Explaining Unequal Access to the Medical Profession: Licensing Policies for Immigrant Physicians in Canada and the United Kingdom



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LIST OF ABBREVIATIONS

CaRMS	Canadian Resident Matching Service
CFPC	College of Family Physicians Canada
FMRAC	Federation of Medical Regulatory Authorities Canada
GMC	General Medical Council
LMCC	Licentiate of the Medical Council of Canada
MCC	Medical Council of Canada
MCCQE	Medical Council of Canada Qualifying Examination
NAC OSCE	National Assessment Collaboration Objective Structured Clinical Examination
NHS	National Health Service
RCGP	Royal College of General Practitioners
UKVI	United Kingdom Visas and Immigration
WFME	World Federation for Medical Education

Abstract

While the Global North increasingly relies on internationally trained family physicians to address labour shortages, countries diverge in their licensing policies and control over access to the medical profession. This thesis analyses the causes of internationally trained family physicians' licensing policy divergence between Canada and the United Kingdom. Both countries attract a significant number of internationally trained family physicians, yet access to the medical profession differs. I argue that different institutional arrangements determine the entry and alignment of licensing actors to influence the policy making process, thereby shaping the extent of professional closure by the medical profession. Using theory testing process tracing, I demonstrate that Canada's federalist system permits greater and more powerful veto points to crowd out other actors, thus retaining a high degree of professional closure. In contrast, the UK's unitary state enables greater interaction with other actors involved in ITFPs' policy making process, resulting in fewer veto points and less dominance by the medical profession to inhibit professional closure.

1. Introduction

Occupational regulation, particularly for highly specialised professions, is a key feature of modern labour markets (Tani, 2018). Licensure is the toughest form of regulation, providing individuals with the "right to practise" (Kleiner and Vorotnikov, 2017). Licensure refers to "the ability to practise medicine based on governmental regulations," including credential recognition (Maddock *et al*., 2023, p. *4*).

To manage healthcare personnel shortages, the Global North increasingly relies on internationally trained family physicians (ITFPs) (Brennan *et al.*, 2023). ITFPs are physicians that have completed their medical education outside the country they intend to practise. While their education enables them to migrate, divergent ITFP licensure policies restrict their opportunities to practice medicine. Some countries hold ITFPs to different licensing standards than domestically educated physicians, whilst other countries grant licences to ITFPs more easily (Neiterman *et al*., 2015). This topic is particularly significant because mismatches between immigration and licensure contribute to underemployment and skill devaluation (Foster, 2008). Though healthcare and immigration reforms have been pursued intensely in post-industrial societies, health workforce reform has garnered relatively little attention, despite mounting family physician shortages (Nielsen, Dustmann, and Ku, 2023).

The purpose of this thesis is to explore and explain variations in the licensing design for ITFPs in Canada and the United Kingdom, which otherwise share similar aspects of their welfare states. Family physicians have been selected because, compared to specialists, their licensure pathway is less varied across the cases. To standardise comparisons, I focus on recent graduates (i.e., with one-year of post-graduate medical experience) seeking to obtain full registration. Full registration permits ITFPs to unsupervised medical practice (Bourgeault and Grignon, 2013).

While both Canada and the UK have points-based immigration schemes, their licensing paths diverge. This thesis demonstrates that Canada exhibits a more restrictive licensing system compared to the UK. It also puts forward an original explanation of Canada's comparatively restrictive licensure resulting from the greater number and power of veto points, primarily through its devolved regulatory colleges, which crowd out other actors' positions to retain a high

degree of professional closure. In contrast, the UK's centralised licensing process permits greater interaction with other licensing entities, reducing the power of veto points and potential for professional closure.

In this thesis, open and restrictive systems are conceptualised at the nexus of a country's migration and foreign credential recognition policies, marked by three variables: ITFPs' entry, credential recognition, and licensing conditionality. While seldom explored in the social policy literature, this thesis contributes to the literature on internationally educated health professionals. The study adds an institutionalist, explanatory dimension to understand diverging licensure requirements by comparing the ITFP licensing policy making process in both cases. Using theory testing process tracing, I uncover key reforms concerning ITFP licensure since 2021. I leverage policy documents (e.g., reports, white papers), regulatory frameworks, and peer-reviewed literature to trace these reforms.

2. Research Questions

This thesis explores two research questions:

1. ***How do Canada and the United Kingdom differ in the design of their licensure policies for internationally trained family physicians?***
2. ***Why is the United Kingdom's licensing system for internationally trained family physicians more open than Canada's licensing system?***

3. Literature Review

The complexity of ITFP licensure has resulted in a robust literature. The scholarship is interdisciplinary, drawing from sociology, public health, and legal studies, but not explicitly comparative social policy (Turin *et al.*, 2021; Brennan *et al*., 2023). In this literature review, I first introduce ITFPs as skilled migrants. I then examine the extent to which existing explanations account for the drivers of ITFP policy divergence by summarising and critiquing literature concerning migration policies, medical profession dominance, and institutional constraints.

3.1 ITFPs as Skilled Migrants

Advanced capitalist countries grappling with demographic shifts including ageing populations and declining fertility increasingly rely on skilled migrants, namely internationally educated healthcare professionals, to address labour shortages (Cerna and Czaika, 2016). Skilled migrants include individuals with an advanced degree and/or experience in a professional field (e.g., engineering, medicine) (Iredale, 2001). The literature on skilled migrants is largely qualitative and centres on migration to the USA, Canada, and Western Europe (Turin *et al*., 2021; Cerna and Czaika, 2016).

The extant literature identifies migration "push" factors, compelling people to leave their country of origin, and "pull" factors, drawing ITFPs to certain countries (Turin *et al*., 2021). A human capital theory proposes ITFPs' pull factors, including educational and clinical training and higher compensation in the Global North (Iredale, 2001). In contrast, push factors refer to interpersonal considerations, such as familial relationships and safety concerns in their departing countries (Bourgeault and Neiterman, 2013).

The literature on ITFPs as skilled migrants is marked by debates and controversies. Some scholars perceive ITFPs as playing a crucial role in tackling healthcare shortages (Nwadiuko, Varadaraj, and Ranjit, 2018). They are lauded for their linguistic diversity in serving increasingly heterogeneous populations and supporting labour market expansion (Monavvari, Peters, and Feldman, 2015; Turin *et al.*, 2021). Others adopt a more critical approach to disincentivise ITFPs' recruitment. From this view, the out-migration of physicians from low-and-middle income countries skews physician workforce supply; indirectly, this creates further healthcare access inequities in the Global South (Flood *et al.*, 2017; Runnels, Labonté, and Packer, 2011).

Tensions between ITFPs' agency to migrate and the "brain drain" of physicians is further highlighted by international organisations' public statements condemning recruitment (Emeka, 2015). In 2010, the World Health Organisation (WHO) developed a Global Code of Practice on the International Recruitment of Health Personnel, providing a policy framework to address health workforce shortages (*WHO*, 2010). However, the code is voluntary and as such, member states are merely encouraged to apply the framework (Aluttis, Bishaw and Frank, 2014).

3.2 Migration Policies

The extant literature considers the role of migration policies in accounting for diverging licensure. In a comparison between ITFPs in Canada and Sweden, Neiterman and Bourgeault (2015) partially attribute licensing differences to varying migration policies. The authors propose that Canada favours skilled migrants. ITFPs' education enables them to migrate to Canada; however, they face obstacles when re-entering the medical profession. In contrast, the authors contend that many of Sweden's immigrants move for family unification purposes, or under the category of asylum-seeking refugees. Thus, ITFPs in Sweden often consider themselves as migrants first; their professional status as doctors is not the focal point of migration policies. Exclusion from the medical profession, despite the valuation of their education in the migration process, has created a "professional diaspora" of immigrant physicians in Canada (Neiterman, and Bourgeault, 2015, p. 14). This finding is notable, as Sweden has historically upheld restrictive policies toward immigrants but ITFPs do not report the same restrictions as those in Canada (Cerna, 2014).

Scholars argue that diverging licensing policies are influenced by different immigration priorities, often driven by labour market shortages. Several Western European nations are transitioning to knowledge-based economies, drawing in highly skilled migrants (Cerna and Czaika, 2016). Human capital-oriented immigration systems, which aim to attract highly skilled migrants, are increasingly common (Ehrlich and Kim, 2015). Migration policies are shaped and operationalised by political actors, namely political parties. Yet, European governments have not coordinated their migration approaches as they are keen to keep sovereignty over domestic migration priorities (Cerna and Czaika, 2016). Diverging migration priorities contributes to disjointed policies for foreign-credential recognition (Weggemans *et al*., 2017). Some countries uphold selective policies, while others adopt more liberalised recognition and stay regulations (Cerna and Czaika, 2016). Thus, while many developed countries may be converging toward a preference for skilled labour migration, systems that facilitate their access to regulated professions differ across countries.

