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Rethinking Healthcare Spending in Canada

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Rethinking Healthcare Spending in Canada: Addressing Systemic Gaps for a Better Future

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Introduction

The Canadian healthcare system prides itself in being a publicly funded and universally accessible system that provides healthcare services to all Canadian citizens and permanent residents. However, despite the progress that has been made in the past few decades, many challenges and barriers still exist in providing equitable healthcare to all Canadians, especially when considering the drastic costs of healthcare spending that Canada invests in annually.

Canada invests over $270 billion annually in healthcare spending, which is significantly higher than many other high-income countries with similar universal healthcare systems [1]. However, despite this substantial investment, Canada faces performance challenges in various healthcare indicators when compared to its international peers. For instance, Canada ranks 6th highest among 28 universal healthcare countries for healthcare expenditure as a percentage of GDP and 10th highest for healthcare expenditure per capita [1].

This data reflects a significant financial commitment to the healthcare system, but despite this funding, lags behind in certain terms. The number of physicians per capita is poor (ranking 26th out of 28) and the availability of hospital beds is concerning (ranking 22nd out of 28) [1]. Long wait times for healthcare services are another pressing issue in Canada. Emergency department patients often experience extended delays before seeing a physician, ranging from a few hours to over 30 hours. And as many of us are far too familiar, perhaps one of the biggest concerns in the Canadian healthcare system at present is the shortage of family physicians. According to a recent national survey, over 6.5 million Canadians (one in five) don't have access to a family doctor or nurse practitioner that they can see regularly [2].

While the Canadian government continues to increase its healthcare spending with each annual budget release, these gaps in our system may not be fully addressed by simply adding more funds. In fact, according to another national survey, two-third (66%) of Canadians believe that there are structural problems within the Canadian healthcare system that far surpass the lack of funding [3]. Advancing our healthcare system requires fundamental changes in rethinking our spending and addressing underlying systemic issues to improve our outcomes.

As medical students, we recognize the weight that legislative, economic, and political factors have on shaping the health policy landscape and ultimately impacting the outcomes of Canadian citizens and residents. At the end of the day, the knowledge needed to treat disease and promote health is only valuable in the context of a system that efficiently and equitably provides the staff, supplies, and systems to put it into practice. In the face of a strained healthcare system and mediocre outcomes despite high health expenditures, it is therefore our priority to advocate for healthcare spending and overall system aligns closely with not just the principles of the Canadian Health Act but also the values and aspirations of the Canadian people for a responsive, equitable, and effective healthcare for themselves and their loved ones when they need it most.

Our Asks

1. **Adjusting the current per capita basis Canada Health Transfer Formula to a needs-based allocation formula that accounts for demographic structure and geographic distribution of populations.**
    - Currently, the Canada Health Transfer (CHT) formula is allocated on a per capita basis. However, the current CHT model allocates funds to provinces based on purely population size, which ignores the differing healthcare cost drivers across regions.
    - Many critics have since called for an adjustment of the current CHT formula to a more needs-based one that accounts for these differences.
    - Adjusting this formula to account for demographic structure of the population (specifically age) and geographic distribution would ensure more equitable access to healthcare and improve system funding.

2. **Improving training and licensure for international medical graduates (IMGs) by increasing IMG residency training spots and developing a national Practice Ready Assessment (PRA) program.**
    - Canada at present has a severe shortage of family physicians, with nearly 6.5 million individuals lacking access to a primary care provider.
    - Increasing IMG residency training spots can bridge this gap. A recent report found that funding of 750 additional residency spots per year for IMGs would result in 6,000 new practice ready family physicians within a decade. These new family physicians would serve an estimated 1,500 patients each, which equates to approximately 1.1 million additional Canadians per year for every IMG cohort that exits residency.
    - Furthermore, there are only a handful of PRA programs available nationally, across nine programs, and many of them are fragmented and difficult to access. A national PRA program would streamline the assessment and licensing process, ensuring that IMGs meet a consistent set of standards across the country and have equitable access to this program

3. **Establishing a pan-Canadian licensure to improve physician mobility**
    - The current system of licensure presents a number of challenges to physicians, including financial and administrative burdens.
    - According to a 2022 survey of Canadian Medical Association (CMA) members, 95% of respondents were in support of Pan-Canadian licensure. 70-75% claimed it would improve access to rural/remote communities, primary care, specialist care, and better facilitate virtual services.

