"Unmet Demand and Untapped Supply": Licensing Provinces' Internationally-Trained Providers to Reduce Healthcare Wait Times

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ISSUE SUMMARY:

How to reduce healthcare wait times for primary-care services while limiting spillover effects, upholding public trust, and maintaining stability across existing provincial policies and jurisdiction.

I. RECOMMENDATION

It is recommended that provincial regulatory bodies (Colleges of Physicians and Surgeons) pilot a new licensing option for internationally-trained healthcare providers (ITHPs). Eligible ITHPs would include Canadians trained at select foreign medical schools and foreign nationals already in Canada who hold medical degrees from select institutions. This regulatory license would include a limited scope of practice that meets the demands of primary-care services while mobilizing the untapped supply of trained healthcare providers, all while preserving provinces' existing regulatory landscape and the trust that Canadians have in existing titles (e.g., nurses/doctors) and the broader healthcare system.

II. PROBLEM OVERVIEW

Unmet Demand

Across Canada, where healthcare falls to individual provinces under the 1984 Health Canada Act, Canadians are experiencing increased and unsustainable wait times for primary and specialty care services. A 2016 report ranked Canada last among ten of its peers for its waitlist times (Common Wealth Fund, 2016), while more recent studies have found that Canadians wait an average of 71 days for specialist care; an average that has grown steadily since tracking began (Liddy, 2020). These wait times impact Canadians disproportionately, with low-income individuals waiting longer for health services than their high-income counterparts (Hajizadeh, 2017). For those without a family doctor - 20% of Canadian adults - more than a third (35%) have been looking for a physician for more than a year, while 30% report "giving up" on finding a family doctor (figure 1).

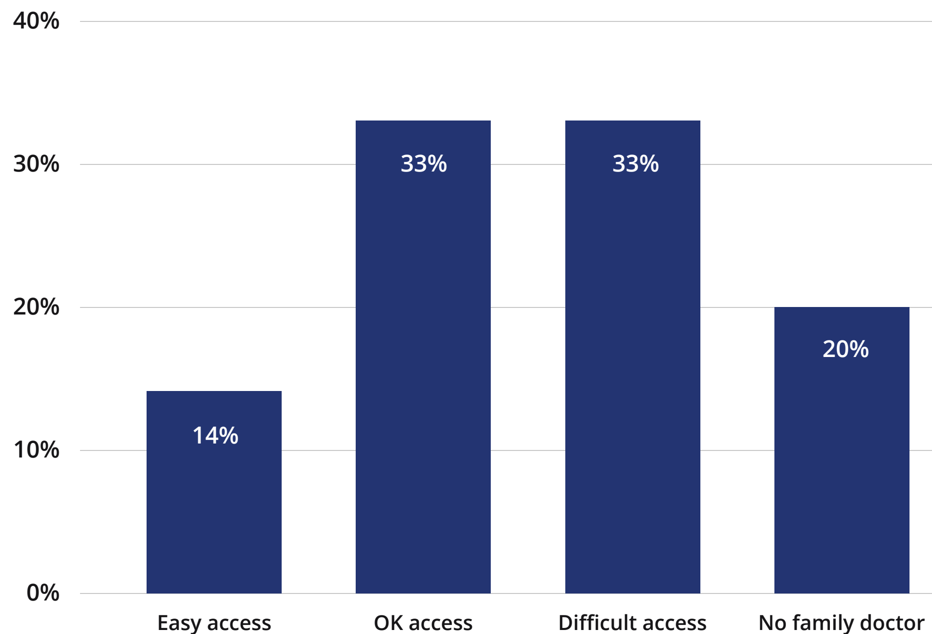

Figure 1. Demand-side shortcomings
Source: Angus Reid Institute, 2022

At the national level, Canadians report longer wait times than their peers in New Zealand and Switzerland (countries similarly lauded for their healthcare systems) and report difficulty accessing same-day care from either family physicians or walk-in clinics (Senn et al., 2019). The consequences of long wait times have been well documented, including negative health outcomes, patient stress, worsening medical conditions, increased long-term health costs, and declining trust in the healthcare system (Sanmartin et al., 2006; Ansell, 2017; Royal College of Physicians of Canada, 2018; Harrington et al., 2019).

