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• (1100)

[*Translation*]

The Chair (Hon. Hedy Fry (Vancouver Centre, Lib.)): Good morning, everyone.

[*English*]

I call this meeting to order. Welcome to meeting number 13 of the House of Commons Standing Committee on Health.

We meet on the unceded territory of the Algonquin Anishinabe people. Today's meeting is in person.

I want to remind participants of the following points. I know you know what they are, but I have to tell you anyway, for the record. Don't forget that you have this little round decal in front of you where you should put your phones or any other electronic equipment so that they don't interfere with the transmission. It can cause problems with the interpreters.

Always turn off your microphone when you are not speaking, and turn it on when you are. Please wait until I recognize you before speaking. Everything you say should go through the chair and not directly to each other. Again, if you wish to speak, raise your hand. We will make the list as we see the hands around the room.

Again, thank you for coming this morning. We have our list of witnesses. They are officials from Health Canada and IRCC. From the Department of Health, we have Jocelyne Voisin, senior assistant deputy minister, health policy branch; and Michelle Owen, executive director, health human resources task force. From the Department of Citizenship and Immigration, we have Louise Baird, assistant deputy minister, strategic policy; and Soyoung Park, assistant deputy minister, economic programs.

We are doing a study pursuant to the motion adopted on Tuesday, September 23, 2025, to study the impact of immigration policy on health care and barriers to integrating internationally trained professionals.

I will begin by saying to the witnesses that each of your groups will have five minutes. I'll give you a shout-out at one minute and again at 30 seconds so that you can wrap up. If you can't finish everything you want to say, obviously you have the opportunity during the question and answer period to say what you have to say.

I will start with Jocelyne Voisin from IRCC.

You have five minutes, please, Ms. Voisin.

Jocelyne Voisin (Senior Assistant Deputy Minister, Health Policy Branch, Department of Health): I'm from Health Canada.

The Chair: I'm sorry.

You're sitting in the wrong places.

Voices: Oh, oh!

The Chair: You sat the other way last time.

Thank you. Go ahead.

Jocelyne Voisin: Thank you, Madam Chair and honourable members of the committee. We appreciate the opportunity to appear before you as part of your study on the impact of immigration policy on health care and barriers to integrating internationally educated health professionals into the health care system.

Canada's health care sector is facing critical shortages of health professionals, including doctors, nurses and other health workers. These shortages are having an impact on access to care for many Canadians.

Immigration is a vital part of addressing Canada's health workforce shortages. Internationally educated health professionals bring valuable skills and experience to the Canadian health care system. However, as the committee has heard, internationally educated health professionals face a number of barriers to entering Canada's health workforce. For example, foreign credential recognition processes, which are managed under provincial and territorial jurisdiction, can be complex, burdensome and costly. Even after becoming licensed, internationally educated health professionals face challenges integrating into the workforce. Many experience burnout or low employment retention due to negative work environments, discrimination and a lack of social and professional supports.

• (1105)

[*Translation*]

The Government of Canada is committed to supporting health care workers in Canada and ensuring that health care workers are supported from coast to coast to coast.

The federal government has made a series of historic investments to strengthen public health care and ease the pressure on provincial and territorial health care systems.

[English]

As you've already heard, budget 2025 will invest \$97 million over five years to create a foreign credential recognition action fund. The government will work with provinces and territories to make credential recognition fairer, faster and more transparent, helping qualified foreign-trained professionals contribute more quickly to Canada's workforce, including in fields facing labour shortages such as health care and construction.

This investment is in addition to the budget 2024 commitment of up to \$77 million over four years to help internationally educated health professionals join the workforce more quickly. This includes funding to create new training positions for international medical graduates, expanded assessment capacity and navigation supports to make credential recognition more efficient.

Health Canada is funding the national registry of physicians, Canada's first integrated source of physician licensure data, and Nursys in Canada, a national platform for nursing licensure data to facilitate information exchange between regulators to improve labour mobility, making it easier for doctors and nurses to move practices across the country.

Finally, Health Canada also funds Health Workforce Canada, an independent organization that is working to improve access to health workforce data and planning capacity across the country. This will help ensure that health workforce planners and decision-makers are better equipped to ensure that we have the right mix of health professionals, including internationally educated health professionals, in the right places to deliver timely, high-quality care.

[Translation]

Health Canada, in collaboration with Employment and Social Development Canada and Immigration, Refugees and Citizenship Canada, is working with provincial and territorial governments to streamline immigration processes for health professionals, remove barriers to the recognition of foreign credentials, and support initiatives that promote the integration and long-term retention of international health professionals in the health sector.

Provinces and territories are working to develop innovative models for the recognition process of foreign credentials in their respective jurisdictions.

[English]

For example, as you will hear later today, Nova Scotia developed the Physician Assessment Centre of Excellence, which provides licensure assessment for internationally trained physicians while also providing primary care to the community. British Columbia has developed the Inspire Global Assessments program, which determines competency for registered nurses, licensed practical nurses and health care assistants all at once.

[Translation]

Health Canada will continue to collaborate with provinces, territories, regulatory bodies and other partners in the health care system to support these efforts.

I would like to thank the committee for inviting me to testify today. I will be happy to answer any questions members may have.

[English]

The Chair: Thank you very much. You had one minute left. That's good.

Jocelyne Voisin: I'm good. Thank you.

The Chair: Now we will turn to Louise Baird, deputy minister, IRCC. Thank you.

Soyoung Park, you're going to be the speaker. Okay. Thank you.

Soyoung Park (Assistant Deputy Minister, Economic Programs, Department of Citizenship and Immigration): Yes, I'm Soyoung Park from IRCC.

Thank you, Chair and members of the committee.

At IRCC, our role is to ensure sustainable admissions of temporary and permanent residents and to support the integration of internationally educated professionals to fuel economic growth. Canada's latest immigration levels plan advances this work by aligning future immigration with priority labour needs, including in health care.

● (1110)

[Translation]

Immigration operates in parallel with provincial and territorial health care systems. Planning, licensing and delivery of health services are their responsibilities.

During our consultations on the 2025-27 immigration levels plan and our ongoing dialogue with the health sector, we were consistently told that Canada needs more health professionals.

Immigration, Refugees and Citizenship Canada is responding to this demand in three ways. First, we have implemented temporary worker programs that respond to the immediate needs of the labour market. Second, we have launched permanent residence programs that support the health sector. Third, we offer settlement services that promote the recognition of credentials and integration.

[English]

One, temporary foreign worker programs allow employers to fill gaps in hospitals and long-term and community care settings. As of September 30, 2025, over 16,000 temporary workers had permits to work in a range of health care occupations.

[Translation]

These programs also offer flexibility with regard to regulated professions. They allow candidates who are on track to obtain a licence to work in the sector while continuing the process of having their credentials recognized.

[English]

A recent study by Statistics Canada found that temporary worker programs played an important role in filling labour gaps to reduce the burden on overworked domestic health care workers. In addition, one year after transitioning to permanent residence, nearly two-thirds of temporary foreign workers remain working in the health care sector.

Two, on permanent residents, more than 11,000 health care workers arrived in 2024 and another 8,000 so far this year. There have been criticisms that we are admitting foreign doctors who are underemployed. We know that not all internationally trained medical professionals, regardless of whether they are Canadian citizens or obtained permanent residence through IRCC programs, are able to work in their field right away. In all cases, licensing requirements from regulators must be met.

[Translation]

However, limiting the permanent residence options for these individuals would only reduce the pool of qualified candidates who could obtain a licence later and contribute to the Canadian health care system.

[English]

At the federal level, we select candidates based on skilled work experience, education, language ability or high human capital. Economic immigrants consistently demonstrate strong labour market outcomes, including high employment rates and earnings. Health care workers are not the exception.

Number three is IRCC settlement services. Credential recognition remains the major factor in how quickly internationally educated health professionals can work as health professionals in Canada. While licensing is carried out by provincial and territorial regulators, IRCC works closely with Employment and Social Development Canada and Health Canada to support labour market integration.

IRCC-funded settlement services help newcomers prepare for their credential pathway and understand labour market expectations. Pre-arrival services such as PASS for nurses offer counselling, connections to regulators and mentors and guidance on the steps required to practice in Canada.

[Translation]

Our approach to immigration is designed to meet economic needs while respecting the capacity of communities. Health professionals who come to Canada play a vital role in strengthening health systems nationwide.

[English]

The Chair: You have 30 seconds.

Are you finished? I'm sorry. I didn't mean to stop you.

Soyoung Park: My last point was to thank you.

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

I now go to the question and answer segment. The first segment is a six-minute segment. I repeat that the six minutes are for questions and for answers, so I would like everybody to be as succinct as they can be so that we can give everyone an opportunity to ask questions.

We begin with the Conservatives for six minutes.

Mr. Bailey, go ahead.

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

I would like to continue on a little bit with what we discussed on Tuesday with the immigration minister.

Ms. Baird, on the Health Canada interim federal health program website, it outlines who's eligible for coverage under this program. Eligible groups include asylum claimants and detainees who have illegally crossed the border into Canada. On Tuesday, the immigration minister said falsely that once the process is concluded, the coverage ends.

I'd like to confirm for the record that the website also includes asylum claimants who are waiting for decisions as to whether the claim is eligible and asylum claimants whose claim for refugee protection has been rejected by the IRB.

My first question is this: How many asylum claims were rejected in 2024?

• (1115)

Soyoung Park: I'll take that question on behalf of IRCC.

The decisions on the asylum claims that are rejected or refused are made by an independent tribunal, as the minister stated, which is the IRB. In fact, the number rejected in 2024 was around 16% to 17%.

Burton Bailey: Okay. I have a number of 11,761.

Soyoung Park: That's right.

Burton Bailey: Okay. There is a number.

What about 2025? Do you know the number of rejected claims?

Soyoung Park: As of June 30, 2025, the IRB had rejected 6,947, so it's about 17%.

Burton Bailey: Of these rejected claims, how many have received health care coverage under the IFHP?

Soyoung Park: As the minister explained, failed claimants also have a right to appeal their decisions, so during the time that they are in Canada, before or if they are removed and they failed in their claim for appeal, they would still be eligible for the interim federal health program.

Burton Bailey: Okay. We don't have a number.

Does the immigration department or the health department track the number of bogus claimants who are receiving health care?

Soyoung Park: We just went through the numbers of rejected claims.

Burton Bailey: Why does the immigration department not track the number of bogus asylum claimants who are receiving health care funded by Canadian tax dollars?

