables grappling with Canada's health workforce challenges are jointly seeking solutions. The recommendations laid out in this report can help move the needle on expanding the number of family physicians providing primary care across Canada, not only in rural and remote communities, but in Canada's cities. Federal resources could be put behind their implementation by establishing a federal fund, mandated by the appropriate FPT tables, and directed by the relevant ministries.

This fund to scale and enhance PRA programs would provide support to provinces, PRA programs, regulators, national medical bodies and ITP organizations to move very targeted initiatives forward. It could be structured to incentivize inter-provincial and inter-organizational collaboration, pan Canadian harmonization of standards and requirements, and adaptation of what's working to different contexts.

It could support:

- Direct costs of scaling on a sustainable basis: e.g. assessor compensation, physical infrastructure and assessment technology for clinics, creation of dedicated assessment "hub" clinics for hub and spoke delivery models.
- Improving delivery: start up and sustaining funding for delivery improvements e.g. expansion of current capacity for central intake, referral, applicant documentation and info hub.
- Harmonizing/standardizing program eligibility e.g. national research to produce evidence for eligibility criteria; updating of MCC NAC PRA standards.

Recommendations:

→ Establish a federal fund for scaling and enhancing Practice Ready Assessment programs, with an FPT mandate to support the scaling of PRA programs across Canada.

[16] Kutcher and Ravalia, *Resolving Canada's doctor crisis*

V. SUMMARY OF RECOMMENDATIONS

Canada's primary care crisis demands urgent action. With 6.5 million Canadians lacking a family doctor and an estimated need for over 4,300 additional family physicians, Canada cannot afford to overlook the substantial reservoir of talent represented by ITPs. The current system wastes resources and human potential by underutilizing ITPs when a fast and cost-effective solution exists.

PRA represents a proven solution that is faster and more cost-effective than requiring experienced ITPs to redo residency training and compete for limited residency spaces. The PRA track record demonstrates both feasibility and impact. The potential contribution PRA could make to addressing physician shortages is being dramatically under-leveraged, at tremendous cost to those Canadians unable to access care by a family physician.

The barriers preventing the scaling of PRA are neither insurmountable nor inevitable. The recommendations outlined in this report provide a roadmap for solving barriers to scaling and enhancing program efficiency by investing in: exploring new models and adapting current ones to increase assessor supply; centralizing information provision and administrative elements of the application intake process; standardizing and reforming candidate eligibility criteria including recency of practice based on solid evidence; and supporting post assessment integration. All of this can be achieved by unlocking federal investment to support scaling up assessment numbers.

Scaling PRA nationally requires political will and strategic investment, coordinated action, and collaboration across federal and provincial governments, regulatory colleges, healthcare authorities, and the ITP community itself. Far exceeding the investment needed to unlock this solution are costs of inaction measured in economic losses, delayed care, and continued physician shortages across Canada. Those impacted most are patients struggling to find accessible healthcare while this rich resource of experienced ITPs settled in Canada remains untapped. Canada has the resources and the ITP candidates ready to help address its primary care crisis. What is required now is the commitment to remove barriers and accelerate this pathway for ITPs to serve patients in Canada.

1. Increase scale by increasing the supply of assessors and assessment sites

- → Support the development, testing, adaptation/modification, and expansion of models that increase the supply of assessors for PRA programs and allow programs to increase the number of assessments they are able to complete annually.
- → Support the necessary physical and technological infrastructure and team-based approaches to allow PRA programs to expand.

2. Improve efficiency through a centralized applicant documentation portal

Expand and enhance the MCC's Physicians Apply portal to:

- → Provide a centralized and digitally updated source of information on all PRA programs presented in a comparable and easily navigable format.
- → Direct ITPs to the PRA programs for which they are eligible.

- → Serve as the digital wallet for all required PRA applicant documentation including storage, verification and sharing of all documentation.
- → Collect data on which PRA programs applicants have applied to and been accepted to.

