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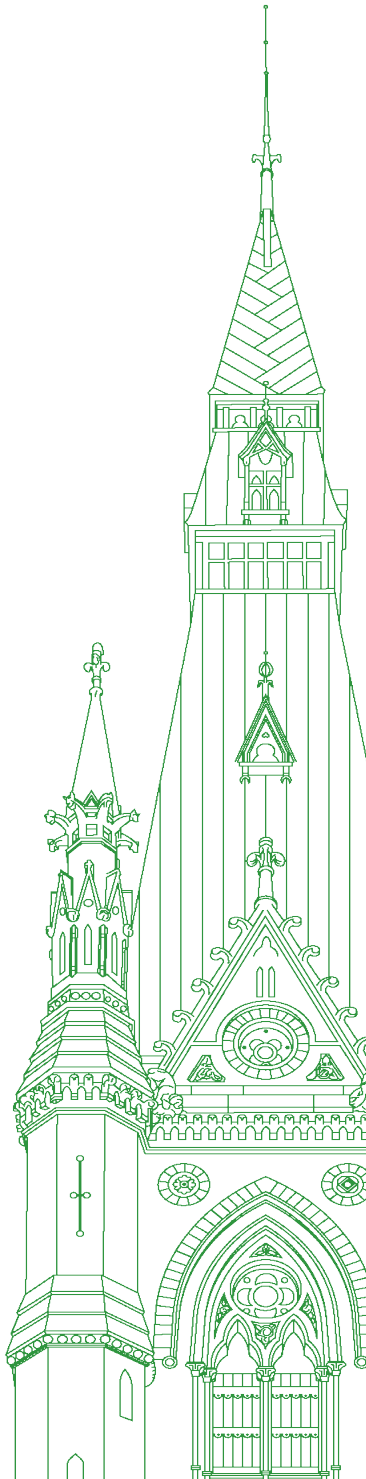

Chair: Hedy Fry

Standing Committee on Health

Thursday, October 30, 2025

● (1105)

[*English*]

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

[*Translation*]

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

[*English*]

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

Today's meeting is taking place in a hybrid format. I want to remind participants of the following points. You have heard this message before, but I have to read it into the record.

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 yourself when you're not speaking. For interpretation, you can choose English or French or the floor language.

All comments should be addressed through the chair.

For members in the room, if you want to speak, please put your hand up. The clerk and I will try to see your hand and will go in the order of the hands we see first.

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

I want to welcome our witnesses. Today, as an individual, we have Dr. Pantea Barati, and, from the Canadian Nurses Association, we Valerie Grdisa, chief executive officer.

We will start with Dr. Barati.

I want witnesses to know that you each have five minutes. I will give you a one-minute and then 30-second warning. I would like to ask you to finish your speech by the time the 30 seconds are done. If you didn't get to say everything you wanted to say, sometimes you get an opportunity in the question and answer session to elaborate on things you wanted to put on the table. Thank you.

Dr. Barati, you have five minutes for your opening remarks. Please begin.

Pantea Barati (Doctor, As an Individual): Chair and honourable members of the Standing Committee on Health, I appreciate the opportunity to contribute to this important discussion.

I come before you not only as a physician but also as someone who believed deeply in Canada's promise that skill, dedication and compassion would find a home here. My goal is not to criticize but to share what I and many others have lived through, in the hope that our experiences can help shape a fairer, more coherent system that truly serves patients and honours the values this country stands for.

Canada's immigration programs actively recruits physicians and nurses, yet residency training—the gatekeeper to independent practice—is largely inaccessible to international medical graduates, IMGs. A recent analysis shows that just 13.6% of immigrant IMGs in Canada are licensed to practise, even though 84.7% of them held independent licences before immigrating. There were about 1,800 IMGs waiting for residency placements in 2023, but only about 370 residency positions were available. Provinces cap IMG participation at roughly 10% of the positions, meaning that qualified doctors compete for a fraction of the spots while many positions are filled by visa-sponsored trainees who are funded by foreign governments and who often return home. Federal immigration targets have increased, yet provincial licensing bodies offer too few residency slots and impose duplicative testing.

These restrictions contradict the promise of Canada's skilled immigration system. After years of delays, I accepted a psychiatric position in the U.K. to maintain my skills. The professional fulfilment came at great cost. I left my husband and my community behind. Friends have moved to the United Kingdom, Australia and the United States, where integration pathways are clearer and fairer. Their departures represent more than personal choices; they are an exodus of talent that could have alleviated Canada's health care crisis.

Taking the position in Wales was not just a career move; it was a reminder of why I chose medicine in the first place. I love my work there. I am treated as a professional whose education and experience matter, and the system allows me to use the full scope of my training. The result is deeply rewarding. I see patients benefit directly from my skills, and I feel respected by colleagues, who value what I bring to the team. The sense of welcome and belonging contrasts sharply with the uncertainty I faced in Canada and highlights what is possible when policy aligns with need.

My experience and the experiences of thousands of other international medical graduates reveal a glaring contradiction. Canada invites us to fill critical gaps yet bars us from doing so. I am not calling for shortcuts or special treatment; I am asking for fairness, coherence and respect. At what point do we acknowledge that discrimination and poor planning, rather than climate or geography, drive IMGs away?

If Canada wishes to uphold universal health care and remain a destination for skilled immigrants, it must align immigration targets with workforce planning, harmonize licensing pathways and remove arbitrary barriers. Doing nothing is not neutral; it perpetuates a crisis that harms patients, squanders talent and diminishes Canada's standing. Change will require collaboration between federal and provincial governments, medical schools, regulatory bodies and immigrant-serving organizations. It must begin with listening to those whose lives are affected by these policies.

The time for excuses has passed. Canada can choose to be honest about its failures and bold in its reforms, or it can continue to watch both its doctors and its reputation slip away. For the sake of IMGs, patients waiting for care and a health care system that lives up to its ideals, we must choose change.

● (1110)

Behind every policy are lives on hold, families divided and patients waiting. This is not a complaint but a call for coherence, to align Canada's compassion with its practice. Change is not only possible; it is necessary if we are to honour the promise Canada extends to those it invites.

It's been an honour to share my experience. Thank you for listening.

The Chair: Thank you very much.

I now go to the next presenter..

Valerie Grdisa, go ahead, please. You have five minutes.

Valerie Grdisa (Chief Executive Officer, Canadian Nurses Association): Good afternoon and thank you, Madam Chair and members of the committee, for the opportunity to appear before you today.

My name is Dr. Valerie Grdisa, and I'm the CEO of the Canadian Nurses Association. I have practised as a registered nurse and nurse practitioner for more than 34 years in two provinces in Canada, and I've had the privilege of serving as the CEO of a community-based health care organization during the global pandemic and integrating internationally educated health professionals into the workforce. We look forward to bringing forward proven solutions.

Before going further, I wanted to share that I'm joining you today from Toronto, situated on Treaty 13, which was signed with the Mississaugas of the Credit and is the traditional territory of the Anishinabe, the Chippewa, the Haudenosaunee and the Wendat peoples and is now home to many diverse first nations, Inuit and Métis peoples.

As nurses and nurse practitioners, we have a duty to respond to the calls to action of the Truth and Reconciliation Commission of Canada.

CNA is the national professional voice of approximately half a million nurses across Canada, representing all categories of regulated nurses. For over a century, CNA has worked to advance nursing practice, shape health policy and improve the health and well-being of people in Canada and around the world. The nursing profession is deeply committed to ensuring that every person in Canada has timely and equitable access to care. This includes access to nurse practitioners, who already provide comprehensive primary care to many Canadians and must be part of the solution to closing the access gaps.

CNA's vision for federal health policy is outlined in our policy road map for 2025 and beyond, entitled "Building a Healthier Canada, Powered by Nurses". This road map provides practical, evidence-based solutions to strengthen Canada's health system, including optimizing the nursing workforce so every nurse, including internationally educated nurses, IENs, can work to the full extent of their legislated scope of practice; expanding team-based models of primary care to increase access; strengthening retention and well-being supports for nurses, including IENs; and advancing a pan-Canadian framework for harmonized nursing regulation to improve labour mobility across jurisdictions.

Today's discussion on the impact of immigration policy on health care is timely and vital. IENs have long enriched Canada's health system. In the 1960s, nurses from the Philippines were recruited via direct employment programs and were able to start working the day after their arrival. Nowadays, too many nurses face unnecessary barriers that delay or prevent their full participation in the workforce. Credential recognition can remain slow, inconsistent and costly. CNA has called for a streamlined, transparent and competency-based approach that maintains rigour while removing duplication.

IENs come to Canada through multiple pathways, including express entry, provincial nominee programs, temporary foreign worker programs and refugee settlement routes. These pathways, however, are complex, resource-intensive and sometimes difficult to navigate. Many nurses take alternative routes, such as live-in caregiver programs, which further delay their entry into the health workforce.

Credential recognition is equally challenging. Multiple assessment services and inconsistent equivalency lists across jurisdictions create inequities and delays, yet there are strong examples of innovation and advancements within the nursing regulators. Nova Scotia's Office of Healthcare Professionals Recruitment provides a centralized one-door model, while nurse-led initiatives like the CARE Centre for IENs and University Health Network's IEN pathway help nurses integrate successfully.

Despite this, many IENs remain underemployed or lose skills with significant delays to entering the workforce. Solutions exist, but national coordination is needed.