Untapped Supply

While wait times have been studied by both policy analysts and healthcare professionals alike, the complex nature of healthcare reform in Canada remains a 'wicked' problem. The complexity of the problem is driven in part by unique provincial rules between regulatory colleges, siloed public insurance models provided by provinces, and barriers to entry for would-be physicians. As a result, the persistent problem of long wait times is not unique to any one province, but rather a Canadian problem that requires an approach led by and attuned to the unique contextual needs of each province.

Though funded in part by the per-capita-based Canada Health Transfer (CHT) from Ottawa, provinces administer their own healthcare systems, including public health insurance programs delivered through their Ministry of Health. In addition to the uniqueness of billing and coverage provided by these plans, provinces also maintain their own regulatory bodies for nurses and doctors, which include licensing requirements and determining the scope of practice (i.e., the services/procedures providers can and cannot do). Though provinces maintain the regulatory tools to license physicians trained at one of Canada's 17 medical schools, graduates follow a standard path to practice: passing the Medical Council of Canada Qualifying Examination (MCCQE Part I) followed by a post-graduate residency facilitated by the Canadian Resident Matching Service (CaRMS).

There are, however, additional, oft-prohibitive barriers for physicians trained outside of Canada. In 2023, among 1,661 Canadian citizens trained abroad, only 439 (or 27%) were matched to a post-graduate residency (CaRMS, 2023). Among physicians entering the workforce through CaRMS, the popularity of family medicine is also falling, with a drop in first-choice ranking from 35% in 2013 to 30% in 2023 among Canadian medical graduates. Further, while only 33 family medicine positions went unfilled in 2019, this number rose to 100 in 2023. While these family medicine residencies remain unfilled and up to 6 million Canadians are without a doctor, there are an estimated 13,000 internationally-trained doctors living in Canada, many of whom have received Permanent Resident status, but who are unable to work in the healthcare sector due to regulatory barriers. This untapped surplus of trained healthcare professionals is particularly worrying given an expected shortage of nearly 44,000 physicians by 2028 (RBC, 2023).

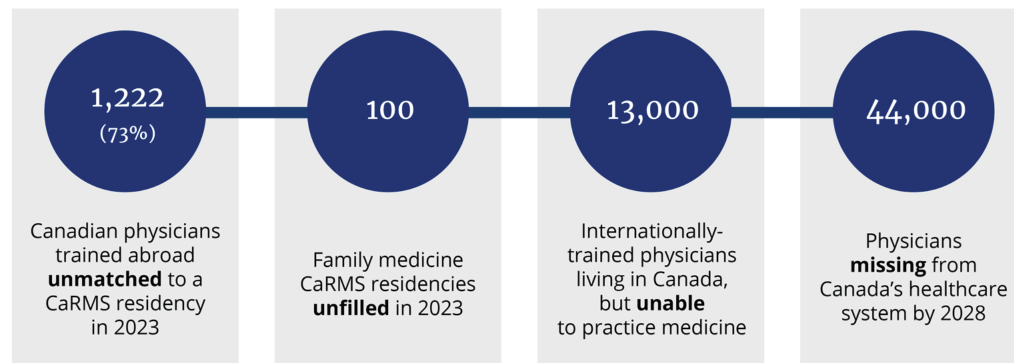

Figure 2. Supply-side constraints
Source: CaRMS Report 2023; RBC 2023

III. PROPOSED SOLUTION

The proposed policy should strive to be a high-impact, low-cost, politically feasible reform to reduce healthcare wait times. Given the complex nature of Canada's healthcare system, the overlapping funding from federal and provincial sources, and provincial jurisdiction over regulatory and healthcare services, any proposed solution should be evaluated for its technical and political feasibility, its effectiveness, and its costs in terms of both fiscal inputs and administrative resources. Particular attention should be paid to the realities of provincial healthcare jurisdiction and the interwoven local and regional healthcare systems in place in each province such that feasibility is of the utmost priority. These feasibility considerations extend to proposed national-level or pan-Canadian solutions which are likely to run up against the constitutional division of healthcare responsibilities.