Soyoung Park: I think we just went through the numbers. I have already explained that the actual body that makes the decision on whether or not someone is a failed claimant is in fact the Immigration and Refugee Board.

Burton Bailey: Okay.

For these people who are coming into Canada on bogus asylum claims and receiving health care funded by Canadian tax dollars, including supplementary care like dental, vision, medical devices and mental health services that many Canadians don't even receive, do we know how long the coverage lasts if they're rejected?

Soyoung Park: It lasts until either their status changes and they're covered under provincial health care or they depart Canada.

Burton Bailey: According to a government brief from June 2025, in fiscal year 2024-25 alone, you provided health care coverage for 623,365 beneficiaries, including 440,000 asylum claimants with expenses of \$900 million.

Does the department break down the number of people based on the groups listed on the website?

For example, how many asylum claimants, how many detainees and how many individuals are granted eligibility at the minister's discretion? Is there a breakdown?

Soyoung Park: Are you asking about eligibility? I'm not sure how you're using the term "eligibility" there.

Burton Bailey: I'm looking for a breakdown. We have these large numbers. A lot of money is being spent on health care.

I would like to know how many the minister, at her discretion, allowed this health care. I'd like to know how many asylum claimants and how many detainees there are.

Soyoung Park: I can tell you that of that number, about 440,537 are in fact asylum claimants.

However, as you will note, just because you are an asylum claimant, it doesn't mean that there has been a determination of whether or not it is a founded claim.

Burton Bailey: Yes, I actually said that number, but that's okay.

Do you not think it's in Canadians' interests and the best interests of the federal government to know what kind of people are entering into this country and receiving potentially better health care than the Canadians who are funding the program?

Soyoung Park: I'm not sure I would describe it as better health care.

Burton Bailey: I sure would.

When I look at the amount doctors are billing to that department, at five times the rate.... They are seeing doctors more quickly than average Canadians.

• (1120)

Soyoung Park: The IFHP uses fee schedules and pricing structures that are aligned with provincial and territorial rates.

Burton Bailey: That's not true.

You are being billed at a higher rate than the provinces and you are just paying it. You're not following any fee guide.

Soyoung Park: We do verify for eligibility prior to the payment.

Burton Bailey: You verify that you're going to pay it, but they can bill whatever they wish and the rate is five times. The anaesthetist and the surgeon are billing you at five times the rate that they would normally charge the province that they work in.

Soyoung Park: I am not sure what point you're trying to make there.

Burton Bailey: I am making a point that we are spending \$900 million on health care, and I think that the system is being abused. I would like to have some accountability, so I am asking you questions and you're not really answering them for me, but that's okay.

I came across a federal immigration department information sheet and I'm going to show it to you.

Are you familiar with this sheet? I can pass it down.

Soyoung Park: No, I am not.

Burton Bailey: You're not familiar with it. That's too bad.

This is an up-to-date information sheet. It would be given to an individual when they come into Canada, but you're not aware of it, so I won't even bring it up.

What kind of information do you give to people when they come into Canada to explain our health care system? Do you give them anything?

Doug Eyolfson (Winnipeg West, Lib.): I have a point of order.

The member had six minutes and we're well over seven minutes into his round.

The Chair: You are absolutely right. I am sorry.

Burton Bailey: I would like a one-minute warning.

The Chair: I didn't give you one and I am so sorry. That's my fault, but your time is up anyway.

Thank you, sir.

Burton Bailey: We're not going to hear my—

The Chair: Your time is up.

I give you a one-minute warning because I happen to do that as this chair. Many people don't give a warning because you're supposed to be checking your own time yourselves and just tell you when your time is up. That's fine.

Burton Bailey: Thank you, Chair.

The Chair: Let's move on, then.

Ms. Sidhu is next for the Liberals.

Sonia Sidhu (Brampton South, Lib.): Thank you to all the witnesses for coming here today on this important study. Your insight is very important.

My first question is for the health department.

Budget 2025 provides \$5 billion over three years for the health infrastructure fund. We have heard from witnesses that addressing the health worker shortage also requires having the physical and educational infrastructure in place.

Can you speak about how the new fund is intended to support provinces and territories in expanding and modernizing these facilities, so they can better meet the needs of Canadians?

Jocelyne Voisin: Thank you for the question.

The budget committed \$5 billion over three years for health infrastructure. That included mention of hospitals and also medical schools. We have heard from faculties of education that they do need to upgrade their infrastructure. Obviously, provinces and territories are very happy about hearing the news of potential investments in health infrastructure.

We're still working with Housing, Infrastructure and Communities Canada to design the program, but there is certainly a lot of interest there. The provinces and territories are telling us that they have aging health infrastructure and they also have needs in terms of medical schools, so this will be very welcome.

Sonia Sidhu: As a follow-up, this budget includes significant investment to attract international talent to Canada, including funding for the Canadian Institutes of Health Research, or CIHR, to support international doctoral students and post-doctoral fellows and give support for universities to recruit international assistant professors.

Can you explain how these investments will continue to play a part so that Canada's health system becomes strong in areas like clinical education and medical research, and how they complement broader efforts to address health system capacity and workforce shortage?

• (1125)

Jocelyne Voisin: I can, absolutely.

There was a \$1.7-billion investment in the budget for the attraction of international research excellence. As you noted, CIHR will be receiving some funding from that announcement. One of the key things that we want to ensure as part of that for the health sector is that the health academic research centres are also included. This means that we can attract top researchers and associate professors to those health facilities, which will bolster clinical trials and add more research and innovation in new treatments and approaches to care.

It is huge for the health system, because many of these research hospitals also have community hospitals networked with them, so they reach out into the community and have strong relationships with the primary care sector as well.

Sonia Sidhu: Thank you, Ms. Voisin.

The next question is for the IRCC department.

In January, the number of spaces available under the provincial nominee program was greatly reduced as the government moved to restore balance and sustainability to the immigration system. Since then, you have been able to increase spaces under the PNP as we refocus on economic migration.

How much flexibility do provinces and territories have to use the PNP to fill their health care workforce vacancies? Are they currently using their spaces this way, or could they do more?

Louise Baird (Senior Assistant Deputy Minister, Strategic Policy, Department of Citizenship and Immigration): In the most recent levels plan, as you pointed out, we did increase the number of admission spaces for provinces and territories to use through their provincial nominee programs. During our consultations, we certainly heard from provinces that they would like to see an increase. It allows them to target their economic immigration to the specific regional needs in their jurisdictions.

Certainly, we know that health care is an area that many provinces are focusing on, and they are using significant portions of their PNP to attract and bring health care workers to Canada.

Sonia Sidhu: To follow up on that, I would like to know more about the IRCC regional and pilot programs that are being used to confront our health workforce challenges.

We have programs for rural and francophone communities in regions in the country, but also for workers in specific fields, including caregiving. Can you elaborate on that quickly?

Soyoung Park: To add to what my colleague just stated, for all regional programs—provincial nominee, Atlantic immigration, rural and northern immigration pilots—about 35% of health care admissions between 2023 and 2025 were from those programs. I just wanted to point that out.

Some of the top occupations related to nurses, dentists and general practitioners and family physicians.

The Chair: Thank you.

I now go to Ms. Larouche for six minutes, please.

[*Translation*]

Andréanne Larouche (Shefford, BQ): Thank you very much, Madam Chair.

I will come back to the witnesses a little later, because I would like to use the first few seconds of my speaking time to make sure of one thing.

At the last committee meeting, I moved a motion to have access to the digital binder. I want to make sure I have the committee's approval in this regard, so that my assistant and I can finally have access to it.

[English]

The Chair: I think if you are replacing a permanent member, then you should be able to get access to the digital binder without permission from anybody. Are you going to be permanently replacing Mr. Thériault?

[Translation]

Andréanne Larouche: Madam Chair, I had tabled a motion to have access to the digital binder until December 31, 2025, or until a change in the list of members rendered this measure unnecessary.

[English]

The Chair: You are not getting access. Is that what you're trying to say?

Can we suspend this?

[Translation]

Andréanne Larouche: My assistant still does not have access to it.

I tabled a motion at the last meeting, and I want it to be officially approved now.

• (1130)

[English]

The Chair: Do you want it to be officially approved by the committee? It doesn't have to be, but go ahead. I'll ask the committee.

Does everyone agree with Ms. Larouche getting the digital binder access?

Some hon. members: Agreed.

The Chair: Everyone nodded, Madame Larouche.

[Translation]

Andréanne Larouche: Madam Chair, what I mean is that the clerk confirmed that this was the procedure. I hope that my request will be approved and that I will now be able to put my questions to the witnesses.

[English]

The Chair: Everyone approved. Everyone nodded.

Mr. Mazier, do you have a point of order?

Dan Mazier (Riding Mountain, CPC): You should have had access—

The Chair: Mr. Mazier, I'm sorry. You are not allowed to speak across the floor, unless you are asking a question. We're in a study right now, so unless you have a point of order...

Dan Mazier: Yes, I have a point of order. She should have had access on the day she asked for it—Tuesday.

Do you have access right now?

The Chair: That's not a point of order, Mr. Mazier.

Ms. Larouche has asked a question. We're answering it. Everyone agreed. I told her that she should be getting access.

Are you getting access, Ms. Larouche?

[Translation]

Andréanne Larouche: I submitted a formal motion at the last committee meeting. I now want the committee to approve my request so that my assistant and I can have access to the digital binder.

[English]

The Chair: Are you getting access, though?

[Translation]

Andréanne Larouche: My assistant still does not have access to it. That is why I want to make this official.

[English]

The Chair: You do not have access still. All right. We will ensure that you get access.

[Translation]

Andréanne Larouche: Thank you.

I will now ask the witnesses my questions.

Ms. Voisin, in your opening remarks, you said that professionals face costly obstacles. That is what I noted. Indeed, there is a cost associated with the recognition of a degree. Moreover, as we all know, issues of economic immigration and degree recognition fall under Quebec's jurisdiction.

Tax measures are a federal responsibility. Could they be implemented to support immigrant professionals during their studies or their efforts to have their qualifications or titles recognized?

Jocelyne Voisin: I would say yes. As you mentioned, there are obstacles.

When a professional submits an application to various regulatory bodies, among others, it costs them money. It also takes time, because they have to find all their documents. Depending on their country of origin, it is not always easy to obtain all the documents they need. There are costs associated with the application.

As for tax measures, I'm not sure I understand what you're referring to.

Andréanne Larouche: When someone comes here to take classes, they are not working. Often, these individuals do not have a lot of savings to live on and pay for housing or groceries.