Understanding the Canadian Healthcare System

In order to analyze Canadian healthcare spending, it is first important to recognize the foundational policy landscape that shapes the delivery of health services in Canada. The defining landmark of this landscape is naturally the 1984 Canadian Health Act, which lays down the 5 key principles of the Canadian system [4]:

- **Public administration:** The provincial and territorial plans must be administered and operated on a non profit basis by a public authority accountable to the provincial or territorial government.
- **Comprehensiveness:** The provincial and territorial plans must insure all medically necessary services provided by hospitals, medical practitioners and dentists working within a hospital setting
- **Universality:** The provincial and territorial plans must entitle all insured persons to health insurance coverage on uniform terms and conditions.
- **Portability:** The provincial and territorial plans must cover all insured persons when they move to another province or territory within Canada and when they travel abroad. The provinces and territories have some limits on coverage for services provided outside Canada, and may require prior approval for non-emergency services delivered outside their jurisdiction.
- **Accessibility:** The provincial and territorial plans must provide all insured persons reasonable access to medically necessary hospital and physician services without financial or other barriers.

Embedded in the formation of these principles is a tacit understanding of and compromise with the provincially sovereign nature of local healthcare legislation that actually delivers and directly pays for vital services; the Health Act effectively serves as a driving force mandating interoperability between the 13 unique provincial and territorial systems. In fact, the centralized Medicare system itself is better defined as a set of standards supported by a federal framework for which provincial and territorial systems adhere to, thus producing the appearance of a homogenous national system that is the central point of pride for Canadians across the country [5]. Outside of nationally funded organizations (including research organizations) and interfacing advisory committees, the primary role of the federal government lies simply with providing cash payments via the Canada Health Transfer to remunerate provinces and territories for aforementioned vital services [6]. This then provides provincial governments with local authority to oversee and finance the delivery of health services, though not directly; the vast majority of services are delivered via private not-for-profit organizations or even for-profit enterprises and then remunerated via a negotiated schedule of benefits [6].

This ‘patchwork’ design creates complexities that continue to impact the health system today. As an example, the Canadian Agency for Drugs and Technologies in Health (CADTH) serves as a national body to review promising pharmacologic and technologic developments. However, conclusions drawn by the CADTH are ultimately seen effectively as recommendations for provincial and territorial systems to decide upon due to the aforementioned decentralization of administration [7]. This means that while a novel therapeutic agent may receive approval from the CADTH, it must also then undergo lengthy provincial approval procedures in order for patients to begin to benefit. From an economic perspective, the reality is that only 70.9% of all medical services are truly publicly funded, with the remainder being satisfied by private payments either directly out-of-pocket or via private insurance plans usually provided by employers [8].

Current Landscape

Comparing Canada's healthcare expenditures' and outcomes

While Canada has historically been regarded as a model country for its publicly-funded and universally-accessible healthcare system, the country's spending has increased steadily over the last few decades. As a result, Canada now ranks as the highest country in terms of healthcare spending as percentage of growth domestic product (GDP) out of 38 member countries in the Organisation for Economic Co-operation and Development (OECD) [1].

