CMA Submission:

Reducing barriers to physician mobility and for a more uniformed healthcare system in Canada

Submission to the Standing Senate Committee on Banking, Trade and Commerce

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Association médicale canadienne
Canadian Medical Association

The Canadian Medical Association (CMA) is the national voice of Canadian physicians. Founded in 1867, the CMA's mission is helping physicians care for patients.

On behalf of its more than 83,000 members and the Canadian public, the CMA performs a wide variety of functions. Key functions include advocating for health promotion and disease/injury prevention policies and strategies, advocating for access to quality health care, facilitating change within the medical profession, and providing leadership and guidance to physicians to help them influence, manage and adapt to changes in health care delivery.

The CMA is a voluntary professional organization representing the majority of Canada's physicians and comprising 12 provincial and territorial divisions and over 60 national medical organizations.

Introduction

On behalf of 83,000 physician members, the Canadian Medical Association (CMA) welcomes this opportunity to provide input to the Standing Senate Committee on Banking, Trade and Commerce study on internal barriers to trade. For the purposes of this brief, an internal barrier to trade is any regulation or policy that restricts mobility or otherwise creates a perverse incentive for mobility.

The CMA and other national medical organizations have a longstanding interest in the ability of physicians to move easily from one jurisdiction to another, and in the ability of the population to receive comparable access to health care no matter where they live. In the comments that follow, the CMA respectfully puts forward recommendations for measures that could be taken by the federal government to further facilitate the reduction in barriers to mobility of physicians and to enhance uniform access to care.

Basic Facts on the Canadian Physician Workforce

The physician workforce in Canada has always been a mobile one. As of January 2016, just over one in four (26%) licensed physicians who graduated from one of Canada's 17 medical schools was practising in a different province from the one where they obtained their medical degree.[1] It might be added that only 8 of Canada's 13 provinces and territories have medical schools. Another important dimension of mobility is the fact that Canada continues to rely to a significant degree on the medical services provided by International Medical Graduates (IMGs). Presently, IMGs represent 24% of practising physicians in Canada, and this figure has remained steady over the past two decades (and previously) despite significant increases in medical enrolment.[1] A key reason for this dependence is that Canada trains fewer physicians relative to population than other developed countries. According to the Organization for Economic Cooperation and Development (OECD), in 2013, Canada ranked 28th out of 34 member countries in terms of medical graduates per 100,000 population; at 7.5 graduates per 100,000, Canada was one-third below the OECD average of 11.1.[2] Another key consideration of the physician workforce in Canada is that beyond the tuition that medical students pay at the undergraduate level, it is virtually exclusively publicly funded. By way of illustration, in 2012, 99% of physician professional incomes came from the public purse in Canada, compared to an average of 72% for the 22 OECD countries for which data were available.[3]

National Standards for Eligibility for Licensure

The medical profession was well out in front of the 1994 Agreement on Internal Trade (AIT) and its objective in Chapter Seven of eliminating or reducing measures maintained by the provinces and territories that restrict or impair labour mobility in Canada.[4] In 1992, the Federation of

Medical Licensing Authorities of Canada, the Association of Canadian Medical Colleges and the Medical Council of Canada adopted a standard for portable eligibility of licensure in all provinces except Quebec.[5] When the AIT was revisited in the late 2000s, the Federation of Medical Regulatory Authorities of Canada (FMRAC) worked on the development of an agreement on national standards that was endorsed in all jurisdictions in 2009. This has continued to evolve, and presently, the *Model Standards for Medical Registration in Canada* set out the:

- Canadian standard for full licensure;
- route from a provisional license to a full license (which would apply to most IMGs that do not come through the post-MD system in Canada); and
- requirements for provisional licensure.[6]

The result of this effort is that the number of different medical licences in Canada has been reduced from more than 140 to fewer than 5.

Since the early 2000s the federal government has played a strong leadership role in assisting the professions to come into compliance with the labour mobility provisions of the AIT. In the case of the medical profession, the key issue has been the mobility of IMGs. In 2002, the federally funded Advisory Committee on Health Delivery and Human Resources established the *Task Force on Licensure of International Medical Graduates*, which brought together representatives from national and provincial/territorial health ministries, medical regulatory and certifying bodies and medical schools with a mandate to aid in the integration of IMGs into the Canadian medical workforce. The recommendations in the 2004 final report of the Task Force essentially set out a workplan that has resulted in considerable progress on several initiatives.[7]

Federal funding through programs such as Employment and Social Development Canada's (ESDC) *Foreign Credential Recognition Program* and Health Canada's *Internationally Educated Health Care Professional Program,* in addition to significant investments by the medical bodies themselves, has contributed to several successful initiatives on the part of the Medical Council of Canada (MCC) and FMRAC and its provincial/territorial members. These have included:

