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# Standing Committee on Health

EVIDENCE

**NUMBER 008**

Tuesday, October 28, 2025

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Chair: Hedy Fry





## Standing Committee on Health

Tuesday, October 28, 2025

• (1110)

[*Translation*]

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

[*English*]

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

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

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

I would like to remind participants of the following points.

Please wait until I recognize you by name before speaking. For those participating by video conference, click on the microphone icon to activate your mic and mute your microphone when you're not speaking. At the bottom of your screen, you can select the appropriate channel for interpretation. The options are floor, English or French.

I remind you that all comments should be addressed through the chair.

For members in the room, I'm going to remind you of the little icon here and to put your phones down and speak into the microphone without a lot of disturbance, because it does affect the hearing of the interpreters.

Again, if you raise your hand, the clerk and I will try to recognize you as we see your hand come up.

[*Translation*]

The meeting is on the impact of immigration policy on health care and barriers to integrating internationally trained health professionals.

[*English*]

Pursuant to the motion adopted on Tuesday, September 23, 2025, we're resuming that study.

I would like to welcome our witnesses for this first hour.

As an individual, we have Dr. Scott Alexander, medical adviser. From the Medical Council of Canada, we welcome Dr. Viren Naik, chief executive officer. From the Society Of Canadians Studying Medicine Abroad, we have Rosemary Pawliuk, president, and Dr. Douglas Munkley, physician.

Each group has five minutes, but you can split your five minutes any way you want. I will give you a one-minute shout-out, and then I'll give you a 30-second shout-out so you know to wrap up. If you don't finish what you're saying, you can probably include it in an answer to a question.

Yes, Helena.

**Helena Konanz (Similkameen—South Okanagan—West Kootenay, CPC):** Madam Chair, are we going to be able to get the full hour? I know we have some witnesses from B.C. Will we get the full hour?

**The Chair:** We have until one o'clock. If we need more than five minutes or so of further time, we're going to have to ask if we have the resources to do that.

**Helena Konanz:** Will this hour go until 12:10?

**The Chair:** Everyone would have to agree they can stay. If not everyone can stay, we won't be able to go past one o'clock.

**Helena Konanz:** This hour—

**The Chair:** Basically, you're asking for this. That means if we go beyond this hour, we're going to be cutting short the next hour if everyone is not in agreement to stay afterwards.

**Dan Mazier (Riding Mountain, CPC):** Chair, with all due respect, we have witnesses who came here all the way from B.C. I think the least we could do is allow them the first full hour and full second hour to be here.

**The Chair:** We can cut the people in the second hour short. Is that what you're saying?

**Dan Mazier:** No, we're going for the full two hours.

**The Chair:** We have to get agreement, Mr. Mazier, to stay in this room until after one o'clock. We have to get agreement from every one of the members of this committee to stay after one o'clock. It's not up to one person to do that.

**Dan Mazier:** Call the question, then. Do we have agreement from the committee?

**The Chair:** I will ask the committee.

Do we have agreement to stay after one o'clock?

Clerk, do we have resources for after one o'clock?

Okay, we do. All right. That's good.

• (1115)

**Dan Mazier:** Thank you, Chair.

**The Chair:** It's always going to require consent from the committee. It's not just one group or one person who can say so.

I hear what you're saying, Mr. Mazier. I'm trying to get it done according to process. Thank you.

I will begin with Dr. Alexander.

You have five minutes. I shall give you those shout-outs like I said.

**Scott Alexander (Medical Advisor, As an Individual):** Thank you very much, Madam Chair, and everyone in the committee, for having us here.

My name is Scott Alexander, and I was born and raised in North Vancouver, British Columbia. I graduated from the University of Queensland school of medicine in 2017 and returned to Canada with the intention of completing a residency and practising here, but I'm now a non-licensed physician in Canada because I was unable to obtain and secure a postgraduate residency position.

I discovered my calling for medicine after transitioning from the University of British Columbia to Simon Fraser University, where I studied biomedical physiology and kinesiology and fell in love with the science of the human body.

I started later than many applicants to medical school and faced some early setbacks, which unfortunately included playing junior hockey. With a master's degree, I tried to strengthen my application, but it did not gain me admission to Canadian medical schools. I then self-funded my education in Australia at a personal cost of over \$250,000 Canadian, intending to return home to practise here and raise my family.

After graduation, I did return to Canada and started my family, and I did apply for residency positions in both family medicine and psychiatry. However, two unsuccessful applications were followed by some retroactive changes to the exam requirements that declared the exams I had taken, the MCCEE and the NAC OSCE, were no longer acceptable, and I was required to take resident-level examinations, the MCCQE part I, before entering residency, and an updated NAC OSCE with a new format.

These changes effectively erased my progress towards licensure, as was the case for many internationally trained Canadians like me, and prevented me from applying to residency in further years. Therefore, I had to pivot, and I moved into medical affairs in the pharmaceutical industry.

For the last eight years, I've worked to bring innovative medicine to the patients in Canada and scientific education to the physicians across the country. I take real pride in improving patient care, but on a different scale than I had expected. This career change was not in my plans, and it does reflect some of those systemic barriers that prevent qualified Canadians trained abroad from practising at home.

I'm very fortunate that I have a physician-facing role and that I get to engage with doctors across Canada and build relationships with them. One of the icebreakers that I typically do when introduc-

ing myself is to share my story. Almost without fail, there is shock and sympathy, and immediate offers of help with things like observerships, preceptorships or letters of recommendation are given my way.

However, these offers come from the individual physicians themselves. In discussions with them, I've come to understand that a lot of the programs do not have the capacity to take on more training. One of the bottlenecks I've heard about does happen to be the foreign-trained visas. While they don't directly compete with residency positions, they do limit the number of supervised training positions available because of the constraints on teaching capacity and the limited hours that physicians have for supervision. It was not something I had considered as a barrier before having these conversations with the doctors, but on speaking with them, while they're burning out and struggling with their patient care, it seems to come to the front presently.

The medical school I attended was one of the largest international institutions, with a student body of 250 international students. There were 60 Canadians in my year. When I graduated in 2017, only two students tried to come back to Canada. Fifty-eight of my Canadian colleagues decided to stay in Australia and are now serving the Australian population as fully trained consultants.

Many of my peers would like to return, but they tell me that the barriers are prohibitively high and that the process lacks transparency for them. This frustration and loss of trained clinicians to other health systems is a problem for Canada.

In conclusion, I'd just like to say that while I would like to acknowledge that Canada invests in its people, we should not, through this unclear and inconsistent process or through retroactive changes, be losing Canadians who have already trained and been invested in.

**The Chair:** I'm sorry to interrupt. You have 37 seconds.

**Scott Alexander:** My personal thoughts are to remove some of these bottlenecks that come from the visa programs and capacity constraints, to restore predictability in the assessment and licensing and to expand supervised clinical training capacity so that qualified internationally trained Canadians can complete the final steps that are required here at home. Doing so will restore fairness to individuals and their families, deliver trained clinicians where they are desperately needed and strengthen health care for all Canadians.

I ask this committee to recommend concrete time-bound measures to help make that happen.

I thank you all very much for your time.

• (1120)

**The Chair:** Thank you very much.

Now I will go to the Medical Council of Canada and Dr. Naik.

**Viren Naik (Chief Executive Officer, Medical Council of Canada):** Good morning, Madam Chair and honourable members.

[Translation]

Thank you for the invitation to appear today.

[English]

My name is Viren Naik, and I am the CEO of the Medical Council of Canada. I'm also a practising anesthesiologist helping with the shortage here in the nation's capital, which you heard about in previous weeks.

Canada is absolutely in a crisis, and you've heard testimony and staggering figures to that effect. This isn't just a Canadian problem; it's a global problem. The World Health Organization has predicted that we will be short 10 million health care workers by the year 2030.

The Medical Council of Canada was enacted as an act of Parliament in 1912 to serve regulation and licensure by setting the national standard for the competencies we expect of physicians.

In crises, we do see erosions of the standards. I don't think that today is the day to lower or remove standards, but we absolutely do have to modernize those standards, making them efficient, effective and relevant. The national standard needs to evolve, just as medical practices evolve. If we do that right, we can maintain patient safety and keep the public's trust. Our licenciate and our examinations are good measures of whether someone is ready to enter supervised practice.

I put it to you that we support the national standard in three ways. One is through credential verification. Thankfully, in today's day and age, we see the incidence of fraudulence to be low, but it's not non-existent, so this is an important check to test medical knowledge and, more importantly, the ethical and cultural considerations we'd want to see in our doctors. Recognizing that no single test is going to tap all these competencies, importantly, professionalism and communication, we are leaning into assessor tools and training so that we can bring valid and defensible decisions to workplace-based assessment through the practice-ready programs you discussed.

I said it's a global crisis. Well, inherently, that means it's also a global competition. We are going to have competition in our provinces and our territories, but we cannot allow that competition to increase the complexity and confusion with heterogeneous pathways and heterogeneous processes. We have to recognize that all recruitment needs to be ethical, but if we can do this right, given this global crisis, we can have Canada as a destination of choice for physicians who choose to migrate.

More importantly, for those who are already here, we can bring clarity, as opposed to confusion, to the pathways that are accessible to them.

We know from our exams that we leave a thousand candidates every year on the table after they've demonstrated the competencies that show they're ready for supervised practice and potentially for moving on to licensure. That's because they can't access enough residency and PRA positions.

My recommendations to this committee are threefold.

One, let's bring clarity, not through a provincial and territorial lens, but through a national lens, about the requirements for international medical graduates and set expectations so that the migrating doctor can make an educated decision on whether Canada is a destination, but more importantly, so that we can navigate those who are already here, as opposed to having them try to understand the system.

Two, we need to expand opportunities for supervised placements that can lead to licensure. That includes bridging programs and clinical assistant positions to address recency of practice, increasing our residency spots and dramatically expanding our PRA programs, which we know are the most efficient way to bring people to licensure.

That includes the innovative Physician Assessment Centre of Excellence in Nova Scotia that you've heard about, of which we are a partner. That innovative program directly addresses the bottlenecks and capacity issues that we see in this program.

Finally, I think we do need to build upon digital platforms like the National Registry of Physicians so that we have a single source of truth for credentials, for practice locations and for scope of practice. If we have that information, then we can remove the redundant credential checks throughout the system. We can facilitate mobility between our provinces, and probably most importantly, do the HHR planning so that we don't end up in a situation like this in generations to come.

I look forward to your questions.

Thank you, *merci* and *meegwetch*.

**The Chair:** Thank you very much.

I now go to the Society of Canadians Studying Medicine Abroad.

I'm going to call on Dr. Pawliuk. Are you going to be the speaker?

• (1125)

**Rosemary Pawliuk (President, Society for Canadians Studying Medicine Abroad):** Actually, we're going to split it. Dr. Doug Munkley will speak first, and I'll speak second.

**The Chair:** All right.

Dr. Munkley, you have two and a half minutes.

**Douglas Munkley (Physician, Society for Canadians Studying Medicine Abroad):** Thank you, and good morning.

I'm Doug Munkley, and I have been a full-time emergency physician in a high-volume community hospital in Niagara for over 30 years. I've also worked in walk-in, urgent care and primary care settings. As well, I'm the medical director for Niagara EMS, the ambulance service that provides care to over 500,000 people in our region.

