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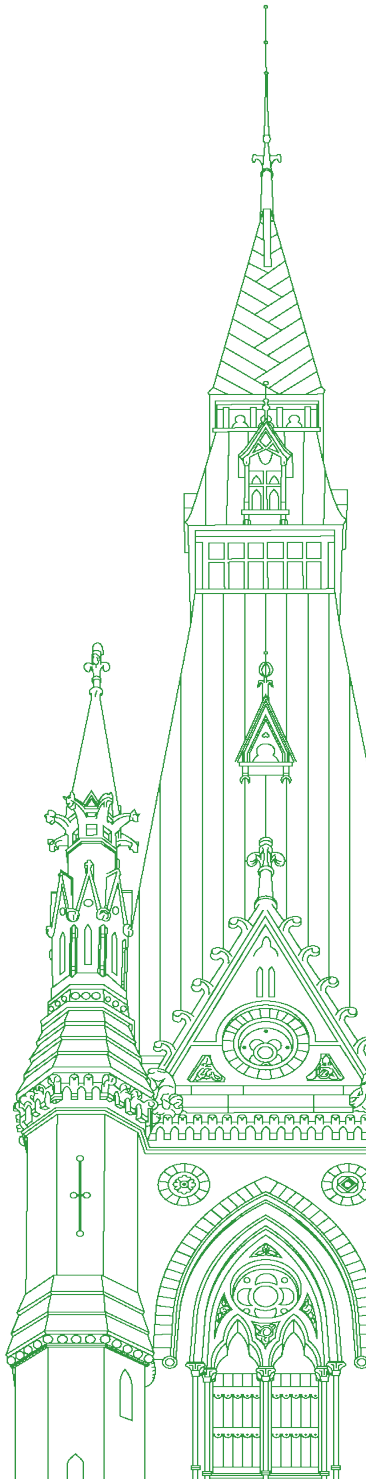
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Chair: Sukh Dhaliwal

Standing Committee on Health

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● (1105)

[*English*]

The Chair (Sukh Dhaliwal (Surrey Newton, Lib.)): I call this meeting to order.

Good morning. Welcome to meeting number 41 of the House of Commons Standing Committee on Health.

Today's meeting is taking place in a hybrid format, pursuant to the Standing Orders. I would like to remind participants of the following points. Please wait until I recognize you by name before you speak. For those participating by video conference, click on the microphone icon to activate your mic. Please mute yourself when you are not speaking. At the bottom of your screen, you can select the appropriate channel for interpretation: floor, English or French. For those in the room, if you wish to speak, please raise your hand. For those on Zoom, please use the raise hand function.

All comments should be addressed through the chair, but I have some leeway here. I don't want to interrupt honourable members and witnesses, because you need to have your clips ready. My style will be this. Honourable members, raise your hand if you want witnesses to stop speaking. Honourable witnesses, please keep eye contact with the honourable member who is asking the question. As soon as they raise their hand, please stop speaking. If I raise my hand, the same thing applies.

The clerk and I will manage the speaking order as best as we can. We appreciate your patience and understanding in this regard.

Pursuant to Standing Order 108(2) and the motion adopted by the committee on Wednesday, September 23, 2026, the committee shall commence its study of diagnostic imaging capacity.

Before I welcome the witnesses, I would love to welcome my dear friend Brad to the meeting. Mr. Redekopp and I have worked together on other committees.

Turning now to our witnesses, we have, from BC Cancer, Dr. Devin Schellenberg, senior executive medical director, radiation therapy and medical programs.

Dr. Schellenberg, welcome.

From the First Nations Health Authority, we have Gary Housty, vice-president, quality, chief nursing and allied health officer; and Dr. Karen Mooder, director, provincial clinical innovation, office of the chief nursing and allied health officer.

Welcome, Mr. Housty and Dr. Mooder.

From the Society of Rural Physicians of Canada, we have Dr. Sarah Giles, president and rural generalist physician.

Dr. Giles, welcome to the meeting.

I would like to remind all witnesses that committee members may ask questions in English or French. If you need interpretation, please take a moment now to prepare your earpiece and select the listening channel you need in advance in order to take full advantage of the time allotted for questions and answers.

Each organization will have five minutes for opening remarks.

We will start with Dr. Schellenberg.

Dr. Devin Schellenberg (Senior Executive Medical Director, Radiation Therapy and Medical Programs, BC Cancer): Good morning, and thank you for inviting me.

My name is Devin Schellenberg. I'm a radiation oncologist who sees patients and has an administrative position, as you've already alluded to. Two of the pertinent medical programs I oversee are the small radiology department at BC Cancer—Vancouver and the provincial molecular imaging therapy program responsible for the four publicly health-funded PETs within the province of B.C. I'm calling in from the Surrey cancer centre today in the lands of the Coast Salish peoples.

Prior to this call, I was able to connect with Mr. Ken Winnig, who heads the provincial medical imaging office; and Dr. Maura Brown, who is the radiologist leading the Vancouver cancer centre radiology department. Though my expertise is in cancer treatment, I do recognize the wide-reaching aspects of diagnostic imaging beyond cancer care.

I will limit myself to a few crucial points in responding to the six aspects listed in the motion adopted by the committee on June 16, 2026, pursuant to Standing Order 108(2).

Obviously, across B.C., we've seen wait times for CT and MRI increase substantially over the past five years. This has not kept up with blossoming demand, though capacity has increased. Currently, we aim to scan priority two or urgent patients within seven days, but it takes us 43 days to scan 93% of those priority two patients. We don't have numbers specific for cancer, but the waits are similar whether you have cancer or not.

The wait is not surprising as CT and MRI per capita are lower in Canada than almost all OECD nations. Across the OECD, on average, there are 32 CTs per million people. Within Canada, there are only 14.

It's important to acknowledge that it's not only a bottleneck of CT, MRI, and PET infrastructure, but also a lack of human resources. A 2026 B.C. survey identified shortages for all of our radiology technologists, but most acutely in CT and PET, where approximately 15% of positions are vacant. This is even greater in small cities and towns.

This leads to consequential delays. For my practice, this means initial cancer diagnosis delays or forgoing a PET scan to get onto treatment in a more timely manner. I also think we've mislabeled it as diagnostic imaging. This is a disservice to what the scans truly are.

These are scans that are not used just to make diagnoses; these also guide treatment decisions. They are imperative to ongoing surveillance of whether a treatment is working, and they are needed so that one doesn't miss a point in time when changing a treatment course might alter survival. We don't need one diagnostic scan in cancer; we need ongoing scans to monitor the patient and give further lines of chemotherapy and radiation. We've modelled our scanner needs poorly because, though we were accounting for population growth and aging, we did not account for the improved cancer survival and each person needing scans over a five- to 10-year horizon versus a simple diagnostic scan.

What are the barriers? I think I've touched on many regarding the scanners and staff, but efficiency is also a barrier presently. We have multiple requests coming in. We have doctors hospitalizing patients to facilitate scans. These are inefficient processes.

What are the innovative approaches? Well, I think AI is one of them. Artificial intelligence can reduce acquisition times for MRI sequences and improve quality and clarity. It allows CT sequences to be individualized to body parts or certain pathologies.

In B.C., another approach that has been undertaken is a non-universal model. B.C. has private imaging options for CT, MRI and PET. Health authorities have partnered with private clinics to increase capacity with the caveat that this may increase costs, draw technologists and radiologists outside of the public system, and undermine confidence in a public, universal system. We aim to reduce our reliance on the private system if that is possible.

What can the federal government do? I think the government can fund infrastructure. This includes medical infrastructure—such as scanners and software from training programs—and bursaries and return of service agreements, to encourage technologists and radiologists.

We are bringing in outside health care workers presently for good jobs in Canada, which is very important, but even more so, we need strong domestic training programs to train Canadians for those good jobs.

Thank you, Mr. Chair.

● (1110)

The Chair: Thank you, Dr. Schellenberg.

We will now go to the First Nations Health Authority.

Between the two of you, you have five minutes. Please take your time.

Gary Housty (Vice President, Quality, Chief Nursing and Allied Health Officer, First Nations Health Authority): Thank you, Mr. Chair.

Yáu ḥaíxsʔáukva. Greetings. Hello. Good morning to the chair and the committee.

We are appearing on behalf of the First Nations Health Authority in British Columbia. Karen and I are calling in from the Coast Salish territories of the Squamish Nation.

My hereditary chieftainship title is Náċi, and my ancestral Heiltsuk name is Ḵvsḷm̓ṇixv. I am Gary Housty, a registered nurse, the vice-president of quality and chief nursing, and the allied health officer here at the First Nations Health Authority.

Karen Mooder (Director, Provincial Clinical Innovation, Office of the Chief Nursing and Allied Health Officer, First Nations Health Authority): Good morning, Mr. Chair.

My name is Karen Mooder. I am a settler of northern European ancestry and a clinical scientist by background. I serve as the director of provincial clinical innovation with the FNHA's chief nursing and allied health office.

Gary Housty: The First Nations Health Authority is Canada's first and only province-wide, first nations-led health organization, serving 203 first nations communities across British Columbia. Since 2013, FNHA has been responsible for the planning, funding and delivery of health and wellness services that were previously delivered by Health Canada to first nations in British Columbia.

We are grateful for this opportunity to highlight two key issues relating to diagnostic imaging capacity and inequitable access experience by first nations peoples living on reserve in British Columbia.

The first is access barriers arising from the placement of diagnostic imaging services in urban, colonial centres, far away from the rural, remote and isolated reserve communities where first nations peoples live in B.C., because of colonial policies.

Second, given the historical and ongoing first nations-specific racism within the Canadian health system, it is important to embed cultural safety and cultural humility across diagnostic imaging legislation, regulation, workforce planning, funding and accountability.

Addressing these barriers and facilitating first nations' access to diagnostic imaging capacity holds immense potential for enhancing health outcomes and generating cost efficiencies. My colleague Karen is going to share an example of how the FNHA has demonstrated this potential by implementing X-ray systems in remote first nations communities. Karen is also going to bring a focus to four areas of opportunity to promote diagnostic imaging scaling while enhancing equitable access and culturally safe health outcomes for first nations in British Columbia.

