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Chair: Hedy Fry



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• (1100)

[English]

The Chair (Hon. Hedy Fry (Vancouver Centre, Lib.)): I call the meeting to order.

[Translation]

Welcome to meeting number 10 of the House of Commons Standing Committee on Health.

We recognize that we are meeting on the unceded territory of the Algonquin Anishinabe peoples.

[English]

Today's meeting is taking place in a hybrid format, pursuant to the Standing Orders.

I want to remind participants about the usual points. Please wait until I recognize you by name before you speak. For those of you participating by video conference, please turn off your microphone when you're not speaking. If you click on the microphone icon, you can get your interpretation going and choose floor, French or English. If you look at your computer, you will see that icon.

All comments should be addressed through the chair. To members in the room, if you wish to speak, please raise your hand. The clerk and I will try very hard to pick you up quickly and get you in the right order. I will manage the speaking order.

I will also tell you that I will give you a one-minute and a 30-second hint to wrap up when you are speaking.

Pursuant to the motion adopted on Tuesday, September 23, 2025, the committee will resume its study of the impact of immigration policy on health care and barriers to integrating internationally trained professionals.

Dan Mazier (Riding Mountain, CPC): Chair?

The Chair: Yes, go ahead, Mr. Mazier.

Dan Mazier: I have a question. Actually, it's a point of clarification.

I would like to move the following motion upon the request of the clerk—

The Chair: May I finish starting the meeting?

Dan Mazier: No, I have the floor. This is a quick motion.

I move:

That the clerk distribute to members the witness lists submitted by each party with personal information redacted, and the corresponding work plan related to

the committee's study of women's health in the 44th Parliament, no later than October 31, 2025.

This is a motion that was requested by the clerk for clarification. We did pass this motion by unanimous consent before at this committee, but it was just in words. It wasn't written down on paper. This is just a point of clarification for the clerk.

I'm seeking UC if possible.

The Chair: Is everyone on side with this?

(Motion agreed to)

The Chair: I have unanimous consent, so we can continue with the order of the day.

I want to welcome our witnesses.

We have, from the Town of Oliver, Martin Johansen, mayor, and then we have, virtually, Jodi Hall, chief executive officer of the Canadian Association for Long Term Care.

Each of you will have five minutes.

We will start with Mayor Johansen.

Mayor Johansen, I will give you a one-minute and a 30-second hint so that you can wrap up. If you don't get to finish everything you want to say in your five minutes, I'm sure you can flesh it out during the question and answer sessions.

Begin, please, Mayor Johansen. You have five minutes.

Martin Johansen (Mayor, Town of Oliver): Good morning, Madam Chair and members of the committee. It's a pleasure to be here today.

My name is Martin Johansen. I'm the mayor of the Town of Oliver. In addition, I sit as chair of the Okanagan Similkameen Regional Hospital District. I also sit as vice-chair of the SOS Health Care Society—"SOS" stands for South Okanagan Similkameen. I'm a board member of the SOS PCN steering committee.

My involvement in health care started when I was elected as mayor in 2018 and has evolved over time, with increasing involvement due to the frequent and ongoing closures of the South Okanagan General Hospital—30 this year and counting. Unattached patients, estimated to be 4,500 in the south Okanagan—that would be the Oliver/Osoyoos area—continue to be a barrier to timely physician visits and access to essential health care services for our residents.

Rural communities across the South Okanagan, including Princeton, Osoyoos, Keremeos and Oliver, face mounting difficulties in recruiting and retaining family physicians. Despite strong local collaboration, long-term primary care is strained by gaps in training, locum support and community infrastructure like housing and child care, which is needed to attract and retain providers.

Retaining and recruitment of providers are further challenged by the workload associated with rural practice. In small towns, one doctor may cover emergency, maternity, long-term care and clinic patients with limited backup. To manage the excessive workload, the lack of work-life balance and the mental health challenges associated with burnout, providers are reducing their level of service, such as giving up their hospital privileges or leaving for more urban communities.

ED closures in rural communities are unfortunately becoming the norm. There was an ED closure earlier this year in Delta that created a huge uproar, calling for immediate action from the provincial government; however, a few hundred rural community ED closures throughout the year barely make the news anymore.

Is there a solution? Well, for sure there is no silver bullet that's going to address the issues of recruitment and retention overnight. However, it's becoming increasingly clear that there's an opportunity to address the shortfall of available health care resources through residents, international medical graduates, Canadians studying abroad and internationally educated health care professionals living in Canada who are not working in their profession. These professionals want to practise in Canada and are ready and willing to come to rural communities, where they are desperately needed.

Increasing the resources available to evaluate candidates in a timely manner, top up training programs and streamline the credentialing process should be priorities. In addition, I think it's critical that part of the solution needs to be making sure that these professionals land in communities where the need is highest.

The health care system is under considerable strain, and I think rural communities are facing some of the biggest challenges in this country. Our aging population, with their increasing level of complex medical concerns, the administrative burden on physicians and the lack of timely care being available are adding to the sickness level and the advanced stages of diseases for residents.

Thank you for the invitation to come here today. I look forward to any questions the committee members may have.

• (1105)

The Chair: Thank you.

My goodness, you have one minute and 44 seconds left. That was efficient. Thank you, Mr. Johansen.

I now go to Ms. Jodi Hall.

Ms. Hall, you have five minutes, please. Welcome.

Jodi Hall (Chief Executive Officer, Canadian Association for Long Term Care): Thank you, Madam Chair and committee members.

Thank you for the opportunity to appear before you today to discuss Canada's long-term care sector and, specifically, the challenges that we face with workforce shortages and the opportunities that we see through immigration policy.

The Canadian Association for Long Term Care advocates on behalf of Canada's long-term care sector with a vision for a sustainable system that delivers quality long-term care for all, ensuring that residents live and age with dignity.

I would like to take a moment to express my sincere appreciation for the frontline staff and long-term care leaders who continue to deliver compassionate care and support to residents and families every day in spite of the challenges they face.

Today, I would like to share the current state of long-term care and highlight the specific opportunities for improvement through immigration.

Currently, estimates indicate that nearly double the number of long-term care home spaces will be needed by 2035, and Canada's population aged 85 and older is expected to double by 2040. Waitlists for long-term care homes are at record highs, with many waiting in hospital beds. This is a direct impact on the broader health system, limiting hospital capacity and often resulting in cancelled surgeries and delayed care due to unavailable beds.

According to Statistics Canada, in the third quarter last year, there were nearly 25,000 vacant positions in the long-term care sector. There is work under way nationally to improve workforce data in long-term care, and this will support longer-term planning and domestic solutions; however, our workforce needs are immediate.

Right now, many internationally educated health care providers begin their Canadian careers as personal support workers in long-term care homes while working through foreign credential recognition processes. Long-term care providers often provide extensive settlement supports, such as assisting with housing, transportation, child care and credential recognition, largely from their own resources.

There is significant interest in working with the economic mobility pathways program to bring skilled refugees to Canada to work in long-term care homes, but the processing delays are significant and the costs make it challenging for many long-term care home employers to consider.

Programs such as the temporary foreign worker program play a critical role in addressing many workforce shortages. However, recent changes to the temporary foreign worker program, including the new labour market impact assessment requirements, have created significant administrative and financial burdens for employers, as they need to complete the same process for each temporary foreign worker every 12 months. This is despite the fact that the labour market impact assessment is meant to assess labour market impact, and in long-term care the shortage is already clear and nationally recognized.

However, there are opportunities to strengthen the long-term care workforce through targeted immigration policies. We ask that we expand and simplify immigration pathways, for example by creating a health care-specific pilot for long-term care. This could build on strengths and lessons learned from the home care worker immigration pilot and the Atlantic immigration program.

We ask that we create a health care-specific work permit that is exempt from the labour market impact assessment. The franco-phone mobility work permit is a proven model, and it addresses the significant Canadian interest in supporting official-language minority communities. The same regulatory authority could be applied to health care, another sector of national interest.

Prioritize immigration processing in all programs for individuals already working, or committed to working, in the long-term care sector, while reducing the administrative burden for long-term care employers.

In closing, we recognize that Canada's immigration system must balance many priorities. However, it is essential that we preserve and strengthen what is working, particularly in programs that enable long-term care homes to recruit and retain vital workers.

To illustrate, I'll share a real-life example that's happening right now. An internationally trained long-term care provider with six years of experience in the Philippines began working at a long-term care home in Prince Edward Island in November 2024 under an open work permit. Her permit expired in July 2025, while her Atlantic immigration program application was still in process. Unfortunately, the open work permit was not renewed, and she is now preparing to return to the Philippines, despite having a full-time position available.

This is precisely the kind of situation that we must avoid. If we want a sustainable long-term care system, we must ensure that im-

migration policy supports—not hinders—the ability of long-term care homes to meet workforce needs.