● (1115)

A pan-Canadian strategy should align ethical international recruitment with streamlined integration, bringing together governments, regulators, educators and employers to ensure every qualified nurse can contribute fully to Canada's health system. That's why CNA recommends the federal government convene a national IEN task force as part of the broader health human resource strategy. This task force should align immigration policy, ethical international recruitment and workforce planning with a national nursing dataset to understand our supply and ensure accountability from pre-arrival through employment.

In short, CNA envisions a future where every qualified nurse and nurse practitioner in Canada, educated here and elsewhere, can contribute fully to the health of our population.

Thank you again, Madam Chair and members of the committee. I look forward to your questions and to working together on practical solutions that strengthen the nursing workforce and improve access to care for all.

The Chair: Thank you very much.

We'll now go to the question and answer segment. The first segment is six minutes and that includes questions and answers. Thank you.

I will begin with the Conservatives.

Ms. Konanz, you have six minutes, please.

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

Dr. Barati, I have a couple of questions for you.

Thank you so much for coming today. Your story is extremely concerning, and it's why we're here today, really.

Just recently, there was a headline in Global News. It was disturbing. It said, "Health care systems 'dismantling' in B.C.'s Interior amid physician resignations". Seven obstetricians/gynecologists and four psychiatrists have recently left Interior Health. Regions like where my riding is located are short of doctors. Also, to add to that, Kelowna General Hospital's pediatric unit was forced to close last summer for a while due to a shortage of doctors, yet someone like you—who immigrated to Canada because of your medical training and who was told that you would be able to practise here and that Canada needed doctors—is not permitted to practise in any of our hospitals or clinics.

When you found out that the residency training you needed to practise wasn't truly open to doctors like you, as you were told, did you feel that the rug was being pulled out from under you, as another witness has mentioned?

Pantea Barati: Absolutely. That's the same feeling that everyone is feeling. We came to Canada. We chose Canada because of what we believed about it. There were other countries that were offering the same position, the same opportunities, but we chose Canada for a lot of reasons. One was the openness and the truth behind everything, and we believed it, but when we came here, the reality was very different from what we had heard.

Unfortunately, I'm still hearing news from my colleagues in the U.K. that they've been offered to come to B.C. to practise, yet in Canada, Canadian citizens are waiting to be chosen to practise.

Helena Konanz: Thank you for that.

Just to be clear, you were told you that you would most likely be able to practise in Canada, and that's why you came to Canada.

Pantea Barati: That's correct, yes.

Helena Konanz: Do you feel that you were invited under false pretenses? What do you think is going on here?

Pantea Barati: Absolutely, that's the feeling I have, and that's the reality that I've faced along with many other IMGs. The reality is very different from the policy or what media is saying.

Helena Konanz: I know that you mentioned this in your opening remarks, but is Canada getting a bad reputation in the world by attracting medically trained doctors like you and not allowing them to get residency spots or to practise? We continue to encourage them to come to Canada.

Pantea Barati: Absolutely, that's a fact. In the IMG community, if someone wants to move to Canada, they are highly encouraged not to do that because of that reality. We are telling our friends and colleagues that it's better to choose another country if you are looking to practise as a physician.

● (1120)

Helena Konanz: That's extremely concerning, I'm sure, to everyone in this room today.

Do you think that more training opportunities should be reserved for international medical graduates who intend to practise in Canada or reserved for people who might not be intending to practise in Canada? For example, there's the visa trainee program signed off by our federal government offering short-term training for internationally trained doctors who are not planning on staying in Canada or are not allowed to even stay in Canada.

Pantea Barati: I'm not asking for more seats dedicated to IMGs. What we are suggesting is that, if some seats are not filled, there wouldn't be any harm offering them to an IMG. What is the reason and logic behind offering a lot of seats to different visa-sponsored positions while we have permanent residents and Canadian citizens waiting for those seats? We all know that those doctors are going to leave Canada. There is no way they are going to stay here.

Helena Konanz: On that note, how many doctors do you know personally who we've lost to the U.K., Australia or the United States? Is it too many to count?

Pantea Barati: From my close circle of friends, I could say that at least 50 of us have left Canada.

Helena Konanz: That's a lot, considering that we're so short on doctors.

The Chair: You have 30 seconds.

Helena Konanz: Are there best practices in other countries that you would say Canada should look to adopt to help get more international graduates into our health care system?

Pantea Barati: If you look into the U.K., Australia and the United States, they offer fair chances to IMGs and domestic doctors. If I registered with the General Medical Council, GMC, in the U.K., I would have the same opportunity as a medical graduate from the U.K. I could practise in the same position, and I could earn the same salary. There is no difference between me and them so, if we want to improve Canada's health care system, we need to look into those policies.

The Chair: Thank you very much. We went over time on that.

I now go to the second questioner, who is from the Liberals, Mr. Eyolfson.

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

I would like to thank both the witnesses for coming here today and for their powerful testimony.

Dr. Barati, I'd like to clarify something you said on the number of positions. You said that it is the provinces that are capping the number of these positions. Is that right?

Pantea Barati: That's correct.

Doug Eyolfson: Is there any policy in our federal immigration system that serves as a barrier to your practice, or is it these provincial policies?

Pantea Barati: I'm not aware of that.

Doug Eyolfson: Thank you.

I've said this on other occasions with other witnesses. I have served in the federal government before, and one of the frustrations we have is trying to direct the provinces on direct funding from the federal government. We tend to get push-back saying, “You cannot tell us how to spend the money. Give us the money. This is completely our jurisdiction as to how we spend it.”

Would you be in favour of policies that would direct funding to the provinces? That is, we will give provinces funding for more positions, but the provinces will be obligated to use that money to create those positions.

Pantea Barati: That would be a great idea, but the thing is, health care is a provincial policy. I don't know how much of an influence the federal government is going to have over them unless, as you mentioned, you make legislation or push them to follow by saying something like, “If we give you this amount of money as a budget, you have to spend it on this purpose, otherwise we will withdraw it.”

Doug Eyolfson: Absolutely, I agree with you, and we found that on several other policies in the past. It is something that I personally think would be a great idea, but again, we get the barriers of certain provincial governments saying, “This is provincial decision-making. You as a federal government have no role.”

I thank you very much for that.

Dr. Grdisa, you talked about the barrier for nurses. Again, this is on the same theme here, barriers to new nurses coming in and practising. They used to be able to show up and practise the next day, but now it's taking a long time after they arrive in Canada. Are these federal policies that are preventing them, or are these provincial licensing decisions that are preventing this?

● (1125)

Valerie Grdisa: Again, because of regulations at the provincial and territorial level, it is at a provincial or territorial level.

Where I do believe the federal government has a role, for example, is that the federal government does fund nurses right now. There's an e-platform that's supposed to capture the entire nursing workforce across Canada, because how can we plan for meeting the health care needs of Canadians if we don't know our true supply? When you think about workforce planning and supply distribution, we don't even know right now. We say we that have half a million nurses, but how many of them are engaged in the health side of the workforce, the publicly funded system?

I do believe that there should be levers from the federal government to the provinces and territories with our taxpayer dollars going through the federal government. This would ensure there's accountability to have the best possible evidenced-based workforce planning and distribution and workforce optimization solutions.

Doug Eyolfson: Thank you.

Would you be in favour of federal legislation that actually gave the federal government power to do these kinds of things?

Valerie Grdisa: On behalf of the nurses of Canada, yes, we would like the federal government and the provinces and territories to work together to ensure accountability for the taxpayer dollars spent.

Doug Eyolfson: All right. Thank you.

I've spoken on this with different witnesses from the medical community. Would you be an advocate for pan-Canadian licensing for nurses, whereby, if you are licensed in the province of British Columbia and you wish to move to Manitoba or you wish to work between both, the one licence would be recognized in both provinces?

Valerie Grdisa: We've been working closely with the 23 regulators. I happened to meet with them just last month. What they are moving forward seem like really very strategic solutions. They're moving towards interjurisdictional nurse licensure models. What we need, then, is consistency across the 13 jurisdictions and the 23 regulators. That's where, yes, I think the federal government has a role in terms of harmonization of nursing regulation across the nation.

Doug Eyolfson: Dr. Barati, would you be in favour of a licensing system that was pan-Canadian, so that if you had a medical licence in B.C. and you had an opportunity to work for a few days in the Northwest Territories, you could have your licence recognized to do that work?

Pantea Barati: Absolutely, yes.

Doug Eyolfson: Thank you.

The Chair: I now go to Monsieur Thériault for six minutes, please.

[*Translation*]

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

When I hear Dr. Eyolfson's questions, I get the feeling that our report is going to be difficult to write. I find it rather unusual to be able to say that the provinces are entirely responsible because this falls under their jurisdiction and that the federal government suddenly doesn't want responsibility for what happens in health care. If the federal government wants to have a greater role in health care, it should also assume the accompanying responsibility. The current quotas in all faculties are enormous. The provinces aren't training enough doctors. The skills of internationally educated health professionals should absolutely be used and recognized. The problem has been around for 20 years, and it still hasn't been resolved.

The federal government implemented federal programs to try to resolve the issue in 2009–2010, and it still hasn't been done. The government even invested $115 million over five years in the 2022 budget, and the issue hasn't been resolved. When I ask people who come to meet us here, they either don't know the programs, or they can't tell us whether or not the money has been spent.

That said, I don't want to start an argument over jurisdictions today. Still, if there's a lack of resources, if more staff have to be trained, then there has to be more health transfers. The federal government didn't transfer the necessary money when it promised $4.6 billion a year over 10 years, while the provinces were united in asking for $28 billion a year. For Ontario, that would have meant an extra $8 billion per year in recurring funding to plug the holes and ensure more robust health care networks. If the federal government wants even more jurisdiction, it will one day also have to assume the responsibility that goes with it.