● (1115)

Karen Mooder: In 2022, the FNHA pursued federal digital technology supercluster funds to place X-ray systems in remote first nations communities in B.C. This adoption was driven by FNHA data indicating that, yearly, more than 5,000 first nations people in B.C. use medical transportation to access diagnostic imaging at an estimated cost of $4 million annually.

Initial adoption included two remote nursing station communities, with scope limited to chest and extremities X-rays to address tuberculosis and trauma burdens often faced by first nations communities in B.C. A mobile system was added in 2024 to strengthen access to community TB screening clinics across B.C. These X-ray pathways have now operated for four years, capturing digital images in community and interpreted by both radiologists and TB specialists hundreds of kilometres away.

Results have been encouraging. A first nations-led design has created an equitable X-ray access pathway never imagined by the B.C health system. Provincial TB care coordination has been strengthened, including eligibility assessments for TB preventative treatment that have increased by 400% compared to baseline. The two communities using these X-ray systems have also generated substantive medical transportation savings over four years, with additional savings to regional health authorities and the system at large still being evaluated.

Having demonstrated the feasibility and impact of low-complexity and culturally safe diagnostic imaging modalities such as X-ray in remote first nations communities, FNHA is now focused on expanding and scaling these models. To support broader adoption, we see four key opportunities.

First, provide sustainable capital and operational funding targeted to address unmet diagnostic imaging needs in B.C.

Second, ensure a diagnostic imaging regulatory environment that reflects and responds to the experiences of first nations peoples accessing care.

Third, support innovative health human resource design for diagnostic imaging service delivery.

Fourth, fulfill authentically the Truth and Reconciliation Commission calls to action 18 to 23 to address racism and discrimination in the health system and ensure first nations equitable access to culturally safe diagnostic imaging care.

Due to time constraints, I have kept discussion of these barriers to our written brief. We also acknowledge unmet needs and use cases for other diagnostic imaging modalities, including ultrasound and mammography.

Thank you for inviting us to contribute to this important discussion.

The Chair: Thank you. That was perfect timing.

We'll now go to Dr. Giles.

Please go ahead for five minutes.

Dr. Sarah Giles (President, Rural Generalist Physician, Society of Rural Physicians of Canada): Good morning.

Thank you, Mr. Chair, and members of the committee.

My name is Dr. Sarah Giles. I'm the president of the Society of Rural Physicians of Canada. I represent 3,500 rural physicians and learners across the country. I'm a rural generalist in Kenora, Ontario. I'm a family doctor with extra training in the skills that my community needs.

My hospital is 500 kilometres from our tertiary care centre in Thunder Bay. Until our MRI opened last year, that meant a 1,000 kilometre round trip for my patients along Canada's deadliest stretch of highway to get the imaging they needed.

I want to walk you through what rural patients go through when they're transferred for imaging, and I'll use the example of a patient called Joe.

Joe is an 80-year-old male who lives in Neepawa, Manitoba. He falls off a ladder, hits his head and is taken to the ER. Joe has a normal exam in the ER, but because he's over 65, guidelines suggest that he needs a CT scan of his head to rule out a bleed. However, the closest CT scanner is in Brandon.

The ER doctor phones and arranges the scan and calls for an ambulance, but the paramedic vacancies in that region are 43%, and it takes two and a half hours to find an ambulance crew and a nurse to travel with the patient. They drive Joe 45 minutes to Brandon, he waits for a scan, and then waits an hour for the report. The paramedics and nurse wait with him because they can't leave until they know whether he's going to be admitted, transferred or repatriated. The scan is normal. They all return to Neepawa where Joe is discharged. That normal scan took three hours of paramedic and nursing time and delayed Joe's care by almost six hours compared to a patient in a hospital with a CT scanner.

Underinvestment in rural imaging means dangerous delays, increased morbidity and mortality, higher transportation costs, and fewer ambulances by land and air for other critically ill patients.

Please understand that any accounting for the cost of poor access to diagnostic imaging must include paramedic and nursing time and lost ambulance coverage. A large share of NIHB's medical transportation budget goes to moving patients for imaging. Strategically placed imaging equipment is a better investment than transportation. It improves outcomes, saves money and is a step towards reconciliation.

How important is advanced imaging? For perspective, the Canadian Forces ran not one but two CT scanners in Kandahar in 2009. Seventeen years later, each territory—Yukon, Northwest Territories and Nunavut—has just one CT scanner, and Yukon has the only MRI north of 60.

Readying our northern border for military presence, not to mention the social responsibility we owe people living in that region, will necessitate large investments in diagnostic imaging. Kenora, where I live, shows what is possible. We serve 15,000 people and 11 nearby first nations. Since our MRI opened in September 2025, our hospital estimates that it has saved $1 million in travel grants and $352,000 in inpatient and transfer costs. It has also freed up roughly 3,000 MRI spots in Thunder Bay and Winnipeg. Simply adding another MRI in either of the big cities would not have produced these savings. Rural investment pays dividends.

We see four practical opportunities.

First, run existing machines around the clock. Many MRIs and CTs sit idle for hours. Running them longer adds capacity and shortens wait times.

Second, centralize regional intake for imaging referrals. Today, patients collect multiple referrals to see which is fastest. A single point of entry would allow consistent triage and let rural patients choose between speed and care closer to home.

Third, use remote technology to stretch scarce technologists. Telerobotic ultrasound is already running in five northern Saskatchewan communities, operated by a sonographer in southern Saskatchewan. In B.C., there was a trial of remote scanning platforms, letting one on-call technologist run CT and MRI scans across several sites.

Fourth, we need to harness the power of AI. My emergency department uses AI to help read X-rays. It can help act as a second set of eyes, and it has caught fractures that I have missed. Using AI reduces patient callbacks and helps to improve efficiency.

Finally, there are two cautions.

First, private imaging clinics in southern Canada that allow paying patients to skip the line likely draw technologists and radiologists away from rural and remote communities. Governments need to scrutinize these facilities through an equity-informed lens and under the Canada Health Act.

Second, more scanners alone are not the answer. Scans can produce incidental findings that lead to more scans. Solutions must be built around equity for rural and remote patients, the workforce pressure on diagnostic imaging technologists, radiologists, nurses and paramedics, and sound fiscal policy.

Thank you. I look forward to your questions.

● (1120)

The Chair: Thank you. That was perfect timing, Dr. Giles.

Honourable members, because there are four witnesses, if you can mention to whom your question is directed, that will make it easier for me, and I won't have to intervene.

As a friendly reminder to witnesses, please keep eye contact with the honourable member asking questions because it's their time. If they raise their hand, please try to stop. At the end of the time allocated, I will raise my hand, which means that the time is up for the honourable member.

With that, we will go to Mr. Bailey for six minutes.

Please go ahead.

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

Dr. Giles, through the chair, I'd like to ask you a few questions.

A recent report from Deloitte and the Canadian Association of Radiologists shows that medical imaging wait times are costing Canada's GDP $64 billion per year. Canadians in rural and remote communities face systematically longer wait times and far less local access to CTs and MRIs than people in urban centres.

Is it correct that fewer than 20% of rural hospitals have CTs on site and that 24-hour or weekend MRI coverage is virtually non-existent?

● (1125)

Dr. Sarah Giles: I'm not familiar with the exact numbers, and I would say that it's hard to find exact numbers because there is huge disagreement across this nation as to what is considered a rural or remote hospital. CIHI says that a rural community has fewer than 10,000 people. Mine has 15,000, so I guess we don't count.

I'm not aware of any rural MRIs or CTs that run around the clock. Certainly, our MRI is a banker's-hours operation. One of the huge problems is, of course, staffing that service 24 hours a day.

There is opportunity to increase capacity by having these run 24 hours a day. Of course, you would need technologists, nurses and radiologists to have increased capacity.

Burton Bailey: You indicated that there are 3,500 rural physicians across Canada. Is that because if the population is under 10,000 it's a rural hospital?

Dr. Sarah Giles: I represent 3,500 rural physicians in Canada. They are paying members of my organization. Again, we would love to say how many rural doctors there are in Canada, but everyone has a different definition.

I'd say that if you have one Tim Hortons or fewer, you're probably rural.

Burton Bailey: All right.

A new peer-reviewed study in the Health Policy journal released in October highlights the gross shortage of family physicians. By 2034, it will be over 25,000.

Would Canada benefit from a national licensure standard for physicians, technicians and other medical professionals?

Dr. Sarah Giles: Absolutely. We know we have data from the SRPC that says that rural physicians will not simply move from where they are and go to Toronto. We like where we work and love our communities. However, if we had the ability to hop over a border to help friends, or to head north to help out a similar community, we would do that.

National licensure is one way to help with the distribution of physicians problem.

Burton Bailey: You would rely on locums as well, I'm sure. That would probably be the only chance you'd get to take holidays.

Dr. Sarah Giles: More than 50% of shifts where I work are currently covered by locums, most of whom fly up for one shift at a time.

Burton Bailey: Ouch.

Regarding health care spending, we rank second-highest out of the 32 universal health care countries. In delivery of care, Canada ranks 29th.

Would you say that Canadians are receiving timely and high-quality universal access to care within Canada's health care system?

Dr. Sarah Giles: I think it depends on where you are, who you are and what the situation is.

There are certainly problems with our system. However, I do not believe having a private pay system is beneficial. It creates duplication and takes people out of the public system.

There are definitely ways to improve our system, and bolstering rural and remote medicine is a huge way to improve capacity. By preventing us from needing to ship patients to the city, we save on transportation costs and free up beds in the city. Rural investment pays dividends.

Burton Bailey: We're seeing that. I'll use an example in Alberta. They're using rural ORs.

Are you seeing that in your province, surgeons coming in and using the operating room? Do you have an operating room?

Dr. Sarah Giles: Absolutely. Both of our operating rooms were even running on weekends, with specialists, before they were flooded in April, unfortunately. We lost the ability to use them, but we'll be back up and running in December.