Niagara is a wonderful place to live and work. However, we too have an acute lack of family physicians, and we're designated as such by the Ontario Ministry of Health. That lack of physicians, both GPs and specialists, is felt in a number of ways. Clearly, to those individuals who do not have access to primary care, there are adverse health effects from lack of disease prevention and delayed diagnosis and treatment. For those awaiting specialist consultation or surgery, those delays also have profound effects.

However, there are other consequences of the lack of family physicians or after-hours physician services. Patients often have nowhere to go except the emergency department. Provincial tele-health services, which are risk averse, will direct patients to the ED, as will doctor's offices. These factors are part of a systemic issue causing widespread emergency department overcrowding. When EDs are overcrowded, ambulances cannot offload their patients and, therefore, they are not available to respond to emergency calls.

What are some of the solutions to this doctor shortage?

There are 3,500 Canadian students studying in highly respected medical schools around the world. We need to provide a fair and equitable process for Canadian medical students studying abroad to obtain residency positions, and we need to remove the licensing barriers to enable these physicians to come home to practise in Canada.

**The Chair:** Thank you.

Ms. Pawliuk, go ahead.

**Rosemary Pawliuk:** As Doug said, there are 3,500 of us studying abroad, and 800 graduate every year. Last year, there were fewer than 200; there were 181. We've had as few as 119 of those 800 apply to come back to Canada, not because we don't want to but because the barriers are so significant, and we're so unwelcome.

International medical graduates, IMGs, are segregated from graduates of Canadian medical schools when applying for residencies. IMGs are limited, for the most part, to a small number of residency positions in a small number of medical disciplines. In B.C., out of 30 disciplines, we are able to apply to four, most in family medicine and only on the condition that when we're done licensing, we have to work where we're told.

This is why so few people come back home. They feel unwelcome. They feel they're second-class citizens, and it hurts. It's simply not viable. This is after we have proven we have the knowledge and skills expected of graduates. These barriers exist despite having proven equivalency.

We advocate for equal opportunity. Once substantial equivalency has been proven, every Canadian who meets the Canadian standard should have equal access to apply for resident physician jobs. We also advocate for uniform exams. A lot of negative stereotypes have arisen, such as that our constituents are rich kids, which is simply not true. As a matter of fact, most of our constituents are not from well-off families.

The one thing I want to advocate most strongly for is the revocation of bulletin 230. We have raised how sensible it is to have more doctors practising. Resident physicians provide necessary medical

treatment. They get on the bus and they're working the first day. They're working right away.

When we asked the faculties of medicine for more residency positions, even privately funded ones, we were told the faculties simply do not have the capacity to train more doctors. That's why we made an application for the revocation of bulletin 230 in 2019, but it's been sitting, despite problems. There has been nothing but stalling.

Residency positions are jobs. Residencies provide necessary medical services. They're paid under a collective agreement. The Immigration and Refugee Protection Act requires that before a work visa is issued to a foreigner, the employer has to go through the labour market impact assessment to prove that foreigners are not taking away jobs from Canadians.

In 2010, The faculties of medicine convinced Service Canada and Immigration, Refugees and Citizenship Canada that they should not require this assessment, so foreigners come in and take residency positions and fellowship positions and displace the 1,000-plus people Viren was talking about.

• (1130)

**The Chair:** Ms. Pawliuk, your time is up. Thank you. You can fill it in during the question and answer segment.

**Rosemary Pawliuk:** Yes, I'd like that, if you want to hear it.

**The Chair:** Now I will begin the question and answer segment.

The first round is a six-minute round. The six minutes include the questions and answers. I will do the same here. I will give you a one-minute prompt and a 30-second prompt.

We'll begin with the Conservatives.

I have Mr. Mazier for six minutes, please.

**Dan Mazier:** Thank you, Chair.

Thank you to the witnesses for being here today.

Dr. Naik, did the federal immigration department consult with the Medical Council of Canada on this year's federal immigration levels plan?

**Viren Naik:** They did not.

**Dan Mazier:** Did the federal immigration department ask for any data on the current capacity of Canada's health care system with regard to this year's immigration levels plan?

**Viren Naik:** No, they did not.

**Dan Mazier:** My next questions are for the Society Of Canadians Studying Medicine Abroad.

Is the federal immigration department approving permits that allow foreign doctors to train in Canada through the visa trainee program?

**Rosemary Pawliuk:** Yes. That's without the LMIA process, so there's no analysis of the impact on Canadians. They are allowing it despite our objections and despite our application. They are ignoring our application to insist on finding out what the impact on Canadians is.

**Dan Mazier:** Once these visa trainees complete their medical training in Canada, do they stay to practise here, or are they required to return to their home countries to practise?

**Rosemary Pawliuk:** Under their contracts with their sponsor, they're required to return to their home country. Most of them do, but some of them ignore their contract and stay.

**Dan Mazier:** Why is the federal government approving work permits for foreign doctors to train in Canada under the visa trainee program only to send them home afterwards while thousands of qualified Canadians studying medicine abroad can't secure a training spot here?

You both can answer.

**Rosemary Pawliuk:** That's a darn good question. Why are they doing that?

We know this came about through the request of the faculties of medicine of Ontario, supported by the others.

What's happening is that the faculties earn \$100,000 on an application. That's what they charge each year to these foreign physicians. It's a very good source of income. Millions of dollars are earned every year by the faculty. They can use that money at their discretion.

What they're doing is using taxpayers' resources and our trained doctors to train these foreigners so that they can then have a lot of extra money for the purposes they want, whether it's research or whatever.

I'm not against their making money. What I'm against and what we're struggling with is that Canadians are literally dying. They're not able to get back to work. They're losing their homes because they can't get their problems.... That should be far more important than the faculty being able to make a little bit of extra money.

Literally, thousands.... As Viren said, this year there were a thousand qualified people ready to go to work as resident physicians who were not able to.

A few years ago, the ministry of defence wanted to fund 50 residents. The faculties said no, and they gave them five. They said, "We have the capacity to do five." The next year they did eight.

• (1135)

**Dan Mazier:** Thank you for that explanation. That leads nicely to my next question.

Are foreign-funded visa trainees using medical training capacity that could otherwise be available for Canadians who study medicine abroad?

**Rosemary Pawliuk:** Absolutely, and the numbers are great.

**Dan Mazier:** Dr. Munkley, did you want to add anything to this?

**Douglas Munkley:** Yes.

The teaching hospitals rely on residents. They're a source of good labour and they provide a lot of the care in hospitals. I certainly believe there's capacity to train more.

**Dan Mazier:** How many Canadians are currently studying medicine abroad but are unable to obtain a residency position in Canada after graduation?

**Rosemary Pawliuk:** There are 3,500 who are studying abroad. About 800 graduate every year. In this last year, off the top of my head, there were 181 who applied. That actually is in response to more residency positions. In 2022, because of the barriers, only 119 Canadians out of 800 applied after graduation.

The chances are so slim. In Australia, you're almost guaranteed a place.

**The Chair:** You have one minute.

**Dan Mazier:** What country is benefiting the most from the visa trainee program?

**Rosemary Pawliuk:** It's the United States of America.

I'm sorry; was that which countries benefit from the visa trainees?

**Dan Mazier:** It's the visa trainees, yes. I switched back to visa trainees.

Which country is benefiting—

**Rosemary Pawliuk:** It's Saudi Arabia. There are currently 1,117 Saudi Arabians training in Canada.

**Dan Mazier:** Before the federal government brings in more foreign doctors through immigration, should it first make sure that qualified Canadians who studied medicine abroad can return home to practise here?

**The Chair:** You have nine seconds to answer.

**Rosemary Pawliuk:** Yes.

**The Chair:** Thank you.

I will now go to the Liberals.

Ms. Chi, you have six minutes, please.

**Maggie Chi (Don Valley North, Lib.):** Thank you, Chair. Through you, I want to thank all the witnesses for appearing today. Thank you for making the time to come to Ottawa on a chilly morning. It's getting colder and colder.

My first question is for Dr. Naik.

You mentioned that the system in Canada in terms of assessment or workforce planning remains somewhat fragmented.

From your vantage point, where do you see the biggest misalignments today, and what practical steps would you say we can take to better link these systems so that physicians who arrive ready to contribute can be practising sooner?

**Viren Naik:** For a migrating physician, we have to be very clear about what the requirements are and what the expectations are.

Assessment and meeting a national standard do need to occur. That's not necessarily an examination, but rather a program of assessment. We need to make all of that more clear up front or upstream so that a person can make an educated decision before they come.

The realities are that all provinces and territories are looking to serve their constituents. We see nuances and heterogeneity in the requirements in different provinces. If we could be more consistent and have a national approach to this, it would bring clarity to those coming and to those who are already here.

By definition, we are a federated model, but when you look at countries that have more of a national approach to this in this global competition, you see that they provide more clarity to the international medical graduate and internationally trained physician.

**Maggie Chi:** On the idea of that federal coordination piece, could you expand on that? Is it more digital infrastructure and more data sharing? Is it more in program design?

You mentioned the centre of excellence in Nova Scotia. Does it play a role? How does it play a role?

**Viren Naik:** To be similar to our residency match, which is nationally based, and be similar to our practice-ready assessments, we can move to more nationally consistent requirement and application models. Both could be made more consistent.

The advantage there is that while repeating residency is an option and is certainly something we see people apply to, we know that a mid-career physician coming from abroad may be better served by a workplace-based assessment through practice-ready programs.

If we could become more consistent in those practice-ready programs across all of our provinces and territories, both for primary care and for specialties, it would bring clarity and a more national approach to those programs in general.

• (1140)

**Maggie Chi:** Thank you, Dr. Naik.

My next question is for Dr. Alexander.

Thank you so much for sharing your story of what you went through personally in transitioning from Australia back to Canada. You shared your story about why you wanted to practise. I deeply appreciate it, because I think there are many folks right now who are going through what you went through.

Dr. Naik touched upon some of the coordination piece. Could you expand on what the most confusing part was when you were going through that process?

As the second part to that question, from your perspective, what would have helped you navigate the process? What would improve that process?

**Scott Alexander:** Thank you very much. I appreciate the sentiment.

In all honesty, I think the CaRMS process is fairly straightforward. I think the biggest thing is just the limited access for any international doctor, as Rosemary alluded to. Being from Vancouver, I was trying to apply to the University of British Columbia residency programs, and there were only four options that I could have chosen from. If I had wanted to go into anything as a subspecialty, such as cardiology or endocrinology, that was completely off the table. I was not able to do that, and any kind of surgical positions...there was nothing available for me. I was very grateful that I was trying to get into family medicine and psychiatry, but beyond that there is limited capacity, and the competition was just incredibly steep.

I think that a way to make it more transparent is just understanding why that might be the case, why you might be able to go somewhere and have the want or desire to practise in a certain speciality, but then, in trying to come home, understand why that's not available to you. That's one of the major reasons a lot of Canadians I studied with abroad wanted to stay abroad. It was just the option and the availability of the training for them to go into the program that they were committed to, because coming back home was not an option.

**Maggie Chi:** I'm not too sure to whom I should direct this question, but I'll throw it out there.

In terms of other jurisdictions, like Australia or the U.K., is there anything you're seeing that works really well, that we could seize as a model and also emulate, in that sense?

Who wants to start?

**Rosemary Pawliuk:** From my perspective, it seems like a waste of time and energy to be forcing immigrant physicians, who have been practising in their country—there's nothing special about us; I mean, doctors are excellent all over the world—to go through residency training. For instance, a neurosurgeon will have to do seven years. At any rate, in that way, if they were trained, as Dr. Naik talked about, then residency positions could be used for new graduates. They are the ones who really need that period of time of experience in order to ensure public safety.