I'm going to ask the witnesses a quick question. Can they remember a single federal election in which health was such a big issue that it led to a federal government being ousted? Do either of the two witnesses remember that?

● (1130)

[*English*]

The Chair: I would ask the Canadian Nurses Association to take this.

Valerie Grdisa: Yes. Other than the three major areas of delivery that the federal government is accountable for—armed forces and indigenous and public health—outside of the COVID-19 pandemic, when the federal government did step up and had an incredibly systematized and coordinated approach to a global pandemic, I think that, yes, it has not been a huge factor. However, perhaps we have to really rethink the Canada Health Act—

[*Translation*]

Luc Thériault: Okay, but can you remember a federal election in which a government was defeated because of the issue of health? The answer is no.

[*English*]

Valerie Grdisa: In every single election health is a top priority, but I can't think of that being the only reason for a defeat.

[*Translation*]

Luc Thériault: The answer is no; no federal government has been defeated in a federal election because of the issue of health. The only reason for that is that health isn't the federal government's business. On the other hand, countless provincial governments have been defeated in a provincial election because of the health issue, because it's the provincial governments that are responsible for delivering health care.

I'm told that the federal government has to impose even more conditions. If those conditions are imposed, I'd like the federal government to be personally required to ensure accountability when it comes to the effectiveness of systems, which it's unable to fund.

Ms. Grdisa, you were talking about worker retention, consistency and labour mobility. Let's look at the labour mobility situation in Quebec. Do you think the kind of intervention that the Premier of Ontario has made will help ensure that everyone works together more to solve the health issue?

[*English*]

Valerie Grdisa: I can't comment on what the Premier of Ontario's intent was, so I don't think I can respond to that.

What I can tell you, as a nurse for 35 years coming up this year, is that what's happening now is not working. We're the third most expensive health system on the globe and we are in the tens and twenties in terms of performers. We actually have to ensure that for 40 million Canadians, we are managing a health system together.

[*Translation*]

Luc Thériault: How much time do I have left?

[*English*]

The Chair: You have 10 seconds.

[*Translation*]

Luc Thériault: I could ask a supplementary question, but one thing is certain: To have a more robust health care system, it takes the necessary funding and resources. These systems have been chronically underfunded, and now the body that underfunds them would like to impose conditions when the situation is a complete disaster.

We can come back to this, but it's clear that the Bloc Québécois will never consider that adding conditions to health care will guarantee an improvement in the situation when the funding isn't there.

That's obvious from our discussions.

● (1135)

[*English*]

The Chair: Thank you. We've gone well over time.

I'm going to move to the second round. It's a five-minute round and we'll start with the Conservatives.

Mr. Bailey, you have five minutes, please.

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

I have a few questions for the Canadian Nurses Association.

What is the current number for the shortage of nurses in Canada?

Valerie Grdisa: Because it's provincial and territorial, every single province and territory would have a different percentage point. Recently, I heard from the chief nurse of Ontario, Dr. Karima Velji, that they are nearing less than 15%. They've been filling the vacancies post-COVID.

I think we're actually having a conversation about shortage when we also have to look at workforce optimization and the conditions. There have been recent reports that our young, highly talented new graduate nurses are leaving the workforce because of the conditions within the workforce. We can keep saying we can throw more money at it, but 12.4% of GDP spend is on health care right now. That's astronomical in terms of the increase of over $100 billion in just a decade.

There are other solutions and other health systems that better optimize the workforce, have more innovative models of care and team-based models of care. Actually, we're seeing the end result of us not innovating, not responding to nor fully optimizing our highly educated and talented workforce. It's not only our domestic supply, but obviously it's bringing in the internationally educated health professionals to ensure they're fully optimized, have a better enculturation experience and have roles.

Thank you.

Burton Bailey: I was looking for a number. It's been reported that 60,000 is the shortage that we're facing across Canada. That's a very big number.

Do you know how many nurses who were trained in other countries are currently not employed in nursing?

Valerie Grdisa: I don't have the exact percentage, but there's a guesstimate that it could be upwards of 21%.

Burton Bailey: My understanding is that Alberta changed the way it is doing language testing for immigrant nurses because of the fact that it was being done in the States. Have other provinces taken that lead?

Valerie Grdisa: The nursing regulators are all working together to have a Canadian solution, so yes. Some of them are even clearing out the rigorous language testing in that there are other opportunities for them to prove their ability to deliver care in one of the two official languages.

Burton Bailey: Is it safe to say that we're working on that backlog of nurses who are here in Canada and who aren't able to work as nurses?

Valerie Grdisa: Yes. Over the last three years, there has been substantive effort by the nurse regulators to shorten the time period from application to actually getting the licence to be able to practise. As I mentioned in my opening remarks, there are several enculturation programs. Is it enough? No. The reality, though, is that the bigger issue is that once they get into the workforce, we're struggling to retain them. We're not creating the conditions for enculturation and actually stamping out racism and discrimination, because that occurs for internationally educated nurses here in Canada.

Burton Bailey: Certainly.

One of the things we're finding in our areas is that nurses have been replacing so many different positions in hospitals, and they've become data collectors. A lot of the senior nurses who are not computer-friendly are retiring. Is that a fair statement?

Valerie Grdisa: There's a huge administrative burden. We're in the world of technology and advanced technology. The fact that there is so much documentation and record-keeping, when we believe only 20% of any data that's actually collected from patients and through diagnostics, etc., is actually utilized, yes, that is a huge burden on the workforce.

I would say that the nurses who are more senior—

The Chair: There's one minute left.

Valerie Grdisa: Sorry.

Burton Bailey: One thing KPMG indicated was that once some of these data systems are in place, we'll have too many nurses. Would you care to comment on that?

● (1140)

Valerie Grdisa: These are projections and scenario generations. To go back to an original point I made, until we actually have a current understanding of our supply, and we map that against population health needs and look at where the supply is distributed, we can't even make those projections at this point in time with the data we have in our nursing reports.

Burton Bailey: Has immigration ever contacted the nursing association and discussed numbers so that we can hire enough nurses and have enough staff in our hospitals?

Valerie Grdisa: I do work with the Chief Nursing Officer for Canada. She works with all the different bodies of nursing to try to get the supply question that you're asking, but—

Burton Bailey: So she has contacted you.

Valerie Grdisa: Definitely. We communicate bimonthly, at minimum.

The Chair: Thank you.

We'll now go to the Liberals.

Ms. Sidhu, you have five minutes, please.

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

Thank you to the witnesses for coming in and giving your testimony.

My questions will be for Dr. Grdisa.

Thank you for the work you are doing, and thank you to all the nurses for the work they are doing on the front line. I really admire that.

First of all, I know that health care delivery and professional licensing fall largely under provincial and territorial jurisdiction, but from your experience, what do you see? What are some of the key challenges that arise because of the shared responsibility between the federal and provincial governments? How could coordination be improved without overstepping jurisdiction and boundaries? You talked about a national IEN task force. Can you elaborate on that?

Valerie Grdisa: Again, at the end of the day, the interface between patient and clinician is where it matters. Patients and families don't really care what's happening in terms of the structure of our health system. What we know is that across this nation there are exemplars, great examples of what's working well. We need to actually, in a systematized way, coordinate and harmonize those efforts to ensure that every internationally educated health professional has the best possible experience of coming to our nation, achieving their goals in coming, and meeting the needs of Canadians as we continue to have population growth and demographic shifts.

Sonia Sidhu: A challenge we have heard about in a past meeting is the lack of consistent data, for example, on how many internationally trained professionals are already in Canada but not practising. How important is better data sharing among the federal government and provincial governments, and regulatory bodies—which is also important—to address these challenges?

Valerie Grdisa: I would hope that as a taxpaying Canadian the sentiment we are seeing around the security and trade tensions that exist, the geopolitical tensions, we would also have around the health of Canadians.

From my perspective, for an example, the federal government has invested in the nurses' database, which is for the regulatory bodies to actually have a standardized database so that we would then have an understanding of the full workforce and could then capture which ones are actually in the publicly funded workforce versus potentially still keeping their RN or NP but not actually contributing within that workforce. Then we can actually start the planning. It has to be coordinated federally, provincially and territorially. There's no other way.

Sonia Sidhu: Thank you.

We have also seen some provinces beginning to pilot a faster credentials recognition program or a bridging pathway. Could you share some examples, if you know of them, of promising provincial initiatives that could be replicated or scaled across Canada?

Valerie Grdisa: There is a federal grant to the Canadian Association of Schools of Nursing that is a bridging pathway. When a nurse comes from another jurisdiction and might not have the educational qualifications based on the program and maybe there were some gaps in terms of content or skills, there's a bridging program that allows them actually to fill those knowledge and skill gaps. That should be better funded across the nation. Right now, it sits within CASN. Also, and I mentioned this in my opening remarks, there are organizations implementing their own programs, but at an organizational level, which then contributes to the inconsistencies and inequities across the nation.

Sonia Sidhu: Thank you.

Can you give an example of which province is doing a great job on this?

Valerie Grdisa: That's the issue, because every province has a different regionalization model, so it's actually more at the regional health authority level or at the health or care organization level where you're seeing those examples of really good transition to practice programs for internationally educated nurses.

I am happy to share anything, and I'm sure that Dr. Leigh Chapman, Chief Nursing Officer of Canada, has tons of examples for you. I mentioned UHN. I mentioned the CARE program for internationally educated nurses. I'm happy to share anything else that you'd like to see. The problem is that there are tons of exemplars in Canada.

