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CANADA

THE FEDERAL ROLE IN THE SCOPE OF PRACTICE OF CANADIAN HEALTHCARE PROFESSIONALS

Report of the Standing Committee on Health

**Ben Lobb
Chair**

MAY 2015

41st PARLIAMENT, SECOND SESSION

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THE STANDING COMMITTEE ON HEALTH

has the honour to present its

TWELFTH REPORT

Pursuant to its mandate under Standing Order 108(2), the Committee has studied Best Practices and Federal Barriers: Practice and Training of Healthcare Professionals and has agreed to report the following:

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THE FEDERAL ROLE IN THE SCOPE OF PRACTICE OF CANADIAN HEALTHCARE PROFESSIONALS

INTRODUCTION

In February 2014, the House of Commons Standing Committee on Health (Committee) agreed to

undertake a study of up to 10 meetings of best practices and federal barriers related to the scope of practice and skills training of healthcare professionals, provided that this study will focus on 3 areas: (a) the federal role in the scope of practice of Canadian healthcare professionals; (b) highlight best practices on the use of scope of practice, both in Canada and internationally; and (c) federal role and support for skills training and curriculum development.¹

Four meetings were held in March and April 2014 on this study.

On 24 February 2015, the Committee passed a motion to “have only two additional meetings with witnesses Tuesday, March 10, and Thursday, March 12, and that, tentatively, the Committee consider a draft report of its findings on Tuesday, April 21, 2015.”²

The Committee heard from a total of 39 witnesses representing 29 organizations, drawn from a wide range of health-related professions, and received 16 briefs. This report is based on the testimony of those witnesses and the content of those briefs.

DEFINING SCOPES OF PRACTICE

Witnesses, noting that there is no formal consensus as to the definition of “scope of practice,”³ provided their views of what “scope of practice” entails.⁴ Taken together, witnesses suggested that it was defined by a combination of legislation identifying the extent and limits of activities permitted for any given profession or occupation, preparation provided by educational programs and institutions, and certification by a regulatory body overseeing that profession.

1 House of Commons, Standing Committee on Health (HESA), [Minutes of Proceedings](#), 2nd Session, 41st Parliament, Meeting No. 15, 25 February 2014.

2 HESA, [Minutes of Proceedings](#), 2nd Session, 41st Parliament, Meeting No. 51, 24 February 2015.

3 HESA, [Evidence](#), Michele Brenning (Assistant Commissioner, Health Services, Correctional Service Canada), 4 March 2014, 0900; [Evidence](#), Danielle Fréchette (Executive Director, Health Systems Innovation and External Relations, Royal College of Physicians and Surgeons of Canada), 3 April 2014, 0920; [Evidence](#), Judy Morrow (Board Member, Canadian Association of Practical Nurse Educators), 8 April 2014, 1005 and Barbara Mildon (President, Canadian Nurses Association), 8 April 2014, 1020.

4 HESA, [Evidence](#), Debra Gillis (Acting Director General, Interprofessional Advisory and Program Support, First Nations and Inuit Health Branch, Department of Health), 4 March 2014, 0905; [Evidence](#), Barbara Mildon (President, Canadian Nurses Association), 8 April 2014, 0855; [Evidence](#), Ann Wright (Director, Dental Hygiene Practice, Canadian Dental Hygienists Association), 10 March 2015, 1530.

Other witnesses, including two government officials,⁵ pointed out that scope of practice is also determined, to some extent, by the employment situation in which a healthcare professional is working. Witnesses described how a scope of practice may be inconsistent with the “scope of employment,”⁶ that scopes of practice change in response to shortages of healthcare professionals and other factors,⁷ and the need for common skill sets for each profession across jurisdictions.⁸

These themes – the roles and responsibilities of educators, legislators, regulators, employers and practitioners – recur throughout sections of this report. The next major section of the report focusses on the federal role with respect to the scope of practice of healthcare professionals, followed by an overview of “best practices” identified in testimony and briefs, and a further section on less direct federal support for curriculum development and skills training in the health and allied professions.

THE FEDERAL ROLE IN THE SCOPE OF PRACTICE OF CANADIAN HEALTHCARE PROFESSIONALS

As noted in a brief to the Committee, “[s]copes of practice are determined largely by provincial and territorial governments, and each jurisdiction has developed its own regulations regarding what health professional groups may do and under what circumstances.”⁹ However, there are particular responsibilities that implicate the federal government more directly in the definition and administration of scopes of practice for healthcare and allied professionals.

While describing multiple players in the definition of scopes of practice at both the national and provincial levels,¹⁰ a Health Canada official told the Committee that provincial governments are responsible “for health professional legislation and regulation, payment mechanisms, education, and health human resources planning, all of which impact scopes of practice.”¹¹

She described the federal government role as “supportive,”¹² with roles in “research, health human resources programming, related regulatory responsibilities,

5 HESA, [Evidence](#), M. Brenning, (Correctional Service Canada), 4 March 2014, 0900 and Debra Gillis (Acting Director General, Interprofessional Advisory and Program Support, First Nations and Inuit Health Branch, Department of Health), 4 March 2014 0905.

6 HESA, [Evidence](#), J. Morrow (Canadian Association of Practical Nurse Educators), 8 April 2014, 1005.

7 HESA, [Evidence](#), D. Fréchette (Royal College of Physicians and Surgeons of Canada), 3 April 2014, 0920.

8 Ibid., 0925.

9 Canadian Medical Association, *Best Practices and Federal Barriers: Practice and Training of Healthcare Professionals – Submission to the House of Commons Standing Committee on Health*, 17 March 2015, p. 3.

10 HESA, [Evidence](#), D. Gillis (Department of Health), 4 March 2014, 0905.

11 Ibid.

12 Ibid., 0910.

and working within established scopes of practice for the delivery of care to federal populations.”¹³ In particular, the next sections of this report focus on health services to federal populations and some of the federal regulatory framework that has a direct impact on scopes of practice for health and allied professionals, including the federal/provincial/territorial *Agreement on Internal Trade*, the *Controlled Drug and Substances Act*, and extended health benefits for federal employees. Discussions of federal initiatives with respect to health human resources planning and coordination are described in a later section devoted to the federal role in health human resources planning and development.

A. HEALTHCARE SERVICES TO FEDERAL POPULATIONS

The federal government is directly responsible for healthcare services provided to particular populations, including: members of the Armed Forces, veterans of those Forces, people in federal corrections facilities, and First Nations and Inuit. As noted by one federal official, “[A]s a provider of services to federal populations ... the federal government has a direct role to play in championing novel approaches to healthcare delivery, including with respect to scopes of practice.”¹⁴

Occupation-specific recommendations with respect to services to federal populations called for the inclusion of “pharmacist-provided medication management services”¹⁵ and the inclusion of chiropractors in “team-based models that would enhance federal programs – better care at a lower cost.”¹⁶

More generally, a witness representing the Canadian Physiotherapy Association described the value of the Federal Healthcare Partnership¹⁷ in bringing interdepartmental coordination to such issues. The Committee recommends:

13 Ibid.

14 Ibid.

15 HESA, *Evidence*, Phil Emberley (Director, Pharmacy Innovation, Canadian Pharmacists Association), 10 April 2014, 0855.

16 Canadian Chiropractic Association, *MSK Health: A Priority for Canadians*, Written submission to HESA, distributed to Committee 13 April 2015.

17 The Federal Healthcare Partnership was defined by Health Canada in a [Health Human Resources Action Plan](#) in 2005 as “partnership of federal departments created to identify, promote and implement more efficient and effective healthcare programs through the collaborative effort of all member departments,” with the two goals “to increase the efficiency and effectiveness of all activities related to providing healthcare services that could otherwise not be achieved through the individual departments acting on their own; and to provide strategic leadership on federal or pan-Canadian issues of common interest.” Its members at the time were Health Canada, Veterans Affairs Canada, the Royal Canadian Mounted Police, Correctional Service Canada, Department of National Defence and Citizenship and Immigration Canada.

RECOMMENDATION 1

That the federal health care partnership engage with all interested stakeholders to ensure their full participation in ongoing efforts to facilitate strategic partnerships in support of better programs, interdisciplinary care and evidence-based policy.