Could we acknowledge that there is a cost associated with all of this? When people arrive here, they cannot work. They also have to take a French language course—I hope to have time to revisit this issue with a representative from the Department of Immigration.

I want to ensure that it is possible to implement tax measures to support them during this process.

Jocelyne Voisin: Ms. Baird could perhaps tell you about the services the department offers to immigrants, to those arriving in the country.

What I can say is that some provinces offer support programs to professionals who come to their province.

Andréanne Larouche: The federal government could also put measures in place to help them. Otherwise, people get discouraged and they give up on their journey. That's why, in the end, they don't get their qualifications or diplomas recognized. We can't leave all the burden on Quebec; we have to help these people and support them along the way.

I will now move on to the important issue of francization.

Do you plan to improve the 1991 agreement to include funds that would be allocated to francization?

Louise Baird: Under the Canada-Quebec Accord, a payment is made to Quebec so that it can provide settlement and integration services. Each year, financial compensation is paid by the federal government for these services, including francization services.

In 2024-25, Quebec received \$867.3 million.

• (1135)

Andréanne Larouche: However, there are still students who face financial barriers. They arrive here, but they don't have enough money to live on while they wait for their degrees to be recognized or while they learn French. All of this comes at a cost.

It is true that money has been invested in this area. However, do you agree that, when it comes to francization, the needs are even greater and that we may need to improve the 1991 Quebec-Canada Accord, particularly with regard to the issue of francization?

The language issue is a barrier in Quebec. It would therefore be important to ensure that more funds are allocated to this area.

Louise Baird: These are services provided by the government of Quebec. However, the federal government makes a payment to the provincial government for these services, an annual compensation that includes language services, such as francization.

Andréanne Larouche: This agreement could still be improved.

It is true that Quebec is responsible for francization, but the Quebec-Canada Accord could be improved so that Quebec can fulfill its responsibility in this area.

[English]

The Chair: Thank you very much.

I would like to repeat to the committee that all questions or inquiries, anything you want, should go through the chair. Thank you.

Now we go to the second round. It's a five-minute round.

Mr. Mazier, for the Conservatives, you have five minutes, please.

Dan Mazier: Thank you, Chair.

Through the chair, according to the immigration department, the government is planning to admit 395,000 permanent residents and 673,650 temporary residents into Canada this year. Is this correct, yes or no?

Louise Baird: Yes, those are the numbers from last year's plan.

Dan Mazier: That's over one million people. How many of these people are doctors?

Louise Baird: I don't have that number.

Dan Mazier: Is there any information on that? Do you do an analysis on that?

Soyoung Park: I provided some numbers earlier, but so far in 2025, under permanent residents, there have been over 9,000 admitted in health care. I would have to look up exactly what.... It depends on what you mean by—

Dan Mazier: Do you have that information for doctors?

Soyoung Park: For doctors, I can tell you that for—

Dan Mazier: If you could just table that information, the breakdown, that would be great.

Soyoung Park: I believe we've already responded to a request that breaks it down by family physicians and specialists in surgery and clinical medicine.

Dan Mazier: If you haven't tabled it to the committee, could you please table that to the committee?

Soyoung Park: Yes.

Dan Mazier: Thank you.

On October 13, the immigration department made a post on social media to promote Canada's free health care system to potential newcomers. It was viewed on Twitter almost two million times worldwide. Who approved this post when 6.5 million Canadians don't have access to a family doctor?

Louise Baird: Our communications group in the department issues tweets and uses other social media to talk about immigration to Canada. Some of the things they include in that communication would be the situation in Canada. Obviously, there are a lot of things to consider if you're thinking about a big move to another country. It was part of some of those efforts to talk about not only the process in getting here but what Canada is like.

Dan Mazier: Okay.

Does the immigration department or, in this case, the communications department pay for any advertisements promoting our health care system to non-Canadians?

Louise Baird: There's nothing that I am aware of. I'm not sure that I can say that categorically, but there's nothing I am aware of that would have been paid advertising.

Dan Mazier: Could you table that information on how the communications department works with health care?

Louise Baird: Yes.

Dan Mazier: Is the minister aware of these communications?

• (1140)

Louise Baird: I don't know if she would be aware. She would not be aware of some of the day-to-day routine communications that go out from the department.

Dan Mazier: Just so that we're clear on what I'm asking to be tabled, could you table with the committee all advertisements and social media posts relating to the promotion of Canada's health care system that the immigration department has published since 2020, including all costs associated with them? Thank you.

Does the immigration department conduct a specific analysis of Canada's existing health care capacity prior to setting immigration levels, yes or no?

Louise Baird: I'm not sure there's a yes or no answer. I can answer it to the best of my ability.

We do extensive analysis and consultation. Looking at health care capacity was certainly one of the things we looked at, in close collaboration with provinces and territories.

Dan Mazier: Could you table that analysis as well? That would be appreciated.

Is a labour market impact assessment required prior to approving Saudi-funded visa trainees to train in Canadian hospitals?

Soyoung Park: A labour market impact assessment is not required for visa trainees.

Dan Mazier: A labour market impact assessment is a check in the system to make sure that there are no Canadians available.

Soyoung Park: Yes...for the temporary worker program.

Dan Mazier: It's to assess and to make sure that there are no Canadians available to fill those spots.

Soyoung Park: That's correct. Under the TFW program, there is a labour market assessment test.

Dan Mazier: Yes.

Soyoung Park: We also—

Dan Mazier: That's good.

I have another question.

The Chair: Thank you.

You have eight seconds, Mr. Mazier.

Dan Mazier: How many work permits did the immigration department approve last year for Saudi-funded visa trainees to train in Canadian hospitals? If you don't have that information, please table it.

The Chair: Thank you. The time is up.

I now go to Mr. Eyolfson for the Liberals.

You have five minutes, please.

Doug Eyolfson: Thank you, Chair.

This was confirmed earlier, but I want to ensure again that it's on the record, as it has been brought up again. I will confirm that these visa trainees, these Saudi residents coming in, are not taking spots away from Canadian trainees. These are extra spots funded by the Saudi government in addition to funding to the medical schools.

They do not take spots from Canadians who would be training and staying. Is that correct?

Soyoung Park: That is correct. Those are additional spots. They're not just funded by the Saudi government—

Doug Eyolfson: It's by other governments as well, yes.

Soyoung Park: The agreements are between the medical institutions and the governments.

Doug Eyolfson: All right. Thank you.

Ms. Park, you said that you consult with provinces regarding their labour needs. Is this all labour? Specifically, do you consult with the provinces regarding their medical labour needs in granting permits?

Soyoung Park: It's not necessarily at the level of granting permits.

However, there are annual consultations that happen related to the immigration levels plan and also in relation to economic immigration and the types of labour market needs that provinces and territories would have. There is regular communication with our provincial counterparts to make sure that our programs are aligned.

Doug Eyolfson: Thank you.

Ms. Voisin, you said that there's a national database of health care needs by province. Do the provinces have ready access to this database?

Jocelyne Voisin: I talked about a national registry of physicians—

Doug Eyolfson: Yes.

Jocelyne Voisin: —which is not about health care needs. It's a regulatory database of physician licences that will allow labour mobility across the country. That is being onboarded by regulators across the country.

Doug Eyolfson: Good. Every province will have access to this database so that they can better plan for their own health care needs.

Jocelyne Voisin: Absolutely. They have access to the database, especially when physicians are applying to move from one province to another so that they understand the licensing status of those physicians.

Doug Eyolfson: Would a system of, if not a single Canadian licence, at least agreements between provinces that would allow a licensee in one province to practice in another assist with these labour needs within different provinces?

Jocelyne Voisin: Absolutely, it would. I think labour mobility would be very helpful in addressing some of our workforce shortages, especially in rural and remote communities where they are in need of locums, physicians who come in to do temporary work placements.

It would also be helpful in the retention of our health care workers in general if they had the opportunity to follow their family by moving from one place to another and also to serve in emergency events so that we can move our health care resources across the country when there is an urgent need.

• (1145)

Doug Eyolfson: Thank you.

Ms. Park, when we talked about rejected refugee claimants, the word “bogus” was used. That’s defined as fake or not genuine.

Would that word be an accurate description of all rejected claimants? Are they all fake?

Soyoung Park: No, not necessarily. It is a word that has been used, but we talk about the actual refusal rate, as opposed to the acceptance rate, at the Immigration and Refugee Board. That would probably be a better assessment.

Doug Eyolfson: Thank you. I believe that’s my time.

The Chair: Thank you. That was well done.

[*Translation*]

Ms. Larouche, you have the floor for two and a half minutes.

Andréanne Larouche: Thank you very much, Madam Chair.

Ladies, there are important requests for Quebec concerning the two departments you represent.

I will first turn to Ms. Baird or Ms. Park.

The government of Quebec is requesting \$733 million for the reception of asylum seekers and \$500 million to cover social assistance. It is also requesting compensation for all services, including schooling and support services.

Will you agree to Quebec’s request? Have you discussed with Quebec the reimbursement of these sums spent on asylum seekers?

[*English*]

Louise Baird: Yes, Quebec has accepted a fairly high number of asylum claimants over the last several years. The federal government has compensated Quebec for some of those costs, including through the interim housing program. To date, since 2017, the total amount has been about \$1.1 billion.

As you mentioned, there is an additional ask from Quebec for more recent costs that they have incurred. The program that we have at IRCC is specifically for interim housing costs, so we’re reviewing the request and looking at some of the costs that Quebec has put forward.

[*Translation*]

Andréanne Larouche: I will now turn to Ms. Voisin or Ms. Owen.

The latest budget mentioned investing in infrastructure, such as hospitals, but no additional funds were allocated to health transfers, as requested by the Bloc Québécois. It is not enough to have new infrastructure; we also need human resources.

Do you plan to allocate funds not only to infrastructure and hospitals, but also to health transfers?

Jocelyne Voisin: What I can tell you is that the budget allocates funds to health services. Quebec will receive \$38.3 billion over 10 years, based on the working together to improve health care for Canadians plan.

This has also been confirmed in the budget.

• (1150)

[*English*]

The Chair: Thank you.

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

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

I have a question for Ms. Baird or Ms. Park.

There’s been a lot of defence around the table of Saudis training in our hospitals who need to go home after the training, and for sure their spots would not be taken if they weren’t here, which is very interesting, because there are thousands of people looking to train in hospitals who would stay here in Canada. It’s a very interesting situation for sure that we’re trying to follow up on.

