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CANADA

ADDRESSING CANADA'S HEALTH WORKFORCE CRISIS

Report of the Standing Committee on Health

Sean Casey, Chair

MARCH 2023
44th PARLIAMENT, 1st SESSION

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NOTICE TO READER

Reports from committees presented to the House of Commons

Presenting a report to the House is the way a committee makes public its findings and recommendations on a particular topic. Substantive reports on a subject-matter study usually contain a synopsis of the testimony heard, the recommendations made by the committee, as well as the reasons for those recommendations.

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THE STANDING COMMITTEE ON HEALTH

has the honour to present its

TENTH REPORT

Pursuant to its mandate under Standing Order 108(2), the committee has studied Canada's health workforce and has agreed to report the following:

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SUMMARY

Canada's health workforce is in crisis. The stress of the COVID-19 pandemic amplified pre-existing challenges in the health care system leading to widespread staffing shortages as well as exhaustion and burnout among health care professionals. Over the course of seven meetings, the House of Commons Standing Committee on Health (the Committee) conducted a study on Canada's health workforce to determine how the crisis can be addressed, with a focus on the retention and recruitment of health care providers. The Committee received testimony from national and regional health profession organizations, educational institutions, not-for-profit organizations, individual health care professionals and other health workforce stakeholders.

Through oral and written testimony, witnesses outlined the extent of the workforce crisis in Canada's health care system. The testimony highlighted how longstanding issues with lack of supply of health professionals and mental health issues among health professionals currently in the workforce were exacerbated by the COVID-19 pandemic. Witnesses stated that resolving this crisis will involve both short- and long-term solutions and that the federal government should play a role in rebuilding this essential sector. Witnesses suggested a variety of solutions for revitalizing Canada's health workforce. These suggestions included recruiting and training internationally trained health care workers, pan-Canadian licensure, improving data collection and implementing innovative models of health care delivery as well as various supports and financial incentives for health care workers.

This report summarizes the Committee's findings and provides twenty recommendations that outline the ways in which the federal government can collaborate with provinces, territories, Indigenous Peoples and health care stakeholders to address this pressing issue. Some of the initiatives recommended include: increasing the number of residency positions, particularly for family medicine and international medical graduates; improving upon and expanding pathways to licensure for international physicians; establishing pan-Canadian licensure for health professionals; developing a Pan-Canadian Health Data Strategy to improve Canada's collection, access, sharing and use of health data; and implementing a Pan-Canadian Mental Health Strategy for health care workers.

LIST OF RECOMMENDATIONS

As a result of their deliberations committees may make recommendations which they include in their reports for the consideration of the House of Commons or the Government. Recommendations related to this study are listed below.

Recommendation 1

That the Government of Canada collaborate with provincial and territorial governments and consult with organizations involved in recruiting internationally trained health workers, as well as Immigration, Refugees and Citizenship Canada where necessary, to streamline and simplify the process to recruit from countries known to train health workers in excess of their domestic needs. 25

Recommendation 2

That the Government of Canada collaborate with provincial and territorial governments to provide more residency positions for international medical graduates. 26

Recommendation 3

That the Government of Canada collaborate with provincial and territorial governments and professional regulatory bodies to improve upon and expand pathways to licensure for international physicians who have already completed their residency and who practiced abroad, such as the National Assessment Collaboration’s (NAC) Practice-Ready Assessment (PRA) program and other similar initiatives. 26

Recommendation 4

That the Government of Canada support expedited pathways to licensure and practice for internationally trained health care professionals. 26

Recommendation 5

That the Government of Canada collaborate with provincial and territorial governments and professional regulatory bodies to facilitate the licensing and, where necessary, additional education and training needed for licensing of nurses and other health care professionals working in fields where existing programs are unable to address the workforce shortages. 28

Recommendation 6

That the Government of Canada collaborate with provincial and territorial governments to increase the number of residency positions, particularly for family medicine..... 29

Recommendation 7

That the Government of Canada work with the provinces, territories, and professional regulatory bodies to establish pan-Canadian licensure for health professionals..... 30

Recommendation 8

That the Government of Canada work with the provinces, territories, and professional regulatory bodies to optimize the scope of practice for primary care professionals, including nurse practitioners and pharmacists. 30

Recommendation 9

That the Government of Canada in collaboration with provinces, territories and Indigenous Peoples, continue its work in developing a Pan-Canadian Health Data Strategy to improve Canada’s collection, access, sharing and use of health workforce data and lay the foundation for a world-class health data system. 32

Recommendation 10

That the Government of Canada collaborate with the provinces and territories to create and implement a Pan-Canadian Health Human Resource Strategy to facilitate better identification of gaps in the health care workforce and more efficient action to address those gaps..... 32

Recommendation 11

That the Government of Canada, in consultation with the provinces and territories, and advised by diverse experts from the health community, develop a national strategy on the promotion and implementation of effective health care teams across Canadian society to ensure patient issues are treated by the appropriate member of the health care team to get the best care possible. 34

Recommendation 12

That the Government of Canada work with the provinces and territories to explore and share best practices in alternate payment mechanisms, specifically towards alleviating physician burnout. 34

Recommendation 13

That the Government of Canada work with the provinces and territories to expand access to long-term care beds, home care services, and palliative care. 34

Recommendation 14

That the Government of Canada work with the provinces and territories to improve Canada’s preventative health strategies and increase federal investment in preventative health measures. 34

Recommendation 15

That the Government of Canada work in collaboration with the provinces and territories as well as Indigenous Peoples, and stakeholders to expand digital infrastructure, and other system improvements, to increase access to high quality, safe virtual care, where appropriate. 36

Recommendation 16

That the Government of Canada work with the provinces and territories, and/or utilize powers within its purview, to create incentives for health care workers to encourage the retention, and return, of health care workers to help address the workforce crisis. 38

Recommendation 17

That the Government of Canada work with the provinces and territories to provide incentives to attract more physicians into family care and retain them. 38

Recommendation 18

That the Government of Canada collaborate with the provinces and territories to develop strategies to recruit, train, and adequately support, health care workers for rural, remote, and northern communities. 39

Recommendation 19

That the Government of Canada, in partnership with provinces, territories, Indigenous Peoples and stakeholders share best practices in an effort to reduce administrative burdens on health care professionals, where appropriate, to ensure that time is not unnecessarily taken away from patients, and to reduce the significant contributor of administrative burdens to burnout. 40

Recommendation 20

That the Government of Canada work with the provinces and territories to implement a Pan-Canadian Mental Health Strategy for health care workers. 41



ADDRESSING CANADA'S HEALTH WORKFORCE CRISIS

INTRODUCTION

On 9 February 2022, the House of Commons Standing Committee on Health (the Committee) adopted a motion to undertake a study on Canada's health care human resources to explore initiatives that could be taken to revitalize that workforce. The motion, in part, stated:

That, pursuant to Standing Order 108(2), the Committee, in recognition of exhaustion and burnout amongst health care professionals, undertake a study on how the federal government can facilitate the recruitment and retention of physicians, nurses, nurse practitioners and other health care providers to the public health care system...¹

The Committee held seven meetings between 16 February and 9 May 2022, heard from 43 witnesses and received an additional 22 written submissions. This report summarizes the makeup of Canada's health care providers, describes the state of the country's health workforce prior to the COVID-19 pandemic and details the impact the pandemic has had on the workforce. Finally, the report provides a description of potential solutions as provided by the witnesses, followed by recommendations to the federal government to re-invigorate Canada's health workforce going forward.

PROFESSIONS WITHIN CANADA'S HEALTH WORKFORCE

The Canadian Health Workforce Network indicates that Canada's health workforce includes "frontline clinical staff who work directly with patients, those who provide support to these staff, and those who manage the health workforce and health system."² This interpretation means that the workforce is not limited to health professions such as physicians, nurses, pharmacists, etc., but also includes clerical, administrative, custodial, managerial staff as well. While the Committee's study focussed on retention and recruitment of health professionals, some witnesses emphasized the importance of

1 House of Commons Standing Committee on Health [HESA], *Minutes*, 9 February 2022.

2 Ivy Lynn Bourgeault, Caroline Chamberland-Rowe & Chantal Demers, *Introduction to the Health Workforce in Canada*, Canadian Health Workforce Network, Introduction, p. 2, 2021.



including employees who provide support to health workers when implementing strategies to strengthen Canada’s health workforce.

The list of health professionals is long, and the Committee was told that more than 10% of the Canadian workforce are members of the health workforce.³ Health care, once limited to medical appointments and hospital admissions, now encompasses a vast array of interventions for prevention, screening, diagnosis, treatment and follow-up care related to a multitude of diseases and conditions. Most health professions are regulated, at the provincial level, although some professions, such as personal support workers, are unregulated. The range of health professions that make up Canada’s health workforce is summarized in table 1.

Table 1—Health Professions in Canada

Profession	Number of Programs	Number of Students per Year	Regulated/Not Regulated
Audiologist/Speech-Language Pathologist	17	N/a	Regulated in BC, AB, SK, MB, ON, QC, NB, NL, and NS
Chiropractor	2	200	Regulated
Community Health/Personal Support Worker	N/a	N/a	Not Regulated
Dental Assistant, Hygienist, Therapist	More than 130	N/a	Regulated
Dentist, Dental Surgeon and Specialist	10	491	Regulated
Denturist	6	N/a	Regulated
Dietitian	16	N/a	Regulated in BC, AB, SK, MB, ON, QC, NB, PEI, NL, and NS
Medical Laboratory Technologist	32	N/a	Regulated in AB, SK, MB, ON, QC, NB, NS, and NL
Medical Radiation Technologist	45	N/a	Regulated in AB, SK, ON, QC, NB, and NS

3 HESA, *Evidence*, 16 February 2022, 1625 (Ms. Linda Silas, President, Canadian Federation of Nursing Unions).

Profession	Number of Programs	Number of Students per Year	Regulated/Not Regulated
Midwife	6	N/a	Regulated in BC, AB, SK, MB, ON, QC, NB, NS, NL, NWT, and NU
Nurse	59 institutions with various programs	N/a	Regulated
Occupational Therapist	14	773	Regulated in BC, AB, SK, MB, ON, QC, NB, NS, PEI, and NL
Optometrist/Optician	2	136	Regulated
Paramedic	N/a	N/a	Regulated
Pharmacist, Pharmacy Technician	10	N/a	Regulated
Physician Assistant	4	N/a	Regulated in MB, NB, and AB
Physician and Surgeon	17	2900	Regulated
Physiotherapists	15	More than 486	Regulated
Psychologist	23	More than 156	Regulated
Respiratory Therapist	24	N/a	Regulated in AB, SK, MB, ON, QC, NB, NS, and NL

Note: N/a means "not available."

Source: Prepared by the Library of Parliament from information contained in Ivy Lynn Bourgeault, (Ed), *Introduction to the Health Workforce in Canada*, Canadian Health Workforce Network, 2021.

Within some of these professions are additional sub-categories. Nursing, for example includes registered nurses, licensed practical nurses, registered psychiatric nurses and nurse practitioners.⁴ The category of physicians and surgeons includes dozens of specialties and sub-specialties.⁵

4 Christine L. Covell & Shamel Rolle Sands, *Introduction to the Health Workforce in Canada*, Nursing, p. 2, 2021.

5 Lindsay Hedden, *Introduction to the Health Workforce in Canada*, Physicians and Surgeons, p 6, 2021.



THE STATE OF CANADA'S HEALTH WORKFORCE

During this study, the Committee heard from a variety of witnesses from different health professions. A central theme that emerged was that the health workforce in Canada is in crisis. The witnesses set it out as follows:

Our health workforce is in the biggest crisis we've ever seen.... Prior to this pandemic, our health care system was ailing. Today, it finds itself with more cracks than ever. Worse, those who work and care for Canadians are exhausted, burnt out and leaving. The result will affect every single Canadian and put at risk their health and ability to access their health system. This crisis has ballooned past what any jurisdiction can manage alone.⁶

This is a critical moment for nurses and the people whom we care for. Today's crisis has been years in the making. If we don't act now, we risk suffering a system-wide failure of our treasured universal public health care system.⁷

The status quo is clearly no longer an option. Failing to act now will lead to lower quality care, longer wait times and worse health outcomes.⁸

The extent of the health workforce crisis is discussed in detail below.

Canada's Workforce Prior to the COVID-19 Pandemic

Many witnesses spoke of the longstanding challenges of Canada's health workforce that pre-date the COVID-19 pandemic. Mr. Bacchus Barua, Director of Health Policy Studies at Fraser Institute, spoke about Canada's health system performance as compared with member countries of the Organization for Economic Cooperation and Development (OECD) as described in a 2021 report⁹ based on 2018 and 2019 data. He pointed out that the report found that, among 28 countries, Canada ranked 6th for health expenditure as a percentage of gross domestic product and 10th for per capita health expenditure.¹⁰ Despite the higher than OECD average health spending, he emphasized that Canada's scarcity of physicians had spanned decades and that Canada ranked 26th among 28 countries for the number of physicians per thousand population and 25th among

6 HESA, *Evidence*, 16 February 2022, 1630 (Dr. Katharine Smart, President, Canadian Medical Association).

7 Ibid., 1625 (Ms. Linda Silas, President, Canadian Federation of Nurses Unions).

8 Ibid., 1645 (Mr. Paul-Émile Cloutier, President and Chief Executive Officer, HealthCareCAN).

9 Mackenzie Moir and Bacchus Barua, *Comparing Performance of Universal Health Care Countries, 2021*, Fraser Institute, 2021.