1. Armed Forces and Veterans' Affairs

The Deputy Surgeon General of the Canadian Forces, Colonel Hugh MacKay, in his presentation to the Committee, indicated that the Surgeon General of the Canadian Forces “controls ... all clinical matters, including scopes of practice, distribution of occupations, health education and training, allocation of clinical resources, etc.”¹⁸ He identified a challenge in operating across provincial and territorial jurisdictions.¹⁹

Other witnesses identified mental health, particularly post-traumatic stress disorder, as a significant challenge for meeting the health needs of active members of the Canadian Forces.²⁰ While Colonel MacKay told the Committee that care is provided in these cases “as close to home as possible and as close to their family support system as possible,”²¹ another witness identified the need to extend services beyond the member of the Forces to his or her family and other supports.²²

Colonel MacKay told the Committee that the Canadian Forces “have both uniformed and civilian psychiatrists who work in our mental health clinics or who work in our operational trauma support centres.”²³ A witness representing the Canadian Psychological Association identified the value in including clinical psychologists in healthcare teams serving the Department of National Defence (DND).²⁴ The Committee recommends:

18 HESA, [Evidence](#), Colonel Hugh MacKay (Deputy Surgeon General, Canadian Forces, Department of National Defence), 4 March 2014, 0850.

19 Ibid.

20 HESA, [Evidence](#), Dr. Roger Bland (Member, Professor Emeritus, Department of Psychiatry, University of Alberta, Canadian Psychiatric Association), 10 April 2014, 0950 and Karen Cohen (Chief Executive Officer, Canadian Psychological Association), 10 April 2014, 1010.

21 HESA, [Evidence](#), Col. MacKay (Department of National Defence), 4 March 2014, 0935.

22 HESA, [Evidence](#), Dr. R. Bland (Canadian Psychiatric Association), 10 April 2014, 0950.

23 HESA, [Evidence](#), Col. MacKay (Department of National Defence), 4 March 2014, 0915.

24 HESA, [Evidence](#), K. Cohen (Canadian Psychological Association), 10 April 2014, 0950.

RECOMMENDATION 2

That the Department of National Defence consider reviewing the make-up of their intercollaborative mental healthcare teams, which include psychologists, psychiatrists, mental health workers, and social workers, to ensure that service delivery on the front lines and at home continue to meet the needs of our forces.

A witness representing the Canadian Chiropractic Association told the Committee that “our soldiers have less access to chiropractic care than other federal employees,” and that “[t]hese injured soldiers go on to become veterans.”²⁵ Another witness said that Veterans Affairs “prohibit[s] dental hygienists from practising to their full scope by permitting only the most basic level of dental hygiene services for veterans.”²⁶

2. Correctional Service of Canada

The Assistant Commissioner of Health Services at the Correctional Service of Canada (CSC) told the Committee that the agency “relies on approximately 1,250 health staff, as well as contractors, who work in interdisciplinary teams and include nurses, psychologists, social workers, occupational therapists, general practice physicians, psychiatrists, and pharmacists.”²⁷ Like DND, CSC operates across provincial jurisdictions, and faces “barriers to optimizing efficient delivery of healthcare.”²⁸ The witness from CSC told the Committee that the absence of easy interprovincial transfers for health “significantly limits the mobility of registered professional staff across Canada, thereby limiting matching staff availability to the geographic area of need.”²⁹ As this issue was raised by a wide range of witnesses and organizations submitting briefs, recommendations are included in the later section of the report entitled “Pan-Canadian Coordination of Professional Scopes of Practice.”

Other witnesses identified challenges within CSC, particularly with respect to the provision of mental health services. A witness representing the Canadian Psychological Association told the Committee that CSC is the largest employer of psychologists in Canada.³⁰ In addition, witnesses representing the Canadian Nurses Association³¹ and the Canadian Council of Registered Nurse Regulators³² both described the particular

25 HESA, [Evidence](#), Ward MacDonald (Member, Canadian Chiropractic Association), 10 March 2015, 1545.

26 HESA, [Evidence](#), Ann Wright (Director, Dental Hygiene Practice, Canadian Dental Hygienists Association), 10 March 2015, 1530.

27 HESA, [Evidence](#), M. Brenning (Correctional Service Canada), 4 March 2014, 0900.

28 Ibid.

29 Ibid.

30 HESA, [Evidence](#), K. Cohen (Canadian Psychological Association), 10 April 2014, 1025.

31 HESA, [Evidence](#), B. Mildon (Canadian Nurses Association), 8 April 2014, 1030.

32 HESA, [Evidence](#), Anne Coghlan (President, Canadian Council of Registered Nurse Regulators), 8 April 2014, 1025.

challenges facing nurses in prison settings in responding to the mental healthcare needs of patients. A representative of the Canadian Association of Occupational Therapists suggested that members of that profession could be helpful in meeting those mental health needs.³³

3. First Nations and Inuit

An official from Health Canada described the role of the federal government with respect to the provision of health services to First Nations and Inuit:

Working to improve the health outcomes of Aboriginal peoples is a shared undertaking among federal, provincial, territorial governments, and Aboriginal partners. Health Canada's role involves supplementing and supporting provincial and territorial health services to provide culturally appropriate health programs and services that work to improve the health status of first nations and Inuit communities. To fulfill this role, Health Canada funds or directly provides public health, health promotion and disease prevention, addiction and mental health, and home and community care on all first nation communities, and primary care services in 85 remote and isolated communities.³⁴

a. Rural and Remote Communities

While not all remote and isolated communities are Aboriginal communities, many are. A Health Canada official identified the specific challenges of providing health services in these communities, and how they often required the provision of primary care in the absence of physicians.³⁵

Similarly, a witness representing the Canadian Association of Midwives described situations in remote communities where “midwives work to an expanded scope and provide a broader range of services to meet the needs of the population.”³⁶ At the same time, the Association described the demonstrated need for services of midwives in Aboriginal communities, but identified a barrier to their being hired by First Nation communities, because they are not “listed as a recognized profession under the Health Occupational Group Structure within the Treasury Board of Canada.”³⁷ As proposed by the Association, the Committee recommends:

RECOMMENDATION 3

That Treasury Board review its Health Services Occupational Group to consider how midwives may be included.

33 HESA, [Evidence](#), Paulette Guitard (Professor and Former President, Canadian Association of Occupational Therapists), 10 March 2015, 1640.

34 HESA, [Evidence](#), D. Gillis (Department of Health), 4 March 2014, 0910.

35 Ibid.

36 HESA, [Evidence](#), Emmanuelle Hébert (President, Canadian Association of Midwives), 12 March 2015, 1555.

37 Ibid. More information on the Health Services Occupational Group as defined by Treasury Board is available on its [website](#).

Many of these challenges in meeting the needs of rural and remote communities, including First Nation and Inuit communities, relate to recruitment and retention of health and allied professionals in such communities.³⁸ A Health Canada official noted that there is “on average, around a 30% vacancy rate of nurses in remote and isolated communities,”³⁹ forcing the department to rely on contract agencies. A number of witnesses suggested that recruitment within these communities, particularly First Nation and Inuit communities, would contribute to the retention of healthcare professionals and could contribute to a more stable supply of healthcare professionals in those communities.⁴⁰

A witness from the Canadian Association of Schools of Nursing told the Committee that special efforts were being made to provide schools of nursing in remote areas, including the Northwest Territories and Nunavut, “to improve the recruitment and retention of Aboriginal nursing students.”⁴¹ Some suggestions for the recruitment of Aboriginal students and others from rural and remote communities related to specific occupations, including dietitians⁴² and mental health practitioners.⁴³

Representatives of the College of Family Physicians of Canada⁴⁴ and the Canadian Dental Hygienists Association⁴⁵ suggested that particular efforts must be made to ensure access to healthcare services in rural and remote communities. As a means to achieving such access, HealthCareCAN called on the federal government to “[e]nsure broadband access for rural and remote communities to expand the telehealth models which have proven to increase general accessibility.”⁴⁶

38 HESA, [Evidence](#), M. Brenning (Correctional Service Canada), 4 March 2014, 0900

39 HESA, [Evidence](#), D. Gillis, (Department of Health), 4 March 2014, 1010.

40 HESA, [Evidence](#), Bryce Durafourt (President, Canadian Federation of Medical Students), 12 March 2015, 1715; [Evidence](#), P. Guitard (Canadian Association of Occupational Therapists), 10 March 2015, 1635 and Kate O'Connor (Director, Policy and Research, Canadian Physiotherapy Association), 10 March 2015, 1650.

