

HEALTHCARE

POLICY

Politiques de Santé

*Health Services, Management and Policy Research
Services de santé, gestion et recherche de politique*

Volume 12 + Number 4

The Sociopolitical Context of Canada's National Standard
for Psychological Health and Safety in the Workplace:
Navigating Policy Implementation

CINDY MALACHOWSKI ET AL.

Retention Patterns of Canadians Who Studied Medicine Abroad
and Other International Medical Graduates

MARIA MATHEWS ET AL.

Reforming Refugee Healthcare in Canada: Exploring the Use
of Policy Tools

ETHAN HOLTZER ET AL.

Public Health Policy in Support of Insurance Coverage for Smoking
Cessation Treatments

ROBERT SCHWARTZ ET AL.

Data Matters + Discussion and Debate + Research Papers

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POLICY

Politiques de Santé

Health Services, Management and Policy Research
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Healthcare Policy/Politiques de Santé seeks to bridge the worlds of research and decision-making by presenting research, analysis and information that speak to both audiences. Accordingly, our manuscript review and editorial processes include researchers and decision-makers.

We publish original scholarly and research papers that support health policy development and decision-making in spheres ranging from governance, organization and service delivery to financing, funding and resource allocation. The journal welcomes submissions from researchers across a broad spectrum of disciplines in health sciences, social sciences, management and the humanities and from interdisciplinary research teams. We encourage submissions from decision-makers or researcher–decision-maker collaborations that address knowledge application and exchange.

While *Healthcare Policy/Politiques de Santé* encourages submissions that are theoretically grounded and methodologically innovative, we emphasize applied research rather than theoretical work and methods development. The journal maintains a distinctly Canadian flavour by focusing on Canadian health services and policy issues. We also publish research and analysis involving international comparisons or set in other jurisdictions that are relevant to the Canadian context.

Politiques de Santé/Healthcare Policy cherche à rapprocher le monde de la recherche et celui des décideurs en présentant des travaux de recherche, des analyses et des renseignements qui s'adressent aux deux auditoires. Ainsi donc, nos processus rédactionnel et d'examen des manuscrits font intervenir à la fois des chercheurs et des décideurs.

Nous publions des articles savants et des rapports de recherche qui appuient l'élaboration de politiques et le processus décisionnel dans le domaine de la santé et qui abordent des aspects aussi variés que la gouvernance, l'organisation et la prestation des services, le financement et la répartition des ressources. La revue accueille favorablement les articles rédigés par des chercheurs provenant d'un large éventail de disciplines dans les sciences de la santé, les sciences sociales et la gestion, et par des équipes de recherche interdisciplinaires. Nous invitons également les décideurs ou les membres d'équipes formées de chercheurs et de décideurs à nous envoyer des articles qui traitent de l'échange et de l'application des connaissances.

Bien que *Politiques de Santé/Healthcare Policy* encourage l'envoi d'articles ayant un solide fondement théorique et innovateurs sur le plan méthodologique, nous privilégions la recherche appliquée plutôt que les travaux théoriques et l'élaboration de méthodes. La revue veut maintenir une saveur distinctement canadienne en mettant l'accent sur les questions liées aux services et aux politiques de santé au Canada. Nous publions aussi des travaux de recherche et des analyses présentant des comparaisons internationales qui sont pertinentes pour le contexte canadien.

FROM THE EDITOR-IN-CHIEF

- 6 Demystifying the Publication Process
JENNIFER ZELMER

DISCUSSION AND DEBATE

- 10  The Sociopolitical Context of Canada's National Standard for Psychological Health and Safety in the Workplace: Navigating Policy Implementation
CINDY MALACHOWSKI, BONNIE KIRSH AND ELLEN MCEACHEN

RESEARCH PAPERS

- 18  What Do We Know and Not Know about the Professional Integration of International Medical Graduates (IMGs) in Canada?
ELENA NEITERMAN, IVY LYNN BOURGEAULT AND CHRISTINE L. COVELL
- 33  Retention Patterns of Canadians Who Studied Medicine Abroad and Other International Medical Graduates
MARIA MATHEWS, RIMA KANDAR, STEVE SLADE, YANQING YI, SUE BEARDALL AND IVY LYNN BOURGEAULT
- 46  Reforming Refugee Healthcare in Canada: Exploring the Use of Policy Tools
ETHAN HOLTZER, ALICIA MOORE-DEAN, AMIRRTHA SRIKANTHAN AND KERRY KULUSKI
- 56  Public Health Policy in Support of Insurance Coverage for Smoking Cessation Treatments
ROBERT SCHWARTZ, FARZANA HAJI, ALEXEY BABAYAN, CHRISTOPHER LONGO AND ROBERTA FERRENCE
- 69  Bifurcation of Health Policy Regimes: A Study of Sleep Apnea Care and Benefits Coverage in Saskatchewan
GREGORY P. MARCHILDON, CAROLINE A. BECK, TARUN R. KATAPALLY, SYLVIA ABONYI, JAMES A. DOSMAN AND JO-ANN EPISKENEW




Peer Reviewed






DE LA RÉDACTRICE EN CHEF

- 8 Démystifier le processus de publication
JENNIFER ZELMER

DISCUSSIONS ET DÉBAT

- 10  Contexte sociopolitique de la Norme nationale du Canada sur la santé et la sécurité psychologiques en milieu de travail : aperçu de la mise en œuvre de la politique
CINDY MALACHOWSKI, BONNIE KIRSH ET ELLEN MCEACHEN

RAPPORTS DE RECHERCHE

- 18  Que sait-on et qu'ignore-t-on au sujet de l'intégration professionnelle des diplômés internationaux en médecine au Canada?
ELENA NEITERMAN, IVY LYNN BOURGEAULT ET CHRISTINE L. COVELL
- 33  Schémas de rétention du personnel chez les Canadiens qui ont étudié la médecine à l'étranger et chez les autres diplômés internationaux en médecine
MARIA MATHEWS, RIMA KANDAR, STEVE SLADE, YANQING YI, SUE BEARDALL ET IVY LYNN BOURGEAULT
- 46  Réforme des services de santé pour les réfugiés au Canada : examen de l'utilisation des outils stratégiques
ETHAN HOLTZER, ALICIA MOORE-DEAN, AMIRRTHA SRIKANTHAN ET KERRY KULUSKI
- 56  Politique de santé publique en faveur de la couverture d'assurance pour les traitements visant à mettre fin au tabagisme
ROBERT SCHWARTZ, FARZANA HAJI, ALEXEY BABAYAN, CHRISTOPHER LONGO ET ROBERTA FERRENCE
- 69  Bifurcation des régimes de politiques de santé : étude des soins pour l'apnée du sommeil et des couvertures d'assurance en Saskatchewan
GREGORY P. MARCHILDON, CAROLINE A. BECK, TARUN R. KATAPALLY, SYLVIA ABONYI, JAMES A. DOSMAN ET JO-ANN EPISKENEW



Examen par les pairs

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Demystifying the Publication Process

ACADEMIC CONFERENCES RARELY HAVE STANDING-ROOM-ONLY SESSIONS, but 'meet the journal editors' panels that promise to demystify the publication process tend to be a draw. To save readers from sore feet, I've devoted my editorial in this issue to a quick overview of the route by which manuscripts become publications.

When we receive a submission, our Managing Editor, Ania Bogacka, does an initial screening. She checks to make sure that the article is in line with the journal's mandate and requirements in the *Instructions for Authors*, such as the maximum length of submissions and currency of data.

Next, manuscripts come to me, as Editor-in-Chief, for initial triage. I scan each one for fit with the journal's mandate; whether it is sufficiently well-developed to warrant review; the strength of the science and arguments; the degree to which the submission adds to what is already known; likely interest for our audience of health system managers, practitioners, policy makers, educators and academics, and potential ethical issues. My reference point is the journal's *Instructions for Authors*, which have been developed and refined by our editorial team over many years. I try to give the benefit of the doubt to authors at this stage. At *Healthcare Policy/Politiques de Santé*, papers are more likely to be triaged for review than not to be.

Papers that pass initial triage are then assigned to one of the journal's editors. They oversee the review process. I am fortunate to work with a talented and committed team of editors from across the country: François Béland, Roger Chafe, Raisa Deber, Mark Dobrow, Eric Latimer, Joel Lexchin and Claude Sicotte, as well as Contributing Editor Steven Lewis.

The lead editor then works with Ania to select reviewers. Matching papers with reviewers' expertise is obviously key, but we also need to consider practical factors such as language and workload. We could not publish a high-quality journal without thoughtful reviewers who donate their time and expertise in the service of supporting the publication of relevant evidence that influences policy and practice.

I would like to take this opportunity to thank all those who have served in this capacity during the past year (see p. 86). Your continuing contributions and support are highly appreciated. Want to join the process? We welcome expressions of interest via our online reviewer database at <http://www.longwoods.com/reviewer-registration/healthcare-policy>.

Good reviews provide constructive feedback to inform both authors and editors, indicating the strengths and weaknesses of a manuscript. We also ask reviewers to provide a clear rationale for their publication recommendations and to flag any important issues for the editors' consideration, such as potential conflicts of interest. Editors aim to resolve significant

conflicts among reviewers and/or to identify which issues authors should focus on if a revise/resubmit decision is reached.

Most papers that are eventually accepted go through at least one revise/resubmit cycle. Sometimes only minor revisions are needed; other times changes requested are more significant. Authors' responses to the reviews are assessed by the responsible editor – sometimes in consultation with peer reviewers – before a final decision is reached in consultation with me.

Acceptances are fun to send; rejections are not, but the reality is that we receive many manuscripts and need to make difficult choices among them. Manuscripts that are accepted then proceed to final editing and, upon assignment of the volume and issue number, to production. After the page proofs are ready, authors have a chance to review them one more time to ensure accuracy.

We encourage authors to consider opportunities to proactively share their work with others. Longwoods Publishing works with authors in this regard, leveraging the publisher's social media, global dissemination, and other networks. The goal is to help spread key findings and thoughtful discussion and debate conclusions that appear in the journal's pages. Hopefully, readers will be inspired to take those findings further, informing policy, practice, or additional research ... and so the cycle begins anew.

To close, herewith my top tips for getting a "we are pleased to inform you" e-mail:

- *Submit*: Yes, this is obvious, but how many of us have completed research languishing in partially completed manuscripts?
- *Choose your journal well*: Journal mandates vary widely. You are wasting your time – and the editors' – if you don't carefully consider the match between your paper and the journal's focus, scope and audience.
- *Read the Instructions for Authors – and follow them*: Failure to do this, particularly failure to follow standard guidelines for reporting research and failure to support Discussion and Debate arguments with evidence – is the second most common reason that manuscripts fail to pass the initial triage, after a lack of alignment with the journal's scope.
- *If you are over the word limit, tighten and tighten again*: Yes, we occasionally make exceptions to the word limit where doing so is essential to accurately reflect research findings, but those situations are rare. Tightly written articles are more likely to be read and therefore more likely to have an influence on policy, practice, and the scholarly community. It behooves us all to streamline where we can.
- *Respond quickly and thoroughly to revision requests*: Clearly show how you have responded (or if not, why not) to the reviewers' comments. Also, delays in revising and resubmitting tend to be the longest stage in the publication process. The sooner an author follows up, the sooner we can move the manuscript forward.

We look forward to receiving your submissions!

JENNIFER ZELMER, PHD
Editor-in-chief

Démystifier le processus de publication

IL Y A RAREMENT, DANS LES COLLOQUES SCIENTIFIQUES, DES SÉANCES À GUICHETS FERMÉS, mais les panels où les éditeurs de revues démystifient le processus de publication sont souvent pleins à craquer. Pour épargner au lecteur les longues files d'attente, je consacre cet éditorial à un bref aperçu du chemin qu'empruntent les manuscrits avant d'être publiés.

Quand un article nous est soumis, notre directrice de rédaction, Ania Bogacka, effectue la présélection. Elle s'assure que l'article répond au mandat et aux exigences de la revue, conformément aux *Instructions pour les auteurs*, notamment pour les questions de longueur maximale et d'actualité des données.

Ensuite, en ma qualité de rédactrice en chef, je reçois les manuscrits pour le triage initial. Je les révise un à un pour voir s'ils sont conformes au mandat de la revue, pour déterminer si le développement justifie une révision, pour soupeser la force des arguments et du contenu scientifique, pour évaluer ce qu'ils apportent de plus aux connaissances actuelles, pour voir à quel point ils intéresseront notre auditoire de gestionnaires, de cliniciens, de décideurs, d'enseignants et d'universitaires et, finalement, pour détecter d'éventuels enjeux d'ordre éthique. Pour ce travail, je me réfère aux *Instructions pour les auteurs*, qui ont été développées et peaufinées par l'équipe de rédaction au cours des ans. À cette étape, je tente d'accorder le bénéfice du doute aux auteurs; le triage initial des manuscrits présentés à *Politiques de Santé/Healthcare Policy* a donc plus de chance de donner lieu à une révision qu'à un refus.

Les articles retenus après le triage initial sont assignés à un des éditeurs de la revue, qui supervise le processus de révision. J'ai la chance de travailler avec une équipe d'éditeurs talentueux et dévoués, provenant d'un peu partout au pays : François Béland, Roger Chafe, Raisa Deber, Mark Dobrow, Eric Latimer, Joel Lexchin et Claude Sicotte, de même que le conseiller de rédaction Steven Lewis.

L'éditeur principal travaille ensuite avec Ania pour choisir les réviseurs. Jumeler les articles à l'expertise des réviseurs est évidemment un élément déterminant, mais il faut aussi tenir compte de facteurs pratiques tels que la langue ou la charge de travail. Il nous serait impossible de publier une revue de qualité sans la contribution des réviseurs qui donnent de leur temps et prêtent leur expertise pour assurer la publication de données pertinentes qui influencent les politiques et la pratique.

Je profite de l'occasion pour remercier tous ceux qui ont travaillé comme réviseurs au cours de l'année écoulée (voir p. 86). Leur contribution et leur soutien sont vraiment très appréciés. Cela vous intéresse? Faites-nous part de votre intérêt par l'entremise de la base de données en ligne des réviseurs, à <http://www.longwoods.com/reviewer-registration/healthcare-policy>.

Les bonnes révisions donnent lieu à une rétroaction constructive qui renseigne tant les auteurs que les éditeurs, tout en indiquant les forces et faiblesses d'un manuscrit. Nous demandons aussi aux réviseurs de justifier clairement leurs recommandations et de signaler à l'éditeur toute question importante, par exemple, la possibilité d'un conflit d'intérêts. Les éditeurs

s'efforcent de régler les divergences entre les réviseurs et de repérer les points sur lesquels devraient se pencher les auteurs quand une décision de révision ou de resoumission est prise.

La plupart des articles acceptés passent par un cycle de révision ou de resoumission. Parfois, ce ne sont que des révisions mineures; parfois, les changements demandés sont plus importants. La réponse des auteurs est évaluée par l'éditeur responsable – quelque fois en consultation avec les pairs réviseurs – avant la décision finale à laquelle je participe.

Il est agréable d'envoyer les lettres d'acceptation; les refus sont plus malencontreux, mais nous recevons beaucoup de manuscrits et il faut faire des choix difficiles. Les manuscrits acceptés passent par la correction finale puis, une fois le numéro et le volume assignés, vont en production. Quand les épreuves sont prêtes, les auteurs ont l'occasion de les réviser une dernière fois pour s'assurer que tout est bien en place.

Nous encourageons les auteurs à partager proactivement leur travail. Longwoods Publishing travaille avec eux en ce sens, mettant à profit ses médias sociaux, sa diffusion mondiale et ses autres réseaux. L'objectif est de diffuser les résultats et les conclusions émanant des discussions et des débats qui paraissent dans les pages de la revue. Nous espérons que les lecteurs trouveront des idées pour véhiculer ces résultats, éclairer les politiques, la pratique ou d'éventuelles recherches; et ainsi se renouvelle le cycle.

Pour terminer, voici quelques conseils pour recevoir un courriel du type « Nous sommes heureux de vous annoncer ... » :

- *Soumettre* : Oui, cela est évident, mais combien parmi nous avons dans nos tiroirs des manuscrits à moitié terminés qui présentent des travaux de recherche?
- *Bien choisir la revue* : Les mandats varient beaucoup d'une revue à l'autre. Vous perdez votre temps – et celui des éditeurs – si vous ne tenez pas bien compte de l'adéquation entre votre article et la portée, l'auditoire et les intérêts de la revue.
- *Lire et respecter les Instructions pour les auteurs* : Le non-respect des directives pour présenter la recherche ou pour présenter les données en appui aux arguments dans les discussions et les débats constituent la deuxième raison la plus fréquente pour le refus d'un article au stade du triage initial, juste après la non-concordance avec la portée du journal.
- *Si vous dépassez la limite de mots, couper et couper encore* : Il est vrai que nous faisons parfois exception à la limite de mots quand cela est nécessaire pour présenter fidèlement les conclusions de recherche, mais cette mesure demeure rare. Les articles concis ont plus de chance d'être lus et donc d'avoir une influence sur les politiques, la pratique et les milieux universitaires. La concision bénéficie à tous.
- *Répondre rapidement et consciencieusement aux demandes des réviseurs* : Démontrez clairement comment vous avez répondu aux commentaires des réviseurs (et pourquoi pas, dans le cas contraire). Les délais dans la révision et la resoumission sont souvent les plus longs stades dans le processus de publication. Plus l'auteur assure rapidement le suivi, plus le manuscrit avancera rapidement dans la chaîne de production.

Nous attendons avec impatience vos soumissions!

JENNIFER ZELMER, PHD

Rédactrice en chef

The Sociopolitical Context of Canada's National Standard for Psychological Health and Safety in the Workplace: Navigating Policy Implementation

Contexte sociopolitique de la Norme nationale du Canada sur la santé et la sécurité psychologiques en milieu de travail : aperçu de la mise en œuvre de la politique



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Abstract

In January 2013, Canada introduced the National Standard for Psychological Health and Safety in the Workplace. This paper describes how the standard, which is the first of its kind internationally, came to be the instrument of choice within the current Canadian sociopolitical climate. A key consideration was that the policy tool had to be packaged in a manner that would be accessible and relevant across all workplaces and across all provinces and territories. This paper explores possibilities for future regulation of the standard.

Résumé

En janvier 2013, le Canada présentait la Norme nationale du Canada sur la santé et la sécurité psychologiques en milieu de travail. Cet article décrit comment la norme, première du genre au monde, est devenue l'instrument de prédilection dans le contexte sociopolitique canadien actuel. Un des principaux critères pour la conception de l'outil était qu'il devait être accessible et pertinent pour tous les milieux de travail ainsi que dans toutes les provinces et territoires. Cet article explore d'éventuelles réglementations liées à la norme.

Introduction

In January 2013, Canada introduced the National Standard for Psychological Health and Safety in the Workplace. This National Standard was created to address the rising legal, social and economic costs of mental health issues in Canadian workplaces. Until the announcement of the Standard, there was no national Act, regulation or standard that explicitly dealt with workplace conditions that could be the cause of mental injury (Lippel 2011).

The objective of the Standard is to promote employees' psychological health and prevent psychological harm due to workplace factors. It identifies 13 organizational factors that impact organizational health, such as organizational culture, psychological job fit, workload management, engagement, balance and psychological protection, and it provides a set of guidelines, tools and resources to address these (Shain and Nassar 2009). Key topics covered in the standard include the following: understanding the diverse needs of the organization's population so they can be appropriately addressed; establishing a policy and planning process to implement the system; identifying the organization's particularly hazardous substances (PHSs), assessing risks and implementing preventive and protective measures; ensuring infrastructure and resources are in place to support the system; providing education and awareness; and ensuring key people are trained and competent. The policy has been championed by the Mental Health Commission of Canada (MHCC) and developed by the Canadian Standards Association (CSA Group) and the *Bureau de normalisation du Québec*.

It is important to consider the sociopolitical context of the Canadian workplace to gain insight into the factors underlying the creation of the Standard. This article provides an overview of the development of the current conceptualization of policy on workplace mental health in Canada. We review policy alternatives, and discuss how the Standard came to be the instrument of choice within the current sociopolitical climate.