10 HESA, *Evidence*, 16 February 2022, 1615 (Mr. Bacchus Barua, Director, Health Policy Studies, Fraser Institute, as an individual).

26 countries for the number of acute care hospital beds per thousand population.¹¹ Canada ranked 14th among 28 countries for the number of nurses per thousand population, just above the OECD average.¹²

The Committee notes more recent data from the Canadian Institute for Health Information, indicating that although Canada was above the OECD average in terms of per-person spending on health care in 2020, Canada's public-sector share of total health expenditure (75%) was at the OECD average (75%).¹³ Furthermore, while Canada is among the highest spenders on overall health care in the OECD, Canada spends less than most other countries on hospital services, at \$1,858 per person, compared with the OECD average of \$2,080 in 2020.¹⁴ When limited to government/compulsory spending, Canada spends \$1,694, compared with the OECD average of \$1,877.¹⁵ Of 34 selected OECD countries, 20 spent more on hospitals than Canada on a per person basis.¹⁶

Mental Health

Several witnesses described the state of the health workforce prior to 2020 from their perspectives in terms of personal mental health and supply of health professionals.

Ms. Linda Silas, President of the Canadian Federation of Nurses Unions (CFNU), cited the results of a survey of over 7,000 nurses that was conducted by that organization between May and September 2019.¹⁷ Ms. Silas revealed that 29% of nurses surveyed reported clinically significant symptoms of burnout and that the levels of symptoms associated with post-traumatic stress disorder, major depression and anxiety were comparable to those symptoms observed in public safety officers.¹⁸ The poor state of mental health among nurses is likely a result, as noted in the CFNU survey, of being

11 Ibid.

12 Mackenzie Moir and Bacchus Barua, *Comparing Performance of Universal Health Care Countries, 2021*, Fraser Institute, Table 3, p. 12, 2021.

13 Canadian Institute for Health Information (CIHI). *National health expenditure trends, 2022 — Snapshot*, How does Canada's health spending compare? 2022.

14 CIHI. *How does Canada's hospital spending compare internationally?* 2022.

15 Ibid.

16 Ibid.

17 Andrea M. Stelnicki, R. Nicholas Carleton, Carol Reichert, *Mental Disorder Symptoms Among Nurses in Canada*, Canadian Federation of Nurses Unions, 2020.

18 HESA, *Evidence*, 16 February 2022, 1625 (Ms. Linda Silas, President, Canadian Federation of Nurses Unions).



overburdened by working above capacity with insufficient staff.¹⁹ Mr. Syllas Coletto, a registered nurse practicing in Saskatchewan, echoed the emotional toll that nurses bear and added that nurses are often subjected to physical, sexual and verbal abuse, for which there is little or no recourse.²⁰

Committee members were told that physicians have been similarly affected with stress, anxiety and depression. Dr. David Gratzer, a psychiatrist who appeared as an individual, explained that three components characterize burnout; emotional exhaustion, depersonalization, and a decreased sense of accomplishment.²¹ Dr. Adam Kassam, of the Ontario Medical Association, indicated that a March 2020 survey revealed that 29% of Ontario physicians were suffering severe burnout. He explained that such burnout results from workplace stressors such as inefficiencies of work processes and environments as well as clerical burden.²² Similarly, Dr. Katharine Smart, President of the Canadian Medical Association, stated that the root cause of burnout is working within a dysfunctional system.²³ Dr. Martin Champagne of the Association des médecins hématologues et oncologues du Québec, noted that prior to COVID-19 40% of the members of his organization reported emotional exhaustion while 57% indicated that there were suffering from burnout, despite reporting high levels of support and respect from their colleagues.²⁴

This issue is not limited to physicians and nurses. The Committee received briefs from various organizations noting similar trends of burnout, including medical radiation technologists, social workers, and the mental health and substance use health workforce. Medical radiation technologists reported an 80% increase in reported signs of burnout between 2018 and 2021.²⁵ Among social workers surveyed in 2018, three out of four who worked in child welfare roles reported having unmanageable workloads, while almost half of those who left the field (45%) said they left because of burnout or vicarious trauma.²⁶ Harm reduction service providers also reported high levels of

19 Andrea M. Stelnicki, R. Nicholas Carleton, Carol Reichert, *Mental Disorder Symptoms Among Nurses in Canada*, Canadian Federation of Nurses Unions, p. 51, 2020.

20 HESA, *Evidence*, 28 March 2022, 1535 (Mr. Syllas Coletto, Registered nurse, as an individual).

21 HESA, *Evidence*, 25 April 2022, 1535 (Dr. David Gratzer, Physician and Attending Psychiatrist, Centre for Addiction and Mental Health, as an individual).

22 HESA, *Evidence*, 2 March 2022, 1635 (Dr. Adam Kassam, President, Ontario Medical Association).

23 HESA, *Evidence*, 16 February 2022, 1650 (Dr. Katharine Smart, President, Canadian Medical Association).

24 HESA, *Evidence*, 28 March 2022, 1550 (Dr. Martin Champagne, President, Association des médecins hématologues et oncologues du Québec).

25 HESA, *Brief*, Canadian Association of Medical Radiation Technologists.

26 HESA, *Brief*, Canadian Association of Social Workers.

burnout and secondary traumatic stress in a 2019 survey on the impacts of the drug toxicity crisis.²⁷

Supply of Health Professionals

Overall, witnesses explained that a chronic lack of resources, human capital and infrastructure, has led to an overburdened health care system and the people working within it. The Committee was told that almost 70% of health spending goes to salaries.²⁸ As such, a lack of funding, and cuts to funding, translate to fewer jobs.

With respect to nursing, the Committee heard about a 2009 report released by the Canadian Nurses Association (CNA). The report stated that “[a] stable and sufficient supply of health professionals continues to be one of Canada’s greatest health-care challenges.”²⁹ Acknowledging the upcoming exodus of nurses as the baby boomers reach retirement age, in 2009 the CNA predicted a significant shortage of nurses by 2022 unless action was taken collaboratively by governments, employers, unions, professional associations, colleges and other stakeholders. However, most actions recommended were not implemented and as Mr. Michael Villeneuve, President of the CNA, told the Committee, “CNA predicted Canada would be short 60,000 nurses by 2022, and here we are with the crisis we're living in now.”³⁰ It is now predicted that there will be a shortage of 117,600 nurses in Canada by 2030.³¹ The Committee was told that there have been efforts to increase the number of nurses trained in Canada. Ms. Cynthia Baker of the Canadian Association of Schools of Nursing explained that the number of annual nursing graduates has increased from less than 5,000 in 2000 to over 12,000 in each of the past five years due to increasing the number of nursing schools and the number of seats available in existing schools.³²

There has also been a chronic shortage of physicians in Canada. Dr. Adam Kassam of the Ontario Medical Association revealed that one million Ontarians do not have a family

27 HESA, *Brief*, Canadian Centre on Substance Use and Addiction.

28 HESA, *Evidence*, 16 February 2022, 1625 (Ms. Linda Silas, President, Canadian Federation of Nurses Unions).

29 Canadian Nurses Association, *Tested Solutions for Eliminating Canada’s Registered Nurse Shortage*, Report Summary, p. 1, 2009.

30 HESA, *Evidence*, 2 March 2022, 1630 (Mr. Michael Villeneuve, Chief Executive Officer, Canadian Nurses Association); HESA, *Evidence*, 9 May 2022, 1535 (Mr. Tim Guest, Chief Executive Officer, Canadian Nurses Association).

31 HESA, *Brief*, Canadian Federation of Nurses Unions.

32 HESA, *Evidence*, 28 March 2022, 1605 (Ms. Cynthia Baker, Executive Director, Canadian Association of Schools of Nursing).



physician³³ while Dr. Anne-Louise Boucher of the Fédération des médecins omnipraticiens du Québec noted that Québec has a lower ratio of family practitioners per capita compared to the rest of Canada.³⁴ Dr. Francine Lemire of the College of Family Physicians of Canada indicated that about 4.6 million Canadians are without a family physician.³⁵ The shortage is particularly severe in rural and remote areas of Canada.³⁶

While many witnesses indicated a shortage of family physicians, Mr. Barua indicated that while the overall number of physicians has been low compared to other OECD countries, the shortage has been greater with respect to specialists than for family physicians.³⁷ In this

regard, Dr. Martin Champagne of the Association des médecins hématologues et oncologues du Québec indicated that demand for this specialty, which includes the diagnosis and treatment of blood disorders and cancers, has been increasing due to the aging population.³⁸ Dr. Louis Perrault of the Association des chirurgiens cardiovasculaires et thoraciques du Québec indicated that the number of surgical residents has decreased by half in some provinces over the past decade.³⁹ Dr. Gilles Soulez of the Canadian Association of Radiologists emphasized that a shortage of radiologists as well as a lack of investment in imaging infrastructure has resulted in increasing wait times over the

“CNA predicted Canada would be short 60,000 nurses by 2022, and here we are with the crisis we're living in now.”

Mr. Michael Villeneuve,
Chief Executive Officer, Canadian Nurses
Association

33 HESA, [Evidence](#), 2 March 2022, 1635 (Dr. Adam Kassam, President, Ontario Medical Association).

34 HESA, [Evidence](#), 25 April 2022, 1555 (Dr. Anne-Louise Boucher, Director, Planning and Regionalization, Fédération des médecins omnipraticiens du Québec).

35 HESA, [Evidence](#), 4 April 2022, 1555 (Dr. Francine Lemire, Executive Director and Chief Executive Officer, College of Family Physicians of Canada).

36 HESA, [Evidence](#), 2 March 2022, 1635 (Dr. Adam Kassam, President, Ontario Medical Association); HESA, [Brief](#), Canadian Centre on Substance Use and Addiction.

37 HESA, [Evidence](#), 16 February 2022, 1615 (Mr. Bacchus Barua, Director, Health Policy Studies, Fraser Institute, as an individual).

38 HESA, [Evidence](#), 28 March 2022, 1550 (Dr. Martin Champagne, President, Association des médecins hématologues et oncologues du Québec).

39 HESA, [Evidence](#), 4 April 2022, 1635 (Dr. Louis Perrault, President, Association des chirurgiens cardiovasculaires et thoraciques du Québec).

course of decades.⁴⁰ Dr. Guylaine Lefebvre of the Royal College of Physicians and Surgeons of Canada revealed that physician stakeholder groups have been collaborating within the Canadian Medical Forum's Physician Resource Planning Working Group and that Organizations for Health Action brings together a broad range of health professionals to address these human resource challenges.⁴¹ Committee members were also told about a collaboration between the College of Family Physicians of Canada and the Rural Physicians of Canada to produce the "Rural Road Map" in 2017, which addressed recruitment and retention of physicians in rural and remote areas of Canada.⁴²

In addition to doctors and nurses, Committee members heard about the supply of some other professions within the health workforce. Members were told that an increased supply of occupational therapists (OT), speech-language pathologists (SLP) and audiologists is needed due to Canada's aging population. Ms. Giovanna Boniface of the Canadian Association of Occupational Therapists stated that the number of OTs has increased from 7,500 in 1997 to 20,000 in 2021, but that more are needed. She also indicated that there is an uneven distribution of OTs in Canada, where only 3.7% of OTs are in rural and remote locations. By comparison, almost 20% of Canada's population lives outside of urban settings.⁴³ Members were told that there are 7,000 SLPs and audiologists in Canada⁴⁴ but that capacity to train people in these fields needs to increase. That is, despite a doubling of Canada's capacity to train new SLPs in the past six years,⁴⁵ the shortage of these health professionals was described as massive, and that Canada has half the number of SLPs per capita than the United States.⁴⁶

The Committee also received written briefs highlighting supply shortages of other professionals including dental professionals, medical laboratory professionals and occupational therapists. The Canadian Dental Association explained that even before the

40 HESA, *Evidence*, 16 February 2022, 1620 (Dr. Gilles Soulez, President, Canadian Association of Radiologists).

41 HESA, *Evidence*, 4 April 2022, 1605 (Dr. Guylaine Lefebvre, Royal College of Physicians and Surgeons of Canada).

42 *Ibid.*, 1735 (Dr. Brady Bouchard, President, College of Family Physicians of Canada).

43 HESA, *Evidence*, 28 March 2022, 1555 (Ms. Giovanna Boniface, President, Canadian Association of Occupational Therapists).

44 HESA, *Evidence*, 4 April 2022, 1615 (Ms. Dawn Wilson, Chief Executive Officer, Speech-Language & Audiology Canada).

45 *Ibid.*, 1640 (Ms. Susan Rvachew, Full Professor, Speech-Language & Audiology Canada).