41 HESA, [Evidence](#), Cynthia Baker (Executive Director, Canadian Association of Schools of Nursing), 8 April 2014, 0910.

42 Dietitians of Canada, *Best practices and federal barriers: practice and training of dietitians: Submission to HESA*, distributed to the Committee 18 November 2014, p.2.

43 Canadian Counselling and Psychotherapy Association, *Brief to the House of Commons Standing Committee on Health: Best Practices and Federal Barriers: Practice and Training of Healthcare Professionals*. 20 March 2015, p. 5.

44 HESA, [Evidence](#), Dr. Francine Lemire (Executive Director and Chief Executive Officer, College of Family Physicians of Canada), 3 April 2014, 0855.

45 HESA, [Evidence](#), A. Wright (Canadian Dental Hygienists Association), 10 March 2015, 1535.

46 HealthCareCAN, written submission to the Committee, distributed 16 March 2015, p. 3.

b. Non-Insured Health Benefits Program

As described in an internal audit report by Health Canada:

To support First Nations people and Inuit in reaching an overall health status that is comparable with other Canadians, Health Canada's Non-Insured Health Benefits (NIHB) Program provides coverage for a specified range of drugs, dental care, vision care, medical supplies and equipment, short-term crisis intervention mental health counselling, and medical transportation for approximately 926,000 eligible First Nations people and recognized Inuit.⁴⁷

The Health Canada official described a recent review of scopes of practice within the NIHB program and their alignment with provincially mandated scopes of practice. As a result, changes

being implemented include the introduction of collaborative and interdisciplinary teams; the introduction of providers not currently included in primary teams, such as X-ray technicians and pharmacy technicians; the increased presence of nurse practitioners; and the increased use of e-health services.⁴⁸

The Committee also heard that specific professions are not able to operate within their full scopes of practice under the terms of the NIHB. These included dental hygienists,⁴⁹ occupational therapists,⁵⁰ physiotherapists⁵¹ and midwives.⁵² The Committee also heard that the Minister of Health had undertaken a review of the NIHB in 2014.⁵³

The Canadian Dental Hygienists Association “urged the federal government to move quickly to ensure that all NIHB program recipients have the same access to oral health services across the country,”⁵⁴ and the Canadian Physiotherapy Association called on the federal government “to actually look at how to maximize scopes of practice within federal programs, such as the NIHB program, and invest in interdisciplinary models of care that truly reflect these models.”⁵⁵

47 Health Canada, [Final Audit Report: Audit of the Non-Insured Health Benefits – Medical Supplies and Equipment, Vision Care and Mental Health](#), March 2014, i.

48 HESA, [Evidence](#), D. Gillis (Department of Health), 4 March 2014, 0915.

49 HESA, [Evidence](#), A. Wright (Canadian Dental Hygienists Association), 10 March 2015, 1535.

50 HESA, [Evidence](#), P. Guitard (Canadian Association of Occupational Therapists), 10 March 2015, 1635.

51 HESA, [Evidence](#), E. Hébert (Canadian Association of Midwives), 12 March 2015, 1555.

52 Ibid., 1600.

53 HESA, [Evidence](#), K. O'Connor (Canadian Physiotherapy Association), 10 March 2015, 1645.

54 HESA, [Evidence](#), A. Wright (Canadian Dental Hygienists Association), 10 March 2015, 1535.

55 HESA, [Evidence](#), K. O'Connor (Canadian Physiotherapy Association), 10 March 2015, 1650.

The Committee recommends:

RECOMMENDATION 4

That Health Canada review the roles of dental hygienists, occupational therapists, physiotherapists and midwives within the Non-Insured Health Benefits program to improve its ability to provide needed health services in rural and remote communities as part of a healthcare team.

B. AGREEMENT ON INTERNAL TRADE

According to a federal government document in 2014,

Signed in 1994, the Agreement on Internal Trade (AIT) governs the movement of people, goods, services and investments within Canada. It is a political accord that creates a framework for the reduction of barriers to trade within specific economic sectors. Its creation followed the signing of the North American Free Trade Agreement (NAFTA) and was supported broadly by Canada's business community.⁵⁶

The seventh chapter of the Agreement is entitled "Labour Mobility," whose stated purpose is

to eliminate or reduce measures adopted or maintained by the Parties that restrict or impair labour mobility in Canada and, in particular, to enable any worker certified for an occupation by a regulatory authority of one Party to be recognized as qualified for that occupation by all other Parties.⁵⁷

The chapter of the Agreement "applies to measures adopted or maintained by a Party relating to.... [c]ertification requirements, other than residency requirements, for workers in order to practice an occupation or use a particular occupational title, and occupational standards."⁵⁸ Exceptions allowing parties to require additional education or training can be sought when:

- a) there is a material difference between the scope of practice of the occupation for which the worker is seeking to be certified in its territory and the scope of practice of the occupation for which the worker has been certified by the regulatory authority of another Party; and
- b) as a result of that difference, the worker lacks a critical skill, area of knowledge or ability required to perform the scope of practice of the occupation for which the worker seeks to be certified.⁵⁹

56 Industry Canada, [One Canada, One National Economy: Modernizing Internal Trade in Canada](#), 2014, p. 1.

57 [Agreement on Internal Trade: Consolidated Version](#), Article 701, 2015, p. 85.

58 Ibid.

59 Ibid., p. 89.

Health Canada, in a submission that followed up on testimony by its officials before the Committee, reported:

With the recent implementation of the Agreement on Internal Trade (AIT), Chapter 7 on Labour Mobility, there will be increased consistency in scopes of practice across jurisdictions to allow for the freer movement of workers.... It is expected that this will result in greater efficiency and productivity, as provinces and territories will recognize each other's qualified workers without requiring reassessment, retraining or retesting, unless this requirement is based on a legitimate objective such as health, safety or consumer protection grounds.⁶⁰

Witnesses involved in the regulation of doctors,⁶¹ nurses⁶² and dentists⁶³ described progress in meeting the terms of the AIT. However, of the 14 "approved exceptions by occupation," 9 are health or related occupations, including paramedics, psychologists, midwives and dental hygienists.⁶⁴

For example, a witness from the Canadian Psychological Association told the Committee that mobility for psychologists under the AIT is based on the "least rigorous" of standards that vary across the country, and not on the "very robust standards for training in psychology established and maintained by the Canadian and American Psychological Associations ...that define training in psychology across North America."⁶⁵ The Committee recommends:

RECOMMENDATION 5

That the federal government work with the provinces and territories to review the provisions of the Agreement on Internal Trade to ensure the harmonization of certification requirements for psychologists while maintaining requirements to ensure these professionals have training required for their work.

HealthCareCAN called for a federal coordinating role to improve the impact of the AIT, suggesting that Health Canada could work with them and others "... to further harmonize legislation and regulations across the country," adding that "[t]his would also support the Agreement on Internal Trade (AIT) which was intended to break down

60 Health Canada, "HESA Study on Best Practices and Federal Barriers: Practice and Training of Healthcare Professionals: Health Canada's Follow-up Response to March 4, 2014 appearance," p. 4.

61 HESA, [Evidence](#), Dr. Fleur-Ange Lefebvre (Executive Director and Chief Executive Officer, Federation of Medical Regulatory Authorities of Canada), 3 April 2014, 0910.

62 HESA, [Evidence](#), A. Coghlan (Canadian Council of Registered Nurse Regulators), 8 April 2014, 0955.

63 HESA, [Evidence](#), Benoit Soucy (Director, Clinical and Scientific Affairs, Canadian Dental Association), 10 March 2015, 1540.

64 Forum of Labour Market Ministers, Labour Mobility Coordinating Group, [Approved Exceptions by Occupation](#).

65 HESA, [Evidence](#), K. Cohen (Chief Executive Officer, Canadian Psychological Association), 10 April 2014, 0950.

interprovincial barriers enabling the free flow of health and other workers, increasing overall efficiency in labour markets.”⁶⁶

Representatives of some of the “approved exception” occupational groups described greater challenges in achieving mobility. Several of these challenges are related to differing scopes of practice, and are addressed in a later section of the report entitled “Pan-Canadian Coordination of Professional Scopes of Practice.”