● (1145)

There are tons of exemplars of excellence that we're not spreading, scaling up and actually implementing in a more structured, consistent and harmonized way across the nation. When the health care professionals and leaders come together, we are getting frustrated with this plan to plan to plan. We are known as the nation of pilots, and we need to actually take some bold action to make sure any human being who wants to come to Canada and has the qualifications has that incredible enculturation experience with the right supports.

The Chair: Thank you very much.

I now go to Mr. Thériault for two and a half minutes.

[*Translation*]

Luc Thériault: We agree on the objectives.

Dr. Barati, what year did you start your efforts?

[*English*]

Pantea Barati: In 2012.

[*Translation*]

Luc Thériault: Since then, have you seen an improvement in the navigation that was mentioned when it comes to getting licences and practices recognized?

[*English*]

Pantea Barati: Some provinces try to change their examination format, like some of them added more exams and some of them reduced some of the exams. You are asking a lot of doctors and educational health care professionals to come to Canada with the hope of starting their lives, but you don't have the resources to help us to enter the workforce. You don't have many opportunities to offer to immigrants. Although the government is providing and asking for more immigration, I have no idea what outcome we are looking at in entertaining that many doctors and nurses to come to Canada when we don't have that many resources or are not planning to...do that.

No, it's getting worse compared to 2012.

[*Translation*]

Luc Thériault: For someone from abroad who wants to come practise here, does Immigration Canada have clear practices and rules that would, among other things, ensure that the person doesn't lose their ability to practise? Some people have immigrated here and learned, once they arrived, that they had to have practised medicine for at least one year in the last three years, which has forced them to leave the country to meet that requirement. They didn't know that until they got here.

If Immigration Canada's rules were more transparent and clearer, I imagine it would be easier.

[*English*]

The Chair: I'm sorry, but you're running out of time.

[*Translation*]

Luc Thériault: The application could be made from abroad, and people could meet the requirement of having practised for one year.

[*English*]

The Chair: I am going to give you 10 seconds to answer that. We are well over time on this round.

[*Translation*]

Luc Thériault: Thank you.

[*English*]

Pantea Barati: Well, there was no transparency from Immigration Canada, from the first day I started my application to enter Canada. Since then, I've never seen any transparency to say what the limitations and restrictions are for any health care professional when they are immigrating to Canada.

The Chair: Thank you.

Now we go to the Conservatives. Mr. Strauss, go ahead for five minutes, please.

Matt Strauss (Kitchener South—Hespeler, CPC): Thank you, Dr. Barati. I'm just interested to hear more about your story. When and where did you do your medical training? What training did you undergo?

● (1150)

Pantea Barati: I did my medical schooling back in Iran, and it was a seven and a half years of education, so it is considered a general practitioner.

Matt Strauss: What I find so amazing about your story is that you live in Canada, you are Canadian, but you had to go to the United Kingdom to have your credentials recognized. What was the process to have your credentials recognized in the U.K.?

Pantea Barati: For the U.K. recognition, I had to have two exams, and then, right away, I got my licensing.

Matt Strauss: You passed those exams, obviously.

Are you allowed to write the corollary exams, the Canadian equivalent of those U.K. exams, right now?

Pantea Barati: Well, the point is we all do the exams, but there is no promise or guarantee that, with all those exams and expenses...there is no future for it.

Matt Strauss: I see, so it's been made clear to you that, if you were to write the exams in Canada, still, you would not receive the credentials to practise here?

Pantea Barati: That's correct.

Matt Strauss: I just want to remind the committee that, when Stephanie Price was here from the federation of medical regulators, she said that if somebody gets their national credentials from the national bodies, which are respondent to the federal Parliament, 100% they would get a provincial licensure, so the holdup is the credentialing.

What I find so remarkable about your story is the United Kingdom is a first world, developed country with a highly sophisticated health care system, and you're allowed to work there but you're not allowed to work here, where you live. Can you just tell me, how often do you have to travel to the U.K. and what is the cost of that to you?

Pantea Barati: To meet my family, at least, I have to travel every two to three months. Each time, it might cost over $3,000 Canadian.

Matt Strauss: What sort of work are you doing in the U.K. when you get there?

Pantea Barati: I'm working in psychiatry in-patient work, as a physician.

Matt Strauss: Is that as an independent physician?

Pantea Barati: Yes.

Matt Strauss: Is it or is it not the case that we are absolutely crying for mental health physicians in Canada?

Pantea Barati: At least in my region, which is Kitchener-Waterloo, the wait time to see a psychiatrist is over a year, and it is offered as only a one-time appointment for consultation, and the follow-up is transferred to the family physician rather than a psychiatrist.

Matt Strauss: You are a Canadian. I imagine you've had experiences with the Canadian health care system. You're working in the U.K. health system. Can you think of any reason that a physician who's working in mental health in the U.K. couldn't do that same work in Canada? Why could we not just recognize U.K. credentials and get you to work tomorrow?

Pantea Barati: Unfortunately, I don't have a clear answer to that. There are just rumours going around that we don't want them to work here. Other than the knowledge, everything is similar. Human beings are similar. It's just some culture differences.

The other thing is that the U.K.'s population is much larger than the Canadian population. Their resources are much more limited than our resources. I honestly don't have any clear answer why we in Canada cannot employ a doctor who has worked in another country.

Matt Strauss: I have a couple of questions for the Canadian Nurses Association. I'm an ICU doctor. Over the pandemic, fantastic ICU nurses I had worked with for 10 years up and left. The words they often used were “burnout,” “fed up” or “frustrated.” It wasn't as though aliens beamed away all of our nurses, yet we see emergency rooms shutting down because nurses are burnt out or fed up. Is that about your impression of the situation? Can you tell us what they're feeling that way about?

Valerie Grdisa: There are reports about burnout and forced or involuntary overtime, which is a significant issue when you think of someone trying to balance work and life.

Again, there was a massive adjustment post-COVID in almost every position in the health system and in nursing too. We saw a major shift. It goes back to some of the fundamentals we need to have for nurses, like workplace conditions that support choice, such as in scheduling—often they don't have choice in scheduling and they live complex lives— and, obviously, any type of involuntary overtime; once in a blue moon, anybody will stay and do a double shift, but if it's being asked every other day, then they don't feel they have that control in their life.

There's a hidden situation you would know about as a doctor working in the health system. There's a lot of toxicity in the health system because of so many things being out of control. People do leave workplace environments where they don't feel they have any control and/or respect and aren't valued.

That's why we've seen these changes over the last few years with nurses speaking up and speaking out about workplace conditions and increased violence in the workplace. Although there's federal legislation and provincial legislation around no tolerance for violence, there isn't a substantial change in terms of that—

● (1155)

Matt Strauss: What seems so dangerous to me about the situation is it seems like the more nurses get burnt out and leave the workforce, the more the remaining nurses will get burnt out and leave the nursing force. It starts as a snowball rolling downhill that becomes an avalanche.

Would you agree there is a danger to that? If we don't fix this problem and get the nursing workforce optimized, it's going to accelerate.

The Chair: Ms. Grdisa, I have to ask you to answer that in another round. We've gone well over time here. Thank you.

I now go to Mr. Powlowski for the Liberals. You have five minutes, please.

Marcus Powlowski (Thunder Bay—Rainy River, Lib.): Dr. Grdisa, currently, how many foreign-trained nurses are working in the Canadian health care system?

Valerie Grdisa: The rough estimate would be about a quarter. In terms of immigrant nurses, the nurses for whom Canada was not their country of birth, it's almost 50%.

Marcus Powlowski: Wow, that's great.

I have to play a bit of politics here. I bring it up because the Conservatives have continued to try to portray this image that the problem with the health care system is the number of immigrants, whereas the reality is a big part of the fact we still have a health care system is because of the immigrants. We owe a big thanks to all the immigrants working in nursing.

Could you talk about agency nurses? I know up around Thunder Bay and in northwestern Ontario this is a big issue and a problem coming out of our lack of adequate numbers of nurses. I certainly hear a lot about it. Not only does it cost the hospitals a lot to be bringing nurses up from Toronto but it creates animosity within the health care facilities when the local nurses are making significantly less than the agency nurses.

Valerie Grdisa: I do want to recognize the Canadian Federation of Nurses Unions for bringing forward a report that clearly outlines the risks related to any health system or organization when a certain percentage of your workforce is not actually the permanent workforce. There's such a significant compensation differential.

Marcus Powlowski: Could you send that report to us? We could, then, possibly include it.

Valerie Grdisa: Definitely. I can ask my colleagues at the CFNU.

When you're a nurse, and you're committed to your organization or your unit, and you're working, and someone beside you comes in under an agency staffing model at a higher price point, they're bringing home more money and there's not that continuity for the patients and families, that is not the model of care that should exist anywhere, in any jurisdiction, in Canada. We should have staffing models that actually staff to what we anticipate the population health needs are for communities, and then we should create the conditions within those organizations, with the right price point—meaning the right compensation models—to keep nurses in place. That's what we're struggling to do in Canada right now, retain our nurses.

Marcus Powlowski: My wife went to nursing school in the Philippines. We are still in contact with a lot of the people she went to nursing school with. A number of them came to Canada. It certainly impressed me...the variability of requirements from province to province and time to time. Sometimes they couldn't even get in and licensed in certain provinces, but then in other provinces they were in there within a couple of days after they applied. The same goes for the United States. Is there any kind of homogeneity of requirements among the provinces, or is it just a catacomb of different requirements?