Thank you once again for the opportunity to speak with you today.

● (1110)

The Chair: Thank you very much.

Now I'm going to go to the question and answer segment. The first round is a six-minute round. The six minutes are for the questions and the answers, so I'm going to ask everybody to be as concise as possible so we can get in as many questions as possible. Thank you.

I will begin with the Conservatives and Ms. Konanz.

Helena Konanz (Similkameen—South Okanagan—West Kootenay, CPC): Thank you, Chair.

Mayor Johansen, I want to thank you for attending today in your role as the chair of the Okanagan Similkameen Regional Hospital District. I think it's important that parliamentary studies like the one we're pursuing here include voices from regions across the country and rural regions.

Specifically in the case of South Okanagan General Hospital, we both know that we've heard from residents and media multiple times about sudden closures of emergency room services. How many closures have there been in the last year, roughly?

Martin Johansen: There have been exactly 30 closures within the last year, from September 30 to October 1.

Helena Konanz: Yes, when I counted from last September, I counted 37, but there are a lot.

That's pretty serious, the closure of an emergency room. How much notice are you or residents of South Okanagan given about the closures, which occur very regularly?

Martin Johansen: We're given one to two hours at the most when we hear that the hospital is being closed.

Helena Konanz: One to two hours before the doors are closed, the local government finds out and then media is alerted.

• (1115)

Martin Johansen: I should clarify that it's not one to two hours before the doors are closed. We get one to two hours' notice of a closure, and usually that closure happens.... Depending on the day, sometimes we get notice in the late afternoon that it's going to close in the morning. It's those types of things. There's not much notice, though. It's not enough time for it to really get out to the public to make sure that they're aware, so that if somebody can't go to SOGH anymore, they can go to Penticton.

Helena Konanz: How do you let the people of the region know that the doors are closed and locked, and that if their child falls and breaks their arm or hits their head, they can't go to their local hospital at that time?

Martin Johansen: The only notification is through the media, through Castanet news, with a PSA from Interior Health.

Helena Konanz: It sounds very dangerous to me, last-minute closures.

Have you witnessed serious situations when people have shown up to the door and needed someone right away but had no one to help them at the hospital?

Martin Johansen: For sure, I have gotten calls from residents telling me stories of tragedies that have almost happened when they've gone to the hospital and the hospital's been closed, and they've had to head up to Penticton.

Of course, the ambulances are aware of that, and they do transport as well, but you're half an hour away, at a minimum, for that transport.

That's about all I can say on that.

Helena Konanz: How long would it take for an ambulance, if they were called suddenly, to get to the hospital if someone showed up to the hospital doors? Penticton is, depending on traffic, 45 minutes or an hour away.

Martin Johansen: Penticton is 35 to 45 minutes away, and then, of course, the ambulances are available as they are available. If they're responding to calls within the area, they may be delayed as well.

Anybody with that level of sickness, I would hope, is calling an ambulance to their home, as opposed to showing up at the hospital and then calling an ambulance.

Helena Konanz: Why are these closures happening? In your role as the chair of the regional hospital board and the mayor of the local community, can you say why these closures are happening?

Martin Johansen: It's basically a lack of physicians. We've had enough nurses through our travel nurse program to be able to support the hospital, but a lack of physicians is where it comes from.

Probably 40% of the resources to keep our hospital open come from outside of the town of Oliver. The real root cause of the problem is that we do not have enough physicians in our community who are able to support the hospital as part of their practice in the Oliver area, so doctors have to come from outside of our community to support the hospital.

Helena Konanz: B.C. Interior Health recently reported a loss of seven obstetricians and gynecologists and four psychiatrists. We

know that Kelowna, which is a drive of over an hour away, lost their pediatric ward temporarily, the pediatric ward for the area.

Do you think our region is losing doctors at a rate above replacement levels?

Martin Johansen: I would think so. We have been warned about this before, about the retirements that are coming. One challenge that happens is that a lot of doctors who have been providing service for the last 50 years are running larger panels of patients. They have larger groups of people to take care of. The demand from the population increase is there. When one of those physicians retires, they're not being replaced one-for-one. It's probably two or maybe three physicians to that one physician, because of the work-life balance that new health care workers are looking for.

The Chair: Thank you, Helena. I think your time is up. You have one second.

Helena Konanz: Just quickly, have you, as a community, attempted to get any doctors to come in, yes or no? Have you, as a community, as the Town of Oliver, or has the board been trying to get new doctors?

The Chair: Answer yes or no, please. We are over time.

Martin Johansen: Yes, we have.

Helena Konanz: Thank you.

The Chair: Now I go to the second questioner. That's from the Liberals, Mr. Eyolfson for six minutes.

Doug Eyolfson (Winnipeg West, Lib.): Thank you, Chair.

Mr. Johansen, thank you so much for coming. I often travel to that area of B.C. I love it there.

I'm an emergency physician in Manitoba. I'm aware of the problems we have with rural area closures. I work in a community hospital in Winnipeg. We often receive patients from other areas because the hospitals there are closed. The ambulances come right to us. It's something I'm very familiar with.

Has there been any provincial response, in terms of how the Province of British Columbia is going to be responding to this?

• (1120)

Martin Johansen: We have formed a rural mayors group with a number of mayors from rural communities, and we are working with the Minister of Health, Josie Osborne. We are looking at solutions in different communities. One thing you'll find with rural communities is that a solution that works in one community doesn't necessarily work in another community, which adds some challenges to it. Some communities are considerably more remote than Oliver is, so they have trouble attracting physicians to come there. We have challenges in our community. We don't necessarily have all the amenities that people are looking for in those rural communities. They want to go to Penticton, so to speak.

One thing we were able to do in Oliver recently was to get a contract payment model for the physicians who come to our hospital, which creates pay equity. Before, they were attracted to Penticton; now it's the same pay whether you go to Penticton or Oliver.

Doug Eyolfson: Thank you.

One frustration I have had is this: I have a licence to practise in Manitoba; I also had a licence to practise in Ontario for a few years. You have to go through the whole application for licensing and pay a fee. Now it's \$2,500 a year for that licence. I could hop across the border from Winnipeg to Kenora, Ontario, which often has shortages. I could hop across there for a few days and do some shifts, but I would have to maintain this Ontario licence. If I were to have a few days when I could come out to Oliver and practise, first of all, I would have to go through the process to apply for a licence in British Columbia, and then pay an annual fee for that licence.

Would a pan-Canadian licensure system, or some system where my credentials to practise would be recognized in any other province—even if on a sessional basis—help communities such as yours?

Martin Johansen: Absolutely. A bigger pool that we're able to draw from and attract physicians from would definitely help with the problems we're having. One thing we're doing in Oliver as well is building some dedicated housing for health care workers, so when physicians or nurses are able to come, they'll have a place to stay. We're trying to make it easier for people to come in and support our community. One thing, for sure, is the credentialing process; being able to just walk into the community and support the hospital would be amazing.

Doug Eyolfson: Thank you.

Ms. Hall, thank you so much for coming.

I also, from my emergency work, appreciate the difficulties with the lack of long-term care beds. We have a lot of patients actually sitting in emergency because they basically just can't cope at home anymore. They don't have an acute medical illness, so medicine won't admit these people, because they're not sick, but we have to find some place for them to go. They will often spend over a week on a stretcher in our hallway in the emergency department until we're able to find a bed for them. We've also had some barriers in that our provincial government, a number of years ago, closed three hospitals in Winnipeg, and also cancelled a \$6-billion expansion in long-term care, and we're seeing the effects of it to this day.

You were talking about credentialing. I have the same question I had for Mr. Johansen. Would a system that allowed free mobility of workers, allowing them to travel between provinces, as opposed to having to apply for a licence in every single province...? Would it help if there was a way of having recognition of a licence throughout Canada? Do you believe that would help your staffing problems?

Jodi Hall: We are supportive of initiatives for labour mobility, especially as it relates to matters of foreign credential recognition. That is an area where many long-term care home employers are often trying to support newcomers, who are often working in homes as personal support workers. It would create opportunity for them

to be employed in other areas within the long-term care home as well.

● (1125)

Doug Eyolfson: Thank you.

You mentioned that you are relying a lot on temporary foreign workers right now and the restrictions that have been put on it are causing problems for you. I'm hearing some advocates claiming that we should be getting rid of the temporary foreign worker program entirely. What effect would that have on staffing in your long-term care facilities?

Jodi Hall: According to Statistics Canada, since 2019, 40% of temporary foreign workers are employed in long-term care homes, so that is a significant impact for this sector.

Doug Eyolfson: Thank you.

The Chair: Thank you very much. Time is up.

Thank you, Mr. Eyolfson.