The process of accurately evaluating and reporting the performance of Canada's healthcare system is critical for ensuring accountability and transparency among Canadians. By comparing the performance of healthcare systems across different countries with that of Canada's, policymakers and the provincial governments can identify important areas of improvements and measures of quality to target. One of the most comprehensive reports that compares the Canadian healthcare system to other developed nations is published by the Fraser Institute [1]. This report compares the performance, value and efficiency of healthcare systems of the 38 member countries of the OECD. As part of its analysis, the report assesses the effectiveness of each country's healthcare system based on two factors: the expenditure on health care and the return value of health care. This value is measured using dozens of quality outcomes and factors, but these fall under four broad categories: availability of resources, use of resources, access to resources, and clinical performance & quality. These sections will each be explored to understand how Canada ranks among other developed nations.

Availability of Resources

Human resources include the labour workforce that is required to operate healthcare facilities and hospitals. This includes the number of practice-ready physicians, nurses, technicians, and a multitude of other healthcare personnel. This workforce relies on physical capital—hospital beds, diagnostic machines, and equipment—to deliver high-quality patient care. Together, these two factors constitute the biggest limiting factors to a well-functioning healthcare system. Among 30 high-income OECD nations that have universal healthcare systems, Canada is positioned 28th in terms of physician numbers, 13th for nurse availability, 23rd in somatic-care beds (from a total of 29), 23rd for psychiatric care beds per thousand people (also out of 29), and 9th for long-term care beds per thousand of the population aged 65 and over (out of 16), all adjusted for age [1].

Utilization of Resources

Another key factor of an efficient and cost-effective healthcare system is its utilization of available resources. Simply measuring the total amount of human and physical capital fails to capture the level of efficiency at which a healthcare system operates at. Without considering the accessibility and usage rates of healthcare facilities by those with health demands, any policy focused on increasing healthcare funding will not improve a healthcare system's productivity and value. Per the report, following age adjustment, Canada is ranked 16th among 28 countries for the number of doctor consultations per capita, at the bottom as 27th out of 27 for the rate of curative-care discharges per 100,000 people, 18th out of 26 for MRI scans per thousand population, and 13th out of 26 for CT scans per thousand population [1]. As a result, Canada consistently ranks below average among other high-income OECD countries.

Access to Resources

Medical resource availability and usage offer insights into accessibility, with direct measures of accessibility being crucial across physical, financial, and psychological dimensions. Timeliness of care, often gauged through waiting lists, is a key aspect of accessibility with objective data more readily available. In Canada, a significant percentage of individuals report negative impacts on their lives due to waiting for specialist visits, non-emergency surgery, and diagnostic tests, experiencing worry, stress, anxiety, pain, and daily living challenges. Canada ranks low among countries with universal-access health care systems in measures of care timeliness, including same-day appointments, ease of finding after-hours care, and waiting times for specialist appointments and elective surgery. Despite poor rankings in timeliness, Canada's performance on cost as a barrier to access aligns with the average in a comparison of 10 countries, ranking 7th out of 10 [1].

Clinical Performance and Quality Outcomes

In terms of Primary Care, Canada ranks 14th out of 24 in diabetes-related lower extremity amputation rates, aligning with the OECD average [1]. In Acute Care, it ranks 7th out of 21 for the rate of hip-fracture surgery within 48 hours of admission, 9th out of 25 for 30-day mortality after hospital admission for acute myocardial infarction, performing better than average, 12th out of 25 for 30-day mortality after hospital admission for hemorrhagic stroke, similar to the OECD average, and 14th out of 25 for 30-day mortality after hospital admission for ischemic stroke, also similar to the OECD average [1]. Mental Health Care reports a 0.06% rate of in-patient suicides among those diagnosed with mental disorders, ranking 12th out of 18, which is consistent with the OECD average [1]. In Cancer Care, Canada ranks 5th out of 28 for 5-year survival rate after breast cancer treatment, 11th out of 28 for 5-year survival rate after cervical cancer treatment, 8th out of 28 for 5-year survival rate after colon cancer treatment, and 6th out of 28 for 5-year survival rate after rectal cancer treatment, all performing better than average [1]. However, in terms of Patient Safety, Canada ranks last (23rd out of 23) for performance on obstetric trauma during vaginal delivery with and without an instrument [1]. Overall, Canada shows good performance on five clinical performance and quality indicators but average or poor on six others [1].

