



# BRIEF

## **BRIEFING ON THE EMERGENCY SITUATION FACING CANADIANS IN LIGHT OF THE COVID-19 PANDEMIC**

**Submission to the House of Commons  
Standing Committee on Health  
June 2021**

## Summary

The COVID-19 pandemic has exposed and exacerbated gaps in Canada's health care system. Rural, remote, and Indigenous communities have faced unique challenges that must be addressed effectively. In regions hardest hit by outbreaks, health care workers have often found themselves short-staffed, exhausted, and barely able to cope with the number of patients requiring care. These crises were often even more dire for vulnerable populations, particularly in rural and Indigenous communities.

The mobilization of health care resources and health care providers from one part of the country to another to help communities in need was limited. This inability to recruit adequate numbers of health care professionals to meet increased needs has led many health care workers to suffer from burnout or illness. In many cases, the lack of a licence to practise in the jurisdiction was a key barrier to providing the help needed in rural, remote, and Indigenous communities.

Just as we have seen these challenges laid bare, we have also been able to spotlight opportunities for improvement. The Society of Rural Physicians of Canada (SRPC) calls for a national approach to licensure that would allow health care professionals to work anywhere in Canada. This would enhance access to care for patients and increase the workforce coverage available to support and sustain health care professionals.

As part of the House of Commons Standing Committee on Health's review of the pandemic, the SRPC requests that the following recommendations be considered:

**Recommendation 1:**

*The federal government should facilitate the establishment of a reciprocal agreement between provinces and territories that allows health care professionals, including but not limited to physicians and nurses, who are licensed in one jurisdiction to practise elsewhere in Canada.*

**Recommendation 2:**

*Once the reciprocal agreement described in Recommendation 1 is established, a federal agency should create and maintain a centralized roster of nationally licensed physicians and other health care workers; this directory could be used to facilitate the redeployment of health care workers with the required skills to address health crises as needed anywhere across Canada.*

**Recommendation 3:**

*If Recommendation 1 is deemed to be unconstitutional, over the long term the federal government should promote the creation of a national regulatory body for health care professionals, similar to the Australian Health Practitioner Regulation Agency.*

**Recommendation 4:**

*The federal government should formulate a plan or process to extend reciprocal licensing agreements to include the delivery of virtual health care and address the ongoing need for and expansion of these services across Canada.*

## Conclusion

The SRPC urges the federal government to support piloting a national licensure program so that health care providers can mobilize rapidly during times of crisis and provide coordinated, high-quality care to everyone in Canada at all times, regardless of the jurisdictions in which they live. The time to act is now.

## Introduction

The COVID-19 pandemic has revealed the pre-existing gaps and weaknesses in Canada's health care system. Rural, remote, and Indigenous communities have also faced unique challenges that must be addressed effectively. Barriers to the mobility of health care professionals across jurisdictions must be removed. Everyone in Canada deserves high-quality health care and equitable access to care—not only during crises, but always.

Mobilizing help from one part of the country to another has not been easy. During the third wave of the pandemic, hard-hit jurisdictions such as the Greater Toronto Area required rescue teams of health care professionals, including doctors and nurses, to travel from other provinces, such as Newfoundland and Labrador, to relieve burned-out local health care providers. The provincial government enacted Ontario Regulation 305/21 of the Emergency Management and Civil Protection Act so that fully licensed professionals from other jurisdictions were able to begin work immediately in Ontario.<sup>1</sup> Without this regulation, out-of-province health care professionals would have needed to comply with the lengthy and expensive process of obtaining licensure in another province.

Prior to the pandemic, many rural hospitals across the country were already struggling to maintain their health human resources, leaving programs such as obstetrical care, emergency care, and surgical care at risk of closing. For example, some surgical programs are kept open by a single surgeon who is on-call 24 hours a day, seven days a week. In some communities, services have been temporarily or permanently closed due to a lack of staff.

Having national licensure would allow health care professionals to work anywhere in Canada. This would promote better access to care for patients and improve opportunities for coverage among providers.

We can look at the experiences of other jurisdictions to address this issue and find a new path forward. Ten years ago, the government of Australia and all its states cooperated to enact national registration through the Australian Health Practitioner Regulation Agency,<sup>2</sup> which allows providers to work anywhere in the country. The Society of Rural Physicians of Canada (SRPC) believes such a strategy is also possible in Canada.