I will go now to Monsieur Thériault for six minutes, please.

[*Translation*]

Luc Thériault (Montcalm, BQ): Thank you, Madam Chair.

It's rather discouraging to hear about the reality that Quebec and the provinces are experiencing every day, as well as the challenges they must face.

Questions are being asked about the capacity of provinces to meet those needs. However, the current state of things must also be taken into account, especially when it comes to recruiting and retaining labour, as well as chronic underfunding of the health sector.

Underfunding has been going on for years. It was not rectified the last time the provinces came together to ask the federal government to increase its contribution to health expenditures from 21% to 35%. Among other things, it would significantly help with retaining labour.

Ms. Hall, I don't know how this is playing out for you, but for us, there are many problems with retaining labour, especially nursing staff.

We saw the trend of private agencies popping up. They owe their existence to the fact that, in the public sector, nurses no longer have a quality working environment. And so, they would rather lose benefits and wages to be able to practise their profession decently.

What is that looking like for you?

[English]

Jodi Hall: When we look across the country, I think there absolutely is use of nursing agencies for long-term care. For us, it's a symptom of a much larger problem, which is the tremendous shortage we're facing. There are over 25,000 vacant positions, according to StatsCan data from the third quarter of 2024. From what we're hearing from our members on the ground, there's tremendous competition for the same cohort of employees. It's an incredibly challenging circumstance, and it has driven the use of agency nurses across the country.

[Translation]

Luc Thériault: What do you think is behind the use of these agencies and this competition?

[English]

Jodi Hall: I think that the use of agency nursing has been driven by the shortages. It's incredibly difficult to work without sufficient staff or the required number of staff in a long-term care home, and it has a direct impact on working conditions when a full team is not in place.

Rather than putting staff and residents at risk, homes are moving to other options, such as agency nursing, while we continue to work to find strategies for recruitment.

[Translation]

Luc Thériault: In Quebec, agencies popped up, particularly in the nursing care sector. It has a lot to do with the government's requirements or intentions regarding health care. In any case, I don't think any government or provincial premier whatsoever wants to create problems in health. Usually, they want to solve them with the money, the means and the resources they have available.

Nurses were being asked to work overtime hours, but without the possibility of being able to refuse. Those were therefore mandatory overtime hours.

It led to a particular phenomenon in Quebec. Health professionals felt that they were putting the lives of the public in danger. After working 18 consecutive hours, they felt they could make mistakes and could no longer ensure patient safety.

As a result, it caused stress. We saw nurses with serious mental health problems. They were living under pressure; they felt they could not give the best possible patient care.

The only thing we had to offer them was to refuse to let them go home. We then saw the trend of agencies popping up. They popped up like little mushrooms! These agencies recruited staff and took human resources away from the public system and put them back into the health network under very different conditions.

Am I wrong? Are you experiencing the same thing in your environment?

• (1130)

[English]

Jodi Hall: When we talk with our members across the country, we hear that what has driven the use of agency nursing has been the shortages that they're experiencing, in an effort to support retention

so that people are not in working conditions that make it impossible—

[Translation]

The Chair: You have 30 seconds left.

[English]

Jodi Hall: —for them to meet the quality of care that's expected in support of residents' quality of life, as well as issues with workload. The shortages have driven the use of agency nursing, and of course with that come challenges with appropriate cost and a variety of other things that need to be considered.

There are examples of best practice approaches to this coming into play. We see the provincial governments adding some direction or guidelines, and certainly as homes use agencies, we have encouraged homes to take a best practice approach by having a standard contract in place so that many of the challenges that we see in care delivery are addressed right up front.

The Chair: Thank you, Ms. Hall.

Now we go to the second round. That round is a five-minute round, beginning with Mr. Bailey for the Conservatives.

You have five minutes, please, Mr. Bailey.

Burton Bailey (Red Deer, CPC): Thank you, Chair.

Ms. Hall, thank you for joining us virtually today.

In a February 2025 briefing, your organization noted a shortage in long-term care staffing. It cites StatsCan reports of about 25,000 job vacancies in long-term care. Your recommendation includes ensuring that “health human resource planning has specific considerations for long-term care and is captured in the health workforce sectoral planning”.

With that in mind, did the federal department of immigration consult the Canadian Association for Long Term Care on this year's federal immigration plan, yes or no?

Jodi Hall: No, our organization wasn't consulted.

Burton Bailey: Thank you.

Did the federal immigration department ask for any data on the current capacity of Canada's health care system?

Jodi Hall: No, but we have advocated with information.

Burton Bailey: You would like to be consulted on these targets.

Jodi Hall: Yes.

Burton Bailey: Would you say that in the past 10 years the demand for long-term care has increased, and if so, why?

Jodi Hall: Absolutely, it has increased. I think we just need to look at the aging demographic of our population to understand that.

Burton Bailey: StatsCan states that, in the last five years alone, from 2020 to 2025, over 75,000 people aged 65 and up immigrated to Canada. Given that these individuals are of retirement age, it's likely that many either will be or are already in long-term care.

Do you believe this level of intake of individuals at this age is plausible, requiring more resources in your sector? Is it sustainable?

Jodi Hall: When we look at the demand for long-term care going forward, we're looking at the numbers that are being provided by StatsCan for the Canadian population. I don't have a breakdown beyond that.

Burton Bailey: Does your organization support a standardized national licensure for health care professionals?

Jodi Hall: Yes, we do, especially as we consider foreign credential recognition. We feel that could be extremely helpful.

• (1135)

Burton Bailey: Thank you.

Do you believe that Canada should integrate the roughly 81,000 foreign-trained health care professionals who are already in Canada before bringing in more individuals to work in our health care system?

Jodi Hall: We're extremely supportive of capitalizing on any available workforce.

Burton Bailey: My colleague talked about bed blockers. In Alberta, there were 1,500 people in hospitals who were blocking beds, who should have been in long-term care homes. It was due to the fact that they didn't fill out their income tax.

Are you starting to advise your long-term care organizations that elderly people must fill out their taxes so that they qualify for provincial funding?

Jodi Hall: When someone is admitted to a long-term care home, that is when the role of the long-term care home comes into play.

Yes, they do work with families or act as trustees to ensure that taxes and other required forms are completed.

Burton Bailey: Is it a common practice that you will help individuals who are not capable of filling out their taxes so that they receive provincial benefits, as opposed to them becoming lost in the system?

Jodi Hall: That would be a common approach, although, with 13 different long-term care systems across the country, there may be variation in that approach in each jurisdiction. Support is often given to residents and families.

Burton Bailey: I heard your comments on the temporary foreign worker program. My experience in my constituency is that we are bringing temporary foreign workers and promising them roles in nursing, but they end up not passing their qualification exams. They work in housekeeping and are extremely dissatisfied.

My understanding is that there were a lot of problems with the language exam that was being implemented from the United States. Now, that has since switched, and we have a Canadian exam.

Can you comment on promising these people jobs that they cannot attain?

Jodi Hall: First of all, we absolutely support and adhere to the ethical framework for recruitment of internationally educated nurses. Many come to work in long-term care homes as personal support workers, and then the homes themselves provide an additional amount of support to help them get through the foreign credential process of that jurisdiction. If there were more settlement dollars available to the long-term care homes, then I'm sure they could play a bigger role.

The Chair: Thank you very much.

We now go to the Liberals.

Mr. Powlowski, you have the floor for five minutes, please.

Marcus Powlowski (Thunder Bay—Rainy River, Lib.): Ms. Hall, the Conservatives have suggested that part of the problem with long-term care is that we have all of these people who recently came to Canada as immigrants and refugees taking up beds in chronic care homes. Is this the case?

I certainly don't get the impression that there are a lot of people who just came over from India, the Philippines or Afghanistan in the last couple of years who.... We don't take a lot of elderly immigrants. Those we do, my guess is that their families have brought them over so they could be with them, not to put them in chronic care homes.

Are we overburdened with recent immigrants taking up chronic care beds?

Jodi Hall: The numbers that we would be referring to are numbers produced by StatsCan and by provincial governments. No breakdown is provided regarding newcomers in long-term care or waiting to come to long-term care homes.

Marcus Powlowski: Is it your impression, as somebody who works in chronic care, that there are large numbers of recent immigrants taking up chronic care beds?

Jodi Hall: Not that I am aware of.

Marcus Powlowski: On the other hand—and we have been fighting this battle—I would suggest that in terms of pros and cons of the effects of immigration on the health care system, we overwhelmingly benefit from the immigrants in the health care system. Certainly PSWs are a great example of it.

Can you tell me what percentage of PSWs currently working in Canada were actually born in Canada?

Jodi Hall: Again, that is part of the data challenge we have. There is work being done by the Canadian Institute for Health Information and by Health Workforce Canada to better understand the long-term care workforce, including the personal support workers. Information has been fairly limited for that particular cohort, as it's a largely unregulated group of the long-term care workforce.