One of the things I’d like to know is this: How many work permits does the immigration department plan to approve for Saudi-funded visa trainees this year?

Soyoung Park: I will say that there is no plan, or there is no target, for the number of visas under this category. The actual visas are issued based on the applications that we receive, and the agreements, as I said, are between the medical faculties and the foreign governments and also do not just include Saudi Arabia.

I will also add that this program is actually not unique to Canada. There are other countries, like the U.S. and the U.K., that have similar programs.

Helena Konanz: Again, just to follow up on that, how many Saudi-funded visa trainees are here right now, and how many are going to be required to leave?

Soyoung Park: I don’t know how many on hand are specifically from Saudi Arabia.

Helena Konanz: Okay. Could you find that information, please, and table it to this committee? Thank you.

Another question I have is this: For the IFHP-provided health care, can you please table numbers broken down by categories of groups that are eligible for this health care? The groups on your website are refugee claimants, protected persons in Canada, resettled refugees, victims of family violence, detainees, individuals under specific temporary public policies and individuals who have been granted eligibility at the minister’s discretion.

Can you break those down according to category and table that to the committee?

Soyoung Park: Yes, we can.

Helena Konanz: Super. Thank you.

The next question I have is about the Institute for Canadian Citizenship and the Conference Board of Canada, which found that new immigrants are leaving Canada at near-record rates, with highly educated and highly skilled immigrants leaving Canada at twice the rate of those with less education and lower skills, which is the opposite of what we've been talking about at this committee. It's something we obviously don't want to happen.

Can IRCC table with this committee the information you've collected on the onward migration of medical professionals, specifically the number of permanent residents approved for entry as medical professionals who have come and subsequently left Canada in the last 10 years? Do you have that? Can you table that information?

Louise Baird: I'll certainly check if we have access to that information, and if we have it, we can provide it.

Helena Konanz: Thank you. That would be great.

The federal skilled worker express entry program is for skilled workers who have foreign work experience and want to become permanent residents of Canada.

Is there a specific target number that IRCC has for how many medical professionals it's seeking to have immigrate to Canada through the federal skilled worker express entry program?

The Chair: If you do not have the answer, you could table it, as always, for the clerk to distribute.

Louise Baird: In front of me, I have the total number under the federal high-skilled program in that category, but I don't have the further breakdown.

• (1155)

Helena Konanz: Could you get that information for the committee and table it?

Thank you.

The Chair: Thank you very much. The time is up now, Ms. Konanz.

I'll go to Mr. Powlowski for the Liberals for five minutes, please.

Marcus Powlowski (Thunder Bay—Rainy River, Lib.): To the people from the Department of Health, I think, if I heard correctly, that when the minister was here, she said we are in the process of negotiating agreements with colleges in various provinces. I would assume those to be the colleges of physicians and surgeons and the colleges of nursing.

What sorts of agreements...? Is that money from the federal government going towards those colleges to help them address the issue of licensing foreign-trained medical professionals?

Jocelyne Voisin: I think what the minister was referring to was the funding that was provided through budget 2024, which was focused on new training positions for international medical graduates, assessment spots and navigation supports.

We are in the process of negotiating agreements to flow that funding. Some of those agreements are with provinces to support some of their medical schools.

Marcus Powlowski: Can you go a bit into what those agreements are? What's that money for? Is it to create practice-ready assessments, or is that...? Where is the money going?

Jocelyne Voisin: There are three different streams of that funding.

The first stream of that funding is for creating new training positions for international medical graduates. That's a mix of residency positions, meaning new residency positions in medical schools and practice-ready assessment positions to increase opportunities for those international medical graduates to complete their training and have their skills assessed to practise in Canada.

The second stream is for navigating foreign credential recognition. These are projects like information hubs for key professions like nurses, physicians and physiotherapists. They have step-by-step guides on how to navigate the process to get their credentials recognized: exam preparation materials, resources and learning modules.

The third stream is increasing assessment capacity. That's one of the gaps. There are not enough assessors for these physicians. These are projects that can accelerate assessment and bolster capacity to, for instance, enhance training for assessors or develop alternative certification pathways or practice-ready assessment supports.

Marcus Powlowski: On the residencies, you said that the first stream was to go towards helping create residency positions and practice-ready assessments. Does that mean that the federal money is going directly to pay for people's residencies? Does that money create residency positions?

You're paying people for their residency positions, because otherwise, that comes from the medical schools and the hospitals. Am I right?

Jocelyne Voisin: Part of the funding will be for residency salaries. We will be supporting those new residency spots or training positions. As per budget 2024, the number is up to 120 new training spots.

Marcus Powlowski: I'm sorry. Did you say 120?

Jocelyne Voisin: It's 120.

Marcus Powlowski: That's across Canada. It's not a lot, given the shortage of physicians. It doesn't seem like a very significant number.

Jocelyne Voisin: It is modest, but I think every bit helps, and the provinces and schools are happy to get the support.

Marcus Powlowski: For the IRCC people, I thought it was the ministry for jobs and families that was involved in issuing work permits, or is it the IRCC? Can you explain who has what role?

Soyoung Park: There are two types of temporary work permits. One is jointly administered by ESDC and IRCC. The international mobility program is IRCC's sole responsibility.

For the TFW program, which is the one with ESDC, there is a labour market impact assessment that goes along with that. However, it is only IRCC officers who actually issue the work permit at the end.

Marcus Powlowski: We had somebody come in who represented chronic care homes. They talked about the shortage of PSWs and the difficulty in getting PSWs. They suggested that you should drop the requirement for LMIA for PSWs.

Would you contemplate doing that, given the broad shortage? It would seem like a needless step when there is a well-recognized problem.

• (1200)

Soyoung Park: That's something we would have to discuss in concert with ESDC.

The Chair: Thank you very much.

I would like to thank the witnesses for coming and answering questions so extremely well, and with a lot of expertise and knowledge.

I would like to suspend so that we can get ready for the next hour.

Thank you.

• (1200)

(Pause)

• (1210)

• (1210)

The Chair: I now open the second hour of this hearing.

We have three witnesses with us for the second hour: Dr. Aaron Burry, chief executive officer, Canadian Dental Association; Dr. Keri McAdoo, chief executive officer, Physician Assessment Centre of Excellence; and Dr. Peter Nickerson, the Association of Faculties of Medicine of Canada, who is appearing virtually.

Welcome.

I will just run through the process. You each have five minutes to present. I will give you a one-minute shout-out and a 30-second one. You don't have to thank me. It's just to let you know where you are in time. Second, we have a question and answer period after that. Thank you.

Please begin, Dr. Burry, for five minutes.

Dr. Aaron Burry (Chief Executive Officer, Canadian Dental Association): Good afternoon.

Thank you, Madam Chair and members of the committee, for the opportunity to appear. As mentioned, I'm Aaron Burry, the CEO of the Canadian Dental Association.

The CDA is a trusted voice of dentists working to improve the oral health of all people living in Canada. We promote oral health, support our members and advance the dental profession. The CDA

represents over 21,000 practising dentists across the country, and it is a trusted source of information for and about the dental profession on both national and international issues.

Today, I'm going to provide an overview of the current state of the oral health care sector. Across Canada, the oral health sector is experiencing significant oral health resource challenges. Dental clinics are struggling to recruit and retain dental assistants and dental hygienists. This is similar to the broader health care system, and the CDA will suggest how the federal policy measures can help improve the situation.

A recent Statistics Canada survey showed that about 80% of dental offices in Canada are experiencing staffing shortages. Nearly half report difficulties hiring dental assistants and hygienists, leaving over 7,200 positions unfilled in 2023, particularly in rural and underserved communities.

A full launch of the Canadian dental care plan means that more Canadians are seeking dental care appointments than prior to its launch. Ensuring that the dental workforce can meet this increased demand is crucial to the program's success in maintaining high-quality care.

Recent reforms to federal immigration policies have removed dental assisting as an eligible field for study under the post-graduation work permit program, preventing dental assistant graduates from working in Canada. This is leading to difficult decisions, where some dental assisting schools are already planning to cancel their programs. If unaddressed, these issues will further strain dental practices.

Due to the urgent need for dental assistants and especially due to pressure from the CDCP rollout, the CDA calls on the federal government to expand the PGWP eligibility to include dental assisting. This would make immigration policies better align with the federal government's own criteria for the PGWP eligibility.

According to Immigration, Refugees and Citizenship Canada, fields of study linked to jobs facing long-term shortages should be prioritized for PGWP eligibility. Dental assisting clearly meets this test, given the widespread shortages across Canada and its essential role in providing oral health care for all people living in Canada. This evidence-based policy change will help address the dental assisting shortage, attract international talent and provide a fair pathway for graduates to contribute to Canada's health care system, ensuring timely and accessible care.

While the greatest workforce pressures are among dental assistants and hygienists, it's also important to consider the broader dental workforce. Although Canada does not face a shortage of dentists, there's an uneven distribution, with urban centres well served and rural areas lacking access.

Another issue is the challenges related to the credential recognition and pathways into practice for internationally trained dentists. They represent about 8% of all the internationally educated health professionals in Canada, yet only one-quarter of them are actually practising as dentists. Overall, internationally trained dentists represent 33% of the licensed practitioners in Canada, and this is growing year over year.

Continued collaboration between federal and provincial partners is improving credentialing processes, and it will help ensure that our dental workforce remains strong, competent and responsive to evolving health needs.

In conclusion, Canada's oral health system is at an important juncture. Targeted, practical policy decisions, such as restoring PG-WP eligibility for dental assisting, can help address some of the immediate pressures and improve access for communities across the country.

Thank you, Madam Chair and committee members. I look forward to your questions and to working together on practical solutions that strengthen our oral health workforce.

• (1215)

The Chair: Thank you very much.

I'll now go to Dr. Keri McAdoo from the Physician Assessment Centre of Excellence.

Thank you.

You have five minutes, Dr. McAdoo.

Dr. Keri McAdoo (Chief Executive Officer, Physician Assessment Centre of Excellence): Good afternoon, Madam Chair and honourable members of the committee.

I am Dr. Keri McAdoo. I am the CEO of Nova Scotia's Physician Assessment Centre of Excellence, which I'll refer to as PACE. I practised as a family physician in rural Nova Scotia for 20 years and then served as the deputy registrar at the College of Physicians and Surgeons of Nova Scotia. In the last seven years, I focused on developing licensing pathways for internationally trained physicians. My background led me to this role.