3. Standardize evidence-based eligibility requirements

- → Move towards standardization of evidence-based eligibility requirements for PRA programs across Canada.
- → Undertake collaborative research that would gather evidence across PRA programs in Canada and similar programs internationally to support adoption of standardized evidence-based eligibility criteria.

4. Address recency of practice barriers

- → Undertake collaborative national research to develop evidence to inform appropriate recency requirements. Use this evidence to determine whether recency should be revised or waived for the PRA pathway.
- → Expand the opportunities for ITPs to practice in Canada under supervision to maintain currency.
- → Expand regulated Physician Assistant/Clinical Assistant/Associate Physician roles to jurisdictions where they do not exist, and structure these roles as bridges to PRA.
- → Standardize acceptance of Physician Assistant/Clinical Assistant/Associate Physician experience as eligible recency for PRA.

5. Support post assessment integration supports

- → Support PRA programs to develop or adapt and implement robust post assessment practice integration programs.

6. Establish an FPT-mandated fund to support provincial and pan-Canadian efforts to scale and enhance PRA

- → Establish a federal fund for scaling and enhancing Practice Ready Assessment programs, with an FPT mandate to support the scaling of PRA programs across Canada.

Acknowledgments

This report was authored by Joan Atlin, Principal, Atlin Consulting; Kareem El-Assal, Principal, El-Assal Insights; and Victoria Ogley, Researcher. All authors were affiliated with the Global Migration Institute, Toronto Metropolitan University, for this report. The authors thank those who commented on earlier drafts of the report. Any errors and omissions belong to the authors alone.


Ritter
by MIDMARK

Bibliography

ACCES Employment, *Health English Language Pro (HELP)*. ACCES Employment, December 2026. https://accesemployment.ca/programs/bridging-and-sector-specific-programs/help-program (accessed: January 11, 2026)

Adegoke, Kola, Abimbola Adegoke, Deborah Dawodu, and Temitope Kayode, Systemic Racism in Canadian Healthcare: A Policy and Equity Analysis. *Journal of Primary Care & Community Health* 16 (2025): 1–8. https://doi.org/10.1177/21501319251386672.

Canadian Federation for Independent Business, *Patients before Paperwork*. February 1, 2024. https://www.cfib-fcei.ca/en/research-economic-analysis/patients-before-paperwork (accessed: January 11, 2026).

Canadian Institute for Health Information, *A profile of physicians in Canada*. https://www.cihi.ca/en/a-profile-of-physicians-in-canada (accessed: January 11, 2026).

Canadian Resident Matching Service, *2025 Annual Report*; https://www.carms.ca/pdfs/2025-AR-EN.pdf (accessed: January 11, 2026).

Canadian Resident Matching Service, *2025 CaRMS Forum*. https://www.carms.ca/pdfs/carms-forum-2025.pdf (accessed: January 11, 2026).

Canadian Resident Matching Service, *Salary*. https://www.carms.ca/match/r-1-main-residency-match/salary/ (accessed: January 11, 2026).

Canadian Resident Matching Service, *Unfilled positions after the 2026 Family Medicine Match.* https://www.carms.ca/pdfs/Rhp37kwf4xg_FMES_OverviewByDiscipline_EN.pdf (accessed: January 11, 2026).

College of Physicians and Surgeons of Alberta, *CPSA's Accelerated Route to Registration* https://cpsa.ca/news/cpsas-accelerated-route-to-registration-looking-back-on-the-first-year-of-the-pilot/ (accessed: June 4, 2026)

College of Physicians and Surgeons of Ontario, *Practice Ready Assessment Program*. https://www.cpso.on.ca/en/Physicians/Registration/Registration-Policies/Practice-Ready-Assessment-Program (accessed: January 11, 2026).