Marcus Powlowski: I think anyone who has relatives in long-term care or who has been in a long-term care home recently would tell you—and I would think you could say, without knowing the exact numbers—that there is a large number of people working in chronic care, PSWs, who were not born in Canada. I know you don't have the exact numbers.

• (1140)

Jodi Hall: Yes, certainly there is a presence of individuals who are newcomers to Canada working in those roles.

Marcus Powlowski: Do you have any numbers as to people who are temporary foreign workers currently working in chronic care homes?

You mentioned that 40% of all temporary foreign workers in Canada are employed in chronic care. Is this true?

Jodi Hall: That was a number that was produced in a recent report from Statistics Canada. We can also see that between 2010 and 2019, more than half of the temporary foreign workers who came and worked in health care were still working in the sector after five years. It is a successful program.

Marcus Powlowski: You mentioned that recent changes in IR-CC having to do with LMIA on a yearly basis are creating significant problems in chronic care homes. Can you elaborate a bit on that? Is this, at the moment, adversely affecting patient care?

My colleague, Luc Thériault, talked about the pressure on existing health care workers. Have the changes that make it harder for people to come in as temporary foreign workers created a problem?

Jodi Hall: I think the challenge is the administrative burden that is generated from that. Often, homes need to seek support to complete that when they have a number of temporary foreign workers in the home. Of course, there's a cost associated with that.

A backlog with processing much of that information is being reported. Those collectively create a challenge.

Marcus Powlowski: Would you be in favour of issuing an automatic two-year renewal for anybody who currently has a work permit and is working as a PSW in chronic care homes? The government could do this. That would be a fairly quick and efficient way of ensuring that people who are already here and are needed in the system stay in the system.

Would you be in favour of that?

Jodi Hall: Yes, I would.

Marcus Powlowski: You could send this, because I'm sure we're running out of time. You talked about problems with the economic mobility pathway. Briefly, could you expand on that? If there are refugees here who could work in the system, that would certainly seem to me to be desirable. If you could send us stuff on that, we'd appreciate it. Thanks.

Jodi Hall: Certainly. Thank you.

The Chair: I will now go to Mr. Thériault.

[*Translation*]

Mr. Thériault, you have the floor for two and a half minutes.

Luc Thériault: Thank you, Madam Chair.

Ms. Hall, several witnesses told us that for internationally trained professionals, there is a problem with matching up the requirements between Immigration, Refugees and Citizenship Canada and the criteria that must be met from one profession to the next.

To solve this problem, some suggested setting up a guidance process to help navigate the rules, so that these people can exercise their profession.

They also said the rules contain inconsistencies.

What do you propose to solve these problems?

[*English*]

Jodi Hall: As we consider labour mobility across the country, I think considering foreign credential recognition as part of that would be largely beneficial. Having a greater, standardized approach to licensure and the recognition of credentials would be very beneficial for the workforce, I think.

[*Translation*]

Luc Thériault: You mentioned standardization. Could you tell us more about that?

[*English*]

Jodi Hall: Right now, each jurisdiction across the country has a different approach to licensure. A tremendous amount of work has been done to try to streamline those processes, but I think many continue to advocate for further enhancement of that, so we can see greater consistency, especially regarding foreign credential recognition, where basically we could be asking the same things of newcomers to Canada in each of the provinces and territories.

[*Translation*]

The Chair: You have 11 seconds left.

• (1145)

Luc Thériault: When it comes to low retention capacity, what are the most common causes?

[*English*]

Jodi Hall: I think there are a number of challenges. One is that with our population aging, so is our workforce, and we do see our workforce getting closer to retirement age. That has already started. I think that is a current factor. There is also significant competition across the health care sector for the same group of employees, so a number of factors come into play with wages and working conditions, and long-term care homes work to be as competitive as possible in those areas.

The Chair: Thank you very much. I think we were over time there.

I would like to go now to Ms. Konanz for five minutes, please.

Helena Konanz: I have a couple more questions for Mayor Johansen. We talked a bit about the difficulty of retention of doctors and nurses. South Okanagan General Hospital is not the only hospital in Canada facing multiple sudden closures. We're not even sure of the effects of it—how many people are incapacitated, or might even die, because their hospital is not open.

How difficult would you rate the challenge of recruiting doctors, nurses and other specialists to work in rural hospitals or clinics like the South Okanagan General Hospital, and why?

Martin Johansen: Would you like a rating on a scale of one to 10, that type of thing?

Helena Konanz: Sure.

Martin Johansen: It's probably in the range of seven or eight, for sure.

You would think we would be able to attract physicians to come and work in our area, but one of the challenges we have there, again, is that we have so many unattached patients in our area that our hospital becomes a walk-in clinic. When you come to do a shift in the ER, you have an incredible number of people coming there for very minor things, with a few serious things sprinkled in among them. The shifts are long and hard. Lots of times physicians come there, and they say they will never be back.

Those are the things that are challenging us. It all stems from not having enough people attached to a family physician.

Helena Konanz: Yes. I should say that this is one of the most beautiful places in Canada. It's a high tourist area in South Okanagan.

The hospital is located less than 30 minutes from the border. We recently had several international medical school graduates, who are either Canadians trained abroad or immigrants approved to come to Canada because of their training. They told us that if moving to rural Canada is what it took to practise as a physician, they would do that, but there are bottlenecks and bureaucracy.

Given the challenges that you describe in recruiting physicians to places like the South Okanagan, does it frustrate you that according to the Royal College of Physicians and Surgeons of Canada, there are at least 13,000 internationally trained doctors currently in Canada, including many Canadians, who are not allowed to work as doctors?

Martin Johansen: That's really low-hanging fruit. With people who are already living in Canada, we don't have to deal with the immigration process; we just have to get their credentials verified and get them working.

I know that B.C. has a \$5-million marketing program that is looking at attracting physicians from outside of our country as well. Some of the problems there.... What I'm hearing from having discussions with the Minister of Health for the province is that the biggest barrier to recruiting doctors from across the border isn't licensing; it's getting a work permit and going through immigration. We have doctors who are in the country, and we can't get them working. We have doctors outside the country who are facing some barriers as well. It's already been talked about today that one of the repetitive and time-consuming barriers is the labour market impact

assessment, which requires employers to prove the vacancy needs to be filled by a foreign worker.

I know I've gone a bit off topic here talking about physicians coming in from outside the province, but there's a simple fix or an opportunity there. When you consider that our health care is in crisis, maybe there could be an exemption there.

Helena Konanz: That's an excellent viewpoint, for sure. I know you're on the ground seeing this and have good insight into how to solve this issue. It's very complicated, but according to Health Canada, when you factor in nurses and specialists, there are 80,000 health professionals who live here but can't work in our health care system.

● (1150)

The Chair: You have one minute.

Helena Konanz: I know that MP Bailey has a question he'd like to ask, so I'll cede the final minute to MP Bailey.

Thank you.

Burton Bailey: Mayor Johansen, British Columbia relies heavily on locums from other provinces. Would you support national licensure to make it easy for travelling doctors, especially specialists? We had one gentleman here on the panel who carries six licences and goes around Canada as a travelling locum troubleshooting these closures so that emergency rooms can remain open.

Martin Johansen: I would support that 100%. As I said before, about 40% of the resources that keep our hospital open and working in our community come from outside of our community. One of the biggest barriers to retention is the workload that's associated with a rural community, so locum support is a huge requirement and a huge need and something we are sorely lacking.

Burton Bailey: Ms. Hall—

The Chair: You have eight seconds.

Burton Bailey: I'd like to thank you for joining us today and taking my questions.

The Chair: Thank you, Burton.

We will go to Mr. Hanley for five minutes for the Liberals.

Brendan Hanley (Yukon, Lib.): Thank you very much to both of you. It's a pleasure to listen to your testimony and to have an opportunity to participate in this study. I'm not a regular member of this committee, but it's kind of like coming home because I was, in the last term, part of this committee.

Ms. Hall, there are 25,000 vacant positions, and you talked about the importance of the role of temporary foreign workers in helping to fill the gap but also having to compete with many other sectors.

In general, how attractive would you say this work is? You're speaking from a national level, but what are the incentives within the work to maintain retention?

Jodi Hall: From a personal point of view, this is an extremely attractive area of work. I find it deeply meaningful and purposeful. I think that attracts a certain cohort of health care providers who are interested in that long-term relationship building with the residents of the homes.

With that, there are distinct challenges when it comes to working with shortages. Homes do everything they can to avoid those, because it can be incredibly challenging to meet the needs of residents when there is a shortage of staff. As I noted earlier, that's often where we see short-term solutions through agencies being taken up. There is a lot of energy that goes into dealing with competition and trying to ensure we're providing the best workplace possible, providing mental health supports to ensure retention and doing a lot of engagement with frontline staff to help them feel connected and help them feel that their role really matters. Those are all strategic decisions and efforts that are made.