- $3.5 million from Health Canada to MCC to develop programs to facilitate the integration of IMGs into the physician workforce such as the *National Assessment Collaboration* examination, a standardized examination that assesses the readiness of an IMG for entrance into the Canadian post-MD training system;
- $8.4 million from Human Resources and Skills Development Canada/ESDC to MCC to streamline and standardize the processes of application for medical licensure and to

develop *physiciansapply.ca,* a single electronic web-based application process for registration with each of the 13 medical regulatory authorities; and

- $6.7 million from ESDC to MCC to develop a more flexible MCC Qualifying Examination Part I that can be administered internationally, which will enable IMGs thinking of immigrating to Canada to assess whether they have one of the requirements for full licensure.

The work to date has contributed significantly to the integration of IMGs but much remains to be done. Many IMGs enter practice in Canada without entering the post-MD system through a process of provisional licensure. One process that jurisdictions have developed over the past decade to facilitate this route to practice is called Practice Ready Assessment (PRA). PRA is an assessment process to determine if an IMG is able to provide safe medical care to the Canadian public under provisional licensure. This consists of a period of practice under supervised direct observation of a licensed physician in a clinical setting with patients. This has the advantage of expediting the process of assessment to approximately 12 weeks versus 2+ years in a residency program. To the present, PRA programs have been developing in a non-standardized way across jurisdictions. With support from Health Canada, an initiative is underway at the MCC with collaboration from FMRAC, the regulatory bodies, the certifying colleges and provincial IMG assessment programs to develop a pan-Canadian PRA program.[8] The goal of this program is to address pan-Canadian specialty areas of need, including family medicine, psychiatry and internal medicine. The elements of this program will include:

- IMG candidate orientation to the Canadian health care context;
- identification of core competency for each specialty;
- clinical assessor training;
- standardized assessment tools; and
- guidelines.

This initiative is presently in the implementation phase, and the plan includes development of additional work-based assessment tools.[i]

Recommendation one: The Canadian Medical Association recommends that the federal government continue to support the Medical Council of Canada and the Federation of Medical Regulatory Authorities of Canada in the implementation of a pan-Canadian Practice Ready Assessment Program for International Medical Graduates and the development of work-based assessment tools.

[i] For further information contact MCC – www.mcc.ca or FMRAC – www.fmrac.ca

Mobility and Medicare

The right of Canadian citizens and permanent residents to move freely and pursue a livelihood in any jurisdiction is set out in the 1982 *Canadian Charter of Rights and Freedoms.*[9] This is supported in the objectives of the AIT that refer to an "open domestic market" and "free movement of persons". [4]

This is certainly the spirit in which Canada's Medicare program was established, beginning in the 1950s, and which has now come to be regarded as a much-cherished basic right by Canadians. The preamble of the 1984 *Canada Health Act (CHA)* includes the objective "to facilitate reasonable access to health services without financial or other barriers", and portability of health insurance from one jurisdiction to another is one of five criteria for eligibility for federal funding (subject to a three month waiting period in which benefits are paid for by the originating jurisdiction).[10] However, the letter of the *CHA* defines insured health services as "hospital services, physician services and surgical-dental services provided to insured services"[10] and that is how it continues to be interpreted by the provinces and territories. An issue that has been identified in many recent reports is the uneven access to prescription drugs. The Canadian Institute for Health Information (CIHI) has estimated that in 2014, the federal and provincial governments accounted for 42% of prescription drug spending, with the majority accounted for by private insurance (36%) or out-of-pocket (22%) spending.[11]

There is wide variation in public per capita spending on prescription drugs across the provinces. In 2015, CIHI has estimated that expenditure ranged from $219 in British Columbia and $256 in Prince Edward Island (PEI) to $369 in Saskatchewan and $441 in Quebec.[12] Even more striking variation is evident when looking at household out-of-pocket spending on prescription drugs by income quintile. Statistics Canada's 2014 Survey of Household Spending shows that the poorest one-fifth (lowest income quintile) of PEI households spent more than twice as much ($645) on prescription drugs than the poorest one-fifth in Ontario ($300).[13] Aside from overall differences in public spending, there are also differences in which drugs are covered, particularly in the case of cancer drugs. For example, the Cancer Advocacy Coalition of Canada reported in 2014 that in Ontario and Atlantic Canada, cancer drugs that must be taken in a hospital setting and are on the provincial formulary are fully funded by the provincial government; if the drug is taken outside of hospital (oral or injectable), however, the patient and family may have to pay significant costs out-of-pocket.[14] More generally, the Canadian Cancer Society has reported that persons moving from one province to another may find that a drug covered in their former province may not be covered in the new one. [15]