It's been hugely successful, bringing in specialists rather than shipping our patients out. They get cared for locally. We look after them at their local hospital where their family can visit them. When they're ready, we discharge them home.

Burton Bailey: Do you have nurses and radiologists on call when an emergency arises on a weekend, in order to use those ORs, or is it just not plausible, so they're sent to larger centres?

Dr. Sarah Giles: We have general surgeons who are always here with us and always on call. There are nurses for the OR and an anaesthetist always ready to go, regardless of whether or not we have specialists in-house.

Burton Bailey: What about the radiologist? Would they be on call?

Dr. Sarah Giles: We have a radiologist who works nine to five, Monday to Friday. On off-hours, a group out of Toronto reads virtually for us.

Burton Bailey: I know you talked about Joe a little bit, but right now, for rural patients and urban patients, the national wait times are 84 days for MRIs and 66 days for CTs. What is the existing system not providing? I know you said that 24-hour service might increase it. Are there any other things that would help speed up these wait times?

It will have to be a very short answer.

● (1130)

Dr. Sarah Giles: One thing would be centralized booking, as I said, to maximize triage efficiencies and to give patients the choice of where they want to go. Many patients would be willing to drive several hundred kilometres to get a scan faster.

Burton Bailey: Thank you.

The Chair: We'll go to Dr. Jaczek for six minutes.

Hon. Helena Jaczek (Markham—Stouffville, Lib.): Thank you so much, Mr. Chair.

Thank you to all of our witnesses.

My first question is for Dr. Schellenberg.

Towards the end of your presentation, you talked about specific areas where the federal government could assist in terms of diagnostic-imaging capacity. I think we need to bear in mind, of course, that the delivery of health care is the responsibility of provinces and territories. We know that our Minister of Health, Marjorie Michel, is working very earnestly in terms of the Canada health transfers and working together agreements. Could you just expand again a little bit on what else the federal government in particular could do?

Dr. Devin Schellenberg: Thank you.

For us, there are a couple of issues. All three of us at this meeting have talked about HHR in different formats, and I think that is where the federal government could help, either with bursaries or—with regard to Dr. Giles, I think—with the return of service agreements with rural physicians. Getting people to train outside their home communities is a necessity, but they need to come back to their home communities or to rural communities. That's outside of cancer care, but I definitely see the expansion of slots for both medical professions in radiology—the people running the ultrasounds and running the CT scans—and the physicians reading those as a wonderful investment in terms of giving good jobs to Canadians.

I think the other aspect is....

I'm sorry. I'll let you speak.

Hon. Helena Jaczek: Carry on. I'm really interested in this aspect.

Dr. Devin Schellenberg: The other aspect is infrastructure. I feel that medical infrastructure is important infrastructure for Canada, and we lag behind in terms of the number of PET scans we have across various provinces outside Quebec, and also with CT and MRI. As our population ages and as we grow as a country, having that kind of infrastructure is very important. It's almost as important as roads and bridges. As Dr. Giles said, if we don't have that infrastructure, someone has to take three bridges just to get to the nearest CT scan.

Hon. Helena Jaczek: I concur. The only issue is that, in many cases, federal ministers of health have tried to connect the transfer payments to the provinces with specific areas—in this case, it might be medical technology—and this hasn't always actually resulted in those areas being concentrated on by the provinces and territories. There's been quite a dilemma in terms of that. However, hopefully they would agree when it comes to diagnostic-imaging capacity.

Now, very much like MP Bailey, I think we've been quite astonished by the increase in the number of scans being done across the country. We have some statistics. In the last 15 years, the number of scans has doubled. Our population clearly hasn't doubled. You specifically mentioned staging cancer and the requirement for far more frequent scans, and I can see that this would be part of the reason that we're seeing so many more scans in general.

However, we've also heard that there are private clinics doing whole-body MRIs for, primarily, reassurance of the patient, presumably. You're with BC Cancer, but are you aware of anyone studying whether some of these scans are, in fact, medically necessary? Are there any statistics related to this that you're aware of?

Dr. Devin Schellenberg: No. I don't know; if you're speaking about private clinics, I think the private clinics, at least in B.C., are often doing medically reasonable scans for people who want a scan earlier than they can get in the public system. I don't think a lot of people are just getting scans for reassurance purposes. Unfortunately, I think they're serving a need that a patient perceives is not being met in the public system. I think that's very unfortunate.

● (1135)

Hon. Helena Jaczek: I think it would be an interesting area of study by somebody.

Dr. Giles, I was really impressed that you were able to get the equipment you needed in Kenora. You've been very clear on the cost avoidance in terms of travel, and even the use of paramedic services in transportation, etc. Now that you have the scan you need, I'm extremely interested in the whole issue of personnel required to operate, to interpret and so on. You alluded to the remote staffing use of AI. Could you expand a little bit on how that is being operationalized?

Dr. Sarah Giles: Thank you very much.

Our fabulous community and our summer guests who come from Winnipeg as our cottagers raised $8 million to bring an MRI to Kenora. They must be commended. Local people went and got training to be able to run the MRI. In Kenora they're mostly young women, so we do run into some difficulty sometimes when people have to go on maternity leave or miss for other reasons.

Most of our MRIs are read in town by our radiologists during the day. Some of the more specialized scans are read by others at times. We don't currently have any AI, that I'm aware of, reading our MRI scans. We have AI helping us in the ER. It looks at our musculoskeletal images. I had a gentleman, for instance, who fell off a ladder and hurt his foot. I looked at it and thought, “Oh, that calcaneus doesn't look good.” It agreed with me. We were both on the same page. But sometimes AI and I will have a difference of opinion. That causes you to take another look. It's not perfect, but I'm not perfect either. It's a double-check that is helpful.

We do know that there's technology out there to read—

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

Next is Madame Gaudreau.

Madame Gaudreau, you have six minutes.

[*Translation*]

Marie-Hélène Gaudreau (Laurentides—Labelle, BQ): Thank you, Mr. Chair.

Thank you, witnesses.

You know, health is precious. Obviously, it is entirely legitimate to raise questions about health care. However, I must be clear: the organization and delivery of health care services are the responsibility of the provinces.

Here, we are talking about delivery. My aim, of course, is to ensure that the federal government does its job and that the provinces can do what they do best: manage magnetic resonance imaging, or MRI, particularly in Quebec. This is invaluable. There is even a foundation that has been set up in a small town to acquire an MRI scanner, because more than 20,000 people have to drive two hours to access services.

In 2026-27, the budget of Quebec's Ministry of Health, Prevention and Seniors stands at around $60 billion. However, Quebec's total program expenditure amounts to approximately $134 billion. This means that 45% of Quebec's program expenditure goes towards health and social services.

The federal government, for its part, is responsible for providing the necessary funding to the provinces—the so-called health transfers—for ensuring compliance with the Canada Health Act, for regulating medicines and medical devices, for supporting research and innovation, for taking action on public health—as we have seen in recent years—and for providing certain services to populations under its direct jurisdiction.

I met with the minister—not to say “our minister”—who was the first to say that, given the fine line involved, it is important to ensure that efforts are maximized.

So, I would like to ask you, honourable witnesses: if Ottawa wishes to invest in MRI, why not channel funds down to the provinces rather than managing or setting up new programs? The provinces often have different criteria and different administrative structures. Should Ottawa provide the provinces with what they need?

You may take turns to reply.

● (1140)

[*English*]

The Chair: We'll go to Dr. Mooder, then Mr. Gary Housty, Dr. Giles and Dr. Schellenberg, in that order.

Go ahead, please, Dr. Mooder.

Karen Mooder: Thank you, Mr. Chair.

I'll preface my comments by saying that I don't know if I'm entirely qualified to comment on this question. It's such an important one.

There is a critical role for the federal government. It could bring all the provinces and territories along in a coherent strategy for health, given that it is responsible for the transfer of health funding to each province and territory. However, it is up to the provinces and territories to determine how they are going to best design services when using those funds to their fullest potential. One of the things the Truth and Reconciliation Commission upheld was the importance of the federal government in ensuring that provinces and territories are aligned with the calls to action.

In terms of B.C.'s position, despite DRIPA and commitments made to the Truth and Reconciliation Commission's calls to action, we still aren't seeing profound action to lift up those principles of reconciliation when it comes to health service delivery.

I'll end my comments there and pass it to my colleague Gary.

Gary Housty: Thank you, Mr. Chair.

What I was reflecting on while listening to the question—as well as to my colleagues' presentations and questions— was the work of the First Nations Health Authority. The core mandate is to improve health outcomes for B.C. first nations. The challenges our regional partners have in the province—I heard Dr. Schellenberg share those, as did Dr. Giles, nationally—are compounded when we send our community members to urban centres for diagnostic services. There's a double challenge encountered.

In terms of a rural and remote lens, the first nations population in B.C. is the second-largest, after Ontario's. That's from census 2021. In the geography of British Columbia, these communities are situated remotely and quite far from urban centres, as we've been describing. Often, clients have to travel up to 800 kilometres to get to an urban site and to an X-ray, an MRI or a CT scanner.

The one challenge I would add is that, in our remote sites, we often call nursing stations “outpost nursing stations”, because—

The Chair: Thank you very much, Mr. Housty. The six minutes are up.

Because we went about 30 seconds over on the Liberal side, I'm going to give 30 seconds to the Conservative side and to the Bloc. I'll give Dr. Giles and Dr. Schellenberg 15 seconds each.

Please go ahead.

Dr. Sarah Giles: Very quickly, the federal government has a responsibility to first nations and Inuit health, but this has traditionally been massively underfunded. They could, for instance, grant a one-time catch-up for infrastructure through a massive investment in this portfolio.

● (1145)

The Chair: Thank you.

Dr. Schellenberg.

Dr. Devin Schellenberg: I feel underqualified to answer this question.

Targeted funding might be an option. Certainly, try to use the MRIs and CT scans more on a 24-hour basis. Target funding to rural communities. Mobile CTs could, as Dr. Giles alluded to, help indigenous and rural communities.

The Chair: Thank you.