**The Chair:** Thank you.

We'll now go to the Bloc Québécois, with Mr. Thériault.

[*Translation*]

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

My questions are for Mr. Munkley and Ms. Pawliuk.

You said that the practice instituted by bulletin 230 should be revoked. My understanding, and this was also found by researchers in Quebec and Ottawa, is that international students who come here make a significant financial contribution to medical schools. They're kind of cash cows. Meanwhile, internationally trained Canadian students are having a hard time coming back to work in this country.

Isn't that indicative of something that we haven't talked about since the beginning of our study, which is that the federal government is investing less and less in health, particularly in health transfers? We could train more people here and bring our people home if we put the money in, but the reason we use international students is that they essentially become cash cows.

• (1145)

[English]

**Rosemary Pawliuk:** My French is not good enough to understand it, and our translation isn't working.

**The Chair:** I'll suspend until we get that fixed.

• (1145)

(Pause)

• (1145)

[Translation]

**The Chair:** We can now continue.

**Luc Thériault:** Madam Chair, should I start from the beginning, since the witnesses didn't understand my question?

[English]

**The Chair:** We stopped the clock. It's all right.

You can go ahead. You have three minutes, Monsieur Thériault.

[Translation]

**Luc Thériault:** Madam Chair, I would like all of my time back. It took me two minutes to ask my question, but the witnesses weren't able to answer it because they didn't hear it.

[English]

**The Chair:** I know, but we went back to when the problem occurred. The clock is giving you three minutes and nine seconds.

[Translation]

**Luc Thériault:** No, Madam Chair, I—

[English]

**The Chair:** Are you asking for more, Monsieur Thériault?

[Translation]

**Luc Thériault:** I want my five full minutes of speaking time to make up for lost time. It took me two minutes to ask my question, but the witnesses couldn't hear it because of a technical glitch. If I use another two minutes to ask my question again, they will have only one minute to answer it and I won't be able to ask any more questions.

[English]

**The Chair:** We've given you five minutes, Monsieur Thériault.

[Translation]

**Luc Thériault:** Thank you, Madam Chair.

Hello again.

Medical schools do not have to prove that no Canadians are available to occupy the residencies. That's what you said when you were talking about revoking Bulletin 230. Meanwhile, there are Canadians studying abroad who cannot return to work in Canada as they would under normal conditions. That's the problem you've identified.

We know that this practice exists because schools need money. These international students make a significant financial contribution to medical schools. The real problem is that federal and provincial governments are not investing in training people. Our own people aren't being offered positions because health transfers are inadequate.

• (1150)

[English]

**Rosemary Pawliuk:** What's interesting is that there are organizations that have offered to fund residency positions for Canadian immigrants and Canadians studying abroad. These include municipalities, large corporations that work in areas where they can't get employees because they don't have a doctor, and ethnic communities that want a doctor who will be sensitive to their culture.

The ministries of health have a monopoly over the funding. They do not allow other funding, and the faculties say that they won't train. They prefer foreign training. They turn on the tap, and when they're done, they turn it off. That means if I wanted five today and the ministry of defence wants 20, they have to coordinate, and it's going to be different every year. It is much easier just to turn on the tap and turn it off, rather than train Canadians.

There's funding outside the government. I'm not talking about the funding to the universities. That's another matter.

I do not think that funding is the issue. There's private funding, and certainly the ministries of health could do better. The issue is training capacity, according to the faculties of medicine. They say that they simply can't do it.

They're using our training facilities—

[Translation]

**Luc Thériault:** The training capacity of medical schools depends on resources. The reason they prefer international students is that they can bring in more revenue. The federal government's responsibility is not to withdraw from funding. For health care, the government's share is 21¢ per dollar, whereas it was initially supposed to be 50¢ per dollar.

In the Quebec film *La grande séduction*, a community tries to find a family doctor who is willing to come and practice in their part of the country. The reason communities are forced to do such things is that someone is not chipping in their fair share for health care in Canada. Would you agree?

[English]

**Rosemary Pawliuk:** I guess the question is that if the government funded more, would that change what the faculties are doing, or are they happier with just having money that they can use at their discretion, as opposed to monies?

I don't know the motivations of the faculties, but yes, there should be more funding. We certainly encourage them to fund more so that there can be more residency training, but if there were more funding, is funding to the universities at the root of this? They don't use the funding for training; they use it at their own discretion.

I did a freedom of information request to find out whether or not it was related. The funding is not used for residency training. It's used elsewhere by the universities, for what they want.

[Translation]

**Luc Thériault:** Do you think that a certain form of corporatism emerged in the medical community when the decision was made to remove quotas for the profession and training?

[English]

**The Chair:** Thank you. We've gone over time with this question.

I'm going to move on to the next person and the second round, which is a five-minute round.

We will be starting with the Conservatives.

Ms. Konanz, you have five minutes.

**Helena Konanz (Similkameen—South Okanagan—West Kootenay, CPC):** Thank you all for coming today.

My question is for Dr. Alexander.

Dr. Alexander, thank you for your heartfelt story. It sounds like it's been a difficult road, especially since any Canadian who's listening to this knows we need family medicine and psychologists throughout the country. We're desperate for them, in fact.

After you completed your medical education in Australia and decided to return to Canada, did you know you wouldn't be able to practise? That is my first question.

**Scott Alexander:** In a way, no, I believed that I would still keep applying for residency positions. I took other work in the interim to try to sustain my family for that time, while still trying for residency. It was when the examination requirements changed so that I was no longer eligible that I had to permanently shift.

• (1155)

**Helena Konanz:** You were given false expectations about your ability to practise in Canada after you arrived here. I'm sure you're not the only Canadian who has practised abroad who was also given those false expectations.

**Scott Alexander:** To a certain extent, after the two years of applying for residency with no success, it did feel like the rug had been pulled out from under me, because now there were new requirements for me to even have the privilege of applying for a residency in Canada.

**Helena Konanz:** Did you receive an offer to stay to work in Australia in their health care system?

**Scott Alexander:** Yes, absolutely.

I had to make a personal choice. I had an internship lined up in a rural hospital in Australia. I made the active commitment to come home so that my wife and I could have our family closer to our families. That was the sole reason that we came home.

**Helena Konanz:** That's amazing. Thank you for doing that.

In your experience at the University of Queensland, how many other Canadians studying abroad do so with the intention of returning to practise in Canada, but end up accepting positions in systems such as those in Australia or the United Kingdom?

**Scott Alexander:** That's a very good question.

I would say that when we walked in, the majority of Canadians—and I can at least speak for the 60 Canadians who were in my cohort—had the expectation to come back home after graduating, but I think that after going through the process of going to school and then understanding the requirements for coming home to Canada, more prepared themselves to go to the U.S. through the step programs and try to get residency in the U.S., as opposed to trying to come home to Canada.

Then others settled on the fact that the lifestyle in Australia was very equivalent to Canada's and that they could happily practise there after graduation.

I would say that by the second or third year out of the four years in medical school, most of the Canadians had already made up their minds that they were not going to even try to come home.

**Helena Konanz:** I think you mentioned earlier that 58 out of your class of 60 ended up staying in Australia or going to another country. Were you actively recruited by the Government of Canada or a medical association to come back?

**Scott Alexander:** No, I made that choice to come back on my own and to try to, I guess, get lucky in the residency matching system here in Canada.

I knew my chances were quite low. I think what I fully understood was that it was about 10%, based on the number of applicants versus available positions, so I took the risk. I had assumed I would have more time to try for the residencies—more time, as in more than two years—but that was not afforded to me.

**Helena Konanz:** I'm guessing that you would have loved to stay in Canada to do your studying instead of going abroad.

My next question for you is about the visa trainees.

In this program, international medical school graduates receive postgraduate opportunities in Canada. They study here and take up seats, but they have to leave after they study. I believe one person on the panel mentioned that 1,117 Saudi Arabians were now in those seats. Does it concern you that you weren't able to study here and that those seats were taken for study?

**Scott Alexander:** It does, absolutely.

For a Canadian who funded themselves to go abroad, get the equivalent training and do the equivalent exams in order to be able to come home and practise in their home country, to find out that foreigners are paying their way to come to Canada and are taking up training positions.... I know it's not necessarily a residency position per se, but it takes the same training seat from a physician, and then it is not available to someone in my position.

It reminded me of 2018-19, I think, when the Saudi Arabian government had issues—

**The Chair:** Please wrap up, Mr. Alexander. We're over time.

**Scott Alexander:** —with Canadian physicians, and there were hospitals in Ontario that were going to shut down because of it. That was really the first time that I heard about the foreign-trained visa program and the risk that it posed to the Canadian health care system.

**The Chair:** Thank you very much. We've gone 36 seconds over time on that question. I want people to try to stick to their time.

Mr. Eyolfson, you have five minutes.

• (1200)

**Doug Eyolfson (Winnipeg West, Lib.):** This may be a change since I was there. When I was in residency in the 1990s, we had some of these international residents, particularly from Saudi Arabia.

If I understand correctly, at the time I was there, these people were not taking up spaces that residents could use. These were extra spaces created because of the extra funding and the money top-up to the medical schools to help fund their programs.

Has that changed, or are extra spaces still being created for them that are not taking available spaces from training programs?

**Rosemary Pawliuk:** “Extra” is a very interesting word, because their argument to Immigration, Refugees and Citizenship Canada was that these are extra because somebody else is funding them. Canadians aren't funding them, and there's no Canadian funding, so they're extra.

In fact, they're not extra, because when Canadians ask for more training and for funding to be made available so they can train

Canadians, they say, “Sorry; we don't have the training capacity to do that.”

In my respectful submission, “extra” is a narrative. How could it be extra if there are more than a thousand Canadians who are ready to fill that job, and we're using our training resources in order to do that?

This “extra” stuff is like McDonald's saying they only have money that they're going to dedicate to foreigners, and therefore they're extra—

**Doug Eyolfson:** I'm sorry. I don't mean to cut you off, but I have limited time.

Who is making these decisions? Is this a federal government decision? Is it the universities? Is it the provinces? Who is making this decision?

**Rosemary Pawliuk:** Do you mean to exempt from the LMIA process? That decision was made by Immigration, Refugees and Citizenship Canada and Service Canada on the request of the faculties of medicine, who wanted to use this as a means of income generation.

**Doug Eyolfson:** This is driven by the faculties of medicine.

**Rosemary Pawliuk:** That's correct.

**Doug Eyolfson:** Thank you very much.

Dr. Alexander, I am sorry for what's happened. I do understand the concept of the rug being pulled out from under you. I graduated from medical school in 1993. There were a lot of changes to medical training at that time that affected many people who had certain plans for residencies, and because of the changes, that was pulled out from under them. Others who had gone on to a formal internship with the intention of working and then going into a residency no longer had that option. I do feel that this was not a change that a lot of people thought was positive at the time.

I just want to clarify. To your knowledge, were these changes a federal government decision, or was this done at the provincial level?

**Scott Alexander:** I don't know the official answer to that, but I would assume, based on the fact that it was a CaRMS application issue, it was done more at the federal level than in any of the individual programs.

**Doug Eyolfson:** Thank you.

Dr. Naik, you were talking about how we need to achieve this cross-country coordination of increasing the proper training slots and making sure that any medical graduate, a Canadian who's trained abroad, is able to get a position. How does the federal government do that if we try to make such a pronouncement and the provinces push back and say this is a provincial responsibility and we should stay in our lane?