I appreciate the opportunity to appear before you today. I will be talking about PACE as a scalable, innovative solution, which is improving access to care by way of assessing internationally trained physicians, who represent 20% to 25% of the Canadian medical workforce and have long been a cornerstone of Canada's health care system, particularly in remote and rural communities.

PACE was established on two central principles. First, there's a substantial global cohort of highly competent, internationally trained physicians who wish to practice medicine in Canada. Second, as a rigorous workplace-based assessment, PACE can evaluate physician competence without lowering the bar.

PACE is the first program of its kind in Canada. Its launch in 2025 was made possible through partnership with the Medical Council of Canada and the College of Physicians and Surgeons of Nova Scotia through the leadership and support of the Government of Nova Scotia. The college took the lead on developing PACE, which is now an independent federal non-profit.

PACE operates through three integrated components. First, it is a comprehensive, workplace-based, competence-focused assessment program delivered by well-trained physician assessors. Second, it is a primary care medical clinic providing access to care to thousands of patients who would otherwise be without a provider. Finally, it is a four-day orientation program designed to support physicians new to Nova Scotia as they integrate into our health care system and into our communities.

Allow me to briefly outline how this model functions. PACE provides a pathway to independent licensure for internationally trained physicians who may already be in Canada or may be arriving as new immigrants. Assessments are conducted by fully licensed physicians, trained extensively by the Medical Council of Canada. These assessors are well-compensated for their expertise and are deeply committed to contributing to this innovative solution.

It's important to note that this is not adding to the workload of these physicians but reconfiguring it. Many of their patients, for example, are now patients in the PACE clinic. The internationally trained physicians deliver direct patient care, while being closely supervised by on-site assessors.

PACE also operates as a health home for thousands of Nova Scotians who previously lacked access to primary care providers. Upon successfully completing the assessment and obtaining independent licensure, physicians transition out of PACE and into practice and take on their own patients.

Supporting physicians to integrate into practice plays a key role in retaining these physicians. The College of Physicians and Surgeons offers a four-day orientation program, the welcome collaborative, designed to help internationally trained physicians transition successfully into medical practice in the province. The welcome collaborative also connects physicians to other supports to assist with settling into a community. Since its inception three years ago, 223 physicians have completed the program, and feedback has been overwhelmingly positive.

PACE is expanding. A second clinic will open in December, doubling our capacity. Once both sites are fully operational, we anticipate beginning up to 45 assessments per year. By the end of 2026, we expect to have assessed 64 physicians in total for licensure. Given the size of our province, this represents a transformative increase in physician supply. We estimate the PACE clinic will provide primary care to 6,500 patients by the end of next year.

PACE is expanding beyond primary care. We have created a hospitalist assessment program to address the significant shortage in our province. We anticipate running 30 assessments in this program in 2026.

None of this would be possible without the leadership and financial support of the Government of Nova Scotia and the College of Physicians and Surgeons of Nova Scotia, or the collaboration of the Medical Council of Canada and the Nova Scotia Health Authority.

This year, PACE was honoured to receive the innovation in physician assessment and remediation award from the Coalition for Physician Enhancement, recognizing our program as a global leader in physician assessment innovation.

Thank you for the opportunity to speak with you. I'm happy to answer any questions.

- (1220)

The Chair: Thank you very much.

I'll now go to Dr. Nickerson, Association of Faculties of Medicine of Canada.

You have five minutes, Dr. Nickerson.

Dr. Peter Nickerson (Past Board Chair and Dean, Max Rady College of Medicine, University of Manitoba, Association of Faculties of Medicine of Canada): Thank you very much.

My name is Dr. Peter Nickerson. I am past chair of the Association of Faculties of Medicine of Canada, dean of the Max Rady College of Medicine and a professor of internal medicine at the University of Manitoba.

As an overview, I want to highlight that at the completion of an undergraduate medical doctor degree, graduates are matched to residency positions in Canada via the CaRMS match. People in residency positions are considered paid employees of the health care system in the province where they are working, and residents are also registered learners in an accredited training program in an approved medical school affiliated with the Royal College of Physicians and Surgeons of Canada or the College of Family Physicians of Canada.

International medical graduates are individuals who have graduated from a medical school outside of Canada. They are allowed to apply for residency in Canada if they meet criteria. They are matched to a residency program, again via the CaRMS matching process.

One in three international medical grads applying to CaRMS is a Canadian or a permanent resident who has undertaken medical school abroad due to a lack of space in medical schools in their home region in Canada. The ability to accommodate international medical graduates in a CaRMS residency match is dependent upon sufficient provincially funded residency training capacity for both Canadian medical school graduates and international medical graduates.

Visa trainees are foreign-born trainees whose home country is often paying for them to undergo clinical training in a Canadian residency program. These individuals are accepted by Canadian medical schools and health systems only after Canadian medical grads and international medical grads fill all provincially funded residency positions and there remains residual capacity for training in the health system. In 2023-24, there were 3,140 visa trainees working and learning in Canada.

Internationally trained physicians are physicians who are fully certified to practise medicine in their discipline outside of Canada. To enter practice in Canada, they must meet provincial regulatory standards. This may be a simple review of their training and practice record or a formal assessment of their skills before obtaining a licence to practise.

To give context to this discussion, I have prepared three slides for your review.

On the first slide, you will see Manitoba's medical school training capacity, which in 1982 was 95 seats per million population. Government decreased funding in the 1980s, such that by 1994, the incoming class size was 60 seats per million population. By 1998, in recognition of the physician gap that was created, the seat capacity was progressively increased, reaching 90 seats per million by 2009.

However, in 1999, while the medical school class was expanding, the province stood up a formal internationally trained physician program, especially in family medicine, either as a practice-ready assessment, or PRA, or as a one-year training program to get them ready to practise in Canada.

Unfortunately, as the Manitoban population grew after 2009, there was no expansion in medical school training capacity to keep our seat number at 95 seats per million population. In essence, since 1980, Manitoba, by not maintaining its training capacity steady at 95 seats per million, missed the opportunity to train over 800 physicians. When you look at the gap in Manitoba physicians per million population relative to the Canadian average, you start to understand why we have a shortage in Manitoba.

This is not unique to Manitoba. The same pattern occurred in Canada as a whole.

As one potential solution to the health workforce problem, we can increase the training capacity of medical schools in Canada. Slide two shows the capacity by province. While we have increased our seats across Canada, there's a marked regional heterogeneity. Of note, only one in five applicants to medical school is admitted. Many of those not admitted are quite capable of undertaking the training, but there isn't funded seat capacity to train them. Hence, many Canadians go outside Canada to train.

We could also increase the funded residency positions in Canada. The fact that we're able to accommodate externally funded visa trainees tells us that there's further training capacity in the health system, but the provinces are not funding this capacity.

In slide three, you see the national ratio of residency training spots relative to Canadian medical graduates. In 2018, the ratio is essentially 1:1, and it has increased gradually back to 1.12 in 2025, meaning there are only 12% more funded residency positions than there are Canadian medical graduates. This 12% affords the capacity to accommodate international medical graduates in Canada while meeting the needs of our own medical graduates. In Manitoba, we've actually created our capacity at 1.3 as a ratio, going up to 1.72 as of late.

The third solution is to increase capacity to assess or train internationally trained physicians. Provinces can improve recruitment and retention of internationally trained physicians by enhancing practice-ready assessment capacity or, as in Manitoba, by developing a one-year training program in family medicine for ITPs who require exposure and experience to accommodate to the Canadian health care system.

Thank you very much.

• (1225)

The Chair: Thank you very much.

I now go to the question and answer segment. This first segment is six-minute questions. The six minutes include questions and answers, so I'm asking everyone to be succinct. Then we will move on to a second round if we have time.

I'll start the six-minute round with Mr. Strauss from the Conservatives.

Matt Strauss (Kitchener South—Hespeler, CPC): Thank you, Chair.

Dr. Nickerson, thank you so much for your remarks. I just want to quote from the briefing materials you sent us because I think it's so important, and I feel like the committee has missed this point several times.

You said, "The fact that we're able to accommodate externally funded visa trainees tells us that there's further training capacity in the health system". Do you have reflections on that? It seems to me that every spot that goes to a visa trainee could be going to a Canadian if they were properly funded. Is that a good paraphrase of what you said there?

Dr. Peter Nickerson: I think the answer is that the health system pays for residency positions. It pays the salary of these individuals, and it pays the associated training costs to the universities to oversee them in their programs. It's really up to the provinces to decide how much they're going to fund, how many residency positions they're going to create.

Matt Strauss: Thanks.

I also have a follow-up question about Saudi trainees in particular.

Could you give us an idea of how much funding medical schools get per Saudi visa trainee and how that compares to comparable provincial funding across Canada?

Dr. Peter Nickerson: The cost per trainee, I believe—and I'd have to get back to you with the exact number—is around \$70,000 per year. The cost for training a Canadian individual is at the same

level. We basically are charging what it would cost us to train an individual, a Canadian individual.

Matt Strauss: I just want to make sure that's on the the record, then, because there have been different things that have been said.

Your understanding is that the Kingdom of Saudi Arabia gives the same amount of money per visa trainee that a province would give to a Canadian trainee?

Dr. Peter Nickerson: Would give to a...? I'm talking now about the funding that comes to the medical schools to support the training program. That's correct.

Matt Strauss: Could you table data on that? I would love to see it in black and white.

Dr. Peter Nickerson: Yes, we can get that information for you.

Matt Strauss: Okay. Thank you.

My understanding is that there are 1,000 Saudi visa trainees in Canada. Seventy thousand dollars times 1,000 is, I believe, \$70 million, which, on the scale of the Government of Canada, is not very much money, so I want to tell you a story about why I feel personally scandalized by this.

I'm critical of Chrystia Freeland for many things, but in August 2018, she called for the release of human rights activists in Saudi Arabia who'd been imprisoned for, like, five years because they wanted women to have the right to drive. Then Saudi Arabia pulled funding for these visa trainees and said that it was going to take its trainees back. I was teaching at the Queen's University faculty of medicine at that time, and the administration lost their minds because of the dearth of funding that this would cause.

A few months after that, Jamal Khashoggi was brutally murdered and dismembered. He was a Washington Post journalist who was murdered with a bone saw, and that sort of repression continues in Saudi Arabia to this day. This summer, they just executed a journalist for criticizing the government in tweets.

I personally felt morally scandalized that the faculty of medicine that I was at was lobbying the government to get this money back from a brutally repressive dictatorship. I wonder if you have reflections on that.

Do you think that receiving this amount of money from a brutal, repressive dictatorship morally compromises faculties of medicine in Canada?