These studies underscore the contribution of immigration policies and priorities, primarily human-capital oriented systems, in diverging ITFP policies. However, this literature overlooks

the important actors, including the medical profession, in shaping positions toward foreign-credential recognition.

3.3 Medical Profession Dominance

Using an actor-centric approach, scholars have considered the medical profession's position in licensure divergence. The concept of professionalisation, involving regulatory autonomy over the medical occupation, has been applied to physicians' dominance (Freidson, 1970). Medical dominance is asserted through their collective identity, medical knowledge approval, and lack of direct oversight (Freidson, 1970). Their principal position creates, and perpetuates, a hierarchy in healthcare (Belrhiti, Belle, and Criel, 2021).

Medical dominance has historically been exercised through professional autonomy; physicians invoke control via their distinct representative and professional structures, separated from allied health professionals (Kenny and Adamson, 1992). However, some scholars claim the profession's power is waning; the proletarianisation thesis holds that the medical profession's tasks, content, and location of care are being "divested of control" (McKinlay and Arches, 1985). This has been partially ascribed to increasing interprofessional collaboration, prompting physicians to break siloes between healthcare providers (Bourgeault and Grignon, 2013). In countries like the USA, where private entities (e.g., insurance) and other professional bodies (e.g., nursing) have proliferated, medical dominance is declining, thereby contributing to more open foreign credential recognition policies (Benbassat, 2023).

Medical associations have also been conceived as epistemic communities, referring to "a network of professionals with recognised expertise in a field and an authoritative claim to knowledge of rulemaking" (Haas, 1992, p. 3; Pinto and Côrtes, 2023). With high levels of organisation and expertise, they are well-positioned to protect members' interests and block the entry of foreign-trained professionals (Coburn, 2006). Their proposals often align closely with regulatory colleges, reinforcing their dominant position in policy making processes. Associations set the institutional rules and norms of medical practice, potentially serving as an impediment for internationally trained doctors (Ozkan, 2018).

Medical associations, however, do not solely shape decision-making. Their ability to exert power depends on other political actors, as well as historical legacies and the socio-legal context (Immergut, 1990). For example, in 2007, Spain reformed its foreign credential recognition process once policymakers noticed significant levels of physician out-migration and growing healthcare access disparities (Finotelli, 2014). To address personnel shortages, the Spanish Ministry of Health removed its cap on postgraduate clinical training positions for non-European foreigners (Finotelli, 2014). This measure was enacted, despite pressure from medical associations to maintain the status quo. While regarded as an incremental change, this path-departing measure demonstrated Spain's commitment to reducing healthcare disparities over the medical association's dominance. As such, examinations of the medical profession's influence must consider the institutional context.

3.4 Institutional Constraints

Institutionalism highlights the rules and structures governing decision-making processes within a society (Shaver, 2018). Institutions affect policy actors' actions (Clemens and Cook, 1999). In countries with more restrictive licensure policies, institutional constraints have been studied in-depth. For example, McGrath, Holwea and Wong (2011) identified decentralisation as a driver of restrictive licensure. In Canada, provincial governments are responsible for healthcare provision, while the federal government provides transfer payments to supplement funding, and oversees immigration (Fu and Hickey, 2015; Dauphinee, 2005). Canada lacks a coordinated approach to licensure and immigration, creating gaps in policy implementation. In contrast, countries with centralised licensing and immigration processes, such as Singapore, have a comparatively open licensing system (Ihsan, 2023). Such systems involve immigration schemes for healthcare professionals and a nationalised licensing system to encourage within-country work mobility.

Veto points, conceptualised as instances in the policy making process where actors can prevent the adoption of legislation, are also relevant to discussions concerning ITFP's licensure (Immergut, 1990). Interest groups' ability to exercise their power and shape decision-making is influenced by their access to representatives who can veto proposed legislation (Immergut, 1990). While no studies have explicitly examined the influence of veto points in ITFPs' licensing, scholars have called attention to medical profession's distinct power in shaping health

policy (Sriram *et al*., 2023). Medical associations protect their members from the "infiltration" of unqualified candidates (Finotelli, 2014). They maintain protectionist policies against ITFPs through ethical codes and credential recognition procedures, and in turn, reinforce domestically educated doctors' status (Iredale, 2001). As a result, the medical profession may hold power to veto proposed reforms to licensing policies.

In addition to political institutions and veto points, existing research underscores the role of distinctive licensing requirements in contributing to divergence (Swanson and Roberts, 2016). Several countries have developed their own licensing exams to assess foreign-trained physicians; the exams are unstandardised and often place additional requirements on internationally educated physicians (Boursicot *et al*., 2007). Some scholars have constructed licensing system typologies based on ITFPs' requirements. Price et al. (2018) developed four typologies using national licensing exams, while Leslie et al. (2021) distinguished systems by the extent of state control in regulation. However, existing typologies seldom account for factors beyond requirements, such as migration policies or positions held by regulatory authorities. Furthermore, these typologies fail to integrate the actors driving policy divergence. With this context in mind, this thesis conceptualises and operationalises variables that result in open and restrictive licensing policies by examining Canada and the UK's licensing processes. I first map out the ITFP licensing processes in both cases, then apply process tracing to provide a narrative of Canada and the UK's policy making process.

4. Conceptualising Open and Restrictive Licensing Systems

Before examining how licensing policies diverge, it is critical to conceptualise open and restrictive licensing systems. In doing so, I do not assert that either case is entirely open or restrictive; in this thesis, the differences between the UK and Canada's licensing policies are more a matter of degrees. Countries levy requirements on foreign-trained health professionals to regulate entry to the profession and protect patients' safety (Scheffler, 2019). As such, no case can be considered completely open.

Open and restrictive systems are measured using three variables: ITFPs' entry, credential recognition, and licensing conditionality. Entry refers to ITFPs' migration pathways. Credential

recognition involves the processes and criteria for assessing credentials (i.e., medical degrees), while licensing conditionality is defined as the medical authority's regulatory requirements imposed on ITFPs.

An open system is characterised by several routes to enter the country as a skilled migrant. This involves coordination amongst entities and streamlined application processes. Additionally, open systems offer several routes to recognise foreign credentials and impose few additional requirements on ITFPs, including examinations. The credential recognition processes in open systems also do not invoke significant financial costs. Moreover, systems with open licensing conditionality grant ITFPs the ability to practise medicine across the country, with training requirements commensurate with domestically educated physicians upon credential recognition.

In contrast, a restrictive system offers no, or limited, migration routes specific to skilled migrants. Moreover, credential recognition processes are lengthy, costly, and provide few methods to recognise prior credentials. Such systems also impose several additional requirements on foreign trained professionals. Furthermore, licensing conditionality is limited; ITFPs are permitted to work only in particular jurisdictions after completing additional training requirements.

Before examining the drivers of open and restrictive systems, this thesis first compares the most recent ITFP licensure policies in Canada and the UK (March 2024). To understand how licensure policies vary between Canada and the UK, I collected and analysed primary data from the webpages of the General Medical Council (GMC), the Royal College of General Practitioners (RCGP), the Medical Council of Canada (MCC) and the College of Family Physicians of Canada (CFPC). These entities provide information concerning credential recognition and licensing conditionality. To account for differences in ITFPs' entry, I examined the webpages of Immigration, Refugees, and Citizenship Canada and UK Visas and Immigration. I seek to explain how ITFPs' entry, credential recognition, and licensing conditionality differ across the countries. These three variables capture the extent to which licensing systems can be considered open or restrictive.

5. Theoretical Framework

To explain ITFP licensure divergence between Canada and the UK, this thesis draws on the role of institutions, veto points, medical profession dominance, and key actors' positions. I argue that institutional political differences account for diverging licensing requirements; the different decision-making systems of Canada and the UK (federalist compared to unitary) contributes to diverging licensure policies. Their institutional arrangements contain different numbers and relative power of veto points, influencing the extent of medical dominance and actors' positions toward ITFP licensing.

Institutions refer to the formal rules and structures governing decision-making processes (Shaver, 2018; Béland and Hacker, 2004). While institutions do not solely determine outcomes, they alter actors' behaviour (Hoefer, 2022). More specifically, institutional rules for decision-making influence policy outcomes (Immergut, 1990). Thus, institutions can enable or limit policy change (Pierson, 2000). Canada and the UK's licensing system comprise distinct institutional arrangements.

Canada has a federal style of government, consisting of the federal, ten provincial, and three territorial governments (Field, 1992). Federalism involves constitutional power division between levels of government (Beland and Lecours, 2020, p. 4). In Canada's federal system, the Constitution delegates responsibility for professional licensure to the provincial level (*FMRAC*, 2024). The delivery of healthcare is also under provincial jurisdiction, including establishing and regulating healthcare facilities (Flood *et al.*, 2017). While immigration is conceived as a concurrent power between the federal and provincial governments, the federal government has historically played a more significant role in immigration policy (Cockram *et al*., 2021). The Immigration, Refugees and Citizenship Canada is the national entity responsible for immigration policy.