C. CONTROLLED DRUG AND SUBSTANCES ACT AND REGULATIONS

The Committee heard from a Health Canada official that the federal government’s *Controlled Drug and Substances Act* (the Act) “supports health professions to practice to their full scopes as set out in provincial or territorial legislation,”⁶⁷ referring specifically to 2012 regulatory changes under the Act as examples of that support.⁶⁸

The *New Classes of Practitioners Regulations*⁶⁹ of the Act allow midwives, nurse practitioners and podiatrists to prescribe certain controlled substances if these practitioners are already authorized to do so by the province in which they practice.

The regulations were deemed to be necessary because, while a number of provinces had recognized an expanded scope of practice for these groups in legislation which included prescribing certain controlled substances, the Act authorized only persons registered to practice medicine, veterinarians and dentists to conduct activities with controlled substances.⁷⁰ Midwives, nurse practitioners and podiatrists were therefore unable to prescribe narcotics until authorized by the Act to do so.

In testimony before the Committee, a witness from the Canadian Pharmacists Association noted that this authority was not extended to pharmacists, and suggested that pharmacists should have similar authority under these regulations.⁷¹

While praising the work of Health Canada in achieving these changes to the legislation, one witness pointed out

[T]hat work stops short of brokering a collaboration across the country whereby those changes could be more immediately implemented into practice. What is happening as we speak is that approximately half the country has now reached the ability, under provincial or territorial legislation, to enact those provisions. The other half of the country is still

66 HealthCareCAN, written submission to the Committee, distributed 16 March 2015, p. 3.

67 HESA, [Evidence](#), D.Gillis (Department of Health), 4 March 2014, 0905.

68 Ibid.

69 SOR/2012-230

70 *Canada Gazette* Part I, Vol. 146, *New Classes of Practitioners Regulations*, “[Regulatory Impact Analysis Statement](#)”, (Archived), 5 May 2012

71 HESA, [Evidence](#), Janet Cooper (Senior Director, Professional and Membership Affairs, Canadian Pharmacists Association), 10 April 2014, 0920.

working to do that ... If there were such a table as a federal-provincial-territorial table that looked at harmonizing those at the point of brokering them, we believe there would be more immediate uptake.⁷²

The Canadian Medical Association, in its brief to the Committee, identified other examples of expansions of scopes of practice in various professions that remain uneven across the country.⁷³ In support of the solution suggested by this Association, the Committee recommends:

RECOMMENDATION 6

That the federal government work with provincial/territorial governments and with health professional associations to promote a consistent pan-Canadian approach to scope-of-practice expansions.

A further discussion of how the federal government could encourage more consistency in scopes of practice across provinces and territories is included in the section entitled “Pan-Canadian coordination of professional scopes of practice”.

Another witness pointed out that the legislation does not have a “monitoring and surveillance side,” and recommended that “a national monitoring vehicle” be added to the Act to address the interprovincial mobility of professionals.⁷⁴

D. EXTENDED HEALTH BENEFITS FOR FEDERAL EMPLOYEES

Witnesses identified other administrative obstacles in federal programs that may limit the ability of health and allied professionals to provide optimal service to eligible patients. A witness representing occupational therapists suggested that the Public Service Health Care Plan⁷⁵ be expanded to include that profession in the plan.⁷⁶ A similar recommendation was made with respect to dietitians.⁷⁷

Other witnesses pointed to more general obstacles in the plan and other federally (and privately) administered health programs:

72 HESA, [Evidence](#), B. Mildon (Canadian Nurses Association), 8 April 2014, 0945.

73 Canadian Medical Association, *Best Practices and Federal Barriers: Practice and Training of Healthcare Professionals – Submission to the House of Commons Standing Committee on Health*, 17 March 2015, p. 4.

74 HESA, [Evidence](#), P. Emberley (Canadian Pharmacists Association), 10 April 2014, 0935.

75 The [Public Service Health Care Plan](#) is the responsibility of the [National Joint Council](#), consisting of representatives of federal employers and bargaining agents for employees. The Plan is jointly managed by bargaining agents on the National Joint Council, Treasury Board of Canada, and the Federal Superannuates National Association.

76 HESA, [Evidence](#), P. Guitard (Canadian Association of Occupational Therapists), 10 March 2015, 1640.

77 Dietitians of Canada, *Best practices and federal barriers: practice and training of dietitians: Submission to the House of Commons Standing Committee on Health*, distributed to the Committee 18 November 2014, p. 8.

There are a lot of things within the [extended health benefits for public servants] program that actually don't make sense because they are delaying the access to treatment and access to professionals...⁷⁸

In particular, several witnesses suggested that the requirement for a doctor's referral to an allied health professional imposed a restriction on the scope of practice that is not otherwise imposed by regulation or legislation.⁷⁹ A witness representing physiotherapists cited a study that found "that insurance companies use that doctor's note, the referral or the prescription for physiotherapy, occupational therapy, and other services as a cost containment measure," but added "they are delaying the access to treatment and access to professionals."⁸⁰ The Committee recommends:

RECOMMENDATION 7

That the federal government review the requirement for physician referrals to health services under the Public Service Health Care Plan, in order to assure that access to care remains appropriate.

Similarly, a representative of the Canadian Nurses Association questioned whether physicians should be required to sign forms required for access to federally administered programs including the disability tax credit certificate, [Canada Pension Plan] CPP disability benefits, employment insurance benefits, and benefits under the *Public Service Superannuation Act*.⁸¹ The Committee recommends:

RECOMMENDATION 8

That the federal government review the ability of nurse practitioners to be included as signatories in federal tax and benefit programs, with a view to facilitating access for Canadians to timely benefits that affect their health.

BEST PRACTICES ON THE USE OF SCOPE OF PRACTICE

A. INTERPROFESSIONAL TEAMS

The Association of Faculties of Medicine of Canada described a project which "set out to conduct a thorough review of medical doctor (MD) education in Canada, assess current and future societal needs, and identify the changes needed to better align the two."⁸² One of the resulting recommendations called for advancement of "inter- and intra-

78 HESA, [Evidence](#), K. O'Connor (Canadian Physiotherapy Association), 10 March 2015, 1710.

79 HESA, [Evidence](#), K. Cohen (Canadian Psychological Association), 10 April 2014, 1015; [Evidence](#), P. Guitard (Canadian Association of Occupational Therapists), 10 March 2015, 1710 and K. O'Connor (Canadian Physiotherapy Association), 10 March 2015, 1710.

80 HESA, [Evidence](#), K. O'Connor (Canadian Physiotherapy Association), 10 March 2015, 1710.

81 HESA, [Evidence](#), B. Mildon (Canadian Nurses Association), 8 April 2014, 0905.

82 Association of Faculties of Medicine of Canada, *Presentation to HESA*, 3 April 2014, p. 3.

professional practice.”⁸³ Many witnesses spoke positively about such practices, also called “team” practices, citing their capacity to better meet the needs of patients,⁸⁴ and identifying initiatives to provide training and competency in this approach.⁸⁵

Other witnesses described challenges in identifying and regulating scopes of practice in multidisciplinary teams. For example, a representative of the Royal College of Physicians and Surgeons of Canada told the Committee of ongoing efforts to establish a framework for interprofessional regulation.⁸⁶ Other testimony highlighted the challenge of team-based approaches when health practitioners are each compensated per service provided to an individual patient,⁸⁷ and some health and allied professions are not covered by provincial health plans and rely on patient payment.⁸⁸ Another witness noted the impact the model may have on human resources requirements in the health sector,⁸⁹ addressed in greater detail in a later section entitled “Health Human Resources Planning.”

Testimony and briefs supported a federal role in supporting such practices,⁹⁰ including through funding research and evaluation of this approach.⁹¹ The Committee therefore recommends:

83 Ibid., p. 4.

84 HESA, [Evidence](#), Robert David (Chair, Canadian Chiropractic Association), 10 March 2015, 1550 and K. O'Connor (Canadian Physiotherapy Association, 10 March 2015, 1655; [Evidence](#), Dr. R. Bland (Canadian Psychiatric Association), 10 April 2014, 0955; [Evidence](#), E. Hébert (Canadian Association of Midwives), 12 March 2015, 1555.