Overall Ranking

Canada’s healthcare system has been consistently ranked in the top 10th percentile among all countries. The World Health Organization's (WHO) recent update on Healthy Life Expectancy (HALE) at birth, where Canada stood out as 16th among over 170 countries in 2019, marked it as the highest ranking for any country in the Americas [9]. Additionally, Canada boasts the 15th highest life expectancy at birth worldwide, at 82.24 years, and ranks 8th globally for life expectancy at age 60, with 25.0 years [9]. While Canada's infant mortality rate of 4.5 deaths per 1000 live births surpasses that of the United States, which stands at 5.4 deaths per 1000 live births, it trails behind several European countries like the United Kingdom, Italy, Germany, and France [9]. However, it is important to note that Canada includes babies born weighing less than 500 grams or before 22 weeks of gestation in its calculation for infant mortality rate, whereas its European counterparts do not.

Impact on Rural & Remote Populations

One key priority in addressing health care disparities is in rural and remote areas. Despite 18% of Canada's populations residing in remote communities, they are served by only 8% of practicing physicians [10]. This has yielded significant challenges in access to family physicians, specialty care as well as laboratory investigations and imaging for those in rural and remote regions. Geographic dispersion makes it difficult to implement coordinated care, which is exacerbated by a shortage of family physicians and primary care providers. The current per capita healthcare funding does not account for the higher costs of delivering care to these remote regions, leaving these communities underfunded and underserved. Tailored funding formulas that consider geographic realities are needed to bridge this gap and ensure equitable healthcare access.

Technological advances have been used to help bridge gaps, both historical and current, in these communities with the use of virtual care to facilitate care in collaboration with specialists in distant geographic areas [11]. However, unfortunately large areas of northern and remote Canada are limited in access to internet services and residents as well as health care providers alike often lack the skills, hardware and software to effectively utilize telehealth services [12].

Alternatively, Canada has implemented new initiatives promoting mobile healthcare units, as well as incentive programs to attract healthcare professions to remote and underserved regions [13]. For instance, in February 2024, it was announced that there would be a 50% increase in the Canada Student Loan forgiveness program for doctors and nurses working in under-served rural and remote communities [14]. With these changes, up to $60,000 for family physicians and up to $30,000 for nurse and nurse practitioners will be forgiven [14]. This is expected to attract nearly 1,200 new doctors and 4,000 new nurses to rural and remote communities across Canada over the next 10 year period [14].

Past & Present Efforts

Increasing Annual Health Care Funding

Prior to 1976, healthcare was funded through a 50:50 cost-sharing commitment between federal and province governments. The Hospital Insurance and Diagnostic Services Act of 1957 provided federal funding to provinces for 50% of the per capita cost of services delivered at hospitals. The Medical Care Act of 1966 broadened this funding to cover 50% of all insured medical services, administration costs and patient premiums [15].

To encourage provinces to reduce spending on in-hospital services in favour of more cost effective services such as home care, 50:50 cost sharing was replaced by block grants in which the federal government provides fixed sums based on per capita gross national product (GNP) growth [15]. Block grants were put in place by the Established Programs Financing Act in 1977 and have been the primary mode of federal healthcare funding since, with the Canada Health Transfer being instituted into the federal budget in 2004.

Since the adoption of block grants, healthcare spending initiatives have been predominantly related to adjusting the amount of federal funding received by provinces. In February 2023, the federal government announced an increase in health funding to provinces and territories of $196.1 billion over 10 years [16]. In the most recent announcement in May 2024, the Canadian government announced a guaranteed increase

of 5% per year in the Canada Health Transfer payments from 2023-24 to 2027-28 to provinces and territories [17]. This year, through the *Budget Implementation Act 2024, No.1,* provinces and territories will receive $52.1 billion from the federal government through the CHT, which is the largest amount in Canadian history [17].