Valerie Grdisa: I think it's important for everybody to understand the regulators actually set, for the four types of nurses, the entry-to-practice competencies. They actually accredit the nursing education programs to deliver the education that meets those competencies. Then, there's a nursing licensure exam, the NCLEX. It's a national exam, at least for the registered nurses, for example, and there are exams for the other three types.

You would think that, when the entry-to-practice competencies are set on a standard level, the accreditation's on a standard level and, at least for the RNs and the nurse practitioners, there is a national licensure exam that has the same consistency, there wouldn't be these problems we're facing in terms of harmonization across the 13 jurisdictions.

● (1200)

Valerie Grdisa: That's what we are appealing to, as the Canadian Nurses Association. We have all of the components but, for some reason, we still have this fragmentation.

Marcus Powlowski: You said that federal money went to the Canadian school of nursing to help create bridging programs. How much money went into that? How many people have actually gone through those bridging programs? I know you're not going to get to it, so could you make written recommendations as to what we should do in terms of more funding and creating more such positions?

Valerie Grdisa: I'm sorry, but I don't have those exact numbers. I can definitely get them from the Canadian Association of Schools of Nursing, about the success of the program. I have seen reports. I just don't have them with me.

Marcus Powlowski: Yes, and also recommendations as to the need for more funding and the number of people who have gone through the program.... Thanks.

The Chair: I want to thank the witnesses for coming and for giving us their time and expertise to help us understand this complex issue.

Now I will suspend so that we can bring in the next hour's witnesses. Thank you.

● (1200)

_____(Pause)_____

● (1210)

The Chair: I call this meeting to order.

I thank the witnesses for appearing. We have two witnesses and we have a one-hour meeting.

I would like the witnesses to know that you each have five minutes to speak. I will give you a one-minute and a 30-second warning, so you can wrap up. Sometimes you don't get to finish, but during the question and answer period you will get an opportunity to expand on what you want to say.

The second thing I'd like to say is you need to speak through the chair.

Third, turn off your microphone while you are not speaking; otherwise, it creates feedback for the interpreters, which actually harms their ears.

Mr. Powlowski, please do not turn on your microphone until you're ready to speak. It creates feedback, as I'm told by everyone here. Thank you very much.

We have with us two witnesses.

From the American Canadian School of Medicine, we have Dr. Andrew Padmos, executive vice-president. As an individual, we have Dr. Sandra Rao, who is an emergency room physician.

I'll begin with Dr. Padmos. You have five minutes, sir.

Andrew Padmos (Executive Vice-President, American Canadian School of Medicine): Thank you, Madam Chair, for the opportunity to speak.

It wasn't my intention, but I happened to listen to yesterday's meeting and thought that I had some things to contribute and misunderstandings to correct. I have distributed notes, because I have quite a few things to explain about a very complicated system of education, training, licensure, certification, residencies, fellowships and the difference between various categories of physicians that we need badly in Canada.

My own story is that I attended McMaster University a long time ago, in the first class of their medical school. I stayed there for my training in internal medicine and hematology. I practised first in Calgary, but while I was there, several colleagues were going off to Saudi Arabia to a fabulous hospital. My wife and I and two young boys left for what we thought would be a year or two but turned out to be 15 years of a marvellous experience. I was the only hematologist in Saudi Arabia when I went. I had recruited 12 into the department by the time I left, and we were very busy with a program for the whole kingdom.

I returned to Canada in a quasi-administrative role in Kingston at the cancer centre there. I moved to Nova Scotia as the head of cancer programs in the province. I then moved to the Royal College, where I was the CEO for almost 15 years. Since I sort of retired in 2020, I have been building a medical school at Toronto Metropolitan University in Brampton on an interim dean basis. Then I will hand it over to Dr. Teresa Chan. I'm now working with the American Canadian School of Medicine, the only not-for-profit private medical school in the Caribbean.

Visa trainees are a particular interest of mine because, in 1978, when I was newly at King Faisal Specialist, the first four Saudi graduate physicians from King Saud University came to the hospital to ask about Canada and doing their training there. I told them what I could. They asked about Winnipeg, Toronto, Vancouver and other places. The first one actually turned out to take his training in Halifax. They liked it very much. They were treated very well, and many of their colleagues started following.

By 1990, there were literally dozens of Saudi trainees in Canada. That program then started a visa trainee program, which now has 1,100 Saudi physicians taking training at various stages in Canada. However, it's a misconception to think that those positions the Saudis are filling, if vacated, would provide spaces for Canadian students or those who are immigrating into Canada with an MD. These positions for visa trainees are extra and in excess of those provided through provincial funding, which is matched against what are the perceived needs in Canada.

If those 1,100 positions disappeared, we wouldn't actually have any new positions for other trainees, including Canadians studying abroad, unless the provincial government provided salary support for those positions. In which case, those visa trainee positions would disappear, because they're offered by the universities in terms of having excess capacity only. Currently, out of the 1,100 visa trainees in Canada, only about 120 are in entry-level positions. Twenty-five or so are in family medicine, but even there, they're in their second or third year of training, so, again, their absence or disappearance would not actually create some space.

I'll turn to the problem of our workforce. Our problem in respect of Canadians studying medicine in Canada is that we don't have enough medical schools. I participated, as I said, in opening a school in Brampton that took in 94 students this September and 105 resident positions in postgraduate training. That's only the 18th school.

In comparison, Saudi Arabia, which has the same population, has 38 medical schools. Many of them are private. I have a consulting position to help a new medical school start up in Saudi Arabia, and they're looking for their colleague physicians who did their training in Canada, because they're so highly regarded in that country.

Our problem for Canadians studying abroad in the Caribbean or Australia, as you heard yesterday, is that they can't or even don't apply for residency positions because they feel they won't get them.

● (1215)

That's not as true as it was 10 years ago. Provinces are making designated positions available, and in the match this year, something like 638 international medical graduates were given residency positions at the entry level.

It isn't quite the same problem as it was. Those who apply from outside Canada actually have an 80%-plus chance of getting a residency. The problem is, in the Caribbean, Canadian students—there are 3,500 around the world and about 1,200 to 1,500 in Caribbean medical schools—don't even apply because their schools give them clerkships in U.S. hospitals. The U.S. hospitals find them residencies nearby, because they want them to practise there, so they feed the U.S. hospitals with patients. In Canada, we don't tend to view patients as a revenue source. We see them as a cost and try to reduce the number, but not in the U.S.A.

Many of our Canadian students, who pay their own way to medical school, end up practising in the U.S. I think that's unfortunate. It could be reversed if we provided clinical clerkship positions in Canadian hospitals where those undergraduates would be able to find a clerkship and residency in Canada, because they would audition and create a network that would help them do that.

Thank you.

The Chair: Thank you.

Now I will go to Dr. Sandra Rao for five minutes, please.

Sandra Rao (Emergency Physician, As an Individual): Hello, Madam Chair.

My name is Dr. Sandra Rao, and I am a full-time emergency physician practising in a very ethnically diverse urban setting in the greater Toronto area. I also work in rural hospitals across Ontario. Today, I am here representing myself to provide testimony on the impact of population growth on acute care health care utilization.

In my practice, I see a wide variety of patients from different backgrounds—citizens who were born in Canada and first-generation immigrants who have been here for decades. I also see a substantial number of patients who are newcomers and have only come in the last few years, as well as international students and refugee claimants through the interim federal health program.

According to Statistics Canada, in 2023, the vast majority—around 97.6%—of Canada's population growth came from international migration, both permanent and temporary, and the remaining portion, 2.4%, came from natural increase.

In Ontario specifically, population growth since 2021 has been unprecedented, driven almost entirely by international migration. In 2023, at 3.1%, it had the highest growth of any single year since 1972, which more than doubled the average population growth of 1.3% over the last 50 years. However, our health care infrastructure, particularly acute care beds, emergency departments and family physician supply, has not expanded proportionately.

Though health care is still offered provincially, federal immigration policies impact our health care outcomes directly.

In Ontario, the number of acute care beds has decreased since COVID levels and remained stagnant. At my centre, our ED volumes have increased by at least 11% year over year since the pandemic.

Visits by refugee claimants have increased by almost 490% since 2021. The rate of admission among these ED visits has remained the same, thus the total number of admissions is still rising year over year.

According to the Financial Accountability Office, there were 35,540 funded hospital beds in Ontario in 2024-25. Based on the 2025 budget, there would be sufficient funding for 33,083 beds by 2027-28, resulting in a decrease from 220 beds per 100,000 Ontarians to 203 funded hospital beds per 100,000 Ontarians. This trend would not even meet the needs of an aging population, let alone accelerated immigration.

This is the same story across the country.

Population increases also impact the physician workforce. In a briefing regarding the Ontario Medical Association's negotiations with the Ministry of Health, unprecedented population increases were directly cited as a reason for lower than anticipated compensation for our physicians. As we see what is happening between the Quebec government and their physicians, provincial physician funding has a direct impact on physician attrition in the province.

In our centre, the bulk of increases in our ED volumes are accounted for by ambulatory low-acuity volumes, likely exacerbated by insufficient access to family doctors due to an existing crisis in primary care. According to the Canadian Institute for Health Information, family medicine physicians experienced slightly negative growth of 0.1% from 2022 to 2023. This then spills into ED wait times, referral to specialized clinics and worsened wait times for specialists.

Newcomers often also face challenges in accessing health care, including significant language barriers, lack of primary health care and low health literacy, all of which require additional resources and personnel to properly address. There are also differences in health care expectations. Many newcomers come from countries where there isn't an established primary care system, so they may expect to see specialists or obtain advanced imaging right away, not being aware that such a referral can take months. Thus, the inability to meet health care needs of an increasing population disproportionately affects newcomers. If immigration levels continue to be mismatched with provincial health care delivery, outcomes will suffer for all Canadians.