In contrast, the UK is a unitary state, involving a central government. However, the UK has pursued uneven devolution amongst its constituent countries (*OECD*, 2016). The UK's central government maintains authority, though the constituent countries have varying levels of self-governance. The UK Parliament and the UK Government establish laws, control funding, and set

national policy (*UK Government*, 2024). For example, medical licensing is centralised nationally. Moreover, the UK's Home Office oversees immigration through UK Visas and Immigration, and healthcare is primarily controlled by the National Health Service (NHS).

The diverging decision-making structures in Canada and the UK contribute to more open or restrictive licensure policies through veto points (Immergut, 1990). Veto points are instances in the policy making process in which proposed reforms can be blocked by key actors (Immergut, 1990). Veto points provide a critical starting point to understand influence over the decision-making structures in both cases as their decision-making institutions vary in the number and importance of veto points (Immergut, 1990). Federalist systems comprise greater and potentially more powerful veto points than unitary systems (Immergut, 1990). The greater the number of veto points, the more difficult it is to pursue change. Canada's federalist system contains greater and more powerful veto points, affording greater autonomy to regulatory authorities to control policy making, unlike the UK's unitary system. Canada's system is thus marked by more professional closure, enabling the medical profession to crowd out other actors maintain restrictive licensure.

Though the licensure policy making process occurs outside of the parliamentary arena, veto points can still be applied to understand the interactions between factors producing divergence. In this thesis, I draw attention to the medical profession. Medical regulatory authorities, which grant medical licences, serve as gatekeepers to the profession (Leslie, 2022). Yet, the role of the medical profession is not uniform across countries. The extent of medical dominance, defined as professional autonomy and control exerted by physicians, is influenced by the governance structures of medical regulatory authorities (Belrhiti, Belle, and Criel, 2021). Governance structures include the representation and composition of physicians and members of the public, as well as consultation opportunities and electoral processes for internal governing boards/councils.

Medical regulatory authorities represent critical veto points because they set physicians' practice standards (Coburn, 2006). These authorities implement policies regulating entry to medicine, with varying alignment and interaction with other entities. Systems which invoke greater medical

professional dominance may require less interaction, and thereby less alignment, with other policy actors. This contributes to more restrictive licensure policies. Restrictive systems are marked by a high degree of professional closure, seeking to limit foreign-trained professionals' entry (Chua and Clegg, 1990; Wilson, 1998). This contrasts to governance structures that represent actors beyond the medical profession and involve more interactions with entities throughout the policy making process; in such systems, we expect more alignment with actors toward ITFPs and less professional closure, resulting in more open licensing policies.

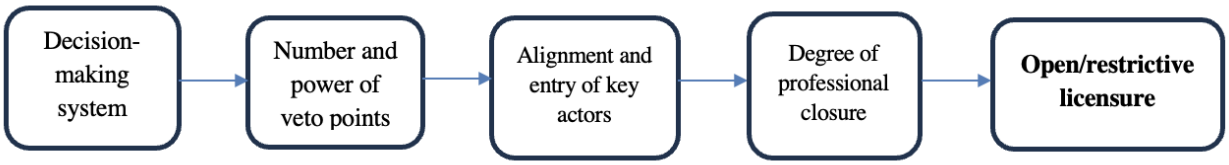
Although regulatory authorities' status in the licensing process is notable, they operate in a complex policy environment. As such, policy outcomes can be conceived as the result of the institutional context and actors' positions (Tsebelis, 1999). Actors convey their positions through public statements to legitimate some form of action over others (Cairney, 2023). The institutional context shapes actors' relative influence in the policy making process (Koduah *et al*., 2015). In this thesis, close attention is paid to how the immigration sectors, medical councils, and national healthcare organisations position ITFP licensure. I examine how Immigration, Refugees, and Citizenship Canada and UK Visas and Immigration problematise ITFP licensure to control entry by implementing pathways for skilled migrants. The positions of national healthcare organisations are explored to understand how they shape licensing conditionality, including their positions toward within-country work mobility and healthcare shortages. Lastly, the medical councils' positions are analysed as they maintain responsibility for ITFPs' credential recognition. This thesis focuses primarily on the medical profession, while acknowledging that political actors influence the composition of regulatory bodies and migration priorities.

6. Hypothesis

Decision-making structures influence the number and power of veto points, shaping key actors' positions toward ITFPs and their extent of alignment, thereby influencing dominance of the medical profession (figure 1). This hypothesised causal mechanism accounts for divergent ITFP licensing policies. The starting condition in the causal pathway is the decision-making system in each country. This influences the number and significance of veto points, which influences the entry and alignment amongst actors to operationalise their positions concerning ITFPs' entry, credential recognition, and licensing conditionality. Ultimately, these factors determine the

extent of professional closure in the licensure policy making process. Systems with a higher degree of professional closure are considered restrictive, while systems with a lower degree of professional closure exhibit more open policies. Given limited comparative explanations and literature, I put forward one hypothesis, which operates distinctly in the cases.

Figure 1: Hypothesised Causal Mechanism



I hypothesise that Canada's federalist system increases the number and power of veto points and facilitates the medical profession's dominant position to crowd out other actors, resulting in restrictive licensure. Canada's federalist and decentralised licensing system invokes greater veto points, primarily through the medical regulatory colleges, which must agree to implement policy changes. I expect that through the colleges, the medical profession crowds out the positions put forward by other actors involved in the licensing policy making process. Given their power to block proposed reforms, the regulatory colleges represent a critical veto point. The colleges uphold a high degree of professional closure, which minimises their need to align positions toward ITFPs with other actors. As a result, Canada maintains a restrictive licensing system.

Figure 2: Hypothesised Causal Mechanism – Canada

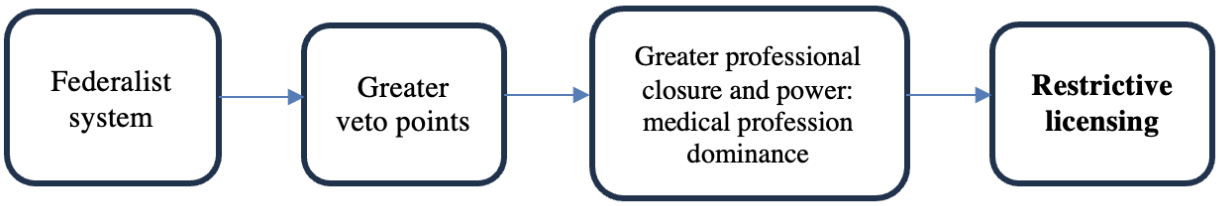
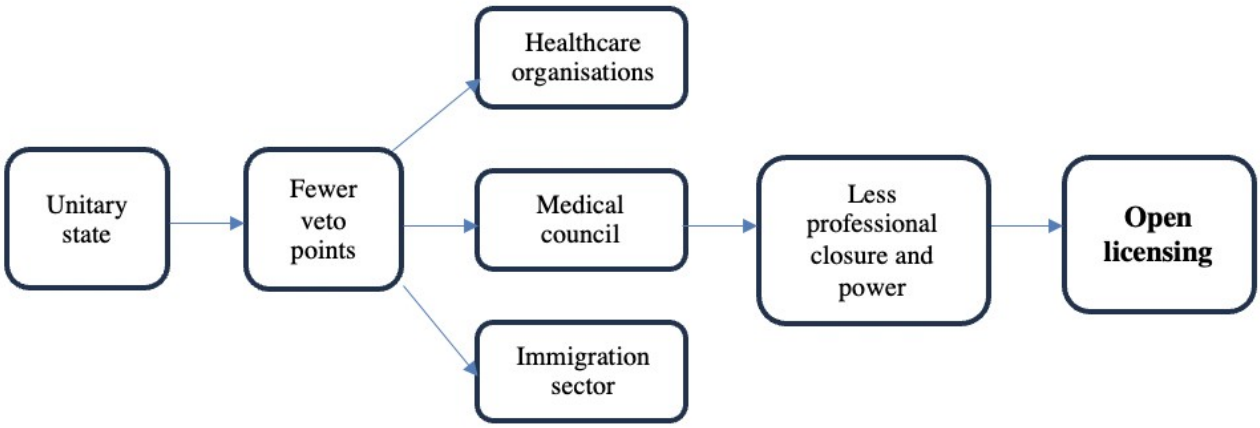


Figure 3: Hypothesised Causal Mechanism – UK



Canada's system contrasts to the UK; the UK's unitary system results in a more centralised licensing process, with fewer and less significant veto points and thus less dominance by the medical profession. As such, the UK's licensing system is marked by less professional closure. The UK's centralised licensing process necessitates greater interaction and thus alignment with other actors involved in the policy making process. With a nationalised licensing system requiring aligned positions toward ITFPs, there are fewer opportunities for the regulatory authority to crowd out positions. Indirectly, this reduces the number and significance of veto points. I hypothesise that the UK's decision-making system, results in a different ITFP licensure policy making process; the UK's unitary system enables greater interaction and alignment with other actors involved in ITFPs' policy making process, resulting in fewer veto points and less dominance by the medical profession to inhibit professional closure. Together, these factors create a more open licensing system than Canada's.