Dr. Peter Nickerson: I don't know that I'm qualified to answer that question.

What I can tell you is that we provide the same level of training, in general, to these individuals who are visa trainees. I think the ideal would be that we actually fund more of our own capacity to train residents who are going to stay here in Canada. Overall, I think the biggest gap that we have across the country is the number of residency positions through which we have the opportunity to maintain those individuals working in Canada to meet the needs of Canadians.

• (1230)

Matt Strauss: Okay. I'm going to push you a bit on that because I think we all have to be kind of qualified to make our own moral decisions in life.

The faculty of medicine that I was at was lobbying the government and basically criticizing Chrystia Freeland's criticism of Saudi Arabia's human rights record in order to get that money flowing back into their medical school.

Do you recall that episode? What thoughts do you have about that episode? Which faculty of medicine were you associated with at that time? Was that faculty of medicine also criticizing Chrystia Freeland for criticizing the brutally repressive regime in Saudi Arabia?

Dr. Peter Nickerson: Thank you.

I would have been at the University of Manitoba. I would not have been in my role at the time as dean. The University of Manitoba does not look at visa trainees as a mechanism of funding that we're dependent upon. We look at the provincial funding that we get at the medical school as being our core funding. If we're funding for visa trainees, that's capacity that we've allowed within the system, but it's not something that we're lobbying anybody for.

Matt Strauss: Thank you.

We have heard testimony from the group that represents Canadians who graduated from medical school abroad and want to come back. There are about 800 trainees per year who can't find a spot through CaRMS. The representative of that organization said that they've offered to provide funding. Municipalities as well as foundations, charities and ethnic associations have offered to fund their trainees to come back home.

Why won't faculties of medicine accept that funding, while they do accept funding from Saudi Arabia?

Dr. Peter Nickerson: Again, I can't comment on individual municipalities because we haven't received that.

What our government has done in Manitoba has given us sufficient funding to have a ratio of 1.72 currently, so we can actually repatriate Canadians back into Manitoba along with other IMGs.

The Chair: Thank you. That's the end of that session, Mr. Strauss.

I will now go to Mr. Powlowski from the Liberals for six minutes.

Marcus Powlowski: Dr. McAdoo, do you get federal funding from the province?

Dr. Keri McAdoo: That's correct.

Marcus Powlowski: The money comes in because...?

I still practice a bit of medicine. I get fee for service, and when we bill to the provincial health care system, I get paid. Does that 100% fund your PACE centre?

Dr. Keri McAdoo: The provincial government funds it—

Marcus Powlowski: Does it directly rather than...?

Do you get an annual amount rather than getting paid per patient seen or per services provided?

Dr. Keri McAdoo: That's correct. It's an annual amount because it is both providing health care as well as providing assessments. It's not a typical clinic in that regard.

Marcus Powlowski: Okay.

I would think that you don't do a high volume of patients. If you were a doctor practising in Nova Scotia, trying to make a decent salary, you'd see lots of people. As a result of seeing lots of people, you would make lots of money. With this PACE centre, they're paying more, I would think, because you're teaching people, so you don't have to see nearly as many people.

I'm just wondering about the efficiency in addressing the health care shortage. The efficiency and the point is to train people, not to see a lot of people.

Dr. Keri McAdoo: It is a different model than a typical clinic, for sure. The funding model is based on the number of assessors in the clinic, and the assessors oversee the work of the internationally trained physicians. We expect that the team would see as many as a full-time family physician would for the funding model. It's not the volume that you would expect in a typical clinic because there's time built in for the assessment work, both for the assessor and for the international trainee.

Marcus Powlowski: Maybe Dr. Nickerson can chime in here. Why do you need PACE? Why couldn't you just have doctors in the community playing the same role, supervising somebody doing a practice-ready assessment?

I think the answer, and maybe Dr. Nickerson can address it, is that it's hard to find a number of people who are willing to do the assessment for PRAs. Is part of why you exist due to the difficulty in getting people to do PRAs in the community?

• (1235)

Dr. Keri McAdoo: Yes. There are definitely challenges in recruiting and retaining assessors in the traditional practice-ready assessment model. In the previous model that other PRAs operate with, physicians are asked to provide an assessment every year or two and may not be doing it regularly. Therefore, they may not maintain their confidence to provide that assessment work. With PACE, the assessors are providing assessment work on a regular basis and feeling confident with that work. They also have extensive training with the Medical Council of Canada, so they're feeling confident that they have the skills they need to do that work.

With this centralized model of PACE, they have developed a community of practice so that they provide support to each other and are able to work together to build their skills, and they are compensated as well.

Marcus Powlowski: Is your program, PACE, open to physicians from any country, or is there some sort of decision that certain countries are going to produce higher-level graduates? Is it all comers?

Dr. Keri McAdoo: It really is based on the competency that we expect to see in the clinic. We have eligibility criteria that are set by the College of Physicians and Surgeons of Nova Scotia and then selection criteria on top of that. We don't identify specific countries. It really is looking at who would be most successful.

Marcus Powlowski: Dr. Nickerson, I know that in Manitoba they've been doing PRAs for a while. My understanding is that it's fairly limited numbers. My guess is that it was about 30-something per year in Manitoba. Why don't they do more?

Is PACE perhaps the answer? Perhaps Manitoba ought to do something similar, so it could get a lot more people out through that kind of approach.

Dr. Peter Nickerson: It's a great question.

We actually launched doing PRAs back around 2000, initially without quite the standardization that you've heard from Dr. McAdoo. We found that it didn't necessarily meet the needs of the internationally trained physicians, so we moved to a one-year program where we essentially give them rotations through various areas—emergency medicine, family medicine and pediatrics—to give them a broader orientation to the Canadian health care system. We found that one-year program to be highly successful. Over the years we've had 20 per year go through that program. We've ramped it up now to 30.

We are ramping up a PRA program in Manitoba that's very similar to what Dr. McAdoo is doing. We are spending time, though, getting the assessors well trained through MCC and developing the same kind of community of practice in Manitoba.

Like Dr. McAdoo, I think it requires some screening for who's eligible for the PRA because you only have three months generally to do the PRA. That really requires that you have a wholesome assessment, so that you can really sign off that they're ready to practice.

Marcus Powlowski: I wanted to get in what I think is a really important question.

The Chair: I'm sorry. I've been so interested in this question, Marcus, that I have let you go. You have nine seconds left.

Marcus Powlowski: I understand there's a group of facilities that offer PRAs that meet and try to set national standards. They're interested in a CaRMS kind of program for PRAs nationally.

Is this something that perhaps the federal government should look to fund?

Dr. Keri McAdoo: I think you're referring to the Medical Council of Canada. I'm not sure if that's what you're describing, but they do have a national assessment collaborative through the MCC that brings various PRAs together. I think that's what you're describing.

The Chair: Thank you very much.

[*Translation*]

Ms. Larouche, you now have the floor for six minutes.

Andréanne Larouche: Thank you very much, Madam Chair.

I would like to thank the three witnesses for being here with us. Their comments are very enlightening.

My first question is for Dr. Nickerson.

Correct me if I am wrong, but in one of your answers, you said that in your opinion and that of the Association of Faculties of Medicine of Canada, retaining those who work in Canada should be a priority.

We believe that the reason we are forced to recruit so many foreign workers is because students from here go to study abroad but do not return to the country after their studies because of working conditions.

Have I understood correctly? Should the priority be to keep students here so that they work in Canada?

• (1240)

[*English*]

Dr. Peter Nickerson: We should be looking at our Canadian medical graduates whom we train. We obviously want to keep them here in Canada. We've invested heavily in them. Most medical students cost, on average, \$430,000 in total to train over the four years.

For those individuals we have enrolled in our residency programs, we would hope that at the end of their residency training, they would stay in Canada and help the Canadian workforce. Absolutely, that's what we should be doing.

[*Translation*]

Andréanne Larouche: To do that, we would need to be able to offer them good conditions.

In the latest budget, it was announced that funds would be allocated to hospital infrastructure. However, Quebec's request for an increase in health transfers and the return of annual indexation at 6% after 2028 has not been met. This is not only a request from Quebec, but also from other provinces.

In your opinion, what is the point of having hospitals if we are unable to offer good working conditions to the people who work there? If we want to keep workers here, we have to offer them good conditions. If we kept those who work here, perhaps we would have less need to seek workers from abroad.

What do you have to say about the issue of health transfers?

[English]

Dr. Peter Nickerson: I think you're making an excellent point in the sense that we've grown the population of Canada significantly over the last several years, so we need to create the infrastructure, both in the medical schools and within the health system, to be able to support both the delivery of health care and the delivery of training.

There's a need to invest in both the university medical school infrastructure and the health system infrastructure to support both capacity and quality in the training environment as well as in the work environment. Why people choose to stay and work in a given area is going to be largely dependent upon the physician group they're joining, as well as the conditions of the health system they're working in.

[Translation]

Andréanne Larouche: That's absolutely right. If we have new operating rooms, they must not be empty. We need to offer good conditions to people who want to come and work here. Obviously, there must be people in an operating room. Retaining students who could work here is crucial.

I will now turn to Dr. McAdoo, who represents the Physician Assessment Centre of Excellence.

I would like to remind you that the issues of economic immigration and the recognition of qualifications are the responsibility of Quebec, in particular.

The people who work in your clinic, who are supervised by your centre, are waiting for their credentials to be recognized. What difficulties are they experiencing? Are they experiencing financial difficulties? They are here, but they have to take steps to get their credentials recognized. There are costs associated with all of this, but they do not have a salary that allows them to live adequately while they are under your supervision.

Would it be helpful for the federal government to implement tax measures?

[English]

Dr. Keri McAdoo: The internationally trained physicians who come to PACE receive a weekly stipend during the time they're under assessment and a monthly stipend for accommodation, but it is definitely financially challenging for the physicians to come and do this work. Housing is definitely a challenge for physicians to attend our assessment centre. That's something that needs to be addressed.

The Chair: Thank you.

I now go to the second round. It's a five-minute round.

Ms. Konanz, you have five minutes.

• (1245)

Helena Konanz: Thank you, Chair.

Dr. Burry, when it comes to dental care being administered through the interim federal health program, has the number of dental users increased over the past 10 years?

Dr. Aaron Burry: I wouldn't have that information. I'd have to get back to you in terms of that particular program. It's federal.

Helena Konanz: The numbers that the government is giving show that there is a 464% increase since 2016, with more than 110,000 more users.

What kinds of bureaucratic hurdles or delays do that many more users in this health program place on dental offices?