Looking at the immigration opportunities, long-term care employers are playing a large role in the settlement of many newcomers into the workforce in a way that helps them feel connected and supported and ultimately supports their retention of employment in the home as well.

Brendan Hanley: Thank you.

Mayor Johansen, thanks for being here.

I have a couple of minutes left.

How long have you been the mayor of Oliver?

Martin Johansen: I've been mayor since 2018.

Brendan Hanley: When you became mayor, did you expect to have a role in health care recruitment as part of your position as mayor?

Martin Johansen: There was a small role, mainly liaising with Interior Health. We didn't have any closures. Then COVID happened and everything changed. The world changed after COVID, and it's continuing to evolve. The mental health issues and the work burnout are really driving some of the problems that we're seeing here.

Brendan Hanley: In addition to that, certainly the pandemic appeared to accelerate a phenomenon that was already happening as we were entering into a health workforce crisis. We addressed this in this committee with many recommendations in 2022 and recommendations in 2023 in a detailed government response.

It's budget day today, budget 2025. We know that one of the already announced items is \$97 million for a foreign credential recognition action plan, working with provinces and territories to improve the fairness, transparency and timeliness of foreign credential recognition. Do you think this is a move in the right direction?

• (1155)

Martin Johansen: Yes, 100%. The process to get into Canada—or, if you're living in Canada, to get your credentials verified—is incredibly complex and complicated. I think putting more resources into that, to be able to identify a process and maybe have people who can guide people through the process, will pay out benefits in the long run.

Brendan Hanley: Oliver is something of a retirement community. People still move to Oliver, or at least stay in Oliver, as a retirement community. Is that right? Would that be a potential factor in health care needs in your community?

Martin Johansen: Yes, it is a retirement community. Of course, the health care needs associated with people who are aging are more complex. It requires many more visits by a patient to a family physician. Yes, 100%, the health care needs in our community are probably higher than those in a community with a younger population.

Brendan Hanley: Thank you very much.

The Chair: Thank you very much.

That brings an end to this hour.

I'm going to suspend so that we can get the next hour going.

• (1155) _____ (Pause) _____

• (1205)

The Chair: I'm calling the meeting to order.

Before I introduce the witnesses, there is a little bit of housekeeping I want to remind you of.

As you well know, we have the second study we're going to do, Monsieur Thériault's on antimicrobial issues. We need to have witness lists for that study submitted no later than Thursday, November 6, at 4 p.m. Then, the next one would be Ms. Chi's on Thursday, November 13, on pharmaceutical sovereignty. We need witness lists by November 13, which is the week off, by 4 p.m.

Let's get those lists together, guys, so we can move and not have to waste time.

Yes, go ahead, Dan.

Dan Mazier: Can we get a week's extension on the witnesses for the antimicrobial study?

The Chair: I don't think so. We will not be able to get enough people to come to the first meeting. If we don't get a list in time for people to call people to ask them to come, then we don't have witnesses, so we don't have a meeting.

Dan Mazier: If we don't have enough witnesses, can we submit them later on, or is that the final drop-off?

The Chair: As you know, Dan, you submit your lists and if, later on, you have a couple of people you want to throw in, you do it.

Dan Mazier: Okay, thank you.

The Chair: All right. That was a bit of housekeeping.

I want to continue our meeting with the next witnesses.

From the Alberta International Medical Graduate Association, we have Deidre Lake, executive director.

I'm sorry; I'm going to have to suspend. We're having mic problems.

Thank you.

• (1205) _____ (Pause) _____

• (1210)

The Chair: I'm calling the meeting to order again.

I would like to introduce the witnesses for this hour.

Yes, go ahead, Dan.

Dan Mazier: Chair, just a point of clarification. In looking at the calendar and our last discussion about witnesses as of the 18th, where's the opioid study at? Is there an update on that?

The Clerk of the Committee (Catherine Ngando Edimo): On November 20, there's an interim report.

Dan Mazier: Yes. How are we coming along with that?

The Clerk: It is the interim report. It's for you to decide what you want to do after.

Dan Mazier: I guess, going back to our original request about extending for witnesses, we won't get to that study until way into November, so—

The Clerk: It's whatever the committee wants to do. It's just a draft. You can say to change it.

Dan Mazier: Yes, but it'll be a meeting—

The Chair: Dan, we don't know if the opioid report will be ready, because it's still in translation. It may or may not be.

Dan Mazier: We're getting an indication that it will be ready.

The Chair: Will it be ready? Good.

Dan Mazier: So I guess the possible extension for witnesses for the antimicrobial—

The Chair: I would like to keep the deadline, and you can extend later on with more witnesses. Thank you.

All right, once again, I'm going to introduce the witnesses.

From the Alberta International Medical Graduate Association, we have Deidre Lake, executive director. As an individual, we have Dr. Shazeen Suleman, clinical associate professor, Stanford University. From the Canadian Federation of Nurses Unions, we have Linda Silas, president, and Baljinder Singh, member, internationally educated nurses advisory committee.

We will begin. This is how it works. Each group will have five minutes—not each person but each group. I'll give you a one-minute and a 30-second prompt so you can wrap up. We are going to have questions and answers after that.

I'll begin with Ms. Lake for a maximum of five minutes, please.

Deidre Lake (Executive Director, Alberta International Medical Graduate Association): Thank you.

I'm the executive director of the Alberta International Medical Graduate Association, also known as the ITP hub. We serve internationally trained physicians across Canada by providing navigation supports and programs and services for the successful integration of ITPs into the health workforce. We're essentially a one-stop shop for every step in the licensure process for all pathways across Canada.

Access to the right supports at the right time matters. Our work is made possible by funding from the governments of Canada and Alberta. We currently have a talent pool of 3,800 active members seeking licensure or alternative careers in health care. We believe every ITP deserves a fair assessment of their skills and knowledge. I'm confident that a timely national process aligning competencies with workforce demands is possible.

A proven approach, utilized by some provinces, is the practice readiness assessment pathway, in which ITPs undergo a clinical field assessment while working under a provisional licence and are assessed for their competence to practise independently. For ITPs who do not meet the eligibility criteria or who meet the criteria but have been out of practice for three or more years, their only options are to return to their countries of origin to practise independently and renew recency or to compete for the limited number of residency seats through our Canadian residency matching system.

Last year, 95% of medical graduates who had trained in Canada matched to residency and could apply for any program of interest. ITPs, however, are not given the opportunity of choice. For comparison, due to the lack of seats, only 48% of ITPs matched. In Alberta, ITPs must demonstrate physical presence during a specified time frame. Ontario recently limited its residency seats to ITPs who have attended two or more years of high school in their province.

These restrictions exclude ITPs from being able to compete broadly. If we are interested in excellence, why are we not letting all eligible ITPs compete for all designated seats? Why are we placing further limitations on a group of individuals who already have limited spots to begin with, at a time when we need physicians?

I have many stories from my 20 years of working with ITPs about how costs of licensure, duplicative and repetitive assessments, and unnecessary and inflexible administrative barriers have led to many experienced physicians not even being able to make it to the plate to be assessed.

One of my most recent Uber drivers was a physician refugee from Afghanistan. He is not pursuing licensure, but he questioned why it's considered unsafe for him to give vaccines. A physician from India, who worked for several years in South Africa, was hired by the municipality of Vegreville, Alberta, but he experienced technical difficulties during his remote therapeutics decision-making exam. A disruption in Internet service and the "one sitting per calendar year" rule meant that he was unable to retake the exam for a year; not only was he out of a job, but the patients of Vegreville were also without access until a replacement could be found.

This year, approximately 40 of our members were denied the ability to compete for residency in Alberta because no window of opportunity is allotted to correct application oversights. Again, it is process over people, and competitive candidates are unable to compete.

This study is a crucial one. We must remove systemic barriers, shift from being exclusive to being inclusive, and streamline processes to allow ITPs to demonstrate their competencies sooner. This means assessing ITPs pre-arrival or upon arrival, determining the scope of practice that aligns with their training and experience, and matching these with health workforce demands.

• (1215)

Let's do better in determining who is able to go directly into independent practice versus who needs partial or full residency training. Let's expand upon the number of approved jurisdictions using evidence-based decision-making, remove redundancy for those applying to CaRMS and offer bridging opportunities to ensure that ITPs are equipped with the necessary supports to work to their full potential and to get doctors where doctors are needed, for the benefit of all of us.

Thank you.

The Chair: Thank you very much, Ms. Lake.

I now go to the Canadian Federation of Nurses Unions, with Linda Silas and Baljinder Singh.