● (1220)

The Chair: Thank you very much.

I shall now go to the question and answer period. We begin with the Conservatives. It's a six-minute round, and the six minutes includes questions and answers.

I would like to begin with Mr. Mazier from the Conservatives, please.

Dan Mazier (Riding Mountain, CPC): Thank you, Chair.

Thank you to the witnesses for being here in person today.

Dr. Rao, is population growth increasing demand on Canada's health care system?

Sandra Rao: I believe that it is.

Dan Mazier: Dr. Rao, how are the immigration levels set by the federal government impacting Canada's health care system?

Sandra Rao: As I stated in my comments, the immigration levels are directly impacting particularly urban centres, especially where I work. They are directly increasing wait times and the number of visits per day, even though the number of physicians and nursing staff that we have in order to meet these demands is not increasing.

Dan Mazier: Dr. Rao, the federal health minister recently said there's no alignment between immigration and the need for doctors. Should immigration levels be tied to health care capacity to ensure our system can adequately support both Canadians and newcomers?

Sandra Rao: Absolutely.

Dan Mazier: Dr. Rao, what portion of your current billings is for refugee claimants?

Sandra Rao: I would estimate around 15%.

● (1225)

Dan Mazier: Have you seen this number rise over the past decade?

Sandra Rao: I couldn't give you a number personally over the past decade, but it has certainly increased over the last two to three years since I have been in practice.

Dan Mazier: Dr. Rao, last year there were over 1,000 Saudi Arabian citizens training in Canadian hospitals through the visa training program. Almost all visa trainees will never work a day in Canada after they complete their training because they will return to their home country.

Do you believe the Canadian health care system has become too dependent on the visa training program?

Sandra Rao: I believe there was an instance in 2016, I want to say, where there was a conflict between Saudi Arabia and the Canadian government where Saudis were being pulled from residency programs. That did cause a significant strain on our system at the time.

Dan Mazier: Elaborate on that. How are we becoming too dependent on that program?

Sandra Rao: Hypothetically, if we were to lose Saudi trainees for any specified period of time, residency programs would fail to meet the needs provided by those programs in delivering care at their local teaching hospitals.

Dan Mazier: Dr. Rao, the cost of the interim federal health program has skyrocketed from $66 million a year in 2017 to $800 million a year today. Doctors have reported that some of their colleagues are exploiting the federal program by billing inflated premiums for services provided to refugee claimants. According to the interim federal health program's benefit grid, which outlines the rates doctors can charge, many services have no maximum dollar amount.

Why do strict billing limits exist for Canadians under provincial plans but not for services billed under the federal program for refugee claimants?

Sandra Rao: Physicians are supposed to bill the program what we would generally bill the provincial government, and not more. However, the stringency with which that is being enforced is likely variable. I personally am not aware of anyone having their billings rejected from that program, but I would say that is probably related to the auditing process.

Dan Mazier: We can go over the grid right here. There is nowhere that says there is a maximum dollar limit. If you go through other procedures, there are actually prescribed limits, but on these particular ones, there's no limit. The doctor can write in anything they want. Is that correct?

Sandra Rao: In theory, yes, and in theory, there's no maximum annual amount that a patient can bill the system. I am not aware of any maximum amount that a physician can bill per service rendered.

Dan Mazier: Do you believe there needs to be stronger oversight and accountability for the interim federal health program?

Sandra Rao: Yes, I do.

Dan Mazier: Should the federal government align the interim federal health program's billing caps with those of provincial health plans?

Sandra Rao: Yes, it should.

Dan Mazier: Dr. Rao, when an uninsured patient receives care in Canada but doesn't pay the bill, who ultimately covers that cost? Can you provide examples of how that typically plays out?

Sandra Rao: If a patient comes to the ER without any health insurance and they do not have any means to pay, the physician and the hospital do not get paid for those services.

Dan Mazier: Does that happen to you much?

Sandra Rao: Not infrequently...once a month, let's say.

Dan Mazier: What would that be, typically? Would that be an hour of your time once a month?

Sandra Rao: Approximately, yes. It has definitely happened to me and my colleagues that complex resuscitations do not get covered.

Dan Mazier: Is there any cost? When you get stiffed, how much would that be, approximately?

Sandra Rao: It would be somewhere between $100 and $500.

Dan Mazier: Thank you very much.

The Chair: We go to the second questioner, and that's for the Liberals, Mr. Eyolfson.

Doug Eyolfson: Thank you, Madam Chair.

Dr. Padmos, I'd like to thank you for the point...I think I was making this point in other meetings. When I was staff at a teaching hospital in the early 2000s, we had many residents from Saudi Arabia. I want to confirm that these are residents who are not taking up spots from Canadian residents who would have applied. When I was there, these residents—all of the training expenses and salaries—were paid for by their sponsors. As well, there was a payment to the funds of the medical school to help it run its operations. Is that still the case?

● (1230)

Andrew Padmos: Yes, that's still the case. The Saudi positions are offered by universities through the Saudi cultural bureau here in Ottawa. The University of Ottawa will tell the Saudi bureau, “Next year we have positions for two in general surgery, maybe one in ophthalmology, maybe none in anaesthesiology this year.” The Saudis then find suitable candidates, often very highly qualified candidates, to take those positions. However, the majority of the Saudis are here not in entry-level, first-year positions because they now have medical facilities in Saudi Arabia, with Canadian-trained faculty who are teaching them in the early years of their specialty training. We're now getting a preponderance of trainees coming in at the fourth-, fifth- and sixth-year level, at which point they're not only not a block; they're actually a benefit to Canada because we have a highly trained physician who's working with Canadian patients, and at no cost to the system.

Doug Eyolfson: Thank you.

Dr. Rao, you mentioned that our system may be relying a little too heavily on these visa trainees. Would that be helped if the provincial governments were to fund more training positions?

Sandra Rao: I believe it would. I believe that the provincial government would need to fund more residency positions for CMGs, but also, there have to be more resources at every level. You would also need more staff physicians in order to provide the training to these trainees.

Doug Eyolfson: You would recommend that the province also fund those. Is that correct?

Sandra Rao: That's correct.

Doug Eyolfson: I want to clarify again because I want to see the federal government doing more on these things, but it's difficult when we have provincial governments that keep insisting that we just write the cheques, with no influence. Would you be in favour of directed, targeted federal funding to help assist with these programs?

Sandra Rao: I think that would be helpful, yes.

Doug Eyolfson: Now, you may have different billing tracking systems from what we have in Manitoba. You're fee-for-service, I understand. Is that correct?

Sandra Rao: It's a complicated system, but it's a blended AFA, an alternative funding plan, along with a heavily skewed fee-for-service system.

Doug Eyolfson: I know in Manitoba we have a system where they were basically paid by the hour. If you go in, is it basically that you are paid by the hour when you go to emergency, or does what you're reimbursed depend on what happened during the shift?

Sandra Rao: We get paid a stipend to show up for that particular shift. Then we are allocated a certain number of points for seeing a certain number of patients. The number of points depends on time of day and complexity. We're also paid shadow billings of around 37% for the amount that we bill the ministry.

Doug Eyolfson: Thank you.

Dr. Padmos, we talked about how we need more medical schools. I would be the first to agree. I started medical school in 1989, and I was watching in horror as many provinces, my own included in Manitoba, said that we had to get health care costs under control. They said that medical providers were among the greatest drivers of health care costs and, therefore, to get health care costs under control, they needed fewer providers and said they should cut the number of medical school spots. That was the actual rationale stated by provinces in the 1980s.

I think the provinces are starting to get around this and have started to reverse this. Do you agree that the provinces need to be kicking in more for this to fund more medical schools, more medical training positions and more residencies?

Andrew Padmos: Yes, I do.

Recall that in 1964, I believe, the federal government set aside what I believe was $500 million that was used to fund new medical schools at McMaster, Sherbrooke and Calgary, and I'm not sure of the fourth school, but there was a big tranche of federal money that went in. I wish it had been around when I was working with Toronto Metropolitan University, because it didn't....

The issue is that Canada should have somewhere in the neighbourhood of 40 medical schools if it wanted to be self-sustaining. However, we have always depended on the immigration of foreign-trained people, and now Canadians who go abroad to study, in order to fill up our needs for medical care, and we're still short.

By the way, physicians are only one part of the problem. You know we're short of nurses and almost everything else as well, so there needs to be a concerted, coordinated effort in this regard.

● (1235)

Doug Eyolfson: Thank you.

The Chair: Now we go to the next questioner, who is Mr. Thériault.

[*Translation*]

You have the floor for six minutes.

Luc Thériault: I would like to welcome the witnesses.

Earlier, Dr. Eyolfson asked you whether it would be appropriate for the federal government to make targeted investments to increase care. If that improves the situation, fine, but if it means the government has to make cuts elsewhere in the health care system, is that really desirable?

You talked about all the issues earlier, including the fact that health care funding hadn't increased in line with population growth. You talked about a loss of 3,000 beds. Should money be injected into the system to keep 35,000 beds, or should there be targeted investments determined by the federal government, which doesn't know the needs of the provinces on the ground?

There's currently a health transfer trend where the federal government tells the provinces that it will give them money, but that it will decide where they should invest it, as if it had the necessary authority to determine that. You're on the ground, and you see what's happening. The federal government is telling the Conservatives that immigration has no impact on service delivery, that it isn't right to say such a thing, and that they're trying to stigmatize people who come from elsewhere. You told us earlier about the problems related to that. It's important to treat the people who come here with dignity.