To address the supply-side and demand-side contentions of long healthcare wait times, provinces should consider implementing a pilot program through their respective Colleges of Physicians and Surgeons whereby a new license, the Internationally-Trained Healthcare Provider (ITHP) license, is made available to Canadians trained at select foreign medical schools and foreign nationals already in Canada who hold medical degrees from select international institutions.

This would entail developing specific licensure requirements (using existing provincial regulations as a template) that outline access for 1) Canadians who went abroad to complete their training at a select list of recognized schools whose training meets a threshold for rigour and compatibility with Canadian medical schools and 2) Individuals who either hold or are in the process of having their Permanent Resident status reviewed and who completed their medical training and previous licensure and practice in a select list of countries such that their prior education and experience meets a similar threshold for rigour and compatibility with Canadian medical schools. This "threshold" level acknowledges that internationally-trained healthcare providers may not meet the requirements to hold the title of "doctor" but ensures that highly-trained healthcare professionals can contribute their much-needed skillset to the provincial healthcare systems and labour markets, thereby upholding the integrity of Canadian medical schools and the doctors they train.

The ITHP license would not be commensurate with that of physicians but would instead include a limited scope of practice that bridges the supply-side surplus with the demand-side shortcomings, such that ITHPs can take on primary care roles in family medicine clinics, ambulatory care settings, community health centres, long-term care homes, and other lower-risk settings, as determined by each province. Herein, ITHPs are not using the protected title of doctor (as prohibited by each College) or altering the training and exceptionally high standards Canadian physicians are held to, but instead easing pressure on the healthcare system in lower-risk settings where both patient trust and safety can be upheld. In particular, provinces' pilot programs could strive to license previously "unmatched" internationally-trained Canadian medical graduates who did not complete their CaRMS residency, effectively bringing in the expertise of an initial 1,200 ITHPs.

For those who hold newly-created ITHP licenses, their scope of practice would be limited to boundaries outlined by each College of Physicians and Surgeons such that a new regulatory college would not be required. This would limit administrative duplication, ensure compliance with existing limits, and provide contingency planning where provinces could opt to sunset this pilot program. Further, ITHPs would be integrated into existing provincial health plans such that billing practices match those already in place. The ability of the policy solution to be integrated within existing provincial healthcare institutions lends itself to low costs, political feasibility, and ease of evaluation in both the short- and medium-term.

This ease of implementation is also highlighted by existing policies and programs at provincial regulatory colleges. For instance, the College of Physicians and Surgeons of Alberta allocates $4.6 million to "physician registration" while the Ontario College allocated nearly $1.5 million to "project expenses" such that additional projects could be undertaken alongside the more than $3 million in revenue from licensing fees. Mirroring these licensure operations would limit cost overflows while ensuring Colleges are recouping licensure costs (2021/22 budgets, publicly available).

IV. ALTERNATIVE PROPOSALS

Beyond considerations made for this proposed ITHP model, decision-makers should examine alternatives and the documented challenges they pose. In particular, recent turns to virtual and AI-powered solutions have gained popularity. However, among those who see their doctors virtually, 35% report being dissatisfied with the model of care, with young women reporting even higher levels of dissatisfaction (Angus Reid Institute, 2022). While the convenience of virtual care may expedite some physician consultations, the problem of wait times should not push Canadians to accept lower-quality healthcare or depend entirely on virtual or AI-powered home care. Further, the convenience of virtual care, including telehealth and AI options, may increasingly marginalize those who encounter obstacles in the healthcare system, particularly Black and Indigenous patients (Dickens et al., 2021). Telehealth solutions are also likely to exclude those lacking in technological literacy and may not be feasible in Canada's most rural areas given limited broadband coverage (Peddle, 2007; Shahid et al., 2023). Finally, calls for telehealth or virtual options should be cognisant of the levels of care required in sectors with the greatest wait times, especially for vulnerable populations and seniors who may lack technological literacy and who often have the greatest healthcare needs in terms of frequency and severity (Mao et al., 2023).