Problem Recognition

In a report titled "Making the Case for Investing in Mental Health in Canada", the MHCC (2013) reported that approximately 21.4% of the working population in Canada experienced mental health problems and illnesses, representing a cost of more than \$6 billion in lost productivity from absenteeism, presenteeism and employee turnover. This also represents a significant

social problem as mental ill-health has been shown to be a predictor of unemployment, reduced career goals, decreased quality of life and diminished community participation (Stuart 2004).

Over the past two decades, an increasing number of mental health-related legal claims have been filed under occupational health and safety, human rights laws and across other areas, including labour relations, employment standards, tort law (negligence) and workers' compensation (Shain 2010a). Mental health problems in the Canadian workplace account for approximately 30% of short- and long-term disability claims, and are identified by >80% of employers as one of the top three drivers of disability claims (MHCC 2013). These factors have led to a focus on employers' duty to provide a psychologically safe workplace and have led to what Shain (2010b) has depicted as a perfect legal storm for prompting improvements to Canadian workplace mental health.

Federal standards are not needed for policy areas that fall under provincial jurisdiction. *The Constitution Act, 1867*, allows provincial and territorial legislatures in Canada to create employment laws governing health and safety; therefore, Canada has 14 sets of Occupational Health and Safety (OHS) laws from its various jurisdictions (Pang 2013). Many jurisdictions began to address psychological health and safety by adding the concepts of workplace violence or psychological harassment (including bullying) to their existing OHS laws and regulations. For example, as early as 2004, Quebec became the first jurisdiction in North America to acknowledge workers' right to a workplace free of psychological harassment, placing responsibility on employers for preventing workplace harassment (Lippel 2011). A uniform policy at a national level would provide a benchmark for all Canadian provinces and territories, and would deliver a standardized framework to help employers improve psychological health and safety in workplaces with a consistent approach across Canada.

Policy Arena for Workplace Mental Health Reform

The Canadian workplace mental health policy community consists of various levels of government, academia, special interest groups, and public and private organizations that appear to share a common goal: to improve the lives of individuals living with mental health issues. Once largely considered to fall within the realm of the biomedical model, a paradigm shift over the past two decades in psychiatry now positions mental illness as a bio-psychosocial issue (Ramon and Williams 2005).

The global emphasis on workplace mental health can be traced to the World Health Organization (WHO), which led to the development of a series of information modules to guide governments to strengthen mental health policies and legislation plans. One of the modules specifically addresses the government's role in "establish[ing] policy and legislation in key areas, including safety and health at work, mental health policy and services, and reduction of unemployment" (WHO 2005: 2), which had been reflected in Canadian discourse and practice.

An example of a national targeted workplace strategy to create a mentally healthy workplace is the government-funded "Heads Up" initiative in Australia (2017). Although

this initiative has not been introduced as a policy or a standard, it is funded through the Commonwealth Department of Health. "Heads Up" provides individuals and businesses across Australia with free tools and resources to address mental health in the workplace. The estimated return on investment of this program is significant: for every dollar (AU\$) spent on creating a mentally healthy workplace in Australia, there is on average AU\$2.30 in benefits to be gained by the organization (PricewaterhouseCoopers 2014).

In Canada, workplace mental health is complicated by the provincial healthcare system structure, in which planning and decision-making in healthcare are delegated to provincial governments, resulting in provincial variations within the healthcare system (Deber 2003) and provincial mental healthcare delivery. This arrangement has resulted in provincial disparities in mental health service delivery, which were highlighted in a federal report that reviewed the current and future states of healthcare in Canada: *The Health of Canadians – The Federal Role*, released in 2002 (Canada Parliament 2002). Canada's overall mental health service provision was identified as problematic. The Standing Senate Committee on Social Affairs, Science and Technology was then authorized to further examine and report on the mental health system in Canada (Kirby and Keon 2006). This committee assessed the status quo as unacceptable, and made 118 recommendations to improve the system (Kirby and Keon 2006). A key recommendation was to establish the MHCC. The MHCC was established with a mandate to improve mental health services across the country, and to change the attitudes and behaviours of Canadians around mental health issues (MHCC 2012).

The MHCC's delivery of the first National Mental Health Strategy, *Changing Directions, Changing Lives*, provides a common vision for Canada's mental health system (MHCC 2012), and acknowledges that mental health is "not the concern of the health sector alone" (MHCC 2012: 9). Workplace mental health is captured within the first strategic direction "promotion and prevention" (MHCC 2012). The MHCC Workforce Advisory Committee was created to undertake three primary projects, one of which was to establish the Standard for Psychological Health and Safety in the Workplace. For the first time in Canadian history, the workplace was identified as a venue for mental health recovery and for the prevention of mental health issues.

Is a Formal Legislative Framework Possible?

The Standard for Psychological Health and Safety in the Workplace is voluntary. Criticisms of voluntary standards include the generous latitude that comes with self-regulation and also that voluntary standards may lead to imperfect outcomes (Castro 2011). Formal legislation could circumvent these limitations. However, legislation comes with its own complexities, as a legislated Standard would also have to intersect with different existing federal and provincial Acts and Regulations, and could lead to imperfect outcomes. Therefore, the remainder of this article discusses pros and cons of formal policy alternatives, drawing on Vedung's (1998) typology of policy instruments.

This national initiative – as indicated earlier, it also includes Quebec – faced limited workplace mental health policy options. The policy tool had to be packaged in a standardized manner that would be accessible and relevant across all workplaces and across all provinces and territories. Targeting only high-incident industries and/or penalizing some organizations and not others were not options. The policy tool also had to be relatively non-threatening to those adopting it. As such, swift regulations or potentially paternalistic interventions (as described by Vedung and van der Doelen 1998) were less feasible than introducing a standard as a first, voluntary measure. This would help the public to “soften up” to the idea, and possibly create a climate receptive to more significant changes in the future if needed (Kingdon 2003).

Vedung (1998) identifies three key policy instruments: economic means (“carrots”), regulations (“sticks”) and information (“sermons”). As the new standard is essentially a set of systematic guidelines, it is a “sermon”: the least intrusive policy initiative to address a public problem (Vedung and van der Doelen 1998). This type of information program within the public policy process uses the least amount of coercion exercised by government. It aligns private and public interests (Vedung 1998) by promoting an enhanced, healthy and productive workforce.

Introducing the Standard as a voluntary initiative also provides opportunity to develop infrastructure to support more formal regulation and to evaluate the effectiveness of the policy. The Standard could be monitored for perverse effects, such as boomerang effects, or a shift in the attitude in the direction opposite to that intended (Vedung and van der Doelen 1998).

Looking forward, National Standard evaluations are a logical starting place for the design of optimal policy instruments. For instance, the federal or provincial governments could eventually introduce economic policy instruments (e.g., economic subsidies, tax credits or an accreditation system) to incentivize compliance with the National Standard (Vedung 1998). Stronger government control could also take the form of mandatory compliance. Organizations failing to comply with the National Standard could face economic sanctions. Such a regulation might be justified on the grounds that it can help correct the significant economic costs associated with mental health in the workplace.

It is possible that had the voluntary Standard been first introduced as national or federal regulation, the reaction by affected social groups would have been positive. However, the implementation of the regulation may have faced resistance from employers; the cost of implementation, lack of infrastructure and uncertainty of the impact would present significant concerns. More significantly, an infrastructure to monitor and regulate such a policy would have been needed. Formal enactment of the policy as a regulation would require the right political climate and national mood (public opinion) to provide a political window of opportunity for enduring change (Kingdon 2003).

Uptake of the Standard

To facilitate uptake of the National Standard, the MHCC introduced an implementation guide for employers in 2014 (CSA Group and MHCC 2014). This guide was introduced to help employers understand the Standard, and to provide a framework that addresses the

stages of implementation to develop a psychologically healthy and safe workplace. In addition to the implementation guide, the CSA Group, *Bureau de normalisation du Québec* and the MHCC have provided a free, voluntary Standard Audit Tool that organizations can access to conduct an internal audit (CSA Group et al. 2013). Information gleaned by means of this tool can be used to highlight areas within the organization that require further attention to meet the requirements of the Standard.

Despite the introduction of the guidebook, and the strong legal and scientific arguments underpinning the development of the Standard, there are many challenges to overall adoption in the workplace. Preliminary investigations indicate that the scope and complexity of the Standard can pose challenges for its uptake and application in the workplace, and that some employers had limited awareness of the Standard altogether (Kalef et al. 2015; Kunyk et al. 2016). Simplified engagement and implementation strategies may be needed along with a tailoring of the Standard to nuanced differences between types and sizes of industries.

Discussion

The 2013 Standard is the first national attempt towards remediation of psychologically unhealthy workplaces. Despite activities to facilitate the uptake of the new voluntary Standard, significant barriers remain. These barriers include the comprehensive nature of the Standard and a lack of visible outcomes for employers adopting the Standard, which may impact the speed at which employers take it up. Another potential barrier is the significant investment required by employers, as resources and human capital may need to be allocated to ensure that the policy is being implemented and supported within their organization. Finally, another challenge to the uptake of the Standard is stigma towards mental health issues, which remains pervasive in the Canadian workplace.

If the Standard remains voluntary, there is potential for selective uptake, which could contribute to workforce inequalities across provinces and territories and/or across industries and work sectors. The impact of the Standard as a voluntary initiative will have to be carefully monitored, and it will require continued research and discussion. Depending on the outcome of the implementation of the voluntary Standard, the government might consider a more controlling policy such as (dis)incentives or regulation. For this to happen, the Standard would have to be integrated into existing provincial policy and legislation. The political climate and public perception, including among employers, would also have to be ripe to accept more stringent regulation. Nonetheless, by introducing the voluntary Standard, national public policy makers have made a first step towards improving workplace conditions for psychological health and safety. The political climate and the policy agenda will ultimately determine if the Standard will remain voluntary or if it will become regulation in Canada.

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What Do We Know and Not Know about the Professional Integration of International Medical Graduates (IMGs) in Canada?

Que sait-on et qu'ignore-t-on au sujet de l'intégration professionnelle des diplômés internationaux en médecine au Canada?



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Abstract

Background: The literature on international medical graduates (IMGs) in Canada is growing, but there is a lack of systematic analysis of the literature.

Objectives: To examine (1) the major themes in academic and grey literature pertaining to professional integration of IMGs in Canada; and (2) the gaps in our knowledge on integration of IMGs.

What Do We Know and Not Know about the Professional Integration of IMGs in Canada?

Methods: This paper is based on the scoping review of academic and grey literature published during 2001–2013 about IMGs in Canada.

Results: The literature on IMGs focuses on (1) pre-immigration activities; (2) early-arrival activities; (3) credential recognition/professional recertification; (4) bridging and residency training; (5) workplace integration; and (6) alternative paths to integration. The gaps in the literature include pre-immigration and early-arrival activities, and alternative paths for integration for those IMGs who do not pursue medical license.

Conclusion: Pre-immigration and early-arrival activities and alternative career paths for IMGs should be addressed in academic and policy research.

Résumé

Contexte : Il existe de plus en plus de littérature sur les diplômés internationaux en médecine (DIM) au Canada, mais il y a un manque d'analyse systématique de cette littérature.

Objectifs : Examiner (1) les principaux thèmes de la littérature scientifique et grise au sujet de l'intégration professionnelle des DIM au Canada; et (2) les lacunes en matière de connaissances sur l'intégration des DIM.

Méthode : Cet article se fonde sur un examen de portée de la littérature scientifique et grise sur les DIM au Canada publiée entre 2001 et 2013.

Résultats : La littérature sur les DIM porte principalement sur (1) les activités avant l'immigration et (2) dans les premiers temps après l'arrivée; (3) la reconnaissance des titres de compétence/la recertification professionnelle; (4) la formation de transition et en résidence; (5) l'intégration au milieu de travail; et (6) les autres parcours d'intégration. Les lacunes de la littérature touchent aux activités avant l'immigration et dans les premiers temps après l'arrivée ainsi qu'aux autres parcours d'intégration pour les DIM qui ne convoitent pas un permis de pratique médicale.

Conclusion : Les activités avant l'immigration et dans les premiers temps après l'arrivée, ainsi que les autres parcours de carrière, devraient faire l'objet de recherches universitaires et politiques.

Introduction

The status of international medical graduates (IMGs) and the role they play in provincial and territorial health systems have been a consistent topic within public and policy dialogues for over a decade. On the one hand, IMGs are seen as a pool of highly skilled professionals, who, with the right assessment and/or upgraded training, can practise medicine in Canada. On the other hand, concerns about the ethical aspects of recruiting IMGs have been raised with the corollary focus on domestic production towards the goal of self-sufficiency (ACHDHR 2009). Reflecting these tensions has been a growing literature on the role of IMGs in Canada. Synthesizing this literature is both timely and necessary for informed policy making.

This paper summarizes the key findings from the knowledge synthesis conducted by the Canadian Health Human Resources Network (CHHRN) on the role of Internationally

Educated Health Professionals (IEHPs) in Canada with a focus on IMGs. Specifically, it synthesizes the existing academic and grey literature on the professional integration of IMGs in Canada and addresses the following questions:

1. What are the major themes in the academic and grey literature pertaining to professional integration of IMGs in Canada?
2. What are the gaps in our knowledge on integration of IMGs that can be addressed in policy and research?

Generating this knowledge can help inform better health human resources policies.

Methods

We conducted a scoping review of academic and grey literature about IMGs in Canada as part of a large review of IEHPs. Our work was guided by an updated version of Arksey and O'Malley's (2005) six-step methodological framework for scoping reviews. Using the keywords (alone and in combination) *physicians, foreign-trained, foreign-graduate, international medical graduate, health professionals, internationally educated, migrant, immigrant* and *Canada*, we searched CINHALL, EMBASE and PubMed electronic databases for academic and peer-reviewed literature that was published from 2001 to 2013 about IMGs in Canada. The same keywords' strategy was used to identify grey literature via the Canadian Electronic Library and the Canadian Health Human Resources Network (CHHRN) Library – an online repository of academic and grey literature on health human resources in Canada. We also conducted Internet searches of federal, provincial and territorial governments and professional and immigrant associations' websites and hand-searched the bibliographic information of both the grey and academic literature. Both French and English sources were collected for the analysis.

An advisory council of stakeholders (experts from academia, government and professional organizations on the integration of IEHPs [and IMGs]) was consulted throughout the project and near the conclusion. The stakeholders recommended additional literature not identified in the formal searches and provided feedback that we used to interpret the findings.

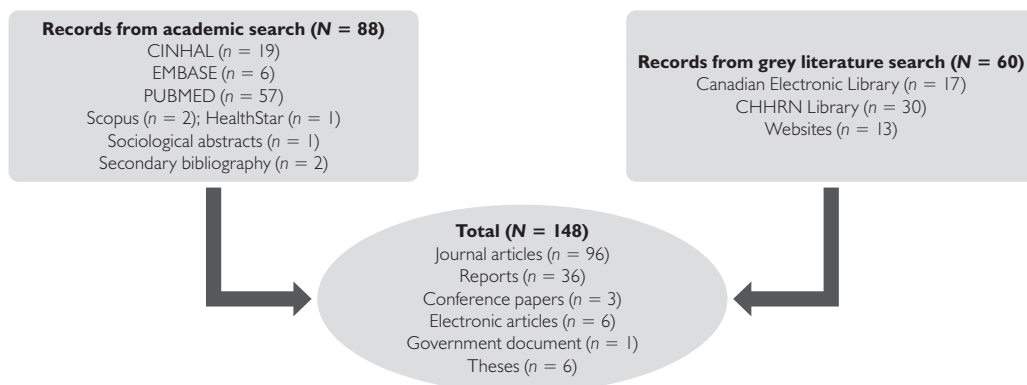
To be included in the analysis, the identified sources had to be about IMGs in Canada, published during 2000–2013, and written in either English or French. We reviewed the abstract (or first page/executive summary) of each source to ensure it followed our inclusion criteria. Our coding scheme was developed inductively from the literature (Bradley et al. 2007) and was operationalized in the form of a literature extraction tool created in Microsoft Excel. A team of five researchers worked on the coding scheme and analysis using the literature extraction tool. Each source was coded under one of the following six major themes: pre-immigration activities, early arrival, credential recognition and professional recertification, bridging and residency, workforce integration and alternative paths to integration, and, if warranted, under one or more minor themes. To confirm the reliability of the coding

scheme, each investigator independently coded 10 sources (Zhang and Wildemuth 2009). We then compared our results and discussed discrepancies in our coding until consensus was reached; we refined our coding scheme accordingly (Fereday and Muir-Cochrane 2006).

Results

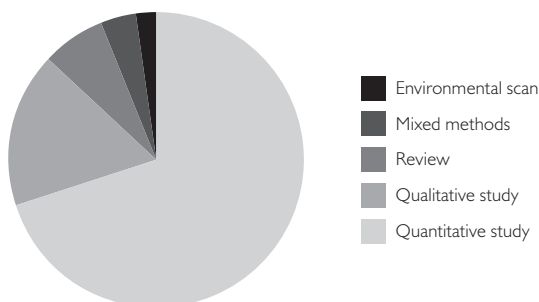
In total, 148 sources were retained for analysis (see Figure 1).

FIGURE 1. Literature search



Articles in academic journals were the most common source for information about IMGs (N = 96). They were followed by academic and government-issued reports (N = 36). More than half (58.1%) of the literature summarized empirical studies (see Figure 2 for breakdown of empirical methods used).

FIGURE 2. Empirical studies (N = 86)

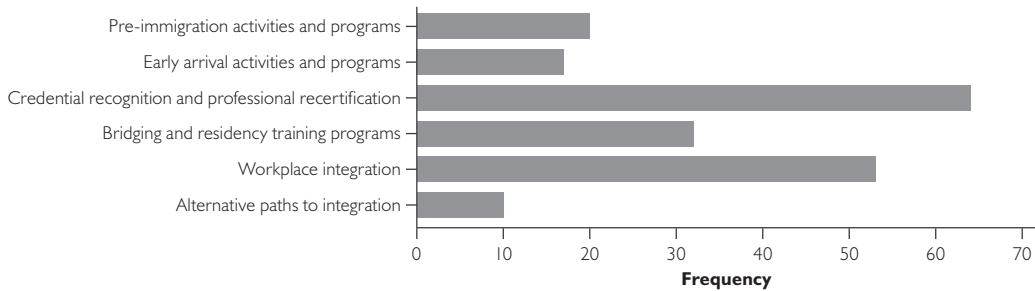


Over half of all literature (55%) was focused on Canada in general or multiple jurisdictions across Canada. This was followed by the literature focused specifically on the provinces of Ontario (14%, N = 21), British Columbia (8%, N = 12) and Alberta (7%, N = 11). The rest of the provinces and territories were discussed much less often (each <5%).

We found that the literature on IMGs can be broadly mapped into the following six major categories: (1) pre-immigration activities and programs; (2) early-arrival activities; (3) credential recognition and professional recertification; (4) bridging and residency training programs; (5) workforce integration; and (6) alternative paths to integration.

Because some sources were coded in more than one theme, a total of 196 sources were coded in these thematic categories (see Figure 3).

FIGURE 3. Frequency of thematic categories of the Canadian IMG literature



IMG = international medical graduate.

In what follows, we provide a brief overview of each of the major themes, identify gaps in our knowledge and offer recommendations for research and policy.

Pre-immigration activities and programs

In this thematic category, we coded the literature that examined the recruitment of IMGs, push and pull factors that drive IMGs to leave their home country and/or choose Canada as a country of destination, and the activities that are or should be undertaken *before* IMGs arrive in Canada to facilitate the process of professional integration. In terms of the push and pull factors that motivate physicians to move to Canada, most of the literature links the decision to immigrate to the poor economic and social conditions that IMGs experience in their home country (de Carvalho 2007; Klein et al. 2009). It seems that Canada is chosen by IMGs because of its political and economic stability, professional opportunities and personal considerations (Bourgeault et al. 2010). Other than noting these factors, the literature does little to enumerate which of these factors are the most important causes for either push or pull.