Increasing funds in Canada's healthcare budget, while beneficial, do not address the systemic issues in the healthcare system, such as the shortage of family physicians, long wait times, among many other indicators that our country has shown to be ranked poor in. Critics have argued that time and time again, despite increases to funding, Canada continues to perform poorly, questioning a critical look into the deeper-rooted issues within our system [18, 19].

Measuring Improvements in Shared Health Priorities

In 2017, the federal, provincial, and territorial governments (FTP) developed a *Common Statement of Shared Health Priorities,* which outlined their commitment to work collaboratively with the Canadian Institute of Health Research (CIHI) to develop and report common indicators of health [20]. In specific, they developed 12 common indicators which spanned mental health and substance use services, as well as access to home and community care [21]. CIHI reports on these 12 indicators on an annual basis to help identify strengths and gaps in these services. In the 2023 federal budget, the Canadian government announced an additional investment of $200 billion over the next 10 years to support the *Working Together to Improve Health Care for Canadians Plan* [20]. This plan outlines an additional 8 common indicators and focused efforts on the following 4 shared health priorities:

- expanding access to family health services, including in rural and remote areas
- supporting health workers and reducing backlogs for health services such as surgeries and diagnostics
- improving access to quality mental health, substance use and addictions services
- modernizing the health care system with standardized information and digital tools so health care providers and patients have access to electronic health information

Health Human Resource Planning

On average, Canada is behind other OECD countries in terms of human resources, with only 2.41 physicians per 1000 people [22]. The CMA has called for stronger federal leadership for health human resource planning and has been collaboratively closely with the federal government to share their recommendations [23] In May 2022, Health Canada hosted a Health Human Resources (HHR) Symposium to convene stakeholders across provinces and territories to align on shared priorities of the current HHR crisis [24]. Together, they identified multiple key solutions, including creating a pan-Canadian health workforce data strategy. Furthermore, in December 2023, the federal government launched Health Workforce Canada, an independent organization aimed at facilitating data sharing and planning for long-term, equitable and sustainable care across the country [25]. The CMA has been closely tracking the progress of these many multi-faceted initiatives and recommendations as part of the greater HHR planning [26].

Budget Analysis

Canada Health Transfer Formula

The federal government's approach to funding has changed significantly since the inception of the Canadian public health care system. Early on (between 1957 – 1977), the federal government covered 50% of provincial and territorial expenditures on insured hospital and physician services [27]. Over time, federal funding shifted to include a mix of direct cash transfers and tax points. The current program for federal contributions to health care is called the 'Canada Health Transfer', which distributes funds to provinces and territories on a per capita basis. However, in order to receive the funding, the provincial and territorial governments must abide by the rules and regulations outlined in the *Canada Health Act* (CHA) [28]. As of 2020 – 2021, 22% of public-sector health care spending was covered by these funds ($45.9 billion) [29].

Canada Health Transfer funds are allocated on a per capita basis and is "…legislated to grow in line with a three-year moving average of nominal gross domestic product (GDP), with total funding guaranteed to increase by at least 3 per cent per year [29]." CHT funds can be withheld if a province or territory contravenes the Canada Health Act. If the province/territory rectifies the violation, the withheld fund may be reimbursed [29].

In 2007, the federal government altered the structure of the Canadian Social Transfer and the Canadian Health Transfer. The changes, implemented in 2014/15, shifted from a tax point and per capita cash system to one that made transfers on a solely per capita basis [30]. Some scholars have raised concern over the equity of the policy change. The foundation of the Canadian healthcare system is built on the premise that all Canadians deserve access to the same quality of healthcare, regardless of where they reside. However, provinces differ in the challenges they face while providing this public service. The current CHT model allocates funds to provinces based on purely population size, which ignores the differing healthcare cost drivers across regions. Aging populations, chronic conditions, and population density have been identified as key factors influencing the provision of health care at the provincial level. Without accounting for these variations between provinces, disproportionate burden is placed on provinces with higher healthcare needs [31]

Many research scholars and organizations, including the CMA, have argued for a needs-based formula that adjusts for these factors. One article proposed adjusted specifically for age demographics of the population and geographic dispersion. This would ensure that provinces with higher healthcare needs receive more funding to maintain equitable access to universal healthcare.