In addition to proposed virtual and AI-powered solutions, calls for nationalizing healthcare portals and triage systems have gained popularity alongside proposals to reconfigure inter-provincial funding. However, given the complex billing systems and, most importantly, provincial jurisdiction over healthcare and licensing, calls to formalize national triage or alternative billing services will encounter administrative complexity and provincial pushback (particularly from Quebec), including at the constitutional level (Tuohy, 1999; Bakvis & Skogstad, 2020). While these alternative proposals for virtual care or cross-region portals may be advantageous in local settings and specific instances, wait times are largely driven by supply-side constraints and require flexible, provincially-led solutions compatible with *existing* billing, regulatory, and legal systems.

V. CONSIDERATIONS AND IMPLEMENTATION

Consideration of the recommended internationally-trained healthcare provider (ITHP) policy intervention and next steps should account for the following: administrative complexity; interaction within current policies; effectiveness; intergovernmental and legislative challenges; political feasibility; and unique provincial socio-equity factors, as described below and in the proposed timeline (figure 3).

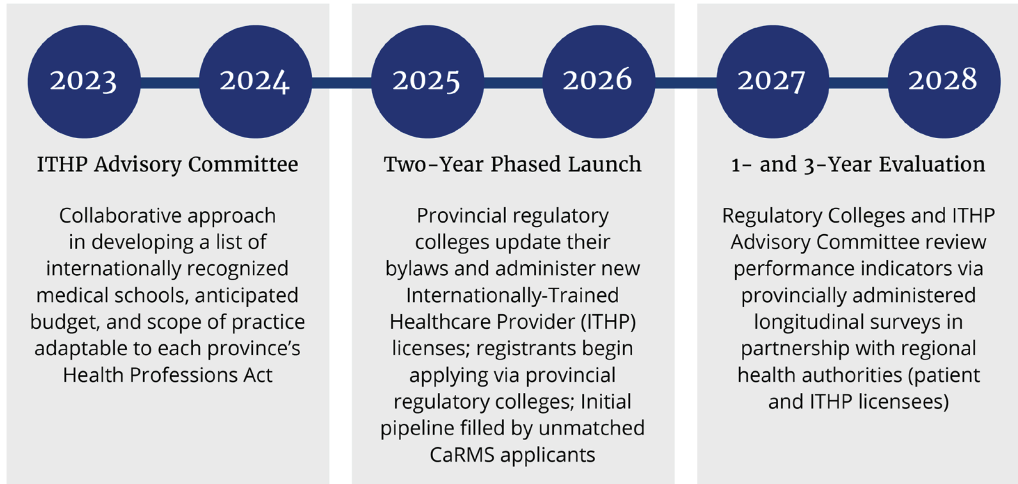

Figure 3. Proposed Implementation Timeline

Costing

Provincial governments should consider specific budgeting parameters for the pilot program in terms of registration fees, costs to develop the scope of practice and costs for amending their respective Health Professions Act to include coverage for ITHPs under the pilot program. The earlier creation and amendments to Nurse Practitioner licensing would serve as a useful basis for cost estimates, as these will vary by province. For example, the province of New Brunswick allocated $13.3 million to launch a new 'Step Up to Nursing' pilot project, which aims to train and license additional licensed practical nurses (LPNs) and registered nurses (RNs). Further, Saskatchewan introduced legislation to regulate physician assistants (PAs) in the province for $1.3 million in 2023-24 for 12 new positions. Similarly, British Columbia recently introduced licenses for associate practitioners, which offer some internationally-trained medical graduates opportunities to work under the supervision of an attending physician (College of Physicians and Surgeons of BC, 2023).