46 *Ibid.*, 1630.



pandemic, 36% of dental offices had vacant dental assistant positions.⁴⁷ The Medical Laboratory Professionals' Association of Ontario noted that not only did 70% of laboratories enter the pandemic short-staffed, but 73% of laboratory professionals actively desire to leave their role.⁴⁸ A study presented by the Association of Occupational Therapists suggests that between 2019 and 2028, there will be a shortage of 2,200 occupational therapists to fill vacant job openings.⁴⁹

The Impact of the Pandemic on Canada's Health Workforce

The harsh impact of the COVID-19 pandemic has been felt across the health workforce, with severe burnout among all health care workers having nearly doubled over pre-pandemic levels.⁵⁰ While most witnesses emphasized that the COVID-19 pandemic accentuated gaps and deficiencies in Canada's health care system that predated 2020, others described the current state of the health workforce as even more dire. For example, Dr. Perrault stated that "[o]ur system showed during COVID that it was not on the brink of disaster but had already collapsed. COVID simply made things evident not only in Quebec but all over Canada."⁵¹

Committee members heard that the pandemic has produced unprecedented levels of burnout among physicians.⁵² Dr. Gratzner noted that half of Canada's physicians now report suffering from burnout,⁵³ and members were told that the situation is similar for all health care workers.⁵⁴ Dr. Champagne observed that reduced physical contact with colleagues and patients likely further aggravated the already existing burnout among surveyed Québec physicians where it has increased from 35% pre-pandemic to 61% during the pandemic. He noted as well that the delays for cancer diagnosis and treatment caused by pandemic shutdowns mean that doctors expect higher fatality rate

47 HESA, [Brief](#), Canadian Dental Association; HESA, [Brief](#), Canadian Dental Hygienist Association; HESA, [Brief](#), The Canadian Dental Assistants' Association.

48 HESA, [Brief](#), Medical Laboratory Professionals' Association of Ontario.

49 HESA, [Brief](#), Canadian Association of Occupational Therapists.

50 HESA, [Evidence](#), 2 March 2022, 1630 (Mr. Michael Villeneuve, Chief Executive Officer, Canadian Nurses Association).

51 HESA, [Evidence](#), 4 April 2022, 1550 (Dr. Louis Perrault, President, Association des chirurgiens cardiovasculaires et thoraciques du Québec).

52 HESA, [Evidence](#), 16 February 2022, 1630 (Dr. Katharine Smart, President, Canadian Medical Association).

53 HESA, [Evidence](#), 25 April 2022, 1535 (Dr. David Gratzner, Physician and Attending Psychiatrist, Centre for Addiction and Mental Health, as an individual).

54 Ibid., and 1540 (Dr. Arjun Sahgal, Professor of Radiation Oncology, University of Toronto, as an individual).

for cancer, which further increases physician stress.⁵⁵ Staffing shortages have led to surgeries being delayed, which is weakening public trust in the health care system.⁵⁶

Similarly, witnesses described the increased stress experienced by nurses during the pandemic. As much as 94% of nurses report experiencing symptoms of burnout and many are leaving their jobs as a result.⁵⁷ Ms. Silas noted that nurses have been mandated to work longer shifts during the pandemic due to staffing shortages, an unsafe and untenable situation.⁵⁸

It was explained to Committee members that pharmacists are often the first, and sometimes the only, point of contact with the health care system for some Canadians. This became true for even more Canadians as pharmacies remained open in the early days of the pandemic when doctor's offices and non-urgent hospital procedures were shut down.⁵⁹ Pharmacists took on a larger role to fill in gaps in in-person services during the pandemic, while facing issues of "burnout, labour shortages and patient harassment."⁶⁰ Dr. Danielle Paes of the Canadian Pharmacists Association revealed that the organization had recently conducted a survey of its members which found that "during the pandemic, almost half of respondents experienced abuse or harassment from patients at least once a week, and some even daily."⁶¹ She added that the drug shortages that were experienced in the earlier days of the pandemic further added to pharmacist anxiety.⁶²

55 HESA, [Evidence](#), 28 March 2022, 1550 (Dr. Martin Champagne, President, Association des médecins hématologues et oncologues du Québec).

56 HESA, [Brief](#), Nathan Litt; HESA, [Brief](#), Teri Mcgrath.

57 HESA, [Evidence](#), 2 March 2022, 1630 (Mr. Michael Villeneuve, Chief Executive Officer, Canadian Nurses Association).

58 HESA, [Evidence](#), 16 February 2022, 1625 (Ms. Linda Silas, President, Canadian Federation of Nurses Unions).

59 HESA, [Evidence](#), 2 March 2022, 1620 (Ms. Geraldine Vance, Chief Executive Officer, British Columbia Pharmacy Association); HESA, [Evidence](#), 4 April 2022, 1600 (Dr. Danielle Paes, Chief Pharmacist Officer, Canadian Pharmacists Association).

60 HESA, [Evidence](#), 4 April 2022, 1600 (Dr. Danielle Paes, Chief Pharmacist Officer, Canadian Pharmacists Association).

61 Ibid.

62 Ibid., 1700.



As a result of the increased stress from being overburdened before and during the pandemic, many health care professionals have been re-evaluating their future.

Mr. Paul-Émile Cloutier of HealthCareCAN, which represents hospitals, research institutes and health organizations, told Committee members that, according to a survey conducted by the Ontario Hospital Association, the resignation rate in Ontario hospitals increased by 45% between 2020 and 2021.⁶³ Committee members heard that some physicians are leaving the profession, reducing their work hours or retiring ahead of schedule.⁶⁴ Similarly, Mr. Villeneuve emphasized that exhaustion is leading many nurses to leave their jobs, sometimes even the nursing profession.⁶⁵ Ms. Silas specified that as many as half of Canada's nurses may be considering such a move within the next year.⁶⁶

Pharmacists as well may be leaving their chosen profession due to the added strain of the pandemic. Dr. Paes explained that pharmacists, as well as their support staff, have reached a breaking point from the stressors and abuses of the past two years and may choose to leave their jobs.⁶⁷

“[O]ur system showed during COVID that it was not on the brink of disaster [,] but had already collapsed. COVID simply made things evident not only in Quebec but all over Canada.”

Dr. Louis Perrault,
President and Cardiac Surgeon,
Association des chirurgiens cardiovasculaires et
thoraciques du Québec

63 HESA, [Evidence](#), 16 February 2022, 1655 (Mr. Paul-Émile Cloutier, President and Chief Executive Officer, HealthCareCAN).

64 HESA, [Evidence](#), 16 February 2022, 1640 (Mr. Paul-Émile Cloutier, President and Chief Executive Officer, HealthCareCAN) and 1630 (Dr. Katharine Smart, President, Canadian Medical Association), HESA, [Evidence](#), 4 April 2022, 1555 (Dr. Francine Lemire, Executive Director and Chief Executive Officer, College of Family Physicians of Canada) and HESA 25 April 2022, [Evidence](#), 1540 (Dr. Arjun Sahgal, Professor of Radiation Oncology, University of Toronto, as an individual).

65 HESA, [Evidence](#), 2 March 2022, 1630 (Mr. Michael Villeneuve, Chief Executive Officer, Canadian Nurses Association).

66 HESA, [Evidence](#), 16 February 2022, 1625 (Ms. Linda Silas, President, Canadian Federation of Nurses Unions).

67 HESA, [Evidence](#), 4 April 2022, 1600 (Dr. Danielle Paes, Chief Pharmacist Officer, Canadian Pharmacists Association).

Mr. Cloutier indicated that the trend of leaving health care jobs applies not only to health workers in the clinical setting but across the health system including the heads of health care institutions.⁶⁸

Some witnesses spoke about the constraints of working within the publicly funded health care system. OTs, SLPs and audiologists work in a wide range of settings. OTs, Committee members were told, work with patients to provide function and occupation-focussed care. They help seniors to age in place, provide some mental health services, assist injured workers to return to work, etc. Ms. Boniface suggested that OTs could be an important member of primary health care teams but that they do not always work within the public system.⁶⁹

Similarly, Ms. Wilson explained that SLPs and audiologists work in a wide range of settings such as child daycare, schools, hospitals and long-term care facilities within the publicly funded system, they also can work in private practice.⁷⁰ These witnesses indicated that stress of the pandemic and limited compensation within the public system has resulted in some of their members choosing to leave and enter private practice.⁷¹

As a result of insufficient numbers of health care professionals, inappropriate distribution of them across Canada, and increasing numbers of people leaving these professions due to COVID exhaustion and burnout, members were told about increasing numbers of job vacancies. Succinctly put by Dr. Soulez, “[o]ur workforce is burned out and insufficient in number.”⁷²

Mr. Cloutier emphasized that there are job vacancies throughout the health system now and that there are more to come.⁷³ Similarly, Dr. Smart warned that repercussions for the health workforce will be felt for years.⁷⁴ While the Committee was told that the pace

68 HESA, *Evidence*, 16 February 2022, 1710 (Mr. Paul-Émile Cloutier, President and Chief Executive Officer, HealthCareCAN).

69 HESA, *Evidence*, 28 March 2022, 1620 (Ms. Giovanna Boniface, President, Canadian Association of Occupational Therapists).

70 HESA, *Evidence*, 4 April 2022, 1610 (Ms. Dawn Wilson, Chief Executive Officer, Speech-Language & Audiology Canada).

71 *Ibid.*, 1645 (Ms. Susan Rvachew, Full Professor, Speech-Language & Audiology Canada).

72 HESA, *Evidence*, 16 February 2022, 1620 (Dr. Gilles Soulez, Canadian Association of Radiologists).

73 *Ibid.*, 1640 (Mr. Paul-Émile Cloutier, President and Chief Executive Officer, HealthCareCAN).

74 *Ibid.*, 1630 (Dr. Katharine Smart, President, Canadian Medical Association).



at which people are leaving the health workforce is unsustainable,⁷⁵ Mr. Villeneuve suggested that currently the total number of vacancies across the health and social sectors across Canada may be as high as 120,000.⁷⁶

Members were told that rural and remote regions lack health care professionals, for example, 325 more physicians are needed in northern Ontario.⁷⁷ Nursing job vacancies have doubled across Canada over the last two years,⁷⁸ amounting to 20,000 in Ontario alone.⁷⁹ Provinces are having difficulty filling existing OT jobs⁸⁰ and job openings for SLPs and audiologists will outpace the supply for years to come.⁸¹

Dr. Kassam emphasized that the present health care crisis cannot be addressed within the current system without producing even more burnout of Canada's health workforce because "Ontario physicians face years of working above capacity just to clear the pandemic backlog of more than 21 million delayed medical services, let alone reducing the wait times that have plagued the system for decades."⁸² Dr. Kassam noted that a publicly funded and universally accessible health care system is a cornerstone of Canadian values and implored the federal government to provide the tools and resources required by the provinces to effect sustainable and meaningful change.⁸³

REVITALIZING CANADA'S HEALTH WORKFORCE

Several witnesses alluded to the considerable effort that has been focussed over many years to address recruitment and retention issues in Canada's health workforce. Mr. Villeneuve lamented that studies, reports and money has been spent in research pointing to the same problems and offering the same solutions.⁸⁴ Mr. Bradley Campbell,

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- 75 HESA, [Evidence](#), 28 March 2022, 1615 (Mr. Bradley Campbell, President, Corpus Sanchez International Consultancy, Inc.).
- 76 HESA, [Evidence](#), 2 March 2022, 1630 (Mr. Michael Villeneuve, Chief Executive Officer, Canadian Nurses Association).
- 77 Ibid., 1635 (Dr. Adam Kassam, President, Ontario Medical Association).
- 78 HESA, [Evidence](#), 16 February 2022, 1625 (Ms. Linda Silas, President, Canadian Federation of Nurses Unions).
- 79 Ibid., 1650.
- 80 HESA, [Evidence](#), 28 March 2022, 1555 (Ms. Giovanna Boniface, President, Canadian Association of Occupational Therapists).
- 81 HESA, [Evidence](#), 4 April 2022, 1615 (Ms. Dawn Wilson, President, Speech-Language & Audiology Canada).
- 82 HESA, [Evidence](#), 2 March 2022, 1635 (Dr. Adam Kassam, President, Ontario Medical Association).
- 83 Ibid.
- 84 Ibid., 1630 (Mr. Michael Villeneuve, President, Canadian Nurses Association).

a consultant for the health care sector, said that there have been federal commissions and expert panels spanning decades that have offered solutions to health care challenges. He mentioned the Lalonde Report published in 1974 by Canada's Minister of National Health and Welfare, as well as *Building on Values—The Future of Health Care in Canada* and *The Health of Canadians—The Federal Role* (also called the Kirby report) both published in 2002.⁸⁵ Ms. Brenda Payne, a nurse educator, noted that the federal government had developed a Health Human Resource Strategy,⁸⁶ which was described by Mr. Campbell as a Health Canada initiative launched in 2005 to pursue strategies in the supply of health care workers, effective use of skills and talent, creation of healthy workplaces and effective planning and forecasting.⁸⁷ Ms. Silas stated that due to a health human resources crisis in 1997, the federal government conducted work on the issue through to 2008. However, she suggested that the recession that hit at that time caused the federal government to reduce its focus in this area.⁸⁸

Witnesses provided several suggestions for addressing retention and recruitment in Canada's health workforce, which are discussed below.

Internationally Trained Health Care Workers

Committee members heard that several health care professions recruit internationally trained professionals to supplement domestically educated health workers. However, witnesses described barriers that discourage some people from pursuing this option while others successfully emigrate to Canada but are then unable to get accreditation to work within the profession for which they were trained.

“Our workforce is burned out and insufficient in number.”

Dr. Gilles Soulez,
President, Canadian Association of Radiologists

Ms. Elaine Watson, a human resources officer with HealthCareCAN, stated that the application process for internationally trained health care workers is difficult to

85 HESA, *Evidence*, 28 March 2022, 1610 (Mr. Bradley Campbell, President, Corpus Sanchez International Consultancy, Inc.).