7. Data and Methods

7.1 Case Selection

This thesis is a small-*n* comparative case study, contrasting the ITFP licensing design in Canada and the UK (table 1). The selected countries are liberal welfare regimes, with points-based, human capital-oriented immigration schemes (Foster, 2008). These cases also feature multi-level governance structures, and transnational epistemic communities (Rajamani and Peel, 2021).

Table 1: Variable Overview: Canada and the UK

Variable	Canada	United Kingdom
Immigration system (skilled workers)	Points-based system	Points-based system
Healthcare access	Universal health coverage	Universal health coverage
Practising physicians per 1,000 population	2.5	3.2
Percentage of international medical graduates	24%	41%

Canada and the UK attract a significant number of internationally educated health professionals through their immigration pathways (*OECD*, 2019). Their healthcare systems enable universal coverage, employing statutory frameworks for financing (Brown, 2003). In both cases, however, physicians initially opposed public healthcare financing and delivery over concerns about their clinical and economic autonomy (Kinney, 2015). These also countries face growing physician shortages, exacerbated by the COVID-19 induced exodus of healthcare workers (Brennan *et al*., 2023).

Despite sharing structural similarities, their approaches to ITFP licensure diverge. As such, this thesis employs a loose application of Mill's Method of Difference, which involves comparisons across cases that are similar but differ in a defined outcome of interest (Mill, 1843). In the context of this thesis, the differences in physician workforce compositions between Canada and the UK distinguish one system more open than the other.

International medical graduates comprise nearly 24% of Canada's physician workforce (Gutman *et al*., 2021). Most of Canada's practising ITFPs completed their medical education in Europe (*CaRMS*, 2013). Annually, nearly 190 post-graduate training positions are available to ITFPs across Canada, though more than 2000 apply (*CaRMS*, 2023). The UK's physician workforce employs a greater number of ITFPs than Canada (~ 41%) (Lane, Shrotri, and Somani, 2024). This figure is rising; in 2022, approximately 52% of physicians entering the UK's workforce

were international medical graduates (*GMC*, 2022). Moreover, most international medical graduates entering the UK studied in the Middle Eastern region (*GMC*, 2020).

7.2 Methodology

Policy problems cannot be addressed in isolation; as such, methods like process tracing help construct complex networks of entities and interrelationships to temporally explore problems (Collier, 2011). The topic requires a comparative design to uncover the determinants of divergent approaches to ITFPs, despite both facing healthcare shortages. This thesis uses process tracing to conduct within-case and comparative analysis to understand ITFP licensure differences between Canada and the UK. Process tracing involves using "evidence from within a case to make inferences about causal explanations of that case" (Bennett and Checkel, 2014, p. 5). Because this topic is seldom explored from a comparative lens, I use theory testing process tracing.

Canada's ITFP licensing policy making process is traced from May 2021, in which the Medical Council of Canada reformed its qualifying examination for ITFPs (MCCQE) to enhance rigour and comparability to Canadian standards (*MCC*, 2019). The UK's policy making process is traced from the introduction of the International Medical Graduate Induction Programme in 2021 (*GMC*, 2021). This programme aims to enhance international medical graduates' integration through funding, mentorship, and support with navigating the UK's healthcare system (Hodkinson and Lok, 2022). The programme was developed by the NHS, in conjunction with the General Medical Council and the British Medical Association in response to calls for a UK-wide introductory programme for international medical graduates (Hodkinson and Lok, 2022).

In my comparative case analysis for research question one, I map out the entities involved in ITFP policy making, their respective roles, and their degree of overlap in functions. Data sources include official publications (e.g., white papers, reports), regulatory frameworks, and medical regulatory authorities' webpages. I obtained grey literature from licensing entities' webpages and policy documents uploaded to Overton, an online policy document index. These sources were used to explore the influence of decision-making institutions (federalist compared to unitary state). Appendix A contains all documents referenced.

For research question two, I analysed approximately 30 documents published from 2021 to 2024. Data sources included parliamentary documents detailing each case's state structure, policy making documents (e.g., parliamentary submissions, medical council statements), and healthcare and licensure regulation policies. Using the documents outlined in Appendix A, I provide a narrative of the ITFP licensure policy making process in Canada and the UK. This is guided by the hypothesis put forward in section six. In doing so, I uncover veto points and the comparative influence of the medical profession in ITFP licensure policy making in the UK and Canada. This informs my understanding of key actors' positions toward ITFP licensure and how their positions are reflected in the variables of interest (entry, credential recognition, and licensing conditionality) (table 2).

I examined positions toward ITFPs' licensing from the immigration sector, healthcare organisations, and medical councils from 2021 to 2024, providing a temporal analysis. In addition to analysing content, I assessed the degree to which actors' positions were aligned. To understand the extent of professional closure by the medical profession, I identified the governance structures of regulatory authorities granting licensure. I examined the representation of physicians and the public on the entities' governing boards, electoral processes for governance, and consultation opportunities. Collectively, I aimed to capture physicians' entry points to decision-making and their interactions with other licensing entities.

Table 2: Key Actors in ITFP Licensure

Entity	Canada	United Kingdom	Data sources
Immigration	Immigration, Refugees and Citizenship Canada	UK Visas and Immigration	Departmental plan, webpages for applicants
Healthcare organisations	Health Canada	National Health Service	Long-term workforce strategy/departmental plan
Medical councils (national)	Medical Council of Canada	General Medical Council	Reports/publications

8. Case Analysis: Research Question 1

This case analysis builds a descriptive overview of the ITFP licensing process in Canada and the UK based on three variables: ITFPs' entry, credential recognition, and licensing conditionality.

8.1 ITFPs' Entry

Historically, ITFPs have immigrated to Canada through the Federal Skilled Worker Programme (i.e., Express Entry) (*IRCC,* 2024). Established in 1967, Express Entry employs a points-based system for skilled migrants with at least one year of professional work experience. Applicants must pass an approved English language test, requiring renewal every two years.

In addition to Express Entry, four provinces offer Provincial Nominee Programmes for recently graduated ITFPs. Ontario, Nova Scotia, Alberta, and Prince Edward Island operate points-based Provincial Nominee Programmes, providing an alternate route for skilled migrants seeking settlement in a particular province (*Government of Canada*, 2023).

ITFPs immigrate to the UK through the Skilled Worker Visa or the Health and Care Visa, both operating points-based systems (*UK Government,* 2024) (table 3). In August 2020, the Health and Care Visa was introduced, permitting foreign-trained medical practitioners to work in the UK. Both visas require an approved UK job offer, with a salary of at least £20,960, and English language proficiency demonstrated by the Common European Framework of Reference for Languages Scale (*UKVI,* 2024).

In contrast to Canadian employers, the NHS plays a more prominent role in immigration through the provision of financial and administrative support for applicants (*NHS,* 2018). Canadian employers do not offer this arrangement, partly due to the decentralised provincial healthcare systems.

Table 3: National Points-Based Immigration Routes: Canada and the UK

Express Entry (Canada)	Skilled Workers Visa (UK)
Age	Job offer by approved sponsor in the UK
Education	Job offer at required salary standard
Work experience	English language skills
English and/or French language skills	Education qualification (additional points)
Adaptability (i.e., likelihood of settlement)	Job in a shortage occupation (additional points)
Canadian job offer (additional points)	

8.2 Credential Recognition

Credential verification is a necessary step toward licensure (Hawthorne, 2016). In both Canada and the UK, credential verification is overseen by their national medical councils. The Medical Council of Canada (MCC) is a national organisation which establishes medical school requirements. Canadian credential recognition mandates applicants to possess a medical degree listed in the World Directory of Medical Schools (WDMS). The WDMS, containing more than 3,700 medical schools, was first published by the WHO to help standardise medical school accreditation (*WDMS*, 2024). The MCC subsequently requires ITFPs to complete an Educational Credential Assessment (ECA) to ensure foreign medical degrees are "comparable to Canadian medical degrees" (*MCC*, 2024).

Credential recognition via the WDMS and ECA marks ITFPs' first step. Throughout the licensing process, ITFPs complete four exams, while Canadian-trained physicians undertake three (see Appendix B). Among these assessments, the NAC OSCE, administered by the MCC, is only required for international medical graduates (*MCC*, 2024). In total, licensing exams cost $8824 (£5,162) (table 4).