85 HESA, [Evidence](#), J. Morrow (Canadian Association of Practical Nurse Educators), 8 April 2014, 0845; [Evidence](#), J. Cooper (Canadian Pharmacists Association), 10 April 2014, 0850, Harold Lopatka (Executive Director, Association of Faculties of Pharmacy of Canada), 10 April 2014, 0900 and Dr. R. Bland (Canadian Psychiatric Association), 10 April 2014, 0955.

86 HESA, [Evidence](#), Dr. F-A. Lefebvre (Federation of Medical Regulatory Authorities of Canada), 3 April 2014, 1035.

87 HESA, [Evidence](#), Dr. R. Bland (Canadian Psychiatric Association), 10 April 2014, 0955; HESA, [Evidence](#), Dr. F. Lemire (College of Family Physicians of Canada), 3 April 2014, 0935 and Dr. Geneviève Moineau (President and Chief Executive Officer, Association of Faculties of Medicine of Canada), 3 April 2014, 0945; [Evidence](#), Sabrina Wong (Interim Director, UBC Centre for Health Services and Policy Research), 12 March 2015, 1645.

88 Canadian Medical Association, *Best Practices and Federal Barriers: Practice and Training of Healthcare Professionals – Submission to the House of Commons Standing Committee on Health*, 17 March 2015, p. 5.

89 HESA, [Evidence](#), D. Fréchette (Royal College of Physicians and Surgeons of Canada), 3 April 2014, 0925.

90 HESA, [Evidence](#), Dr. F. Lemire (College of Family Physicians of Canada), 3 April 2014, 0855; [Evidence](#), P. Emberley (Canadian Pharmacists Association), 10 April 2014, 0855.

91 HESA, [Evidence](#), S. Wong (UBC Centre for Health Services and Policy Research), 12 March 2015, 1645.

RECOMMENDATION 9

That the federal government, through Health Canada, work with provincial and territorial governments to support the development, implementation and evaluation of interprofessional team approaches to the provision of primary healthcare and that it support research in this direction.

B. PAN-CANADIAN COORDINATION OF PROFESSIONAL SCOPES OF PRACTICE

The Committee heard from most witnesses that differing scopes of practice across provinces and territories relate to curriculum differences, accreditation requirements and regulatory requirements, particularly with respect to the range of competencies required by each profession. As noted above, the interprofessional team approach being introduced in many healthcare settings makes the role of each team member subject to change.

Witnesses and submissions described the variations in scopes of practice across Canada.⁹² The national associations of educators, practitioners and regulators both acknowledged the primary role of provincial and territorial governments in establishing scopes of practice and called for continuing federal support of efforts in the development and harmonization of scopes of practice across Canada.⁹³

In addition, witnesses representing federal organizations responsible for healthcare services also identified the value in greater “standardization” of scopes of practice.⁹⁴

In support of suggestions by witnesses, the Committee therefore recommends:

92 HESA, [Evidence](#), Col. MacKay (Department of National Defence), 4 March 2014, 0955; [Evidence](#), A. Wright (Canadian Dental Hygienists Association), 10 March 2015, 1530, Canadian Association of Medical Radiation Technologists, *Brief to the House of Commons Standing Committee on Health*, distributed to the Committee 8 October 2014. and Canadian Medical Association, *Best Practices and Federal Barriers: Practice and Training of Healthcare Professionals – Submission to the House of Commons Standing Committee on Health*, 17 March 2015, p. 3.

93 HESA, [Evidence](#), Dr. G. Moineau (Association of Faculties of Medicine of Canada), 3 April 2014, 0850; [Evidence](#), C. Baker (Canadian Association of Schools of Nursing), 8 April 2014, 0905 and B. Mildon (Canadian Nurses Association), 8 April 2014, 0940; [Evidence](#), A. Wright (Director, Canadian Dental Hygienists Association), 10 March 2015, 1535, K. O'Connor (Canadian Physiotherapy Association), 10 March 2015, 1655 and Pierre Poirier (Executive Director, Paramedic Association of Canada), 10 March 2015, 1655; [Evidence](#), S. Wong (UBC Centre for Health Services and Policy Research), 12 March 2015, 1645, William Tholl (President and Chief Executive Officer, HealthCareCAN), 12 March 2015, 1700 and E. Hébert (Canadian Association of Midwives), 12 March 2015, 1555; Canadian Association of Medical Radiation Technologists, *Brief to the House of Commons Standing Committee on Health*, distributed to the Committee 8 October 2014; and Canadian Association of Optometrists, *Submission to the Standing Committee on Health*, March 2014, distributed to the Committee 2 April 2015, p.2.

94 HESA, [Evidence](#), Col. MacKay (Department of National Defence), 4 March 2014, 0955 and M. Brenning (Correctional Service Canada), 4 March 2014, 0900.

RECOMMENDATION 10

That the federal government, in collaboration with provincial and territorial governments, encourage pan-Canadian harmonization of scopes of practice.

The Committee heard that new communication technologies could support more mobility for Canadians and professionals alike through the development and implementation of electronic health records, allowing professionals across the provinces and territories to share the same information.

A witness from DND told the Committee that fully functional electronic medical records already exist for members of the Canadian Forces, and that their experience is being shared with others within the federal government.⁹⁵ Witnesses from other organizations described the importance of the implementation of electronic health records in their own work.⁹⁶ The Committee therefore recommends:

RECOMMENDATION 11

That the federal government continue its work with provincial and territorial governments and other stakeholders to support the implementation of electronic health records across Canada.

Other witnesses described the application of new communication technologies to expand the reach of their services.⁹⁷

C. RECOGNITION AND USE OF ALTERNATIVE HEALTHCARE DELIVERY

The Committee heard from witnesses who identified alternative healthcare delivery approaches and occupations. One witness described what she saw as the limitations of the mainstream approaches:

The focus of our current system is on how to diagnose and treat disease, and few resources are given to prevention. In fact, as physicians and other allied healthcare providers, we are left to mop up when patients, who perhaps haven't learned how to take care of themselves properly or optimally, develop significant and chronic diseases.⁹⁸

95 HESA, [Evidence](#), Col. MacKay (Department of National Defence), 4 March 2014, 0945.

96 HESA, [Evidence](#), J. Cooper (Canadian Pharmacists Association), 10 April 2014, 0935; [Evidence](#), S. Wong (UBC Centre for Health Services and Policy Research), 12 March 2015, 1645; HealthCareCAN, written submission to the Committee, distributed 16 March 2015, p. 3; Canadian Medical Association, *Best Practices and Federal Barriers: Practice and Training of Healthcare Professionals – Submission to the House of Commons Standing Committee on Health*, 17 March 2015, p. 5.

97 HESA, [Evidence](#), Dr. Raj Bhatla (Member, Royal Ottawa Mental Health Centre, HealthCareCAN), 12 March 2015, 1705 and Dr. Janice Wright (Chief Medical Officer, Clinical Services, InspireHealth), 12 March 2015, 1540; Children's Hospital of Eastern Ontario, submission to the Committee, distributed 16 March 2015.

98 HESA, [Evidence](#), Dr. J. Wright (InspireHealth), 12 March 2015, 1540,

A witness representing the Royal College of Physicians and Surgeons of Canada described the increasing collaboration between practitioners of new approaches and of more conventional ones, “especially when we are dealing with populations who are either indigenous or in rural remote communities.”⁹⁹ Another witness suggested that without regulation, “there is a significant variety in the quality of care provided” by alternative health practitioners and added that there is a federal role in determining whether or not an occupation is regulated, which has an impact on the respect it is given.¹⁰⁰

The Committee also heard from two witnesses providing alternative models of healthcare, each of which include both conventional and alternative approaches and practitioners. Dr. John Cline proposed the introduction and implementation of “functional medicine in health care professions' curricula and practices throughout Canada.”¹⁰¹ He told the Committee that “Functional medicine addresses the underlying causes of disease, using a systems-oriented approach and engaging both patient and practitioner in a therapeutic partnership.”¹⁰²

The Committee also heard from Pure North S'Energy, which described the considerable savings to the healthcare system resulting from its program, which featured “simple and effective prevention-focused clinical interventions.”¹⁰³ These interventions included “vitamin D3 and high-quality multivitamin and mineral supplementation, health education, and the safe removal of mercury amalgam fillings.”¹⁰⁴

FEDERAL ROLE IN HEALTH HUMAN RESOURCES PLANNING AND DEVELOPMENT

One witness described the pace of recent changes that affect human health resources and its impact on the need for greater planning:

