CMA submission

Federal Policy Options to Advance Pan-Canadian Licensure

Improving health care by reducing interprovincial and interterritorial barriers

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1) Fund a Federal Health Care Regulator for all populations under federal responsibility

Access to health care for Indigenous communities can be improved with moderate legislative changes. In fact, these changes could address all populations where the federal government is required to deliver health care including armed forces, federal penitentiaries, refugees and veterans.

The federal government should permit any health care provider licensed in a province or a territory serving these populations to do so anywhere in Canada. At this time, these providers are restricted to providing care only within the provincial border of their license. This will allow licensed nurse practitioners, physician assistants, physicians, dentists, pharmacists, psychologists to develop specialty practices and collaborative networks that serve these federal populations without the barrier of having to seek multiple provincial licenses.

Recently, our health care system has harnessed the capacity to deliver some health care services virtually (sometimes referred to as telemedicine) though zoom calls and supported with electronic health records. These include health education, promotion, advisory, counselling, assessments, and screening to facilitate early identification and follow-up management of chronic diseases, including mental health.

A federal precedent for this proposal already exists. The Association of Canada Lands Surveyors (ACLS) was created by an Act of Parliament in 1998 and became a self-governed association and licensing body in March 1999 when the Canada Lands Surveyors Act, SC 1998 came into force. When a survey is required for Canada Lands (e.g., the three territories; national parks, Indigenous reserves, on/under Canada's oceans) the surveyor is licensed by the ACLS as a Canada Lands Surveyor. The CLS certification leverages the provincial licensure system to issue an initial license but the remainder of regulatory work, including discipline for complaints is carried out by the ACLS.

Adopting this model for health care would provide a person living within federal jurisdiction (i.e., Indigenous communities, members of the Canadian Armed Forces, inmates of federal correctional institutions, refugees and veterans) access to care from regulated health professionals from across Canada.

This new self-governing Federal Health Care regulator would require federal legislation and the creation of a Registry (see below) of all provincially licensed health care professionals who would be eligible to provide health care to populations of federal jurisdiction. These practitioners would still be required to maintain one provincial license but would no longer be required to maintain all provincial/territorial licenses. Collaboration and dialogue would be required with provinces to adjust the reimbursement formulae for the health care services provided across provincial borders. It would also require a discipline body to address complaints arising from services to these populations.

2) Fund a pan-Canadian Digital Registry of health professionals

Pan-Canadian licensure for health professionals requires a national digital registry or database that will serve as a single source for professional licensing application information. This Registry will ensure availability of the current file in real-time to authorized decision makers.

This registry would streamline document review (i.e., credential verification) and speed up the licensing of health care professionals seeking to be licensed in a second province. A common digital licensing standard would allow early adoption of digital licenses that can be verified across Canada. For example, a pharmacist or lab technician in one province could verify the prescription or requisition from a physician from another province.

The Medical Council of Canada has a database that can be expanded to act as a Registry. Currently, the database is for physicians, but the model could be applied to other regulated healthcare professions.

Finally, the federal government has the possibility of funding the process to establish provincial territorial agreement for this national Registry for health care providers for the purposes of registration/licensure.

3) Funding to enable interjurisdictional virtual care for all Canadians

As the pandemic taught us, virtual care is now accepted as a safe, flexible and efficient method for the delivery of many health services and is greatly welcomed by Canadian patients.

Virtual care, as a way of care delivery opens the door for cross-border services. When a person moves from one province to another, their access to medical care from their former physician in their former province continues, but only for three months. Then it is cut off and they are required to join a wait list for a physician in their new province. This wait can often be several years long before a person is able to access a physician in

their new province. By not being licensed in the person's new province of residence, their former physician is prohibited from providing care, often including virtual care, which breaks the existing relationship and continuum of care. Given the technological advances of virtual health care services, the three-month limitation no longer is justified and is an unnecessary barrier to the mobility rights under the Charter of Rights and Freedoms and Canada Health Act.

For example, some health care providers want to serve whole communities or families within an Indigenous community, and Indigenous persons may want a provider who will care for their whole family and who share a community of interest. Looking at the example of the Akwesasne territory – it crosses the Ontario, the Quebec and New York borders. The Akwesasne example illustrates the challenges with separations in jurisdictional borders, especially with members of the same family and community, as well as members of the larger Indigenous Nation – in this case, the Mohawk Nation.

Another example are the health networks that can be established to service virtual health care needs of remote communities. Those networks will struggle to get established due to the provincial licensing restrictions.

This proposal would involve funding to investigate and implement the regulation (i.e., standards of practice and licensure) and billing/compensation for cross-border virtual care under the federal government's trade and commerce mandate (or other relevant power). Legislation could establish a pan-Canadian virtual care license limited to the practice of virtual care delivery across provincial and territorial borders.

A federal/provincial/territorial funding model that ensures the appropriate evolution of virtual care across provincial borders will require consultation and adjustments. The outcome would assist with fulfilling promises for every Canadian to have some level of basic health care access.

4) Fund a Parliamentary review of the Canadian Free Trade Agreement

The Canadian Free Trade Agreement (CFTA) has a labour mobility chapter whose original purpose was to permit licensed professionals in one province to secure a license in another province. The CFTA was to eliminate or reduce measures that impair mobility, and, to enable any worker certified to be recognized as qualified. Now, more than five years after this agreement was signed, it is timely to review if the intent of the CFTA is being met.

There are provincial regulators and sometimes provincial legislation that are arguably not within the spirit of the CFTA. The urgency triggered by the pandemic revealed that the CFTA deserves a careful review of whether it is serving the needs of professionals seeking to relocate within Canada and continuing to practice in their profession and therefore increasing more timely access to care.

In its 2022 pre-budget submission, the CMA recommends that the federal government initiate a Parliamentary review of the regulatory provincial territorial legislative barriers to the mobility and deployment of health human resources under the CFTA and whether the CFTA is now meeting its initial goals.

5) Funding a pilot project to promote interprovincial license recognition

The CMA proposes that the federal government establish a funding program as a pilot project to establish licensure recognition amongst a group of interested jurisdictions. The role of the federal government would be financial and leadership support towards the work of inter-governmental agreements of interested provinces to facilitate a single "license". The outcome being that all participating provinces would recognize one license without requiring separate credential review, document or fee collection (other than updating information related to continuing competence, police check, etc.).

For example, Premiers of Atlantic provinces were discussing the creation of a regional certification due to providers and care gaps. The initiative has been stalled; however these provinces have recently signed an agreement that includes collaborating in the recognition of certification. The four Atlantic medical regulators between themselves signed an expedited process for locum licenses, demonstrated sustained interest amongst jurisdictions.