• (1205)

**Viren Naik:** Thank you for the question.

First and foremost, we need the data. The provinces and territories decide what training spots we need through CaRMS, but I think the missed opportunity is around internationally trained physicians. They are the ones who have actually finished their graduate training in another country and have potentially even practised.

In such cases, the practice-ready assessment programs can rapidly bring someone to licensure in as little as eight to 12 weeks. The federal government could have transfer payments to the provinces and territories directed to the establishment and expansion of these practice-ready programs.

Regional hubs, like the Physician Assessment Centre of Excellence in Nova Scotia, are examples of how you can address the bottlenecks in assessor and assessment capacity that could be stood up across the country.

**Doug Eyolfson:** Thank you.

I actually agree with you.

**The Chair:** You have five seconds, Doug.

**Doug Eyolfson:** Thank you.

I would say that we've tried targeted funding before, and the provinces have basically torpedoed that.

I think that's my time. Thank you.

**The Chair:** Thank you.

I will now go to Monsieur Thériault for two and a half minutes, please.

[*Translation*]

**Luc Thériault:** Thank you, Madam Chair.

Dr. Naik, you talked about the global shortage of health care workers. As we know, the World Health Organization predicts that there will be a shortage of approximately 11 million workers by 2030. You also said that recruitment must be ethical.

According to the Organisation for Economic Co-operation and Development, in 2021, the proportion of foreign-trained health professionals recruited in Canada was 24%, which was above the global average of 19%.

What should we be doing? Does our need to bring in people trained abroad conflict with ethical recruitment?

[*English*]

**Viren Naik:** The issue of migration is a complex one. We have obviously signed onto the World Health Organization's ethical recruitment objective, and Health Canada has also produced a paper on it.

Having said that, people will migrate, and while we shouldn't actively recruit, we should certainly accept potential paths of migration. There are countries in the world that aren't on the red list that are actually overproducing doctors, and we should actively recruit from them. India, for example, has between 850 and 900 medical schools. Part of the purpose of the overproduction of doctors is for

migration. We need to seize this opportunity, because in a global competition, other countries are going to the countries that aren't red-listed and doing some active recruitment, and we too could benefit from that.

[*Translation*]

**Luc Thériault:** You talked about countries that train more people than they need. Those could be resources available for recruitment in Canada.

Other than India, what are those countries?

[*English*]

**Viren Naik:** Absolutely. The one thing we have to do is recognize that the training is heterogeneous and do the appropriate assessments, as well as look at countries where training might be substantially equivalent to that in Canada. Those trainees or those doctors could walk on without any assessment or with minimal assessment.

**The Chair:** Thank you very much.

I will now go to Mr. Strauss for five minutes, please.

We will finish this bang on time, guys, with the full one hour.

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

Dr. Naik, thanks for coming.

For everyone's information, what exams in total does the MCC administer?

**Viren Naik:** The MCC administers three examinations.

One is the qualifying examination, which is a written multiple-choice examination that is issued in countries around the world. It is issued over 100 days of the year, in four different sessions, so there's no barrier to taking that exam. That exam is usually done at the end of medical school, prior to supervised practice in residency.

We also have an OSCE examination, which is used for the purpose of selection into residency programs.

We have a selection exam as well, which is used with variable uptake for our practice-ready programs.

• (1210)

**Matt Strauss:** How do the success rates or the pass rates of Canadian medical school graduates, Canadians studying abroad and other IMGs differ?

**Viren Naik:** Our Canadian medical graduates are highly successful on our examinations at the end of medical school. Their grades range between 80% and 98% on their first attempt, and they go up with second and third attempts.

International medical graduates—again with a different curriculum and a recognition that we do ask about Canadian-specific competencies, like indigenous health and other cultural competencies—usually have a success rate of 50% on the first attempt.

Canadians studying abroad are somewhat in between. Part of that reflects the fact that they come to their training with some of the Canadian context and that some Canadians studying abroad are at schools whose purpose is to ready those graduates for return to Canada, so the curriculum and the exam preparation are geared to that. Their pass rates tend to be closer to those of Canadian medical graduates.

**Matt Strauss:** You mentioned that the MCCQE part I exam is administered internationally.

**Viren Naik:** That's correct.

**Matt Strauss:** Are you aware if success on that exam prior to immigrating to Canada affects someone's chances of immigration? Is the immigration industry aware of that, and do they take that into account?

**Viren Naik:** It does not impact immigration per se, but it is an examination that we are trying our best to advise and inform candidates that they should do before submitting their application for immigration.

**Matt Strauss:** As I recall from my own time writing these exams, they're good exams and they're pretty difficult exams.

They are administered in English or French. I would have a really hard time passing those exams if I didn't speak English or French. Do you think that these exams effectively prove language fluency?

**Viren Naik:** Yes, and we also have worry about language being a confounder. For that reason we do, again, advise candidates to take their English equivalency or their OET or their other exams before they do these exams.

**Matt Strauss:** In my years of writing the exams and then working at a couple of different medical schools teaching medicine, I don't recall anyone having old MCC exams. This is in contradiction to the Royal College exams.

Is that your understanding? What accounts for that difference?

**Viren Naik:** I think the difference is that with respect to our examinations, we have many practice examinations available to candidates that are equivalent to the real examination.

In that regard, we hope that we create equity in the system by having that available to Canadian grads and to international grads.

**Matt Strauss:** I think it does and I think you do, and thank you for that.

I have a couple of questions for Ms. Pawliuk.

You mentioned that of about 800 Canadians studying abroad who graduate every year from medical school, only 100-and-some apply to come back. Of that 100-and-some, what is their success rate in finding a residency here?

**Rosemary Pawliuk:** It depends on the year. For instance, when there were only 119, the success rate was quite good, with only 23—off the top of my head, give or take—not matching. However, the higher the number who come back, the lower the success rate.

**Matt Strauss:** Of the 700 or so who don't apply to come back, where do they tend to land?

**Rosemary Pawliuk:** Almost all of the people who study in Australia end up staying there, not because they want to but because they feel they have no choice.

The next-largest group goes to the United States. More than twice as many CSAs end up training in the United States than in Canada.

**Matt Strauss:** This is not a question. I just want to say that it's totally crazy that we're sending Canadian kids to pay a quarter of a million dollars to get medical training elsewhere and then leaving them to the depredations of the American health care system when they could be serving our country, when that's where they want to serve.

You mentioned a couple of times that there's a difference between residence seats and residency capacity. If these visa trainees are using an OR as an anaesthesia trainee and they have a preceptor, then they're taking capacity even if they bring their own funding.

You mentioned private funding a couple of times for Canadians studying abroad. What are the sources of this private funding?

**The Chair:** You have 20 seconds.

**Rosemary Pawliuk:** They are municipalities, corporations, community groups, ethnic groups and non-profit foundations.

**The Chair:** Thank you.

We will now go to the final questioner for the Liberals, Mr. Powlowski.

**Marcus Powlowski (Thunder Bay—Rainy River, Lib.):** Let me start off by saying to Dr. Alexander in particular that we share your frustration. I'm a long-practising physician as well, but as a member of Parliament, it is certainly frustrating that there are a lot of communities in my riding, rural communities, that really want and need doctors, and we look at someone like you and say, what the hell...?

Part of the problem is the fact that a big part of the bottleneck in getting foreign-trained doctors credentialed is that they have to go through the provincial licensure before they can actually practise.

Interestingly, as Dr. Naik mentioned, the Medical Council of Canada was created by an act of Parliament back in 1912. In addition, the Royal College of Physicians and Surgeons sets national standards. Although the regulation of the professions is something within the provincial jurisdiction, it obviously has a federal component to that as well. As my good friend NDP member Don Davies often says, this is an area of shared jurisdiction.

Having said that—and I know, Dr. Naik, that someone pre-empted my question—what more can we do to address the problem of getting foreign-trained people credentialed? You talked about practice-ready assessments. I would note that the federal government, in 2023, gave half a million dollars to the Medical Council of Canada to assist in this.

You've talked about practice-ready assessments and making access to practice-ready assessments perhaps a condition of transfer payments from the federal government to the provinces. There are difficulties with that, because the feds can say they want this or that, but will the provinces actually do it and what can we do if they don't do it?

Since this is an area of shared jurisdiction and is something we want to address as we want to get more foreign-trained people credentialed, is there an avenue so that we could put federal money directly into trying to do more to have more people go through the practice-ready assessment program?

• (1215)

**Viren Naik:** As I think Dr. Alexander and Rosemary and team have said, the CaRMS course is very clear. That's for the graduate who just finished medical school.

For the heterogeneity for the internationally trained physician to the practice-ready assessment, it's felt not just by the trainee, but by the practice-ready assessment programs themselves. I think they would like to be on side. For the governance of those programs, some are in regulator, some are in university and some are run by an external party. However, they are all hungry for a national approach—a national intake or a national matching process—so that they're not diverting resources to that recruitment and the challenges—

**Marcus Powlowski:** Who do you see as the body that would take on that responsibility?

**Viren Naik:** I think that could be a consortium. We stand as stewards of the national assessment collaboration that started the practice-ready assessment in 2017. We have a working group, I'll say, and a committee that comes together, of the practice-ready programs. A desire for a centralized intake would be welcomed not only by them but also by the candidates: to have one application process, just like CaRMS, and know where those practice-ready programs could be available.

On the other end of practice-ready assessment, we could stand up national programs to support the graduates after they leave the practice-ready assessment. One of the biggest challenges, obviously, is their experience and how we best support them for success in rural and remote communities.

**Marcus Powlowski:** Do you think the provinces would be on board with such a national program?

**Viren Naik:** Again, I think the governance of these practice-ready assessment programs lives not with the government. I think the governance and the people who are running the practice-ready assessment programs would welcome it. If they are the ones who are the voices to the government, then it would be accepted.

**Marcus Powlowski:** In terms of the top-up programs we've heard about from other witnesses, foreign-trained doctors need perhaps six months, a year or two years. I don't see a lot of provinces or teaching hospitals doing that. Do you know of anywhere where they have those sorts of top-up programs? What more can we do to add those as a way of getting foreign-trained doctors?

**Viren Naik:** I think Manitoba is the leader in this. It's a bridging program: both an on-ramp and an off-ramp for practice-ready as-

essment. We're seeing some uptake in other provinces, such as Nova Scotia, through hospitalist programs.

Where we have clinical assistants, which means essentially working under a supervised practice, as in British Columbia, that again is a marker of success when you move the person into a practice-ready, high-stakes assessment to move them to more independent licensure.

There are examples. We could absolutely nationalize that.

• (1220)

**The Chair:** Thank you very much.

I think we've come to the end of the session.

Before I thank the witnesses, I want to say, Dr. Alexander, that I know exactly what's happening with you. My son went to study at the University of Sydney against my better advice. He did that because he got a full scholarship from the University of Sydney. He stayed there.

They do a five-year residency program in emergency medicine. I now have to travel to Australia to see my grandchildren, and I feel your pain. I understand it. He actually decided to stay, because he was given all kinds of perks to stay in Australia.

Thank you very much.

Witnesses, thank you for your time and energy and for answering very complex questions.

I will now suspend to set up for the next hour.

Thank you very much.

• (1220)

(Pause)

• (1230)

**The Chair:** We're starting at 30 minutes after 12. We will go to 30 minutes after one.

Again, everyone, please try to keep to your time. We went over the time a lot in the last round.

Are the witnesses all online?

Okay.