Table 4: Licensing Exams Required Only by ITFPs

Country	Exam	Cost	Locations Offered

Canada	National Assessment Collaboration Examination (NAC OSCE)	$1420 CAD (£824)	1 (Canada)
UK	Professional and Linguistic Assessments Board (PLAB)	£1189	16 countries

The UK's centralised licensing body, the General Medical Council (GMC) sets medical school requirements. By contrast with Canada, requirements can be fulfilled via three pathways (*GMC*, 2024). First, applicants could hold a medical degree from an institution listed in the WDMS. Secondly, ITFPs may hold a relevant European qualification, including medical degrees from an institution in the European Economic Area (EEA) or Switzerland. Alternatively, the GMC assesses medical degrees obtained from institutions excluded from the EEA or WDMS on a case-by-case basis (*GMC*, 2024). ITFPs must then verify their medical degrees through the Educational Commission for Foreign Medical Graduates (ECFMG). This process, overseen by the GMC, confirms applicants' degrees are genuine, as opposed to assessing the equivalency of foreign degrees (*GMC*, 2024).

Throughout the UK licensing process, ITFPs complete three examinations, while UK-trained physicians complete two (see appendix C). The Professional and Linguistic Assessments Board test (PLAB), required only by ITFPs, is set by the GMC. The licensing exams cost £2839, imposing a smaller financial burden compared to ITFPs in Canada.

8.3 Licensing Conditionality

In Canada and the UK, entry to postgraduate family medicine training employs a match-based system. Candidates rank their preferences and are assigned positions based on their qualifications, exam scores, and interview performance.

ITFPs in Canada complete two years of postgraduate family medicine training, referred to as residency. Candidates apply through CaRMS, a national organisation responsible for matching

applicants. Entry is managed by CaRMS and Canadian medical schools, which host residencies (*CaRMS,* 2024). In all eligible provinces excluding Quebec, Canadian medical school graduates apply to a separate stream of positions. Yet, there are fewer positions available to ITFPs. In 2022, 439 ITFPs matched to family medicine residencies, while 1,629 Canadian medical graduates matched (*CaRMS,* 2023). Canadian medical graduates also have a higher family medicine match rate (99.4%) than ITFPs (22.6%) (MacFarlane, 2021; *CaRMS*, 2023).

Upon matching to a residency, ITFPs must sign a return-of-service contract (excluding Quebec and Alberta). This contract mandates ITFPs to work in an under-serviced (i.e., rural) region following residency. Return-of-service contract length varies by province, from two years in British Columbia, to five years in Newfoundland and Labrador (*CaRMS*, 2024). If the contract is breached, ITFPs must repay the cost of their post-graduate training, amounting to more than $121,000 (*Government of British Columbia,* 2023). Moreover, the contract is only imposed on graduates from international medical schools.

Each province has its own medical regulatory authority/college (e.g., College of Physicians and Surgeons of British Columbia). The provincial colleges grant medical licences and hold authority for self-governance (*Government of Alberta,* 2023). As such, ITFPs licensed in a particular province are only permitted to work in that jurisdiction. While the MCC sets national standards for medical education, decentralised regulatory authorities can impose additional requirements (table 5).

Table 5: Additional Licensure Requirements

Province	Additional requirements
British Columbia	IMG Clinical Assessment Program: one-day evaluation comprising multiple-mini-interviews to enter residency
Ontario	Complete Pre-Residency Program for Family Medicine: 12-weeks of training prior to ITFP residency comprising interactive sessions and practice simulations
Newfoundland and Labrador	IMGs must have completed core clerkship (clinical) rotations during medical school.

In the UK, ITFPs and domestically educated medical graduates complete the GP Specialty Training Programme, comprising three years of clinical training in hospitals and GP clinics (*GMC,* 2024). Like the Canadian licensing process, candidates are matched to programmes (*GPNRO,* 2024). However, applicants compete for positions in the same stream, regardless of their country of medical education. Entry to the programme is jointly managed by the General Practice National Recruitment Office, GMC, and NHS.

Despite sharing similar healthcare shortages in rural regions, the UK's licensing process does not mandate ITFPs to complete return-of-service contracts (Vaughan and Edwards, 2020). Following the GP Specialty Training Programme and successful completion of the Membership to the Royal College of General Practitioners exam, the GMC issues a Certificate of Completion in General Practice. The GMC grants ITFPs' licensure, establishes medical education standards, and holds regulatory authority (*GMC,* 2024). Since the GMC is a centralised entity, licensed ITFPs are permitted to practise throughout the UK (table 6).

Table 6: Open and Restrictive Licensing Systems: Canada Compared to the UK

Variable	United Kingdom	Canada

Entry	Open	Restrictive
Credential recognition		
Medical school recognition	Open	Restrictive
Degree verification	Open	Restrictive
Examination requirements	Restrictive	Restrictive
Licensing conditionality		
Post-graduate training requirements	Open	Restrictive
Within-country work mobility	Open	Restrictive

9. Research Question 2: Case Analysis

In the following, I separately trace key reforms in the ITFP licensure process to analyse the policy making processes in Canada and the UK. Canada's ITFP licensing policy making process is traced from May 2021, examining reforms to its qualifying examination for ITFPs (MCCQE Part II) (*MCC*, 2019). The UK's policy making process is traced from the introduction of the International Medical Graduate Induction Programme in 2021 (*GMC*, 2021). The UK's programme serves to integrate international medical graduates through funding and mentorship (Hodkinson and Lok, 2022).

9.1 Canada

Reforms to the Medical Council of Canada Qualifying Examination

On May 31, 2021, the MCC announced its removal of a component of its licensure examination (MCCQE Part II), citing delays caused by the COVID-19 pandemic (*MCC*, 2021). This measure was publicised following completion of the CaRMS 2020/2021 residency match cycle, with immediate effect for the upcoming 2021/2022 cycle. Despite initial perceptions of a temporary enactment to reduce the pandemic's administrative burden, the MCC subsequently confirmed MCCQE Part II's permanent elimination in October 2021 (*MCC*, 2021a). Yet, months prior, the MCC stated its commitment to continuing the MCCQE Part II, denoting that the exam helps ensure "safe and effective patient care" (*MCC*, 2021b).

The MCCQE Part II was an objective structured clinical examination which evaluated candidates' clinical decision-making skills and patient interactions (*MCC*, 2021b). With one less exam, the licensing process seemed as though it would become less restrictive. However, to account for removal, the MCC pursued significant changes to its primary licensing examination, MCCQE Part I. The MCCQE Part I was reorganised and strengthened to enhance assessments concerning patient interactions, diagnosis formulas, and communication skills (*MCC*, 2021).

In their public announcement concerning MCCQE Part II's termination, the MCC reaffirmed they are not responsible for granting medical licences; instead, the MCC relayed its position as a national organisation responsible for assessing medical candidates' skills, knowledge, and competencies to meet patient safety requirements (*MCC*, 2021). While the MCC does not hold regulatory authority, this organisation sets the "Canadian Standard", outlining the basic qualifications for pursuing medical licensure (*MCC*, 2024).

Canada's federalist system demarcates responsibility for medical licensure to the provincial level (*FMRAC*, 2024). The power to grant licences is devolved to provincial colleges. However, federalist systems are more constitutionally qualified to enable veto points (Immergut, 1990). In the case of Canada's medical licensure, it is both the strength and number of veto points that contributes to restrictive licensure. As the physician licensing and regulating entities in their respective jurisdictions, Canada's 10 colleges represent critical veto points in the ITFP licensing policy making process (*MCC*, 2024). The colleges are independent bodies, operating distinct from the government, with authority indirectly derived from constitutional legislation (*FMRAC*, 2024).

Although colleges were required to recognise the changes enacted by the MCC in 2021, this did not constrain their ability to impose additional requirements for their provincial pathways to licensure. Colleges implement policy changes but are not bound to recommendations from other entities involved in the licensing process. All 10 of Canada's regulatory colleges are members of the Federation of Medical Regulatory Authorities Canada (FMRAC), a voluntary, membership-based organisation aimed at advancing medical regulation through collaboration and promoting best-practices (*FMRAC*, 2024). The FMRAC operates on behalf of the public. They

demonstrated their public commitment in a January 2023 public statement highlighting the need for fast-tracked and pan-Canadian medical licensure to address chronic physician shortages intensified by COVID-19 (*FMRAC*, 2023). Though the FMRAC first proposed recommendations for fast-tracked licensing in 2019, regulatory colleges have yet to commit to these recommendations (*FMRAC*, 2019)

The regulatory colleges' distinct status in the licensing policy making process allow them to veto proposed changes. Because they regulate entry to the medical profession, the colleges crowd out positions held by other actors forming a country's response to the recognition of foreign trained professionals. The colleges' positions toward ITFPs do not align cross-nationally, or with positions held by other actors. In the Immigration, Refugees, and Citizenship Canada's 2023/2024 departmental plan, the federal department re-stated its commitment to economic immigration, particularly health workers, formally designating them as "essential workers" (*IRCC,* 2023.) They underscore the need to ease access to the medical profession, ensuring physicians can meet Canadian employers' needs facing mounting labour shortages (*IRCC,* 2023). In their departmental plan, Immigration, Refugees, and Citizenship Canada also announced its proposal to pilot measures to address employment barriers faced by skilled migrants, including ITFPs (*IRCC*, 2023).