The time is now to explore and pursue a national approach to licensure, as the current, segmented regulatory framework is an impediment to the sustainability of Canada's health care system.

This submission to the House of Commons Standing Committee on Health highlights key areas of concerns related to the pandemic's impact on access to care for vulnerable populations and barriers that limit the ability of the health workforce to provide care in Canada where it is most needed. The SRPC welcomes an opportunity to discuss its recommendations further with the Standing Committee on Health as it continues to study the impact of COVID-19 on access to health care.

## Key issues

### i) Impact of COVID-19 on access to health care for rural populations

At the start of the pandemic, federal, provincial, and territorial governments called for the closing of borders. Just as people were feeling anxious about contracting COVID-19, this created new fears about access to primary care and other specialized medical services, especially among vulnerable populations. The SRPC heard stories from its members about patients in some provinces and territories not having access to family physicians or primary care teams in rural and Indigenous communities. These challenges included limited access to critical mental health services and patient transfers (such as if patients had to travel to an urban hospital for medical treatments related to COVID-19 or for specialist care outside their province) as well as travel and quarantine restrictions affecting both patients and health care providers.

Other inequalities were also exposed, as some rural communities had access to virtual health care while others did not have the appropriate bandwidth capacity to support these services. Further, the pandemic demonstrated the importance of virtual health care to meeting patients' needs and reducing the risk of disease transmission.<sup>3</sup> The ability to provide care virtually in remote communities is currently limited, and a key challenge is physicians not being licensed in the jurisdictions where patients live. For example, for patients in Nunavut receiving care from physicians in Ottawa, many specialists were unable to provide telehealth care unless they had a Nunavut licence; this caused delays that forced patients to wait months to see a visiting specialist in person or resulted in significant costs and inconvenience, as patients would be flown to Ottawa to be seen and then have to quarantine for an extended period on their way home. During the pandemic, patients unable to access virtual appointments were directly put at risk due to medical travel, as often they would often have to leave a region with low COVID-19 rates to travel to a city (or another community) with higher rates of COVID-19 infection.

The SRPC also heard stories about patients in rural areas not having access to medications and certain services. The challenges are that patients (who live in northern Manitoba) would have difficulty accessing primary and/or specialty care from Ontario physicians, for example, cancer treatments or prescriptions, because they need to see the physicians that are based in Thunder Bay, northern Ontario. Ontario physicians would be unable to prescribe medications for Winnipeg patients as Ontario provincial legislation does not allow them to provide care to patients in another province.

Excerpt of a story from an SRPC member:

*“We are in the far west of the province [of Ontario]. We could tap into a large Winnipeg workforce if there was national licensing; without it, however, we may have to close our very busy ER—forcing patients to travel to Winnipeg or Dryden. Dryden has far fewer resources than we do and it would overwhelm them and lead to huge patient wait times and many transfers to Thunder Bay. As it is, we may lose overnight lab services (which is unimaginable) because of a lack of lab techs—again, patients will have to wait and their care will suffer.”*

Despite the Canada Health Act legislating that all Canadians be given universal and accessible health care, many people living in rural and remote communities do not have access to care. Many of these

communities affected have large Indigenous populations, exacerbating systemic inequities that must be eliminated.

## **ii) Deployment of health care resources and personnel**

Resource shortages were revealed early in the COVID-19 pandemic, including amounts of personal protective equipment (PPE), intensive care unit capacities, and ventilator availability. Health care resources were rapidly redeployed to address COVID-19 needs, which reduced access to routine and ongoing care and left many patients with cancelled referrals, tests, and procedures.<sup>3</sup> Non-urgent surgeries have been cancelled and as reopening commences, decisions will need to be made about prioritization for care.<sup>3</sup>

The health care workforce has needed to adapt quickly to the COVID-19 landscape. Enormous pressure due to the lack of PPE, high workloads, and safety concerns has added considerable stress to health care workers,<sup>3</sup> many of whom already had high levels of burnout prior to the pandemic.<sup>4</sup> Staffing challenges were disproportionately higher in rural communities, particularly in Indigenous communities. These difficulties are heightened in times of crisis (such as a pandemic), but licensure limitations have for a long time created a lesser and inconsistent standard of care in many rural areas. Health workforce planning must ensure that enough health care providers are being trained in the added competencies necessary for high performance in disaster situations, in rural and remote settings, and when working with Indigenous communities.