We have with us, as an individual, Dr. Arun Anand. Dr. Anand is online. Then we have the Canadian Post-M.D. Education Registry, with Geoffrey Barnum, senior manager. On internationally educated health professionals in Canada, we have, for the Canadian Medical Foundation, Eva Slawecki, adviser.

I'll tell you how the show runs here. You have five minutes, each one of you, to make your statement. I will give you a one-minute shout-out and then a 30-second one, so that you know to wrap it up. We will have a question and answer session after that. That will go until 1:30.

Thank you very much.

I shall begin with Dr. Anand.

You have five minutes, Dr. Anand.

**Arun Anand (Physician, As an Individual):** Good morning, Chair and members of the committee.

I am Dr. Arun Anand and I am an anesthesiologist practising in Alberta. I am the co-founder of several initiatives aimed at improving surgical access and workforce sustainability in our province.

I have also worked with indigenous and rural communities previously to strengthen access to surgical and dental care in Manitoba. I currently have or have had medical licences in Ontario, Alberta, New Brunswick, Manitoba and Saskatchewan.

I appreciate the opportunity to speak with you today about the systemic constraints facing our health care system and how federal policy can play a stronger role in aligning immigration, credentialling and infrastructure planning with the realities on the ground.

It is my observation that Canada's immigration, credentialling and health system planning are running on separate tracks. That mismatch is now visible in workforce shortages, long waits and rising hospital deficits.

Federal leadership can help align these pieces.

First, immigration targets should be coordinated with health care capacity.

Canada plans for 395,000 permanent residents in 2025, with notional targets of 380,000 in 2026 and 365,000 in 2027, after posting the fastest population growth since 1957: plus 3.2% in 2023, with 1.27 million people. Our system capacity is not keeping pace.

Canada has 2.8 physicians per 1,000 people versus the 3.7 physicians per 1,000 for the OECD average, and 2.6 hospital beds per 1,000 versus the 4.3 OECD average. Immigration is nation building, but it has to be matched to training seats, OR time and beds.

Second, credentialling barriers block physician mobility. We've made partial progress. The Atlantic Registry shows regional mobility can work, but national portability remains patchy. A colleague of mine qualified through Alberta's practice readiness assessment cannot work in B.C., but somehow is safe to practise in Alberta. Clearly, this reflects inconsistent pathways between provinces. A pan-Canadian licence or true mutual recognition would at least partially help to address some of the workforce challenges.

Third, fragmentation is costly. Annual college fees alone are over \$2,000 in Alberta and B.C. before professional association dues and CMPA premiums. Also, these costs multiply when you register across provinces to serve underserved or vulnerable populations. CMPA premiums also vary by region and scope of work, adding friction to interprovincial service. For example, for me to

have my licence in Ontario, I pay double the CMPA cost and have thus considered abandoning my Ontario licence, despite travelling there often and picking up days in Ajax when I am available.

Fourth, Canada is losing momentum on training-to-practice pathways, especially in surgery. Royal College employment studies show that 14% to 19% of new specialists lacked specialist work at certification, in several years. In orthopaedic surgery, an average of 37% reported no job at certification between 2011 and 2018, citing OR time, beds and staffing limits, not lack of patients. Recent Canadian Journal of Surgery analysis confirms early career orthopaedic surgeons often rely on locums and part-time work due to insufficient positions.

When opportunities are constrained, graduates look to the U.S. In 2020, according to the Canadian Orthopaedic Association, 72 percent graduates in 2020 left to work full time outside of Canada. Clearly, there's a gap in our human resources and infrastructure planning, and it's not necessarily about credentialling foreign doctors. There are mismatches across all levels of all systems.

Fifth, federal health programs that are often considered uninsured or not covered by provincial health plans often cost our system substantially more money and require more resources, for several reasons. Namely, because services are not covered by provincial plans, physicians can bill up to five times more for their physician fees in these programs, including federal programs that support refugee claimants. Often, we need language lines and we keep translators online for extended periods of time. Additional time is required to obtain consent, dispel misinformation and communicate with these patients.

I want to make no mistake: I am empathetic to refugee claimants and other immigrants, being a child of immigrants myself. However, these efforts need coordination. When our health care system is already strained, this needs to be considered before we can safely allow an influx of additional families. It's basic human resource and workforce planning.

Sixth, finances are tightening. The Ontario Hospital Association reports—

• (1235)

[*Translation*]

**Luc Thériault:** A point of order, Madam Chair.

[*English*]

**The Chair:** Excuse me. I'm sorry. Stop, please.

[*Translation*]

**Luc Thériault:** There's been a problem with the sound for 30 seconds, and interpretation is not available. The problem must be fixed, Madam Chair.

[*English*]

**The Chair:** We will suspend.

You have 30 seconds left, Dr. Anand, but we will suspend until we get this fixed.

• (1235)

\_\_\_\_\_ (Pause) \_\_\_\_\_

• (1245)

**The Vice-Chair (Dan Mazier):** Okay. I'm calling this meeting back to order.

Mr. Barnum, you have five minutes.

**Geoffrey Barnum (Senior Manager, Data, Canadian Post-M.D. Education Registry):** Thank you.

My name is Geoffrey Barnum. I am the senior manager of data at the Association of Faculties of Medicine of Canada, of which the Canadian Post-M.D. Education Registry, CAPER, is an initiative. I have that oversight role of the CAPER initiative. The initiative was initially formed in 1986 to be the definitive source of national longitudinal information and analysis on trainees within the Canadian postgraduate medical education system.

I want to spend a minute or two talking about how we train doctors in Canada so that we're all on the same page.

The typical journey for a Canadian looking to become a doctor is that they complete a bachelor's degree, or sometimes a CEGEP degree in Quebec, and then apply to one of the 18 Canadian medical faculties. It was 17 until this year. Toronto Metropolitan University just opened up this year, making it 18. Once admitted, students spend three or four years, again, depending on which faculty they go to, developing their core medical competencies through a combination of lectures, labs and actual experiential learning out in the field, or what we call "selectives" and "electives".

During the fourth year of their medical education—or third, for a shorter school time—the medical students apply to the R-1 match, which is administered by the Canadian resident matching service, CaRMS, and has been previously discussed. This is where medical students get attached to a specific specialty. That would be family medicine, psychiatry, general surgery and so on and so forth. They then spend two years, in the case of family medicine, and usually about five years for the other specialties, in completing their residency training—unless they go down the super subspecialty role route—and do their exams and go out to practise medicine here in Canada.

Together, the AFMC and the CAPER initiative collect, analyze and report data on the status of the medical education system throughout the individual's journey to become a physician. AFMC focuses on the undergraduate side, where they're earning their MD. CAPER focuses on the post-MD side when they're doing their residency or a fellowship.

Another area that sometimes gets a little confusing is the different types of postgraduate trainees who are in Canada.

We have residents. Those are individuals who are going for their initial certification with either the Royal College or The College of Family Physicians of Canada. Those are the ones that typically last two to five years.

There are also clinical fellows. These are fully trained physicians who are looking to specialize in a very specific area. Most fellowships last about a year. Some are a bit shorter. Some are a bit longer. Really, it's that super-duper specific training, right? Maybe you're a heart surgeon. This would be a fellowship on a very specific type of heart surgery.

The other topic that comes up often is the type of trainee. There are Canadian medical graduates and international medical graduates. That is how the system currently divides individuals. As the name would suggest, a Canadian medical graduate got their MD degree from a Canadian faculty, and an international medical graduate got their degree from outside Canada. This is mutually exclusive from their legal status in Canada. At CAPER, we recognize Canadian citizens and permanent residents as compared to visa trainees. Those are the individuals coming into Canada for training.

There's been a lot of discussions surrounding visa trainees in residency and fellowships. The majority of visa trainees are enrolled in clinical fellowships, doing that really specific training and actually administering that treatment to Canadians. For many of those, the salary and cost of training are paid for by foreign governments or institutions, and CAPER does collect that information. During their training, they provide complex tertiary and quaternary care to Canadians.

• (1250)

**The Chair:** You have one minute.

**Geoffrey Barnum:** Thank you.

There is a group, as has been mentioned, of visa trainees who do come to do residency training in Canada in those supernumerary positions, which was so well discussed earlier.

I want to note that any questions relating to the specific data I'm discussing is available in our international medical graduate report, which I would like to table for this committee. It's available on our website. I've included the links in my speaking notes for the English and French versions.

**The Chair:** Thank you.

You have 31 seconds. Are you finished, Mr. Barnum?

**Geoffrey Barnum:** I think I'm good, thank you.

**The Chair:** Well done. Thank you very much.

I'll now go to the Internationally Educated Health Professionals in Canada, Ms. Slawecki.

Thank you.

**Eva Slawecki (Advisor, Canadian Medical Foundation, Internationally Educated Health Professionals in Canada):** Thank you.

Honourable chair and members of the standing committee, thank you for the opportunity to speak today on behalf of the Canadian Medical Foundation.

About three years ago, we partnered with Pegasus on the internationally educated health professionals initiative. This includes support for refugee health professionals as well as IEHPs to continue their health careers in Canada.

In the last year alone, thousands of IEHPs—nurses, doctors, pharmacists, dentists and others—have accessed our resource hub, and hundreds have participated in our capacity-building activities, networking events and mentoring programs.

What we are doing is not enough, though. Let's look at the numbers. In 2021, an estimated 260,000 IEHPs resided in Canada. While 76% of them were employed, only 58% of those worked in health-related occupations. The rest were driving taxis, were working in retail or were sidelined entirely—their talents wasted while our health care system suffered severe staffing shortages.

With over 20% of Canadians being immigrants, we need a diverse health workforce that fosters cultural competence and that builds trust for improved health outcomes for our multicultural population. Integration of IEHPs will create a health workforce that truly reflects and serves Canadians.

Canadian immigration policies do actively attract skilled professionals, such as nurses; however, we hear repeatedly about IEHPs who arrive full of hope, only to then encounter a labyrinth that keeps them from practising and that squanders their training and expertise.

Today, I'll highlight some of the real human and systemic barriers they face.

The core issue lies in the barriers to licensing.

First, the pathways themselves are complex and fragmented. What seems straightforward on an immigration application becomes a maze of assessments, exams and bridging programs.

Second, IEHPs are faced with a glut of scattered online resources, many of which are inaccurate, outdated or not even legitimate. Recent IRCC cuts led to reductions in several newcomer programs that once provided basic guidance and system navigation. Without this, IEHPs can waste months, even years, chasing dead ends, all while their skills atrophy and their families struggle financially.

A doctor trained abroad might spend years navigating equivalency requirements, only to find their credentials outdated, which brings us to the third barrier. The longer the licensing process, the more likely they are to lose their recency of practice requirements.

Finally, IEHPs arrive without the social capital that Canadians take for granted. Newcomers have left their personal and professional relationships behind. They need mentors, connectors, networks and communities to better access opportunities for employment and integration, but our immigration system assumes IEHPs will figure all of this out alone. What is the impact of all of this? IEHPs face prolonged unemployment, deskilling and frustration while Canada misses out on a ready workforce.

However, there is hope. Many provinces are introducing practice-ready assessments for experienced physicians, and we've heard there are also plans to increase residency spaces for doctors. Several educational institutions have bridging programs for professionals to top up their skills, without starting their training from scratch.

Initiatives like ours have already helped hundreds by providing a first-stop shop for access to legitimate pathways and professional mentoring to support these IEHPs in understanding Canada's health system and to navigate the complexity of licensure and employment readiness.