Similar to the position held by the federal department for immigration, one of Health Canada's 2024 priorities is guaranteeing internationally educated healthcare practitioners' credentials are more easily recognised (*Health Canada*, 2024). Health Canada, the federal department for health planning and management, actively promotes foreign trained physicians' integration; they highlight ITFPs' critical contribution to Canada's health human resource shortages (*Health Canada*, 2024). Both Health Canada and Immigration, Refugees, and Citizenship Canada are funded by the federal Government of Canada and accountable to the parliament. While these two national entities' positions toward ITFPs closely align, they are disconnected from the MCC's commitments. In the MCC's most recent annual report, the organisation justifies its role in administering examinations to assess international medical graduates' competencies (*MCC*, 2023).

The MCC justifies their rigorous examinations using patient safety and protection claims, drawing attention to discrepancies in qualifying exam scores between foreign and domestically educated physicians (*MCC*, 2023). In response to increased media attention concerning ITFPs' skill devaluation, the MCC published a statement in June 2023. Indirectly, the organisation shifted blame to the provincial colleges for their role in granting licences (*MCC*, 2023). The MCC also develops decisions in private deliberation; the organisation offers few and sporadic opportunities for public consultation, despite establishing the "Canadian Standard" for licensure (*MCC*, 2024). In doing so, the MCC retains professional closure by physicians.

Canada's federalist licensing system permits colleges to veto proposed legislation aimed at reducing restrictive licensing, but also enables these colleges to crowd out positions held by other actors. As devolved gatekeepers to the medical profession, they require fewer interactions with other licensing entities, facilitating actors' divergent positions. Moreover, provincial colleges benefit from physician-led regulation arrangements; their governance structures are dominated by domestically educated physicians (Tezuka, 2014; *CPSA*, 2024; *CPSO*, 2024; *CPSBC*, 2024). Lay members representing the public, are outnumbered by the medical profession on colleges' governing councils, which steer decision-making and provide performance oversight (*CPSBC*, 2024). Despite calls from the federal government for reforms to self-regulation throughout the 1980s, changes were pursued unevenly across provinces, and major reforms were not enacted (Adams, 2017). Furthermore, governing councils are elected by medical practitioners, strengthening professional closure.

Colleges justify medical dominance through the lens of professionalism, referring to an "implicit agreement between society and the medical profession" (*RCPSC*, 2024). Professionalism enables physicians to exert considerable influence over policy making processes. Collectively, Canada's 10 provincial colleges maintain a high degree of professional closure, supplanting recommendations from other licensing entities and positions held by key actors. Federalism constitutionally qualifies greater and stronger veto points through the colleges, which must agree to proposed reforms as they control access to the medical profession.

9.2 United Kingdom

Introduction of the International Medical Graduate Induction Programme

In 2021, the NHS launched its International Medical Graduate Induction Programme to better acclimate internationally trained doctors to the UK's healthcare system (*NHS,* 2021). The programme, developed in partnership with the GMC and British Medical Association, provides a standardised introductory programme for foreign-trained doctors, following a gap analysis conducted by the NHS (Hodkinson and Lok, 2022). This analysis uncovered inadequate supports for internationally educated doctors and unequal induction programmes across the UK (*NHS,* 2022). As such, this programme offers integrative support throughout international medical graduates' postgraduate training. Furthermore, the programme targets recently graduated physicians without clinical experience. While not developed in response to challenges presented by COVID-19, the pandemic heightened the need for a standardised introductory programme.

Through the programme, international medical graduates receive comprehensive information concerning settlement and health system navigation. Participants are also offered financial support to aid with visa costs and sponsorship, and monthly clinical placement bursaries (*NHS*, 2021). While initiated by the NHS, the programme was developed in close collaboration with licensing entities, including the GMC, to facilitate seamless licensure (*NHS*, 2022). The GMC supplemented this programme by introducing their Welcome to UK Practice virtual education modules in 2021, reaffirming their commitment to ITFPs' integration (*GMC*, 2021).

The GMC is the UK's only medical regulatory body. With the 1858 Medical Act, UK Parliament transferred regulatory authority to the GMC, permitting the council to control entry to the register, licence physicians, and administer qualifying examinations (*GMC*, n.d.). The GMC also verifies medical credentials and regulates post-graduate training throughout the UK (*GMC*, n.d.).

The UK's unitary system permits fewer veto points, exemplified by the GMC's key role as the country's regulatory authority. Despite the GMC's considerable power, the council is not the sole entity involved in the ITFP policy making process. The UK's policy making process involves horizontal interactions with other entities, including the Royal College of General

Practitioners (RCGP). The RCGP administers the membership to the RCGP examination but aligns its criteria with standards developed by the GMC (*RCGP*, 2024).

The GMC interacts with actors throughout the policy making process, permitting the entry of other entities, including the immigration sector and healthcare organisations. The GMC has been vocal about physician shortages and the direct impact on patients (*GMC,* 2023). Their position toward ITFPs closely aligns with the UK's immigration entities. UK Visas and Immigration's announced its priorities in 2022, including migration to foster economic prosperity (*Home Office*, 2022). The Home Office continues to prioritise Health and Care Visas, committing to fast-tracked applications and reduced visa costs (*UKVI*, 2024).

While UK Visas and Immigration's position aligns with the GMC's priorities, positions held by the NHS signals tension. In particular, the NHS Long Term Workforce Plan, published in June 2023, is contentious. Commissioned by the government-funded Health and Social Care Select Committee in 2021, the publication recommends strategies to address healthcare shortages (Geary, McKee, and Petty-Saphon, 2024). The workforce planning document urges training domestic NHS staff over recruiting internationally educated healthcare practitioners (*NHS,* 2023). The NHS frames ITFPs' contributions as temporary; the rising reliance on ITFPs is seen as unsustainable, given increasing global demand for international medical graduates (*NHS,* 2023). Their position, however, is called to question as the NHS continues to host and fund the International Medical Graduate Integration Programme.

The workforce plan relies on comparative evidence; the NHS compares the UK's growing dependence on international medical graduates to the stagnant supply in Canada (*NHS,* 2023). In response to the NHS's call for action, the GMC published a Workforce Report in November 2023. The GMC directly criticises the plan's recommendations, noting that fostering the UK's domestic physician supply will not bring immediate changes. In the interim, the country maintains its reliance on ITFPs, citing their notable workforce contributions (*GMC*, 2023). The GMC also draws attention to the immediacy of physician shortages, particularly family physicians, and prioritises attracting "skilled and experienced international medical graduates" (*GMC*, 2024, p. 14).

As the UK's ITFP policy making process allows the entry of, and interactions with other licensing entities, the NHS's contrasting position will need to be considered in future reforms. Yet, the significance and extent to which their position will be ratified depends on the GMC as the UK's regulatory body; the power to veto proposed changes lies with the GMC, not the NHS. In contrast to the NHS's position, the GMC does not permit a high degree of professional closure. The GMC is governed by a council containing 12 members, an equal split amongst medical members and the public (*GMC*, 2024). The council is appointed by the Privy Council, adhering to standards set by an external body, the Professional Standards Authority. This authority has developed standards for designating leadership councils to healthcare regulatory bodies (*GMC*, 2024).

The UK has upheld lay membership representation on healthcare regulatory bodies since the 1970s. The Merrison Commission (1975) urged changes to the GMC's governance, including greater lay member representation. This commission sought to reduce control by the medical profession, thereby limiting the extent of professional closure (Adams, 2017). Further reforms were pursued in 2008, in which lay members were appointed to oversight entities, including the Professional Standards Authority, to curtail self-regulation (Adams, 2017; Waring *et al*., 2010).

The GMC also exhibits open licensure policy making through its consultation opportunities, bringing together medical educators, practitioners, patients, and the public (*GMC*, 2022; *GMC*, 2024a). The regulatory body demonstrates accountability by regularly offering and publishing consultations publicly (*GMC*, 2024b). Collectively, the GMC's interaction with other licensing entities, lay member representation, and frequent consultation opportunities reduces professional closure, resulting in a more open ITFP licensing system.

10. Discussion

The previous sections mapped out differences in the licensing processes between Canada and the UK, as well as detailed case analyses of the ITFP policy making process. The following section compares the factors resulting in a more open licensing process in the UK, compared to the more restrictive process in Canada.

The MCC's decision to remove one licensing examination in 2021 to alleviate COVID-19's administrative burden presented an opportunity to reduce restrictions to licensure. Instead, however, the organisation strengthened its primary exam to maintain high levels of patient safety (*MCC*, 2021). At this juncture, the UK pursued different reforms; the NHS launched its International Medical Graduate Induction Programme to help ITFPs adapt to the UK's healthcare system. The programme not only provides mentorship and learning opportunities, but also offers financial aid (*NHS*, 2024). Moreover, the programme was developed with licensing and healthcare entities, mobilising widespread support for ITFPs' integration (*NHS*, 2021).