The literature does, however, problematize the “pull” factors. Much of it condemns the practice of “poaching” physicians from abroad, finding it ethically problematic (College of Physicians and Surgeons of Ontario 2010; Dauphinee 2005). It is also evident that the gaps in the distribution of physicians have driven many provinces to recruit physicians from abroad (Audas et al. 2004; Physician Recruitment Agency of Saskatchewan 2012; Shuchman 2008; Urowitz et al. 2008). Finally, some literature explores the implications of poor health human resources (HHR) planning and “boom–bust cycles”, where the perceived shortages of physicians are followed by the cycles of perceived oversupply (Dauphinee 2005; Deber 2010).

The literature also examines IMGs’ pre-arrival activities or lack thereof. The Foreign Credentials Referral Office (2011), for example, notes the importance of initiating the process of professional recognition early. Although the Medical Council of Canada offers Evaluating Examination (MCCEE) at more than 500 centres worldwide (Medical Council of Canada

2010), at the time of the review only about half of IMGs attempted to write it before arriving in Canada. This may be because some newcomers are led to believe that the immigration point system that is implemented to assess their eligibility to immigrate to Canada reflects their employability (de Carvalho 2007). Therefore, many are disillusioned once they arrive in Canada and begin the process of professional integration (Neiterman and Bourgeault 2012).

Early-arrival activities and integration programs

Only a relatively small proportion (8.67%) of the literature addressed the particular immigration route that IMGs took and the role of government organizations, settlement agencies and professional associations in facilitating the process of professional integration of IMGs early in their arrival process. Generally, the literature suggests that, upon arrival, IMGs are often experiencing confusion and lack of knowledge about the system navigation in Canada, which can result in unnecessary delays in the process of professional recertification (Bourgeault et al. 2010). In addition to these issues, one of the major barriers for professional recertification is a financial one (Johnson and Baumai 2011). Overall, the reports from the literature indicate that physicians recruited under Provincial Nominee Programs or those holding provisional licenses are more rapidly integrated than those who arrive as skilled workers (or through other immigration categories, such as family class or refugees) and are trying to certify independently (Johnson and Baumai 2011). The literature also raises concerns about physicians' "brain waste" and calls for better integration between federal and provincial immigration/labour policies (Dove 2009; Nelson et al. 2011). To address this problem, some provincial programs subsidize IEHPs by repaying up to 50% licensure process costs (Prince Edward Island ANC 2011).

Although the importance of providing support to the newcomer IEHPs is recognized in research and policy, the literature discusses only a handful of government programs and organizations that cater to the needs of newly arrived healthcare professionals (Health Force Ontario 2012; Jablonski 2012). Generally, such programs and organizations have been found to be very effective and highly beneficial to the integration of IMGs. For instance, the Access Centre for Internationally Educated Health Care Professionals run by Health Force Ontario (2012) addresses the needs of newly arrived IMGs and other IEHPs by providing counselling, orientation and information services, as well as some on-site courses. The Association of Faculties of Medicine of Canada provides training to IMGs and their teachers about the experiences of IMGs and the challenges on their route to professional integration (Armson and Crutcher 2006). Many services are also offered by local associations of immigrant physicians, such as the Association of International Physicians and Surgeons of Ontario (AIPSO) or Alberta International Medical Graduates Association (AIMGA) (AIPSO 2013; Bobrosky 2010; McMahan 2009). These organizations may also advocate on behalf of IMGs with provincial governments (AIPSO 2000; McMahan 2009). These efforts notwithstanding, the literature on early-arrival activities and system navigation is not particularly rich, and we need to learn more about the experiences of IMGs upon their arrival in Canada.

Credential recognition and professional recertification

In this largest thematic category (32.7%, $N = 64$), the literature focused on credential recognition, national examinations, Canadian Resident Matching Service (CaRMS) and various barriers that may complicate the process of licensure for IMGs. Most of this literature discusses the many challenges experienced by IMGs, including credential verification, financial barriers, limited assessment options and (lack of) bridging opportunities; however, the key challenge for IMGs at this juncture seems to be the national licensure examinations (Boyd and Shellenberg 2008; Kogo 2012; Office of the Fairness Commissioner 2009; Ontario Ministry of Health and Long-Term Care 2013). Canadian Medical Graduates (CMGs) significantly outperform IMGs on the Medical Council of Canada professional exams (MCCEQ1 and MCCEQ2) (MCC 2013). CMGs also do much better than IMGs on the certification examinations of the College of Family Physicians of Canada (CFPC) (e.g., 90.4% versus 66% for 2007) and Royal College of Physicians and Surgeons of Canada (95% versus 75% for 2005–2009) (Walsh et al. 2011). The reasons for these differences have been attributed to IMGs' unfamiliarity with such types of examinations (MacLellan et al. 2010; Peters 2013; Vallevand and Violato 2012), problems with communication skills and different training (Baig et al. 2009; Peters 2013), as well as financial burden, problems with self-esteem and cultural competency (Bourgeault et al. 2010; Sharieff and Zakus 2006).

The Medical Council of Canada Evaluating Examination (MCCEE) received the most controversy in the literature because this exam has been written only by IMGs as a prerequisite for regular examinations (Boyd and Shellenberg 2008). Some IMGs suggested that this examination is expensive and discriminatory (Ahmed 2003; AIPSO 2013). It is worth to note, however, that there is significant correlation between IMGs' success on the MCCEE and their subsequent performance on MCC and certifying examinations – there is 70% more likelihood of passing MCC qualifying exams for IMGs who passed the MCCEE on their first attempt (McMahon 2009). The fact that Canadians Studying Medicine Abroad (CSAs) and some IMGs have a much higher passing rate of the MCCEE than others suggests that medical school and culture play a role in the success at the MCCEE (McMahon 2009). A number of studies note that racial and ethnic background and the country of graduation can determine one's likelihood of receiving professional license (Boyd and Shellenberg 2008; Foster 2008; McDonald and Worswick 2010).

The need to achieve some national standards for assessment of IMGs' training and education has been recognized by federal and provincial stakeholders, including the Federation of Medical Regulatory Authorities of Canada (FMRAC), the Royal College of Physicians and Surgeons of Canada (RCPSC) and the College of Family Physicians of Canada (CFPC). In 2009, the Pan-Canadian Framework for the Assessment and Recognition of Foreign Qualifications was established with a promise to assess medical education starting 2012, with the goal to streamline the process of credential assessment for IMGs in Canada (McMahon 2009). The literature identifies other promising practices, such as an establishment of national

Objective Structured Clinical Examination (OSCE) and the new electronic process that simplifies the application for licensure for IMGs by allowing immigrant physicians to apply to all provinces simultaneously (Doyle 2010). The report of the IMGs national database provides statistics and data for IMGs' registration for each province (AFMCC 2006).

In sum, IMGs face cultural, financial, structural and organizational barriers during the process of professional integration (Banner et al. 2013; Neiterman and Bourgeault 2012). The literature highlights the sense of confusion that IMGs report when navigating the system (Matejicek 2009; Wong and Lohfeld 2008). Policy makers are evidently aware of these challenges and work towards streamlining the process of credential recognition for IMGs (Bowmer 2005; Canadian Medical Association 2008; Doyle 2010; Masalmeh 2009).

Bridging programs & residency training

A small proportion of literature on IMGs (16.3%) examined the bridging programs and residency training available to immigrant physicians. The number of IMGs entering postgraduate residency positions increased from 77 in 2000 to 407 in 2012, over a 528% increase (CaRMS 2013), but IMGs are still less likely to obtain residency training than CMGs (Table 1). It is interesting to note that one of the key bottlenecks to IMG integration – securing a residency – while certainly present, is not reflected in the frequency of its treatment in the literature.

TABLE 1. CaRMS results for IMGs 2006–2012

Year	IMG participation	Match results	Percentage
2006	932	111	11.9
2007	1,125	69	6.2
2008	1,299	305	23.5
2009	1,387	294	21.2
2010	1,497	274	18.3
2011	1,920	380	19.8
2012	2,156	407	18.9

CaRMS = Canadian Resident Matching Service; IMG = international medical graduate. Source: CaRMS 2013.

In addition to the notable difficulties in obtaining residency positions, IMGs also face challenges once in residency. These include cultural or ethnic discrimination (Bates and Andrew 2001; Crutcher et al. 2011), lack of cultural capital and communication barriers (Allan et al. 2007; Childs and Herbert 2007; Jain et al. 2012). To address the challenges faced by IMGs in residency, some provinces established mandatory or voluntary pre-residency educational and/or bridging programs (Curran et al. 2008; Stenerson et al. 2009). For instance, in Ontario, a four-month program for family medicine residents is offered through the Centre for the Evaluation of Health Professionals Educated Abroad (CEHPEA, now referred to as the Touchstone Institute) (Thomson and Cohl 2011).

A growing body of literature focuses on the Canadian students studying in overseas medical schools (CSAs). The number of CSAs is reported to be as high as 3,600 (Dhalla 2011). Literature suggests that CSAs typically study in the Caribbean, Ireland and the UK and that >90% of CSAs plan to return to Canada for residency training (Banner et al. 2013; Keenan 2005). The voices of CSAs reflected in the literature call for a distinct path for integration that would recognize their unique set of skills and qualifications (Evangelista 2000; Keenan 2005; Violato et al. 2011).

Workplace integration

The second largest category of the literature on IMGs (27%, $N = 53$) examines the integration and retention of IMGs, their mobility after licensure and their adaptation to the Canadian clinical practice. The literature on workplace integration identifies a number of facilitating factors that contribute to retention of IMGs. These include successful workplace and social integration, difficulties in obtaining full license, remuneration and (if applicable) spouse's satisfaction (Kogo 2012; Mayo and Mathews 2006). Clearly, larger social integration is a key factor for the successful retention of IMGs (Curran 2008).

While IMGs are often recruited to underserved/rural areas, the literature suggests that they do not provide long-term sustainability to rural practice, as they tend to move to urban centres once fully certified (Audas et al. 2009; Landry et al. 2010; Mathews et al. 2008). Evidently, IMGs follow the patterns of interprovincial migration of CMGs (Dauphinee 2006; Watanabe 2008). In addition to interprovincial migration, a small proportion of IMGs (<1% throughout 1995–2005) is leaving Canada to go back to their home countries or to the US (Watanabe 2008). Approximately one-third of these IMGs return to Canada within five years, which suggests complex and non-linear health workforce migration paths.

Literature also examines the differences and similarities between CMGs' and IMGs' clinical practice. It was found that IMGs and CMGs differ in the rates of referrals to some medical tests (colonoscopy), provision of preventative and maternity care, and prescription of antibiotics and other medications (Cadioux et al. 2007; Jacob et al. 2011; Thind et al. 2007, 2008). In general, literature is dominated by the focus on the location of IMGs' practice and not the content of their clinical work.

Alternative paths to integration

There is very little information available about IMGs who have not been certified as physicians in Canada. It is estimated that in 2006, there were almost 14,500 such individuals in Canada (McDonald and Worswick 2010). Given that so many IMGs are unable to integrate professionally in Canada for various personal and structural reasons, it is of concern that we know so little about the alternative paths for integration of IMGs. Only 10 sources were coded in this thematic category, most of which focused on what *should* be done (as opposed to what *is* done) to provide IMGs with alternative employment opportunities (Brotten 2008). The physician assistant (PA) programs have been found to be popular among IMGs (Bhimji 2010;

Magnus 2008); however, representatives of PA programs are reluctant to accept IMGs as students because they are often construed as choosing PA training as a transition stage (Fereday and Muir-Cochrane 2006).

Discussion

The goals of this research were to consolidate the growing literature on IMGs, identify knowledge gaps and provide recommendations for policy and research. Overall, the literature on IMGs is generated by academics, policy makers, professional associations and government bodies and is unevenly spread across Canadian provinces. The key themes identified in our analysis follow the trajectory of professional integration of IMGs from arrival planning to workplace integration (or alternative paths for employment).

Our findings on the state of knowledge about IMGs in Canada are summarized in Table 2.

TABLE 2. State of knowledge on IMGs in Canada

What we know	Gaps in research and policy
Push/pull factors model is often used to explain international mobility of IMGs	Which push/pull factors are most critical for migration-related decision-making?
Pre- and early arrival activities and programs facilitate professional integration	How to improve accessibility of pre-and early arrival activities and programs for IMGs?
Professional integration remains a challenge for IMGs	What is our state of knowledge about the access to residency training for IMGs?
Compared to CMGs, IMGs do not do well on professional examinations	How to ensure that current licensure requirements are transparent and not informed by practices that could be considered discriminatory?
Thousands of IMGs are not successful in obtaining licensure in Canada	What are the alternative career paths for IMGs who are unable to practice medicine?

CMGs = Canadian medical graduates; IMGs = international medical graduates.

We found that the literature on professional certification and workplace integration dominates the field of research on IMGs. Surprisingly, despite its significance as a key barrier for IMGs' integration, the access to residency training is not discussed in the literature as frequently as other integration themes. We also found that pre-immigration activities and programs and early-arrival activities of IMGs do not receive sufficient attention in the literature and policy. Engaging in pre-arrival and early-arrival activities that facilitate professional licensure has been shown to considerably improve the IMG's professional success (FCRO 2011). Another gap in the literature and policy is the lack of literature about (and, possibly, options for) alternative paths of professional integration for those IMGs who do not pursue medical license. Given that thousands of IMGs do not become licensed physicians, it is important to identify how and where their valuable skills can be utilized.

The systematic, transparent and rigorous methods we used to identify the literature, gaps in evidence and future areas for research, as well as our consultation with community representatives, are major strengths of this review (Arksey and O'Malley 2005).

The limitation of our methodological approach is that we did not evaluate the quality of the literature we collected (Grimshaw 2014). Future research can address this by conducting more focused literature synthesis on any of the key themes identified in this review.

In conclusion, we would like to offer a number of recommendations for policy and research. First, there is a need to communicate the importance of pre- and early-arrival activities for IMGs' professional recertification. This includes not only providing IMGs with an *opportunity* to write professional examinations in their home country but also *communicating* the pivotal implications of these activities and *improving access* to early-arrival programs once in Canada. A more contested area for policy discussion is IMGs' demand to reconsider some of the existing requirements for professional integration (e.g., MCCEE). These debates touch upon the fairness of the existing approach and hint at (un)intentional discrimination of internationally trained physicians. Reviewing licensure requirements for IMGs and CSAs may prove useful in making the rationale for their existence more transparent, demonstrating their effectiveness and identifying any redundancies if such exist. Finally, there is a need to pay much more attention in policy and research to IMGs who do not obtain professional license. Providing alternative forms of employment to these highly skilled healthcare professionals can benefit the Canadian healthcare system and give IMGs a sense of fulfillment and a hope that there still is a future for them in Canada.

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Retention Patterns of Canadians Who Studied Medicine Abroad and Other International Medical Graduates

Schémas de rétention du personnel chez les Canadiens qui ont étudié la médecine à l'étranger et chez les autres diplômés internationaux en médecine



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Abstract

Objectives: Are Canadians who study abroad (CSAs) more likely to stay in Canada than other international medical graduates (IMGs)? We looked at retention patterns of CSAs and immigrant IMGs who completed post-graduate medical education (PGME) training in Canada to describe the proportion and predictors of those working in Canada and in rural communities in Canada in 2015.

Methods: We linked the National IMG Database to Scott's Medical Database to track the work locations of CSAs and immigrant IMGs in 2015.

Results: Of the 1,214 IMGs who entered PGME training in Canada between 2005 and 2011, most were working in Canada in 2015 (88.0%). Relatively few IMGs worked in rural communities (9.1%). There were no differences in work location patterns of CSAs and immigrant IMGs.

Conclusion: Contrary to what CSA advocates suggest, CSAs have the same retention patterns as immigrant IMGs. PGME admission policies should treat all IMGs in the same manner, regardless of their citizenship or residency before medical school.

Résumé

Objectifs : Les Canadiens qui ont étudié à l'étranger (CEE) sont-ils plus susceptibles de rester au Canada que les autres diplômés internationaux en médecine (DIM)? Nous avons examiné les schémas de rétention du personnel chez les CEE et chez les DIM immigrants qui ont terminé un programme de formation médicale postdoctorale (PFMP) au Canada, et ce, afin de décrire la proportion – et les indicateurs correspondants – de personnes qui travaillent au Canada et dans les collectivités rurales canadiennes, en 2015.

Méthode : Nous avons effectué un croisement entre la Base de données nationale sur les DIM et la Base de données médicales Scott's afin de localiser les lieux de travail des CEE et des DIM immigrants en 2015.

Résultats : Parmi les 1 214 DIM qui ont participé à un PFMP entre 2005 et 2011, la plupart travaillaient au Canada en 2015 (88,0 %). Relativement peu de DIM travaillaient dans des collectivités rurales (9,1 %). On ne remarque aucune différence dans les schémas de lieu de travail entre les CEE et les DIM immigrants.

Conclusion : Contrairement à ce que les défenseurs des CEE suggèrent, les CEE connaissent les mêmes schémas de rétention du personnel que les DIM immigrants. Les politiques d'admission aux PFMP devraient traiter tous les DIM de la même façon, sans égard à leur citoyenneté ou à leur programme de résidence avant l'école de médecine.

Introduction

International medical graduates (IMGs) are an important source of new physicians to Canada. Although many IMGs are able to immigrate to Canada and immediately practice on restricted or provisional licenses (Audas et al. 2004, 2005; Basky 2000; Nasmith 2000),

other IMGs must complete post-graduate medical education (PGME) training, typically in the form of a residency. The term “IMG” includes Canadian citizens and residents who graduated from medical school abroad (Canadians who study abroad [CSAs]). Compared to Canadian medical graduates (CMGs), a larger proportion of CSAs are male, older, have more post-secondary education, have a parent who is a physician and have applied fewer times for admission to medical schools in Canada (Banner et al. 2010). Compared to immigrant IMGs, a larger proportion of CSAs are male, younger than 35 years old, single and without children (Szafran et al. 2005).

Like most IMGs, CSAs must complete PGME training to qualify for examinations needed for full licensure in Canada. Most CSAs have few opportunities to complete PGME training where they went to medical school and thus return to Canada to complete PGME training and practice (Banner et al. 2010). Recent studies have found that CSAs are more likely to obtain PGME training positions than their immigrant IMG counterparts (Thomson and Cohn 2011b), and that there is some evidence to support the suggestion of bias in the selection process (Andrew 2010). Despite having less clinical experience, CSAs appear to be more successful than immigrant IMGs in obtaining a residency position (Szafran et al. 2005). Thomas and Cohn (2011b) attribute the difference to initial screening criteria that emphasize recent medical school graduates and clinical experience in North America. Unlike immigrant IMGs, CSAs are closer to their undergraduate medical training (many CSAs apply for residency during the fourth year of medical school) and are more likely to have done clinical rotations in North America as part of their undergraduate medical program (Banner et al. 2010; Thomson and Cohn 2011a). Szafran et al. (2005) suggest that interviews may play an influential role in the selection process and may disadvantage immigrant IMG applicants.

Post-graduate training positions for IMGs are a limited resource in the medical education system, and there has been increasing pressure to accommodate CSAs by providing post-graduate training spots for them (Thomson and Cohn 2011b), thereby enabling them to work in Canada. CSA advocates argue that given their existing ties to Canada, CSAs are more likely than immigrant IMGs to work in rural communities and provide a more long-term solution to physician shortages in these communities. However, we were unable to find any data on whether CSAs remain in Canada, and in rural communities, longer than immigrant IMGs.

Do the retention patterns of CSAs and immigrant IMGs differ? This study compares the retention patterns of CSAs and immigrant IMGs who completed PGME training in Canada. Specifically, we describe the proportion and predictors of: (1) working in Canada in 2015 and (2) working in rural communities in Canada in 2015. We hypothesize that a larger proportion of CSAs than immigrant IMGs will work in Canada and in rural communities in 2015.