In closing, our system excels at recruitment but falls short with true integration. We need to dismantle these barriers. This isn't just about policy tweaks but also about humanizing immigration's promise. By investing in navigation, coordination and wraparound supports, and by developing the social capital of IEHPs, we can boost integration, increase workforce entry and witness the success that our immigration policies promise.

● (1255)

On behalf of those we represent, thank you for your time and attention. I welcome your questions.

**The Chair:** Thank you very much.

We'll now go to the question and answer session. The first round is six minutes. I am going to be harsh with everybody to get them to stay on time.

I will begin with the Conservatives and Mr. Bailey for six minutes.

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

Thank you, Dr. Anand, for your patience with our technology. I'm going to ask you to speak slowly and loudly for us, and I'll keep my questions brief.

Do you believe that national licensure recognition would be beneficial in Canada? Answer yes or no, please.

**Arun Anand:** Yes.

**Burton Bailey:** Do you believe the recency of practice requirement should be reformed to streamline internationally trained grads to acquire licensure in Canada? Answer yes or no, please.

**Arun Anand:** Yes, I think there is opportunity there.

**Burton Bailey:** Should the recency of practice and other recognitions be conducted before the individual comes to Canada?

**Arun Anand:** I think that would streamline things and prevent many issues along the process.

**Burton Bailey:** There are roughly 80,000 foreign-trained medical professionals in Canada who aren't working in health care. Do you believe the government should work on licensing and integrating the health care professionals already in Canada before thinking about bringing in more people?

**Arun Anand:** I agree with that. I got cut off because of the technical issues, but I want to talk about our pilot program with clinical assistants in Red Deer.

We piloted a program for anaesthesia clinical assistants, where I personally supervised international medical graduates. Some needed a year or two of support and education. Some needed three weeks just to understand how to communicate more effectively with patients. The pilot ended, but at least two of those trainees are either practising anesthesiologists or working in residency programs.

There is a big opportunity, and Red Deer, your home constituency, has had great success with surgical assistants and clinical assistants. Those candidates eventually make it into residency programs and contribute to the Canadian health care system.

**Burton Bailey:** Thank you for that.

Does population growth impact the demand on the health care system?

**Arun Anand:** Absolutely.

**Burton Bailey:** Is immigration a form of population growth?

**Arun Anand:** Yes.

**Burton Bailey:** I'm going to ask you some basic questions about some of your medical licensing.

How much does it cost to get your medical licence in Alberta?

**Arun Anand:** It costs between \$2,000 and \$3,000.

**Burton Bailey:** You indicated that you have multiple licences because you work as a locum in underserved areas across Canada. Could you give us an idea of what the cost is for you, as an individual?

**Arun Anand:** It is about \$20,000 in total, because my CMPA to practise in Ontario is about \$11,000, and there is not much reimbursement there. For each individual province, it's between \$2,000 and \$3,000.

• (1300)

**Burton Bailey:** This seems very bureaucratic and onerous. In order for you to be an anaesthetist and do the same job in multiple

provinces, you carry licences in each of those provinces. I am having trouble with that.

How many licences do you carry with that \$20,000? I should get that clarified.

**Arun Anand:** I recently got my Saskatchewan licence, and I was reimbursed by its health care authority. There are so many inefficiencies across the country with regard to this. In Ontario, I paid for my CMPA myself. In Alberta, the Alberta government reimburses me for the CMPA insurance costs, so some of that is recouped. There are annual renewals in all of these provinces. Some of those are reimbursed, and the government wastes money on that, and some of them come out of my own pocket.

**Burton Bailey:** The cost of this process of licensure is obviously a barrier to entry for many medical professionals.

**Arun Anand:** It's an inconvenience, for sure, and I think it dissuades people. For example, I gave up my Manitoba licence. In that practice, I was going to serve indigenous communities with pediatric dental care. The travel was a lot and I didn't want to keep my licence up to date, so I discontinued paying for it. It was a barrier that made me give it up.

**Burton Bailey:** Thank you.

I'll share my time with my colleague Dr. Strauss.

**Matt Strauss:** Thank you, Mr. Bailey.

**The Chair:** You have one minute and 18 seconds, Matt.

**Matt Strauss:** Dr. Anand, you made in your opening statement a very interesting remark about it being common practice to charge insurance for refugees who are receiving health care five times more than for a public-pay Canadian citizen. Can you tell me more about that? That seems kind of crazy, if I'm being honest.

**Arun Anand:** Of course. For federal programs, including prisoner and other federal programs, physician fees are not covered by the province, so you submit invoices to Blue Cross. The AMA publishes a fee guide. They actually suggest that doctors bill between two and five times more than regular fees for those programs that are considered uninsured.

**Matt Strauss:** It seems to me that if you have hundreds of thousands of asylum claimants in Canada receiving health care and the physician is receiving five times more, that's a significant drain of resources.

In the last hour, we had some conversation about capacity versus funding for training seats. Anaesthesia is a really interesting example, because it seems to me that you either have an anaesthetist willing to take a student into the OR that day and teach them or you do not, irrespective of funding. Can you reflect on that for me? It becomes relevant when we talk about—

**The Chair:** The time is up, Dr. Strauss.

**Matt Strauss:** I'm looking for whatever reflections you have on that, please.

**The Chair:** I'll give you 30 seconds to answer that question.

**Arun Anand:** I agree with your statement. For example, we have paramedics who have to come to Red Deer all the time. I don't get paid anything for that, actually. I'm asked to volunteer for that, just to help the community.

Irrespective of funding, depending on whether there's availability to take on students, that is an infrastructure question fully. Of course funding can play into some of that, but I think as physicians we're here to contribute to and help support the Canadian health care system.

**The Chair:** Thank you very much.

People, I will have to ask you, if you're going to share, don't give the other person only a minute, because it goes over time.

For the Liberals, we have Ms. Sidhu.

**Sonia Sidhu (Brampton South, Lib.):** Thank you, Madam Chair.

Thank you, witnesses, for joining us today and for your insight.

I'm from the riding of Brampton South in the community of Peel. We are feeling a gap in our resources of 220 people. That's why this meeting is very, very important. It's a shared responsibility, of course.

There's one thing I really want to put on the record. The federal government has expanded support for foreign credential recognition to help internationally trained health professionals join the workforce more quickly. Through the working together bilateral agreements, the federal government is providing \$25 billion over 10 years to support shared priorities so that we can work together with provinces and territories to bring more health resources to Canadians.

Mr. Barnum, I know that you're working on data collection a lot. What additional data is needed to support national planning for internationally trained health professionals? How can this information be collected consistently across Canada and across jurisdictions?

• (1305)

**Geoffrey Barnum:** That's a great question.

One of the challenges we run into at AFMC and CAPER is that we get our data directly from the medical faculties themselves. Unless a physician, particularly an internationally trained physician, has some sort of contact with our medical faculty, we simply don't know they exist. Getting data on how many physicians are coming

into Canada who are maybe trained outside the country would be absolutely amazing for our needs.

I'm not sure about the mechanics of how we would actually get that data, per se, but it would be some sort of data connection between us and the immigration department. We don't even need to know who they are, necessarily. We just need to know how many there are and what area of medicine their specialty is in. Is it family medicine? Is it surgery? Is it psychiatry?

Does that answer your question?

**Sonia Sidhu:** Yes.

A previous panel was talking about how many others have a registry. We all know there's a gap. What changes would you recommend to make it easier for Canadian medical graduates trained in the U.S., or in Sydney, as we heard, or in any other country so that they can come back? They're Canadian but they went to study abroad. While maintaining high professional standards, what can be done? How can we fill that gap?

**Geoffrey Barnum:** That's outside my area of expertise as a senior manager of data. Reflecting on what I see in the data, I would suggest some sort of system.... I'm sorry. This is really outside my area of expertise.

**Sonia Sidhu:** Could you chime in, Ms. Slawecki?

**Eva Slawecki:** I'm sorry. I'll need you to repeat the question, please.

**Sonia Sidhu:** It's a shared jurisdiction. What steps can be taken so that more IMG doctors and international students can easily come to the country?

**Eva Slawecki:** I don't know that the issue is having them at the front and what we need to do more to get them to come. I think the issue is that we have people already in the country who need support, and because they haven't been adequately supported since arriving and getting into the practice, we are seeing these gaps.

A lot needs to be done before immigration to inform people of some of the challenges, some of the barriers and some of the processes they need to undertake. That would be extremely helpful.

**Sonia Sidhu:** Thank you.

Dr. Anand, you were talking about longer wait periods and a mismatch within the system's capacity. Can you elaborate on that? What can be done?

**Arun Anand:** This may tie into your last question. There are multiple layers.

Number one, for university planning with residency spots, is that we train orthopaedic surgeons and they can't get jobs afterwards. Just within our own management of Canadian-trained medical practitioners, there should be better human resources planning, rather than having residency positions just to support big academic institutions.

Number two is having a pathway for practice-ready assessments for Canadians who have been internationally trained so that they can come back and integrate into the system in a streamlined approach and a way that's consistent across the provinces. This would probably be beneficial.

Number three is that we could utilize IMGs, who are non-Canadian citizens who have trained internationally, in a clinical assistant or associate division program so that they can be supervised indirectly, work with Canadian-trained physicians and get extra training. It would be a kind of top-up. They'd eventually go to a practice-ready assessment or another formalized program where they can be given an okay, and then they could go and help underserved and rural communities.

A multipronged approach is probably the way to go about solving a complex problem.

• (1310)

**The Chair:** Thank you.

I will now go to Monsieur Thériault for six minutes.

[*Translation*]

**Luc Thériault:** Thank you, Madam Chair.

First of all, I want to say I'm sorry Dr. Anand had technical difficulties earlier.

Ms. Slawecki, at the last meeting, we heard from Dr. Bichay, who spoke rather eloquently about all the problems she encountered as an internationally trained health professional.

The committee will have to evaluate how effective existing measures are and make recommendations about what should be done and created.

The problem we're talking about today isn't a new one. In 2009, the federal government created the pan-Canadian framework for the assessment and recognition of foreign qualifications. In 2010, it created the foreign credential recognition program.

Are you aware of those programs? Based on your real-life experience, are they effective or not?

**Eva Slawecki:** Thank you, Mr. Thériault.

[*English*]

I'm not actually familiar with those programs. They happened over 15 years ago. I'm not sure of the success or results of those programs.

What I know is that there are ways to make it easier for people to get into practice. We have heard a lot of these solutions around national standards. It would be really helpful to be clear about them, because I don't know that people are aware of the different nuances between the different provinces when they immigrate. Having a national program would definitely be extremely helpful in streamlining many processes.

[*Translation*]

**Luc Thériault:** I will come back to the possibility of national standards.

Were you aware that budget 2022 allocated \$115 million over five years to expand the foreign credential recognition program? The government said it would help 11,000 foreign-trained health professionals get their credentials recognized in Canada.

[*English*]

**Eva Slawecki:** Yes, I'm aware of that program.

[*Translation*]

**Luc Thériault:** Okay.

Did that \$23 million per year ever flow? Did it help improve things?

[*English*]

**Eva Slawecki:** I think it's a good first step. There's a lot more that needs to be done. I can't speak to the efficiency of that investment.

[*Translation*]

**Luc Thériault:** Witnesses have told us that money needs to be invested in that. The government actually planned to invest.

What would we have to do to measure the effectiveness of that investment and ensure the money is being used to eliminate problems and barriers?