Patient transfer protocols designed to support rural physicians, regardless of geography or health care jurisdictional authority, are needed to improve quality of care and access to specialized services, such as mental health care for rural and Indigenous populations. Inadequate access to networks of care and the inability to transfer patients when needed have been prevalent during the pandemic.<sup>5</sup>

SRPC members have reported challenges in recruiting enough nurses and laboratory technologists to keep emergency departments, diagnostic facilities, and, in some cases, rural hospitals open. Rural hospitals also face difficulties in finding locum physicians, which contributes to service gaps and can lead to an increase in the need for patient transfers.

## **iii) Barriers to national medical licensure**

Licensing of regulated health professionals such as physicians and nurses is under provincial and territorial jurisdiction. Physicians and nurses licensed in one province cannot work in another province without going through an application process through their regulatory colleges that can take months. The administrative burden this places on rural health care providers, including the significant fees required, is unnecessary.<sup>7</sup>

A number of the challenges experienced in retaining doctors in rural areas can be attributed to frustrations related to accessing high-quality health care for their patients outside their own communities. There are many examples of towns near provincial borders that have this problem. In Gatineau, Quebec, patients have trouble accessing care in neighbouring Ottawa. Lloydminster is a town cleaved in half by the provincial border of Alberta and Saskatchewan. Other examples include a recent call for urgent fill-ins for the Weeneebayko Area Health Authority in Northern Ontario that resulted in out-of-province physicians wanting to help but being unable to do so. Bella Bella, British Columbia, is flying physicians in for a single day at a time at significant cost. Towns in Alberta, such as Rocky

Mountain House and St. Paul, are desperate for ER coverage. Places like Hay River in the Northwest Territories consistently have to shutter emergency rooms annually for periods of time when there is no coverage available. Unfortunately, each area can draw from only a small pool of locum physicians due to licensure barriers.

Excerpt of a story from an SRPC member:

*“Nobody is going to pay \$2,000 and go through all the rigamarole of a licence application to help out in Bella Bella for a day to keep the ER open. We hear time and time again from rural colleagues that we would love to help each other out, but the licensure process stops us.”*

The Canadian Armed Forces feel the full force of regulatory diversity when caring for military patients, whether locally, domestically, or internationally. Those health care providers who wish to work in their new home province’s civilian medical system must apply for a new licence. The Federation of Medical Regulatory Authorities of Canada, which includes all the provincial and territorial licensing colleges, advises that no licence portability is possible without provincial or territorial government legislation that allows it.<sup>7</sup>

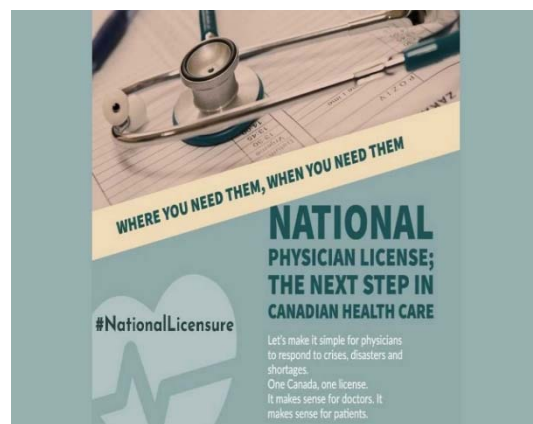
A 2019 national survey by the Canadian Medical Association (CMA) confirmed that 91% of physicians supported national licensure and believed it would improve care for patients. Forty-five per cent of physicians reported that if national licensure existed, they would work in other provinces to support their colleagues in times of need, 42% said they were willing to go to rural or remote regions, and 30% said they would do this on an ongoing basis.<sup>8</sup> As initially proposed by the CMA,<sup>9</sup> the SRPC urges the federal government to support piloting a national licensure program so that health care providers can opt to practise in regions experiencing health care crises or where there is a shortage of providers.

## Recommendations for a national approach to licensure

The SRPC proposes that a national approach to licensure that includes assembling a roster of highly skilled health care providers be developed to better enable Canada to respond to urgent health workforce needs.