Dr. Aaron Burry: That program is a very limited program, primarily focused on very urgent and emergent care, so I think the biggest issue with the program is exactly that: People are arriving with needs that are far greater than the program is designed to deliver.

Helena Konanz: I was wondering about that. My hat is off to the local Rotary club that I belong to. We've been fundraising for local Ukrainian children for their dental service, and I was wondering why they weren't being serviced. The cost has gone up to \$256 million, and a decade ago it was only \$13 million.

Is there a different process that dentists' offices must take with the interim federal health program dental coverage if services are rendered to a refugee applicant whose application has been rejected by the Immigration and Refugee Board, as compared to services rendered to an approved refugee?

Dr. Aaron Burry: I would have to get back to you on the details of that. It has been a while since I've treated refugees under that program as well as publicly. There are many different classifications of individuals coming in. Each one of those may have a different approach.

Helena Konanz: Do you think you could table that information for me when you receive it?

Dr. Aaron Burry: Certainly.

Helena Konanz: That would be great.

I have one more question.

Actually, I think I'm going to turn my questions over to Mr. Mazier at this point.

Dan Mazier: Thank you.

Madam Chair, I have the floor. I would like to move the following motion since we're getting close to one o'clock.

I move that, given that the cost of the—

The Chair: Excuse me. Are you taking some of Ms. Konanz's time?

Helena Konanz: I did say that, yes.

The Chair: All right. Thank you.

Dan Mazier: I move:

That, given that:

The cost of the Interim Federal Health Program has increased from \$66.3 million in 2016-17 to \$797.2 million in 2024-25; an increase of more than 1,100% in less than 10 years.

The total number of users that incurred Interim Federal Health Program claims has risen from 84,967 users in 2016-17 to 426,750 in 2024-25; an increase of more than 400% in less than 10 years.

In Quebec alone, the number of users that incurred Interim Federal Health Program claims has risen from 11,900 users in 2016-17 to 108,440 in 2024-25; an increase of over 810% in less than 10 years.

During the health committees' study on the impacts of immigration policy on health care in Canada, the committee heard testimony regarding a lack of program oversight, questionable billing practices, and a sharp rise in program usage and costs for the Interim Federal Health Program;

the committee:

- a) instruct the chair to write to the Auditor General of Canada, suggesting that she conduct a comprehensive audit on the federal government's Interim Federal Health Program to examine the significant increase in costs, usage, and impacts on provincial health care systems by February 07, 2026;
- b) instruct the chair to write to the Parliamentary Budget Officer requesting that he conduct a fiscal analysis of the Interim Federal Health Program to project future expenses and assess the drivers behind recent significant cost and usage increases by January 30, 2026; and
- c) invite the Auditor General of Canada and Parliamentary Budget Officer to appear before the committee separately to present and discuss their respective findings if they publish a report.

From what we've heard here over the past committees, I think this is a very important subject. We really do have to get a handle on this important subject.

• (1250)

The Chair: I have a list of speakers. There's a motion on the floor.

Go ahead, Mr. Bailey.

Burton Bailey: I'm sorry. I have nothing to say at this time.

The Chair: All right.

Ms. Chi.

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

If I may, I believe this is out of order. We're still dealing with the witnesses. We were just in the middle of a questioning round.

I just got the notice of motion. Don't we need an advanced period of circulation before we vote on it? That's my understanding of the orders.

The Chair: I'm sorry, Ms. Chi. If you want to suspend to look at the motion, I'd be happy to do that.

This is in order because it is a subject we're discussing right now.

I will suspend to look at it. Is that what you're asking for?

Some hon. members: No.

The Chair: You just want to discuss it. Okay. I won't suspend.

Ms. Chi, you have the floor.

Maggie Chi: That's the point I wanted to make.

The Chair: We will move on to Mr. Eyolfson.

Doug Eyolfson: Thank you.

I need clarification as to whether this is a point of order. Do we not need to be formally in committee business in order to raise a motion like this?

The Chair: If there is a motion pertaining to the issue under discussion right now—and this motion is—it is allowable as a motion. It means that I may just have to.... Given the time and the list of people I have, it might very well be that I have to thank our witnesses for appearing and for their excellent interventions.

You may leave if you wish because we're discussing this now. Thank you.

Go ahead, Doug. Did you want to speak to this or not?

Doug Eyolfson: No, thank you. My point's been made.

The Chair: I'm going to Mr. Powlowski.

Marcus Powlowski: I certainly want to speak to this, especially with the witnesses being here. I think we're kind of getting to the heart of the problem and how we can address this problem of foreign credentialing. We have some excellent people here whom I would like to be asking questions of. Instead, we're going down this rabbit hole, which is really a spending issue. We're the health committee and this is an issue of spending and the efficiency of spending.

There are a whole lot of health issues we could be talking about. I'd like to do our cancer study. There's the opioid crisis study that we could be addressing. There are a lot of health issues we could be addressing. We're going after this Conservative notion that we're wasting money on these foreigners who are coming in here and using our health services—I know that appeals to a certain Conservative base that wants to hear that there are too many foreigners and that we're spending Canadian dollars on foreigners—instead of doing what we actually should be doing as a health care committee, which is addressing health issues. Therefore, I totally disagree with us spending money and time on this issue.

The Chair: Mr. Bailey.

Burton Bailey: I totally disagree. Call the vote, please.

The Chair: Are you speaking to the motion or not?

I will decide when to call the vote, Mr. Bailey, when I have no one else speaking to this motion.

If you're speaking to the motion or against the motion, I'm giving you the floor. If you're telling me to call a vote, I will not give you the floor because it's inappropriate.

Mr. Mazier, I heard you muttering. Do you want to speak?

Dan Mazier: Yes, actually I was requesting to speak.

Just to Mr. Powlowski's point, we could just vote on this. That's what I'd recommend. We had the witnesses here. We can bring them back and away we go.

That's what I would recommend. Let's have the vote if no one else wants to say anything.

The Chair: You can recommend that we have the vote; however, until I have no list of speakers, we cannot vote, Mr. Mazier.

I'm looking to see. We have Ms. Chi.

Maggie Chi: Thank you, Madam Chair.

I tend to agree with Dr. Powlowski. We're in the middle of inviting witnesses and they made the time to come in person. We really wanted to delve a little bit deeper into the PACE program in Nova Scotia because they're demonstrating a model that helps to train doctors and family physicians. I had a lot of questions around that. I think it's really important to get that in the study.

It is disappointing to me. This is time the witnesses have given us.

Given that, I move to adjourn the meeting.

• (1255)

The Chair: There's no debate on the move to adjourn the meeting.

Those in favour of adjourning the meeting....

Mr. Mazier, will you allow me to chair a meeting and stop yelling at me from the sidelines, please? I am speaking. You don't let me finish. You yell at me. Stop yelling at me. Please, let me finish my job. Thank you.

We have a motion on the floor to adjourn. It is not debatable. I'm going to call the vote on the motion to adjourn.

(Motion negatived)

The Chair: We remain in session. We have five minutes left.

We have a motion and there's no one wishing to speak for or against the motion.

I will call the vote on the motion. Would you like a recorded vote?

Marcus Powlowski: I'd like a recorded vote, please.

(Motion agreed to: yeas 5; nays 4)

The Chair: We have four minutes. I see someone here who's still on virtual. Would you want to take another four minutes?

I could make it five minutes. The person up for the five minutes would be Mr. Eyolfson.

Doug Eyolfson: Thank you, Chair.

I'm sorry about the interruption, folks. It's part of how committees work. These things happen.

Dr. Nickerson, I am Doug Eyolfson. It's good to see you again. It's been quite some time.

You talked about the cuts in medical school and residency positions since the 1980s and how the situation has been improved. You said it was the provincial governments that were cutting those. Is that right?

Dr. Peter Nickerson: Yes. The provincial governments set the seat numbers that the universities can have. They were all decreasing through the 1980s into the late 1990s, and then they were ramped back up again to the level they are today.

Doug Eyolfson: All right. Thank you.

Having served in the federal government before and being back now, I know that there is sometimes difficulty in trying to coordinate with the provinces. We want to encourage provinces to do certain things, such as funding spaces, but we tend to get push-back if we designate any funding toward any particular initiative.

Would you encourage the provincial governments to work with the federal government to increase the number of medical school and residency spots?

Dr. Peter Nickerson: Yes. I think that's what we really need: federal-provincial co-operation to further increase the current capacity.

If we compare ourselves to other OECD countries, at the current level of 93 per million on average, we're well below what is occurring in Australia or the U.K., which is up in the 120 to 130 per million range. Clearly other countries are outpacing where we're at today.

Doug Eyolfson: Thank you so much.

Dr. Burry, you talked about how dental assistants were not part of this eligibility. What program was it that they're not eligible for?

• (1300)

Dr. Aaron Burry: It's the PGWP. It's a federal program related to priority groups.

Doug Eyolfson: Okay. Had they previously been part of this?

Dr. Aaron Burry: Yes, they had been.

Doug Eyolfson: Was a reason given for their removal?

Dr. Aaron Burry: No.

Doug Eyolfson: I'm assuming you would encourage that to be reversed, then.

Dr. Aaron Burry: That's essentially what we're asking. It's to do everything we possibly can with what we're foreseeing as shortages.

Doug Eyolfson: All right. Thank you.

Among the dental assistants and dental hygienists, are any of them that you're aware of currently with the temporary foreign worker program?

Dr. Aaron Burry: Not that I'm aware of...no.

Doug Eyolfson: All right. Thank you.

Dr. McAdoo, you were talking about your program and how it is funded by the province and by the Medical Council of Canada. There's the fee for billing, and then is there a stipend provided to the physicians working in this for training?

Dr. Keri McAdoo: The funding comes through the provincial government. The Medical Council of Canada does not provide funding. Part of that funding goes towards stipends for the physicians under assessment.

Doug Eyolfson: Would an increase in funding for this program from the federal government help you better do your job?

Dr. Keri McAdoo: There are lots of ways that we could improve how we do things. I mentioned earlier the housing piece, looking at expanding the welcome collaborative, looking at expanding post-PACE settlement into community, looking at mentorship.... There are lots of ways to improve the program.

Doug Eyolfson: Thank you.

Dr. Nickerson, a point was brought up about the federal health care infrastructure and how provinces are under a lot of financial constraints on infrastructure and personnel.

When the federal government is funding health infrastructure, does that not effectively make more money available for a provincial government like Manitoba's to spend on things like improving personnel levels, working conditions and these sorts of things?