There has been relatively little attention paid to the impact of system and organizational change on health human resources in comparison to the extent to which such changes have occurred during the past decade.¹⁰⁵

In a brief that followed the appearance of its officials before the Committee, Health Canada described two components – a Pan-Canadian Health Human Resources Strategy and an Internationally Educated Health Professionals Initiative – of a major funding program, pointing out that they both support activities in the health human resources

99 HESA, [Evidence](#), D. Fréchette (Royal College of Physicians and Surgeons of Canada), 3 April 2014, 1000.

100 HESA, [Evidence](#), Dr. G. Moineau (Association of Faculties of Medicine of Canada), 3 April 2014, 0945.

101 HESA, [Evidence](#), Dr. John C. Cline (Medical Director, Cline Medical Centre), 12 March 2015, 1530.

102 John Cline, Submission to the Committee, distributed 12 March 2015.

103 HESA, [Evidence](#), Allan Markin (Founder, Pure North S'Energy Foundation), 12 March 2015, 1550.

104 Ibid.

105 HESA, [Evidence](#), S. Wong (UBC Centre for Health Services and Policy Research), 12 March 2015, 1640.

area.¹⁰⁶ These are two of the specific topics addressed in greater detail in the next sections of the report.

A. HEALTH HUMAN RESOURCES PLANNING

Witnesses described human resources planning initiatives in which the federal government is a key player, including the federal-provincial-territorial advisory committee on health delivery and human resources¹⁰⁷ and the Physician Resource Planning Task Force.¹⁰⁸ Recommendations from several witnesses called for federal “leadership” in health human resources information gathering and planning,¹⁰⁹ while others proposed federal involvement in and support for such initiatives.¹¹⁰ In particular, a witness representing the Royal College of Physicians and Surgeons of Canada identified the potential for “a pan-Canadian or a national human resources for health institute or agency...to garner the benefits and strengths of the learnings, evidence, and experiences from provinces, territories, professional agencies, and researchers.”¹¹¹

In support of these witness suggestions, the Committee recommends:

RECOMMENDATION 12

That the federal government work with provincial and territorial governments and other interested stakeholders to assess health human resources planning challenges, particularly in rural and remote areas, and to facilitate the sharing of best practices and planning data.

106 Health Canada, *Health Canada's Follow-up Response*, distributed to the Committee 17 March 2015, p. 1.

107 HESA, [Evidence](#), D. Gillis (Department of Health), 4 March 2014, 09120.

108 HESA, [Evidence](#), B. Durafourt (Canadian Federation of Medical Students), 12 March 2015, 1650

109 HESA, [Evidence](#), D. Fréchette (Royal College of Physicians and Surgeons of Canada), 3 April 2014, 0930; [Evidence](#), P. Emberley (Canadian Pharmacists Association), 10 April 2014, 0855; [Evidence](#), A. Wright (Canadian Dental Hygienists Association), 10 March 2015, 1535; [Evidence](#), B. Durafourt (Canadian Federation of Medical Students), 12 March 2015, 1650.

110 HESA, [Evidence](#), H. Lopatka (Association of Faculties of Pharmacy of Canada), 10 April 2014, 0910; [Evidence](#), Paul Fisher (Chairperson, Canadian Council for Practical Nurse Regulators), 8 April 2014, 0915; [Evidence](#), P. Poirier (Paramedic Association of Canada), 10 March 2015, 1715; Dietitians of Canada, *Best practices and federal barriers: practice and training of dietitians: Submission to the House of Commons Standing Committee on Health*, November 2014, p. 8; HealthCareCAN, written submission to the Committee, distributed 16 March 2015, p. 3; Canadian Medical Association, *Best Practices and Federal Barriers: Practice and Training of Healthcare Professionals – Submission to the House of Commons Standing Committee on Health*, 17 March 2015, p. 6; Canadian Counselling and Psychotherapy Association, *Brief to the House of Commons Standing Committee on Health: Best Practices and Federal Barriers: Practice and Training of Healthcare Professionals*, 20 March 2015, p. 4

111 HESA, [Evidence](#), D. Fréchette (Royal College of Physicians and Surgeons of Canada), 3 April 2014, 0930.

B. INTEGRATION OF INTERNATIONALLY EDUCATED HEALTH PROFESSIONALS

A witness from Health Canada told the Committee that the department's work on the integration of foreign-trained nurses and physicians has involved

working with Citizenship and Immigration Canada, with Employment and Social Development Canada, with the medical and nursing colleges, and education boards. We have been working very closely over a number of years to break down some of those barriers, but ensuring that foreign-trained health workers are meeting the same standards that all physicians or nurses or others in Canada must meet.¹¹²

In a follow-up to its appearance before the Committee, Health Canada described broader efforts through its Internationally Educated Health Professionals Initiative (IEHPI), which was “established in 2005–2006 to increase the supply of health professionals in Canada by promoting the integration of internationally educated health professionals into the Canadian health workforce.”¹¹³ The document outlined the seven priority occupations under the initiative: physicians, nurses, physiotherapists, pharmacists, occupational therapists, medical radiation technologists and medical laboratory technologists, with additional investments “in additional occupations, such as midwives.”¹¹⁴

A related initiative by the Medical Council of Canada, described to the Committee, “is developing pan-Canadian standards to assess international medical graduates who may qualify to practise in Canada without further training, for those who are not seeking to enter postgraduate training or residency.”¹¹⁵ Health Canada reported that “[b]etween January 2012 and December 2013, over 2,100 international medical graduates have been assessed using the tool, with over 1,020 international medical graduates entering residency training.”¹¹⁶ Health Canada described a similar initiative with respect to internationally educated nurses.¹¹⁷

Health Canada also reported that a Saskatchewan project

promotes and supports the retention of internationally educated health professionals in Saskatchewan, providing career planning, referrals to training, mentorship and peer networking opportunities with the goal of improving the skills necessary to attain professional licensure and to better integrate into the Province's health workforce,¹¹⁸

112 HESA, [Evidence](#), D. Gillis (Department of Health), 4 March 2014, 1025.

113 Health Canada, *Health Canada's Follow-up Response*, distributed to the Committee 17 March 2015, p. 2.

114 Ibid.

115 HESA, [Evidence](#), Dr. F-A. Lefebvre (Federation of Medical Regulatory Authorities of Canada), 3 April 2014, 0910.

116 Health Canada, *Health Canada's Follow-up Response*, distributed to the Committee 17 March 2015, p. 2.

117 Ibid.

118 Ibid., p. 3.

and that services have been provided to 442 internationally educated health professionals.¹¹⁹

The Committee also heard testimony about initiatives by specific organizations, including the Canadian Association of Occupational Therapists¹²⁰ and the Federation of Medical Regulatory Authorities of Canada.¹²¹ Occupation-specific recommendations came from the Dietitians of Canada for continuing federal support for “bridging programs for internationally educated health professionals including dietitians,”¹²² and from the Association of Faculties of Pharmacy of Canada for a resetting of “immigration quotas for internationally trained pharmacists,” pending “a comprehensive assessment of current and future pharmacist manpower.”¹²³

C. SKILLS DEVELOPMENT AND RETENTION

Witnesses testified with respect to both initial training and continuing education of healthcare professionals, and identified current federal roles. These roles include “some targeted funding and initiatives in the area of rural and remote training”¹²⁴ and an on-line training program focussed on patient care for pharmacists.¹²⁵

Witnesses saw opportunities for the federal government, particularly in its role as an employer, to contribute to the training of healthcare professionals, including nurses¹²⁶ and psychologists.¹²⁷ The Committee recommends:

RECOMMENDATION 13

That the federal government review existing internship or student programs, such as the Federal Student Work Experience Program and Health Canada’s Student Bridging Inventory, to consider training opportunities for healthcare professionals.

Some witnesses also called for a federal role in supporting ongoing training for healthcare professionals, particularly physicians, though the development of “a national

119 Ibid.

120 HESA, [Evidence](#), P. Guitard (Canadian Association of Occupational Therapists), 10 March 2015, 1635

121 HESA, [Evidence](#), Dr. F-A. Lefebvre (Federation of Medical Regulatory Authorities of Canada), 3 April 2014, 0950

122 Dietitians of Canada, *Best practices and federal barriers: practice and training of dietitians: Submission to the House of Commons Standing Committee on Health*, distributed to the Committee 18 November 2014, p. 8.