86 Ibid., 1540 (Ms. Brenda Payne, Nurse, as an individual).

87 Ibid., 1610 (Mr. Bradley Campbell, President, Corpus Sanchez International Consultancy, Inc.).

88 HESA, *Evidence*, 16 February 2022, 1715 (Ms. Linda Silas, President, Canadian Federation of Nurses Unions).



navigate.⁸⁹ In terms of nursing, members were told that 9% of Canada's workforce is foreign-trained.⁹⁰ Initial assessment of foreign trained nursing applicants is conducted by the National Nursing Assessment Service, a U.S.-based company which is contracted to assess the qualifications of nurses wanting to come to Canada. The assessment process, which can take up to a year, identifies gaps in training that the applicant may have, which can subsequently be filled through bridging programs offered at nursing schools or provincial nursing colleges. Candidates are then further required to undertake competency examinations within the province or territory in which they have applied.⁹¹ Mr. Villeneuve added that the process is too complex and the language requirements too strict.⁹²

Members were told that the process of recruiting internationally trained nurses was less complex before switching to a centralized assessment service with an American-based exam around 2015.⁹³ Ms. Silas explained that this approach made it easier to attract nursing candidates to the U.S. rather than Canada and that it relinquished control from health ministers to a U.S.-based organization. She said that she would like provincial health ministers and nursing colleges to do more to resolve the application, assessment and accreditation processes.⁹⁴

Witnesses emphasized the need to simplify and streamline the process for recruiting internationally trained nurses. Ms. Watson suggested an expedited process with minimal bureaucracy for candidates who exhibit the skills and training needed to fill critical jobs in Canada.⁹⁵ Mr. Campbell told Committee members that Prince Edward Island and Nova Scotia have implemented changes to eliminate some barriers.⁹⁶ He also noted the importance of discussing the issue at a national level:

89 Ibid., 1730 (Ms. Elaine Watson, Chief Human Resources Officer, Covenant Health, HealthCareCAN).

90 HESA, [Evidence](#), 2 March 2022, 1740 (Mr. Michael Villeneuve, President, Canadian Nurses Association).

91 HESA, [Evidence](#), 28 March 2022, 1700 (Ms. Cynthia Baker, Executive Director, Canadian Association of Schools of Nursing) and 1705 (Mr. Bradley Campbell, President, Corpus Sanchez International Consultancy, Inc.).

92 HESA, [Evidence](#), 2 March 2022, 1650 (Mr. Michael Villeneuve, President, Canadian Nurses Association).

93 HESA, [Evidence](#), 16 February 2022, 1735 (Ms. Linda Silas, President, Canadian Federation of Nurses Unions) and HESA, [Evidence](#), 28 March 2022, 1705 (Mr. Bradley Campbell, President, Corpus Sanchez International Consultancy, Inc.).

94 HESA, [Evidence](#), 16 February 2022, 1735 (Ms. Linda Silas, President, Canadian Federation of Nurses Unions).

95 Ibid., 1745 (Ms. Elaine Watson, Chief Human Resources Officer, Covenant Health, HealthCareCAN).

96 HESA, [Evidence](#), 28 March 2022, 1610 (Mr. Bradley Campbell, President, Corpus Sanchez International Consultancy, Inc.).

The federal government can help coordinate these efforts on a national level, partnering with provinces and territories to understand local needs while driving toward a comprehensive pan-Canadian health human resources strategy. This does not mean that all solutions will be applicable in all areas, but consistency of purpose can enable local solutions to be created within an overarching context.⁹⁷

Some witnesses suggested that more could be done to complete the assessment and credentialing processes prior to candidates arriving in Canada. Ms. Gail Tomblin Murphy, a researcher with the Canadian Nurses Association, revealed that some provinces are being innovative in finding ways to work with candidates in their home country to provide distance learning, including language training.⁹⁸ Ms. Silas indicated that some provinces do send accreditation teams abroad, mostly to the Philippines, to resolve some of the complex process before candidates come to Canada.⁹⁹ Ms. Watson suggested that improved collaboration between provincial licensing bodies and their international counterparts would help resolve some issues before people get to Canada.¹⁰⁰

Some witnesses suggested that bridging programs are required to address training gaps identified during the assessment process. Some witnesses identified these programs as another aspect of the process that should be improved. Mr. Villeneuve acknowledged that these have improved¹⁰¹ but Ms. Silas indicated that more still needs to be done.¹⁰² Ms. Baker suggested collaboration between provinces, perhaps through national coordination, to standardize bridging programs across Canada and make them more flexible which would facilitate the ability of internationally trained nurses to practice in different jurisdictions.¹⁰³

Witnesses representing physicians had differing opinions about recruiting internationally trained doctors as a solution to the workforce crisis. Dr. Kassam indicated that any health workforce recruitment strategy would require an international component including a pathway to credentialing. He noted that this is a complex process involving the Royal College of Physicians and Surgeons of Canada, the College of Family Physicians of

97 Ibid.

98 HESA, *Evidence*, 2 March 2022, 1740 (Ms. Gail Tomblin Murphy, Vice-President, Research, Innovation & Discovery, Canadian Nurses Association).

99 HESA, *Evidence*, 16 February 2022, 1745 (Ms. Linda Silas, President, Canadian Federation of Nurses Unions).

100 Ibid., 1730 (Ms. Elaine Watson, Chief Human Resources Officer, Covenant Health, HealthCareCAN).

101 HESA, *Evidence*, 2 March 2022, 1650 (Mr. Michael Villeneuve, President, Canadian Nurses Association).

102 HESA, *Evidence*, 16 February 2022, 1735 (Ms. Linda Silas, President, Canadian Federation of Nurses Unions).

103 HESA, *Evidence*, 28 March 2022, 1715 (Ms. Cynthia Baker, Executive Director, Canadian Association of Schools of Nursing).



Canada, as well as the provincial colleges of physicians and surgeons.¹⁰⁴ Dr. Perrault and Dr. Hugh Maguire, a psychiatrist in rural Nova Scotia, acknowledged that internationally trained health care professionals, including physicians, is part of the short-term solution to recruiting into the health workforce.¹⁰⁵ Dr. Champagne and Dr. Maguire emphasized the need to support these recruits as well as their families in welcoming them to a new environment, and that the process needs to be streamlined.¹⁰⁶ Dr. Maguire also observed that the immigration process itself needs to be streamlined. He suggested that communication between Immigration, Refugees and Citizenship Canada and provincial health authorities needs improvement.¹⁰⁷

However, some witnesses questioned whether Canada should focus on recruiting internationally trained physicians. Dr. David Pichora from the Kingston Health Sciences Centre in Ontario, for example, pointed out that Canada is among many countries looking to recruit health professionals. He indicated that the U.S. was experiencing a deficit of 122,000 physicians and 1.2 million nurses.¹⁰⁸ With health human resources becoming scarce in many countries, some witnesses questioned the ethics of making it too easy to come to Canada and of Canada being seen as taking scarce resources from other countries. In the long-term, Canada must become self-sufficient in supply of physicians.¹⁰⁹ Mr. Campbell agreed that we should be aware of the concern of aggressively pursuing recruiting strategies in other countries simply to meet our own needs. However, he pointed out that several countries including the Philippines intentionally train more health professionals than they need domestically and that it

104 HESA, [Evidence](#), 2 March 2022, 1730 (Dr. Adam Kassam, President, Ontario Medical Association).

105 HESA, [Evidence](#), 4 April 2022, 1635 (Dr. Louis Perreault, President, Association des chirurgiens cardiovasculaires et thoraciques du Québec) and HESA, [Evidence](#), 4 April 2022, 1625 (Dr. Hugh Maguire, Head of Psychiatry, Dalhousie University, as an individual).

106 HESA, [Evidence](#), 28 March 2022, 1555 (Dr. Martin Champagne, President, Association des médecins hématologues et oncologues du Québec) and HESA, [Evidence](#), 4 April 2022, 1625 (Dr. Hugh Maguire, Head of Psychiatry, Dalhousie University, as an individual).

107 HESA, [Evidence](#), 4 April 2022, 1545 (Dr. Hugh Maguire, Head of Psychiatry, Dalhousie University, Dalhousie University, as an individual).

108 HESA, [Evidence](#), 2 March 2022, 1630 (Dr. David Pichora, President and Chief Executive Officer, Kingston Health Sciences Centre).

109 HESA, [Evidence](#), 16 February 2022, 1715 (Dr. Katharine Smart, President, Canadian Medical Association) and HESA, [Evidence](#), 4 April 2022, 1715 (Dr. Brady Bouchard, President, College of Family Physicians of Canada) and 1700 (Dr. Guylaine Lefebvre, Executive Director, Royal College of Physicians and Surgeons of Canada).

could be mutually beneficial for Canada to pursue internationally trained health professionals from such countries.¹¹⁰

Committee members heard that several categories of internationally trained health professionals are currently in Canada but have been unable to obtain proper credentialing to work in their chosen field. Dr. Bouchard noted that, internationally trained physicians may be ineligible for retraining and assessment programs if they have been in Canada but not employed as physicians.¹¹¹ Dr. Smart indicated that there are issues with the practice readiness assessment including the unpaid apprenticeship model, the cost licensing, and a lack of Canadian physicians to support and integrate foreign-trained physicians into the system.¹¹² Mr. Villeneuve acknowledged that many internationally trained nurses are waiting to practice in this country. While he indicated that the number of applicants already in Canada but unable to work is not known,¹¹³ Ms. Baker stated that the number is quite high.¹¹⁴ Committee members heard that instead of efforts to streamline the immigration and credentialing process for internationally trained health professionals, more efforts should be put into getting those who are already in Canada and not working into the health workforce and into training sufficient numbers within Canada to meet our domestic needs.¹¹⁵

The Committee therefore recommends:

Recommendation 1

That the Government of Canada collaborate with provincial and territorial governments and consult with organizations involved in recruiting internationally trained health workers, as well as Immigration, Refugees and Citizenship Canada where necessary, to streamline and simplify the process to recruit from countries known to train health workers in excess of their domestic needs.

110 HESA, [Evidence](#), 28 March 2022, 1610 (Mr. Bradley Campbell, President, Corpus Sanchez International Consultancy, Inc.).

111 HESA, [Evidence](#), 4 April 2022, 1715 (Dr. Brady Bouchard, President, College of Family Physicians of Canada).

112 HESA, [Evidence](#), 9 May 2022, 1555 (Dr. Katharine Smart, President, Canadian Medical Association).

113 HESA, [Evidence](#), 2 March 2022, 1740 (Mr. Michael Villeneuve, President, Canadian Nurses Association).

114 HESA, [Evidence](#), 28 March 2022, 1630 (Ms. Cynthia Baker, Executive Director, Canadian Association of Schools of Nursing).

115 HESA, [Evidence](#), 16 February 2022, 1715 (Dr. Katharine Smart, President, Canadian Medical Association) and HESA, [Evidence](#), 4 April 2022, 1700 (Dr. Guylaine Lefebvre, Royal College of Physicians and Surgeons of Canada) and HESA, [Evidence](#), 25 April 2022, 1610 (Ms. Janet Morrison, President and vice-Chancellor, Sheridan College).



Recommendation 2

That the Government of Canada collaborate with provincial and territorial governments to provide more residency positions for international medical graduates.

Recommendation 3

That the Government of Canada collaborate with provincial and territorial governments and professional regulatory bodies to improve upon and expand pathways to licensure for international physicians who have already completed their residency and who practiced abroad, such as the National Assessment Collaboration's (NAC) Practice-Ready Assessment (PRA) program and other similar initiatives.

Recommendation 4

That the Government of Canada support expedited pathways to licensure and practice for internationally trained health care professionals.

Capacity to Train Health Professionals

Training health professionals is the role of provinces and territories.

Several witnesses commented on the need to increase the number of health professionals graduating in Canada each year. With respect to nurses, as noted earlier in this report, Canada graduates 12,000 new nurses each year. However, members were told that more nursing school seats are needed, as well as clinical placement spots after graduation.¹¹⁶ Ms. Baker noted that there is no capacity to further increase the spots available in nursing schools as they are stretched to full capacity. She also noted that if additional seats are added to nursing schools, or if more schools are created, additional educators are also required. Ms. Baker suggested implementing accelerated nursing programs for people with degrees in other disciplines and creating nursing residency programs to support new graduates in their transition from academic to clinical practice.¹¹⁷

116 HESA, *Evidence*, 2 March 2022, 1630 (Mr. Michael Villeneuve, Chief Executive Officer, Canadian Nurses Association).

117 HESA, *Evidence*, 28 March 2022, 1606 (Ms. Cynthia Baker, Executive Director, Canadian Association of Schools of Nursing).

Members heard that Canada's capacity to train physicians should be increased.¹¹⁸ Dr. Lemire noted that medical schools had recently increased their capacity to train family practitioners, but she emphasized the need to focus efforts to increase supply in under-serviced areas, specifically rural and remote regions of Canada.¹¹⁹ Mr. Montana Hackett of the Canadian Federation of Medical Students suggested the best approach

for this is to recruit students from rural and remote regions of Canada as these students are likely to return to practice in these areas.¹²⁰ As well, Dr. Maguire indicated that students who are well-suited to working in rural and remote areas are being identified within medical schools across Canada and their training can be tailored to suit those needs.¹²¹ He also revealed that Memorial University and some Ontario medical schools have implemented efforts to recruit students from rural and remote areas and designed rural and remote training programs.¹²² Members were also told that increased spots in post-secondary institutions need to be met with increased teaching resources. Ms. Hernandez noted that in Québec the compensation structure for family physicians disincentivizes them to take on teaching responsibilities and she suggested that this leads to less enthusiasm among students to pursue family medicine.¹²³

Witnesses emphasized that if Canada increases the number of new physicians graduating each year, it must also ensure that the number of residency placements and

“We are way too small a country to expect 13 jurisdictions to have all the data, all the best practices and all the experts.”