Dr. Peter Nickerson: Yes, I would hope so. Hopefully, we'd realize that at the front lines of the hospital structure and for the support staff within that infrastructure.

Doug Eyolfson: Thank you. I have no further questions.

The Chair: You had six seconds left. Very good. Thank you very much.

I will now go to Ms. Larouche.

[*Translation*]

Ms. Larouche, you have two and a half minutes.

Andréanne Larouche: Thank you very much, Madam Chair.

I too will address Mr. Burry.

In your opening remarks, you spoke about the effects of the new insurance program. In Quebec, we already have a form of dental insurance; it does not cover everything, but it exists. The Quebec government requested a transfer of funds in order to improve its dental program. Quebec knows what the needs are on the ground. Moreover, this is within its jurisdiction. It knows what an improvement to the dental program would entail.

If I understand correctly, this program has generated more requests, which means that we need to find more employees here and abroad. We need staff.

Would it have been preferable to respond to Quebec's request rather than impose a new program without first assessing labour needs? Quebec already has a program, and its knowledge of the needs could have helped improve the program. That is one of the problems that has been created.

Dr. Aaron Burry: Thank you for your question.

[*English*]

From a Canadian Dental Association perspective, we don't really look at which jurisdiction is involved in trying to provide oral health care. What we need for those is to have—

The Chair: I think we're having some problems with interpretation.

[*Translation*]

Andréanne Larouche: Indeed, Madam Chair, I did not have access to interpretation.

Now that I have access to interpretation, could you give the witness a few more seconds so that he can answer my question?

• (1305)

[*English*]

The Chair: Yes, we have done that.

Let's go again and see what happens.

Dr. Aaron Burry: Madam Chair, in terms of the delivery or the level of government that delivers oral health care services, the Canadian Dental Association does not have a specific position related to that.

What we want to see are the most effective programs possible to deliver oral health care to Canadians, whether that's at the federal level or the provincial level at this time.

[*Translation*]

Andréanne Larouche: We have, as it happens, noted problems with the program's effectiveness. In Quebec, people have told us that not all applications were accepted. There are also doctors who did not want to join the program because it lacked clarity or because they did not have enough information.

Have you noticed the same thing?

[*English*]

Dr. Aaron Burry: Yes, in terms of the challenges with this particular program, we have certainly seen them, but at the same time we've been working directly with Health Canada to look at solutions.

Again, our interest is very much that Canadians get the oral health care they need.

The Chair: Thank you very much.

I will turn to Mr. Bailey for five minutes, please.

Burton Bailey: Through the chair, I'd like to speak with Dr. Nickerson from Manitoba, please.

Could you clarify this? You said it costs \$430,000 to train a medical student. In Alberta, they're claiming it's over a million dollars. Are you including the stipends that they would receive?

Dr. Peter Nickerson: No, I was quoting based on a Senate document from 2002, adjusted for inflation, as a Canadian average.

Burton Bailey: Could you tell me how many CaRMS matches there are in Winnipeg? Give me a general breakdown. One is family medicine and then, of course, the rest are specialists.

Would you have 90 spots?

Dr. Peter Nickerson: We have 190 spots that we offer. In terms of family medicine, we have 82 spots.

Burton Bailey: Is it possible that you're not aware that the Saudi government makes donations to the University of Manitoba for taking on these Saudi students?

Dr. Peter Nickerson: We don't have donations, as far as I'm aware.

What we have for visa trainees is a set amount that they pay the institution to train those individuals.

Burton Bailey: Would you be aware if the Saudi government were giving donations to the university, or would that be something you would not be aware of?

Dr. Peter Nickerson: I would not be aware of that.

Burton Bailey: Okay. I appreciate that.

Is there anything that requires your graduates from your CaRMS match to stay in the province?

Dr. Peter Nickerson: For the Canadian medical graduates, no.

We have a return of service for international medical grads to stay in Manitoba for a period of time.

Burton Bailey: Thank you.

Through the chair, Dr. McAdoo, thank you for the work you're doing. I have not been to your centre yet, but I have spoken to many people who have. I would like to ask you what sorts of challenges you faced when you were starting up your program. Do you think this is something that could be incorporated into other provinces?

Dr. Keri McAdoo: Thank you for that.

There were a lot of time pressures, for sure. It was announced in October, and we were operating in January. We started our first assessments in February, so time was definitely a pressure. Finding enough clinic space in that short period of time was a challenge as well. We were constrained by the number of assessments we could do based on the number of clinical exam rooms we had available to us. That's why we're opening another space in December. Obviously, we had to recruit all of our team, our candidates and our assessors. That was part of it. We were building the program in a very quick period of time.

We now have a very strong foundation and have proven that it is scalable. We've scaled already and are still in our rapid growth phase. We started at a very small number of candidates and are increasing them on a regular basis. We'll double our capacity in December for the office-based primary care program.

As for the challenges ahead, we are going to be looking at expanding the orientation program, potentially, that's run through the College of Physicians and Surgeons of Nova Scotia to expand its scope and hopefully breadth. We will also be looking at building purpose-built space so that we have more space to do these assessments and continue to develop the program. Of course, we're going to get into program evaluation as well. We'll be collecting a great deal of data, which will help with informing how these types of programs move forward.

To answer the final question, which I believe is whether it could be done in other areas, it is certainly scalable locally. It could be done on a regional basis. As we scale up, we will have capacity to do that type of work. It could be done in other provinces as well, if there is a will to do so.

• (1310)

Burton Bailey: Thank you so much. I'm finished.

The Chair: Thank you.

Ms. Chi.

Maggie Chi: Thank you.

Thank you to all the witnesses for joining us today. My questions are for Dr. Nickerson. I have a couple of clarification questions.

Who decides the number of medical school seats and residency positions? Can you quickly go through that?

Dr. Peter Nickerson: Sure. That's approved by the Ministry of Advanced Education of the Manitoba government.

Maggie Chi: Thank you.

As you noted before, visa resident trainees are only accepted after all provincially funded residency positions for Canadians have been filled. Then, the provinces are explicitly asked whether they want to fund these remaining positions. If a province declines to fill the leftover spots and the visa trainee pays to train, does that take anything away from a Canadian graduate?

Dr. Peter Nickerson: No. In fact, we've had discussions with the provincial governments around having visa trainees. They want to make sure we're not taking visa trainees in spots where we have an urgent need to train individuals who will stay in Manitoba.

Maggie Chi: If a province did want to fund those leftover positions for, say, a Canadian graduate, they could—meaning that visa trainees only ever access unclaimed capacity. Is that correct?

Dr. Peter Nickerson: Right. We fill all 190 of our seats. We still have some visa trainees in the province, but they are not dependent upon those seats being empty. It's a matter of whether the system has the capacity to accommodate them within the health care system. The home country pays for the training.

Maggie Chi: I will be sharing my time with Dr. Powlowski.

Marcus Powlowski: Dr. McAdoo, I started to get into this question. Maybe it's the Medical Council of Canada. It was the head of the Medical Council of Canada who told me about this. I thought there was some informal group of the various bodies that are involved in establishing practice-ready assessments. In some provinces, that's the college of physicians and surgeons. In other provinces, it's an independent body. In other places, it sounds like it's teaching hospitals. Are you trying to set national standards for practice-ready assessments?

Dr. Keri McAdoo: Yes, it is through the Medical Council of Canada that the groups voluntarily get together.

Standards were developed quite a few years ago for certain disciplines for practice-ready assessment programs, but I would leave it to the Medical Council of Canada to describe what they have—

Marcus Powlowski: Our government has committed a fair bit of money towards helping foreign-trained health care workers get credentialed in Canada. It would seem to me—and you could make this recommendation—that we could put money into having a more formal organization of bodies that would administer practice-ready assessments.

The other thing I'd heard was that there was some interest in having a national match so that physicians coming into Canada could, rather than applying to each province, have a CaRMS kind of process whereby there would be just one place to put in their applications, and then the various provinces could choose the people they would bring in. Would you be in favour of creating that kind of match?

Dr. Keri McAdoo: I haven't considered that before, but making it more accessible to more people would be a reasonable way to go.

I forget what the first question was. You had a two-part question.

Marcus Powlowski: It was just about a national match. I would have thought that a national match would be desirable.

Dr. Keri McAdoo: Yes. Having access to the information so that international-trained physicians would not have to replicate applications would definitely be valuable.

Marcus Powlowski: Finally, Dr. Nickerson, I think Manitoba is the only province that has this one-year bridging program to kind of scale up the skills and the knowledge of foreign-trained physicians.

Are you the only province, and would you suggest that this could be a place to put money into dealing with this problem? Perhaps it would be good to put federal money into helping to create similar kinds of institutions in other provinces.

• (1315)

Dr. Peter Nickerson: Yes, we are the only ones in the country who have this program. It's been highly effective. We've seen the individuals graduate out of the program and we've not seen complaints by patients afterwards from the college. Also, we know that 75% of those individuals stay in Manitoba and practise long term.

Marcus Powlowski: Just formally, would you recommend this as a good model that other provinces may want to follow?

Dr. Peter Nickerson: Yes, we think it's leading edge. It should be recommended nationally.

Marcus Powlowski: Thank you.

The Chair: Thank you to the witnesses for staying through this. It was fortuitous, actually, that you stayed and we could bring you back.

Thank you, everyone. I now adjourn this meeting—

Dan Mazier: Madam Chair—

The Chair: Yes, go ahead.

Dan Mazier: I have just a couple of questions.

The Chair: Is it a point of order or just a question?

Dan Mazier: They're questions.

What are we doing next Tuesday for an agenda?

The Chair: On Tuesday, we have the dean's replacement coming.

We asked the dean's replacement to come on that date, and she responded. The dean from Toronto, whom we summoned to come on Tuesday, is sending Dr. Houston. I discussed this with you while we were suspended, Mr. Mazier, and you agreed.

Dan Mazier: That's the 27th. That's not Tuesday. What date is next Tuesday?

The Chair: Next Tuesday is the 27th, I think. No. Next Thursday is the 27th.

Next Tuesday, we are going to be discussing the opioid epidemic and the toxic drug crisis in Canada, and the interim report that was asked for by Luc.

Dan Mazier: Thank you.

As my other question, we asked for a lot of data from the departments in the first hour. I wonder if we could make a request that we have that by next Wednesday for the committee.

The Chair: We could make a request, but the department will decide how long it takes to gather it.

Dan Mazier: Yes, if we could just hear back on how long it would be...

Thank you.

The Chair: All right. Is there anything else?

The meeting is adjourned.

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