We'll go to Dr. Strauss for five minutes and 30 seconds.

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

Dr. Schellenberg, I was really interested in your testimony about this seven-day benchmark that exists for priority cancer scans and how it takes 43 days to get 90% of such scans done. Obviously, the benchmark is not being met at all.

I was also very interested when you said that hospitals are partnering with private clinics, but that sometimes it seems that patients are partnering with private clinics without the hospitals. As you were giving that testimony, I put “private MRI” into Google Maps. I was searching in Vancouver. I found 20 clinics immediately. I clicked on one called “Priority MRI”. It's offering to do my brain MRI at 3T for $750 to $850.

Could you walk me through how one of your patients at a Surrey cancer clinic would decide to go to Priority MRI or one of these other private clinics to get their MRI done? Do you have to give them the recommendation? How does that conversation go? Do you inform them that it's going to take up to 43 days to get their urgent cancer screen done? I'm wondering about the human aspect on the patient side and how that goes.

Dr. Devin Schellenberg: I want to clarify one thing before I go forward.

The stats I quoted were not for cancer. These are general stats for CT scans. We don't have stats for cancer-specific wait times for a CT or an MRI. We don't have that sublevel of accuracy. This is just a general diagnostic scan, coded as to be done within seven days, that is taking 43 days to do 90%, as you alluded to.

I treat lung cancer. I treat gastrointestinal cancer. The cancers I treat grow fairly rapidly, so my patients need to be prioritized. I am not asking them to go privately. I am advocating for them in my local health authority. I do have patients, particularly at scan. I don't have patients getting private MRIs.

I hope your brain is perfectly fine and you don't need one. I would not advocate that you go that way either. I'm advocating, all that I can, within the public system.

Occasionally, in my experience, when patients feel that the wait for a PET scan is long, then they do seek out the private PET institution and go there directly. Basically, if it comes up, I will tell them where it is, but as you say, there's Google Search and they know before I even inform them of what is out there in terms of options.

Matt Strauss: So that I understand fully, you have determined that a PET scan is medically necessary. The patient has discovered that their PET scan is not going to be happening in a medically required period of time. I think you agree on that point.

Dr. Devin Schellenberg: I wouldn't say “medically required”, but medically optimal. I think we'd probably be parsing words here.

Matt Strauss: Yes, a little bit. If that person chooses to go to a private clinic to get what I understand to be a medically insured service generally, is it not the case that the provincial health care system ought to pay to access that PET scan? I'm thinking of my own dental insurance. If I get dental work done and it's insured, I send the bill to my insurance. Why am I not able to send the bill for that PET scan to the provincial health plan?

Dr. Devin Schellenberg: I think that's more of a funding issue than anything else. We are trying to prioritize as best we can with the dollars that we have. We're not allowing people to get reimbursed to jump the queue or skip the line. Everyone has to access the system as best we can afford to build the system.

Matt Strauss: In terms of hospitals partnering with private clinics, why is it the case that my hospital doesn't partner with that same private PET scanner? If you're partnering with some private clinics but not others, you end up with this inequitable mishmash, where some things have a private partnership so I can get my scan done in a private clinic, and some things do not. It doesn't seem that there's any intelligence determining which those are, unless you can shed some light on it.

● (1150)

Dr. Devin Schellenberg: I think a universal public system would be the most equitable way to do things. When the system is constrained, especially the diagnostic systems, then it's not the local hospital but the health authorities in British Columbia—it's like a global group—that would look for other means of serving their patients and potentially look to a partnership with a private place that has capacity.

Matt Strauss: The system that you're describing to me right now doesn't seem consistent with the Canada Health Act by any means.

If you, as a cancer doctor, tell me that I need a PET scan, and the public PET scanner is telling me that they're not going to be able to do it in a medically optimal time, so I pay out of pocket for a medically insured, medically necessary service, that's a failure. Isn't that right? Do you agree with me that it's a failure? That is not what is supposed to happen under the Canada Health Act, where medically necessary covered services are supposed to be paid for by the province.

The Chair: You are already 30 seconds over, so give a short answer, Dr. Schellenberg, please.

Dr. Devin Schellenberg: Yes. I think that's why we're here today discussing how we can get more resources into diagnostic imaging in the Canadian system.

The Chair: Thank you very much.

We'll go to Mr. Rana for five minutes.

Please go ahead.

Aslam Rana (Hamilton Centre, Lib.): Thank you, Mr. Chair.

Dr. Giles, you work in emergency care in a hospital in Kenora. When imaging is not available quickly, how does that change the decisions you make like whether to transfer a patient or treat without a confirmed diagnosis?

Dr. Sarah Giles: We got our MRI a year ago. The normal situation we would see with that would be someone who was struggling with intravenous drug use who we were concerned had an epidural abscess. They would then be admitted to our institution, put on very large antibiotics to treat them as if they had an epidural abscess, and then they would wait up to five to seven days to be transferred with a nurse and paramedics to Thunder Bay. They would have their MRI done there. They would wait for it to be read. If it was negative, they would be flown back and then dealt with from there. On average, it added between five and seven days to admission as well as a very expensive flight.

When we have to treat without having definitive imaging, we are always conservative. We cover the things that are going to be important to patients like life and death and loss of limbs. It can be expensive and also drive antibiotic resistance.

Aslam Rana: Thank you very much.

Governments have committed, through the working together agreement, to make it easier for health professionals to work across provinces. How would easier licensing, including letting radiologists read scans remotely, change access for rural patients?

Dr. Sarah Giles: Having the capacity to have radiology groups read, for instance, in different time zones can be quite helpful. Everyone passes the same nationwide exam to be a radiologist, so they should be able to read scans from anywhere.

The interoperability part, which the Liberal government has begun to address, is huge. We cannot look at any imaging done in Manitoba, which is just 42 kilometres to the west. Being able to have our friends come and help us here and our being able to see their imaging would be a huge boon to patient care.

Aslam Rana: Thank you.

How much do rural physicians rely on point-of-care ultrasounds when a CT scan or MRI is not close by? What would help more of them get trained and supported to use it?

Dr. Sarah Giles: That's a fabulous question.

Right now, it is very dependent on who you are. We pay for all training that is done outside of residency.

I finished my training 20 years ago and, since then, nothing has been paid for my training. I have paid out of pocket over $100,000 for different upgrades. I have point-of-skill training, but it is entirely up to the individual to get that training.

Having a fund like the national advanced training program that the SRPC ran with funds from ESDC helps rural physicians have the skills their patients need.

Aslam Rana: Thank you very much.

Dr. Mooder, when a scan is done in community and the patient is later sent to a hospital, does the image travel with them? What would make that easier?

● (1155)

Karen Mooder: At this time, there is no interoperability between the information system that we're using in first nations communities and those that are used by regional health authorities in B.C.

The challenge is upstream in regulation, in the lack of recognition by the regional health authorities that an image captured in a first nations community is done so to the highest levels of quality assurance and that there should be interoperability facilitated. Regulation is essentially saying that, if you're not accredited through the same means as the regional health authorities, regulation will prevent those interoperable images from transferring.

The opportunity in front of us is to amend the regulatory landscape to acknowledge the need for first nations communities to be able to generate images in community and have those transferred to the next level of care to effectively coordinate care services.

Aslam Rana: Which new tools, including AI and portable imaging, look most useful for remote first nations communities? Is there anything in the federal approval process that slows down...?

Karen Mooder: That's also a great question.

Dr. Giles has spoken very eloquently about the opportunities for AI in medical imaging, yet we're still at a point where it'll be important to clinically validate the quality of these AI modalities. When it comes to portable technologies, Dr. Giles also referenced being able to use ultrasound remotely. There is a great opportunity for investment and attention in this space.

The Chair: Thank you very much.

We'll go to Madame Gaudreau for two and a half minutes.

[*Translation*]

Marie-Hélène Gaudreau: Thank you, Mr. Chair.

I'd like to return to what I was saying. I get the impression that it is as if we were trying to address the legislative assemblies directly. I feel as though I can hear my counterparts—whether from Quebec, Ontario or anywhere else—telling us to ask them what they need and to pass that on to Ottawa, because they need a helping hand. I worked for years in a network—a hospital—before the merger. I'm not a doctor, but I've seen all the departments, and they have significant needs. So I know what I'm talking about.

My question is quite simple. Right now, we're trying to discuss access to magnetic resonance imaging. I would have expected that here in Ottawa, we'd be talking about technology, innovation and research, and making these accessible. Instead, we're talking about service delivery.

Unfortunately, I only have one minute left. I'd like to ask—perhaps of someone who hasn't spoken yet—what the provinces are telling you about this issue, generally speaking, not just in relation to first nations?

[*English*]

Dr. Sarah Giles: My colleagues in northern Quebec say that there are two X-ray machines in all of Cree territory, and that they cannot access what they need at the very basic level, so before we can get to AI and MRIs, they need access to X-rays.

[*Translation*]

Marie-Hélène Gaudreau: What can Ottawa do? We're talking about the accessibility of service delivery. What can we do? That is what is important to know.

[*English*]

Dr. Sarah Giles: First nations and Inuit health are under federal legislation, so I think there is room to make significant advances there.

[*Translation*]

Marie-Hélène Gaudreau: As I understand it, we really ought to focus on MRI services for first nations and not on anything else. For the other provinces, there are hospital centres.

So, there you have it. I hope that the next witnesses will provide us with statistics, information on innovation and research, and solutions to ensure accessibility for first nations, but not on the provision of services in our hospitals.

Thank you.

[*English*]

The Chair: Thank you, Madame Gaudreau. The time is up.

We'll go to Dr. Strauss for three minutes and then to Madam Chi for three minutes.

Please go ahead, Dr. Strauss, for three minutes.

Matt Strauss: I'm just returning to Dr. Schellenberg.

I think you've dropped a bombshell here. If I'm a cancer patient in Surrey, British Columbia, and you've asked for me to have a PET scan, but the health authority can't do it in time, I go and pay out of pocket for it. The whole point of the Canada Health Act is that if I've had to do that, the provincial system is supposed to reimburse me because I've paid out of pocket for a medically necessary cancer scan, or the federal health minister is supposed to claw back that funding from the provincial government.