123 HESA, [Evidence](#), H. Lopatka (Association of Faculties of Pharmacy of Canada), 10 April 2014, 0905.

124 HESA, [Evidence](#), Dr.F. Lemire (College of Family Physicians of Canada), 3 April 2014, 0900.

125 HESA, [Evidence](#), J. Cooper (Canadian Pharmacists Association), 10 April 2014, 0850.

126 HESA, [Evidence](#), B. Mildon (Canadian Nurses Association), 8 April 2014, 0905.

127 HESA, [Evidence](#), K. Cohen (Canadian Psychological Association), 10 April 2014, 0950.

consultation on continuing professional development,¹²⁸ signalling the federal government's support for "the maintenance and enhancement of physician competence and performance by supporting credentialing bodies."¹²⁹ Other witnesses called for the establishment of "a standard that allows people to work to their full and optimal scopes of practice by helping to establish standards for practicums and residencies that foster interprofessional competencies" and the encouragement of "post-licensure credentialing work."¹³⁰

Other profession-specific suggestions included federal government support for "a national framework to guide the future of nursing education based on an examination of the scopes of practice of nurse practitioners, registered nurses, and practical nurses, as well as intraprofessional and interprofessional collaboration as part of this framework,"¹³¹ for "Improve[d] access to medical education for individuals from socio-economically diverse backgrounds,"¹³² and for incentive programs to attract youth to train for high-demand jobs and to encourage the recruitment and retention of counsellors/psychotherapists across Canada.¹³³

D. CANADA STUDENT LOANS

A federal government website describes the Canada Student Loan Forgiveness program for "family doctors, residents in family medicine, nurse practitioners, and nurses who work in rural or remote communities."¹³⁴ This program specifies that loan forgiveness could reach \$40,000 for doctors and residents in family medicine (\$8,000 per year for up to 5 years), and up to \$20,000 for nurses and nurse practitioners (\$3,000 per year for up to 5 years). Eligible practitioners must have been employed for a full year (12 consecutive months) and have provided a minimum of 400 hours (or 50 days) in-person service in designated communities.

According to a witness representing the Canadian Federation of Medical Students, "As of November 2013, this program had enabled more than 1,150 family doctors and nurses to receive some loan forgiveness."¹³⁵ However, the same witness described what

128 HESA, [Evidence](#), Dr. G. Moineau (Association of Faculties of Medicine of Canada), 3 April 2014, 0855.

129 HESA, [Evidence](#), Dr. F. Lemire (College of Family Physicians of Canada), 3 April 2014, 0900.

130 HESA, [Evidence](#), S. Wong (UBC Centre for Health Services and Policy Research), 12 March 2015, 1645.

131 HESA, [Evidence](#), C. Baker (Canadian Association of Schools of Nursing), 8 April 2014, 0905.

132 Canadian Federation of Medical Students, *Improving Canadian Student Loan Deferral for Family Doctors and Nurses*, distributed to the Committee 2 April 2015, p. 5.

133 Canadian Counselling and Psychotherapy Association, *Brief to the House of Commons Standing Committee on Health: Best Practices and Federal Barriers: Practice and Training of Healthcare Professionals*, 20 March 2015, p. 4.

134 Government of Canada, "[Canada Student Loan Forgiveness for Family Doctors and Nurses](#)," *CanLearn*.

135 HESA, [Evidence](#), B. Durafourt (Canadian Federation of Medical Students), 12 March 2015, 1650.

the Federation sees as the limitations of the program, as it requires beneficiaries of loan forgiveness to have outstanding student loans:

The barrier to maximizing the number of new family doctors taking advantage of the program lies in ensuring that they have outstanding federal government loans when they are in a position to take advantage of the program... Most medical residents choose at the start of their residency training to consolidate their Canada student loans to a line of credit from their financial institution. This shift of debt significantly reduces the incentive that has been created to draw new doctors to rural and remote communities.¹³⁶

The Dietitians of Canada identified specific circumstances that, in its opinion, result in “federal policy with regard to Student Loan Assistance and Interest-Free status [continuing] to hamper efforts of post-degree programs to provide practicum training.”¹³⁷ Their brief points out that repayment must begin 6 months after graduation, but “[d]ietetic internships (about 40 weeks) do not provide a stipend for living expenses and there may be a registration fee.”¹³⁸

The group concluded that “[f]or some dietetic interns, the repayment requirements (with no option for delay or continuation of interest-free status) combined with lack of income for living expenses (no access to student loans) becomes a barrier to completing their studies.”¹³⁹ The Committee recommends:

RECOMMENDATION 14

That the federal government review repayment requirements under the Canada Student Loan Program to ensure that health professions are treated fairly, and do not face unreasonable barriers to completion of their education.

In its discussion of the student loan forgiveness initiative, a witness representing the Royal College of Family Physicians of Canada told the Committee that “We do hear of rural communities being able to recruit but having great difficulties with retention,”¹⁴⁰ and therefore encourages the measurement of the impact of incentives in the Student Loan program on retention of health professionals.¹⁴¹

136 Ibid., 1655.

137 Dietitians of Canada, *Best practices and federal barriers: practice and training of dietitians: Submission to the House of Commons Standing Committee on Health*, November 2014, p. 6.

138 Ibid.

139 Ibid.

140 HESA, [Evidence](#), Dr. F. Lemire (College of Family Physicians of Canada), 3 April 2014, 0900.

141 Ibid.

E. SUPPORT FOR RESEARCH

The Committee heard that the federal government is a major funder of health research.¹⁴² For example, witnesses explained that federally funded research supported the expansion of pharmacists' scope of practice¹⁴³ and the Canadian Collaborative Mental Health Initiative.¹⁴⁴

Witnesses identified further research initiatives that could support the maximization of scopes of practice and the optimal performance of the healthcare system. A witness from the UBC Centre for Health Services and Policy Research called on the federal government to

invest in an infrastructure to measure and monitor scopes of practice of Canadian healthcare professionals linked to appropriate dimensions of care. A federal role is needed to implement systematic monitoring and evaluation, with a specific focus on inputs and outputs, to estimate costs incurred for introducing change and the long-term return on investments.¹⁴⁵

The witness further recommended that the federal government “ earmark research funds to address gaps in the literature and our knowledge in a number of areas. (e.g., payment models and electronic medical records).”¹⁴⁶ Finally, she recommended that the federal government

fund research to assess the impacts of selected key health system innovations on health human resources in both urban and rural settings; to develop a national framework for guidelines and quality standards for optimal, expanded, and overlapping scopes of practice; and then to promote best practices and facilitate subsequent scale-up and sustainability of initiatives across the country.¹⁴⁷

In a written submission to the Committee, HealthCareCAN wrote that

[the Canadian Institutes for Health Research] CIHR could contribute research funding to address evidence gaps in the current literature – such as cost-benefit analyses and [return on investment] ROI relative to different models of care and scopes of practice, and the impact of changes on patient outcomes.¹⁴⁸

142 HESA, [Evidence](#), Dr. R. Bland (Canadian Psychiatric Association), 10 April 2014, 0955.

143 HESA, [Evidence](#), J. Cooper (Canadian Pharmacists Association), 10 April 2014, 0850.

144 HESA, [Evidence](#), Dr. R. Bland (Canadian Psychiatric Association), 10 April 2014, 0950.

145 HESA, [Evidence](#), S. Wong (UBC Centre for Health Services and Policy Research), 12 March 2015, 1645.

146 Ibid.

147 Ibid.

148 HealthCareCAN, written submission to the Committee, distributed 16 March 2015, p. 3

A witness representing the Canadian Psychiatric Association also identified a “need [for federal funding] to support demonstration projects on how collaborative care can help address common problems faced by healthcare systems, particularly with reference to underserved populations, such as the Aboriginal, homeless, rural, and isolated communities.”¹⁴⁹

149 HESA, [Evidence](#), Dr. R. Bland (Canadian Psychiatric Association), 10 April 2014, 0955.

LIST OF RECOMMENDATIONS

RECOMMENDATION 1

That the federal health care partnership engage with all interested stakeholders to ensure their full participation in ongoing efforts to facilitate strategic partnerships in support of better programs, interdisciplinary care and evidence-based policy. 4