Another consequence of the "patchwork quilt" of prescription drug coverage in Canada is the potential for "job lock" among those with employer sponsored benefits. Research carried out by Ipsos Reid for the CMA in 2012 among Canadian adults found that 51% of respondents had employer-sponsored supplementary benefits, with almost all of them reporting prescription drug coverage. Among those with employer benefits, just over four in 10 (42%) indicated that their employer benefits program would be a factor in whether or not they would switch jobs.[16]

Uneven access to and coverage of prescription drugs across Canada raises two concerns with respect to population mobility. On one hand, there could be a temptation to move to another jurisdiction with better access and coverage, and on the other, there could be a reluctance to move to another jurisdiction for fear of lesser access and coverage. Uncertainty about health care coverage should not be a factor in Canadians' decisions about where they choose to live and work.

One concrete step that the federal government could take to mitigate these concerns would be to introduce a program of drug coverage that would cap high out-of-pocket drug costs for individual Canadians. In 2015, the Conference Board of Canada conducted research for the CMA to estimate the cost of a drug program that would cover prescription drug costs that are greater than either $1,500 per year or 3% of household income (so-called catastrophic costs). They estimated that this would cost the federal government $1.6 billion in 2016.[17]

Recommendation two: As a positive step toward comprehensive, universal coverage for prescription medication, the Canadian Medical Association recommends that the federal government establish a new program for catastrophic coverage of prescription medication.

The Canada Health Act and Physician Mobility

In his 1979 review of the Medicare program that led to the *CHA*, Justice Emmett Hall clearly recognized the power imbalance of the shift to an exclusive public payer for physician services, stating "*I reject totally the idea that physicians must accept what any given Province may decide unilaterally to pay. I reject too, as I did in the report of the Royal Commission, the concept of extra-billing."*

Justice Hall's recommended solution to this imbalance was provision for that "*when negotiations fail and an impasse occurs, the issues in dispute must be sent to binding arbitration, to an arbitration board consisting of three persons, with an independent chairperson to be named by the chief justice of the relevant Province and one nominee from the profession and one from the Government".*[18]

Provision for reasonable compensation was built into the *CHA* in sections 12 (1) and (2). In most jurisdictions, bargaining disputes between the government and the medical association over

the amounts that physicians should be paid are subject to a binding dispute resolution mechanism that includes some form of arbitration, as Justice Hall envisioned. However, in Ontario, the physicians have been without a contract since March 31, 2014, and Nova Scotia has given Royal Assent to, but not yet proclaimed the *Public Services Sustainability (2015) Act,* which suspends the right of the medical association (Doctors Nova Scotia) to arbitration.

As noted in the basic facts enumerated above, Canadian physicians are highly mobile, but they should not be motivated to move on the basis of unfair treatment by the government, as is currently the case in Ontario. There is recent precedent for amending the *CHA*. In 2012, the *Jobs, Growth and Long-term Prosperity Act* amended the CHA to remove members of the Royal Canadian Mounted Police from the list of exclusions of insured persons.[19]

Recommendation three: The Canadian Medical Association recommends that Section 12(2) of the *Canada Health Act* be amended to require:

(a) Provincial and territorial governments to enter into an agreement with the provincial/territorial organization(s) that represent(s) practising medical practitioners in the province; and

(b) The settlement of disputes relating to compensation through, at the option of the provincial/territorial organization(s) referred to in paragraph (a), conciliation or binding arbitration that is equally representative of the provincial/territorial organization(s) and the province/territory and that has an independent chairperson, to satisfy the "reasonable compensation" criterion in s. 12(1)(c) of the Act for full federal funding.

Incorporation Eligibility and Access to the Small Business Deduction

A significant proportion of Canada's physicians are self-employed, small business owners, whose medical practices are incorporated as Canadian-Controlled Private Corporations (CCPCs). The ability to incorporate and access to the small business taxation rate play an important role in the allocation of resources in Canada's health care system.

As explained in the CMA's recent submission to the Minister of Finance[20], incorporation eligibility for medical professionals has been advanced by provincial governments to support the achievement of health policy objectives and, in part, to level the playing field with other self-employed individuals.

The CMA strongly welcomed the federal government's recognition in the budget of the contribution of health care practitioners as small businesses. However, the CMA has significant concerns with the proposed amendments (clause 54 of the Notice of Ways and Means Motion

to Amend the Income Tax Act and Other Tax Legislation) to alter eligibility to the small business deduction. It is not clear whether these measures will impact group medical structures.