Are you aware that this clawback is happening? You're describing that this happens fairly commonly. Are you aware that this clawback or any part of that procedure, which is the whole basis of the Canada Health Act, as far as I'm aware, is occurring?

● (1200)

Dr. Devin Schellenberg: Can you ask that question again?

The Chair: I'll stop the watch. Go ahead, Dr. Strauss.

Matt Strauss: My understanding of the way the whole Canada Health Act works is if my provincial health coverage plan is not paying for medically necessary, insured services, which includes diagnostic imaging, then if I'm having to pay out of pocket for that because my provincial health authority is not paying for it, the federal health minister is supposed to write a letter to the province and claw back the Canada health transfer.

Dr. Devin Schellenberg: I think the Canada Health Act is paying for medically necessary services. It's just not paying for it at a time point when the patient desires it. Sometimes that's because the patient wants a thing done now—

Matt Strauss: Can I interrupt you right there? You started your testimony by saying there's a seven-day benchmark, and this is frequently not being met.

Dr. Devin Schellenberg: Yes, it is frequently.... I agree with you there.

Matt Strauss: Okay, so it's—

Dr. Devin Schellenberg: We are trying to deliver medical care, as best we have, with the scans that we have. We cannot get all people through within seven days. I fully acknowledge that.

Matt Strauss: Okay. I'm not putting it on you. I'm saying that this is a clear violation of the Canada Health Act, and perhaps the Liberals will want to bring a motion to this effect. I'm just saying it's a bombshell. This is not how the health system is supposed to be doing medically necessary scans, to my understanding of the Canada Health Act and the health care system that we all operate in.

Turning quickly to Dr. Giles, you said something really interesting about a $1-million estimate on savings. Can you just describe that for me again? You went quite quickly.

Dr. Sarah Giles: Sure. For patients who need to drive the 1,000 kilometres to Thunder Bay and back for an MRI, they're eligible for a travel grant of up to $800. Also, there's some money available if they were to go to Winnipeg to have the MRI there. We looked at the cost savings from not having those travel grants or having smaller ones for shorter distances.

Matt Strauss: Why was it on you to do this analysis, or who did this analysis?

Dr. Sarah Giles: It wasn't on me. I was able to tap into our hospital's analysis and ask them what information they had that showed that our MRI was helpful to the greater community.

The Chair: Thank you very much, Dr. Strauss.

We will go to Madam Chi for three minutes.

Please, go ahead.

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

Thank you to all the witnesses for presenting to committee today.

My first question is to Dr. Giles.

First of all, thank you. The whole community of rural physicians, I think, really represents jacks of all trades, for lack of better words. You take on responsibilities in a remote area with limited resources, but you somehow make it work.

Dr. Giles, you mentioned the idea of a central booking system. If you can, help us explore that idea a little more, especially now that we are working with provinces and territories on opening up some of the data pieces, trying to enhance interoperability. Would that help, or what additional measures would be helpful in that sense?

Dr. Sarah Giles: Sure. Let's say we have a region where there are four different CT scans. In the past, what we used to see is that a patient would see their doctor, and they would just do a requisition to the local one. Then the patient would come back and say, “Listen, they're saying it's a three-month wait. Can you refer me to another one, and we'll see which one we get first?”, which tends to make waiting lists look longer than they actually are. Then each radiologist is having to duplicate the work of the other by triaging it.

If you had a centralized booking—all four communities used the same booking office—and a patient said, “Listen, I'll drive to any of them, regardless of distance,” or they said, “I don't drive. I'm only interested in the one that's closest to me,” which allows patients to show their preference, this would allow everybody to be triaged under the same lens and prevent duplication through the system.

● (1205)

Maggie Chi: Thank you so much.

The other point that really was interesting to me is on the innovation front. I think rural physicians had to learn on the spot how to operate some point-of-care devices. Innovation, we do hear, is one of the measures that help with opening up access. I think Dr. Mooder also alluded to that fact.

I want to see from your perspective, either from Dr. Giles' rural and remote perspective or from Dr. Mooder, if there are any additional things that you want to add on that topic.

Dr. Sarah Giles: For instance, I was talking about remote ultrasound technology. Rather than flying the technologist to a bunch of different communities, you have, for lack of a better word, a robot in a northern community, and the ultrasonographer in the south is holding a probe, moving it through the planes, which the robot in a distant community is doing as well. It provides images that are of great quality without needing the sonographer to travel. For instance, they might do a half day in one community and a half day in the other.

In Saskatchewan, they're doing this with prenatals, and I believe they're also doing some echocardiograms. It's really an interesting way to go about the technology shortage and collapse the distance while not hurting image capture.

The Chair: Thank you.

The time is up, though I will give a few seconds to the First Nations Health Authority.

Gary Housty: I was just going to share a couple of words around the opportunity around innovation, similar to Dr. Giles. The question that we're getting on this panel is about what Ottawa can do to continue to transform the system to improve health outcomes.

When I think about remote communities, that is where we've started some innovation, and our opportunity is to scale it.

Dr. Giles did talk a little bit about a Cree nation, as well, with X-ray systems. We want to scale that across British Columbia, in remote first nations communities. The opportunity is to change the legislation with the B.C. College of Nurses and Midwives so that registered nurses can also have that opportunity to be handlers and to take these X-rays. That's the opportunity for us to move the dial and to improve health outcomes as well.

The Chair: Thank you very much.

On behalf of the committee members, I would love to thank the witnesses. I'll start with my hometown.

Thank you, Dr. Schellenberg, Dr. Mooder, Vice-President Gary Housty and, last but not least, Dr. Giles. Thank you very much for your valuable input.

With that, I'll suspend the meeting, for the next witnesses to take the stage.

● (1205)

_____(Pause)_____

● (1215)

The Chair: I would like to call the meeting back to order.

On behalf of the committee members, I would love to welcome our witnesses.

We have with us, from Breast Cancer Canada, the CEO, Ms. Kimberly Carson; from the Canadian Association of Medical Radiation Technologists, Mr. Christopher Topham; and from the Canadian Association of Radiologists, Dr. Alison Harris.

Welcome to the committee.

I would like to first make a few comments for the witnesses.

Please wait until I recognize you. I have leeway here. Once the honourable member is asking questions, you can keep eye contact with the honourable member.

Also, as soon as I raise my hand, I would like you to wrap up and stop speaking at the end of the five- or six-minute round—whatever I've allocated for the members—which means that's the end of that particular round.

Please make sure that you have your mic on, because this is bilingual in both official languages. French and English run simultaneously.

Honourable members, please ask the questions by name and have your stopwatch running. Last time, Mr. Bailey did an excellent job, because he knew that were near the end of the time and he asked the witness for a short answer. That way, I don't have to interrupt when you are speaking. Please, let's try to work together to make sure that we finish the rounds on time.

With that, I will give five minutes for the opening remarks to all three witnesses.

We will start with Ms. Carson for five minutes, please.

● (1220)

Kimberly Carson (Chief Executive Officer, Breast Cancer Canada): Thank you very much, Mr. Chair, and thank you to the members of the committee for having me here today.

I am Kimberly Carson. I'm the CEO of Breast Cancer Canada. It's the only national breast cancer organization focused on research, advocacy and education.

This year, as you may know, over 32,000 women will be diagnosed with breast cancer. Over 5,400 of them are going to die from this disease, which leaves us at about 15 women per day in this country. The numbers are still one in eight, and we have not yet seen a huge improvement on the number of deaths, compared to that one in eight.

For almost every one of those, the journey starts with screening and mammography. It's still our first line of defence for this disease. Those images are so important because they tell us where that woman is in the journey, how early on they are, whether or not they're going to need surgery, where their staging is, how accurate it is and how it's going to be treated. It's still very important as our first line of defence in this disease.

I want to leave you with something today. For women with breast cancer, it's not even about the wait to have the screening. It's about the wait through the entire system and what that actually means. It's from the screening and the diagnostics right straight through to the biopsy and the pathology reading. All of these pieces add to the delay and the wait time for a woman. Each one of them compounds the amount of time it takes for a woman to get her diagnosis and start her treatment.

The national data looks like this. The target is that 90% of women should receive a biopsy within seven weeks of that initial abnormal screening. Based on 2020 data from CPAC, the Canadian Partnership Against Cancer—this is the most up-to-date data, which is also a bit of a problem—the only province that's doing it is Alberta. It's a little bit of a problem when we're looking at that entire pathway and that entire screening pathway.

The question becomes, how does Alberta do it? How do we use the best practices here in Canada? Alberta has done it through a centralized diagnostic lab system. It's working. On top of that, we have an eastern Ontario network of 16 hospitals right here in the national capital region that are working together. Again, we're getting the results faster, so there are some Canadian ways that are able to do some of this stuff.

The Canadian Association of Radiologists, which is going to speak today, is saying that one-third of our equipment in Canada is really dated—it's over 10 years old—making that even more difficult to deal with when we're trying to get women through these systems. Then the systems don't talk to each other.

These are all things that we've spoken about, but the screening from mammography really matters. Women are able now to self-refer at the age of 40 in most provinces. We're still asking for the national guidelines to be changed to 40—they have yet to be lowered to the age of 40—to help us work through this system with women, because we know that the sooner we catch it, the better the outcomes.

There are a few things I think we can do at the federal level.

The first is to measure the whole patient journey. Breast Cancer Canada has developed a PROgress Tracker, which tracks the patient's journey from beginning to end. We track them for 10 years. We can certainly scale that up nationally across this country to help with the data and give more timely data. It's the data from patients. It's a self-referred study that patients can enter anywhere and anytime. I'm pleased to say that right now, after running it for a couple of years, we have every province and territory represented in our database. However, it certainly needs to be scaled.

Secondly, we obviously need to invest in more equipment.

Third, we need more innovation. We're looking at new innovation that's coming. We have blood tests and breath tests coming, which may help reduce the burden on the system. If we can do a blood test or a breath test up front and know that a woman needs a mammogram more frequently, or if we can use AI to predict it, then do we actually have to send as many women for mammograms as frequently? I think there's going to be more technology.