Only a handful of studies have examined the retention and migration patterns of IMGs who begin practice in Canada, and most have focussed on IMGs who work immediately in Canada on restricted licenses (Audas et al. 2009; Stenerson et al. 2009). Retention rates are higher among IMGs who complete residency training in Canada than provisionally licensed physicians; compared to provisionally licensed physicians, 78% of IMGs who completed

residency in Canada remained in the country five years after completing training (Thurber 2003). To date, no study has examined whether CSAs display the same retention and migration patterns as immigrant IMGs.

This study is part of a larger project on CSAs in Canada. The study responds to calls from policy makers and medical educators for more information about CSA and immigrant IMG performances at the various stages of the credentialing and licensing process and their contribution to the supply of physicians in Canada (Canadian Post MD Education Registry 2011; Ministry of Health, Ministry of Advanced Education and University of British Columbia's Faculty of Medicine 2011). The study provides information to guide policies related to the limited numbers of IMG residency positions in Canada.

Methods

The Newfoundland and Labrador Health Research Ethics Board (HREB#14.154) approved this study.

Sources of data

We linked data from the Canadian Post MD Education Registry's (CAPER) National IMG Database with data from Scott's Medical Database (SMD). The National IMG Database was funded from 2005 to 2011; it captures longitudinal data to track IMGs as they qualify for licensure and join the physician workforce, and it includes data from various agencies that are involved in the training, assessment, certification and licensing of IMGs (Canadian Post MD Education Registry 2011). SMD is a listing of physicians in Canada and is the most comprehensive database available to track physician locations (CIHI 2015; MD Select 2004). As part of its ongoing monitoring of work locations of PGME residents (Canadian Post-MD Education Registry 2015), CAPER had data from SMD for 2015.

Variables

Using a cohort study design, we examined two dichotomous (Y/N) outcomes in the analyses: (1) work in Canada in 2015; and among those working in Canada, (2) work in rural communities in 2015. We identified rural communities (population <10,000) based on 2011 census data (Statistics Canada 2011), and accounted for Metropolitan Influence Zone (MIZ). Statistics Canada defines a strong MIZ as municipalities where "at least 30% of the CSD's [census sub-division, i.e., municipality] resident employed labour force commute to [larger city]" (Statistics Canada 2011). This population cut-off is used in studies of rural communities in Canada (Hutten-Czapski and Thurber 2002).

The independent variable was type of IMG. We defined CSAs as IMGs who were born in Canada and/or who are Canadian citizens or permanent residents before entering medical school. Immigrant IMGs were IMGs who were neither born in Canada nor Canadian citizens or permanent residents. Preliminary analyses suggested that IMGs who graduated from medical school in Western (the UK, Ireland, Western Europe, New Zealand and

Australia) or Caribbean countries have different outcomes than IMGs who did not graduate from medical schools in these countries (Mathews et al. In Press). We therefore created an independent variable that captured both legal status and training site variables included in the National IMG Database. We examined four groups of IMGs:

- Canadian (citizens/permanent residents) who graduated from Western and Caribbean medical schools (CSA/Western).
- Canadian (citizens/permanent residents) who graduated from other (not Western or Caribbean) medical schools (CSA/non-Western).
- Immigrant international medical graduates of Western and Caribbean medical schools (OtherIMG/Western).
- Immigrant international medical graduates of other (not Western or Caribbean) medical schools (OtherIMG/non-Western).

Co-variables were gender (male/female), age at start of PGME, years between medical degree and start of PGME, participation in a skills assessment/training program (Y/N), specialty type (family medicine/specialty), PGME region (Ontario/non-Ontario), first PGME rank (resident/fellow) and eligibility for a full license (Y/N). We coded the age at start of PGME variable as younger than 30 years old and 30 years and older. For years between medical degree and PGME, we calculated the difference between the year in which an IMG first entered a Canadian post-graduate medical education program and the year of graduation from medical school and coded the IMG as either a recent graduate (0–5 years) or older graduate (6+ years). After a preliminary analysis, we coded PGME region as Ontario and outside Ontario based on the location of the medical school. Eligibility for a full license refers to whether an IMG passed both the Medical Council of Canada Qualifying Examination Part 2 (MCCQE2) and specialty examinations. Specialty examinations refer to the Canadian College of Family Physicians examination and any of the examinations through the Royal College of Physicians and Surgeons of Canada. For first rank, we coded trainees whose first ranks ranged from PG1 to PG7 as residents (in a residency program) and those whose first rank was PG9 or higher as fellows (in a fellowship program) (Canadian Post MD Education Registry 2015).

Sample

To be eligible for the study, IMGs had to have first entered a family medicine PGME program between 2005 and 2009, or have entered a specialty PGME program in 2005 or 2006. These cut-off periods allow sufficient time to qualify for the exams. IMGs who first entered PGME programs before these dates may have passed the MCCQE2 before 2005 (before the start of the Database) and would be coded as not passing the examination. CAPER data in the National IMG Database include all enrolment in PGME programs from 1988 onward. Moreover, the cut-off period allows IMG trainees sufficient time to complete their programs

and write specialty examinations. We included fellows because a substantial number of IMGs use fellowship programs to qualify for practice in Canada (Mathews et al. In Press).

We excluded US graduates because a number of agencies in Canada (e.g., CaRMS, Collège des médecins du Québec) consider graduates of accredited US medical schools as CMGs (MacLellan et al. 2010; Szafran et al. 2005). We excluded visa trainees because they are funded by their home countries to complete their residency training in Canada with the expectation that they will return to practice in the home country (Canadian Post MD Education Registry 2012; Hall et al. 2004).

Statistical Analysis

Using SPSS (version 23.0), we described the characteristics of the sample. We used chi-square tests to compare the characteristics of the four groups of IMGs and identify potential interactions. Where the four-group test was significant, we conducted post hoc chi-square tests comparing two groups at a time. We also used chi-square tests between each outcome and relevant predictors, and multiple logistic regression to identify significant ($p < 0.05$) predictors for each outcome. Variables were examined for possible co-linearity a priori. If variables were correlated (e.g., “age at start of PGME” and “years between medical degree and PGME”), we included only one of the variables in the model. Predictors were removed from the model if they were not significant (based on the Wald test) and if they did not significantly improve the change in the -2 log-likelihood value (Tabachnick and Fidell 2001). The tables list the variables included in the final regression models.

Results

There were 1,214 IMGs who first entered a family medicine PGME program between 2005 and 2009, or who first entered a specialty PGME program in 2005 or 2006. More than half the sample was an OtherIMG/non-Western IMG (50.3%), was female (55.4%), was an older graduate (61.9%), had not participated in a skills assessment/training program (75.1%), was a family physician (70.2%), had trained outside Ontario (50.5%), had the qualifications to be eligible for a full license (71.3%) and had first entered a PGME program as a resident (92.5%) (Table 1). Most IMGs (88.0%) were working in Canada in 2015. Of the IMGs working in Canada, 9.1% worked in a rural community in 2015.

TABLE 1. Characteristics of IMGs who entered family medicine PGME training in 2005–2009 or specialist PGME training in 2005–2006, by full cohort and by group type ($N = 1,214$)

Characteristics	Full cohort, n (%)	IMG type				p -value
		CSA/ Western, (%)	CSA/non- Western, n (%)	OtherIMG/ Western, n (%)	OtherIMG/ non- Western, n (%)	
Gender						
Female	673 (55.4)	79 (40.3)	234 (61.3)	19 (76.0)	341 (55.8)	0.001***
Male	541 (44.6)	117 (59.7)	148 (38.7)	6 (24.0)	270 (44.2)	

Retention Patterns of Canadians Who Studied Medicine Abroad and Other International Medical Graduates

Characteristics	Full cohort, n (%)	IMG type				p-value
		CSA/Western, (%)	CSA/non-Western, n (%)	OtherIMG/Western, n (%)	OtherIMG/non-Western, n (%)	
Age at start of PGME						
Under 30	237 (19.5)	96 (49.0)	56 (14.7)	11 (44.0)	74 (12.1)	0 ^{§,†,‡,***}
30+	977 (80.5)	100 (51.0)	326 (85.3)	14 (56.0)	537 (87.9)	
Years between MD and PGME						
Recent graduate (0–5 years)	462 (38.1)	189 (96.4)	130 (34.0)	14 (56.0)	129 (21.1)	0 ^{§,†,‡,0,***}
Older graduate (6+ years)	752 (61.9)	7 (3.6)	252 (66.0)	11 (44.0)	482 (78.9)	
Had skills assessment						
Yes	302 (24.9)	9 (4.6)	94 (24.6)	5 (20.0)	194 (31.8)	0 ^{§,†,‡,0}
No	912 (75.1)	187 (95.4)	288 (75.4)	20 (80.0)	417 (68.2)	
Specialty type						
Family medicine	852 (70.2)	168 (85.7)	292 (76.4)	17 (68.0)	375 (61.4)	0 ^{§,†,‡,0}
Specialist	362 (29.8)	28 (14.3)	90 (23.6)	8 (32.0)	236 (38.6)	
PGME region						
Ontario	601 (49.5)	72 (36.7)	203 (53.1)	17 (68.0)	309 (50.6)	0 ^{§,†,‡}
Other	613 (50.5)	124 (63.3)	179 (46.9)	8 (32.0)	302 (49.4)	
Full license eligible						
Yes	865 (71.3)	151 (77.0)	272 (71.2)	21 (84.0)	421 (68.9)	0.077
No	349 (28.7)	45 (23.0)	110 (28.8)	4 (16.0)	190 (31.1)	
First rank						
Residents	1,123 (92.5)	195 (99.5)	371 (97.1)	20 (80.0)	537 (87.9)	0 ^{†,‡,0}
Fellows	91 (7.5)	1 (0.5)	11 (2.9)	5 (20.0)	74 (12.1)	
In Canada in 2015						
Yes	1,068 (88.0)	179 (91.3)	342 (89.5)	22 (88.0)	525 (85.9)	0.146
No	146 (12.0)	17 (8.7)	40 (10.5)	3 (12.0)	86 (14.1)	
In rural Canada in 2015*						
Yes	97 (9.1)	26 (14.5)	27 (7.9)	1 (4.5)	43 (8.2)	0.045 ^{§,†}
No	971 (90.9)	153 (85.5)	315 (92.1)	21 (95.5)	482 (91.8)	

CSA = Canadian who studies abroad; CSA/non-Western = Canadian citizen, not Western/Caribbean graduate; CSA/Western = Canadian citizen, Western/Caribbean graduate; IMG = international medical graduate; MD = medical degree; OtherIMG/non-Western = non-citizen, not Western/Caribbean graduate; OtherIMG/Western = non-citizen, Western/Caribbean graduate; PGME = post-graduate medical education. *of IMGs working in Canada.

Post-hoc tests: [‡]CSA-Western significantly differs from CSA/non-Western; [†]CSA-Western significantly differs from OtherIMG/Western; [†]CSA/Western significantly differs from OtherIMG/non-Western; [‡]CSA/non-Western significantly differs from OtherIMG/Western; [§]CSA/non-Western significantly differs from OtherIMG/non-Western;

**OtherIMG/Western significantly differs from OtherIMG/non-Western.

As expected by variable definitions, all CSA-Western and OtherIMG/Western IMGs had graduated from medical schools in Western and Caribbean countries (Table 1). The largest proportion of CSA/non-Western IMGs graduated from medical school in Eastern Europe and Asia, whereas the largest proportions from the OtherIMG/non-Western group graduated from medical schools in the Middle East and North Africa and Asia. Female IMGs made up a lower proportion of CSA-Western IMGs than the three other groups. Those from the OtherIMG/Western group had a larger proportion of females than OtherIMG/non-Western IMGs. IMGs from Western medical schools (CSA/Western and OtherIMG/Western) had larger proportions of IMGs who were under 30 years of age at the start of their PGME programs than non-Western IMGs (CSA/non-Western and OtherIMG/non-Western). CSA/Western had the largest proportion of younger graduates (96.4%), followed by OtherIMG/Western (56.0%), CSA/non-Western (34.0%) and OtherIMG/non-Western (21.1%). Almost one-quarter (24.9%) of those in the study participated in a skills assessment/training program. A smaller proportion of CSA/Western IMGs participated in skills assessment and training programs than each of the other groups. A larger proportion of CSA/Western IMGs was in family medicine programs than each of the other groups. A smaller proportion of CSA/Western IMGs entered PGME programs in Ontario than all other groups. For retention outcomes, a larger proportion of CSA/Western IMGs than OtherIMG/non-Western IMGs worked in rural communities in 2015.

Compared to IMGs who did not work in Canada in 2015, a larger proportion of IMGs who worked in Canada were Canadian citizens, were family physicians, were eligible for a full license and were a resident when they first entered PGME (Table 2). After controlling for other significant predictors, IMGs who were eligible for a full license were 4.28 times more likely to work in Canada in 2015 (Table 3). Fellows were 0.38 times as likely as residents to work in Canada.

In total, 97 (9.1%) of the 1,068 IMGs who worked in Canada in 2015 worked in a rural community. Compared with those who did not work in a rural community, a larger proportion of IMGs who worked in a rural community were a CSA/Western IMG, were male, were a recent graduate and were a family physician (Table 2). After controlling for other significant predictors, male IMGs were 1.77 times more likely to work in a rural community in 2015 than female IMGs (Table 3). Specialists were 0.43 times as likely as family physicians to work in a rural community.

Discussion

The vast majority of IMGs in the study were working in Canada in 2015 (88.0%), up to nine years following their training. Among IMGs who worked in Canada, a small proportion of IMGs worked in rural Canada in 2015 (9.1%). The rural retention rates of IMGs (97 of 1,214) is 8.0%; lower than the rate for CMGs reported in the literature (11.2%) (Hutten-Czapski and Thurber 2002). Studies have highlighted the importance of cultural communities in the work locations of IMG physicians; small rural communities may not offer the cultural network that IMG physicians prefer (Mayo and Mathews 2006).

Retention Patterns of Canadians Who Studied Medicine Abroad and Other International Medical Graduates

TABLE 2. IMGs who worked and did not work in Canada in 2015 and rural Canada in 2015, among a cohort of IMGs who entered family medicine PGME training in 2005–2009 or specialist PGME training in 2005–2006

Variable	In Canada in 2015			In rural Canada in 2015*		
	Yes, n (%)	No, n (%)	p-value	Yes, n (%)	No, n (%)	p-value
Type of IMG						
CSA/Western	179 (16.8)	17 (11.6)	0.146	26 (26.8)	153 (15.8)	0.045
CSA/non-Western	342 (32.0)	40 (27.4)		27 (27.8)	315 (32.4)	
OtherCSA/Western	22 (2.1)	3 (2.1)		1 (1.0)	21 (2.2)	
OtherCSA/non-Western	525 (49.2)	86 (58.9)		43 (44.3)	482 (49.6)	
Gender						
Female	596 (55.8)	77 (52.7)	0.485	43 (44.3)	553 (57.0)	0.017
Male	472 (44.2)	69 (47.3)		54 (55.7)	418 (43.0)	
Age at start of PGME						
Under 30	209 (19.6)	28 (19.2)	0.911	18 (18.6)	191 (19.7)	0.792
30+	859 (80.4)	118 (80.8)		79 (81.4)	780 (80.3)	
Years between MD and PGME						
Recent graduate (0–5 years)	413 (38.7)	49 (33.6)	0.233	48 (49.5)	365 (37.6)	0.022
Older graduate (6+ years)	655 (61.3)	97 (66.4)		49 (50.5)	606 (62.4)	
Had skills assessment						
Yes	264 (24.7)	38 (26.0)	0.732	19 (19.6)	245 (25.2)	0.219
No	804 (75.3)	108 (74.0)		78 (80.4)	726 (74.8)	
Specialty type						
Family medicine	773 (72.4)	79 (54.1)	0	82 (84.5)	691 (71.2)	0.005
Specialist	295 (27.6)	67 (45.9)		15 (15.5)	280 (28.8)	
PGME region						
Ontario	538 (50.4)	63 (43.2)	0.102	50 (51.5)	488 (50.3)	0.809
Other	530 (49.6)	83 (56.8)		47 (48.5)	483 (49.7)	
Full license eligible						
Yes	810 (75.8)	55 (37.7)	0	77 (79.4)	733 (75.5)	0.393
No	258 (24.2)	91 (62.3)		20 (20.6)	238 (24.5)	
First rank						
Residents	1,010 (94.6)	113 (77.4)	0	93 (95.9)	917 (94.4)	0.551
Fellows	58 (5.4)	33 (22.6)		4 (4.1)	54 (5.6)	

CSA = Canadian who studies abroad; CSA/non-Western = Canadian citizen, not Western/Caribbean graduate; CSA/Western = Canadian citizen, Western/Caribbean graduate; IMG = international medical graduate; MD = medical degree; OtherIMG/non-Western = non-citizen, not Western/Caribbean graduate; OtherIMG/Western = non-citizen, Western/Caribbean graduate; PGME = post-graduate medical education.

TABLE 3. Predictors of IMGs who worked and did not work in Canada in 2015 and rural Canada in 2015, among a cohort of IMGs who entered family medicine PGME training in 2005–2009 or specialist PGME training in 2005–2006

Variable	In Canada in 2015		In rural Canada in 2015*	
	OR (95% CI)	p-value	OR (95% CI)	p-value
Full license eligible				
Yes	4.28 (2.92, 6.27)	0	NS	NS
No	1.00		NS	
First rank				
Residents	1.00	0	NS	NS
Fellows	0.38 (0.23, 0.63)		NS	
Specialty type				
Family medicine	NS	NS	1.00	0.003
Specialist	NS		0.43 (0.24, 0.75)	
Gender				
Female	NS	NS	1.00	0.009
Male	NS		1.77 (1.16, 2.70)	

95% CI = 95% confidence interval; IMGs = international medical graduates; NS = not significant predictor (not included in model); OR = odds ratio; PGME = post-graduate medical education. *IMGs working in Canada.

Male IMGs were more likely to work in rural communities in 2015 than female IMGs. This finding likely reflects traditional gender roles; men may be more likely to head single-income households or have more influence in work locations. Moreover, given the importance of opportunities for spousal employment in the rural communities, non-physician male spouses may have greater difficulty finding suitable employment in rural communities (Mayo and Mathews 2006; Myroniuk et al. 2016).

Family physicians are more likely to work in small rural communities, which may not have sufficient patient size to support a sub-specialist. Similar findings have been reported for CMGs (Mathews et al. 2015).

Almost three-quarters of the IMGs in the cohort qualified for a full license. Although eligibility for full licensure was a predictor of working in Canada in 2015, one-quarter of the study physicians who worked in Canada in 2015 were not eligible for a full license. Roughly one-fifth of IMGs in the study cohort exit PGME programs without full license credentials (Mathews et al. In Press); however, data from the National IMG Database do not reveal why. For example, studies have shown that IMGs do not perform as well as CMGs in PGME programs (Andrew 2010; Bates and Andrew 2001; MacLellan et al. 2010; Thomson and Cohn 2011a). Alternatively, IMGs who did not intend to remain in Canada may have chosen not to write the MCCQE2 or specialty examinations. Obtaining a residency position is competitive and many qualified IMGs are unable to secure a

training position. Further research is needed to understand and improve IMG performance in PGME.

There were no differences in the work location patterns of different groups of IMGs. Contrary to our hypotheses, CSAs were not more likely to remain in Canada or work in rural communities than immigrant IMGs. These findings refute suggestions that CSAs are more likely to be a solution to rural physician shortages than other IMGs. In response to earlier reports that highlighted biases in the selection of IMG post-graduate applicants (Thomson and Cohn 2011b), medical schools in Canada have strengthened policies around applicant screening, ranking and selection (Best Practices in Applications and Selection Working Group 2013). The findings from this study lend further weight to these initiatives.