Linda Silas,
President, Canadian Federation of Nurses Unions

118 HESA, [Evidence](#), 2 March 2022, 1725 (Dr. Adam Kassam, President, Ontario Medical Association) and HESA, [Evidence](#), 4 April 2022, 1720 (Dr. Brady Bouchard, President, College of Family Physicians of Canada).

119 HESA, [Evidence](#), 4 April 2022, 1555 (Dr. Francine Lemire, Executive Director and Chief Executive Officer, College of Family Physicians of Canada).

120 HESA, [Evidence](#), 25 April 2022, 1705 (Mr. Montana Hackett, Director of Government Affairs, Canadian Federation of Medical Students).

121 HESA, [Evidence](#), 4 April 2022, 1545 (Dr. Hugh Maguire, Head of Psychiatry, Dalhousie University, as an individual).

122 Ibid., 1740.

123 HESA, [Evidence](#), 25 April 2022, 1640 (Ms. Santanna Hernandez, President, Canadian Federation of Medical Students).



clinical positions increases.¹²⁴ Mr. Hackett explained that establishing and funding residency positions is a provincial responsibility, and he described the challenges already faced by medical graduates in securing residency positions. He revealed that each year several medical graduates do not get matched to a residency position and are therefore unable to train in any of their chosen specialties.¹²⁵ However, members were also told that many residency positions go unfilled each year. Dr. Boucher indicated that medical graduates in Québec favour residencies in other medical specialties over family practice, resulting in several unfilled general practice residencies in that province.¹²⁶ Notably, in 2022, 90 family medicine residency positions in Québec were not filled during the first round of matching.¹²⁷ Ms. Hernandez also explained that the compensation structure in some jurisdictions discourages medical graduates from applying for some residencies, which contributes to residency positions going unfilled.¹²⁸ Finally, Dr. Smart noted that the high cost of medical school is a barrier to students wishing to enter the profession and also negatively impacts the diversity of students who are able to access medical school.¹²⁹

Committee members were also told that Canada needs to create additional spots to train speech-language pathologists and audiologists.¹³⁰

The Committee therefore recommends:

Recommendation 5

That the Government of Canada collaborate with provincial and territorial governments and professional regulatory bodies to facilitate the licensing and, where necessary, additional education and training needed for licensing of nurses and other health care

124 HESA, [Evidence](#), 16 February 2022, (Mr. Bacchus Barua, Director, Health Policy Studies, Fraser Institute, as an Individual), HESA, [Evidence](#), 2 March 2022, 1725 (Dr. Adam Kassam, President, Ontario Medical Association) and HESA, [Evidence](#), 4 April 2022, 1720 (Dr. Brady Bouchard, President, College of Family Physicians of Canada).

125 HESA, [Evidence](#), 25 April 2022, 1545 and 1710 (Mr. Montana Hackett, Director of Governmental Affairs, Canadian Federation of Medical Students).

126 Ibid., 1550 (Dr. Anne-Louise Boucher, Director, Planning and Regionalization, Fédération des médecins omnipraticiens du Québec).

127 HESA, [Brief](#), Fédération des Médecins Omnipraticiens du Québec.

128 HESA, [Evidence](#), 25 April 2022, 1645 (Ms. Santanna Hernandez, President, Canadian Federation of Medical Students).

129 HESA, [Evidence](#), 16 February 2022, 1750 (Dr. Katharine Smart, President, Canadian Medical Association).

130 HESA, [Evidence](#), 4 April 2022, 1730 (Ms. Dawn Wilson, Chief Executive Officer, Speech-Language & Audiology Canada) and 1640 (Ms. Susan Rvachew, Full Professor, Speech-Language & Audiology Canada).

professionals working in fields where existing programs are unable to address the workforce shortages.

Recommendation 6

That the Government of Canada collaborate with provincial and territorial governments to increase the number of residency positions, particularly for family medicine.

Pan-Canadian Licensure

The regulation and licensing of health professionals is a provincial and territorial responsibility. Notwithstanding this, witnesses representing physicians, nurses and pharmacists, indicated the need for national, or pan-Canadian, licensure for their respective professions, citing the benefits of increased mobility potential, increased access for patients and facilitate replacements of health care professionals during their absences, particularly in rural and remote locations.

Dr. Paes and Mr. Coletto noted the increased potential for interprovincial mobility of pharmacists and nurses, respectively, under pan-Canadian licensure.¹³¹ Dr. Smart urged pan-Canadian licensure for physicians, referring to provincial licensing as a barrier to working where doctors would like and where they are most needed.¹³² Further, she noted that pan-Canadian licensure would facilitate a national approach to credentialing which would help to remove regulatory barriers for internationally trained physicians.¹³³ Ms. Santanna Hernandez of the Canadian Federation of Medical Students described the administrative and financial burden of applying to multiple jurisdictions for licensure.¹³⁴ Dr. Maguire noted that pan-Canadian licensure would be beneficial to rural and remote areas as it would make it easier to fill vacancies and to temporarily replace physicians leaving on vacation or other personal reasons.¹³⁵

Related to licensure is professional scope of practice, which describes the actions and procedures that a health professional may perform under their licence to practice.

131 Ibid., 1725 (Dr. Danielle Paes, Chief Pharmacist Officer, Canadian Pharmacists Association) and HESA, *Evidence*, 28 March 2022, 1730 (Mr. Syllas Coletto, Registered nurse, as an individual).

132 HESA, *Evidence*, 16 February 2022, 1630 (Dr. Katharine Smart, President, Canadian Medical Association).

133 Ibid., 1740.

134 HESA, *Evidence*, 25 April 2022, 1550 (Ms. Santanna Hernandez, President, Canadian Federation of Medical Students).

135 HESA, *Evidence*, 4 April 2022, 1545 (Dr. Hugh Maguire, Head of Psychiatry, Dalhousie University, as an individual).



Scopes of practice are determined provincially and therefore are subject to variation between jurisdictions. The Committee heard that the scope of practice of pharmacists, in particular, varies across Canada. In this respect, members were told that only in some provinces and territories are pharmacists allowed to prescribe medication for certain conditions and give vaccinations.¹³⁶ Ms. Geraldine Vance of the British Columbia Pharmacy Association noted that this results in inequality in access to care for patients, especially for those for whom the pharmacist may be the only point of care.¹³⁷ She further indicated that a national scope of practice would allow pharmacists across Canada to work to their maximum level of expertise and that this would be particularly important in rural and remote areas, where access to physicians and nurses is often difficult.¹³⁸ Dr. Paes added that working to their full scope of expertise allows for personal and professional fulfilment, while the inability to do so can disincentivize pharmacists to work in certain jurisdictions.¹³⁹ In addition to pharmacists, members heard that certain minor procedures currently only conducted by specialists could be considered in wider scopes of practice for other health professionals, for example nurse practitioners performing colonoscopies.¹⁴⁰

The Committee therefore recommends:

Recommendation 7

That the Government of Canada work with the provinces, territories, and professional regulatory bodies to establish pan-Canadian licensure for health professionals.

Recommendation 8

That the Government of Canada work with the provinces, territories, and professional regulatory bodies to optimize the scope of practice for primary care professionals, including nurse practitioners and pharmacists.

136 HESA, [Evidence](#), 2 March 2022, 1620 (Ms. Geraldine Vance, Chief Executive Officer, British Columbia Pharmacy Association) and HESA, [Evidence](#), 4 April 2022, 1600 (Dr. Danielle Paes, Chief Pharmacist Officer, Canadian Pharmacists Association).

137 HESA, [Evidence](#), 2 March 2022, 1620 (Ms. Geraldine Vance, Chief Executive Officer, British Columbia Pharmacy Association).

138 Ibid.

139 HESA, [Evidence](#), 4 April 2022, 1600 (Dr. Danielle Paes, Chief Pharmacist Officer, Canadian Pharmacists Association).

140 HESA, [Evidence](#), 28 March 2022, 1720 (Dr. Martin Champagne, President, Association des médecins hématologues et oncologues du Québec).

Data Collection and Access

Availability of, and access to, data about the health workforce were frequently mentioned by witnesses and in briefs. Dr. David Peachey, a consultant in clinical services planning, explained that assessing the supply and demand of health care resources requires comprehensive data collection, collation, and analytics.¹⁴¹

Committee members were told that existing health workforce datasets are insufficient as they may be limited to single jurisdictions, rely on self-reporting or are managed by for-profit organizations. In addition, they are not designed as a tool for human resource planning, and they lack necessary information on equity, diversity and inclusion for fostering a health workforce that is representative of the broader population.¹⁴²

Dr. Lefebvre explained that the existing database of physicians is the private Scott's database to which the Canadian Institute for Health Information provides limited access.¹⁴³ She noted that comprehensive datasets are necessary for all health care professionals, not just physicians.¹⁴⁴ Some witnesses explained that data on the distribution of health workers is not available.¹⁴⁵ Dr. Lefebvre stated the data that is available does not make clear whether Canada has enough physicians, or the right mix of physicians, as it does not allow an analysis of distribution across the country.¹⁴⁶

It was suggested that datasets need to be analyzed and projected so that health professions react to growing needs before it becomes an issue.¹⁴⁷ The need for more data extends beyond statistics. Dr. Lemire suggested that data should be collected on the services caregivers provide within their practice, whether that differs from their scope of practice, and on their career trajectories.¹⁴⁸

141 HESA, *Evidence*, 25 April 2022, 1600 (Dr. David Peachey, Principal, Health Intelligence, Inc.).

142 HESA, *Evidence*, 4 April 2022, 1610 (Dr. Guylaine Lefebvre, Royal College of Physicians and Surgeons of Canada).

143 *Ibid.*, 1725.

144 *Ibid.*

145 HESA, *Evidence*, 4 April 2022, 1735 (Dr. Brady Bouchard, President, College of Family Physicians of Canada) and 1725 (Dr. Danielle Paes, Chief Pharmacist Officer, Canadian Pharmacists Association).

146 *Ibid.*, 1705 (Dr. Guylaine Lefebvre, President, Royal College of Physicians and Surgeons of Canada).

147 HESA, *Brief*, Canadian Ophthalmological Society.

148 HESA, *Evidence*, 4 April 2022, 1555 (Dr. Francine Lemire, Executive Director and Chief Executive Officer, College of Family Physicians of Canada).



The Committee therefore recommends:

Recommendation 9

That the Government of Canada in collaboration with provinces, territories and Indigenous Peoples, continue its work in developing a Pan-Canadian Health Data Strategy to improve Canada’s collection, access, sharing and use of health workforce data and lay the foundation for a world-class health data system.

Recommendation 10

That the Government of Canada collaborate with the provinces and territories to create and implement a Pan-Canadian Health Human Resource Strategy to facilitate better identification of gaps in the health care workforce and more efficient action to address those gaps.

Innovative Health Care Delivery Models

Dr. Peachey suggested that health care workers will continue to feel undervalued, and the status quo will continue to prevail in the health workforce if Canada fails to implement innovative models of care.¹⁴⁹ Dr. Arjun Sahgal, professor of radiation oncology, was among the health professionals who testified that new models of health care delivery should be explored in order to more efficiently utilize scarce resources.¹⁵⁰ Members heard that there should be greater use of the medical home model of care in which primary care is delivered through an interprofessional, interdisciplinary, team-based model.¹⁵¹ Such an approach would allow a needs-based approach to the makeup of such teams to best serve the unique needs of communities across Canada. In addition, members were told that team-based care would increase access to primary care physicians through greater use of other professional health workers in the team.¹⁵² Further, it could reduce health care costs by optimizing the scopes of practice of all team

149 HESA, *Evidence*, 25 April 2022, 1605 (Dr. David Peachey, Principal, Health Intelligence, Inc.).

150 *Ibid.*, 1540 (Dr. Arjun Sahgal, Professor of Radiation Oncology, University of Toronto, as an individual).

151 HESA, *Evidence*, 16 February 2022, 1705 (Ms. Linda Silas, President, Canadian Federation of Nurses Unions) and 1710 (Dr. Katharine Smart, President, Canadian Medical Association).

152 *Ibid.*, 1630 (Dr. Katharine Smart, President, Canadian Medical Association).

members, which can divert some expensive acute care to less expensive community and home care.¹⁵³

As a component of health care delivery models, some witnesses discussed the remuneration of health care workers. Dr. Smart stated that the fee-for-service model can be a barrier to some choosing to practice family medicine and suggested that alternative payment models should be explored.¹⁵⁴ Dr. Lemire indicated that a blended funding model might be preferred, whereby fee-for-service would be supplemented with a fee-per-patient.¹⁵⁵ This approach would acknowledge the additional expenses incurred by family physicians with respect to additional overhead costs for office space and staff salaries.¹⁵⁶ Committee members also heard that physicians, who currently have to self-fund their pensions, would look favourably on a structured pension, which could also act as an incentive to enter the profession.¹⁵⁷

As noted earlier in this report, the services of other health professionals are not always adequately financed within the public system.¹⁵⁸ Ms. Boniface stated that a significant proportion of physicians have difficulty referring their patients to publicly funded occupational therapy¹⁵⁹ where private care costs about \$250 to \$300 per visit.¹⁶⁰ Similarly, Committee members were told that speech language pathologists and audiologists can work within the publicly funded health system but they may prefer to work in the private sector where earning potential is higher. Ms. Susan Rvachew urged that public funding for services and early intervention would bring downstream savings to the health system.¹⁶¹

153 HESA, [Evidence](#), 28 March 2022, 1555 (Ms. Giovanna Boniface, President, Canadian Association of Occupational Therapists); HESA, [Brief](#), Spectrum Health Care.