Then, obviously, we're looking for the age to be lowered to 40.

● (1225)

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

We'll go to Mr. Topham for five minutes.

Please go ahead.

Christopher Topham (Director, Advocacy and Communications, Canadian Association of Medical Radiation Technologists): Thank you, Mr. Chair and members of the committee, for the invitation to appear before you today.

My name is Christopher Topham. I am director of advocacy and communications at the Canadian Association of Medical Radiation Technologists.

Medical imaging is essential to a strong, accessible and well-supported health care system, which is the foundation of Canadian well-being, stable communities and a thriving nation. Medical radiation technologists, or MRTs, are the largest contingent of the medical imaging workforce. Though often overlooked, they care for patients at some of the most critical junctures in their lives.

As representatives of CAMRT, Kelly and I represent Canada's 23,000 medical radiation technologists, 20,000 of whom work in medical imaging in the disciplines of radiologic technology, nuclear medicine and MRI. The remaining 3,000 deliver cancer care as radiation therapists.

On the ground today, we see severe workforce shortages that have made medical imaging a major bottleneck for Canadians seeking care. For Canadians with cancer, as we just heard, this bottleneck means delays in obtaining a diagnosis and cancer being detected at later stages. For Canadians awaiting surgery, imaging bottlenecks delay surgery and its potential benefits while also prolonging time outside the workforce for many. For others, imaging bottlenecks may also limit access to innovative therapies like radioligand therapy, which combines diagnosis and treatment, or new Alzheimer's medications that rely on imaging. These barriers may lead some Canadians to look to other countries for solutions.

The clearest sign of the bottleneck is the sharp increase in the wait times we've seen for important imaging exams and procedures. A 2025 Deloitte study, on which we worked with our colleagues here from CAR, also identified the enormous annual economic costs for Canadians due to medical imaging wait times, including "$17.9 billion in lost employment income...$64.2 billion in lost GDP and $6.1 billion in lost tax revenues for government treasuries."

MRT shortages exist due to chronic underinvestment in medical imaging infrastructure and workforce, just as demand for imaging explodes with a growing and aging population.

CAMRT works closely with MRTs throughout Canada and has collected workforce data for more than a decade. These data show vacancy rates rising from 2% in 2015 to 10% in MRI and 15% in general radiography and nuclear medicine today. These rates are troubling in themselves, but deep and sustained shortages also fuel a vicious cycle of low morale, burnout and depersonalization, making professionals less inclined to stay in the profession.

Currently, the pipeline for adding more MRTs to the workforce consists of professionals trained at educational institutions in Canada and MRTs that come to Canada after being educated and practising elsewhere. In 2025, we saw some encouraging first signs of growth in both groups, but the addition of 130-odd MRTs over and above the 2024 numbers is modest in the face of the thousands of new MRTs we need to cover the shortages associated with a 10% to 15% vacancy.

We believe there may be many innovations and solutions that will play a part in addressing this crisis that we face in medical imaging capacity. We also believe that all these solutions require investment to grow and stabilize the medical imaging workforce.

As such, we are asking the federal government to partner with provinces to implement funded, actionable strategies to eliminate critical medical imaging backlogs with direct emphasis on human resources. Since the education of Canadian MRTs will be such a critical component for bringing about the end of this crisis, CAMRT is also recommending that the federal government commit new, dedicated federal funding that targets initiatives that can rapidly scale up MRT education across Canada.

Together, we are asking that governments work together to bring an end to this crisis in medical imaging, so that it can work as it should for the health care system and the Canadians who rely on it.

Thank you, Mr. Chair. I welcome your questions.

● (1230)

The Chair: Thank you, Mr. Topham.

We'll go to Dr. Harris for five minutes.

Dr. Alison Harris (President, Canadian Association of Radiologists): Thank you, Mr. Chair, vice-chairs and members of the committee, for the invitation to appear today.

My name is Dr. Alison Harris. I'm a radiologist and the president of the Canadian Association of Radiologists.

Radiologists are uniquely positioned to see the impact of delays in diagnostic imaging. Behind every statistic is a Canadian waiting for an answer to a health concern. In emergency departments, the CT scanner is sometimes called the donut of truth. Ten minutes in the CT scanner can help define what hours of examination cannot—whether a patient is having a stroke, a migraine, an internal hemorrhage or a minor injury. However, a scanner can only tell a truth if it's working effectively, staffed adequately and available when patients need it.

Diagnostic imaging is the gateway to further care. Delays in treatment prolong uncertainty for patients and families, increase hospital pressures and cost our economy billions. We are doing more imaging than ever, yet patients are waiting longer. Between 2019 and 2024, hospitals performed 16% more MRI and CT scans, but wait times lengthened. AI integration has been proposed as a possible solution, but AI cannot scan a patient. It needs a modern scanner, a trained technologist and a radiologist accountable for the results.

Addressing wait times and diagnostic capacity requires attention to three key factors. The first is equipment—the CT, MRI and other machines we use to capture patient images. Second is people—our MRTs, radiologists, sonographers and medical physicists. Third is innovative technologists.

Let's start with equipment. Canada ranks 27th out of 31 universal health care systems for MRI units per capita and 28th for CT. More than one-third of our scanners are over 10 years old. Older machines break down more often, cost more to maintain and cannot run the newest software required to shorten scan times. The federal government can and, in our opinion, should lead capital investment to renew and expand imaging infrastructure. However, a scanner sitting idle cannot shorten a wait-list.

That brings me to people. Human health resources are currently the biggest constraint on our imaging capacity. Hospitals struggle to recruit and retain technologists, sonographers, medical physicists and radiologists. Federal projections show an ongoing shortage of technologists. In many regions, staffing gaps leave scanners unused in the evenings, overnight and on weekends. We cannot just buy our way out. New scanners need trained technologists to operate them and radiologists to interpret the results. Investment in equipment infrastructure must be matched by investment in training and workforce planning.

Finally, I have a word on technology, including AI. Used well, AI can make our equipment and our people go further. AI-assisted image reconstruction can cut scan times and increase throughput. Clinical decision support tools can ensure that every patient gets the right test at the right time.

However, technology is not a substitute for equipment or staff. It multiplies their value within the system. For an AI tool to work safely, it must be tested for Canadian patients on our scanners and in our hospitals. Today, that job falls to individual clinicians, one hospital or clinic at a time. That's why the Canadian Association of Radiologists helped to found HAIVN, or the Health AI Validation Network, which is an independent, not-for-profit entity, for which we propose federal funding.

Provinces and territories deliver health care, but our challenges do not stop at provincial borders. We have enough evidence to know that there's a problem, but we lack a complete picture of solutions due to the lack of system integration. Some national datasets are updated only periodically, and jurisdictions are measuring staffing, equipment downtime, utilization and wait-lists inconsistently. This makes it hard to identify what's working, where action is needed and where progress is occurring.

The goal should not be just to collect more data or commission another study. We must use existing data to guide action. This commission is an important step toward stronger federal leadership and a more coordinated national approach to diagnostic imaging.

Through our advocacy and recent pre-budget submissions, the CAR has consistently emphasized four key priorities: renewing an increasing imaging infrastructure, strengthening our workforce, supporting innovation that improves efficiencies and improving accountability frameworks so we can measure progress. Together, these priorities can help ensure that investments translate into measurable improvements in capacity, access and better health outcomes for our patients.

Thank you for your interest in this. I look forward to taking questions.

● (1235)

The Chair: Thank you, Dr. Harris.

I will go to the rounds with the honourable members. If there is consensus, we might go until about 1:15, unless you have any issues with the time.

Dr. Eyolfson, go ahead.

Doug Eyolfson (Winnipeg West, Lib.): Begging your pardon, I have to be at another meeting at 1:15. It's a meeting that I'm chairing.

The Chair: How about 1:10?

Doug Eyolfson: Thank you.

The Chair: Thank you.

Let me start with Madam Dancho for six minutes.

Please go ahead.

Raquel Dancho (Kildonan—St. Paul, CPC): Thank you, Mr. Chair.

Thank you to the witnesses for their excellent testimony. There is a lot to cover.

I want to start on the people or technologist side. Mr. Topham and Dr. Harris outlined that there's quite a significant shortage.

Mr. Topham, I read research from your organization. There is a 2,300-person deficit just to get to a 5% vacancy rate. Right now, we're hovering around a 15% vacancy rate.

Is that correct?

Christopher Topham: That's correct.

So you can understand, our data comes from a survey of managers that we run. It's not a head count. It's purely an estimate, but that's where we think it is.

Raquel Dancho: Often, when people think of MRIs, they think of the physical machine—which is, of course, a key part of this. As was mentioned, in terms of the OECD or peer nations, we rank 28th out of 31 for MRIs, CTs and PET scanners. We have 26 per million people, whereas the average—again, it's not even the top performers—is 51 per million people. That is almost double what Canada has. If we could wave a magic wand and get all these machines overnight, we would still need people to do the work to get these scans in the first place. We would still need to get radiologists for them.

You mentioned education being a pretty big key, and I know your organization is calling for federal funding. Can you elaborate a bit on this?

Perhaps Dr. Harris has some feedback as well.

Christopher Topham: Sure.

There's capacity to bring in people internationally. With the explosion of demand for this—which comes from a growing and aging population—there needs to be a national response appropriate to the number of technologists trained in Canada. For the last 10 years, that response, in terms of increasing seats and technologist output, hasn't been there. Therefore, we need to coordinate in some way, while looking at data and working with provinces, to make sure an adequate number of people are trained.

Raquel Dancho: I'll jump in there, because you made a really good point.

Our population is growing naturally but also through very high immigration numbers. We also have the largest generation in history, the baby boomers, very much aging in our health care system. I'm not a physician, but my understanding is that the older you get, often, the more scans you need. As bad as the system is now, if nothing changes nationally or at any provincial level, it's going to get a lot worse.

Is that accurate, Mr. Topham, then Dr. Harris?

Christopher Topham: I'd probably defer to Dr. Harris to answer that one.