Who has the jurisdiction to decide where the money should be invested, then? We say that it's the people on the ground who provide the care. That's the issue that's emerging from our work: The federal government wants to decide everything and tell the provinces where to invest the money it gives them.

What's your reaction to that?

[*English*]

Sandra Rao: It's interesting to listen to French and English interpretation at the same time. I'll do my best to answer your questions.

The idea that the federal government should provide funding to provincial governments in order to target health care expenditures and spending and address these problems is certainly a good idea, but I don't believe giving money for the sake of giving money will solve the problem. Certainly, it should be targeted toward programs that will be beneficial, but what we have is also not necessarily an issue of money. I do believe provinces have a lot of funding, but it's not necessarily being allocated responsibly. I also believe we do have—

● (1240)

[*Translation*]

Luc Thériault: You say that the money is not being allocated in the most responsible way. Can you give me some examples?

[*English*]

Sandra Rao: We have certain metrics that the provinces meet and are being given funding for and that I don't know necessarily improve outcomes. Just off the top of my head, I believe certain hospitals are given money for attaining certain sickle cell metrics that hospital systems do work very hard in order to meet, but on a grand scheme of population-level base care and meeting wait time needs, I'm not really sure that is where our money needs to be spent.

[*Translation*]

Luc Thériault: However, those discussions are taking place on the ground. You have directors and a very strong public service that manage the health networks. Some choices may not be the best, but who has the jurisdiction to manage the health care system? Is it those who aren't accountable for the results, or is it those who are accountable? Who knows what the needs are, is it the provinces or the federal government?

That's a basic principle, because money is limited. The provinces said they wanted an additional $28 billion per year for the next 10 years to ensure the network's strength, and the federal government offered them $4.6 billion a year for all of Canada.

Do you think that's a responsible attitude, as we come out of a pandemic?

[*English*]

Sandra Rao: I think that both federal and provincial governments have a responsibility to work together in order to meet these demands.

The Chair: Thank you very much.

I now go to the next round. It's a five-minute round, starting with Mr. Strauss for the Conservatives.

You have five minutes, please.

Matt Strauss: Thank you, Chair.

Dr. Padmos, that was very interesting testimony. Just for some housekeeping, I want to ask, have you ever received any sort of compensation, salary or funding from the Government of the Kingdom of Saudi Arabia?

Andrew Padmos: Certainly, when I worked there, I was treated very well financially, and, in fact, many of my colleagues enjoyed the same privilege. Since returning to Canada, no, I have not received any funding from Saudi Arabia.

Matt Strauss: How long were you in Saudi Arabia?

Andrew Padmos: I was there for 15 years.

Matt Strauss: I also see you're listed as being on the medical board of an outfit called iGan Partners. Is that accurate?

Andrew Padmos: iGan Partners is a Toronto-based venture capital firm. They have a clinical advisory panel, which meets occasionally. It hasn't met for the last year. It talks about medical devices and how they might be commercialized.

Matt Strauss: I see, on iGan's website, that they recently launched a $250-million fund called iGan Arabia, which was hosted at a Riyadh conference. Are you aware of that $250-million fund, and what amount of that—

Andrew Padmos: I'm aware of it. I haven't participated in any activities related to its function.

Matt Strauss: Do you know how much of that $250 million comes from the King of Saudi Arabia?

Andrew Padmos: Well, I think their plan is to attract $250 million from Saudi Arabian investors, in order to bring them into that ecosystem of health innovation.

Matt Strauss: How much money would you say, in total, you've received in compensation from iGan Partners?

Andrew Padmos: iGan Partners, for the advisory board, pays expenses and a stipend of $1,000 a day. That might be, in the most...year, would be four days at $4,000, but it hasn't met in two years, so nothing recently.

Matt Strauss: For the 15 years you were in Saudi Arabia, what would you say your total compensation was from the kingdom?

Andrew Padmos: Well, I know that, in the first year I went, which would have been 1978, I think my salary was just under $100,000. When I left, 15 years later, I think my salary was in the neighbourhood of $300,000. I'd say that was comparable to my cohort in Canada. The difference was that we were also provided with housing and transportation benefits, which made it, financially, quite attractive to be there. That was one of the advantages. The other advantage was that the sun shone almost every day.

● (1245)

Matt Strauss: Those sound like significant advantages.

In your work at medical schools and the Royal College.... My understanding of this whole visa training program is that the Saudis send extra money to have these trainees, and then that money rolls into the general funds of the medical school programs. Was your compensation at these medical schools in any way from the Government of Saudi Arabia as well?

Andrew Padmos: Well, I wasn't working for a medical school, in the sense that I have a privileged appointment at medical schools, but receive no salary as a result.

When I was in Nova Scotia, my salary was paid from the department of health, but for my administrative work, not from the university for an academic appointment. That's why I'm an adjunct professor, not a full professor in the university, and that's been through the Royal College. When I was there, of course, I was a salaried employee of the Royal College.

Matt Strauss: You were never a salaried employee of a medical school.

Andrew Padmos: No...well, when I worked for Toronto Metropolitan, I was there for two years to start up the medical school, and I was paid consulting fees to do that.

Matt Strauss: Does any of this amount to a significant conflict of interest to you?

Andrew Padmos: Well, I don't think so. In fact, I'm here because I firmly believe that the Saudi visa training program and many other programs known as the King Abdullah scholarship fund, which sent other students across the world, many to Canada in engineering and science areas, was probably one of the world's greatest technology transfer projects ever undertaken. It was socially transforming, because those trainees who came to Canada brought their families with them and went back imbued with our values, and I think—

Matt Strauss: I'm sorry. I have one other thing I want to get to.

You mentioned in your testimony that you recruited 12 hematologists to Saudi Arabia when you were there.

Andrew Padmos: That's correct.

Matt Strauss: Where did you recruit them from?

Andrew Padmos: They were from Europe, England and North America. We had one American, a couple of Canadians and a couple of Brits, and one was Danish.

Matt Strauss: I'll just put on the record that this all seems tantamount to producing a significant conflict of interest to me.

I'll bring to the committee's attention that at our first meeting, we discussed asking witnesses to disclose their conflicts of interest before speaking to the committee. I'll note that it is my understanding, Dr. Padmos, that you were invited by the Liberal members to speak at the committee. Is that correct?

Andrew Padmos: I'm not sure who invited me. I—

Matt Strauss: That is my understanding.

I have no other questions. Thank you.

Marcus Powlowski: I have a point of order.

The Chair: We have gone over time now. Thank you very much.

I think I'll go to the next questioner. That would be Mr. Powlowski for the Liberals.

Marcus Powlowski: I was just going to reply as a point of order on the conflict of interest. I don't think we've established that there's any conflict of interest.

I listened, and I know that Mr. Strauss asked Dr. Padmos a bunch of probing questions, which I think he responded to very well. I personally do not see any conflict of interest. He was asked quite a number of detailed questions.

Dr. Padmos, I'll give you the opportunity. You started to talk about the benefits of this program to Saudi Arabia and the culture of the medical community in Saudi Arabia. I would tend to agree with you that there are probably some very useful and helpful spinoffs as a result of this program. I'm going to give you the opportunity to continue your thoughts on that subject.

Andrew Padmos: Over the course of 45 years, the visa program has done all or part of the postgraduate training of some 20,000 Saudi physicians now practising in Saudi Arabia. They are pillars of their health system and they reflect and certainly connect to Canadian medical schools, Canadian hospitals and Canadian science in terms of advancing health care, both in Saudi Arabia and in any other countries where they interact.

Medicine is a scientific program. It requires a lot of brains working with shared goals, and I think that training up a whole cadre of Saudi physicians is a benefit not only for that country but also for the region, and definitely a benefit to Canada. Many of their Saudi graduates have had distinguished careers in fields of medicine and surgery.

In fact, I know personally of one who was a colleague at King Faisal who was invited back to do pediatric cardiac surgery in Canadian hospitals because he was a world-class, world-renowned physician. There are many benefits there that could and should apply to other types of training, because Canada has the advantage of a well-regarded system with extra capacity potential and the willpower to reach out and try and bring what we know and what we value to other countries around the world.

● (1250)

Marcus Powlowski: I certainly agree with you on that.

Dr. Rao, I don't know if you're aware of this, but I think your testimony will be added to the testimony of some other people the Conservatives brought before this committee, the theme being that immigrants are a big part of the problem in the health care system.

I've worked in health care. I was an emergency room doctor for 35 years. For the last five years, I haven't practised emergency medicine because I'm mostly here in Parliament, but I do some walk-in clinics.

I don't know if you're aware, but the last figure I could find was that 23% of the Canadian population was not born in Canada, so 23% are immigrants. However, 50% of the nurses working in Canadian health care are immigrants. I would suggest that the numbers are probably pretty similar for doctors. For PSWs, the numbers are even much higher.

On balance, yes, there are some costs to immigration, but there are also some benefits to immigration. If you're going to weigh the costs and benefits of immigration to the Canadian health care system, I would say, overwhelmingly, that immigrants have helped our health care system, not caused problems in our health care system.

You practise. You're practising a lot more than I am at the moment.

In my walk-in clinic, yes, I see people who are here on work permits, people who have PR status. Yes, there are quite a few of them, but for the most part they're young. There's nothing wrong with them. They don't need artificial knees. They don't need artificial hips. They don't need colonoscopies. They don't need biopsies. They don't go to ICUs. They're not the people come in with oxygen prongs in their noses. They're not the people who are asking for drugs. They're not the people with mental health problems.