[*English*]

**Eva Slawecki:** A lot more research needs to be done, with a lot more studies and with better data collection. We know there are a lot of gaps in the data and that there are a lot of nuances in the types of data collected.

In terms of the return on investment, I think that as well needs to be taken into consideration. Again, a lot more work needs to be done on understanding where the money goes and how it's spent.

[*Translation*]

**Luc Thériault:** You talked about the possibility of establishing national standards. Have you identified differences between standards in Quebec and the other provinces?

• (1315)

[*English*]

**The Chair:** You have one minute.

[*Translation*]

**Luc Thériault:** If so, could you provide documentation to the committee? That would help us understand how provinces and territories differ.

[*English*]

**Eva Slawecki:** Certainly, we can submit a further document to answer some of those questions about the differences in licensure. I think that organizations like MCC and other institutions might be better equipped, but I'd be happy to collaborate with others on collecting that information for you.

**The Chair:** You have 23 seconds.

[*Translation*]

Are you done, Mr. Thériault?

**Luc Thériault:** Oh, do I still have time, Madam Chair?

[English]

**The Chair:** No, you have 11 seconds now. I called 23 seconds for you.

[Translation]

**Luc Thériault:** Okay.

Ms. Slawecki, do you have a sense of what kind of national standards should be established?

[English]

**Eva Slawecki:** Basically, the big one would be for the practice-ready assessments to make sure there's a common basis for evaluation of the skills of health professionals to ensure there's consistency across the country, then if they pass a practice-ready assessment in one province, it's applicable in others. A lot of that speaks to consistency across the country.

**The Chair:** Thank you.

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

We'll begin with Mr. Mazier for the Conservatives for five minutes please.

**Dan Mazier:** Thank you, Chair.

Mr. Barnum, how many visa trainees were in Canada for the medical training in 2024?

**Geoffrey Barnum:** I brought tables.

**Dan Mazier:** I have the information here for you. Let's take a look at it.

**Geoffrey Barnum:** One moment, please.

**Dan Mazier:** This is burning into my time, so according to "The National IMG Database Report", there were 3,458 visa trainees in Canada for medical training in 2024.

Is that correct?

**Geoffrey Barnum:** Yes.

**Dan Mazier:** How many visa trainees were in Canada for medical training in 2015?

Do you have that in front of you?

**Geoffrey Barnum:** I don't have that in front of me, no.

**Dan Mazier:** If you could provide that information to the committee, that would be great.

**Geoffrey Barnum:** I would be happy to, yes.

**Dan Mazier:** Thank you.

The vast majority of visa trainees are required to return to their home country after completing medical training in Canada.

Is this correct?

**Geoffrey Barnum:** Yes.

**Dan Mazier:** We've learned that the Government of Saudi Arabia is funding visa trainees to complete medical training in Canada.

How many Saudi-funded visa trainees were in Canada for medical training in 2024?

**Geoffrey Barnum:** I believe that number was about 700 or 800.

**Dan Mazier:** According to "The National IMG Database Report", there were 1,117 visa trainees from Saudi Arabia in Canada for medical training in 2024.

**Geoffrey Barnum:** That is correct.

**Dan Mazier:** Thank you.

Dr. Anand, the interim federal health program is administered by the federal immigration department for individuals not eligible for provincial health insurance. It includes coverage for refugee claimants, even if their claims are later found to be bogus. According to the government, the cost of this program was \$800 million last year. This is up from \$66 million in 2017.

Do you have any indication why the cost of this program has skyrocketed?

**Arun Anand:** There's probably a multifactorial basis to that.

One, there are probably more people entering through these programs. Two, because it is uninsured and there's less accountability, physicians are more aggressive with their billing practices. They charge premiums on these programs and services.

I believe it is inefficient and a poor use of resources.

**Dan Mazier:** Dr. Anand, are doctors charging higher rates for services charged through the interim federal health program compared to the standard provincial rates charged to Canadian patients?

• (1320)

**Arun Anand:** Yes.

**Dan Mazier:** Mr. Barnum, there were some audio issues before, so I'm going to ask you question one again.

How many visa trainees were in Canada for medical training in 2024?

**Geoffrey Barnum:** There was a total of 3,487, of which 3,458 were international medical graduates. There were 29 Canadian medical graduates who were visa trainees. Those would have been individuals who came to Canada to earn their MD and then carried on into their residency.

**Dan Mazier:** Ms. Slawecki, there are currently over 13,000 internationally trained doctors in Canada who are not working as doctors. The government keeps on saying that we need more immigrants to solve our health care problem, but it has failed the immigrant doctors who are already here in Canada.

Do you believe the government should focus on licensing immigrant doctors already here in Canada first—

**The Chair:** You have one minute.

**Dan Mazier:** —before adding more people to a broken system?

**Eva Slawewski:** There does need to be more support for the doctors who are already here.

**Dan Mazier:** Do you have some ideas on that?

**Eva Slawewski:** We have already talked about the practice-ready assessments and the residency spaces, and so forth, so yes, those are good ideas.

**Dan Mazier:** Have you ever been asked that question by the federal government on how to fix the system?

**The Chair:** You have 30 seconds.

**Eva Slawewski:** No.

**Dan Mazier:** Thank you.

That's it.

**The Chair:** Thank you.

We'll now go to the Liberals with Mr. Powlowski for five minutes, please.

**Marcus Powlowski:** We have a thousand Saudi doctors out there working somewhere and I don't know if they're aware how disparaged they're being today in this testimony. The suggestion, or the accusation, has been made that they're taking Canadian residency positions.

I don't know whether that is really true. The fact that we take them.... Okay, the Saudis are actually paying their salary, right? Isn't that the case with the Saudis? Are we also making extra money on it?

I would suggest, if we are taking the Saudis, and the medical schools have costs, and if they're bringing in income because they're training the Saudis, this might be something that's actually desirable, no?

**Geoffrey Barnum:** That would be accurate, yes.

Don't forget, they are actually providing care to Canadians as part of that training.

**Marcus Powlowski:** I know. They're free labour for us. They're looking after Canadians, and the Saudi government is paying.

I don't think that's a bad deal, number one. Number two, how much are we making per resident on top of just paying their salaries, for example, per resident or fellow?

**Geoffrey Barnum:** I don't have an exact number, but I know the Royal College recently indicated that it costs about \$125,000 a year to train a fellow or a resident.

**Marcus Powlowski:** Let's say you're a fellow in pancreatic or liver transplants, and it's a one-year or two-year fellowship. If we're putting Canadians through that program.... How many people do we need transplanting livers and pancreases?

We get the Saudis to work for us for free. I would have thought the surgeons in those professions would be happy to have the help. Would that not be the case? I'm just thinking about how we rationalize allowing the Saudis to have fellowship positions here.

**Geoffrey Barnum:** I'm just the data guy. I can't speak to the rationalization of the faculty. It's not my—

**Marcus Powlowski:** I guess I did already.

Ms. Slawewski, you talked about the difficulties foreign graduates have navigating the complex licensing process. I totally understand this. I have a couple of friends from a country I won't name where there's chronic warfare. There are people in the health care profession who would like to come to Canada. They're asking how to do it and what the regulatory requirements are. It's so frustrating. They have to look at and talk to the Royal College and then they have to look at each of the provinces. Even for me, as someone in the profession, and with a law background as well, it is very time-consuming and frustrating.

You mentioned something about IRCC cuts to existing programs. Did our government ever provide information, perhaps online, to help foreign graduates navigate their way through the system?

**Eva Slawewski:** Yes. N4 is one example of an organization that lost IRCC funding. It's the National Newcomer Navigation Network. The acronym is N4.

• (1325)

**Marcus Powlowski:** I'm sorry. What's the name of it?

**Eva Slawewski:** N4. It closed because it lost its funding. It did excellent work on navigation pathways and support for newcomers, including IEHPs. Our initiative worked with it, and we are trying to pick up some of those pieces to support navigation.

Navigation is a huge issue. You've talked about the complexity—

**Marcus Powlowski:** Do you think there would be a role for the federal government to have a site to help people get through this?

As you said, there are multiple sites online. You don't know the accuracy of those sites. Some of them are outdated. If there were to be one site to try to help people out—I'm thinking about where we would get the best bang for our buck in terms of federal money—perhaps the federal government should put some resources into establishing it to help people navigate the system.

**Eva Slawewski:** Absolutely. There needs to be such a site. Whether it needs to be developed by the federal government or by non-profit organizations, which tend to be a bit more nimble, I don't know, but there is definitely a need for better navigation of the system.

**The Chair:** You have 29 seconds

**Marcus Powlowski:** I'll cede my time, because I know my colleague needs to go someplace.

**The Chair:** All right. That's it.

We'll move to Monsieur Thériault for two and a half minutes.

[*Translation*]

**Luc Thériault:** Thank you, Madam Chair.

Earlier, I asked Dr. Naik a question about the World Health Organization and concerns about how some countries are robbing Peter to pay Paul, as they say. I'm talking about what are known as ethical recruitment agreements.

I'd like your thoughts on that given that Canada is well over the global average in terms of foreign-trained health professionals working here. According to 2021 numbers, we are about 6% higher.

[*English*]

**Eva Slawewski:** I'm sorry. The sound wasn't great, so I may have missed some of the question.

Absolutely. We need to be mindful of the ethical recruitment of health professionals. We don't want to contribute to the brain drain in countries that can't afford to lose any of their health professionals. The recruitment that takes place tends to be from countries that produce health professionals for work outside of the home country. I know that takes place.

Are we exceeding the actual numbers or not? I can't really say, but people should be allowed to move for their employment and migrate as needed. That freedom, the right to move and relocate, is very important.

[*Translation*]

**Luc Thériault:** How much time do I have left, Madam Chair?

**A voice:** [*Inaudible*]

[*English*]

**The Chair:** Excuse me, please. The meeting is in progress. If you want me to suspend, I will.

**A voice:** No.

**The Chair:** Okay. That's the end of that.

[*Translation*]

**Luc Thériault:** I'll go on, Madam Chair.

Ms. Slawewski, the issue of labour mobility was raised. Could there be a solution there? Given that labour is under provincial jurisdiction, the federal government hasn't commented on the current situation in Quebec for the simple reason that it's none of its business.

[*English*]

**The Chair:** We are now 30 seconds over.

[*Translation*]

**Luc Thériault:** Isn't labour mobility an important element to consider in addressing this problem?

[*English*]

**The Chair:** Thank you.

I will now move to Mr. Strauss for the Conservatives for five minutes, please.

**Matt Strauss:** Thank you, Madam Chair.

Mr. Barnum, thank you for being here. You look after the Canadian Post-M.D. Education Registry. You have this fantastic report and have compiled lots of data about what sorts of doctors are being trained in Canada.

I take it from this data that we can have a pretty good analysis of what the health care workforce is going to look like in Canada, at

least as far as physicians are concerned. It's a terrific report with terrific data.

I'm curious. When the immigration ministry decided to bring about a million more newcomers to Canada this year, did they consult with your office? Did they read this report? Did they ask you any questions about it?

• (1330)

**Geoffrey Barnum:** Not that I'm aware of.

**Matt Strauss:** That seems like a crying shame to me.

In looking at the report, of interest to me is table B5i, which is about visa trainees in Canada. For one thing, I note that anaesthesia has the highest number of any discipline for visa trainees in Canada. I also note that it's increasing rapidly. Does your office have any idea of or opinion as to why that might be? It has gone from 113 in 2020 to 185 in 2024 for anaesthetists being trained.