154 HESA, [Evidence](#), 16 February 2022, 1710 (Dr. Katharine Smart, President, Canadian Medical Association).

155 HESA, [Evidence](#), 4 April 2022, 1645 (Dr. Francine Lemire, Executive Director and Chief Executive Officer, College of Family Physicians of Canada).

156 *Ibid.*, 1720 (Dr. Brady Bouchard, President, College of Family Physicians of Canada).

157 HESA, [Evidence](#), 2 March 2022, 1730 (Dr. Adam Kassam, President, Ontario Medical Association).

158 HESA, [Brief](#), Canadian Physiotherapy Association.

159 HESA, [Evidence](#), 28 March 2022, 1555 (Ms. Giovanna Boniface, President, Canadian Association of Occupational Therapists).

160 *Ibid.*, 1640.

161 HESA, [Evidence](#), 4 April 2022, 1645 (Ms. Susan Rvachew, Full Professor, Speech-Language & Audiology Canada).



The Committee therefore recommends:

Recommendation 11

That the Government of Canada, in consultation with the provinces and territories, and advised by diverse experts from the health community, develop a national strategy on the promotion and implementation of effective health care teams across Canadian society to ensure patient issues are treated by the appropriate member of the health care team to get the best care possible.

Recommendation 12

That the Government of Canada work with the provinces and territories to explore and share best practices in alternate payment mechanisms, specifically towards alleviating physician burnout.

Recommendation 13

That the Government of Canada work with the provinces and territories to expand access to long-term care beds, home care services, and palliative care.

Recommendation 14

That the Government of Canada work with the provinces and territories to improve Canada's preventative health strategies and increase federal investment in preventative health measures.

Virtual Tools

“The pandemic created an almost-overnight digital health revolution, with Canadians accessing care virtually. It cannot replace in-person care, but it has its place.”

Dr. Katharine Smart,
President, Canadian Medical Association

The Committee heard how the use of virtual care steeply accelerated during the pandemic, presenting both opportunities and limitations. Many witnesses spoke of how

virtual care could help enable access to care in Canada.¹⁶² The advantages of virtual care mentioned included the facilitation of safe care during the pandemic, increased flexibility in where, when and by whom care can be provided, more efficient use of time for patients and physicians, enhanced continuity of care and reduced travel burden for rural and remote patients. Considering the benefits, Dr. Smart suggested an investment of \$400 million by the federal government to support the expansion of virtual care tools and services.¹⁶³

Witnesses also highlighted the limitations of virtual care. A common theme in the testimony was that virtual care could be a great asset in certain circumstances, but not in others.¹⁶⁴ Some witnesses emphasized that in-person care is needed for certain health conditions, settings or patient populations. Unintended consequences of increased use of virtual care were noted by Dr. Soulez, Dr. Pichora, and Mr. Barua.¹⁶⁵ These included an increased demand for medical imaging, increased backlog of patients needing referral, and the potential for future challenges from the *Canada Health Act* related to user fees and charges. Other concerns were about equity, particularly given disparities in access to communication technologies or infrastructure needed for virtual care. Dr. Bouchard cautioned that “we don't want to replace a family physician in a rural community with just virtual care.”¹⁶⁶

Members heard that more information is necessary to get a full understanding of when and how virtual care can be applied most effectively¹⁶⁷ and where the risks of virtual

162 HESA, [Evidence](#), 9 May 2022, 1610 and HESA, [Evidence](#), 16 February 2022, 1710 (Dr. Katharine Smart, President, Canadian Medical Association), HESA, [Evidence](#), 2 March 2022, 1755 (Dr. Adam Kassam, President, Ontario Medical Association), HESA, [Evidence](#), 4 April 2022, 1745 (Dr. Danielle Paes, Chief Pharmacist Officer, Canadian Pharmacists Association), HESA, [Evidence](#), 27 April 2022, 1635 (Dr. Fleur-Ange Lefebvre, Executive Director and Chief Executive Officer, Federation of Medical Regulatory Authorities of Canada) and HESA, [Evidence](#), 9 May 2022, 1715 (Dr. Brady Bouchard, President, College of Family Physicians of Canada).

163 HESA, [Evidence](#), 9 May 2022, 1530 (Dr. Katharine Smart, President, Canadian Medical Association).

164 HESA, [Evidence](#), 27 April 2022, 1635 (Dr. Fleur-Ange Lefebvre, Executive Director and Chief Executive Officer, Federation of Medical Regulatory Authorities of Canada), HESA, [Evidence](#), 9 May 2022, 1715 (Dr. Brady Bouchard, President, College of Family Physicians of Canada), HESA, [Evidence](#), 4 April 2022, 1745 (Dr. Danielle Paes, Chief Pharmacist Officer, Canadian Pharmacists Association), HESA, [Evidence](#), 2 March 2022, 1745 (Dr. David Pichora, President and Chief Executive Officer, Kingston Health Sciences Centre).

165 HESA, [Evidence](#), 16 February 2022, 1745 (Dr. Gilles Soulez, president Canadian Association of Radiologists), HESA, [Evidence](#), 2 March 2022, 1745 (Dr. David Pichora, President and Chief Executive Officer, Kingston Health Sciences Centre) and HESA, [Evidence](#), 16 February 2022, 1725 (Mr. Bacchus Barua, Director, Health Policy Studies, Fraser Institute, As an Individual).

166 HESA, [Evidence](#), 9 May 2022, 1715 (Dr. Brady Bouchard, President, College of Family Physicians of Canada).

167 HESA, [Evidence](#), 2 March 2022, 1735 (Dr. David Pichora, President and Chief Executive Officer, Kingston Health Sciences Centre).



care lie.¹⁶⁸ To increase the knowledge base in this area, Dr. Kassam recommended supporting national societies in the development of guidelines on which procedures in their specialty can appropriately be done virtually and which require in-person care.¹⁶⁹

Virtual tools could also aid with distance training and continuing education of health care professionals, particularly in rural and remote areas. Ms. Rvachew, for example, described the long-distance supervision of speech language and audiology students in Northern areas.¹⁷⁰

The Committee therefore recommends:

Recommendation 15

That the Government of Canada work in collaboration with the provinces and territories as well as Indigenous Peoples, and stakeholders to expand digital infrastructure, and other system improvements, to increase access to high quality, safe virtual care, where appropriate.

Financial Incentives and Supports for Health Care Workers

Witnesses suggested a variety of incentives and supports to increase recruitment and retention within the health workforce generally, and to address the rural and remote health workforce specifically. In the short term, members were told, incentives should be offered to retain the health workforce we have. Dr. Lemire suggested time-limited financial incentives to retain family doctors who may be considering leaving.¹⁷¹ Similarly, Mr. Villeneuve suggested incentives to retain nurses and that such incentives could include bonuses, loan forgiveness¹⁷² and tax credits¹⁷³ while Dr. Paes added the

168 HESA, *Evidence*, 16 February 2022, 1805 (Mr. Paul-Émile Cloutier, President and Chief Executive Officer, HealthCareCAN).

169 HESA, *Evidence*, 2 March 2022, 1635 (Dr. Adam Kassam, President, Ontario Medical Association).

170 HESA, *Evidence*, 4 April 2022, 1630 (Ms. Susan Rvachew, Full Professor, Speech-Language & Audiology Canada).

171 *Ibid.*, 1555 (Dr. Francine Lemire, Executive Director and Chief Executive Officer, College of Family Physicians of Canada).

172 HESA, *Evidence*, 2 March 2022, 1630 (Mr. Michael Villeneuve, Chief Executive Officer, President, Canadian Nurses Association).

173 *Ibid.*

suggestion of subsidies for employers who hire students and internationally trained health workers.¹⁷⁴

To incentivize health care professionals to work in rural and remote Canada, witnesses suggested a federal tax relief of 15% and bursaries to be paid out over five years to health care professionals once they have worked in a rural and remote region of Canada for at least five years.¹⁷⁵

The Canadian Chiropractic Association suggested a one-time tax deduction for health care professionals who establish clinics in rural or underserved communities.¹⁷⁶

Several briefs proposed that existing financial incentives, such as the Canada Student Loan Forgiveness program, be extended to other health care professions.¹⁷⁷

Witnesses and briefs discussed various measures to reduce burden, workload and stress, which could improve retention of health care workers. These measures included support for health workers in rural and remote areas such as:

- a) improved connectivity and equipment to support increased use of virtual care;
- b) tools to reduce administrative burden, electronic health records¹⁷⁸ and;
- c) decision support tools to reduce fatigue, peer support programs and support for post-secondary schools.

174 HESA, [Evidence](#), 4 April 2022, 1600 (Dr. Danielle Paes, Chief Pharmacist Officer, Canadian Pharmacists Association).

175 HESA, [Evidence](#), 2 March 2022, 1635 (Dr. Adam Kassam, President, Ontario Medical Association) and HESA, [Evidence](#), 4 April 2022, 1545 (Dr. Hugh Maguire, Head of Psychiatry, Dalhousie University, as an individual).

176 HESA, [Brief](#), Canadian Chiropractic Association.

177 HESA, [Brief](#), Canadian Association of Social Workers; HESA, [Brief](#), Canadian Chiropractic Association.

178 HESA, [Brief](#), Neurological Health Charities Canada.



The Committee therefore recommends:

Recommendation 16

That the Government of Canada work with the provinces and territories, and/or utilize powers within its purview, to create incentives for health care workers to encourage the retention, and return, of health care workers to help address the workforce crisis.

Recommendation 17

That the Government of Canada work with the provinces and territories to provide incentives to attract more physicians into family care and retain them.

Health Workers in Rural and Remote Areas

In addition to the previously described burden faced by the health workforce in Canada, health workers in rural and remote regions have added stressors such as Internet connection, poor access to IT support, and difficulty in securing replacement personnel for both short- and long-term absences. Witnesses discussed the need for improved broadband coverage and better equipment and IT support for virtual care.¹⁷⁹

Ms. Rvachew emphasized the need for high quality connectivity in all regions of Canada for delivering speech-language pathology and audiology services.¹⁸⁰ Finally, members heard about the difficulty experienced in rural and remote areas of securing replacements for health workers during their short- or long-term absences. Dr. Maguire explained that one of the deterrents for physicians to work in rural areas is the concern that they will not be able to leave on vacation, go to conferences or leave on a longer breaks due to the difficulty of finding replacements. He suggested that a federal locum program could help alleviate this worry, especially if national licensure has been implemented.¹⁸¹

179 HESA, *Evidence*, 4 April 2022, 1545 (Dr. Hugh Maguire, Head of Psychiatry, Dalhousie University, as an individual), 1620 (Ms. Dawn Wilson, Chief Executive Officer, Speech-Language & Audiology Canada) and 1650 (Ms. Susan Rvachew, Full Professor, Speech-Language & Audiology Canada).

180 Ibid., 1650 (Ms. Susan Rvachew, Full Professor, Speech-Language & Audiology Canada).

181 Ibid., 1545 (Dr. Hugh Maguire, Head of Psychiatry, Dalhousie University, as an individual).

The Committee therefore recommends:

Recommendation 18

That the Government of Canada collaborate with the provinces and territories to develop strategies to recruit, train, and adequately support, health care workers for rural, remote, and northern communities.

Administrative Burden

The Committee was told that up to 30% of a physician's time is spent on administrative duties such as entering patient data into electronic medical records, contacting physicians for referral and even sending faxes,¹⁸² often after working hours as unpaid time.¹⁸³ Members heard that this burden takes time away from patient care, contributes to delays in treatment and increases risks to patient safety.¹⁸⁴ Dr. Boucher of the Fédération des médecins omnipraticiens du Québec suggested that the fatigue and burnout associated with this administrative burden is a deterrent not only to retaining doctors but to recruiting them as well.¹⁸⁵ It was explained that dedicated funding and streamlined administrative processes with additional clerical staff for physicians and primary health care teams would increase time for direct patient care and help retain health workers.¹⁸⁶ Both the Ontario Medical Association and the College of Family Physicians of Canada identified reducing administrative burden as a priority for alleviating burnout.¹⁸⁷

Some witnesses described the fatigue from having to work with inefficient internal processes and platforms. Members heard that implementation of decision-making tools

182 Ibid., 1720 (Dr. Guylaine Lefebvre, President, Royal College of Physicians and Surgeons of Canada) and HESA, [Evidence](#), 25 April 2022, 1720 (Dr. Arjun Sahgal, Professor of Radiation Oncology, University of Toronto, as an individual).

183 HESA, [Evidence](#), 16 February 2022, 1800 (Dr. Katharine Smart, President, Canadian Medical Association).

184 HESA, [Evidence](#), 25 April 2022, 1550 (Ms. Santanna Hernandez, President, Canadian Federation of Medical Students).