With annual assessment, accreditation, and review expenses of $3.6 million, the College of Physicians and Surgeons of BC's new license is distinct from the proposed ITHP license. While similar to the proposed creation of a new class of license, BC's associate physicians are required to identify supervisors and have completed the national exam. While the model may be suitable for cost estimates and serve as a learning ground for the implementation of the proposed ITHP pilot, the program requirements are still extremely rigorous and may be prohibitive to internationally trained physicians looking to practice in a lower-risk capacity without using the title of 'physician.'

Regulatory Compatibility

Provinces should consider collaborating directly with regulatory colleges and provincial medical associations to ensure knowledge sharing across provinces when developing the list of recognized international schools and ITHP regulations more broadly. The federal government could consider playing a role by providing grant-based funding for the development phase of the pilot programs, though it should be mindful to avoid conditional funding where subsequent jurisdictional disputes may arise. Provincial regulatory colleges would be required to update their Health Professions Act and bylaws to introduce this new license, though this is feasible at the provincial level and each college can ensure compliance in creating specific bylaws and licensure requirements (e.g., rural placements, language proficiency, supervisory requirements, scope of practice, etc.).

Quality Assurance

Policymakers should consider assembling an Advisory Committee consisting of key stakeholders, including representatives from provincial regulatory colleges, patient-advocacy groups, physician associations and Ministries of Health to launch pilot development. To streamline the proposed policy, provinces should consider developing the new licensure requirements and scope of practice within a two-year time frame with the goal of launching a limited, three-year pilot that includes milestone evaluations throughout with a cap on licenses and funding to limit unintended fiscal spillover effects. Further, the Advisory Committee can assist in developing templates for amendments to each province's Health Professions Act and with options for collaboration in developing the list of medical schools or international home countries from which ITHP licensees are recognized.

Feasibility

The policy should remain within the hands of provinces such that they can adapt it to their unique needs, be it urban/rural healthcare gaps (e.g., Ontario), aging populations (e.g., Atlantic Canada), Indigenous health governance (e.g., British Columbia), etc. The flexibility of this policy at the provincial level ensures that it can meet the unique goals of each governing party, such that costs and program impacts are in keeping with the strategic visions of each regulatory college and the legislative goals of provincial governments more broadly. This will ensure political feasibility such that there are no jurisdictional disputes and provinces have the capacity to increase supply with tools shared among existing inter-provincial and national healthcare associations. As noted earlier when considering alternative policy responses, given the politically-charged and complex regulatory and fiscal arrangements, localized and supply-side solutions are best suited to meeting the wait time challenges in each province and territory.

VI. CONCLUSION

The Canadian healthcare system is a collection of provincial healthcare systems, all of which are struggling with long wait times and the risks this poses to patients, healthcare providers, and quality of care in the long term. In addressing this problem, policymakers should strive for a high-impact, low-cost, and politically feasible solution. In recognition of the complex nature of Canada's healthcare system, the overlapping funding from federal and provincial sources, and provincial jurisdiction over regulatory and healthcare services, decision-makers should consider not only the demand-side shortcomings (i.e., patient needs not being met) but also the supply-side opportunities available across provinces (i.e., trained physicians sidelined by regulatory barriers). It is therefore recommended that provincial regulatory bodies (Colleges of Physicians and Surgeons) pilot a new, limited-scope licensing option for internationally-trained healthcare providers (ITHPs).

Canadians should not be forced to accept lower-quality healthcare services such as long wait times or virtual substitutes. Instead, it is policymakers who should bridge the gap by recognizing the skills of Canada's untapped supply of internationally-trained healthcare providers; the health of Canadians and our provincial healthcare systems depends on it.

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