On the other hand, the MCC instituted reform individually amidst the COVID-19 pandemic. Canada's constitution assigns regulatory authority to provincial colleges, invoking power to pursue reforms independently and introduce additional licensing requirements, even amidst healthcare shortages spurred by the pandemic. Canada's federalist licensing system qualifies greater and more powerful veto points through colleges. In this system, the regulatory colleges are not required to implement recommendations from other entities. Since the colleges ultimately control entry to the profession, there are fewer interactions with actors throughout the ITFP policy making process. As a result, there is less pressure to align positions toward ITFPs cross-nationally.

The UK's institutional arrangement for decision-making diverges from Canada's. The UK's unitary state assigns power to the GMC as the sole regulatory authority, resulting in fewer and less powerful veto points. Despite holding substantial power in policy making, the GMC interacts with other entities to align licensing requirements. For example, the RCGP directly engages with the GMC to align standards and confirm completion of training and assessments (*RCGP*, 2024). This enables within-country mobility to practise medicine across the country, easing licensing conditionality. By contrast, physicians in Canada are only permitted to work in the province in which they received licensure. Canada's devolved system does not promote interaction amongst the regulatory colleges, permitting them to uphold restrictive credential recognition.

Actors' positions toward ITFPs also differ in Canada and the UK. Canada's national immigration entity, Immigration, Refugees, and Citizenship Canada, prioritise ITFPs as "essential workers" (*IRCC*, 2023). This position closely aligns with Health Canada, denoting ITFPs' critical contributions to Canada's workforce (*Health Canada*, 2023). Yet, the MCC diverges and seemingly favours Canadian-trained physicians to address healthcare shortages. In comparison, the GMC continually supports ITFPs, even in response to the NHS's Long Term Workforce Plan; the plan outlines recommendations to reduce reliance on foreign-trained health professionals, pointing to Canada's comparatively smaller supply of ITFPs (*NHS*, 2023). The position held by the NHS contrasts to both the GMC and UK Visas and Immigration, which promotes its Health and Care Workers Visa, indirectly recruiting foreign-trained professionals via reduced visa costs and expedited application processes (*UKVI*, 2024).

The substantial veto power and limited interaction with other entities displaces positions held by actors in favour of regulatory colleges in Canada, demonstrated by unsuccessful attempts to reduce self-regulation during the 1980s (Adams, 2017). The federal government sought reforms to promote pan-Canadian licensure and constrain the medical profession's power, backed by international organisations including the WHO (Adams, 2017). However, their attempts were ineffective given devolved regulation. This is further illustrated by the colleges' electoral processes, which are unstandardised, thus permitting physicians to retain control over decision-making processes.

While the federal Government of Canada's attempted "across-the-board" reforms did not allow to counter the dominance of the medical profession, the UK's regulatory reforms effectively challenged dominance (Adams, 2017). In the UK, the 1975 Merrison Commission brought more lay members onto the GMC's governing council. In 2008, electoral processes were reconstituted, resulting in lay member appointment through external entities, including the Professional Standards Authority. This measure prohibited full control by the medical profession (Waring *et al*., 2010). Resultantly, the GMC's governing council involves equal representation of the medical profession and lay members, as well as more frequent consultation opportunities, bringing together the public and other licensing entities (*GMC*, 2024).

In comparison to the UK, Canada's ITFP licensing process involves greater institutional fragmentation. Institutional fragmentation refers to a systemic lack of coordination amongst entities concerning policy development and implementation (Champion and Bonoli, 2005). Federalist systems which divide responsibility across different levels of government display more institutional fragmentation than unitary systems (Mirza and Munir, 2023). The lack of coordination amongst regulatory colleges, as well as the diverging responsibilities between the federal and provincial colleges, fragments responses toward ITFP licensure. At the federal level, influence over medical licensure is limited. Provincial colleges retain power to implement changes, despite pressure from other entities. This contributes to Canada's more restrictive licensing process. The UK displays less institutional fragmentation through its comparatively centralised process.

The diverging licensing systems of Canada and the UK closely, though not entirely, match with the hypothesised causal pathways (figures 1 and 2). The UK's efforts to reduce self-regulation have created a more open licensing system with less professional closure. I hypothesised this would result in more alignment between actors' positions but did not account for the NHS' divergent position. The NHS's divergence, exemplified by their recent Long Term Workforce Plan, marks a radical departure from their extant position toward ITFPs. Though the NHS has historically supported ITFPs' integration, their 2023 workforce plan calls for reduced reliance due to rising demand for international medical graduates. The divergent position also demonstrates the interconnectedness between healthcare and immigration, as the UK seeks to limit migrants' entry post-Brexit (Cerna and Czaika, 2016). While not accounted for in my hypothesis, the recommendations strain the historic alignment between the NHS and GMC.

In addition to distinctive decision-making systems and veto points, the extent of professional closure between the UK and Canada differs. Lay members in Canada's regulatory colleges' boards are outnumbered by the medical profession, which comprises physicians, medical school deans, and medical students/residents (tables 7 and 8). Moreover, consultation opportunities are not standardised across the country due to the considerable power afforded to regulatory colleges. Collectively, this governance structure limits the entry of other actors, facilitating a high degree of professional closure. Dominance by the medical profession throughout the policy

making process thus results in a more restrictive ITFP licensing process compared to the UK. As displayed in table 7, the GMC is governed by an equal number of lay members and the medical profession, thereby reducing professional closure. The GMC's council is also independently appointed by the Privy Council, further limiting opportunities for medical profession dominance. Successive reforms throughout the 1970s and 2000s challenged medical dominance, enabling representation beyond the medical profession (Adams, 2017).

Table 7: General Medical Council (GMC) Governance

Regulatory Authority	Governance Structure
General Medical Council	A council of 12 members, 6 of whom are medical members and 6 of whom are lay members. The council is appointed by the Privy Council through a process which follows the Professional Standards Authority's guidance for making appointments to healthcare regulatory bodies.

Table 8: Canadian Regulatory College Governance

Regulatory Authority	Governance Structure
College of Physicians and Surgeons of British Columbia	A board of 10 peer-elected physicians and five members of the public, which are appointed by the ministry of health.
College of Physicians and Surgeons of Alberta	A council of 7 physicians, 5 members of the public, and 4 medical school representatives. Physician councillors are selected by other physicians, while public members are appointed by Alberta's Lieutenant-Governor in Council. Medical school representatives include the medical school deans of the University of Alberta and the University of Calgary, as well as medical students and residents.
College of Physicians and Surgeons of Saskatchewan	A council comprising 14 peer-elected physicians, 5 non-medical members, and the dean of medicine (University of Saskatchewan).
College of Physicians and Surgeons of Manitoba	A council comprising 8 peer-elected physicians, 6 public representatives, three of whom are appointed by the minister and three of whom are appointed by Council, 1 regulated member of the College who is a practising physician and selected by the

	Faculty of Medicine at the University of Manitoba.
College of Physicians and Surgeons of Ontario	A council comprising 15 peer-elected physicians, 14 members of the public appointed by the Lieutenant Governor, and 6 medical school representatives.
Collège des Médecins du Québec	A board of directors comprising 11 peer-elected physicians and 4 representatives of the public.
College of Physicians and Surgeons of New Brunswick	A council comprising 13 peer-elected physicians and 3 members of the public.
College of Physicians and Surgeons of Nova Scotia	A council comprising 10 peer-elected physicians, 2 medical school representatives, and 5 members of the public.
College of Physicians and Surgeons of Prince Edward Island	A council comprising 6 peer-elected physicians and 3 members of the public.
College of Physicians and Surgeons of Newfoundland & Labrador	A council comprising 7 peer-elected physicians, 4 physicians appointed by the Minister of Health and Community Services, 2 physicians nominated by the provincial Medical Association, 1 medical school representative, and 3 members of the public.
Yukon Medical Council	A council comprising 4 peer-elected physicians and 2 members of the public.

10.1 Limitations, Future Research, and Implications

This comparative case study offers an exploratory and explanatory analysis to uncover the factors resulting in a more restrictive (i.e., Canada) or open (i.e., the UK) ITFP licensing process. Using process tracing, I detailed key events constructing Canada and the UK's ITFP policy making process in a delimited period for specific cases, with limited external validity. Future research should extend the period analysed, integrating immigration reforms. Future studies should also examine public perceptions toward ITFPs, particularly as Canadian regulatory colleges justify stringent licensure through the lens of patient safety.

Canada's restrictive licensure process underscores several policy implications. To begin with, ITFPs' underutilisation, during a time at which approximately 6,000,000 Canadians do not have family doctors, is a point of tension (Islam, 2022). While the MCC asserts its "Canadian Standard" is in place to protect patients, the systemic healthcare access disparities through family

physician shortages harms patients through delayed diagnoses, increasing morbidity and mortality rates (Ansah *et al*., 2018). Moreover, the disjointed positions of Canada's immigration sector and the MCC unfavourably impact ITFPs since Canada prioritises skilled migrants through its points-based system, but face restrictions to entering the profession. This phenomenon contributes to "brain drain", since skilled migrants leave their country of origin, hindering local health system capacities (Mullan, 2005).