Although return-of-service agreements are part of rural physician recruitment and retention programs, we are unable to assess the exact role of return-of-service agreements in the work location patterns of IMGs in the study because these data are not included in the National IMG Database. Return-of-service agreements provide physicians with financial incentives (usually during training) in exchange for a commitment to work in an underserved community following training (Bärnighausen and Bloom 2009). Before 2007, return-of-service agreements were generally voluntary for IMGs. Starting in 2007, return-of-service agreements were mandatory in most provinces for IMGs who entered the first match of the residency matching process (Mathews et al. 2013). Because most IMGs in the study would have participated in the CaRMS match before 2007, they are unlikely to have had a mandatory return-of-service agreement. An evaluation of return-of-service agreements in Newfoundland and Labrador found that a large proportion of IMGs (most with mandatory agreements) did not fulfill service commitments (Mathews et al. 2013); however, this study examined agreements implemented before changes to the residency match (and return-of-service agreements) in 2007. A 2013 study of family physicians initially located in rural areas indicated that, although a greater proportion of new IMGs go to rural areas than CMGs, they migrate out of rural areas much sooner than the CMGs who do not typically have return-of-service agreements (Buske 2013). Further research is needed to assess how mandatory agreements have influenced work location and retention of IMGs who completed residency training after 2007.

The study also demonstrates the utility of data sets, such as the National IMG Database, that link data from various agencies involved in the training, credentialing and licensing of the health professionals. Research using these data sets provides a valuable means to inform policy debates and support health workforce planning.

The study has a number of limitations. As previously described, we created a proxy variable to identify IMGs who qualified for a full license, and used SMD to identify work locations. Some physicians who work in Canada may not be included in SMD, and therefore, we may underestimate retention rates. Our sample size was limited to the period covered by the National IMG Database (2005–2011). Our analyses identify IMGs who are Canadian citizens or permanent residents, but we are unable to describe how long they have lived in the

country or when they became citizens or permanent residents relative to their entry to medical school. Moreover, the National IMG Database does not include information on rural background or province of origin – known predictors of work locations among Canadian medical trainees (Myroniuk et al. 2016).

Conclusion

We linked data from the National IMG Database and SMD to examine the retention of IMG PGME trainees. Most IMGs were working in Canada in 2015 (88.0%); 9.1% of these physicians were working in a rural community. There was no difference in the work location patterns of CSA and immigrant IMGs. CSAs are as likely to remain in Canada or work in rural communities as their immigrant IMG counterparts. The study findings support the equal treatment of all IMG physicians (CSA and immigrant) in PGME selection and training. It also highlights the need to improve IMG PGME training so that more IMGs are able to obtain credentials for independent practice. Finally, it reinforces the need to retain IMG PGME trainees.

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Reforming Refugee Healthcare in Canada: Exploring the Use of Policy Tools

Réforme des services de santé pour les réfugiés au Canada : examen de l'utilisation des outils stratégiques



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Abstract

Refugee healthcare in Canada has been a controversial and heavily debated topic over the past several years. In this paper, we present a policy analysis of the 2012 Canadian federal government decision to change the criteria and funding of the Interim Federal Health Program (IFHP). The IFHP provides federally funded healthcare coverage for refugees until they gain access to provincially funded health insurance. The paper offers a policy

perspective on the changes to refugee health coverage over time. We draw on the policy concepts of agenda setting, framing, venues and causal stories to explore this topic. We suggest that these concepts represent a set of tools for both researchers and laypersons to critically appraise any issue on the policy agenda, and understand how certain topics become policy issues and why they are “solved” in particular ways.

Résumé

Les services de santé pour les réfugiés au Canada constituent un vif sujet de controverse et de débat depuis quelques années. Dans cet article, nous présentons une analyse politique de la décision prise en 2012 par le gouvernement fédéral, visant un changement des critères et du financement du Programme fédéral de santé intérimaire (PFSI). Le PFSI offre aux réfugiés une protection en matière de soins de santé jusqu'à ce qu'ils obtiennent accès aux services de santé provinciaux. L'article propose un point de vue politique sur les changements dans la protection en matière de santé pour les réfugiés au cours du temps. Pour étudier ce sujet, nous nous appuyons sur les concepts de mise à l'agenda, de formulation, de lieu et d'anecdotes. Nous suggérons que ces concepts représentent un ensemble d'outils, pour les chercheurs ou autres, leur permettant d'évaluer de façon critique tout enjeu qui figure à l'ordre du jour politique, notamment la façon dont certains sujets deviennent des enjeux politiques et pourquoi ils sont « réglés » d'une façon particulière.

Introduction

The number of refugees accepted into Canada fluctuates considerably, with numbers peaking to 25,356 in 2011 and dropping to 10,424 in 2013 (Government of Canada 2016). The cost to support these refugees also fluctuates. In 2010–2011, \$84.6 million was spent on the Interim Federal Health Program (IFHP) (Government of Canada 2012a). The IFHP ensured these refugees had health support similar to provincial and territorial plans and, in some cases, additional dental, drug and vision care services (Barnes 2012). From 2009 to 2012, the Conservative Canadian Federal Government's framing of Tamil and Roma refugees began to shift the discussion on the IFHP. Changes soon followed to the IFHP such that refugees were placed into categories that either resulted in a reduction of coverage or eliminated coverage all together (Barnes 2012). The IFHP policy change initially developed within a larger federal immigration reform, intent on improving security, and then shifted to a provincial healthcare arena. To understand these changes, it is important to recognize that policy making and policy decisions are often highly political.

Policy concepts are needed to understand the policy process by which decisions were *actually* made. Some of these include agenda setting, framing, venues and causal stories. In this paper, these concepts are applied to the topic of refugee healthcare policy reform in Canada. Next, the events and policy decisions that contributed to refugee health policy changes are outlined chronologically. Lastly, the paper reviews the implications of these policy concepts in influencing refugee healthcare policy.

Policy Concepts: Agenda Setting, Venues, Causal Stories and Framing

Agenda setting is a strategy that places issues at the forefront of public attention before instituting policy changes. It is commonly supported through the use of media to portray images and messages that shape public perception of important issues. Agenda setting serves as an important tool for political actors and parties, to first craft an agenda designed to place certain issues at the centre of political attention before making significant policy decisions (Green-Pedersen and Walgrave 2014). Once placed on the policy agenda, venues are strategically selected to increase buy-in from the public or special interest groups, to fuel policy change or policy adoption (Crynes 1998). *Venues* are the “institutional locations where authoritative decisions are made concerning a given issue – they are the locations at which policies originate, obtain support and are adopted as binding decisions” (Jordan and Turnpenny 2015). For example, the legal system represents a venue for evaluating the issues that ultimately affect the fundamental rights and freedom of the citizens. *Framing* and *causal stories* are used throughout the stages of policy initiation, development and implementation. A causal story is defined as the process by which problems are represented through images and transformed into stories that assign cause, blame and responsibility (Stone 1989). Framing is a way of describing the policy to influence understanding and rationale behind reform, or essentially a way in which policy actors help people understand core issues. For example, framing is on display during the question period at the House of Parliament, where each political party presents issues through the beliefs and values of their party.

Agenda Setting: Formation

In 2009, the MV *Ocean Lady* arrived on the coast of Vancouver, British Columbia, Canada, carrying 76 Tamil asylum-seeking refugees. The arrival of the *Ocean Lady* triggered the enactment of the *Balanced Refugee Reform Act* in 2010, which included measures to strengthen the immigration system by reducing identity fraud through the use of biometric data such as fingerprints and photos. The arrival of the MV *Sun Sea* boat one year later carrying 500 additional Tamil asylum-seeking refugees sparked additional debate and a window of opportunity for the former federal government to add further legislative changes. Politicians began by re-framing public perceptions of refugees. They prompted discussions about the risk of “human smugglers” or “terrorists” among the asylum-seekers, bringing forward debates about the risks to national security and border safety. In this context, Canada was perceived as being an excessively generous humanitarian country. Prime Minister Stephen Harper spoke about the MV *Sun Sea* Incident during a 2010 federal election campaign:

“We will not hesitate to strengthen the laws if we have to, because ultimately as a government, we’re responsible,” Harper said. “It’s a fundamental exercise of sovereignty, and we’re responsible for the security of our borders and the ability to welcome people or not welcome people when they come” (CBC 2010).

Here, the former Prime Minister, Stephen Harper, reframed the image of refugees through the lens of *smuggling* as opposed to a lens of *freedom*, which helped set the agenda for future legislative reform. The choice to situate the stories of the MV Ocean Lady and Sun Sea in the media has influenced the public's perception of the issue and its importance. This approach is well aligned with the agenda-setting theory, which describes the "ability [of the news media] to influence the salience of topics on the public agenda" (McCombs and Reynolds 2002).

The reframing of refugees (from freedom-seeking to smuggling) begins to draw a causal story by linking the event with the possibility that human intervention (i.e., government response) could render the issue avoidable in the immediate future. As a result, the *Protecting Canada's Immigration System Act* was introduced in 2012 as a credible government response to the issue of human smuggling. The Act was sponsored by Jason Kenney, the Conservative Minister of Citizenship, Immigration and Multiculturalism, and approved by the Conservative federal government. Areas of change to this federal immigration and citizenship legislation included an amendment of the safe countries of origin list. This list labelled people from certain countries ineligible for particular rights including the right to an appeal or compassionate and humanitarian considerations (Government of Canada 2012b). Government media releases presented the reforms as necessary to "crack down on human smuggling" (Government of Canada 2012c). The releases ran in contrast to how former refugees have been presented by the government, as people seeking freedom from oppression. For example, in July of 1979, Canada admitted 60,000 Vietnamese refugees, and since 2015, 30 April will be known as Journey to Freedom Day, a day to commemorate the journey of these refugees (Citizenship and Immigration Canada 2015).

Cracking down on Human Smuggling: Implications for Refugee Healthcare

The IFHP has been the federal program that funds refugee healthcare in Canada since 1957 (Government of Canada 2015). Refugees are one of the few groups that fall under the federal healthcare jurisdiction, as the majority of Canadians receive their healthcare under provincial jurisdiction. Cracking down on human smuggling had multiple legislative implications, one of which included reforms to the IFHP. Reforms to the IFHP were driven by Jason Kenney, who framed the funding program as offering "gold-plated healthcare benefits that are better than those Canadian taxpayers receive" (Wherry 2012). Kenney suggested that these benefits led to "the abuse of Canada's overburdened healthcare system by bogus refugees" (Parry 2015). In support of this point, Kenney drew on examples of Hungarian Roma refugees. The former government did not view refugee claimants from Hungary as having a legitimate claim of persecution and felt that they posed an unnecessary burden on social services. Kenney's development of the term "bogus" refugee was described during a speech in 2012 in which he stated:

"Almost none of these European asylum claimants even show up for their hearings — they just overwhelmingly abandon them and withdraw their own claims ...

but they all do show up in Ontario's welfare program" Jason Kenney, Minister of Citizenship and Immigration (Boesveld 2015).

The federal government openly stated that refugee claimants from European states did not have legitimate claims of persecution. These claims were further advanced by a controversial report released by the Canadian Border Services Agency alleging a criminal element and fraudulent undertone amongst Roma refugee claimants (Canadian Border Services Agency 2012). The report outlined the surprisingly large increase in Hungarian refugee claimants from 2009 to 2011, and their high failure rate of acceptance (Canadian Border Services Agency 2012). A retrospective report provided evidence to suggest that Kenney and his government misrepresented Roma refugees. A review by professors at Osgoode Law School noted that anti-refugee rhetoric, institutional bias and quality of council issues compromised the claimant process for Roma refugees (Beaudoin et al. 2015). Nonetheless, the negative rhetoric continued. Kenney presented the issue of bogus refugees by repeatedly referencing the case of Hungarian Roma's refugees and their country of origin. The story tied into the former federal government's announcement of the designated countries of origin list, such that Hungary was one of the countries designated as "safe." The asylum-seeking process for Hungarians would prove more challenging and illustrated a binary construction of "bogus" versus "legitimate" refugees. Kenney established a powerful narrative and moral theory that all failed refugee claimants were bogus claimants seeking to manipulate the system. Reference to asylum-seekers – the status individuals are assigned before having a refugee claim determined (United Nations High Commission for Refugees 2015) – was not specifically addressed. Instead of excluding asylum-seekers from this definition, they were considered as a subset of "bogus refugees." Included in the public debate at the time were accusations that asylum-seekers were "queue jumpers," further constructing "legitimate refugees" as individuals living in refugee camps near conflict zones and "bogus refugees" as anyone else, including those seeking protection within Canada. Cuts to the IFHP were cited as impacting only failed refugee claimants even though it also impacted all refugee claimants, including those in the process of seeking asylum. The policy change underestimated the genuine sense of fear experienced by refugees who felt that they could not return to their country. Some of these refugees had failed claims for a variety of reasons, none of which could be used to categorize them as bogus. A shift in discussion from supporting asylum-seekers to addressing bogus refugees refocused the issue. When the IFHP cuts were sold to the public as affecting failed (or bogus) refugee claimants, this vilified failed refugee claimants and garnered support for IFHP cuts to "save the taxpayer money." It established an arena of policy authority for the former government to legislate top-down reforms to the IFHP. These reforms are best described as top-down because implementation of the revised policy involved minimal public, intergovernmental or front-line worker engagement (Bowman 2014).

Refugee Health Cuts: The Outcome

Many healthcare workers tasked to implement the reforms to refugee healthcare vocalized and organized public opposition. Organizations representing various front-line workers, such

as physicians, nurses, pharmacists and social workers, were among those engaging in direct and indirect action. Media releases, protests, political office sit-ins and refusals to cooperate were a few of the many actions that began to challenge the conditions necessary for successful top-down policy implementation (Bay Observer Staff 2015). A clear gap began to take shape between the original policy intent and the outcome after implementation. As predicted by Dr. Jeff Poston of the Canadian Pharmacists Association, the IFHP reforms were “going to result in costs downloaded to other jurisdictions” (Keung 2012). This cost download fell onto provinces, as healthcare providers carry a legal and ethical responsibility to treat patients in emergencies. When a patient is unable to pay either privately or through government insurance, the costs of care are often assumed by the provider or the province. Organizations like the University Health Network in Toronto, Ontario, had unpaid service debt balloon to upwards of \$800,000 per year because of the IFHP reforms (Keung 2013). Pressure from front-line workers eventually resulted in a change in venue. Although the refugee healthcare policy was originally revised through the venue of the federal legislature as an immigration policy, increasing front-line worker mobilization resulted in a shift to provincial jurisdiction, as a healthcare policy. Provincial governments soon began implementing funding relief for refugee healthcare. The first provinces to implement funding relief were Quebec and Manitoba, with Ontario following. Provincial politicians shared the human impact of the IFHP reforms illustrated through testimonies offered by healthcare workers and organizations working with newcomers. Healthcare professionals framed the IFHP reforms as irresponsible, unethical and harming the most vulnerable. Former Ontario Minister of Health, Deb Matthews, illustrated the importance of these stories when responding to criticism of her introduction of a funding relief program for refugees:

“The implementation of [the federal cuts] means that they have to say ‘sorry, pregnant woman about to deliver baby, you’re not covered, we’re not going to care for you.’ Do you really think our healthcare professionals will do that? Of course they will not, they should not, they cannot. So in the end, we were paying anyway but we were paying more than we would have had we provided better early care” (Morrow 2014).

New provincial refugee funding programs undermined the legitimacy of the federal government’s measures to address bogus refugees and shifted refugee health coverage from a federal immigration venue to a provincial health venue. Concerned by this venue change, the newly appointed Minister of Citizenship and Immigration, Chris Alexander, challenged the policy authority of Ontario’s decision and alluded to using the federal health transfer fund as a tool to enforce jurisdictional compliance:

“We [in the federal government] have respected their [provincial] political decisions including in healthcare, where we’ve given them 6 per cent [funding] escalators. We don’t always agree with all of it, but we recognize that’s provincial jurisdiction. This is a federal jurisdiction” (Wingrove 2014).

The ensuing back-and-forth struggle for policy authority over refugee health coverage ultimately resulted in a policy vacuum, leaving the implementation of public policy up to individual providers and the actions of front-line workers.

Searching for Decisional Authority: Venue of the Courts

Amidst the provincial and federal struggle for power, a 2013 court case challenged the legality of the IFHP reforms. The Canadian Doctors for Refugee Care, Association of Refugee Lawyers and others issued a court challenge. They claimed that the changes to the IFHP violated a number of issues including charter and international law, a claim dismissed by Minister Kenney (Jones 2013). The ruling judge, Justice Mactavish, heard numerous examples of hardship resulting from the denial of medical insurance. For example, Justice Mactavish heard affidavits from six individuals who were forced to choose between food and life-saving medication (Mactavish 2014). After nearly a year in court, the policy changes were found unconstitutional and labelled a form of “cruel and unusual punishment” (Mactavish 2014). This decision, in which the government was denied a stay, ordered the reinstatement of funding to the IFHP. Despite the ruling being under appeal, the former federal government chose to wait until the final day of the court order before partially reinstating aspects of the IFHP (Vaughan 2015). This partial reinstatement resulted in a separate court trial to determine whether the government must fully reinstate funding to the IFHP (Vaughan 2015). In response to these court challenges, the Federal Minister’s spokesperson Kevin Menard stated:

“Our government is defending the interests of Canadian taxpayers as well as the integrity of our refugee determination system. Regrettably, the Federal Court’s ruling is costing taxpayers an extra \$4 million a year” (Keung 2015).

Menard’s comments emphasized the interests of taxpayers and balancing the budget. The comments also avoided reference to bogus refugees, which deflected attention from Justice Mactavish’s ruling and contradicted the moral theory that asylum-seekers were taking advantage of the health system. The focus on taxpayers and budget aligned with a timely, consistent pre-election message. The message tied into the federal party’s 2015 campaign narrative that presented their party as the only party committed to cutting taxes, supporting families and maintaining a strong economy (Conservative Party of Canada 2014). The legal system would ultimately provide the venue for reversing policy changes to the IFHP.

The 2015 Election: A Change in Framing

In the 2015 federal election, the three main political parties clearly outlined their positions on refugee health coverage. At the time, both the challenging parties publicly opposed the previous changes to the IFHP and committed to its funding reinstatement (Liberal Party of Canada 2014; New Democratic Party of Canada 2014). This was in contrast to the view

of the former incumbent federal government; the party remained committed to maintain the IFHP reforms, and any original measures enacted for the purpose of “cracking down on human smuggling.” The future of reforms to the IFHP was largely unclear until the 2015 election of a new majority Liberal Federal government. The new government changed the rhetoric of the IFHP by portraying refugee claimants, in particular Syrian refugees, as legitimately seeking asylum from war and conflict. The federal Liberal Government’s decision to drop the previous federal Conservative Government’s court appeal and announce a reinstatement of IFHP funding was met with praise and support from provincial Health Ministers (CBC 2016). The new federal Liberal Government’s decision helped repair a fractured relationship with the provinces on healthcare and cost the federal government an estimated \$5.9 million annually (CBC 2016).

Conclusion

In this paper, we showed that policy decisions do not result from the collection and assessment of objective, balanced evidence alone; rather, these are highly political processes, framed and legitimized in strategic ways to move ideas into action. This paper used a set of policy concepts – agenda setting, framing, venues and causal stories, and applied these to a controversial policy issue in Canada: refugee healthcare funding. These concepts can be used to aid one’s understanding of other policy issues and reforms (within and beyond the healthcare system). Both researchers and laypersons can use these concepts to critically appraise issues on the policy agenda and illuminate why issues become issues in the first place and why they are “solved” in particular ways. Most importantly, such an understanding of policy processes and outcomes has broader implications for effective citizen engagement and participation in the policy arena.

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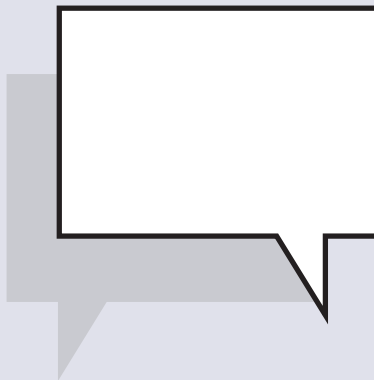
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Public Health Policy in Support of Insurance Coverage for Smoking Cessation Treatments

Politique de santé publique en faveur de la couverture d'assurance pour les traitements visant à mettre fin au tabagisme



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Abstract

Insurance coverage for evidence-based smoking cessation treatments (SCTs) promotes uptake and reduces smoking rates. Published studies in this area are based in the US where employers are the primary source of health insurance. In Ontario, Canada, publicly funded

healthcare does not cover SCTs, but it can be supplemented with employer-sponsored benefit plans. This study explores factors affecting the inclusion/exclusion of smoking cessation (SC) benefits. In total, 17 interviews were conducted with eight employers (auto, retail, banking, municipal and university industries), four health insurers, two government representatives and three advisors/consultants. Overall, SCT coverage varied among industries; it was inconsistently restrictive and SCT differed by coverage amount and length of use. Barriers impeding coverage included the lack of the following: Canadian-specific return on investment (ROI), SC cost information, employer demand, government regulations/incentives and employee awareness of and demand. A Canadian evidence-based calculation of ROI for SC coupled with government incentives and public education may be needed to promote uptake of SCT coverage by employers.