Maybe your experience is different. Do you not feel that, for the most part, these are young people who, despite their numbers, don't have a lot of medical problems?

Sandra Rao: I will say that those experiences are probably reflective of your experience working in the walk-in clinic, so there's a little bit of selection bias.

I certainly do see a substantial number of immigrants, new immigrants, patients here on super visas, refugee claimants who are 80-plus years old—

The Chair: I'll ask you to please wrap up your answer, Dr. Rao.

Sandra Rao: —who have complex medical needs.

The Chair: Thank you.

I go now to Monsieur Thériault.

[*Translation*]

You have the floor for two and a half minutes.

Luc Thériault: Mr. Padmos, how many women from Saudi Arabia are being trained at our universities?

[*English*]

Andrew Padmos: There are quite a few, probably at least 50% of the trainees.

[*Translation*]

Luc Thériault: We're helping to ensure that 50% of the people trained in our universities are women who will practise in Saudi Arabia.

[*English*]

Andrew Padmos: Yes, that's correct.

[*Translation*]

Luc Thériault: Do human rights mean anything to you?

[*English*]

Andrew Padmos: Well, I think we all have challenges. I think the Saudis have particular challenges. I think they've made progress.

Do I believe that it reflects on the individuals I've come in contact with? No, I'd say that these are people I'd be proud to be with, whether in Canada or in Saudi Arabia.

Do I like the politics? Not a lot. Do I like other politics near us? Not a lot.

It's an important question, but it's one that I've learned to live with in my own way.

[*Translation*]

Luc Thériault: The World Health Organization urges us to consider the ethics of this issue. I imagine that things were different in 1978 than they are today, but don't you have any issues with going to practise in Saudi Arabia and putting your skills to use for a regime that doesn't care about human rights?

You could have chosen to practise elsewhere, where human rights are respected. Why did you choose to leave Canada to go to Saudi Arabia? I thought I understood that it was because you had financial benefits that you didn't have elsewhere. Am I wrong?

● (1255)

[*English*]

Andrew Padmos: Well, I think you're mistaken in saying that I left because of the monetary benefits, which were neither extreme nor continuously advantageous. I could have had, and was having, a very promising career here in Canada, so it wasn't really a choice between less and more; it was a choice of where.

As I said, we initially, as a family, went for two years—

The Chair: Dr. Padmos, can you wrap up, please? We're out of time. Thank you.

Andrew Padmos: —and were happy to have the experience to stay there longer.

The Chair: Thank you.

I will go to the Conservatives for five minutes.

Go ahead, Mr. Bailey.

Burton Bailey: Dr. Padmos, am I correct that Saudi training is a source of revenue for universities?

Andrew Padmos: That's correct.

Burton Bailey: You would have lived in a compound while you were in Saudi Arabia. Did you not see the human rights violations that were going on around you in the hospital setting?

Andrew Padmos: I'm not sure which specific type of human rights violation you might be referring to.

Burton Bailey: I mean any, or were you just totally naive to them?

Andrew Padmos: No, I wouldn't say naive. We were open. We accepted any patient in my area with a malignancy. The hospital specialized in that area, so the socio-economic strata were certainly mixed and even.

Burton Bailey: Dr. Rao, I want to get a better understanding of your fee-for-service payment. It's a mix. It's a blend.

Do you have good faith billing in Ontario?

When an individual comes from another country and they're severely injured and you automatically just treat them, would the province pay you, even though they don't have medical insurance? Is there good faith billing?

Sandra Rao: Do you mean patients who have no insurance, or patients covered by OHIP?

Burton Bailey: That's correct. Somebody presents in the emergency room with no coverage, and you treat them. Is there such a thing as good faith billing?

Sandra Rao: We would treat them unconditionally. In terms of the government reimbursing us if the patient does not pay, no, that does not exist.

Burton Bailey: Thank you.

In Alberta, they've just reinstated good faith, because a lot of the physicians were at the point where it was up to $30,000 to $40,000 per physician in the emergency departments and for specialists, and they were not being paid.

What type of data is collected when the patient comes in? Are you familiar with their Ontario health number that shows that they don't have coverage? Do you know if they are...? Is their citizenship data or any type of data collected or presented to you as you're seeing that patient?

Sandra Rao: For any patient coming in, I would be able to see what type of health insurance they have, whether it's OHIP, private insurance or no insurance at all. I personally would not have any access to their citizenship status to know whether they are a permanent resident or a citizen or a temporary worker. It would just be their health coverage.

Burton Bailey: When it comes to uninsured patients, as you said, you treat them in the emergency room. Are you familiar with what happens with them when they get up to the ward and who would offer them services? Have you ever encountered this?

Sandra Rao: While they are on the ward, they continue to be treated by in-patient physicians who, I believe, would individually bill them at their own discretion.

Burton Bailey: They would individually bill them. Okay.

Sandra Rao: That's correct.

Burton Bailey: Do you think it's fair that provinces are having to bear the health care burden for an increased population, without consultation, because of the unprecedented increase in federal immigration policy numbers?

Sandra Rao: No, I do not believe that is fair.

Burton Bailey: Would a standardized national licensure system for health care professionals be a net benefit to Canadian health care?

● (1300)

Sandra Rao: Yes, it would.

Burton Bailey: International immigration has led to an explosion in population growth, far exceeding capacity in health care infrastructure and human resources. Do you believe it is fair that provinces are made to bear all the health care burdens from federal immigration policy without consultation on means?

Sandra Rao: I do not think it's fair. I believe there should be consultation with the federal government in terms of what is feasible at the provincial level.

Burton Bailey: Maybe you were aware of the 1,100 Saudi doctors who are working here. Why could the Canadian-trained physicians who are in Ireland or in this other school that you're opening up in the Caribbean not get the same offer to fill these extra spots that the university creates for privileged people?

Sandra Rao: I can only imagine that it's due to funding, that there's no extra funding by the government for these positions.

Burton Bailey: Thank you.

The Chair: I go to the next questioner—

Doug Eyolfson: Madam Chair, seeing the clock at 1:02, I move that the meeting be adjourned.

Dan Mazier: No. I have a point of order.

The Chair: I'm sorry; a motion to adjourn is not debatable.

(Motion negatived [*See Minutes of Proceedings*])

The Chair: I will allow us to have one more round. I warned this committee at the beginning that we have a difficult time getting people in the middle of a meeting being miked, etc. It takes up time. I will not guarantee, unless this committee unanimously agrees to go overtime in every single meeting, that we will finish.

Ms. Chi, you have five minutes, and then I will adjourn the meeting.

Thank you.

Go ahead, Ms. Chi.

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

I will keep it quick, because we are at one o'clock. Thank you for the witness for staying overtime to support the committee. I will keep it very short.

Dr. Rao, which health network are you working under right now?

Sandra Rao: It's the Scarborough Health Network.

Maggie Chi: I know there are many challenges facing the Scarborough Health Network. Could you outline some of the challenges you've seen? Have you seen provincial investments in opening up new wings or provincial investments in new programs during your time there?

Sandra Rao: Certainly our network is doing a great job at increasing supports for all levels of care within our ED as well as—

Maggie Chi: I'm sorry to interrupt. I just want to keep it very short.

Has there been provincial investment in programs?

Sandra Rao: There has been, yes.

Maggie Chi: Can you outline if it's infrastructure or if it's a new, for example, dialysis centre? Can you outline some specifics?

Sandra Rao: It's supports for primary health care, for interprofessional health teams to meet the unmet needs of primary care in our community.

We are also renovating at least two of the three hospitals.

Maggie Chi: Which hospitals are they?

Sandra Rao: They're Centenary and Scarborough General.

Maggie Chi: Would you say that those are aging infrastructures that haven't been receiving funds for many years and have been left aside by the provincial government?

Sandra Rao: I cannot comment on the specifics of the funding of the hospitals by the provincial government.

Maggie Chi: Are you aware of the funding structure for building hospitals and funding hospitals and resources?

Sandra Rao: I'm not directly informed of the funding structures for these hospitals.

Maggie Chi: Okay. Thank you.

I'm aware of some of the struggles that the Scarborough Health Network is facing. A lot of it is aging infrastructure, as I'm sure you've seen first-hand.

In terms of some of the support, would you agree that the province can do better in supporting folks on the ground?

Sandra Rao: I think the province could always do better.

Maggie Chi: Thank you so much.

Those are all my questions.

The Chair: Thank you very much.

I want to thank—

Dan Mazier: Chair, I have a point of order.

The Chair: Yes, go ahead on a point of order.

● (1305)

Dan Mazier: I just want a simple UC on the previous.... We talked about it last time. It's the clerk's witness list.

The Chair: Excuse me; you cannot move a motion, Mr. Mazier, on a point of order. I'm sorry. This is a motion you're talking about, is it not?

Dan Mazier: It was a UC motion that we all agreed to—

The Chair: Yes, and you cannot move a motion on a point of order—

Dan Mazier: —and the clerk is requesting clarity.

The Chair: You cannot move a motion on a point of order.

Dan Mazier: I have another UC motion, asking for digital binders.

The Chair: You cannot move a motion on a point of order.

I would ask the member to read—

Dan Mazier: I'm not moving a motion. It's all tabled. I'm asking for UC, Chair.

The Chair: It doesn't matter whether the motion's been on the table or not—

Dan Mazier: I'm asking for the committee to hear—

The Chair: You're moving a motion on a point of order.

Dan Mazier: I'm asking—

The Chair: I think you should try reading the rules in the green book.

The meeting is adjourned.