To be effective, these health care providers need the ability to respond to calls for help in a timely manner and skills acquired through past experiences working in rural and remote parts of Canada. This could also help ensure that rural and Indigenous communities have access to high-quality care on an ongoing basis.

The COVID-19 pandemic has highlighted the benefits of national licensure. With virtual health care having a larger role in access to health care, national licensure could ensure virtual care could go beyond provincial or territorial borders. It would allow physicians from other jurisdictions to help in times of crisis. This is already happening in some parts of Canada. For example, the Northwest Territories provided licensing requirement exemptions to Alberta physicians who were willing to provide virtual health care to patients in the territory during the pandemic.<sup>6</sup> The territory provided more than 50 emergency licences to Alberta physicians in 2020. This example suggests national licensure is achievable.



Based on the recommendations of the Canadian Association of Emergency Physicians<sup>10</sup> and its petition to the federal Minister of Health<sup>12</sup> and the recommendations of the CMA,<sup>11</sup> the SRPC supports the following recommendations:

**Recommendation 1:**

The federal government should facilitate the establishment of a reciprocal agreement between provinces and territories that allows health care professionals, including but not limited to physicians and nurses, who are licensed in one jurisdiction to practise elsewhere in Canada.

**Recommendation 2:**

Once the reciprocal agreement described in Recommendation 1 is established, a federal agency should create and maintain a centralized roster of nationally licensed physicians and other health care workers; this directory could be used to facilitate the redeployment of health care workers with the required skills to address health crises as needed anywhere across Canada.

**Recommendation 3:**

If Recommendation 1 is deemed to be unconstitutional, over the long term the federal government should promote the creation of a national regulatory body for health care professionals, similar to the Australian Health Practitioner Regulation Agency.

**Recommendation 4:**

The federal government should formulate a plan or process to extend reciprocal licensing agreements to include the delivery of virtual health care and address the ongoing need for and expansion of these services across Canada.

In 2020 key medical groups signed a collaborative statement calling for a portable locum licence in Canada.<sup>13</sup> Four Atlantic premiers have publicly voiced their support for increased physician mobility across Canada.<sup>14</sup> In 2010 Australia made the transition to a national licensing system.<sup>2,8</sup> Efforts are ongoing by key medical groups such as the Federation of Medical Regulatory Authorities of Canada and the CMA to help streamline the licensing requirements of provincial and territorial medical regulators to provide a faster and simpler process for eligible physicians to obtain licences in other jurisdictions.

Our priority is the appropriate deployment of health care resources and the health care workforce to address long-standing health human resource shortages effectively in rural, remote, and Indigenous communities, and to be prepared for any future crises or disasters affecting vulnerable populations. The time is to act now.

## Conclusion

The SRPC has raised these issues and concerns not only among its medical and health care counterpart groups but also with government stakeholders, including the Senate of Canada. In fact, four senators who are also physicians supported the SRPC's recommendation in creating national licensure for doctors in Canada. Recently, some territorial governments (Northwest Territories and Yukon) have responded to the SRPC's call for a national approach to licensure.

The COVID-19 pandemic has highlighted how our current regulatory framework could be improved. The redistribution of Canada's medical and health workforce to regions with a greater need for personnel has been proven to be difficult and costly. The demand for virtual and mental health care services has increased, particularly in rural, remote, and Indigenous communities.

National licences that allow health professionals to practise across provincial and territorial borders could help fill gaps in coverage. We must continue to explore how we can improve patients' access to timely and high-quality health care across Canada.

The SRPC will continue its efforts to eliminate barriers to national licensure and to promote how it can enhance the deployment of health care professionals to address the current COVID-19 pandemic and potential future emergency health crises. It is what everyone in Canada deserves and expects.

### About the SRPC

**The Society of Rural Physicians of Canada (SRPC) is the national voice of Canadian rural physicians. Founded in 1992, the SRPC's mission is championing rural generalist medical care through education, collaboration, advocacy and research.**

**On behalf of its members and the Canadian public, the SRPC performs a wide variety of functions, such as developing and advocating health delivery mechanisms, supporting rural doctors and communities in crisis, promoting and delivering continuing rural medical education, encouraging and facilitating research into rural health issues, and fostering communication among rural physicians and other groups with an interest in rural health care.**

**The SRPC is a voluntary professional organization with over 1,900 members representing rural physicians spanning the country.**



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