Résumé

La couverture d'assurance pour les traitements fondés sur les données probantes et visant la désaccoutumance du tabac (TDT) favorise l'adhésion et aide à réduire le taux de tabagisme. Les études publiées sur ce sujet concernent les États-Unis, où les employeurs constituent la première source d'assurance maladie. En Ontario, Canada, les services publics de santé ne couvrent pas les TDT, mais peuvent être suppléés par des régimes d'avantages sociaux parrainés par les employeurs. Cette étude examine les facteurs qui affectent l'inclusion ou l'exclusion à ces avantages sociaux. En tout, 17 entrevues ont été menées auprès de huit employeurs (automobile, vente au détail, banque, municipal et universitaire), quatre assureurs, deux représentants gouvernementaux et trois consultants. Dans l'ensemble, la couverture des TDT varie selon les industries; elle était restrictive de façon variable et le montant de la couverture ainsi que la durée des TDT différaient. Les obstacles à la couverture comprennent des lacunes quant aux éléments suivants : rendement du capital investi (RCI) spécifique au Canada, renseignements sur les coûts pour la désaccoutumance du tabac, demande de la part des employeurs, réglementations et incitatifs gouvernementaux, sensibilisation des employés et demande de leur part. Un calcul du RCI fondé sur les données probantes au Canada pour la désaccoutumance du tabac conjugué à des incitatifs gouvernementaux et à l'éducation du publique serait sans doute nécessaire pour promouvoir l'adhésion des employeurs à une couverture pour les TDT.

IN TOTAL, 18% OF ONTARIANS (AGED ≥ 12 YEARS) ARE SMOKERS, REPRESENTING AN estimated 2.4 million people. Smoking remains the leading cause of preventable mortality and morbidity resulting in 13,000 deaths and almost \$7.7 billion in direct health-care expenditures and lost productivity every year in Ontario alone (OAHPP 2010). The Conference Board of Canada (2006) estimates that every employee who smokes can cost an employer up to \$3,396 a year through increased absenteeism, decreased productivity and the costs associated with maintaining and cleaning outside smoking areas.

In 2000, the US Public Health Service Guidelines recognized smoking cessation treatments (SCTs) as cost-effective and clinically sound. SCTs can double or triple the likelihood of quitting smoking compared with quitting without such treatment (Fiore et al. 2000; McGoldrick and Boonn 2010; Penz et al. 2010).

In Canada, eight provinces and territories provide some SCT coverage, whereas four do not (Madore and Tiedemann 2005). Ontario, Canada's largest province by population, is positioned in the middle, providing only prescription coverage for those who are unemployed, have a disability or are aged >65 years through the Ontario Drug Benefit (ODB) program. There is limited knowledge about the extent of SCT coverage by Ontario employers. One study suggests that with the introduction of the *Smoke-Free Ontario Act* (SFOA) in 2006, many private Ontario-based drug plans began to offer smoking cessation (SC) benefits as an option for employers under an increasing demand for wellness initiatives (Jackson et al. 2008). These plans tend to include pharmacotherapy, while nicotine replacement therapy (NRT) is excluded, as it is considered an over-the-counter product (Jackson et al. 2008). However, little is known about the factors that facilitate and/or prevent adoption of SCT coverage under employer-sponsored plans. We chose to study Ontario because many head offices of larger private sector employers in Canada are based in Ontario, and because the public sector employers in Ontario tend to be larger than those in other provinces.

Although no published Canadian or Ontarian research on the use and effectiveness of employer-sponsored SCT insurance coverage is available, several American studies have found employer-sponsored SCT insurance coverage to be effective. As employed Ontarian smokers do not receive SCT coverage from the government health insurance plan, it might be expected that employer-provided supplementary insurance would be an effective tool as it is in the US. In comparing the two countries, it is important to note that although employers are the primary source of health coverage in the US (Juba et al. 1980; Kaper et al. 2005), the government provides insurance coverage for hospital, physician and certain other services in Canada, with some variation in the extent of coverage among provinces and territories. In Ontario, specifically, employer-sponsored benefits tend to complement what already exists through the public health insurance system. This may reduce incentives for employers in Canada to provide SCT insurance coverage, compared to the US.

Research indicates that insurance coverage for evidence-based SCTs such as pharmacotherapy, NRT and behavioural counselling, promotes uptake and reduces smoking rates (Curry et al. 1998; Schauffler 1997; US Department of Health and Human Services 2012). American guidelines recommend a comprehensive tobacco strategy, including counselling, alongside pharmacotherapy treatments for SC within an employer-sponsored, workplace health insurance plan (US Department of Health and Human Services 2009). Access to evidence-based SCTs is likely to reduce employer and healthcare expenditures (Mulligan 2010). Several studies suggest that effects are maximized when SCT coverage is part of a comprehensive approach to SC in the workplace (Au-Yeung et al. 2010; Javitz et al. 2006; Mulligan 2010).

Coverage for SCTs amongst American employers varies despite reports indicating its positive effects on productivity, absenteeism and presenteesim (Barbeau et al. 2001; Harris et al. 2001; Johns 2009). Au-Yeung et al. (2010) identify the following factors that influence employers' decisions regarding health insurance coverage: cost to the employer, utilization/demand within the company, health of employees, evidence of benefit effectiveness and recommendations from advisors. Recent amendments to the *Affordable Care Act* provided for substantial coverage of cessation (see <http://www.lung.org/our-initiatives/tobacco/cessation-and-prevention/tobacco-cessation-treatment-what-is-covered.html>).

The objectives of the current study included the following: (1) to explore the extent of coverage of SCTs among employers in various sectors in Ontario (auto, retail, banking, universities, municipal government); (2) to identify the main factors that influence decisions relating to purchasing and modifying health benefit coverage, including SCT; and (3) to examine the barriers to implementing and/or expanding insurance coverage for SCTs from the perspective of Ontario health insurers, employers, advisors/consultants and regulatory/government representatives.

Methods

Study design and recruitment

This exploratory study applied a qualitative research approach to gain an understanding of the current state of SCT coverage under employer-sponsored health plans. Semi-structured interviews were conducted with 18 key informants, including the following: eight employers, four health insurers, three advisors/consultants who provide services to employers and unions and three government representatives. In addition, relevant documents obtained from interviewees were reviewed (benefit plans, organizational guidelines for health insurance).

Data collection took place between May and December 2012. Representatives of the employers were often benefit specialists, directors of pension and benefits, HR specialists and individuals from the finance department. In some instances, two individuals from an organization participated in the interviews to provide further insight into the benefit negotiation and selection process. Because of recruitment challenges, no employer was selected from the auto industry.

Ethics approval was obtained from the University of Toronto's Research Ethics Board on May 15, 2012. The participants were provided with letters of information explaining the purpose of the study, the aim of the interviews and an outline addressing confidentiality and consent concerns.

Interview guides were developed for each group of key informants and their perspectives regarding factors influencing the purchase of benefits, the provision of health benefits, including SCTs, and the benefits negotiation process were examined. Individuals were also asked to discuss facilitators and barriers in this process (see Appendix 1 for interview guides, available at: <http://www.longwoods.com/content/25098>).

Interviews were conducted over the phone and lasted between 30 minutes and 1 hour. Written and/or oral consent was obtained from each interview participant before commencing the interview. Telephone interviews were digitally recorded, transcribed and then

analyzed using the qualitative data analysis software NVivo 9.2. The data were organized into categories based on responses to questions and emerging themes across interviews. Broader categories or themes were assigned a “node” and subthemes were identified and coded under these heading nodes. A series of attributes was created for each respondent to allow for analysis according to the following key characteristics: occupation (health insurer, government representative, employer, and advisor) and type of employer (car manufacturing, retail, university, municipality and banking), as well as whether an organization provided SCT benefits.

As limited study funding did not enable ensuring representativeness of industries, we sought to purposefully select information-rich case studies of companies/organizations referred to here as employers. The study aimed to select employers within five various sectors/industries chosen to include public and private, white and blue collar, large and small, high or low turnover rates and both unionized and non-unionized employees – as unions often play a role in negotiating insurance benefits packages: retail trade, car manufacturing, banking, universities and municipal government. Criteria that guided selection of employers from each industry included the following: type of employers (public or private), type of employee (white or blue collar), size of employer (large [>500 employees] or small) and level of turnover (high or low). To provide a systematic approach to the recruitment of employers, a matrix was created with the aforementioned attributes and was used to assist in this process. We aimed to select two employers from each industry/sector and interview two key informants from each organization.

Three Ontario municipalities of varying sizes were examined in this study: two large urban centres ($>100,000$ people) and one small community ($<100,000$ people). Employees in all municipalities were represented by several unions. One of the larger municipalities had a segment of their employees that were non-unionized. Two universities were selected, both with several unions embedded within their organizations. Only one retail establishment was recruited into the study. The company had approximately 30,000 employees throughout Canada and is recognized across the world. The organization’s employees were not unionized. Because of recruitment challenges, no employer was selected from the auto industry. One bank was recruited for the study. The bank has 36,000 active employees and 8,000 retirees across Canada.

Results

SCT coverage

In our sample, coverage for SCTs varied greatly. The coverage was typically restricted in terms of the type of SCTs insured (e.g., prescription-only, NRT-only etc.), annual or lifetime monetary amount and length of use (Table 1).

Cessation counselling was available in most organizations through employee assistance programs (EAPs). Insurance coverage is generally focused on pharmacotherapy and sometimes also includes psychosocial counselling.

TABLE 1. Summary of SCT coverage by employers who participated in the study

Employer/industry	Characteristics of SCT coverage
Municipal government	
Municipality (small)	One-time-only \$300 incentive for any SCT
Municipality (large)	Pharmacotherapies only
Municipality (large)	\$400 one-time amount for prescription medication, excluding bupropion
University	
University (large)	No coverage, provides EAP
University (small)	Pharmacotherapies only – NRT recently excluded, EAP offered
Retail	
Retail (large)	\$300/year on any SCT, eight nurse-assisted sessions, EAP offered
Banking	
Banking (large)	Could not provide detailed description of the benefits, EAP offered

EAP = employee assistance program; NRT = nicotine replacement therapy; SCT = smoking cessation treatment.

One university did not provide any coverage for SCTs. The human resources benefits’ specialist explained that smoking is a rare occurrence on campus because of the anti-smoking bylaws. Key informants from both universities sensed that they had a low percentage of smokers and pointed to the lack of employee demand for SCT coverage. Neither offered a wellness program to their employees and cited cost as a significant factor.

The retail organization provided \$300 per year for an employee to use on any SCTs, such as NRT, prescription medication or behavioural counselling. The latter could also be provided through the EAP. In addition, employees could access eight nurse-assisted sessions annually to get SC information and counselling.

Factors affecting employers’ decisions about the coverage of health benefits

Key informant interviews revealed that a number of factors affect decisions on health benefit selection and modification including benefit cost, cost of related conditions (return on investment, absenteeism, etc.), expert support from an advisor, and employee and employer demand.

COST

A majority of employers, representatives of health insurance companies, government officials and advisors agreed that cost is the number one factor that influences insurance plan selection. One health insurance representative noted that cost has become an increasingly important factor within the past 5–10 years:

“... so what we did see like 2008 when the economy melted down, we did see a lot of people that were looking for ways to save money or, or they had, they had to or they were potentially going to have to go out of business ... that included the,

the benefit program too so they, they'd be either get rid of things like OTCs (over-the-counters) or increase the cost sharing so if you had like it didn't cost the plan member anything for a prescription before maybe now they're going to be looking at having to pay five bucks a prescription." – Health insurer

In the same vein, an employer representing the municipal government explained that because of a substantial increase in healthcare cost in the past 5–10 years, it has become difficult to offer insurance plans similar to those used in prior years. He/she explained:

"... you know roll back a little bit you know because it's become so expensive. I mean even ten years ago drugs weren't nearly the cost of what they are now and most employers are facing like ten percent increases in their benefit costs over the years. That's crazy." – Employer [municipality]

Two employers representing the university/education sector also noted that costs have continually increased over the past 5–10 years. One employer commented that universities have been forced to become creative in regards to cost-cutting measures.

"I know it's cost, it all came down to cost. It always does ... Universities on the whole and we're no exception are really pressed for cash so we try to look for things that are not, don't take a lot of money but that's very difficult to find things that have great value that don't cost anything." – Employer [university]

All advisors/consultants who participated in interviews agreed with the perspectives of both health insurance companies and employers. They confirmed that discovering the lowest-cost health insurance plan is the top priority for the employers.

RETURN ON INVESTMENT

The ROI was chosen by all key informants as the second most important factor when purchasing health insurance packages. Providing employees with an EAP, gym memberships, dietary consultations and access to "lunch and learns" were perceived by key informants as potential avenues to reduce absenteeism and medical costs paid through supplementary health insurance, thus providing a return on the investment made. These services are usually discussed with employers as part of a wellness package. As explained by health insurers, wellness benefits are considered for inclusion in a health insurance package if an employer is interested in reducing all costs of related conditions, such as absenteeism and presenteeism, while increasing productivity and employee satisfaction. Because smoking is considered a lifestyle choice, it is typically placed within a wellness package. Along with pension and benefit costs, both universities considered the cost of related conditions (absenteeism and presenteeism) and employee demand to be important during the collective bargaining process.

Several health insurance representatives mentioned that it is often difficult to quantify the social and economic benefits for covering SCTs for Canadian employers. One health insurer explained:

“Yeah it’s, it’s a bit of a different scenario in Canada where and, and we see this a lot of stuff for all kinds of different interventions right, where much, whenever much of your return is based on reduced hospital and medical spend and physician visits and hospitalizations and things like that [in the US], you see a you get that, you build that, get that return back really, really quickly in the US where it’s the employer that’s paying for all that but it, it’s a whole, it’s a different picture in Canada.” – Health insurer

Health insurance companies have particularly struggled with proposing wellness packages, including SCTs, to employers because of difficulties in quantifying the ROI. One health insurance representative explained that although many employers strive to acquire high ROIs on their investments, wellness packages are substantially different from other benefits. He/she explained that the philosophy of a healthy workforce has not yet been grasped by employers:

“Wellness programs have generally struggled somewhat in gaining traction with employers from the standpoint that up until recently, it’s been hard to quantify some of the savings ... Yeah, yeah so you know that’s been a challenge. I think more employers are coming around to the idea that keeping the workforce healthy and productive upfront is a better investment than trying to take care of them once they’re already sick and I mean that’s an across the board thing. That’s our health-care system today is built around that and you know we see some movement on the benefit plan side but it’s a slow evolution. It’s not a wholesale change...it’s again a matter of quantifying the savings, quantifying the benefit ...” – Health insurer

Interviews with employers also highlighted the importance of ROI from a wellness benefits viewpoint. While all employers discussed the importance of the costs of smoking in the forms of absenteeism, presenteeism and low productivity, as an essential factor that determines the scope of health insurance plans, they mentioned that the health benefits were not currently contextualized in that manner. Many employers felt that these costs would increase in importance in the near future, once health insurers and/or advisors would be able to provide further ROI information in regards to wellness benefits.

One employer representing the university/education sector admitted that the idea of preventative measures in the workplace is somewhat new; however, the university is willing to invest in wellness initiatives to reduce the cost of absenteeism in the future.

“... you know for us we also look at the cost related to the condition to the company so we’re starting to get more into looking at things like absenteeism in our sick leave

management side and where we're seeing conditions that are preventable you know we do want to direct some money towards anything of that nature." – Employer [university]

EXPERT SUPPORT FROM ADVISORS

Health insurers and employers agree that the guidance provided by an advisor is essential for the design of a health insurance plan. One health insurer explained that advisors facilitate the selection of health benefits by engaging in negotiations with health insurers on behalf of employers.

During the interviews, advisors shared examples of how their knowledge and expertise informed employers' decisions about selecting coverage for SCTs. Based on the scientific evidence that SC support from physicians can increase successful quitting, one advisor suggested that the employer provide coverage for prescription medication only. This would force an employee to visit a physician to receive a prescription and cessation advice. Another advisor communicated the importance of wellness programs to their employer in addition to the SCTs, based on findings from the literature. As a result, the addition of wellness benefits occurred through an insurance contract amendment.

EMPLOYEE DEMAND

Employee demand for coverage emerged as an essential factor that influences health insurance benefit selection and modification. This held true for organizations with and without unionized employees.

A key informant from a large retail company without union representation mentioned that employee demand was the most influential factor for their organization. This company had a strong organizational philosophy with respect to employee wellness and satisfaction. Although cost is always a concern within any organization, the key informant explained that in comparison to their US-based retail stores, Canadian health benefits are 50% less costly per payroll, and the company would prefer to increase employee satisfaction and wellness of their employees in any way possible.

"Employee demand, definitely [is the number one factor] ... like I said we're fortunate as a company that we've been very successful in the past and we for all kinds of reasons, have kept our healthcare costs in check ..." – Employer [retail]

EMPLOYER DEMAND

Health insurers indicated in interviews that employers rarely ask for SCT coverage to be included in benefits packages. Their perception is that employers have not generally made the connection between SCT coverage and its potential role in decreasing problems such as absenteeism and presenteeism.

Again, I would start with what are they [employers] trying to achieve overall as an objective of their group benefits program, what are their needs you know and we

talked a little bit about that, what challenges are they facing so other than the core benefits they could have specific challenges in the workplace. Maybe they're really struggling with absenteeism, maybe their disability, the experience there is you know it's just getting to the point where they need to do something. That employer has specific needs so they need to talk to carriers and find out what they can do to help so that would also be part of it. – Health insurer

Barriers to adopting and using SCTs

LACK OF CANADA-SPECIFIC ROI WITH REGARDS TO SCTs

Interviews with advisors reveal that even if employers are interested in providing coverage for SCTs and are looking for innovative ways to contain future benefit costs without having to scale back on the scope of the benefits, the challenge has been to demonstrate the potential ROI. Advisors explained that most companies intuitively know that providing SCTs will be profitable to their organization, but they often lose interest in the benefit when they are required to justify its cost to their human resources department. They agreed that limited knowledge of the ROI on SCTs in a Canadian context is a major issue, and further information is required to make employers adopt SCT benefits. The need for Canada-specific ROI analysis stems from the different roles of government in paying for general healthcare costs. In the US, employers also pay for healthcare, so the cost argument looks quite different from that in Canada where the employer does not bear the healthcare costs related to long-term smoking.

Key informants from health insurance companies also pointed to the lack of a Canada-specific ROI on SCTs. They added that Ontario-based studies are needed to examine the use and effects of SCTs by employees and estimate ROI on SCTs. Without this information, it has become difficult for health insurers to persuade employers to purchase an additional benefit for their employee benefit plans.

LACK OF INFORMATION WITH REGARD TO COST FOR SCTs

Surprisingly, in that cost is considered a major factor influencing employers' decisions about the design and scope of benefits plan, lack of information about the specific costs of SCT benefits was regarded as a barrier by many employers. Health insurers and advisors explained that SCTs are often grouped with other wellness benefits, as it is still difficult to quantify the cost of an SC benefit. No advisor, health insurer or employer was able to elaborate on the cost of a SC benefit.