Linda, you have five minutes.

Linda Silas (President, Canadian Federation of Nurses Unions): Thank you so much.

[*Translation*]

Hello, Madam Chair.

[*English*]

Thank you to the committee for letting us appear today. I apologize for not being there in person.

As mentioned, my name is Linda Silas. I'm a registered nurse, a proud New Brunswicker and the president of the Canadian Federation of Nurses Unions. We represent over 250,000 frontline nurses and nursing students.

Let me start with two simple truths. First of all, all recruitments of IENs should be done in an ethical fashion, respecting Canada's relationships with other countries. Second, it is clear that internationally educated nurses, or IENs, face serious challenges in

Canada. Only 42% of employed immigrants in Canada with a nursing degree are currently employed as nurses.

Earlier this year, the CFNU, in partnership with World Education Services, published a comprehensive report on the experiences of IENs. I believe you all received a copy. This was done through workshops with IENs across the country and a comprehensive environmental scan. The report identified barriers that IENs have been facing for years, including fragmented licensure systems, high fees, unpaid clinical placements, lack of mentorship, lack of workplace supports and discrimination.

At a time when our country has tens of thousands of vacant nursing positions, we need to find a way to better support the integration of IENs in Canada. Our report supports that and brings many recommendations. I'll name three.

First, establish a collaborative multi-stakeholder body to assist with strategy, with planning and with coordination of IEN registration, integration and necessary supports. We believe this should be done by Health Canada. Two, standardize the registration process for IENs across Canada's jurisdictions. Three, implement mentorship and anti-bias programs to ensure that once nurses are licensed, they are welcomed and retained in the workforce.

Before we continue, I would like to introduce Baljinder Singh, a member of our advisory committee on our recent report, who will share his experiences.

• (1220)

The Chair: Go ahead, Mr. Singh.

Baljinder Singh (Member, Internationally Educated Nurses Advisory Committee, Canadian Federation of Nurses Unions): Honourable Chair and esteemed committee members, thank you for inviting me to contribute to this important discussion.

My name is Baljinder Singh. I am an internationally educated registered nurse, a member of the CFNU IEN advisory committee and a former member of the NSNU. Currently, I am working as a lecturer at the Dalhousie University school of nursing in Yarmouth, Nova Scotia.

I was born in India and arrived in Canada in April 2017 with several years of clinical nursing experience and a deep desire to continue serving in the health care field. However, the journey to re-entering my profession in Canada was far from easy.

Like many internationally educated nurses, I faced significant barriers, including recent practice requirements, lengthy delays in processing, lack of clear guidance and financial challenges. During this time, I had to take on a variety of jobs far from my nursing profession to support my family. I worked at KFC, on loading docks, as an Uber driver, and later as personal support worker. It took me seven years to receive my RN licence. I had to get licensed in the U.S.A. before finally obtaining my licence in Canada.

Despite these struggles, I am proud to share that with the support of the Nova Scotia Health Authority, I successfully achieved my RN registration in April 2023.

Thank you very much for your time and for allowing me to share my story.

The Chair: Thank you.

You have one minute, Ms. Silas.

Linda Silas: I want to thank Baljinder for his expertise on our committee and highlight to all of us that when you have been a practising nurse in another country and it takes seven years and having to go through the U.S. to get a licence before getting a licence in Nova Scotia, it is a shame. We hope this committee will bring strong recommendations to the federal government.

Thank you very much.

The Chair: Thank you very much.

I now go to Dr. Shazeen Suleman, associate professor at Stanford, who is appearing as an individual.

You have five minutes.

Shazeen Suleman (Clinical Associate Professor, Stanford University, As an Individual): Thank you, Madam Chair.

I'm grateful to be here to speak with you all today. The views that I express today are my own and do not represent Stanford University or any other organization.

By way of introduction, I'm a pediatrician. I'm from Cambridge, Ontario, and I am a child of refugees. As you heard, I am an associate professor at Stanford, but I am also an affiliate scientist at the MAP Centre for Urban Health Solutions at St. Michael's Hospital in Toronto, which is where I practised and taught medical trainees before moving to Stanford three years ago. It is also where I built the Compass Clinic, which cares for children and youth who live at the margins, including children with disabilities and refugee, immigrant and indigenous children. As a clinician scientist, my lab develops and tests interventions with these children and their families to reduce their health disparities.

There are three points I wish to share with you today. The first is that I ask you to remember that no child chooses to be an immigrant or a refugee. These are choices that are made for them. By 2036, nearly half of Canada's children will be these children, as ei-

ther first- or second-generation immigrants, yet they are poised to suffer the consequences of decisions made by adults.

The second is that, like yourselves, as a Canadian pediatrician, my work is bound by the UN Convention on the Rights of the Child, which was ratified by Canada in 1991. It unequivocally recognizes the rights of every child residing in Canada, no matter where they live or what their immigration status is, and especially that they all have the right to health care, yet there are many children in Canada who do not have reliable access to health care and programs that support their health. These include children who live in rural or remote settings, many of whom are indigenous, who may need to take multiple flights just to get to a facility. They include children with developmental disabilities who wait years to access specialized therapies that they need. They also include children who cannot access the Canada child benefit or are separated from their parents, despite the children themselves being citizens of this country.

They include refugee children who can't find a provider that accepts the interim federal health program, or IFHP. When we survey all pediatricians in Canada, less than a quarter knew what the program was, and only 16% knew how to use the program. As a result, many people with IFHP don't know how to use the program themselves and are reluctant to access care until they're in dire straits and end up in our emergency rooms for what could have been preventable.

This brings me to my third and final point. As a signatory to the UN convention, Canada has an obligation to ensure that all children living in Canada have the same access to quality health care, independent of where they live or their parents' immigration status. We can learn from the Province of Quebec, which has provided access to public insurance for all children who live there, independent of their parents' immigration status, under Bill 83. Children in every other province are left without any access to care.

To a pediatrician, it is unacceptable and distressing to see children suffer. Our broken system harms all children in Canada and, in doing so, our future. Having practised in both the U.S. and Canada, in urban and rural settings, I am ashamed that I have been able to provide better care for immigrant children and youth in the United States than I ever could in Canada, because of better access to public health insurance programs and easier processes for internationally trained providers.

There is no denying the shortage of primary care providers in our country. Allowing qualified internationally trained clinicians, including returning Canadians, to practise in Canada is an attractive strategy to fix this.

I said I had three points, but I would like to add a fourth. It is that the children of refugees and immigrants are just like me. They are proud of their country and determined to make Canada better for all. We owe them the opportunity to do so.

Thank you for your consideration.

• (1225)

The Chair: Thank you very much.

We will go to the question and answer segment. The first round is six minutes. The six minutes include the questions and the answers.

I shall begin with the Conservatives and Mr. Mazier for six minutes, please.

Dan Mazier: Thank you, Chair.

Ms. Lake, you mentioned that internationally trained physicians could be tested on their competencies prior to their arrival. This is something we've heard from internationally trained physicians, who feel that they became trapped in a broken system once they arrived in Canada.

Can you explain how pre-arrival competency assessments could help prevent bottlenecks?

Deidre Lake: We provide navigation support. One of the things we often recommend is that individuals consider doing some of the assessments they are able to do abroad, before coming to Canada, to speed up the process. Certainly that is one aspect.

Then it's looking at what tools are needed to measure the competencies needed and align those with health care demands.

Dan Mazier: Thank you.

Ms. Lake, do you believe Canada should implement a national licence for health care professionals, so that doctors can practise across provinces without barriers?

Deidre Lake: I think that eliminating the barriers, particularly for individuals who are here or anyone who is coming, is definitely something that we would support.

Dan Mazier: Are you aware of any barriers? Do you have personal knowledge of people who have challenged these barriers, and can you elaborate on those?

Deidre Lake: Even in my speech... We're limiting access to the competition for people who are here by making residence requirements or limiting their access to seats, and there is a lack of bridging programs or whatnot where people can fill gaps where gaps are identified. That lack of opportunity or being subjected to further limitations certainly creates barriers for people, and we have a lot of people who relocate to different provinces where there are opportunities.

For example, in Alberta, we have associate physician positions. We have one of the largest PRA programs for both specialist and family physicians, and of course there is residency across Canada, but you have to be a resident of Alberta in order to apply for those seats.

Dan Mazier: Ms. Lake, would you support a streamlined national competency-based assessment for internationally trained doctors?

• (1230)

Deidre Lake: Yes. I think there is some work being done right now looking to increase competency-based assessments for physicians. We certainly support that. I think the issue right now is that we have a battery of tests and assessments that people have to do before they're even considered or looked at, or, as I said, they may not even be able to make it to the plate to be assessed.