**Geoffrey Barnum:** I think we actually took a look into that number at one point, just because—you're right—it is a bit of a data anomaly, and that set off my alarm bells to go and make sure it's being accurately reported. It's being primarily pushed by clinical fellowships. Those are the short little ones that are coming in. I remember going back and looking at the residency data. Don't quote me on this number, but I think only eight are actually in a residency position.

**Matt Strauss:** I see.

Likewise in psychiatry, the visa trainee positions have doubled over that same period. That's on the next page, about seven rows down.

**Geoffrey Barnum:** Yes. That has gone from 32 in 2020 up to 67 in 2024.

**Matt Strauss:** I just draw the committee's attention to this. The overall totals, likewise, have massively increased. They've increased by 50% over the last five years.

At the back of the report, section C talks about IMGs in Canada, but the tables there exclude visa trainees. From the report, we don't know if these visa trainees are staying in Canada. Is that because they aren't? As a rule, do visa trainees go back to their home countries?

**Geoffrey Barnum:** Legally speaking, yes, they should be returning to their home country after the conclusion of training.

There is a study out there that I did with Dr. Maria Mathews, I think it was, where we did try to look up some of these visa trainees a couple of years down the road. It was a very small percentage that we were able to find again and who had gone through the legal immigration process to return to Canada and practise medicine.

**Matt Strauss:** I see.

Since anaesthesia is such a big part of it, I'd like to ask Dr. Anand some more questions about visa trainees and anaesthesia, since he's an expert and he's here.

I have a quick story. I did a critical care fellowship with a gentleman from Egypt who was an anaesthetist. He came here and did a fellowship in cardiac anesthesiology. They liked him so much at Western that they asked him to stay, but the requirement was that he redo his whole training, that he go back to PGY-1 in anaesthesia.

Do you have any reflections on that? That seemed crazy to me. It seemed, frankly, that he was being taken advantage of.

**Arun Anand:** Was that Ashraf Fayad?

**Matt Strauss:** No. It was Ahmed Hegazy. He's a professor at Western now. He's a fantastic guy.

**Arun Anand:** Yes, and you know, I think that is a bit ridiculous. My experience in Ottawa was that there were foreign-trained people who came and did the year fellowship. They were phenomenal and went through a different pathway to receive licensure in Ontario. The University of Ottawa had to say that there was some special need for physicians, that they actually wanted to hire Canadian grads into their department, and they had to make some sort of case to hire these exceptional people. Then they came and they became faculty and teachers and some of my mentors.

**The Chair:** You have one minute.

**Arun Anand:** They're great, but then they're locked into the hospital or program that they're at. They don't have the mobility.

Even now for some of my mentors who I'm trying to get out into Alberta, even though they've been practising in Ontario for 20-some years, they're having difficulty getting licensure into Alberta. I'm bringing them in for some initiatives here, and there's a freeze and some roadblocks with the CPSA.

**Matt Strauss:** In the little time that's remaining, there are 185 visa trainees who are training in anesthesiology and going back to their home country after, as they're legally required to.

In your view, how great is the anesthesiologist shortage in Canada right now and how much could 185 extra trainees help to ameliorate that, qualitatively?

**Arun Anand:** I think the 185 trainees would help substantially. There is still a continued worldwide shortage of anesthesiologists, as I'm aware. I think we need to be innovative in some of our approaches, whether we use clinical assistance, anaesthesia care teams or different models to improve the delivery of care in innovative ways and improve our training and output of qualified professionals.

• (1335)

**The Chair:** Thank you very much.

I will now go to the final questioner. That's for the Liberals.

Mr. Eyolfson, you have five minutes, please.

**Doug Eyolfson:** Thank you, Chair,

Dr. Anand, I was listening to Mr. Bailey's comments about having to apply and pay for a licence in every province if you want to do that. I agree completely. I used to have an Ontario licence. I was doing some locums in Toronto. First of all, just to get that second licence, I had to jump through a lot of hoops. Then I had to pay the licence fee. When I wasn't doing that work, I wasn't allowed to pause it; I had to actually cancel it. If I wanted to go back, I had to

start from square one. I agree with what Mr. Bailey said. It's an absolutely absurd process.

The federal government has tried over the years to establish pan-Canadian licensure. We always get the same response. We get the provinces pushing back, saying that this is provincial jurisdiction, so stay in your lane.

Should your colleagues be advocating en masse to your provincial authorities to say that you need this to improve access to health care in Canada?

**Arun Anand:** There are separations between federal and provincial jurisdictions probably for a reason. That's a little bit outside of my expertise, but I definitely think that colleges can all communicate, coordinate and create processes and agreements amongst themselves, similar to what we see in the Atlantic region, so that we can utilize our workforce more efficiently.

**Doug Eyolfson:** Absolutely. I agree with that as well. I find the frustration.... From the federal government, I would love to see this happen, but we get push-back from the provinces saying that it's none of our business.

I do agree with you that this is something we need to do. We need to talk with our provincial counterparts the way they have in Atlantic Canada. There's now affordability of the licensure through the Atlantic provinces. I would certainly be an advocate for our colleges to establish the same throughout Canada.

In regard to medical training, we've talked about this before. I talked about it in the last round. There were changes to medical training back in the early nineties. I graduated from med school in 1993, which is pretty much when they made those changes. There was the opportunity for the general practice, the GP licensure.... You did an internship, which was one year. There was advocating for doing this for two years, which many agreed with. Then they switched gears and said there's no such thing as a GP. They used to have people who, if they didn't get matched to a residency to do their internship, could work as a GP for a few years and then go back into anaesthesia, surgery and these sorts of things or some people just liked it and decided to stay as that.

Do you think that in the medical profession there would be any opportunity or any appetite for restoring that kind of system where you have that so-called third pathway to licensure?

**Arun Anand:** I graduated medical school in 2012 and finished residency in 2017. I had heard about those programs, especially within the context of having ICU extenders and things like that in the residency program. I think that trainees welcome those opportunities; however, with what we have currently, where you have a GP who can do additional training and become a GP anesthesiologist or a GP OB or whatnot, I think that there are limitations in that. In Alberta I saw that we had a lot of GPs become GP anesthesiologists, and then a GP was lost in the community.

I would advocate more towards innovative care delivery models where you have anaesthesia care teams, for example, and have anaesthesia assistants and one anesthesiologist running two rooms, for example. That's a more efficient way than taking a GP out of a community to become an obstetrician or to become an anesthesiologist in a rural community.

I think that they can also provide additional service and complement the system, but taking away from Peter to give to Paul doesn't make a lot of sense.

• (1340)

**The Chair:** Thank you very much.

That ends this particular round and ends this meeting.

I'm sorry for some of the interpretation problems. It's technology again.

Witnesses, I want to thank you for coming, for giving us your time and for helping us to understand even further and dig deeper into this issue.

Thank you very much.

**Dan Mazier:** On a point of order, Chair, I have a couple of housekeeping items.

In creating our supplementary report for the women's health study, we need—

**The Chair:** Excuse me, Dan. May I let the witnesses go?

**Dan Mazier:** You can let the witnesses go, but don't adjourn.

**The Chair:** Thank you.

The witnesses can leave.

I'm not adjourning, Mr. Mazier.

**Dan Mazier:** You had the gavel in your hand.

**The Chair:** I had the gavel in my hand so they would pay attention to my telling them that they could go. That's all.

**Dan Mazier:** Thank you, Chair.

Back to the women's health study, we would ask for unanimous consent from the committee to have the analysts and the clerk produce the witness list for it.

**The Chair:** Is that okay with everybody?

I see consensus.

**Dan Mazier:** There's a problem with it. Because it was in the last parliament, they can't release it unless it's requested by the committee. That's why we're asking for unanimous consent.

**The Chair:** Yes, and there was consensus, thank you. Nobody said no.

**Dan Mazier:** Are we okay, clerk?

**The Chair:** We will make sure that the list is there.

Thank you.

**Dan Mazier:** In another point of order, when it comes to the meeting with the ministers next week, both ministers are appearing for two hours at the same meeting. Is that correct?

**The Chair:** That's what I understand. We have both of the ministers.

**Dan Mazier:** Then could we have another meeting with just officials?

**The Chair:** Once again, you're going to have to ask the committee to give you consensus on that.

**Maggie Chi:** Dan, just to clarify, I thought the officials would come with the ministers.

**The Chair:** Officials come with the ministers.

**Dan Mazier:** They come, but the original motion was one meeting with one minister for one hour and another two-hour meeting with another minister. They're going to come together, so that's a two-hour meeting. It's covered. Then we'll have another two hours with just officials.

**Maggie Chi:** Are you looking to amend? So far, there's no mention in the motion, I don't believe.

**Dan Mazier:** It was one two-hour meeting with one minister and another two-hour meeting with another minister.

**Maggie Chi:** It's not a separate meeting with the officials. Is that correct?

**Dan Mazier:** The ministers have said they're coming together, so we have one two-hour meeting with two ministers and then another two-hour meeting with just officials.

**Maggie Chi:** That's just with the officials.

**Dan Mazier:** Yes.

**Maggie Chi:** Are we amending the original motion?

**The Chair:** He's not amending the motion.

What he is saying is that, since the ministers were asked to come to one meeting each and they're coming together—

**Maggie Chi:** I just want to make sure the officials will still be there.

[Translation]

**Luc Thériault:** A point of order, Madam Chair.

When everyone is talking at the same time, the interpreters can't do their job.

[English]

**The Chair:** I know this happens a lot. Just continue to talk over the Chair.

[Translation]

**Luc Thériault:** Excuse me, Madam Chair.

When everyone is talking at the same time, the interpreters can't do their job well. I'd like to see a bit of decorum.

[English]

**The Chair:** Thank you, Mr. Thériault.

Mr. Mazier, you are suggesting, I understand, that because the ministers are coming together in one meeting, the second meeting, which was set aside for one of the ministers to come with the officials, that officials come instead at one meeting of two hours.

Is that what you're suggesting? I want to make sure that the committee knows what is being suggested before we answer yes or no.

**Dan Mazier:** What it does, Chair, is it cleans it up. The ministers, they're out.... That's the original, I guess, ask....

**The Chair:** We understand the reason.

Can I get a sense of consensus from everyone that they agree to this?

Those opposed to this, raise your hands.

Mr. Thériault, would you like to speak to that?

[Translation]

**Luc Thériault:** I'm quite formal, Madam Chair. I like to be told before things are changed. We had agreed on different hours. We

were supposed to have two ministers for one hour each, not two ministers at the same time.

What might end up happening, depending on what my colleagues are interested in talking about, is that one minister might get more questions than the other, so one would talk a lot more than the other. I would rather we have at least an hour to ask each minister questions to ensure we clearly understand the problem. That's the first point I wanted to make.

The second is this: My experience as a member of the Standing Committee on Health taught me that we waste a lot of time when we have departmental officials as witnesses because they've mastered the art of not answering our questions. If we have two ministers testifying alongside their officials, the meeting will be incredibly unproductive. That's why I would rather have a two-hour block. We want to talk to the elected officials. Talking to departmental officials is a waste of time. I'm sorry to say it, but that's what I think.

● (1345)

[English]

**The Chair:** I do not have unanimous consent to change what is an already agreed-on motion.

Without any further ado, I will adjourn the meeting.

**An hon. member:** Hang on. Take a vote.

**The Chair:** I think we have one person saying no. I was asking for unanimous consent to change this, and I didn't get it.

Thank you.

The meeting is adjourned.







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