Dr. Alison Harris: Absolutely. The CAR has been advocating. We did a pre-budget submission. One of the things we are advocating for is a significant investment in imaging capacity—both renewal and replacement. We estimate that this will require a $2-billion investment over three years.

As Mr. Topham outlined, this doesn't stop at investment in equipment. It needs investment in people as well. Technology, equipment and workforce need to be considered together.

Raquel Dancho: Thank you.

Something the Canadian Association of Radiologists says on its website is, “Clinicians are forced to make difficult decisions about prioritization, and patients across the system feel the impact.”

Could you elaborate a bit on that? Because the situation is so dire, my takeaway is that you're almost having to triage need. Is that correct?

● (1240)

Dr. Alison Harris: For every CT or MRI referral that comes into an institution, the radiologist will look at the clinical information provided and judge, based on that, how urgently a scan needs to be done. For scans that need to be done urgently, within seven days, we do reasonably well getting those patients scanned 70% to 80% of the time, on average.

Patients who have semi-urgent or less-urgent clinical indications should be scanned within either one month or two months, depending on how you prioritize them. Those patients are waiting far longer for those imaging tests. On average, a CT scan that should be done within one month is taking two to three months. An MRI that should be taking a month is done in nine months. In some jurisdictions, it can be up to a year. We're seeing significant delays in patient access to medical imaging.

As a practising radiologist on the front lines, I would say that it's not infrequent that we see patients come in through the emergency department. They've had access issues. They haven't been seen. They have not been able to get appointments. Then they come to emergency because their symptoms have worsened. We scan them in emergency, and we find they have disseminated cancer or a pathology that, if it had been caught much earlier, would have been clinically manageable. At the point when they come, we often have very limited treatment options. This is something we're seeing on the front lines.

The Canadian Association of Radiologists has priority categorizations based on—as I mentioned—clinical indications. However, in provinces across the country, really, the wait-lists fall way outside of those recommended wait times.

Raquel Dancho: Thank you.

This was in the earlier panel we had today. My understanding is that it's rural versus urban, but even some urban centres are far better than others. You may have better luck if you're in Ottawa, Toronto or other jurisdictions, but it's not equitable across the country right now.

Dr. Alison Harris: Yes, we see some very significant delays in patients from rural or remote communities, and that is largely based on the ability to access the equipment.

I caught a bit of the previous session and would concur with what was said in that often, those communities don't have the advanced medical imaging equipment that you'll see in the larger urban centres. We have implemented things like central booking for MRIs, and that has helped streamline some of the access.

Raquel Dancho: Thank you.

The Chair: We'll go to Dr. Eyolfson for six minutes.

Doug Eyolfson: Thank you, Chair.

I'd like to thank all of the witnesses for coming.

Dr. Harris, thank you for what you were saying about emergency departments.

I've been an emergency doctor for 25 years, and I have noticed, particularly over the last 10 years, an increase in the number of advanced cancers that I have diagnosed in the emergency department. People who had followed directions—they'd seen their doctor and their tests were booked—came in with symptoms that were just unbearable. I did the CT and, in the middle of a crowded emergency department, I had to tell someone they had metastatic ovarian cancer. It is heartbreaking. That's where we're really seeing the need, and I've been seeing this for years.

We've talked about access. With technology now, when you get a scan in one place, radiologists in other places can do that. We still have the siloing of our licences. Would that be facilitated if we had nationally recognized licensure? Once they have the scan, would that help facilitate how quickly scans can be read and interpreted?

Dr. Alison Harris: That's an interesting point. Radiologists obviously have national examinations. The licensure occurs provincially, but there are some radiologists who have licensure in several provinces, which allows them to report in other jurisdictions.

It is preferable if the imaging can be reported locally. Part of the reason is that the systems don't necessarily talk to one another, so imaging done in another jurisdiction may not be available for review.

Even in British Columbia—I work in Vancouver—we're not able to see imaging from around the province unless we go to a separate computer system. That can sometimes mean that scans are repeated unnecessarily or that you don't necessarily know a scan has been done somewhere else. It incurs delays and can have an impact on patient care.

● (1245)

Doug Eyolfson: The federal government is working right now on what we call the connected care for Canadians act in an attempt to make all of the systems talk to each other. Would that facilitate this if we had a system where everyone could recognize a given system within and between provinces and could seamlessly talk to each other?

Dr. Alison Harris: We've highlighted the fact that there are problems with system integration. Yes, I think if a patient is travelling across the country, having access to whatever imaging they've had in another jurisdiction would be important. Even having it just within provinces would be a big step forward.

Doug Eyolfson: Thank you.

I'm going to change gears a bit.

Mr. Topham, thank you for what you do.

One of the heartbreaking things I've noticed—I'll say frustrating things—is this. I used to fly for air ambulances. Very often, we had to pick someone up because they had a head injury in a centre that had a CT scanner, but they presented at 4:15 and the scanner closed at four due to a lack of staff. That was in a lot of places.

I know there are a lot of vacancies, and it is likely more acute in smaller, more isolated and northern centres. Are there innovations in training so that instead of having to send people down to a major centre for training...? If you have an MRI in Thompson, Manitoba, and there's someone locally who wants to do it, are there provisions so that a large portion of that training can be done remotely and local people can be trained to do this?

Christopher Topham: Yes, there are. Traditionally, programs have been run from the universities or the colleges, and people have had to spend a substantial amount of time in classrooms there. Clinical placements have always been spread around. I'm not saying that they've been in Thompson in particular, but people have been able to do the clinical portion of their education spread around the country.

As we're able to do more virtual classroom work, there are people innovating in that area to ensure that people would have to do very little time in classrooms at their colleges, so they would then be able to do virtual didactic work and then clinical work in various sites spread across a province or even the country.

Doug Eyolfson: Thank you.

Is there a role in some of these centres, which might have lower volumes for other types of clinical problems or tasks, to cross-train people so that people who are working in one associated area can receive some of this training remotely so they can stay in the community? Is that happening, or is that a possibility?

Christopher Topham: I think an example of that would be cross-training in laboratory and X-ray, for example. Yes, that's happening quite extensively across the country because of the rural nature of Canada. There's a well-defined model for that.

Doug Eyolfson: That's my time. Thank you very much.

The Chair: That was exactly six minutes.

We'll go to Madame Gaudreau for six minutes.

[*Translation*]

Marie-Hélène Gaudreau: Thank you very much, Mr. Chair.

I am grateful for the witnesses' valuable recommendations.

Is the interpretation working properly? I'll take a moment to make sure, because my first question is for you, Ms. Carson. Is everything clear for you? Perfect.

Indeed, when it comes to breast cancer screening—I'm not familiar with the situation across all provinces and territories, but when we decide to act in good time—I'm thinking, amongst other places, of Quebec, where we're currently looking into colorectal cancer screening, which we're not yet in a position to prevent—the earlier we screen, the longer life expectancy becomes.

What do the health ministers of the other provinces and territories say about your desire to have the most resilient network possible?

● (1250)

[*English*]

Kimberly Carson: What we, other provinces and territories and any health ministers I'm speaking to at that level, are looking at is, the sooner we can catch it and know what we can put in place in the way of screening and detection, the better the outcomes. What can we put in place? What technologies are coming? What AI-supported initiatives can we put in place to make that initial detection as early as possible for any of our cancer people, whether it's colorectal, breast or any of your FIT tests? There's early detection now with lungs.

We're also now looking at a new test. It will be a liquid biopsy, a blood test that's coming. We're currently waiting on the FDA to approve that. The independent advisory committee to the FDA has suggested that the FDA approve that, and it will be that initial screening for about 50 different types of cancer. That's being watched very closely. It is available in some of the provinces now through private clinics and through insurance companies. A lot of them are paying for it now. The push is towards the concept that, the earlier we detect it, the better the outcomes, the less impact on the patient and the less impact on the system.

Through our research, we know there's a financial toxicity to any kind of cancer diagnosis. We're looking at how we decrease that, particularly for women in the breast cancer space under the age of 55 who are financially impacted quite significantly with a breast cancer diagnosis. The earlier we can catch it, the better the outcomes for the patient, the less financial toxicity and the better for the system overall. That's what we're looking at.

[*Translation*]

Marie-Hélène Gaudreau: As I was saying earlier, indeed, when I see that it is hospital foundations that are raising several million dollars to gain access to equipment, I have one wish: let us focus on technological development to achieve breakthroughs, particularly with blood tests. Let us provide both the practical expertise and the machinery we need—which we could make available to the whole community.

Thank you, Ms. Carson.

My question is for you, Dr. Harris. I, too, am curious to know what the thirteen provincial and territorial governments and ministers have to say about the $2 billion investment over three years that you mentioned. What do they say about it?

[*English*]

Dr. Alison Harris: We would recommend ideally a federal strategy for equipment. Any funding that is allocated for medical imaging equipment would need to be distributed based on need. There would also need to be accountability. If equipment is going to be funded by the federal government, as I think it was 20 years ago or so, then there would need to be accountability by the provinces.

Now, the funding for the actual equipment is not just for the piece of machinery. There are quite a lot of additional costs for the room renovations. There has to be a lot of preparation to put in a big piece of equipment like MRI or CT equipment. The operational costs also have to be taken into consideration, plus the technologists' needs.

[*Translation*]

Marie-Hélène Gaudreau: I have a question. It's as if trust were lacking. I'll say it: when I speak to our specialists, both in rural areas and in major research centres, they tell me that there's always someone there watching and judging them. They know what they need, and they also have the expertise.

So, obviously, as far as Quebec is concerned, when it comes to accountability, we'll say “no, thank you”, and that we'll continue to make efforts. However, is it conceivable to increase health transfers to enable the provinces and territories to acquire what they need? Is this a viable option, or do you completely disagree?

[*English*]

The Chair: You have 15 seconds.

● (1255)

Dr. Alison Harris: I absolutely agree with what you've just said. I think the federal government should be working closely with the provinces to assess what the individual needs are.

The Chair: Thank you very much.

Madam Dancho, you have four minutes.