LACK OF EMPLOYER DEMAND FOR SCTs

Two health insurers explained that, to date, they have not had many requests for the addition of SCTs from employers/advisors. However, both insurers assured that if SCTs were requested, it would not be difficult to amend current benefit contracts. One insurer commented:

“We'll include it [smoking cessation services] when we hear it, absolutely ... You know what, nobody's ever asked for it.” – Health insurer

LACK OF EMPLOYEE AWARENESS OF AND DEMAND FOR SCTS

Employers without SCT coverage pointed to the lack of demand for cessation products and services as a barrier to insuring SCTs. In particular, a unionized employer indicated that there had not been any discussion regarding SCTs during collective bargaining agreements for the past 15 years.

Employers that reported offering SCTs highlighted the lack of employee awareness of SCT coverage as a barrier. Three employers explained that their employees often do not know if SCTs are covered under the benefit plans and the extent of the coverage. Consequently, utilization of cessation services is often low.

LACK OF GOVERNMENT ASSISTANCE OR INCENTIVES

Employers, both with and without SCT coverage, highlighted lack of government assistance and incentives as barriers to insuring SCTs for their employees. However, they differ in their opinion about the extent of the government responsibility on this issue. Employers with current SCT coverage indicated that coverage of SCT should be a shared responsibility between employers and the government of Ontario, as benefits accrued in the future would benefit the government and the general public. One employer suggested a tax incentive for Ontario employers to provide various forms of SC support to their employees (i.e., health benefit, “lunch and learns” and information sessions). In contrast, employers without SCT coverage felt that the government should take full responsibility for providing SCTs to employees and the general public.

Discussion

The study identified a number of factors that influence the process of selecting health benefits, including SCTs. Consistent with other studies, the cost of benefits carried the greatest weight, followed by ROI considerations, expert support from an advisor and employee demand (Au-Yeung et al. 2010). Interestingly, it is less clear what employers understand about the relative costs and benefits of SCT coverage. This could be limited to the opportunity cost of using those funds for other benefits, it could include the impact on absenteeism and presenteeism, the potential reduction in medications for related illnesses or the impact on publicly funded healthcare system. Evidence from these interviews suggest that the narrowest definition of costs is most often assumed and may account for the lack of confidence in the net benefit of SCTs. The importance of organizational culture supporting the health and wellness of employees was also highlighted as an important factor.

A number of barriers to inclusion and expansion of SCTs in employment-based health benefit plans emerged. Lack of Canada-specific ROI analyses with regards to SCTs were highlighted as a major issue by employers, insurers and advisors alike. ROI analysis for jurisdictions where general healthcare costs are covered through employer insurance plans is not applicable to the Canadian context where these costs are borne by the government. Interviewees indicated a strong need for evidence-based and Canada-specific quantitative data to inform decisions about the inclusion of SCT under employment-based health benefit plans.

This study provides insight into the characteristics of SCT coverage by Ontario employers in various industries. Although most employers examined in this study offer SCTs to their employees, the insurance coverage varies greatly across the employers and is typically restricted in terms of cessation services and medications, annual or lifetime monetary amount and length of use. These restrictions limit employees' opportunities and strategies to make quit attempts and maintain abstinence. Comprehensive cessation strategies, with no extra financial cost to the employee, telephone counselling, on-site group programs, community group programs and effective internal marketing of SCTs available through the health benefit plan would assist in enhancing the effectiveness of SCT coverage (Au-Yeung et al. 2010; Javitz et al. 2006; Mulligan 2010).

An unexpected finding is that the uptake of SCT benefits appears to be low, as employees are reported by employers to have little or no knowledge of the existence of SCTs within their benefit plans. This may, in part, be explained by the lack of effective dissemination strategies tailored to specific categories of employees (indoor vs. outdoor, blue- vs. white-collar workers).

This study has some limitations. One of them is the small convenience sample of study participants. It proved difficult to recruit employers, particularly from the auto industry. Furthermore, researchers found it difficult to recruit employers through HR representatives; therefore, most of the employers were recruited through referrals from other key informants (insurance agents, advisors). Further, although most employers (six out of seven) involved in the study reported providing some coverage of SCTs for their employees, this finding cannot be generalized to represent the current state of coverage of SCTs within and across various industries. Additionally, only two government representatives were able to be reached, where both preferred not to be audio-recorded or share in-depth information. Thus, the results may be of limited generalizability and should be interpreted with caution. In addition, only one person analyzed the interview transcripts. Nevertheless, the study provides insight into Ontario employers' decision-making process regarding the provision of insurance coverage for SCTs and factors influencing their adoption and uptake.

Conclusion

Findings suggest that there is a role for government to play in encouraging SCT coverage in health benefit plans through tax incentives or direct payment and public education. The ROI is there for government because of the cost offsets that have been proven. Without government support, SCT coverage is unlikely to be taken up in a serious way by most employers. Employer ROI is likely poor because employers do not fully bear the health-related costs of smoking, and because employee awareness and demand is low.

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Bifurcation of Health Policy Regimes: A Study of Sleep Apnea Care and Benefits Coverage in Saskatchewan

Bifurcation des régimes de politiques de santé : étude des soins pour l'apnée du sommeil et des couvertures d'assurance en Saskatchewan



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Abstract

Background: A complex, poorly understood bifurcated health policy regime exists for Canada's First Nations people for extended health benefits coverage. This research adds to a small body of literature on the regime's impact on access and quality of care and its role in perpetuating health inequities in First Nations populations.

Methods: Using a case study of sleep apnea care in Saskatchewan, we identified issues of health service access and coverage through a literature review of extended benefits programs, legislation and policies and through 10 key informant interviews with federal and provincial extended benefit program administrators and sleep medicine physicians.

Results: Important access and coverage differences were found for First Nations populations, many of which were recognized by federal and provincial policy makers. Despite these, government respondents recommended few policy ameliorations, perhaps due to system complexities, constitutional constraints or political sensitivities.

Conclusions: We suggest three policy options to ameliorate current hardships wrought by this policy bifurcation.

Résumé

Contexte : Il existe un régime de politiques de santé bifurqué, complexe et peu compris pour les peuples des Premières Nations du Canada quant à l'assurance maladie complémentaire. Cette recherche s'ajoute au peu de littérature portant sur l'impact du régime sur l'accès aux soins et la qualité des soins et sur son rôle dans la perpétuation des iniquités en matière de santé pour les peuples des Premières Nations.

Méthode : Dans une étude de cas sur les soins pour l'apnée du sommeil en Saskatchewan, nous avons repéré des enjeux liés à l'accès aux services de santé et au régime d'assurance, et ce, (i) par une revue de la littérature sur les régimes d'assurance maladie complémentaires, la législation et les politiques et (ii) par 10 entrevues menées auprès d'administrateurs des programmes fédéral et provincial d'assurance maladie complémentaire et auprès de médecins spécialistes du sommeil.

Résultats : On a observé d'importantes différences en matières d'accès aux services et de couverture pour les peuples des Premières Nations, dont plusieurs sont reconnues par les responsables de politiques fédéraux et provinciaux. Malgré cela, les répondants du gouvernement ont peu recommandé de politiques d'amélioration, peut-être en raison des complexités du système, des contraintes constitutionnelles ou des sensibilités de nature politique.

Conclusion : Nous présentons trois propositions de politiques visant l'amélioration des difficultés qu'engendre cette bifurcation politique.

Introduction

Throughout the world, particularly in settler societies such as Australia, Canada, New Zealand and the US, Indigenous populations have lower health status and poorer health outcomes than

the majority population. And although Indigenous health status, as measured by mortality and morbidity, has improved over time, this gap in health status has persisted (Gracey and King 2009). While there are multiple and complex reasons for this persistent outcome, research has tended to focus on the non-medical determinants of health (King et al. 2009).

The purpose of this research is to explore a potential medical determinant of health, specifically access to a set of medical goods and services not deemed by provincial governments to be universally “insured services” as defined by the *Canada Health Act* and provincial Medicare laws and regulations (Health Canada 2017). As a consequence, registered Indians¹ and recognized Inuit,² who form the majority of Indigenous peoples of Canada, are excluded from provincial and territorial extended health benefit coverage. The federal government legally defines the Indigenous peoples of Canada as “Aboriginal”. The *Canadian Constitution Act* of 1982 categorizes Aboriginal people in Canada into the following three groups: First Nations, Métis and Inuit.

While excluded from provincial and territorial extended health coverage, the majority (but not all) First Nations people and Inuit, classified by the federal government as registered Indians and recognized Inuit citizens, are eligible for coverage provided by the Non-Insured Health Benefits (NIHB) program administered by Health Canada. By the end of the 2014–2015 fiscal year, there were 779,300 eligible First Nations individuals and 44,733 eligible Inuit under NIHB (Health Canada 2016), constituting 2.3% of the Canadian population. For services falling under the scope of Medicare, registered Indians and recognized Inuit rely on provincial and territorial plans, but for services beyond Medicare, they rely on the federal government’s NIHB plan.

In this bifurcated policy regime, registered Indians and recognized Inuit are eligible for provincial and territorial Medicare services; however, they are a federal responsibility for non-Medicare coverage for pharmaceuticals, dental care and continuing care (long-term care and home care). This bifurcation of coverage has been cited as an additional burden for this population (Marchildon 2013; Taylor 1987). However, little to no research has been conducted on coverage for conditions, such as obstructive sleep apnea, that require services that are truly on the boundary line between what are treated as universally covered “insured” Medicare services and non-insured services that may be covered under private health insurance or federal or provincial extended health benefit plans. For instance, the management of conditions such as sleep apnea requires physician consultations that are covered by Medicare and treatment using medical equipment that is not covered by Medicare.

Although restricted to hospital and medical services and, therefore, “narrow” in its reach, Canadian Medicare is also deep, in that the 10 provincial and 3 territorial single-payer coverage plans ensure that residents, including all Indigenous residents, have free access to all Medicare services. However, services deemed by provincial and territorial governments to be outside the Medicare basket are subject to different rules. In particular, NIHB-eligible individuals are automatically excluded from access to provincial and territorial extended health benefit coverage and must rely on NIHB or private coverage.

While the treatments for most respiratory health conditions are considered “insured services” under the *Canada Health Act* (and therefore part of Medicare), obstructive sleep apnea falls into a grey area. While physician care for sleep apnea falls under Medicare coverage, the medical devices required for treatment appear to be excluded from provincial and territorial Medicare plans. Because the Government of Canada only recognizes registered Indians and recognized Inuit to be within the federal government’s NIHB responsibilities, this produces differential coverage within Canadian Indigenous populations (Quiñonez and Lavoie 2009). This case study explores the nature and consequences of this bifurcation of health policy in the province of Saskatchewan based on key informant interviews with federal and provincial program administrators and sleep medicine specialists. Based on the 2011 Census, 15.6% of the Saskatchewan population is of Indigenous descent, and 96,160 of the province’s 103,210 First Nations people were registered and eligible for NIHB benefits, with roughly one-half of this number living on reserves (Statistics Canada 2013).

There are two laboratories in the province of Saskatchewan that conduct Level 1 or complete 15-channel polysomnogram overnight sleep studies. These are located at Saskatoon City Hospital with a capability of six patients/night, five nights/week, and at Regina General Hospital with the capability of four patients/night, five nights/week. Referrals may be made to these laboratories by specialists in respiratory disease or neurology. Only specialists with training and/or possessing specialist certification in sleep medicine may work in sleep laboratories to interpret tests and consult patients following the tests. The waiting lists for non-urgent cases to access these laboratories varies from six to eight months to a year. These tests are provided without charge to all persons including First Nations persons under the Saskatchewan Hospital Services Plan.

Level 3 or home-based sleep studies are available in the province provided by a number of public and private sector organizations with very short waiting periods of days to weeks. These are provided variably without charge or nominal fee to all persons, and are quite mobile, as the equipment is often sent by bus to the patient. Level 3 studies are adequate to make a diagnosis of obstructive sleep apnea in the majority of cases.

Health Inequalities and Obstructive Sleep Apnea

Overall, in Canada, Indigenous peoples experience a lower standard of living (Wilson and Macdonald 2010) and have a significantly lower life expectancy than other residents in Canada (Statistics Canada 2010). Using the United Nations Human Development Index, Canada consistently ranks within the top five countries in the world, while its Indigenous population ranks approximately 63rd by the same measure (Reading et al. 2007). Within this context of a wide health gap between Indigenous peoples and other people in Canada, sleep apnea occupies a unique position.

Obstructive sleep apnea is the most common type of sleep apnea and manifests from blockage or collapse of the upper airways during sleep, thus causing episodes of apnea or hypopnea. Attempts at breathing during these episodes usually result in snoring and, overall, the condition

may be associated with poor sleep quality and excessive day-time sleepiness (National Institutes of Health 2012). According to the Public Health Agency of Canada (2009), an estimated 3% (or approximately 850,000) of Canadian adults have been diagnosed with sleep apnea; however, >25% of the Canadian adult population is estimated to be undiagnosed sufferers of the condition.

Sleep apnea is frequently associated with overweight or obese weight status, hypertension, metabolic syndrome, diabetes and high cardiovascular risk (National Institutes of Health 2012). Apart from vulnerability to these co-morbidities, individuals diagnosed with sleep apnea are predisposed to higher risk of motor vehicle accidents (Young et al. 1997), low productivity due to excessive daytime sleepiness (Carter et al. 1996), increased healthcare utilization patterns (AlGhanim et al. 2008) and the inevitable economic costs of these various factors.

While sleep apnea prevalence rates in the Indigenous population are currently unavailable, the disproportionately high poor health outcomes in the Indigenous population of Canada (Lix et al. 2009; Reading 2009) make it probable that sleep apnea prevalence is also higher. Indeed, previous research in Northern British Columbia has identified a higher prevalence of low-quality sleep among Indigenous individuals (Froese et al. 2008; Redline et al. 2004). In addition, the co-morbidities of sleep apnea are especially indicative of Indigenous people's susceptibility to sleep apnea because of higher morbidity and mortality rates from these co-morbidities among Indigenous populations (Lix et al. 2009; Reading 2009).

These unequal health outcomes in Indigenous peoples are linked to deprived access to resources that can be located in proximal social determinants of health such as higher rates of low education attainment, unemployment and poor housing conditions (Elias et al. 2012; Reading and Wien 2009; Reading 1997). As a product of the historical and intergenerational perpetuation of health disparities (Elias et al. 2012; King et al. 2009; Reading 1997; Smith et al. 2005), and as we will argue here using the case of sleep apnea, contemporary conditions of colonization, these differences in determinants and outcomes are ultimately inequitable. This means they are unfair, unjust and avoidable (Braveman 2006).

The health inequities experienced by Indigenous peoples are frequently further magnified by difficulty in access to healthcare because of geographic isolation. Geography is an important determinant of health (Kirby and LeBreton 2002; Ministerial Advisory Council on Rural Health 2002; Romanow 2002) and as "place" is a critical population health variable (Canadian Population Health Initiative 2006). Rural and remote dwelling Indigenous populations face additional challenges. For instance, currently in Saskatchewan, there are only two main (urban) centres for sleep testing and diagnosis: the Sleep Disorders Program in the Saskatoon Health Region (2014) and the Regina Health District Sleep Disorders Centre (Regina Qu'Appelle Health Region 2015). With roughly 50% of First Nations people living on reserves some distance from urban centres in Saskatchewan (Statistics Canada 2013), it is apparent that more than half of Saskatchewan's First Nations population face geographic barriers in accessing sleep apnea care. Apart from the probability of higher susceptibility to not only sleep apnea but also its co-morbidities, Indigenous peoples in Canada face significant social, economic and geographic barriers in accessing sleep apnea care.

In this disadvantaged scenario, a bifurcated healthcare policy regime that leads to differential access to extended health benefits between registered Indians and recognized Inuit, and other people in Canada, further perpetuates inequalities that could ultimately magnify already endemic health inequalities.

Historical Context and Continuing Challenges

Table 1 summarizes the key historical steps that produced a health policy bifurcation for registered Indians in Canada. Federal jurisdiction for First Nations people became part of the Canadian constitution that accompanied the creation of the country in 1867. Within less than a decade, the federal government enacted the *Indian Act* – the law that has since shaped and regulated the government’s relationship with registered Indians and First Nations band governments (Lavoie et al. 2010).

TABLE 1. Historical chronology of bifurcated health policy for Indigenous Canadians

Year	Event
1763	Royal Proclamation establishing legal recognition of Indigenous rights by British Crown and imposing a fiduciary duty of care on the Crown.
1867	Canadian Constitution (originally the <i>British North America Act</i> , 1867, now the <i>Constitution Act</i> , 1867) becomes law with the creation of the Canadian Confederation: established that the federal government has the legislative jurisdiction for "Indians and lands reserved for the Indians."
1876	<i>Indian Act</i> : defined who was and was not "Indian" based on registration or status.
1945	Indian and Northern Health Services becomes part of newly formed federal ministry of National Health and Welfare.
1957	<i>Health and Diagnostic Services Act</i> : federal law that set national standards for universal hospital coverage at the provincial level including the requirement that provincial governments make coverage available to all residents, including all indigenous residents in return for providing 50% of the cost of coverage. Provincial Governments implemented single-payer hospital plans that met national standards between 1958 and 1961.
1966	<i>Medical Care Act</i> : federal law that extended national standards and provided 50% of the cost of coverage for universal medical care coverage for provincial residents, including indigenous residents. Provincial governments implemented single-payer medical care coverage plans that met national standards between 1968 and 1971.
1969	Through the Statement of the Government of Canada on Indian Policy (Trudeau White Paper), the federal government proposed to abolish the <i>Indian Act</i> , terminate treaties and eliminate the distinct legal status of First Nations. Aboriginal groups, who felt that the objective was assimilation rather than equality, rejected the proposal.
1970s	Provincial governments fill some of the gaps in Medicare and employment-based private insurance coverage by establishing more limited and targeted coverage and services for prescription drug therapies, dental care and continuing care (social care).
1979	Indian Health Policy adopted by the federal government: included amalgamating benefits and services into the Non-Insured Health Benefits (NIHB) program.
1984	<i>Canada Health Act</i> passed by the federal Parliament: replaces <i>Health and Diagnostics Services Act</i> and <i>Medical Care Act</i> and locks in national standard on provincial requirement to cover indigenous residents.
1989	Health Transfer Policy: beginning of transfers, including funds for health services, under self-government agreements to indigenous band governments.

In the twentieth century, the federal government gradually increased its provision of basic hospital, medical and other health services to registered Indians and recognized Inuit. These services were transferred to the newly established Department of National Health and Welfare

in 1945. By 1955, the Indian and Northern Services in the Department of National Health and Welfare was operating 18 hospitals providing basic acute care and 40 nursing stations, 59 health centres and 27 clinics providing public healthcare and primary care services for 163,500 eligible “Indians and Eskimos” (Department of National Health and Welfare 1956; Lux 2016). However, in the next decade, with the introduction of universal Medicare, the federal government would fundamentally alter its policy of directly providing hospital and medical services to Indigenous people. This position was shaped by the Government of Canada’s view that it was under no treaty or constitutional obligation to provide free, universal coverage for health services, as stated in the Department of Health and Welfare’s Annual Report of 1956:

To put the relationship between this Service and the Indian population of the country in proper perspective, it must first be emphasized that the Indian is not entitled by law to free medical care. It is the intention of the Government to help these people reach full social, economic, and educational equality with their white neighbours and to assist them, if they choose, to become full partners in the Canadian community. However, they have not been made wards of the State, nor has the State even assumed the responsibility of providing free medical attention to all, irrespective of their legal status or ability to pay. On the other hand, the government votes a certain amount of money to be spent each year for the provision of basic health and treatment services to the Indians and Eskimos. This is done on humanitarian grounds, for the isolation of many of these people is such that even the most primitive facilities would not otherwise be available. (Department of National Health and Welfare 1956: 84)

In 1957, the federal Parliament passed the *Hospital Insurance and Diagnostic Services Act*. The new law encouraged provincial governments to provide universal hospital coverage under a common set of standards by providing 50% of the cost of coverage through annual transfers. The question of who was responsible for providing coverage to Indigenous people was one of the most contentious issues during the negotiations leading up to the implementation of universal hospital coverage. Before and during the First Ministers’ Conferences and the technical meetings of officials and ministers, when universal coverage was being negotiated, provincial politicians and their advisors insisted that the federal government was responsible for the hospital and medical care of Canada’s Indian and Inuit residents (Marchildon 2014).