I certainly think there are improvements that we need to make to allow people a fair assessment of their skills upon arrival and then determine at what scope they're able to practise and which assessments they would need to do to fulfill their competencies.

Dan Mazier: Ms. Lake, according to the Royal College of Physicians and Surgeons of Canada, there are currently over 13,000 internationally trained physicians in Canada who are not working as doctors.

Do you think the government should prioritize licensing internationally trained physicians already in Canada before they start adding people to a bottleneck in a broken system?

Deidre Lake: I think a lot of the changes that are made are benefiting those who are arriving, and I do think there is a large number of people we haven't utilized, people who are underutilized and underemployed and aren't working to their potential. I think any initiative that would support assessing those individuals for their competence and getting them into the health workforce would be of benefit to all.

Dan Mazier: Ms. Lake, do you believe there is a disconnect between immigration policy and health care planning in Canada?

Deidre Lake: I'm not an immigration policy expert. I think there are certainly highly educated and highly skilled individuals coming, and I think having that information so that people could land where their skill sets are needed and having better-coordinated services between those demands and the individuals coming would be helpful.

Dan Mazier: Thank you. There are lots of opportunities for that.

Have you talked to any people who have immigrated and are not in the system? Do you have examples right in your own neighbourhood or in your own community of people you could think of whom this would actually help out tremendously? It would help out our system as well, as far as serving Canadians is concerned.

Deidre Lake: It would help thousands. I know that during the pandemic there were lots of people sitting on the sidelines wanting to help their fellow colleagues. I think there are lots of people still sitting on the sidelines, like the gentleman I made reference to who is working as an Uber driver and who was employed in Afghanistan working for the WHO. He is simply looking for a job where he could provide public health information or vaccines.

Dan Mazier: Ms. Lake, how can practice readiness assessments help get internationally trained doctors licensed and working?

Deidre Lake: I think that an increase in those seats has been a proven model for assessment, so I think expanding upon practice readiness assessment opportunities and associate physician opportunities would be helpful in creating pathways to licensure.

Dan Mazier: Thank you, Ms. Lake.

The Chair: I now go to the Liberals.

We have Ms. Chi for six minutes.

Maggie Chi (Don Valley North, Lib.): Thank you, Madam Chair.

Thank you, Ms. Lake, for coming, and thank you to all the witnesses for joining us this afternoon.

My first question is for Ms. Lake.

In terms of your experience, you talked about the process and sometimes the frustration around it. Which part of the process would you think could be better aligned with the Medical Council of Canada and the provincial colleges to streamline the process a little bit more?

Deidre Lake: It's a good question.

There was some discussion on modernizing assessment processes. I know there is a demand or a request to move to more competency-based assessments. Again, if we were able to align individual skills, for instance, we would have a urologist who is able to work as a urologist. At the current time, specialists are having to do part one of the qualifying exam, which requires them to essentially go back and study all aspects of medicine, when in fact that might not be the area of medicine or the scope of practice that they are eligible to work in, so it is slowing down their process to be assessed. Again, that is one thing—looking at the tools we need to have in place to assess competencies and to ensure safety of practice and being able to assess individuals upon arrival for their competencies and then look at their skills and training.

The other aspect is that for CaRMS, there are a lot of processes that could be changed. There are individuals who are having to apply to CaRMS on an annual basis, for example, and who have to repeat all the same documentation, such as English proficiency exams, every two years. There are also personal attribute tests, which they do on an annual basis. They do three assessments if they're applying to family medicine across Canada, if there are seats available. There are multiple repetitions of tests they do year after year, which compounds the issue and discourages some people from continuing to apply.

• (1235)

Maggie Chi: Thank you, Ms. Lake.

I have a quick question. Based on your testimony, it sounds like there are pathways, and some parts need to be streamlined. Would you agree that it's not a broken system and that it just needs to be streamlined and improved?

Deidre Lake: I think there are lots of proven best practices and emerging practices. We see that in some provinces, internationally educated nurses are able to work in clinical settings while they're preparing for exams. That model has worked; I would love to see that model, and our members would love to have that opportunity

in order to gain clinical experience while they are preparing for exams and learning about the Canadian health care system.

Maggie Chi: Thank you for articulating that.

My final question is for Linda Silas.

Thank you for joining us from the great province of New Brunswick. I have a couple of quick questions.

You mentioned staffing shortages. Would you say it's the number one pressure facing long-term care homes and our system across the board—

[*Translation*]

Luc Thériault: Madam Chair, could you interrupt for a few seconds?

[*English*]

Maggie Chi: Can I pause my time?

[*Translation*]

Luc Thériault: The interpreters are telling me that my colleague is much too far from the microphone and is speaking much too softly for them to be able to interpret correctly.

It's been mentioned to me at least three times now. I just wanted to mention the fact that they can't do their work.

[*English*]

Maggie Chi: Oh, I'm too far from my microphone. Okay.

The Chair: Please speak into the microphone, because the interpreters cannot hear you.

Maggie Chi: Okay.

Is this better?

The Chair: Yes, go ahead.

Maggie Chi: Linda, we're seeing nurses facing that pressure. You talked about workload and retention even as we recover from the pandemic.

I would like to know what that looks like in different provinces depending on how each health care system is structured. Can I get your take on that, please?

Linda Silas: Thank you, MP Chi.

The health care crisis is across the border. In the previous hour, you were hearing from an expert in long-term care. I was listening to Jodi Hall. It is a crisis in long-term care, but it is also a crisis in our hospitals and in our communities.

The keys are the workload and the workplace. We need to change the way we think of the culture of health care, because nurses, doctors and health care professionals are all leaving; they are not staying. Stats Canada reports that we have over 30,000 vacancies just in nursing, which means empty lines. That means we would need about 60,000 new nurses tomorrow to fill those positions, and I'm sure we could have statistics on doctors and other health care professionals.

When we talk about IENs, as I mentioned in my presentation, 42% of them in Canada are not working, and they have degrees in nursing. That is nonsense to us. I am not an expert in regulation, but I am an expert in workplace issues, and the workplace needs them, so we need to find ways to regulate them a lot faster and welcome them into our communities.

Maggie Chi: Thank you.

I just want to do a time check, Chair.

The Chair: You have one minute and 10 seconds.

Maggie Chi: Okay.

I will share my time with Dr. Hanley.

The Chair: Dr. Hanley, you have one minute and nine seconds now.

Thank you.

Brendan Hanley: Ms. Silas, it's great to see you again. You were extremely helpful at this committee when we reviewed the health care workforce crisis that you replied to. Since then, there have been a number of recommendations. There was a detailed government response.

Since I have only one minute, I just want to outline this, as I did in a previous panel. You heard me mention the foreign credential recognition action fund in this budget. How will that fit with your second recommendation of a standardized registration process for IENs across Canadian jurisdictions? Do you see a window of opportunity on that recommendation?

• (1240)

Linda Silas: We're very hopeful that everyone is talking about internationally educated health care professionals. Everyone is talking about personal care workers. We believe that the federal government, the provinces and the territories will find solutions to coordinate regulation and also the entry to practice. That is key.

We're hopeful, and we're open to working with all.

The Chair: Thank you.

We'll now go to Monsieur Thériault.

[*Translation*]

You have the floor for six minutes.

Luc Thériault: Thank you, Madam Chair.

Mr. Singh, I just want to tell you I am completely awed by your experience. Your determination and perseverance are certainly a testament to your excellence in practising your profession. Some say that this profession is a vocation, and you are living proof. I'm delighted to see there are people of your calibre within the Canadian Federation of Nurses Unions.

That said, I will now turn to Ms. Silas.

Ms. Silas, you spoke briefly about the importance of mentorship to ensure acceptance into the environment. According to Catherine Gail Montgomery, who is the scientific director of the team known as "Migration and Ethnicity in Health and Social Services Interventions," recognizing diplomas and credentials is certainly a chal-

lenge. She also said once that's done, there is a particular challenge around integrating into home environments because there are barriers, possibly systemic ones.

What are your observations on that?

Linda Silas: Thank you, Mr. Thériault.

You hit the nail on the head. When we talk about mentorship, we're automatically talking about clinical mentorship. It involves helping people adapt to their environment in hospitals and care homes. However, our internationally trained staff also need cultural mentorship.

As you know, I am from a very rural area in New Brunswick, where it is tough for someone internationally trained to work in a hospital. It requires not only clinical mentorship, but cultural mentorship as well. That's what makes people stay.

For example, fish processing plants in my region have many immigrants from Mexico. So, we built restaurants and grocery stores offering Mexican specialties, and people stayed. We have to think the same way about our communities and every area of our work.

Luc Thériault: You're seeing the challenge of integration both in practice and in institutions.

Am I understanding you correctly?

Linda Silas: Yes, exactly.

Luc Thériault: I see.