Raquel Dancho: Thank you very much.

Ms. Carson, I have a few questions for you.

I want to talk about the real human impacts of long diagnostic wait times. At the outset of this, you mentioned that 32,000 women will be diagnosed in Canada this year, and 5,400 will pass away from their disease. That's about 15 women per day. About one in eight women will get breast cancer at some point in their life.

I remember that when we first met, you talked about the different stages of breast cancer. Please correct me, but my takeaway was that for stages 1 to 2, you have an excellent fighting chance if you can catch it at that stage. If it hits stages 3 and 4, you may very well be in for the fight of your life. Is that an accurate assessment of the way in which breast cancer progresses? How quickly can late stage 2 to stage 3 happen?

Kimberly Carson: Yes, absolutely, we're looking at anything between stage zero to stage 2 as a fairly curable rate five years out. Anything beyond that is a little bit more heavy lifting, I guess, for the patient and for the system, where the patients are experiencing more chemical toxicities from the disease progression. The system is having to respond with much more invasive treatment.

All our treatments are targeted treatments now. When a patient is diagnosed with a type of breast cancer, the type and stage will direct the treatment pathway that the patient is going to take. Certainly, the more advanced the stage of breast cancer, the more treatment will be required.

Raquel Dancho: What do the wait times look like across Canada? I know that from some of the experiences I've seen in Manitoba, it's about four or five months to get from referral to mammogram. Is that a good benchmark globally? Are we doing well there? Is it the same case across the country? What are we looking at nationally?

Kimberly Carson: Nationally, you're looking at very different outcomes depending on where you are. Certainly, as has been mentioned a number of times, our rural population is looking at much longer wait times, having to travel much further to have those treatments done and be away from home much longer. Again, that financial toxicity comes into play in how we manage all of that.

The wait times across the country really vary on where you're located. It's still a bit of a postal code lottery. From Breast Cancer Canada's point of view, we're trying to bring in a standard that looks like guidelines on how patients should be treated so that we can get those patients the same care no matter where they live in Canada with the REAL alliance. Our REAL alliance will be able to provide that pathway to care a lot faster for patients when it's clearer what they need based on their stage and type of breast cancer.

Raquel Dancho: Is there a benchmark for a lead time from the initial physician referral to a mammogram? Is there a global leader?

What's our goal, ultimately?

Kimberly Carson: I think our goal is less than seven weeks.

Raquel Dancho: What percentage of Canada would you say is meeting this seven-week referral benchmark?

Kimberly Carson: Unfortunately, no one is.

Raquel Dancho: No one is meeting the benchmark, yet one in eight women gets this terrible disease, and 5,400 women die annually, or 15 a day. Good work by this committee, by you and by others resulted in the recommendation, although it's not official in many provinces, that we should lower the initial mammogram age from 50 to 40, which is really great for women. I think it will save a lot of lives.

My concern is this: If we're already overtaxed at 50, are you hearing of any plans from provinces to prepare for those additional tests? What are we going to do so that we can all get them at age 40 going forward?

Kimberly Carson: There are a number of different initiatives being brought in.

Do we start to look at the risk score of women at a younger age? Do we start to look at ages 25 to 30 and do a risk score factor at that age to say whether we need to screen them at 40 or if they can wait? Do they have to be screened every two years, or should it be every year or every five years?

The Chair: Thank you.

We'll go to MP Sidhu for four minutes.

Please go ahead.

Sonia Sidhu (Brampton South, Lib.): Thank you to all the witnesses.

My question is for Dr. Harris.

We talked about AI. Which innovations, including AI, have the greatest potential to improve diagnostic imaging capacity and reduce wait times while maintaining patient safety and quality of care?

● (1300)

Dr. Alison Harris: You've touched upon a significant issue. Right now, as it stands, we have AI being deployed across the country, but in a very patchy distribution. There's very little consistency in how and where it's going and how the AI tool is monitored once it's been deployed.

The ones being deployed currently are for things like picking up bleeds in the brain. For someone coming into the emergency department, the scans will be run through an algorithm that can pick up brain bleeds. You have others assisting in the lung cancer screening program to pick up nodules. Then there are AI tools helping to identify abnormalities in mammography. Those are the ones that are diagnostic.

Then there are others in the background that may sort the imaging studies for prioritization or help with the actual booking and scheduling of patients. There are multiple levels.

The Canadian Association of Radiologists has proposed the Health AI Validation Network. This is something we've been working on with our partners in other specialties for a number of years.

We feel that there should be oversight. Products are regulated by Health Canada and they get approval, but there's no post-market surveillance of what happens to them when they go into the market. In addition to assisting the health care system and making it more efficient, there does need to be oversight.

Sonia Sidhu: When you talk about how there is no surveillance, what kind of surveillance are you referring to? Can you elaborate on that?

What kind of surveillance do you need?

Dr. Alison Harris: What you would ideally need is to have the AI tools monitored for their accuracy over a period of time. With any technology, there is always a possibility that it could change based on the population that it's being used on. An upgrade might actually degrade the use of the product. There does need to be constant oversight of those products as they're being deployed.

Sonia Sidhu: Our biggest challenges are in retaining medical radiation technologists within the public health care system. What approach has been the most successful to retain MRTs?

Mr. Topham, you can answer that.

Christopher Topham: The most successful things have been to stabilize the workforce locally where people are.

When we surveyed people to ask how many of them intended to leave, the number was quite high, but when we asked what would make them stay, they said, “Well, I'd stay if you sorted out this workforce crisis that we're facing.”

People love their jobs. People value working closely with patients. They're suffering in these conditions currently. The reinforcements would be number one.

The Chair: Thank you very much.

Mr. Champoux, welcome to the committee.

You have two minutes.

[*Translation*]

Martin Champoux (Drummond, BQ): Thank you, Mr. Chair.

I'm speaking as the session draws to a close, but I would still like to thank the witnesses for being here. We are aware of the gaps in service provision, which are particularly glaring in several regions across Canada. I am referring mainly to Quebec. We see this in regions near where I live; it is quite striking.

Apart from the fact that, obviously, we are discussing a matter that falls exclusively within provincial jurisdiction, it seems to me that there are mechanisms that could perhaps be put in place to address these gaps, which are particularly difficult for the regions to manage and resolve.

Could a voluntary pan-Canadian procurement mechanism enable regions or slightly smaller provinces, which have less purchasing power, to benefit, in a way, from the same conditions as larger regions or more populous provinces?

[*English*]

Dr. Alison Harris: I can respond.

This is a very good question, because we are seeing the smaller provinces miss out on purchasing equipment. A lot of centres rely on their foundations to buy equipment, although that doesn't account for the whole installation process, as I mentioned earlier. The provinces could work independently with companies to make leasing arrangements. There are mechanisms that could be utilized. Where a federal response would be important is in looking at the equipment renewal and replacement in more of a federal landscape than just relying on the provinces to do it individually.

● (1305)

[*Translation*]

Martin Champoux: In a sense, is the issue of underfunding and the federal government's underrepresentation in health care funding a problem in itself? Would addressing this issue by substantially increasing federal health transfers and bringing them up to the level they ought to be at enable these regions in particular, but also the smaller provinces, to resolve these situations?

[*English*]

The Chair: Give a quick answer, please.

Dr. Alison Harris: We would need a federal response and, as I mentioned earlier, we would need accountability for where that money is being spent.

The Chair: Thank you very much.

On behalf of the committee members, I want to thank the witnesses for their valuable input. I'll release you.

The floor will now go to Madam Dancho.

Raquel Dancho: Thank you, Mr. Chair.

Thank you very much, again, to the witnesses.

This is our first meeting on the wait times for diagnostic care in Canada. I think it's a very important moment in Canadian health care that the Standing Committee on Health for Canada is taking this seriously as a national issue.

Thank you very much for kicking this off. We really appreciate your testimony and your expertise.

Mr. Chair, as we discussed, I'd like to move the following motion:

> That, pursuant to Standing Order 108(2), the committee undertake a study of the findings of the Auditor General of Canada's October 2026 report on the Public Health Emergency Stockpile, including the management of the National Emergency Strategic Stockpile and Canada's preparedness for future public health emergencies; the committee dedicate no fewer than two meetings to the study; the committee invite the Minister of Health to appear for no less than one hour, as well as the Auditor General of Canada and officials from the Public Health Agency of Canada; the committee report its findings and recommendations to the House; and that, pursuant to Standing Order 109, the government table a comprehensive response to the report.

Mr. Chair, as I know you're aware, last week the Auditor General released quite a scathing report of the mismanagement of the Public Health Agency that noted significant and persistent weaknesses when it came to managing the country's strategic stockpile of medical supplies that we depend on for national security and the public safety of Canadians should the worst occur, such as a pandemic or a chemical or biological emergency of some kind.

It outlined long-standing problems that have yet to be resolved and indicated that the health agency did not address known deficiencies in stockpile issues that resulted in, for example, $330 million of medical supplies going essentially into the garbage, along with $20 million of pharmaceuticals.

I think that this committee is well-placed to take this report seriously and invite the witnesses to appear.

Thank you, Mr. Chair.

The Chair: We have two minutes left.

I have Madam Chi, then I'm going to either suspend or adjourn the meeting at 1:10.

Maggie Chi: Thank you, Chair. I'll be very quick.

First, I want to thank my colleague for the motion. I will note that the usual practice for an Auditor General report is for the public accounts committee to look at it first, and then the other committees can decide whether they want to look into it, which prevents duplicative work between the committees. This is a very important topic, and we support looking into it.

Given the subject matter with respect to some sensitivities around national security considerations, we think something similar to our meeting of February 10, where Public Health Agency of Canada officials appeared for one hour in camera and one hour in public, would also be appropriate for this.

With that, I have an amendment, which is being emailed to the clerk right now.

I move:

> That the motion be amended by adding after the words “and officials from the Public Health Agency of Canada” the following: “for two hours, with one hour in public and one hour in camera”.

(Amendment agreed to)

The Chair: Now we are on the motion as amended. All in favour?

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

The Chair: The meeting is adjourned.

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