Adjusting for the Demographic Structure of the Population

It is well known that a commonly used indicator for relative healthcare needs is age. Demographic adjustments would account for the fact that provinces with older populations, such as those in Atlantic Canada, face higher healthcare costs due to the increased demand for medical services among the elderly. Examples of this framework are already being implemented at a regional level. For example, in Canada, allocations of funding from the Ministry of Health to regional health authorities in British Columbia, Alberta, and Saskatchewan have already been adjusting the per capita allocation based on age, gender, and socioeconomic status of the population [32].

Researchers have suggested using a modified capitation formula that adjusts per capita funding based on

the age structure of the population. One article by Marchildon & Mou from the University of Saskatchewan outlines this age-adjusted formula by computing the total Medicare expenditure of a province as the sum of the product of average Medicare expenditure for each five-year age group and the forecasted provincial population in the respective age group [33]. The total CHT amount to that province is then based on the province's share in the national total Medicare expenditure. This formula has been proposed as follows [33]:

$$\text{Age} - \text{Adjusted CHT Allocation for a Province/Territory} = \text{total CHT} \times \frac{\sum_{j=1}^{20} (\text{national average Medicare cost for age group j} \times \text{provincial population in age group j})}{\text{country total}}.$$

Based on this proposed age-adjusted formula, researchers have found that in the year 2014/2015, British Columbia, Saskatchewan, Quebec, and the four Atlantic provinces would receive more CHT funds per capita relative to the equal per capita formula, while Alberta, Manitoba, and Ontario would receive less [33].

Adjusting for Geographical Distribution of the Population

It is widely recognized that rural and remote regions in provinces face unique logistical and infrastructure challenges in delivering healthcare. This includes higher costs for transportation, fewer healthcare facilities, and the need for specialized services in isolated communities. These are all factors that consequently drive additional healthcare costs for these populations. Adjusting for geographical distribution means recognizing these differences and ensuring adequate access to healthcare.

This adjustment would involve ensuring that provinces with large rural or remote populations receive more financial support to offset the higher costs associated with providing healthcare in these areas. One proposed method is adding an additional 50% per funding for all individuals living >80km from a population centre with at least 5,000 inhabitants [33]. The formula has been proposed as follows [33]:

$$\text{Dispersion} - \text{Adjusted CHT Allocation for a Province/Territory} = \text{total CHT} \times \frac{\text{provincial population} \times \text{per capita CHT} \times (1 + 50\% \times \text{percentage of remote population})}{\text{country total}}.$$

Finally, the proposed formula for adjusting for both age and geographical distribution of the population has been as follows [33]:

$$\text{Age} - \text{and Dispersion} - \text{Adjusted CHT Allocation for a Province/Territory} = \text{total CHT} \times \frac{\text{provincial population} \times \text{Age} - \text{Adjusted CHT} \times (1 + 50\% \times \text{percentage of remote population})}{\text{country total}}.$$

Implementing these new considerations would promote equity and ensure that all provinces can meet the national standard for healthcare services.

Provincial Budgeting and Accountability

Provincial and territorial government spending on health care accounts for over 75% of public-sector spending on health care [29]. Health care is a major expenditure, and changing population demographics are contributing to an even higher burden on provincial and territorial governments [34]. Premiers have requested that the federal government increase their financial contribution to 35% public-sector health care spending, however the federal contribution only amounted to 24% in the funding deal reached in early 2023 [35].