Several witnesses came and told us about how difficult it is to recruit nursing staff. I've been hearing about the issue of recognizing qualifications for 30 years. It led to human tragedies because we weren't integrating them fast enough. Now there's a labour shortage, and we're finally deciding to act. I think we really missed the boat.

As for recruitment in the field of nursing care, we hear that it's harder to train students. In any case, that was the case in Quebec barely five years ago.

Is that still the trend?

What must be done to retain labour? Working conditions have deteriorated so badly.

• (1245)

Linda Silas: Thank you again, Mr. Thériault.

In nursing schools, we don't hear about problems when it comes to recruiting students. The problem is that after they get their diploma, they don't want to work full time. They accept casual or part-time work, because staffing is problematic and the workload is too high.

Nurses are assigned too many patients. They can't do good work, so they leave. On top of that, there's no flexibility.

That is why we encourage governments to regulate the number of patients per nurse, in Quebec and everywhere else in Canada. Nurses working in a specialized field would then know, scientifically, how many patients they can safely care for.

Luc Thériault: I imagine that all Health Ministers want to offer the best care possible and meet the public's needs. The resistance surrounding setting appropriate ratios in line with scientific practice criteria is specifically connected to the ministers' lack of financial resources. They're concerned about it.

Chronic underfunding of health: Isn't that the elephant in the room throughout the conversations we're having today?

Linda Silas: Yes, that's certainly the case.

I just met with all the Health Ministers. Clearly, they must be at the financial table to make sure we're funding our health care appropriately, be it at the federal, provincial or territorial level.

Luc Thériault: Thank you.

[English]

The Chair: Thank you very much.

Now we go to another round. It's a five-minute round, and I begin with Ms. Konanz for the Conservatives.

Helena, go ahead for five minutes.

Helena Konanz: Thank you, Chair.

My questions start with Ms. Lake. Thank you for coming in today.

How has Alberta integrated international medical graduates into the health care system? How does it differ from other provinces?

Deidre Lake: I think that in Alberta one of the things we have going for us is a long-standing practice readiness assessment program, where general practitioners, or family physicians, as well as specialists are assessed for eligibility. This has meant more opportunity for some people compared to other provinces.

The other aspect we have is that there are about 250 to 300 internationally trained physicians working in acute care settings as associate physicians. They're working there under a provisional licence. I think there is a desire to look at opportunities where those individuals might be able to work as associate physicians, in a hospitalist role or whatnot. That would be something we would support. That's not happening at the current time, but it's a solution for individuals who are demonstrating their competencies in a clinical environment and setting.

Helena Konanz: Do you think this is a template that could be used for the rest of the provinces? Is it working well, would you say?

Deidre Lake: It's a long-standing program. When I first started working with internationally trained physicians in 2004, that program was in existence. It certainly provides a great opportunity for people who meet the requirements to work in a clinical setting.

The one caveat to that particular position is that there is a three-year recency of practice requirement. Some people don't hear about that particular opportunity or may not have the recency of practice. The recency of practice, where they're working under supervision,

is the same as if they are going into the practice readiness assessment position, where they're working independently.

Helena Konanz: I believe you mentioned there are 3,800 people in Alberta seeking licences in health care.

• (1250)

Deidre Lake: Our membership is national, so it's 3,800 people across Canada.

We support individuals in helping them navigate the licensure pathways for all provinces.

Helena Konanz: What can we do better to integrate those who are already here in Canada seeking to acquire their licences and practice?

Deidre Lake: I think certainly doing competency-based assessments, allowing people to demonstrate their skills and also looking at the work experience they have... Often, we look at the training that somebody has, but we don't take into consideration the years of training.

Helena Konanz: Do you believe there is a disconnect between immigration policy and health care planning in Canada?

Deidre Lake: I think we could definitely be more collaborative and coordinated with regard to individuals who are coming, to make sure they get the right supports at the right time. We know that the sooner they get the support, the more likely they are to be successful.

Helena Konanz: Thank you.

I will cede the rest of my time to MP Mazier.

The Chair: You have one minute and 26 seconds.

Dan Mazier: Thank you, Chair.

I'd like to move the following motion:

That, given the desire of the Minister of Health and Minister of Immigration, Refugees and Citizenship to appear together for the committee's study on the impact of immigration on health care, the ministers appear together for a full two hours and that a separate meeting be scheduled to hear from their respective departmental officials.

Can I get on with debate?

The Chair: Yes, you have the floor, Mr. Mazier.

Dan Mazier: The ministers decided to go against the recommendations of our motion, which said that one full meeting would be dedicated to the Minister of Health and officials, and that one full meeting would be dedicated to the Minister of Immigration, Refugees and Citizenship and officials. There were supposed to be two different meetings with their departments and with the two different ministers.

This is a compromise for the ministers, because they indicated that they wanted to meet together. This way, this would be accommodating the committee. Then it would work for the officials as well. The ministers could come in and have their say. Meanwhile, the committee could ask them some reasonable questions. I'm sure Canadians have many, especially when it comes to health care.

The Chair: Go ahead, Ms. Konanz.

Helena Konanz: Speaking to the motion, I think we need to respect the time of the ministers and give them a full hour and also respect the time of the people sitting around this table. We shouldn't have to rush. I think we should be able to ask as many questions as we want. Having them both in one hour.... Having to rush through a meeting won't help anyone in creating this report.

The Chair: I now go to Ms. DeRidder.

Kelly DeRidder (Kitchener Centre, CPC): I think it's imperative that we have the ministers come, because there are six and a half million Canadians without a doctor right now. Also, 10 years of failed immigration has added extra strain to our health care system. On top of that, we have doctors here as taxi and Uber drivers. That was validated right here in committee today. There is no path to foreign credential recognition.

For these reasons, it's important that we hold our government accountable. It's our duty and our responsibility to do so, and Canadians deserve to hear what the government is doing about this. It's absolutely imperative that we have the Minister of Health and the Minister of Immigration come speak to this committee.

Thank you.

[*Translation*]

The Chair: Mr. Thériault, you have the floor.

Luc Thériault: I agree with the first part of the motion. Although I already said I wanted to hear from the ministers separately, proposing one two-hour meeting to have them both is a compromise I can get behind.

However, I also explained that testimony from officials was of very little interest to me. If we have them during another meeting, I would like us to also have other witnesses. If the mover agrees with that, I will get behind the motion.

• (1255)

[*English*]

The Chair: That's an amendment, then, Mr. Thériault.

[*Translation*]

Luc Thériault: We can do it officially, or the mover can include it in his motion.

[*English*]

The Chair: Mr. Mazier, are you fine with that?

Dan Mazier: Yes.

The Chair: However, there is no such thing as a friendly amendment. You should know that.

Go ahead, Ms. Chi.

Maggie Chi: I think that Mr. Thériault said what I wanted to say. I just want to make sure that the officials are coming with the ministers as well, as there could be some questions for them at the same time. When they do get invited, I find it valuable to have other witnesses, if we could do that.

The Chair: Thank you.

I think it's standard that when ministers appear before committee, they bring officials with them anyway. That is standard practice.

Mr. Mazier.

Dan Mazier: The officials are coming for the other meeting, though. Is that right? They can come for both meetings, but they are present in the second meeting.

The Chair: It is my understanding, from what Monsieur Thériault said and you agreed to, that we're going to have the officials come for another meeting, but there are going to be other witnesses as well, not just the officials.

Dan Mazier: Then the ministers are coming for the two hours. Okay.

The Chair: Mr. Powlowski, do you wish to speak to this issue?

Marcus Powlowski: What is the proposal? Is the amendment to have one hour with the officials in the second session and one hour with other witnesses?

The Chair: Is that what you're saying, Monsieur Thériault?

He is nodding, so yes.

Dan Mazier: It's two hours with officials and witnesses.

The Chair: You want a full two hours. That's nice. That's what I would like to do at all times.

It would be two hours with officials and witnesses as one group. Is that good?

Marcus Powlowski: It's a little strange. Are we going to put government officials and random witnesses together?

The Chair: Yes. There's nothing wrong with that.

Marcus Powlowski: Okay.

Dan Mazier: Canadians have a lot to say, Marcus.

The Chair: I'll ask for a vote.

Dan Mazier: Can I ask for a clarification, Madam Chair?

The Chair: Yes, go ahead, Mr. Mazier.

Dan Mazier: Will we have the ministers here for the full two hours in the first meeting?

The Chair: Yes.

Dan Mazier: Okay. Thank you.

The Chair: Do we have a consensus?

(Amendment agreed to)

(Motion as amended agreed to [*See Minutes of Proceedings*])

The Chair: It being two minutes to one o'clock, I'm going to thank the witnesses for coming and helping us by giving us their valuable expertise and testimony.

I now declare this meeting adjourned.

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