The results of a recent survey by the CMA of its membership confirms that the CCPC framework provides a critical tax equity measure that recognizes the unique challenges they face as small business owners and is critical to the operation of the practice model, particularly supporting community-based care. In some cases, the practice model is only economical within this framework. An important fact is that unlike other small business owners, physicians cannot pass on any increases in compliance or operating costs to patients, given the design of Canada's public health care system. Of significance to the committee's study on internal trade, approximately 26% of survey respondents indicated that they would be very or somewhat likely to relocate to another provincial/territorial jurisdiction (26%) or to the U.S. or another country (22%) if they were no longer able to incorporate under the CCPC framework.

Recommendation four: Given the potential for negative unintended consequences, such as rendering group medical structures economically unviable or introducing perverse incentives for mobility, particularly out of country, the Canadian Medical Association strongly encourages the federal government to provide clarification regarding the 2016 budget measures with regard to the Canadian-Controlled Private Corporation framework.

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[1] Canadian Medical Association Physician Masterfile, January 2016.
[2] Organization for Economic Cooperation and Development. OECD Health Statistics, 2015. http://stats.oecd.org/Index.aspx?DataSetCode=HEALTH_REAC. Accessed 05/05/16.

[3] Organization for Economic Cooperation and Development. OECD. Stat. Accessed 05/05/16.
[4] Internal Trade Secretariat. Agreement on Internal Trade. http://www.ait-aci.ca/agreement-on-internal-trade/. Accessed 05/05/16.
[5] Federation of Medical Licensing Authorities of Canada, Association of Canadian Medical Colleges, Medical Council of Canada. Licensure, postgraduate training and the Qualifying Examination. Can Med Assoc J 1992;146(3):345.
[6] Federation of Medical Regulatory Authorities of Canada. Model standards for medical registration in Canada. Ottawa, 2016.
[7] Federal/Provincial/Territorial Advisory Committee on Health Delivery and Human Resources. Report of the Canadian Task Force on Licensure of International Medical Graduates. Ottawa, 2004.
[8] Medical Council of Canada. Practice-ready assessment. http://mcc.ca/about/collaborations-and-special-projects/practice-ready-assessment/. Accessed 05/08/16.
[9] Canadian Heritage. The Canadian Charter of Rights and Freedoms. http://publications.gc.ca/collections/Collection/CH37-4-3-2002E.pdf. Accessed 05/08/16.
[10] Canada. Canada Health Act R.S.C., 1985, c. C-6. http://laws-lois.justice.gc.ca/PDF/C-6.pdf. Accessed 05/08/16.
[11] Canadian Institute for Health Information. Prescribed drug spending in Canada, 2013: a focus on public drug programs. https://secure.cihi.ca/free_products/Prescribed%20Drug%20Spending%20in%20Canada_2014_EN.pdf. Accessed 05/08/16.

[12] Canadian Institute for Health Information. National Health Expenditure Database 1975 to 2015. Table A.3.1.1. https://www.cihi.ca/en/spending-and-health-workforce/spending/national-health-expenditure-trends. Accessed 05/08/14.
[13] Statistics Canada. CANSIM Table 2013-0026 Survey of household spending (SHS), household spending, by age of reference person. Accessed 03/27/16.
[14] Cancer Advocacy Coalition of Canada. 2014-15 Report Card on Cancer in Canada. http://www.canceradvocacy.ca/reportcard/2014/Report%20Card%20on%20Cancer%20in%20Canada%202014-2015.pdf. Accessed 05/08/16.
[15] Canadian Cancer society. Cancer drug access for Canadians. http://www.colorectal-cancer.ca/IMG/pdf/cancer_drug_access_report_en.pdf. Accessed 05/08/16.
[16] Ipsos Reid. Supplementary health benefits research. Final report, 2012.
[17] Conference Board of Canada. Federal policy action to support the health care needs of Canada's aging population. https://www.cma.ca/Assets/assets-library/document/en/advocacy/conference-board-rep-sept-2015-embargo-en.pdf. Accessed 05/08/16.
[18] Hall E. Canada's national-provincial health program for the 1980's 'A commitment for renewal'. 1980.
[19] Canada. Statutes of Canada 2012 Chapter 19. http://laws-lois.justice.gc.ca/PDF/2012_19.pdf.
[20] Canadian Medical Association. Submission to the Minister of Finance: Small Business Perspectives of Medical Practice in Canada. https://www.cma.ca/Assets/assets-library/document/en/advocacy/submissions/cma-brief-medical-practice-as-small-business-march-17-2016.pdf