185 Ibid., 1600 (Dr. Anne-Louise Boucher, Director, Planning and Regionalization, Fédération des médecins omnipraticiens du Québec).

186 HESA, [Evidence](#), 2 March 2022, 1630, (Mr. Michael Villeneuve, Chief Executive Officer, Canadian Nurses Association) and HESA, [Evidence](#), 4 April 2022, 1555 (Dr. Francine Lemire, Executive Director and Chief Executive Officer, College of Family Physicians of Canada) and HESA, [Evidence](#), 25 April 2022, 1540 (Dr. Arjun Sahgal, Professor of Radiation Oncology, University of Toronto, as an individual).

187 HESA, [Evidence](#), 4 April 2022, 1555 (Dr. Francine Lemire, Executive Director and Chief Executive Officer, College of Family Physicians of Canada) and HESA, [Evidence](#), 2 March 2022, 1635 (Dr. Adam Kassam, President, Ontario Medical Association).



such as national guidelines and clinical decision support systems would help reduce stress and minimize unnecessary or duplicated procedures.¹⁸⁸ Physicians also noted the need to finalize the implementation of comprehensive, integrated electronic health records.¹⁸⁹ Dr. Kassam revealed that the lack of interoperability between provincial electronic medical record systems is a significant contributor to burnout and he urged additional federal investment in Canada Health Infoway.¹⁹⁰

The Committee therefore recommends:

Recommendation 19

That the Government of Canada, in partnership with provinces, territories, Indigenous Peoples and stakeholders share best practices in an effort to reduce administrative burdens on health care professionals, where appropriate, to ensure that time is not unnecessarily taken away from patients, and to reduce the significant contributor of administrative burdens to burnout.

Mental Health Support Programs for Health Professionals

Dr. Gratzer expressed optimism regarding the resilience of Canada's health workforce, but he noted that some people may be at a higher risk for negative mental health impacts, including individuals with a history of mental health challenges. He noted, however, that there could be similar consequences after the COVID-19 pandemic as were observed following the Severe Acute Respiratory Syndrome (SARS) outbreak in 2003, in which health care workers who had had direct exposure to the virus as well as others who had survived infection, continued to struggle with mental health challenges after the outbreak.

Dr. Gratzer noted the value of peer support programs to help address stress and burnout among health care workers.¹⁹¹ Committee members heard about some programs that

188 HESA, [Evidence](#), 16 February 2022, 1655 (Dr. Gilles Soulez, President, Canadian Association of Radiologists) and HESA, [Evidence](#), 2 March 2022, 1635 (Dr. Adam Kassam, President, Ontario Medical Association).

189 HESA, [Evidence](#), 2 March 2022, 1635 (Dr. Adam Kassam, President, Ontario Medical Association), HESA, [Evidence](#), 4 April 2022, 1625 (Dr. Hugh Maguire, Head of Psychiatry, Dalhousie University, as an individual) and 1650 (Dr. Guylaine Lefebvre, President, Royal College of Physicians and Surgeons of Canada).

190 HESA, [Evidence](#), 2 March 2022, 1635 (Dr. Adam Kassam, President, Ontario Medical Association), HESA, [Evidence](#), 28 March 2022, 1535 (Mr. Sylas Coletto, Registered nurse, as an individual) and HESA [Evidence](#), 4 April 2022, 1610 (Dr. Guylaine Lefebvre, President, Royal College of Physicians and Surgeons of Canada).

191 HESA, [Evidence](#), 25 April 2022, 1535 (Dr. David Gratzer, Physician and Attending Psychiatrist, Centre for Addiction and Mental Health, as an individual).

were implemented during the pandemic including the Canadian Medical Association's Physician Wellness Hub and the Québec Physicians' Health Program but that more support is needed.¹⁹² Dr. Paes made a plea for federal investment in this area. She suggested that the federal government could offer direct funds to health providers as well as directed funds to the provinces and territories for mental health resources.¹⁹³

The Committee therefore recommends:

Recommendation 20

That the Government of Canada work with the provinces and territories to implement a Pan-Canadian Mental Health Strategy for health care workers.

Independent Organization Dedicated to the Health Workforce

The Committee heard from some witnesses that an independent body established by the federal government would help to bring together all stakeholders and coordinate efforts across the country to effectively tackle the health workforce crisis. Ms. Silas noted that "We are way too small a country to expect 13 jurisdictions to have all the data, all the best practices and all the experts."¹⁹⁴

Members heard that a federal body dedicated to the health workforce should be part of a long-term strategy for health workforce planning.¹⁹⁵ Witnesses suggested that it would be responsible for gathering data on the health workforce, possibly under a national data strategy,¹⁹⁶ to identify and address problems with recruiting and retention strategies and to provide recommendations to provincial and territorial governments,

192 HESA, *Evidence*, 28 March 2022, 1555 (Dr. Martin Champagne, President, Association des médecins hématologues et oncologues du Québec).

193 HESA, *Evidence*, 4 April 2022, 1600 (Dr. Danielle Paes, Chief Pharmacist Officer, Canadian Pharmacist Association).

194 HESA, *Evidence*, 16 February 2022, 1715 (Ms. Linda Silas, President, Canadian Federation of Nurses Unions).

195 HESA, *Evidence*, 16 February 2022, 1625 (Ms. Linda Silas, President, Canadian Federation of Nurses Unions) and 1645 (Mr. Paul-Émile Cloutier, President and Chief Executive Officer, HealthCareCAN), HESA, *Evidence*, 2 March 2022, 1630 (Mr. Michael Villeneuve, Chief Executive Officer, Canadian Nurses Association), HESA, *Evidence*, 4 April 2022, 1550 (Dr. Louis Perrault, President, Association des chirurgiens cardiovasculaires et thoraciques du Québec) and HESA, *Brief*, The Canadian Health Workforce Network.

196 HESA, *Evidence*, 4 April 2022, 1555 (Dr. Francine Lemire, Executive Director and Chief Executive Officer, College of Family Physicians of Canada).



health professional and education organizations on projected supply, needs and distribution across Canada.¹⁹⁷

Increased Federal Health Spending

Several witnesses addressed specific health-related federal transfers and directed funding. With respect to the Canada Health Transfer, several witnesses agreed that a significant increase is necessary.¹⁹⁸ While Dr. Perrault stressed that the need for additional federal health funding was critical prior to the pandemic and therefore must be increased immediately in order to recover,¹⁹⁹ Mr. Cloutier suggested that the federal government increase transfers to the provinces in due course, possibly following a First Ministers' conference on health that assesses the state of health-related costs in the provinces.²⁰⁰ Mr. Cloutier noted that:²⁰¹

[I]f we were to provide funding without knowing what goal we want to achieve or what changes we want to make in the system, we may end up in the same situation as in the past, when funds would be allocated to sectors with virtually no results.

Other federal investments that witnesses called for include:

- \$1.5 billion for medical imaging equipment and human resources.²⁰²

197 HESA, [Evidence](#), 16 February 2022, 1645 (Mr. Paul-Émile Cloutier, President and Chief Executive Officer, HealthCareCAN), HESA, [Evidence](#), 2 March 2022, 1630 (Mr. Michael Villeneuve, Chief Executive Officer, Canadian Nurses Association).

198 HESA, [Evidence](#), 16 February 2022, 1715 (Ms. Linda Silas, President, Canadian Federation of Nurses Unions) and 1725 (Mr. Paul-Émile Cloutier, President and Chief Executive Officer, HealthCareCAN), HESA, [Evidence](#), 2 March 2022, 1635 (Dr. Adam Kassam, President, Ontario Medical Association), HESA, [Evidence](#), 28 March 2022, 1700 (Dr. Martin Champagne, President, Association des médecins hématologues et oncologues du Québec), HESA, [Evidence](#), 4 April 2022, 1635 (Dr. Louis Perrault, President, Association des chirurgiens cardiovasculaires et thoraciques du Québec), HESA, [Evidence](#), 25 April 2022, 1600 (Dr. Anne-Louise Boucher, Director, Planning and Regionalization, Fédération des médecins omnipraticiens du Québec).

199 HESA, [Evidence](#), 4 April 2022, 1635 (Dr. Louis Perrault, President, Association des chirurgiens cardiovasculaires et thoraciques du Québec).

200 HESA, [Evidence](#), 16 February 2022, 1725 (Mr. Paul-Émile Cloutier, President and Chief Executive Officer, HealthCareCAN).

201 Ibid., 1700 (Mr. Paul-Émile Cloutier, President and Chief Executive Officer, HealthCareCAN).

202 Ibid., 1635 (Dr. Gilles Soulez, President, Canadian Association of Radiologists) and HESA, [Brief](#), Canadian Association of Radiologists.

- \$300 million over three years to the provinces and territories for debt relief and incentives supporting retention within health care professions for those in areas of urgent need.²⁰³
- \$300 million over three years through a federal fund that the provinces and territories can access to improve the well-being of health care workers through access to administrative and mental health supports in primary and secondary care settings.²⁰⁴
- Deliver on the \$3.2 billion federal commitment to the provinces and territories for the hiring of new family doctors, nurses, and nurse practitioners. As part of this commitment, dedicate \$1.2 billion over four years to a primary care access fund and \$2 million to undertake an assessment of interprofessional training capacity of family physicians and other professionals in the area of primary health care.²⁰⁵
- \$400 million over four years to the provinces and territories to invest in the primary care setting, expanding on the government's existing work through the FPT Virtual Care/Digital Table.²⁰⁶
- Leverage the \$3.2 billion commitment to the provinces and territories to increase the supply of family doctors, nurses, and nurse practitioners, which will also require investment in training and education infrastructure (e.g., faculty capacity, reimbursing teachers, training sites, etc.).²⁰⁷
- Leverage the \$3.2 billion federal commitment to the provinces and territories to increase the supply of family doctors, nurses, and nurse practitioners by supporting expedited pathways to licensure and practice

203 HESA, [Brief](#), Canadian Medical Association, Canadian Nurses Association and the College of Family Physicians of Canada.

204 Ibid.

205 HESA, [Evidence](#), 16 February 2022, 1630, (Dr. Katharine Smart, President, Canadian Medical Association) and HESA, [Brief](#), Canadian Medical Association, Canadian Nurses Association and the College of Family Physicians of Canada.

206 HESA, [Brief](#), Canadian Medical Association, Canadian Nurses Association and the College of Family Physicians of Canada.

207 Ibid.



for international medical graduates and internationally educated nurses wishing to pursue careers in Canada.²⁰⁸

- Through the election commitment of \$4.5 billion over five years in targeted mental health funding, support the establishment of a long-term Pan-Canadian Mental Health Strategy for Health care Workers. This strategy could be modelled on the federal government’s 2019 Action Plan to support the mental wellness of Canada’s public safety personnel.²⁰⁹
- \$50 million over four years to first enhance health workforce data standardization and collection processes across the provinces and territories. Subsequently, support the establishment of a Centre of Excellence via an existing agency (such as CIHI) to centrally house the data and support jurisdictional planning efforts.²¹⁰

CONCLUSION

The Committee thanks all of those who appeared before it and those who participated in writing for their contributions.

208 *Ibid.*

209 *Ibid.*

210 *Ibid.*

APPENDIX A LIST OF WITNESSES

The following table lists the witnesses who appeared before the committee at its meetings related to this report. Transcripts of all public meetings related to this report are available on the committee’s [webpage for this study](#).

Organizations and Individuals	Date	Meeting
As an individual	2022/02/16	8
Bacchus Barua, Director Health Policy Studies, Fraser Institute		
Canadian Association of Radiologists	2022/02/16	8
Gilles Soulez, President		
Canadian Federation of Nurses Unions	2022/02/16	8
Linda Silas, President		
Canadian Medical Association	2022/02/16	8
Katharine Smart, President		
HealthCareCAN	2022/02/16	8
Paul-Émile Cloutier, President and Chief Executive Officer Elaine Watson, Chief Human Resources Officer, Covenant Health		
British Columbia Pharmacy Association	2022/03/02	10
Geraldine Vance, Chief Executive Officer		
Canadian Nurses Association	2022/03/02	10
Gail Tomblin Murphy, PhD, Vice-President, Research, Innovation & Discovery and Chief Nurse Executive, Nova Scotia Health Michael Villeneuve, Chief Executive Officer		
Kingston Health Sciences Centre	2022/03/02	10
Dr. David Pichora, President and Chief Executive Officer		

Organizations and Individuals	Date	Meeting
Ontario Medical Association Dr. Adam Kassam, President Dr. James Wright, Chief, Economics, Policy & Research	2022/03/02	10
As an individual Sylas Coletto, Registered Nurse Brenda Payne, Experienced Nurse, Educator, Senior Executive and Consultant (Rural and Urban)	2022/03/28	13
Association des médecins hématologues et oncologues du Québec Dr. Martin A. Champagne, President and Hemato- Oncologist	2022/03/28	13
Canadian Association of Occupational Therapists Giovanna Boniface, President and Registered Occupational Therapist Hélène Sabourin, Chief Executive Officer	2022/03/28	13
Canadian Association of Schools of Nursing Cynthia Baker, Executive Director	2022/03/28	13
Corpus Sanchez International Consultancy Inc. Bradley Campbell, President	2022/03/28	13
As an individual Dr. Hugh Maguire, Head of Psychiatry, Nova Scotia Northern Zone, Assistant Professor, Dalhousie University	2022/04/04	15
Association des chirurgiens cardiovasculaires et thoraciques du Québec Dr. Louis P. Perrault, President and Cardiac Surgeon	2022/04/04	15
Canadian Pharmacists Association Dr. Danielle Paes, Chief Pharmacist Officer	2022/04/04	15
College of Family Physicians of Canada Dr. Brady Bouchard, President Dr. Francine Lemire, Executive Director and Chief Executive Officer	2022/04/04	15