However, on this issue, the federal government was unyielding throughout the negotiations – it would not cost-share provincial health insurance unless provincial governments included all residents, including registered Indians and recognized Inuit, in their universal coverage plans. Ultimately, the provincial governments had to accept this condition to secure cost-sharing from the federal government (Marchildon 2014). Over the next two decades, the federal government would close its “Indian hospitals” or transfer the hospitals to provincial governments (Lux 2016; Waldram et al. 2006). One decade later, when universal coverage was extended to include medical care, defined as physician services at the time, the same

dispute between the two orders of government emerged. Once again, the provincial governments reluctantly agreed to provide universal medical care coverage to their respective Indigenous populations as stipulated in the *Medical Care Act* of 1966.

The narrow definition of Medicare resulted in major gaps in service and coverage. From the mid- to late-1970s, provincial governments introduced a number of disparate coverage programs and services that tended to provide highly targeted rather than universal coverage. These gap-fillers included basic drug coverage plans aimed at social assistance recipients and retirees, groups that did not have access to employment-based private health insurance (Boychuk 1998). Some provincial governments experimented with school-based dental plans for children (Mathu-Muju et al. 2013). Almost all provinces introduced means-based subsidies to cover nursing care and accommodation in long-term care facilities. However, these extended health benefits – so called because they extended beyond Medicare coverage – were not provided to eligible Indigenous residents, as they were already receiving some extended health benefits through the Department of National Health and Welfare.

With the introduction of the Indian Health Policy in 1979, these extended health benefits were formally organized under the NIHB program, providing coverage to registered Indians and recognized Inuit for prescription drugs, dental care, medical travel and other extended (non-Medicare) health benefits.

Since then, a registered Indian in Canada has two policy numbers for health coverage. The first is a provincial health number (and card) for Medicare and the second is a federal registration number (and card) from the Department of Aboriginal Affairs and Northern Development Canada that automatically qualifies the individual to be an “eligible recipient” of NIHB. The subsequent passage of the *Canada Health Act* in 1984 and the Health Transfer Policy, first announced in 1986, which has allowed for a certain degree of self-government in the funding and administration of healthcare by First Nations band governments, has not altered this regime in any fundamental respect (Lavoie 2004).

Aside from the confusion it creates for those defined as registered Indians and recognized Inuit and their health providers, there are many continuing challenges created by the policy bifurcation. It creates incentives for cost shifting between the federal and provincial governments and further between government and private health insurers. Provincial and territorial governments tend to deem registered Indians and recognized Inuit as non-eligible for extended coverage and services because they already obtain benefits from federal coverage. At the same time, the federal government insists that NIHB recipients are only eligible for coverage for specific services if they do not have coverage under a private or provincial healthcare plan or program.

By researching obstructive sleep apnea diagnostic and treatment care, we sought to better understand the implications of health policy bifurcation as understood by the administrators of federal and provincial programs and healthcare providers. In exploring these perceptions, we identify areas of agreement and disagreement among these stakeholder groups and assess the implications for potential future policy change.

Methods

A review of federal and provincial government websites using key words and search bars was first undertaken to determine specific policy differences among federal and Saskatchewan government programs for the diagnosis and treatment of sleep apnea. Largely based on federal and provincial legislation, as well as publicly available government documents, this review informed the development of three interview guides for identification and exploration of policy and practice issues among the three key interviewee groups: (1) federal government NIHB program administrators; (2) Saskatchewan government extended benefits program administrators; and (3) sleep medicine specialists responsible for the diagnosis and treatment of sleep apnea. A semi-structured format was used to allow for a broader discussion of issues related to the delivery of health services to patients legally defined as registered Indians.

A snowball recruitment technique was used to recruit interview participants. Contact persons were identified using online government department directories and pre-existing contacts of the researchers. Initial recruitment involved e-mail and telephone contact, and these initial contacts were asked to suggest other potential interview participants. In total, 16 individuals were initially contacted to participate, of which eight felt they were not appropriate to respond from their organization based on their limited involvement in the area of sleep apnea benefits; in those cases, the researchers were instead directed to one or more appropriate individuals who participated on behalf of their organization.

In total, 10 interviews were conducted between September 17, 2014, and November 26, 2014, including federal government NIHB administrators ($n = 3$), Saskatchewan government extended benefit administrators ($n = 4$) and sleep medicine physicians ($n = 3$). The inclusion criteria for government program administrators included the following: (1) having a working knowledge of the policies or procedures related to accessing sleep apnea care in Saskatchewan and (2) being a current employee of the respective provincial/federal government department. The inclusion criteria for sleep medicine physicians included the following: (1) being a practising sleep medicine specialist working in Saskatoon or Regina and (2) having experience treating both NIHB-eligible First Nations patients and other Saskatchewan residents.

Interviews were 30–60 min in length and were conducted in person, with the exception of one telephone interview. All interviews were audio-recorded, transcribed verbatim and de-identified. Participants were offered the opportunity to withdraw portions of their interview transcript so as to reduce any potential risks or repercussions to their employment. Thematic analysis was then carried out on the transcripts using a priori coding based on an extensive review of the secondary and grey literature in combination with inductive coding based on the lead researcher's judgment and knowledge of the content of the interviews. NVIVO software was used for ease and accuracy of coding. Interview participants provided informed consent at the time of interview. Ethical approval was obtained from the University of Regina and University of Saskatchewan respective research ethics boards.

Results and Discussion

The specific differences between service coverage and procedures to access benefits for the respective provincial and federal sleep apnea benefit programs were identified through a literature review (Figure 1). Although both programs provide coverage for the recognized gold-standard treatment of sleep apnea known as continuous positive airway pressure (CPAP) therapy, the eligibility requirements for access to CPAP therapy differ. Provincial coverage is based on CPAP prescription by a Saskatchewan-based respirologist (Government of Saskatchewan 2014), whereas NIHB coverage has historically specified that the gold standard Level 1 test is required to confirm diagnosis (Health Canada 2009). In Saskatchewan, Level 1 testing is conducted exclusively in hospital-based laboratories. A Level 1 test conducted in a laboratory includes 15 channels of information, including electroencephalogram, eye movement, chin tone, leg movements, intercostal muscle movements, electrocardiogram signal, oximetry as a measure of oxygen saturation, two channels measuring air movement at the nose and mouth, motion of the chest and abdomen and a record of snoring. In addition, when monitoring treatment, measurement of airflow in a CPAP mask may replace the air movement channels at the nose and mouth, and pressure(s) within the mask may be monitored. In Saskatchewan, the in-hospital cost of a Level 1 study for First Nations and others is borne by the provincial paying agency, which is the Saskatchewan Hospital Services Plan.

In a Level 3 study, which may be conducted for one night in the home, a simplified set of measurements includes air movement at the nose and mouth, oximetry measured on the finger, a record of pulse and a record of snoring. In certain situations, it may be necessary to refer a patient who has had a Level 3 test to a more advanced laboratory, which, in Saskatchewan, is located in hospitals for a Level 1 test. The medical reasons for this could include uncertainty of diagnosis or complexity of the condition. However, the majority of cases of obstructive sleep apnea can be diagnosed and treated with Level 3 home testing.

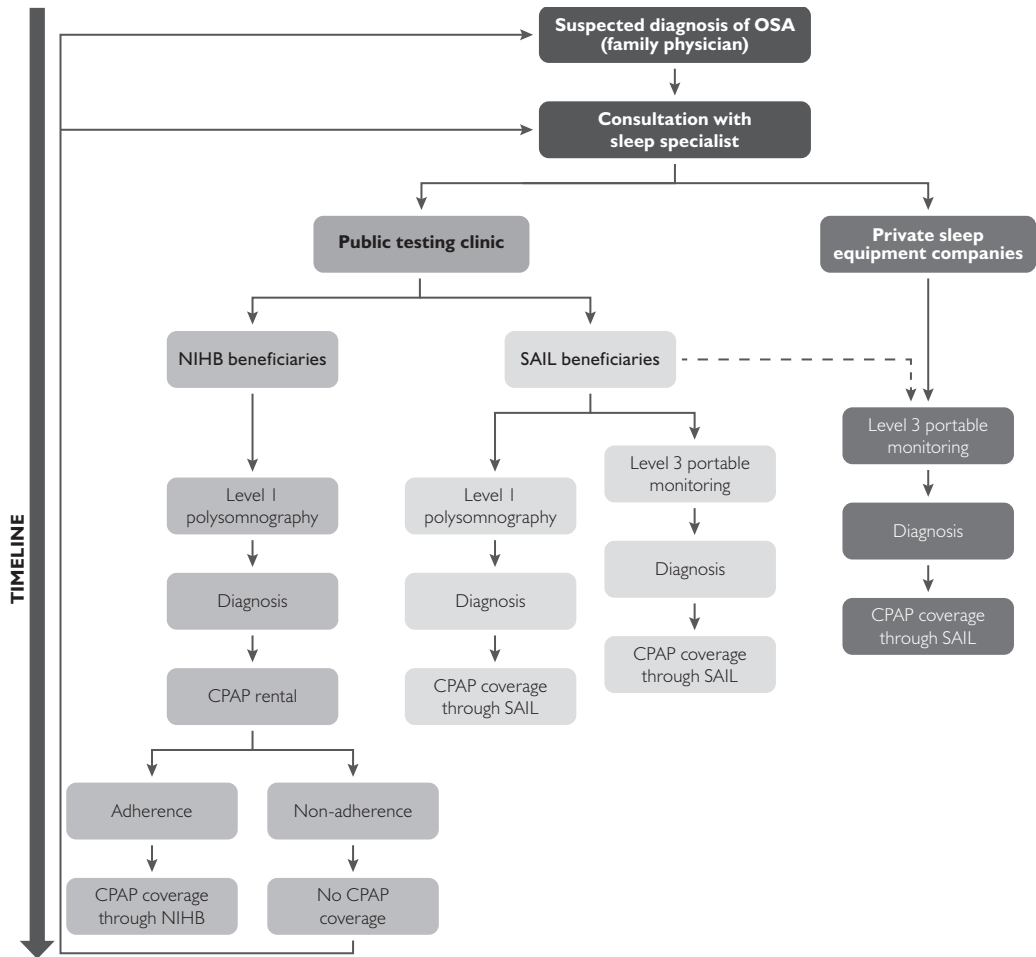
It is now becoming common for insuring agencies to authorize the provision of CPAP treatment equipment on the basis of a Level 3 study with the obvious advantages of ease and low cost. For example, in the US, both Medicare and Medicaid programs authorize payment for treatment equipment on the basis of Level 3 studies. Level 3 studies may be obtained in Saskatchewan by several methods, including free-of-charge, through the Saskatoon Health District, and through several private sector companies in the largest urban centres that charge a nominal amount or perform the test free of charge. In addition, the private sector companies will send the equipment to rural clients outside Saskatoon by bus for home testing.

Thus, in many cases, provincial residents may obtain treatment on the basis of the lower-level and readily available Level 3 study conducted one night at home, which often is available to the client within days. On the other hand, NIHB-eligible residents (i.e., registered Indians) have been required to go through the advanced Level 1 testing in a hospital laboratory with waiting lists that, except in urgent cases, may vary from six months to over one year. This problem is compounded by the fact that many registered Indian clients must travel

from rural and remote areas. NIHB also requires a relatively complex process that involves the necessity of renting an insured CPAP machine for three months, after which clients must provide medical proof of adherence before they will qualify for insured CPAP purchase.

With regard to payment, provincial residents (except for those who are NIHB-eligible) are issued a CPAP machine long-term lend without charge through the Saskatchewan Aids to Independent Living (SAIL) program. The individual client is responsible for completing the package of necessary equipment by the purchase of mask, tubing and heated humidity, the cost of which can be reimbursed by personal insurance programs or are covered by existing programs for social service recipients. For NIHB-eligible residents, following the in-laboratory Level 1 study, three-month rental program and the ‘medical proof of adherence’ requirement, NIHB covers the machine, mask, tubing and humidity.

FIGURE 1. CPAP pathway for NIHB and SAIL beneficiaries in Saskatchewan



CPAP = continuous positive airway pressure; NIHB = non-insured health benefits; OSA = obstructive sleep apnea; SAIL = Saskatchewan Aids to Independent Living. Note: Upon diagnosis, a patient with sleep apnea may decide to forego public coverage provided through NIHB or SAIL and instead purchase a CPAP machine directly from a private respiratory equipment provider.

Although they recognized that both programs ultimately provide CPAP coverage, sleep apnea specialists consider procedural differences a barrier to care for NIHB-eligible patients. Moreover, these physicians described the frustration among their patients in accessing health benefit programs and coordinating benefits among multiple programs:

“I know they won’t get funded for a CPAP machine if I send them for Level 3 testing, regardless who’s providing it, right? So I actually preferentially send people with a Treaty [registration] number for Level 1 polysomnography because I know that it’s going to be an administrative mess for them to try and get a CPAP machine if I don’t do that. It’s just a way of facilitating care for them” (Sleep Medicine Specialist #2).

In addition to these administrative delays, the sleep medicine specialists pointed out that even greater challenges are created because of the geographic isolation of rural and remote reserve communities. Even accessing Level 1 diagnosis is a significant barrier because of the travel, costs and extended time commitments.

Federal and Saskatchewan government program administrators were not familiar with all the federal–provincial differences in program requirements for diagnosis and treatment of sleep apnea. Although they had episodic knowledge of some programmatic differences and could provide examples of some service gaps created by this federal–provincial divide, they could not provide a systematic comparison of coverage.

For federal program administrators, eligibility for services is based on NIHB being a “payer of last resort,” meaning that eligible individuals can only access coverage for services when these services are not insured by other public and private plans, including provincial extended benefit plans. In this view, NIHB coverage is administered on the basis of the coverage of a specific service for a specific beneficiary rather than on the basis of full eligibility for all services based on registered Indian or recognized Inuit status. In this approach, a detailed review of each individual claim submitted to NIHB is required to determine eligibility.

Alternatively, provincial government administrators determined eligibility on a more universal basis through a process of automatic exclusion. Based on provincial regulation, NIHB-eligible patients are automatically deemed ineligible for provincial extended health benefits. This presents a burden where a specific health benefit is available under a provincial program but is not offered under the federal regime, and NIHB-eligible patients pay out of pocket or through private health insurance or go entirely without the service.

[Regarding a specific benefit,] the [provincial] program might say, “Well, we do provide this, but because they’re [registered Indians] First Nations [sic], we think that you should be providing this through NIHB,” and NIHB will say, “But it’s excluded. This piece of equipment we don’t even provide.” So the clients end up getting stuck in the middle of that, right, so sometimes it’s not so much based on benefits, it’s based on Status. (Federal program administrator #3)

Both provincial and federal program administrators recognize the benefits of collaboration to remedy issues of access. However, intergovernmental cooperation has been limited despite Jordan's Principle. In 2007, the House of Commons passed a general resolution on the principle which declared that when jurisdictional disputes occur regarding the responsibility for a First Nations child's health or social care, the government at first point of contact should pay in order to avoid delays in care, and the two governments negotiate fiscal responsibility afterward. However, operational implementation of Jordan's Principle through federal-provincial collaboration has been extremely limited (Jordan's Principle Working Group 2015; MacDonald 2007). Despite the fact that over a decade has elapsed since Jordan's Principle was enunciated, there has been little communication, much less collaboration, between federal and provincial on services such as obstructive sleep apnea, an admittedly difficult area because the condition involves the mixture of "insured services" under the *Canada Health Act* and services under federal and provincial extended health benefit coverage schemes. And where collaboration has occurred on a range of health services, it has tended to address problems after they arise rather than proactively seeking to prevent problems (Blackstock 2016). Federal program administrators in particular noted the challenges involved in aligning the Canada-wide NIHB program with highly variable provincial extended health benefit programs.

Perhaps because they were aware of some of the complexities of federal-provincial relations on Indigenous policy in general, and health policy in particular, the interviewees offered few policy solutions. However, sleep medicine providers expressed interest in federal and provincial governments reconciling funding issues to streamline service delivery and coverage. This was perceived as a way to eliminate differences in service coverage, reduce delays in treatment and lessen the administrative frictions on patients and providers.

Conclusion and Policy Implications

For historical and constitutional reasons, most registered Indians and recognized Inuit in Canada encounter a bifurcated health regime in Canada. Although little research has been conducted on the implications of this policy bifurcation for people trying to access a health service, this case study on sleep apnea suggests that there may be additional burdens that may serve to exacerbate, rather than diminish, existing inequities in health outcomes. While more research is required in other areas of extended health benefits and services, these results suggest a health policy impasse that should be addressed.

In the past, policy options to reduce inequities in health and social services for Indigenous populations have been proposed, although to little or no avail. One approach used by the federal government was to transfer funding for health and other services directly to First Nations governments. Although this was to have permitted a degree of Indigenous self-government, expertise was not transferred and relatively small Indigenous governments were forced to navigate the funding and administration of inherently complex services without the requisite capacity. This problem was exacerbated by the fact that the funds were not increased sufficiently over time.

Using a re-structuring approach, the 2002 Romanow Commission on the Future of Health Care in Canada called for the consolidation of existing funding from all levels of government into single Aboriginal health budgets to allow for greater integration and partnership (Romanow 2002). This recommendation has not yet been examined carefully by governments in Canada, and much might be gained if the council of federal, provincial and territorial ministers or deputy ministers of health struck a working group to assess the viability of such an approach.

There are other policy approaches that could be considered. For example, the federal government could undo its original agreement with the provinces on Medicare and create a new First Nations and Inuit health policy based on the delivery of services by an emerging order of Indigenous governments (Lavoie 2013). However, even if a broad intergovernmental and societal consensus could be reached on the general principles, much less the specific organizational details, of such an approach, it would take a generation or more to implement due to the complexities of the financial and administrative arrangements, and the time required by Indigenous governments to build the requisite administrative and service delivery capacity. Moreover, due to the enormous fiscal risk that such a change implies for the federal government, it is difficult for any federal administration, including the current Trudeau government, which has promised major changes in its relationship with Indigenous peoples in Canada, to pursue this change.

For this reason, it would be worth considering more immediate policy options. One option is for the federal government to realign NIHB coverage to match extended benefits coverage in each province so that diagnosis and treatment is largely the same in each province. The benefit is that all provincial residents, including NIHB-eligible residents, would, in theory, receive identical diagnosis and treatment depending on the province of residence. However, coverage would depend on the province of residence, and it is possible that provincial coverage in at least some jurisdictions likely falls beneath the coverage offered by NIHB at this time – something that could be further investigated.

A more radical option is for a renegotiation of the original federal–provincial compact on Medicare, which would expand the definition of insured services to include at least some of the non-insured services currently covered by NIHB – particularly those such as sleep apnea, which are disease entities not recognized at the time of the original agreements. This would likely require an increase in the federal government’s cash transfers to provincial governments. While more radical, it would certainly clarify current responsibilities between the two orders of government and create a single pipeline for the financing and delivery of medically necessary health services. On the other hand, it would also weaken the accountability linkage between the federal government and Indigenous peoples and may make it more difficult to achieve a self-government approach to health service delivery by First Nations governments and communities. While provincial and territorial governments currently may have few reasons at this time to align their extended health benefit schemes, the federal government might be able to provide the financial incentive to encourage some national-level standard setting.

Notes

1. Registered Indians are Indigenous individuals who hold a certificate of Indian status with the federal government of Canada.
2. The Inuit traditionally lived above the tree line of current day Canada and are part of a larger circumpolar Inuit population that includes Greenland, Alaska and Russia. Recognized Inuit are individuals who are recognized by one of the Inuit land claim organizations. The legal language of “registered Indian” and “recognized Inuit” is used throughout this article to avoid confusion with non-registered Indians, Métis and non-recognized Inuit who are excluded from NIHB coverage and, therefore, eligible for provincial and territorial extended health benefit coverage.

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A Study of Sleep Apnea Care and Benefits Coverage in Saskatchewan

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