COPSIPE, *Discrimination*. Canadian On Paper Society for Immigrant Physicians Equality. https://www.canadianonpaper.com/facts (accessed: January 25, 2026)

Government of Saskatchewan, *More Doctors Recruited to Rural Saskatchewan, August 28, 2024* https://www.saskatchewan.ca/government/news-and-media/2024/august/28/more-doctors-recruited-to-rural-saskatchewan (accessed June 11, 2026)

Government of Ontario, *Ontario Adding 100 New Family Doctors in Rural and Northern Communities*. December 4, 2024. https://news.ontario.ca/en/release/1005450/ontario-adding-100-new-family-doctors-in-rural-and-northern-communities (accessed: January 11, 2026).

Government of New Brunswick: More Internationally trained physicians provide care for New Brunswickers, May 1, 2026. https://www.gnb.ca/en/news/n-b.2026.05.more-internationally-trained-physicians-provide-care-for-new-brunswickers.html (accessed June 4, 2026)

Grant, Taryn, *New Model for Licensing International Doctors Starts Slow, Poised to Ramp Up*. CBC News, December 3, 2025. https://www.cbc.ca/news/canada/nova-scotia/new-model-for-licensing-international-docs-off-to-a-slow-start-9.7001749 (accessed: January 25, 2026).

Jones, Ryan Patrick, *Physicians sound alarm over unfilled Ontario residency spots*. CBC: March 24, 2024. https://www.cbc.ca/news/canada/toronto/ontario-family-doctor-residents-shortage-1.7151071 (accessed: January 11, 2026).

Khan, Ahmar, *Foreign doctors ready to help are 'sidelined' by regulation, experts say*. Global News: November 13, 2021. https://globalnews.ca/news/8369003/foreign-doctors-ready-to-help-sidelined-by-regulations-expert-says/ (accessed: January 11, 2026).

Kutcher, Stan, Mohamed-Iqbal Ravalia, Ratna Omidvar, and Kareem El-Assal, *Maximizing Medical Talent: How Canada can increase the supply of family doctors by 50% quickly and cost-effectively*. October 2024. https://section95.com/wp-content/uploads/2024/09/Maximizing-Medical-Talent-October-2024.pdf (accessed: January 11, 2026).

Kutcher, Stan and Mohamed-Iqbal Ravalia, Resolving Canada's doctor shortage crisis. SenCA+ Magazine. June 13, 2025. https://sencanada.ca/en/sencaplus/opinion/resolving-canada-s-doctor-shortage-crisis-senators-kutcher-and-ravalia/ (accessed: February 2, 2026).

Main, Penelope Ann Elizabeth and Sarah Anderson, *Evidence for recency of practice standards for regulated health practitioners in Australia: a systematic review*. Human Resources for Health: 21:14, February 24, 2023. https://pmc.ncbi.nlm.nih.gov/articles/PMC9951142/ (accessed: January 27, 2026).

Medical Council of Canada. *NAC Examination*. https://mcc.ca/examinations-assessments/nac-examination/ (accessed: January 11, 2026).

Medical Council of Canada, *2024-2025 Annual Report*. https://mcc.ca/wp-content/uploads/2024-2025-MCC-Annual-Report.pdf (accessed: January 11, 2026).

Medical Council of Canada, *2023-2024 Annual Report*. https://mcc.ca/wp-content/uploads/2023-2024-MCC-Annual-Report.pdf (accessed: January 11, 2026).

Medical Council of Canada, *2022-2023 Annual Report*. https://mcc.ca/wp-content/uploads/MCC-Annual-Report-2022-2023.pdf (accessed: January 11, 2026).

Medical Council of Canada, *Pathways for international medical graduates*. https://mcc.ca/credentials-and-services/pathways-to-licensure/pathways-for-international-medical-graduates/ (accessed: January 11, 2026).

Medical Council of Canada, *Practice-Ready Assessment*. https://mcc.ca/examinations-assessments/practice-ready-assessment/ (accessed: January 11, 2026).

Medical Council of Canada, *Your services portal: physiciansapply.ca*. https://mcc.ca/credentials-and-services/services/ (accessed: January 11, 2026).

Moir, Mackenzie, *The Private Cost of Public Queues for Medically Necessary Care, 2025*. Fraser Institute, 2025. https://www.fraserinstitute.org/sites/default/files/2025-05/private-cost-public-queues-for-medically-necessary-care-2025.pdf (accessed: January 11, 2026).