Global budgets are the primary method of allocating public-sector health care funds within provinces and territories. The method relies on previous budgets and estimations of inflation to provide fixed payments to health authorities, hospitals or other care facilities to cover expected yearly operating expenses [36]. Global budgets are fixed, non-adaptable, and provide few incentives for innovation or efficiency initiatives. An alternative to this budget model is activity-based funding, where financial resources are allocated on the basis of services provided, accounting "…patient characteristics such as diagnosis and complexity, along with anticipated volume and intensity of care." [37]. Proponents of activity based funding argue that it will shift the focus of the Canadian health care system towards efficiency and innovation, but detractors suggest that it could encourage hospitals to discharge patients before they are ready to re-enter the community [37]. Internationally, few countries use global budgets exclusively and Canada appears to be following suit. Several provinces have introduced initiatives to move towards mixed funding models [36].

Training & Licensure for International Medical Graduates (IMGs)

There are currently 6.5 million people in Canada that lack access to a family doctor, and that number is projected to reach 10 million in the next decade. We have already seen first-hand impact on this dire shortage with increased strains on emergency departments, longer wait times, and deteriorating health outcomes – all of which have perpetually resulted in our country performing poorer when compared to its international counterparts, despite its excessive healthcare spending. To rethink healthcare spending is to address the primary care crisis first and foremost.

At present, International Medical Graduates (IMGs) undergo a multi-step process to practice in Canada, including verifying their medical credentials with the Medical Council of Canada (MCC) and completing the Medical Council of Canada Qualifying Examination (MCCQE) [38]. Some provinces also require IMGs to pass the National Assessment Collaboration Objective Structured Clinical Examination (NAC OSCE) which assess clinical skills. IMGs must then apply for a residency position through the Canadian Resident Matching Service (CaRMs), which is a highly competitive process with a limited number of spots designated for IMGs. Finally, once matched, IMGs must complete a residency program, obtain licensure from specific provincial/territorial regulatory authority, and in some provinces, may need to undergo a practice readiness assessment (PRA) as well [39].

IMGs have the potential to fill the shortage of physicians; however, this complex process makes it difficult to do so. There are a limited number of residency spots and IMGs have difficulty having their skills and credentials recognized. Currently, only 39% of IMGs initially match to residencies, and just 18% do so in the second round [40]. This highlights a significant mismatch in our system.

Recently, the federal government has announced investing $200 billion to improve health and workforce planning, including focusing on IMG training and licensure [41]. There is a crucial need to increase medical residency positions for IMGs. Though the government plans on adding 120 new medical residency positions for IMGs, more is needed to not only support their training, but also address our shortage at a national level. Often, one of the biggest barriers is accessing a residency spot or PRA, despite having the previous matched credentials. One recent report calls for funding of 750 additional residency spots per year for IMGs [40]. At this pace, this initiative would add 6,000 new practice ready family physicians within a decade. These new family physicians would serve an estimated 1,500 patients each, which equates to approximately 1.1 million additional Canadians per year for every IMG cohort that exits residency [40]. The same report calculates that this expenditure would represent only 0.2% of the total $52 billion the federal government is earmarking to the provinces and territories in the 2024-25 fiscal year through the Canada Health Transfer [40].

In addition to increasing IMG residency training spots, there is also a need for a national PRA program [26]. The PRA provides an opportunity for an IMG to do clinical workplace assessments of their competencies over a period of 12 weeks. There are only a handful of PRA programs available nationally, across nine programs. Furthermore, access to these PRAs are often complicated, requiring significant time to organize with both the employer and provincial regulatory body. Since 2018, only 1000 IMGs have graduated from a PRA program to enter family practice in Canada [40]. A national PRA program would streamline the assessment and licensing process, ensuring that IMGs meet a consistent set of standards across the country and have equitable access to this program [40]. Furthermore, this would also be less costly than adding more residency training spots, while in turn resulting in more family physicians that could care for communities [40].