As skilled migrants face restrictive licensure in Canada, ITFPs may seek opportunities in alternate destinations, such as the UK. While the UK has historically relied on ITFPs, the recommendations presented in the NHS Workforce Plan marks a potentially path-departing change. Although the GMC retains power as the sole regulatory authority, future research should attempt to reconcile the diverging positions of the NHS and GMC, especially with rising anti-immigrant sentiments in the UK following Brexit (Grinan-Moutinho, 2022). This work is critical as the NHS funds the UK's primary internationally trained physician integration programme and aids the GMC in coordinating post-graduate training positions.

Topically, the undervaluation of ITFPs demonstrated by the MCC and NHS is concerning since family physicians are gatekeepers to secondary care (Denis *et al*., 2023; Geary, McKee, and Petty-Saphon, 2024). Placing additional requirements to reduce reliance on ITFPs is also alarming because family medicine is considered an unpopular choice compared to other specialities (Manca, 2008). Family physicians cite underappreciation and low pay as contributing factors; yet ITFPs eager to apply their skills set aside these concerns in hopes to re-enter the medical profession (Weissman *et al*., 2023).

11. Conclusion

This thesis explained the drivers of policy divergence concerning ITFP licensure between Canada and the UK by examining ITFPs' entry, credential recognition, and licensing conditionality. Though both countries attract ITFPs through their respective points-based immigration pathways, Canada's licensing process is more restrictive than the UK's. In analysing reforms from 2021 to present day, this study examined different institutional

arrangements for decision-making, which shapes actors' entry to the policy making process, their alignment, and the extent of professional closure exerted by the medical profession.

Canada's federalist system permits greater and more powerful veto points through regulatory colleges, which enact policy changes. The devolved structure of authority enables colleges to crowd out positions held by other actors throughout the policy making process, thereby strengthening professional closure. This is illustrated by limited reforms to reduce self-regulation within the medical profession during the 1980s, in which the regulatory colleges discounted the federal government's efforts.

Canada's ITFP licensure process involves a high degree of professional closure. Provincial regulatory colleges impose their own licensing requirements, allowing them to defy recommendations from other entities. Unlike the UK, Canada mandates return-of-service contracts for ITFPs, obliging them to work in underserviced communities. These contracts are also not standardised, resulting in varying training timelines for ITFPs. Additionally, colleges' governing boards contain greater representation of the medical profession, supplanting other actors' entry and positions. Ultimately, the colleges maintain professional closure, despite pressure to alleviate restrictive licensure in the face of healthcare shortages (Brennan *et al*., 2023).

The UK's unitary state contrasts with Canada's system; the UK's centralised system reduces the number and power of veto points, facilitating greater interaction with other entities. Though the GMC holds significant power, the council interacts more with other licensing bodies throughout the policy making process, including the RCGP and the General Practitioners National Recruitment Office. Furthermore, as the only regulatory authority in the UK, the GMC permits physicians to practise across the constituent countries.

In the UK, licensing entities beyond the GMC influence ITFP policy making. The entry of other entities arose in part due to effective government-initiated reforms to limit the GMC's self-regulation in the 1970s (Adams, 2017). While actors' positions are not entirely aligned, the UK government triumphantly introduced amendments to control professional closure in the interest

of public safety. As a result, the GMC is equally governed by lay members and the medical profession, limiting medical profession dominance.

Drawing from primary data and public health, sociology, and social policy literature, this thesis brought together institutional factors and actors' positions. In doing so, the study revealed that the extent of professional closure, as shaped by a country's institutional arrangement, is an important contributor to ITFPs' licensing systems. While the UK and Canada are high-priority destinations for ITFPs, their entry to the medical profession is not exclusively determined by the immigration sector; instead, the nexus of a country's migration and licensing policies are shaped by their pathways to entry, credential recognition, and licensing conditionality.

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Appendix A: Data Sources Consulted

Factor	Canadian Data Sources	UK Data Sources
Mapping Variation	• Express Entry: Compare All Programs (2024) • Medical Council of Canada Source Verification (2024) • World Directory Medical Schools (2023) • Medical Council of Canada Examinations (2024) • College of Family Physicians of Canada Membership (2024) • CaRMS Requirements (2024) • CaRMS Guidelines for Return of Service (2023)	• UK Visas and Immigration: Skilled Workers/Health and Care Workers Visas (2024) • General Medical Council: Registration and Licensing (2024) • Educational Commission for Foreign Medical Graduates (2024) • National Health Service Workforce, Training and Education (2024) • Royal College of Family Physicians Membership (2024)

Political Institutions	• Government of Canada: Canada's Health Care System (2024) • Commonwealth Fund: Canada Health Care System Profile (2020) • Medical Regulatory Authorities (provincial - 2023/2024) • Health Workforce Canada (2023) • Pan-Canadian Health Human Resource Strategy (2007/2008)	• GMC: Registration and Licensing (2024) • GMC: The Medical Register (2024) • NHS England: Licensing (2024) • House of Commons Library: The NHS Workforce, Visas for International Doctors, Potential Merits of Training Additional Doctors
Veto Points	• Medical Council of Canada: IMG Pathways to Licensure (2024) • Federation of Medical Regulatory Authorities of Canada: Registration (2024) • Government of Canada: Submission by Federation of Medical Regulatory Authorities of Canada (2023)	• GMC: Registration and Licensing (2024) • GMC: IMG Application Guides (2024) • Royal College of Family Physicians Membership (2024)
Medical profession	• Medical Regulatory Authorities (10 provincial colleges): Governance pages (2023/2024) • Federation of Medical Regulatory Authorities of Canada: National Physician Licensure • Federation of Medical	• General Medical Council: Governance Framework (2024) • General Medical Council: Consultation on reforming regulation (2019) • General Medical Council: Consultation on regulation of

	Regulatory Authorities of Canada: Current Priorities • CanMEDS Role: Professional (2024) - Royal College of Physicians and Surgeons of Canada • College of Family Physicians of Canada: Preparing our Future Family Physicians (2024) • Medical Council of Canada	PAs and AAs (2024) • General Medical Council: Our responses to consultations (2024) • National Health Service: Long Term Workforce Plan (2023) • National Health Service: IMG Induction Programme (2021) • Royal College of General Practitioners: College support for international medical graduates (2024) • UK Visas and Immigration: Skilled Workers/Health and
Actor's positions	Annual Report (2022/2023) • Immigration, Refugees, and Citizenship Canada Departmental Plan (2023/24) • Immigration, Refugees, and Citizenship Canada Express Entry (2024) • Health Canada Departmental Plan (2023/24)	Care Workers Visas (2024), Home Office Departmental Review (2022-2023) • Home Office Outcome Delivery Plan (2021-2022) • Health and Care Visa Guidance (2024) • Skilled Worker visa: immigration salary list (2024) • General Medical Council Annual Report (2022) • National Health Service: Long Term Workforce Plan (2023)

Appendix B: Canadian Medical Licensing Examinations

Licensing exam	Purpose	Cost	Locations	Required by:
Medical Council of Canada Qualifying Examination (MCCQE)	Assesses medical graduates' knowledge and clinical decision-making.	$1420 CAD (£824)	81 countries	ITFPs and Canadian medical graduates
National Assessment Collaboration Examination (NAC OSCE)	A practical exam assessing readiness to pursue post-graduate medical training in Canada (i.e., residency).	$3,145 (£1825)	1 (Canada)	ITFPs
Family Medicine Professional Choices (FMProC)	Situational judgement tests required for residency; assess family medicine skills: professional integrity, adaptability, team collaboration, and empathy.	No cost	Remote	ITFPs and Canadian medical graduates
Certification Examination in Family Medicine (CEFM)	Completed after family medicine residency and required for certification as a	$4,201 (£2,422)	1 (Canada)	ITFPs and Canadian medical

	family physician.			graduates

Appendix C: UK Medical Licensing Examinations

Licensing exam	Purpose	Cost	Locations	Required by:
Professional and Linguistic Assessments Board (PLAB)	Assesses whether ITFPs' possess required medical competencies and skills. The written section examines medical knowledge; the practical section assesses clinical skills and decision-making.	£1189	16 countries	Applicants outside of the UK, EEA, and Switzerland
Multi-Specialty Recruitment Assessment (MSRA)	Assesses professional dilemmas and clinical problem solving for entry to post-graduate medical training.	No cost	1 (UK)	ITFPs and UK medical graduates
Membership of the Royal College of General Practitioners (MRCGP Exam)	Involves three components: **1. Workplace Based Assessments:** formative discussions throughout medical training to track programme completion	£1650	Remote	ITFPs and UK medical graduates

	and patient skills.			
	2. Applied Knowledge Test: examines clinical knowledge, evidence-based practice, and GP-related administrative issues.			
	3. Simulated Consultation Assessments: examine applicants' clinical and professional skills.			