Naik, Viren. *Spotlight on Practice-Ready Assessments*. Health Insight. https://www.healthinsight.ca/innovations/careers-health-care/spotlight-on-practice-ready-assessments/ (accessed: January 11, 2026).

Nova Scotia. *New Centre for Internationally Trained Physicians Now Open*. news.novascotia.ca, February 26, 2025. https://news.novascotia.ca/en/2025/02/26/new-centre-internationally-trained-physicians-now-open (accessed: January 25, 2026).

Ontario College of Family Physicians, *More Than Four Million Ontarians Will Be Without a Family Doctor by 2026*. November 7, 2023. https://ontariofamilyphysicians.ca/news/more-than-four-million-ontarians-will-be-without-a-family-doctor-by-2026/ (accessed: January 11, 2026).

Ontario Medical Association, *Ensure every Ontarian has a family doctor*. https://www.oma.org/advocacy/we-wont-give-up/?shpath=/priorities/ensure-every-ontarian-has-a-family-doctor (accessed: January 11, 2026).

Physician Assessment Centre of Excellence. *How PACE Works*. PACE. https://nspace.ca/about-us/how-pace-works/ Accessed January 25, 2026.

Pham, Thuy-Nga and Tara Kiran, *More than 6.5 million adults in Canada lack access to primary care*. Healthy Debate, March 14, 2023. https://healthydebate.ca/2023/03/topic/millions-adults-lack-canada-primary-care/ (accessed: January 11, 2026).

Practice Ready Assessment - British Columbia. https://www.prabc.ca/ (accessed: January 11, 2026).

Raza, Kashif, *Report Highlights Systemic Discrimination against International Medical Graduates in Canada*. Healthy Debate, February 25, 2025. https://healthydebate.ca/2025/02/topic/report-systemic-discrimination-international-medical-graduates-canada/ (accessed: January 26, 2026).

Raza, Kashif, *Canada's Medical System Is Failing Immigrant Doctors*. Canadian Immigrant, May 5, 2025. https://canadianimmigrant.ca/careers/canadas-medical-system-is-failing-immigrant-doctors-study (accessed: January 25, 2026).

Richardson, Ben and Yadullah Hussain, *Proof Point: Canada needs more doctors–and fast*. RBC: November 23, 2022. https://www.rbc.com/en/economics/canadian-analysis/featured-analysis/insights/proof-point-canada-needs-more-doctors-and-fast/ (accessed: January 11, 2026).

The College of Family Physicians of Canada, *Crisis in Family Medicine*. https://www.cfpc.ca/en/policy-innovation/our-advocacy/crisis-in-family-medicine (accessed: January 11, 2026).

The Suburban, *13,000 foreign-trained doctors in Canada aren't allowed to practice*. March 1, 2023. https://www.thesuburban.com/opinion/letters_to_editor/13-000-foreign-trained-doctors-in-canada-aren-t-allowed-to-practice/article_49e4d241-8dd3-58a2-bbdc-7c76344455d5.html (accessed: January 11, 2026).

World Education Services, *Expanding Pathways to Licensure for Internationally Trained Physicians in Ontario: How to Get There and Why It Matters*. January 2023. https://knowledge.wes.org/canada-report-expanding-pathways-to-licensure-for-internationally-trained-physicians-in-ontario.html (accessed: January 11, 2026).

World Education Services, *Internationally Educated Health Professionals an Untapped Resource in Ontario*. May 3, 2021. https://www.wes.org/announcements/iehp-untapped-resource-in-ontario/ (accessed: January 11, 2026).

Zhang, Tingting, *The Doctor Dilemma: Improving Primary Care Access in Canada*. C.D. Howe Institute: May 2024. https://www.cdhowe.org/sites/default/files/2024-05/Commentary_660.pdf (accessed: January 11, 2026).

Toronto Metropolitan University

Global Migration Institute