RECOMMENDATION 2

That the Department of National Defence consider reviewing the make-up of their intercollaborative mental healthcare teams, which include psychologists, psychiatrists, mental health workers, and social workers, to ensure that service delivery on the front lines and at home continue to meet the needs of our forces..... 5

RECOMMENDATION 3

That Treasury Board review its Health Services Occupational Group to consider how midwives may be included. 6

RECOMMENDATION 4

That Health Canada review the roles of dental hygienists, occupational therapists, physiotherapists and midwives within the Non-Insured Health Benefits program to improve its ability to provide needed health services in rural and remote communities as part of a healthcare team. 9

RECOMMENDATION 5

That the federal government work with the provinces and territories to review the provisions of the Agreement on Internal Trade to ensure the harmonization of certification requirements for psychologists while maintaining requirements to ensure these professionals have training required for their work..... 10

RECOMMENDATION 6

That the federal government work with provincial/territorial governments and with health professional associations to promote a consistent pan-Canadian approach to scope-of-practice expansions. 12

RECOMMENDATION 7

That the federal government review the requirement for physician referrals to health services under the Public Service Health Care Plan, in order to assure that access to care remains appropriate. 13

RECOMMENDATION 8

That the federal government review the ability of nurse practitioners to be included as signatories in federal tax and benefit programs, with a view to facilitating access for Canadians to timely benefits that affect their health..... 13

RECOMMENDATION 9

That the federal government, through Health Canada, work with provincial and territorial governments to support the development, implementation and evaluation of interprofessional team approaches to the provision of primary healthcare and that it support research in this direction..... 15

RECOMMENDATION 10

That the federal government, in collaboration with provincial and territorial governments, encourage pan-Canadian harmonization of scopes of practice..... 16

RECOMMENDATION 11

That the federal government continue its work with provincial and territorial governments and other stakeholders to support the implementation of electronic health records across Canada..... 16

RECOMMENDATION 12

That the federal government work with provincial and territorial governments and other interested stakeholders to assess health human resources planning challenges, particularly in rural and remote areas, and to facilitate the sharing of best practices and planning data. 18

RECOMMENDATION 13

That the federal government review existing internship or student programs, such as the Federal Student Work Experience Program and Health Canada’s Student Bridging Inventory, to consider training opportunities for healthcare professionals..... 20

RECOMMENDATION 14

That the federal government review repayment requirements under the Canada Student Loan Program to ensure that health professions are treated fairly, and do not face unreasonable barriers to completion of their education. 22

APPENDIX A LIST OF WITNESSES

Organizations and Individuals	Date	Meeting
<p>Correctional Service of Canada</p> <p>Michele Brenning, Assistant Commissioner, Health Services</p> <p>Henry de Souza, Director General, Clinical Services</p>	2014/03/04	16
<p>Department of Health</p> <p>Debra Gillis, Acting Director General, Interprofessional Advisory and Program Support, First Nations and Inuit Health Branch</p>		
<p>Department of National Defence</p> <p>Col Hugh MacKay, Deputy Surgeon General, Canadian Forces</p>		
<p>Association of Faculties of Medicine of Canada</p> <p>Geneviève Moineau, President and Chief Executive Officer</p>	2014/04/03	20
<p>College of Family Physicians of Canada</p> <p>Francine Lemire, Executive Director and Chief Executive Officer</p>		
<p>Federation of Medical Regulatory Authorities of Canada</p> <p>Fleur-Ange Lefebvre, Executive Director and Chief Executive Officer</p>		
<p>Royal College of Physicians and Surgeons of Canada</p> <p>Danielle Fréchette, Executive Director, Health Systems Innovation and External Relations</p>		
<p>Canadian Association of Practical Nurse Educators</p> <p>Judy Morrow, Board Member</p> <p>Debbi Templeton, Coordinator, Health Programs for the New Frontiers School Board</p>	2014/04/08	21
<p>Canadian Association of Schools of Nursing</p> <p>Cynthia Baker, Executive Director</p>		
<p>Canadian Council for Practical Nurse Regulators</p> <p>Paul Fisher, Chairperson</p>		
<p>Canadian Council of Registered Nurse Regulators</p> <p>Anne Coghlan, President</p>		

Organizations and Individuals	Date	Meeting
Canadian Nurses Association Barbara Mildon, President Josette Roussel, Senior Nurse Advisor, Professional Practice	2014/04/08	21
Association of Faculties of Pharmacy of Canada Harold Lopatka, Executive Director	2014/04/10	22
Canadian Pharmacists Association Janet Cooper, Senior Director, Professional and Membership Affairs Phil Emberley, Director, Pharmacy Innovation		
Canadian Psychiatric Association Roger Bland, Member, Professeur Emeritus, Department of Psychiatry, University of Alberta		
Canadian Psychological Association Karen Cohen, Chief Executive Officer		
Canadian Association of Occupational Therapists Paulette Guitard, Professor and Former President	2015/03/10	52
Canadian Chiropractic Association Robert David, Chair Ward MacDonald, Member		
Canadian Dental Association Kevin Desjardins, Director, Public Affairs Benoit Soucy, Director, Clinical and Scientific Affairs		
Canadian Dental Hygienists Association Victoria Leck, Manager, Professional Development Ann Wright, Director, Dental Hygiene Practice		
Canadian Physiotherapy Association Kate O'Connor, Director, Policy and Research		
Paramedic Association of Canada Pierre Poirier, Executive Director		

Organizations and Individuals	Date	Meeting
Canadian Association of Midwives	2015/03/12	53
Emmanuelle Hébert, President		
Canadian Federation of Medical Students		
Bryce Durafourt, President		
Cline Medical Centre		
John C. Cline, Medical Director		
HealthCareCAN		
Raj Bhatla, Member, Royal Ottawa Mental Health Centre		
William Tholl, President and Chief Executive Officer		
InspireHealth		
Janice Wright, Chief Medical Officer, Clinical Services		
Pure North S'Energy Foundation		
Mark Atkinson, Director, Quality Assurance		
Samantha Kimball, Research Director		
Allan Markin, Founder		
UBC Centre for Health Services and Policy Research		
Sabrina Wong, Interim Director		

APPENDIX B LIST OF BRIEFS

Organizations and Individuals

Association of Faculties of Medicine of Canada

Canadian Association of Medical Radiation Technologists

Canadian Association of Midwives

Canadian Association of Optometrists

Canadian Chiropractic Association

Canadian Counselling and Psychotherapy Association

Canadian Dental Hygienists Association

Canadian Federation of Medical Students

Canadian Medical Association

Canadian Physiotherapy Association

Cline Medical Centre

Dietitians of Canada

HealthCareCAN

InspireHealth

Pure North S'Energy Foundation

Royal College of Physicians and Surgeons of Canada

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. 16, 20, 21, 22, 52, 53, 55, 59, and 60](#)) is tabled.

Respectfully submitted,

Ben Lobb

Chair

Supplementary Report of the New Democratic Party

New Democrat members of the Standing Committee on Health urge the inclusion of recommendations that enable medical students, nurses and other health professionals to begin repayment of students loans once they have completed medical residencies, practicums or internships required for entry into their profession, and that allow students to take full advantage of existing federal loan forgiveness programs. Furthermore, we are concerned by witness accounts that existing Canada Student Loan repayment policies could be detrimental to recruitment and retention efforts in rural and remote communities.

The Committee heard from the Canadian Federation of Medical Students that delaying loan repayment until after the completion of medical residency would maximize the effectiveness of the Canada Student Loan Forgiveness Program for Family Doctors and Nurses, a program that provides an incentive for doctors and nurses to practice in rural and remote communities. They explained that some students with debt are unable to take advantage of the loan forgiveness program because they are shifting debt into lines of credits with lower interest rates at the start of their residency and can't qualify for loan forgiveness unless they have outstanding student loan debt.

The Royal College of Family Physicians of Canada echoed the concerns of medical students and encouraged an examination of the impacts of the Student Loan Forgiveness Program on the retention of health professionals in rural and remote communities.

The Committee also heard from the Dieticians of Canada that existing student loan repayment policies, combined with a lack of income during the internship, results in some students not completing their studies.

We therefore recommend an examination of Canada Student Loan Program policies that affect the recruitment and retention of health professionals, including a delay in the repayment of Canada Student Loans until the end of medical residency training periods, or practicums and internships that are required for entry into a profession.