Establishing Pan-Canadian Licensure

Pan-Canadian Licensure refers to the ability of physicians to train and practice in any Canadian jurisdiction without the need to apply or pay for more than one medical license. As it stands now, the provision of medical licensure is under the authority of each provincial and territorial medical regulatory authority (MRA). Physicians must register with and obtain a medical license from an MRA in order to train or practice in the corresponding province or territory.

This current system presents a number of challenges to physicians. Medical licensure requires a lengthy application process and thousands of dollars in fees, placing increased administrative and financial burdens on physicians who may want to practice in multiple provinces. These burdens may de-incentify physicians from practicing across province lines, siloing the medical workforce and limiting mobility. This has consequences for rural and remote people who experience geographic inaccessibility to healthcare and frequent shortages of physicians and other health professionals. The delivery of virtual care also has the opportunity to alleviate rural inaccessibility challenges, but is limited by our current provincially siloed medical workforce. Finally, licensing restrictions make it difficult for patients crossing borders as well. After three months in a new province/territory, patients are no longer covered for care from doctors in their home province/territory, forcing them to join waitlists to access local providers. Other services like diagnostic imaging, laboratory tests, and prescriptions cannot be ordered across province/territory lines, meaning a patient must access these services in the same province as their physician.

The benefits of Pan-Canadian licensure are multifactorial and directly address the above concerns, including:

- By creating a single stream for medical registration, this would (1) increase regulatory efficiency and (2) decrease the administrative/financial burdens put on physicians who want to practice in multiple provinces
- Increasing physician mobility between provinces, making it easier for physicians to fill rural locum placements during times of short-staffing or holidays, parental, educational leaves.
- Facilitating inter-provincial virtual care, providing more timely access to primary and specialist services, especially for rural people.
- Allowing patients who move between provinces to retain the same physician and access ancillary health services (e.g., diagnostic imaging, lab work) anywhere in Canada.
- Better facilitating and integrating health workforce planning/responsiveness at a national level.
- Increasing patient safety by creating a single process for disciplinary action, preventing physicians from avoiding sanctions by changing jurisdictions.
- Creating a Pan-Canadian fee structure.

According to a 2022 survey of CMA members, 95% of respondents were in support of Pan-Canadian licensure. 70-75% claimed it would improve access to rural/remote communities, primary care, specialist care, and better facilitate virtual services. In addition, 67% of respondents indicated that it would incentify them to seek inter-provincial locums and 69% said it would encourage them to seek part-time practice in retirement [42].

In creating a mechanism for Pan-Canadian licensure, legislators can draw on Australia's example of national licensure as well as the new Atlantic Registry in Canada. In 2010, Australia adopted all jurisdiction licensure for a number of health-care professionals, including physicians [43]. Since its implementation, this system has improved patient safety, physician mobility, and made it easier for workforce planning [44]. As of May 2023, provinces the four provinces of Atlantic Canada created a registry wherein physicians may freely move and practice across the region. These examples make it clear that Pan-Canadian licensure is attainable.

Critics of national licensure raise the following as considerations or challenges:

- Challenges in reconciling legal and political differences pertaining to medical licensure among provinces.
- The possibility that the ability to take on inter-provincial locum placements would incentivize physicians to preferentially choose locums over long term practice in one place. This could have the effect of exacerbating rural inaccessibility to healthcare services.
- Reduced regulatory accountability if registration and oversight is national as opposed to provincial.

Our advocacy around national licensure should proceed with caution to the above considerations. One paper describes a practical approach to move forward with Pan-Canadian licensure, including [46]:

- Regulators would work at the jurisdictional level.
- Fostering a uniform process for medical registration.
- Creating a national database to be shared among regulators containing information about registration, complaints, disciplinary action, and compliance information.
- Creating a mechanism by which disciplinary restrictions are upheld across all jurisdictions should a medical registrant be sanctioned.
- Establish a pan-Canadian oversight agency of jurisdictional regulators.

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