Organizations and Individuals	Date	Meeting
Royal College of Physicians and Surgeons of Canada Dr. Guylaine Lefebvre, Executive Director Membership Engagement and Programs	2022/04/04	15
Speech-Language and Audiology Canada Susan Rvachew, Full Professor Dawn Wilson, Chief Executive Officer	2022/04/04	15
As an individual Dr. David Gratzner, Physician and Attending Psychiatrist Dr. Arjun Sahgal, Professor of Radiation Oncology	2022/04/25	17
Canadian Federation of Medical Students Montana Hackett, Director of Government Affairs Santanna Hernandez, President	2022/04/25	17
Fédération des médecins omnipraticiens du Québec Dr. Anne-Louise Boucher, Director Planning and Regionalization	2022/04/25	17
Health Intelligence Inc. Dr. David Peachey, Principal	2022/04/25	17
Sheridan College Janet Morrison, President and Vice Chancellor	2022/04/25	17
Association of Faculties of Medicine of Canada Dr. Geneviève Moineau, President and Chief Executive Officer	2022/04/27	18
Canadian Health Workforce Network Ivy Lynn Bourgeault, Director	2022/04/27	18
Federation of Medical Regulatory Authorities of Canada Fleur-Ange Lefebvre, Executive Director and Chief Executive Officer	2022/04/27	18
Pallium Canada Jeffrey Moat, Chief Executive Officer Dr. José Pereira, Scientific Officer	2022/04/27	18
Canadian Medical Association Dr. Katharine Smart, President	2022/05/09	20

Organizations and Individuals	Date	Meeting
Canadian Nurses Association Tim Guest, Chief Executive Officer	2022/05/09	20
College of Family Physicians of Canada Dr. Brady Bouchard, President Dr. Francine Lemire, Executive Director and Chief Executive Officer	2022/05/09	20

APPENDIX B LIST OF BRIEFS

The following is an alphabetical list of organizations and individuals who submitted briefs to the committee related to this report. For more information, please consult the committee's [webpage for this study](#).

Canada Fetal Alcohol Spectrum Disorder Research Network

Canadian Association of Medical Radiation Technologists

Canadian Association of Occupational Therapists

Canadian Association of Radiologists

Canadian Association of Social Workers

Canadian Centre on Substance Use and Addiction

Canadian Chiropractic Association

Canadian Dental Assistants Association

Canadian Dental Association

Canadian Dental Hygienists Association

Canadian Federation of Nurses Unions

Canadian Health Workforce Network

Canadian Medical Association

Canadian Nurses Association

Canadian Ophthalmological Society

Canadian Physiotherapy Association

College of Family Physicians of Canada

Fédération des médecins omnipraticiens du Québec

Litt, Nathan

Mcgrath, Teri

Medical Laboratory Professionals' Association of Ontario

Messier, Cheryl

Neurological Health Charities Canada

Spectrum Health Care

REQUEST FOR GOVERNMENT RESPONSE

Pursuant to Standing Order 109, the committee requests that the government table a comprehensive response to this Report.

A copy of the relevant *Minutes of Proceedings* ([Meetings Nos. 8, 10, 13, 15, 17, 18, 20, 21, 33, 34, 39, 40, 43, 44, 45, 47, 50 and 51](#)) is tabled.

Respectfully submitted,

Sean Casey
Chair

Additional opinion of the Bloc Québécois

The Bloc Québécois would like to emphasize the importance it places on the issue of Canada's health workforce. The Covid-19 pandemic has highlighted the difficult conditions experienced by these workers and it was only fitting that the committee study this issue in order to examine how the federal government can contribute, within the limits of its jurisdiction under the Constitution Act of 1867, to address the shortage of personnel in our healthcare systems.

The Bloc Québécois would also like to thank all the colleagues, witnesses, and support staff who gave their time to this study. Without the dedication and commitment of all these parties, the completion of this study would not have been possible.

Respect for Jurisdiction

First of all, the Bloc Québécois would like to remind that the federal government must act in a manner that respects the jurisdictions of Quebec and the provinces. The Constitution Act of 1867 confers on the provinces the management of hospitals. As a result, healthcare personnel in these institutions are also under provincial jurisdiction. Additionally, professional orders are also under provincial jurisdiction. Considering these facts, we take issue with the recommendations in this report that give the federal government a role in the management of day-to-day operations of hospitals, in the training of the workforce, or in the remuneration formulas for the healthcare workforce. Consequently, because they are *ultra vires*, the Bloc Québécois does not support recommendations 2, 5, 6, 7, 8, 10, 11, 12, 13, 16, 17, 18, 19, and 20.

Asymmetrical federalism

On September 15, 2004, in the wake of the Canada Health Transfer agreements, the federal government acknowledged, alongside with Quebec government, in a press release that:

" Recognizing the Government of Quebec's desire to exercise its own responsibilities with respect to planning, organizing and managing health services within its territory, and noting that its commitment with regard to the underlying principles of its public health system - universality, portability, comprehensiveness, accessibility and public administration - coincides with that of all governments in Canada, and resting on asymmetrical federalism, that is, flexible federalism that notably allows for the existence of specific agreements and arrangements adapted to Quebec's specificity"

The Bloc Québécois believes that any action taken by the federal government regarding healthcare must respect the principles of the asymmetrical federalism. Thus, the federal government must recognize that Quebec is making its own reforms and choices regarding its healthcare system and support its initiatives through the Canada Health Transfer.

Fiscal imbalance

Finally, the Bloc Québécois would like to point out that the root cause of our healthcare system's difficulties is linked to the fiscal imbalance that exists within the Canadian federation. The federal government's disengagement from healthcare funding does not allow Quebec and the provinces to offer the working conditions that all healthcare workers deserve. The Bloc reiterates that the federal government must increase federal transfers for healthcare and the Canada Social Transfer, as well to

transfer tax points to the provinces so that they can carry out all of their social service missions in a predictable and sustainable manner.

SUPPLEMENTARY REPORT OF THE NEW DEMOCRATIC PARTY OF CANADA

Addressing Canada's Health Workforce Crisis

On February 9, 2022, the House of Commons Standing Committee on Health (HESA) adopted a motion to undertake a study on Canada's health workforce crisis. This examination occurred in the unique context of a global pandemic that put unprecedented strain on Canada's health care system and all those who devote their skills, talents and dedication to making it work.

Canada's New Democrats thank all those who participated in this study. In addition, we wish to express our profound gratitude to health care workers across our country who sacrifice so much to take care of us when we need it most.

We think it is important to note that while the COVID-19 crisis exposed many weaknesses in our health care system, in many cases it did not cause them. Without doubt, the COVID-19 pandemic created grueling conditions that are leading health care workers to burn out and leave the profession at unprecedented rates. However, most of the issues that have contributed to the health care human resources crisis have been decades in the making.

One conclusion is strong and clear: if we don't act now, we risk suffering a system-wide failure of our health care system.

The New Democratic Party of Canada endorses the Committee's report and the twenty recommendations contained therein. However, we believe that it can be strengthened. We therefore offer the following supplementary information and recommendations to address Canada's health workforce crisis.

A. Federal responsibility for health care

New Democrats believe it is vitally important to ensure that all levels of government play their part in ensuring high-quality health care is delivered in Canada. In our view, we will not successfully address any of the critical issues facing our health care system, including the human resources crisis, unless both federal and provincial/territorial governments are fully engaged.

It must be recognized that the Canadian Constitution does not expressly grant health care as an exclusive power either to the federal Parliament or provincial/territorial legislatures. Indeed, the Supreme Court of Canada has been clear that "health is not a matter which is subject to specific constitutional assignment but instead is an amorphous topic which can be addressed by valid federal or provincial legislation."¹

¹ *Schneider v. The Queen*, 1982 CanLII 26 (SCC), [1982] 2 SCR 112.

Although the provinces are responsible for the direct delivery of most medical services, establishment of hospitals and the regulation of professions, the federal government uses its spending power, grounded in sections 91 and 106 of the Constitution, to set conditions and criteria for federal health transfers. It also exercises jurisdiction through the criminal law power (used, for example, to regulate prescription medicines) and residually through the Peace, Order and Good Government authority.

Legislatively, the federal role is most commonly expressed via the *Canada Health Act* and the *Federal-Provincial Fiscal Arrangements Act*. It is important to note that federal spending power is wider than the field of federal legislative competence and Parliament is empowered in appropriate circumstances (like emergencies) to disburse federal funds for use in areas within provincial jurisdiction.

This means that both senior levels of government in Canada – federal and provincial/territorial – have critical roles to play in ensuring high-quality, timely and equitable health care is available to all Canadians.

B. Federal health care spending

Although the COVID-19 pandemic has undeniably placed enormous strain on our health care system, the roots of Canada's health workforce crisis can be traced back to decades of poor policy choices at all levels of government and the steady erosion of financial contributions by successive federal administrations.

When Canada's public health care system was first established, it was based on a 50/50 cost sharing partnership between the federal government and the provinces. However, over the years the federal contribution has declined to just 22 percent. While the federal government occasionally disputes this latter figure, it never denies that its share has fallen substantially below 50 percent.

This has profoundly shifted the fiscal burden for health care delivery and exacerbates pressures caused by an aging population, technological advancement, and increasingly expensive treatments and pharmaceutical drugs.

The results of this are clear to see on the frontlines of care.

Where Canada used to have 6.9 hospital beds per 1,000 people, we now have just 2.5. Millions of Canadians are unable to access a family doctor, the primary portal into our health care system. And Canada now ranks near the very bottom of the OECD in the number of physicians *per capita* and wait times for essential care.

C. Public health care delivery

Alarming, the federal government's eroding share of overall health care spending has led to an increase of private, for-profit delivery across the country, or calls for same. This has led to violations of the accessibility criterion of the *Canada Health Act*, with patients increasingly being inappropriately charged to access medically necessary health services at private clinics.

In addition, certain provinces are allowing faster access to essential diagnostic services, like MRIs, to those who can pay for same. This leads to inequity and preferential access to care based on wealth as those diagnostic results often translate into quicker surgery access for those patients, thus facilitating a form of "queue-jumping."

Private clinics across Canada are also exploiting a loophole in the *Canada Health Act* to offer two-tier access to non-emergency surgeries.

This loophole stems from the Act's definition of an insured service: a medically necessary non-emergency surgery is only an insured service when an individual is in their province or territory of residence. However, if they visit another province or territory, non-emergency surgery is not insured and thus not subject to the Act's conditions and criteria. This has led to private, for-profit clinics charging tens of thousands of dollars to Canadian patients desperate for care.

Some provincial governments have recently announced plans to expand private, for-profit delivery to address hospital overcrowding and unacceptably long waitlists for surgeries, diagnostics and other procedures. However, decades of evidence indicates that this approach will simply exacerbate the current crisis.

Most germane to the present study, we are deeply concerned that for-profit providers will divert health care workers from the public system and deepen the health care worker shortage that is already putting severe strain on the public health care workforce. This will increase the serious, widespread burnout that was reported by every health profession who testified before HESA and worsen the recruitment and retention issue in our public system. Private, for-profit care also leads to extended wait times for patients in the public system, once again already unacceptably long.

Economically, for-profit delivery has also been shown repeatedly to be inefficient, drive up costs, deliver worse outcomes, and make governments vulnerable to corporate ransom as resources are shifted from the public to private sectors. If it is expanded, we are concerned that the extra costs of private care will put added pressure on, and reduce resources in, the public system, in turn exacerbating the problems that lie at the core of the present workforce crisis.

It is simply a matter of the strongest evidence that public health care is more efficient, equitable and cost-effective than private, for-profit delivery. The solution to Canada's health workforce crisis therefore lies in strengthening public care, rather than weakening it through privatization.

D. Support staff and allied health professionals

Canada's New Democrats acknowledge that the Committee did not receive testimony from health care support staff as part of this study, as well as from many allied health care professions. This represents a deficiency with the Committee's report. However, we want to use this opportunity to highlight the immense value of their contributions to our health care system and emphasize the urgent need to address the challenges faced across Canada's entire health workforce. Without the skills, talents, and contributions of all those whose physical labour and health care knowledge make our public health care system possible, Canadians would not enjoy the generally high level of care we are privileged to receive.

E. List of supplementary recommendations

The New Democratic Party of Canada recommends:

RECOMMENDATION 1

That the government of Canada increase its share of overall health care spending, with the goal of returning to a full 50/50 funding partnership with the provinces and territories.

RECOMMENDATION 2

That the government of Canada make any additional health transfers to the provinces and territories conditional on public funding being directed towards public health care delivery.

RECOMMENDATION 3

That the Government of Canada strengthen federal powers under the *Canada Health Act* and the *Federal-Provincial Fiscal Arrangements Act* to better protect the integrity of our public health care system. This includes closing all loopholes that make private payment for services possible and bringing diagnostic services fully under public coverage.

RECOMMENDATION 4

That the Government of Canada provide dedicated funding to recruit, train and retain health care support staff in order to create more time and capacity for direct patient care.