Regulatory Delay? Patients Pay. Reframing Regulatory Lag as a Governance Risk – Policy Commentary

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Introduction

Health systems across Canada are under sustained strain. Workforce shortages, rising patient complexity, fiscal constraint, and widening inequities in access to care have become structural rather than episodic challenges. In response, systems have increasingly turned to expanded, advanced, and non-traditional clinical roles to maintain service delivery and quality. Yet while models of care have evolved rapidly, regulatory frameworks governing scopes of practice, delegation, and professional accountability (including legislation, professional standards, and regulator-issued conditions) have often lagged. This persistent misalignment between evolving models of care and formal regulatory authorisation is referred to here as regulatory lag. This misalignment is commonly treated as an external regulatory issue, something to be 'worked around' operationally, rather than addressed strategically. In practice, however, the consequences of regulatory delay increasingly surface at the point of care. When regulation fails to keep pace with service delivery realities, the resulting gap is not neutral. It creates avoidable risks to patient safety, entrenches inequities in access, and places health system leaders, councils, and boards in a position of implicit risk acceptance without explicit oversight. Regulatory lag, in this context, should be understood as a governance issue, not a technicality.

The growing gap between care delivery and regulation

Health systems have long relied on professional regulation to protect the public by defining who may do what, under what conditions, and with what accountability. These frameworks underpin the effective governance of quality and safety standards. However, they were largely designed for more stable service environments, with clearer professional boundaries and slower rates of change. Today's context is markedly different. Evolving advanced practice roles, expanded scopes of practice, task shifting, and team-based care models are no longer experimental; they are central to system functioning. In many settings, professionals are routinely working at or near the edge of their formal authorization or scope to meet patient needs. Where regulatory frameworks adapt slowly or stagnate, systems respond pragmatically. While such adaptation is often necessary to sustain service delivery, adaptation without formal governance shifts risk from the system to individuals and normalises variability rather than controlling it. Informal delegation arrangements, local protocols and directives, supervisory workarounds, and role ambiguity become normalized. These approaches are often well intentioned and necessary in the short term, but they obscure accountability, vary widely between organizations, introduce role confusion across allied health relationships, and rely heavily on goodwill rather than clear authorization or

structure. Over time, the gap between formal regulation and actual practice widens, increasing risk.

Regulatory lag as a patient safety issue

Patient safety risks associated with regulatory delay are rarely dramatic, but they are persistent and cumulative. They include unclear role boundaries, inconsistent escalation pathways, and variability in decision-making authority. When something goes wrong, accountability can be difficult to trace, particularly where practice has evolved ahead of formal authorization. In such environments, safety depends less on system design and more on individual judgement, local culture, and informal supervision. This places an unfair burden on clinicians and exposes patients to avoidable variability in care. From a governance perspective, these are not abstract concerns. Boards are accountable for the quality and safety of services delivered in their organizations, regardless of whether the underlying constraints originate in regulation, policy, or workforce supply. Treating regulatory delay as *"someone else's problem"* does not remove the associated risk or responsibility. When adverse events occur in these conditions, organisational defensibility is weakened. Post-incident review and external scrutiny are more likely to focus on individual clinician judgement, rather than the structural gap between evolving practice and outdated regulatory authorisation. The risk then, is not the evolution of practice itself, but the absence of clear governance to legitimise and contain it. Without formal authorisation and oversight, risk is displaced from the system onto individual clinicians and absorbed unevenly across services.

Equity impacts are not incidental

The equity implications of regulatory lag are often less visible but no less significant. Communities with limited access to clinicians or specialized services, including rural, remote, Indigenous, and structurally marginalized populations are disproportionately affected when healthcare professionals are unable to practice to the full extent of their competence. In such settings, regulatory lag can translate directly into delayed care, unnecessary transfers, or reliance on already overstretched paramedic services. Where workforce solutions exist in principle but are constrained in practice, inequities are not only sustained but reinforced. Importantly, these outcomes can occur even in systems that have made explicit commitments to equity and population health. When regulatory frameworks are misaligned with service needs, equity goals remain aspirational rather than operational. While clinicians may be trained and competent to initiate treatments, adjust medications, or directly refer patients to community-based services, regulatory constraints may prevent these actions from occurring in practice. As a result, patients are referred elsewhere for issues that could have been managed locally, or experience delays while awaiting authorisation from providers who are geographically or temporally unavailable. For populations already facing barriers to care, including Indigenous communities and those with complex social needs, these delays compound existing inequities. The regulatory framework, rather than clinical need or capability, becomes the determining factor in access to timely care.

Why this is a governance issue

Boards, councils, and service leaders do not control professional regulators. However, they remain responsible for identifying and managing risks to patients and communities and are

uniquely placed to elevate evidence-based concerns and advocate for reform when regulation no longer reflects practice realities. Regulatory lag becomes a governance issue when its consequences are absorbed quietly and continuously into service delivery over time. This creates a form of implicit risk transfer. Organizations adapt to regulatory constraints through workarounds (for example, hiring personnel who practice in a grey zone of regulatory oversight), while boards receive assurance on quality and safety that may not fully reflect the underlying fragility of these arrangements. Good governance does not require boards to intervene in regulatory processes, but it does require them to ask informed questions. How dependent are our services on informal delegation? Where are competencies well established but enactment is unclear? Which populations are most affected by scope of practice limitations? How are equity impacts monitored and mitigated? Without such scrutiny, regulatory lag becomes normalized, and its risks are effectively hidden in plain sight.

Practical implications for boards and service leaders

Effective governance does not require eliminating regulatory lag, but making it visible, owned, and actively managed rather than absorbed informally into day-to-day practice. There are however several practical steps boards and senior leaders can take to bring regulatory lag into clearer focus: First, regulatory constraints should be explicitly recognized within organizational risk frameworks where they materially affect service delivery, quality, or equity. This elevates the issue from an operational inconvenience to a strategic consideration. Second, organizations should be able to articulate clearly how advanced and expanded roles are governed in practice, including competencies, supervision models, escalation and referral pathways, and quality assurance and improvement mechanisms. Ambiguity should be treated as a signal to intervene and improve, not an acceptable condition. Third, equity impacts of constrained or restricted scopes of practice should be explicitly assessed. Boards should ask whether regulatory limits disproportionately affect specific structurally marginalized or under-served communities or populations (spoiler: they do) and how this aligns with stated equity commitments of the organization. Finally, engaging with regulators should be framed around public protection and system learning rather than professional advocacy. Evidence from service delivery, safety monitoring, and patient experience can inform constructive regulatory reform and evolution without undermining trust. None of these actions require boards to overstep their role. In fact, they require boards to exercise it.

Looking forward

Regulation remains a cornerstone of public protection in health systems. The challenge is not regulation itself, but its ability to continuously evolve alongside care delivery. Entrenched perspectives on existing regulatory models (and perhaps, a fear of change), combined with oft-observed protectionism of existing structures results in stagnation. When regulatory frameworks lag persistently behind system realities, the resulting risks are borne by patients, communities, and frontline providers. Recognizing regulatory lag as a patient safety and equity issue does not assign blame; it reframes responsibility. In complex systems, governance maturity is reflected not in compliance alone, but in the capacity to see, name, and manage risks that fall between traditional silos. As health systems in Canada continue to adapt to unprecedented pressures, governance-literate oversight of workforce regulation is

no longer optional. It is a core function of any board committed to quality, equity, and public accountability.

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