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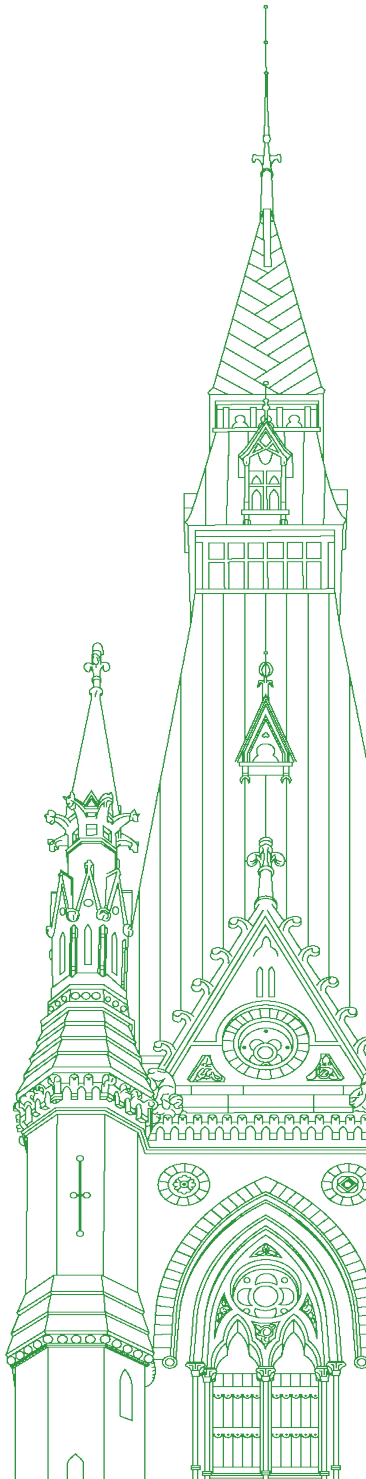

Chair: Sukh Dhaliwal

Standing Committee on Health

Monday, November 16, 2026

● (1110)

[*English*]

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

Welcome to meeting number 43 of the House of Commons Standing Committee on Health. Today's meeting is taking place in hybrid format, pursuant to the Standing Orders.

I would like to remind participants of the following points.

Please wait until I recognize you by name before speaking.

Those participating by video conference, click on the microphone icon to activate your mic, and 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.

Members in the room, if you wish to speak, please raise your hand. Members on Zoom, please use the raise hand function.

I will remind you that all comments should be addressed through the chair. I will give some leeway. When you are talking to the honourable members, you can have eye contact with them. The clerk and I will manage the speaking order as best 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 resume its study of diagnostic imaging capacity.

Before I welcome the witnesses, I would suggest, honourable members, if you are participating online, that you please try to log in 10 to 15 minutes before the meeting starts so that technical issues can be resolved. With regard to witnesses, I will ask the clerk from now on to please ask witnesses to come 10 to 15 minutes before the meeting starts so that technical issues are resolved and we can start the meeting on time.

On Wednesday, Madame Gaudreau will be chairing the meeting. She will also be taking her time when it is her turn. She will be speaking not only from the chair's position but also from a member's position, sitting in the chair's role.

With that, I would now like to welcome our witnesses for the first hour. From the Macdonald-Laurier Institute, we have Dr. Shawn Whatley, physician. From SecondStreet.org, we have Colin Craig, president. From Trillium Health Partners, we have Karli Farrow, president and CEO, and Dr. Ivan Diamond, program chief and medical director, Cator family diagnostic imaging program.

I would like to remind witnesses that committee members may ask questions in either French or English. If you require interpretation, please prepare your earpiece and select the listening channel you need in advance.

Each organization has five minutes for opening remarks, and we will start with Dr. Whatley.

Please go ahead.

Dr. Shawn Whatley (Physician, Macdonald-Laurier Institute): Thank you, Chair.

My remarks assume that there is no new money to spend. I have focused on item (f) of the motion before you regarding opportunities for the federal government.

My written submission offers brief comments on two ideas: first, the opportunity for incentivizing provinces to transition from block-based to activity-based funding and, second, exploration by the federal government of a return to a seed grant or innovations-style approach to health transfer payments. I'm happy to take questions on these later.

For my remaining time, I want to share an essential concept often missed in policy work: Form follows function, and function follows purpose. Policy discussions tend to focus on the form and format of particular policies. Committees might hear about health care in other countries. They might learn about the functionalities of a particular policy—for example, details about funding structure, efficiency or performance metrics. However, most committees rarely find time to debate purpose. Why are we pursuing a particular policy? What overall goal do we hope to achieve? This might seem simple and easy, but it's actually hard and complex.

Let me explain using a family vacation as an example. Imagine your family discussing where to go for spring break—perhaps skiing in Whistler, visiting the EPCOT centre in Florida or even taking a vacation at home. How do you decide on the particular form of your vacation? You might consider the functionalities you hope to achieve on vacation: a break from your phone, decreased screen time for your children or an opportunity to see new things. We almost never ask why we want to go on vacation in the first place. Parents might want rest and reconnection. Children might want entertainment. Which purpose wins out? The success or failure of every family vacation and every policy initiative depends on our assumed purpose.

For example, Roy Romanow seems to hold a clear view of medicare's purpose. As you know, he is a former NDP premier of Saskatchewan, and he led the 2001 Commission on the Future of Health Care in Canada. In 2009, Romanow commented on the Cambie Surgeries and Chaoulli court cases. He said, “this great, redistributive program we call Medicare may not yet be safe.”

If redistribution is a primary purpose of medicare, the performance of a particular policy with respect to DI wait times or efficiency, for example, matters little. If questioned about long wait times, Mr. Romanow and those who agree with him can say, in so many words, that medicare continues to do well overall. It meets its redistributive purpose. We need to focus on keeping it safe. If, however, you—like most Canadians—believe medicare exists to provide care when you and your family get sick, wait times and access matter a great deal.

In your current work on DI capacity, I'm not suggesting that you can achieve unanimous support for either redistribution or timely access to care as the primary purpose, but you might explore whether you can find common purpose in something else—for example, incentivizing activity-based funding or adopting a new mindset on the use of federal spending power. If we don't tackle questions of purpose, we will remain tangled in endless debates about form and functionality. The federal government has a unique opportunity to create space for policy innovation if it avoids getting distracted by new program creation.

I look forward to your questions.

Thank you.

● (1115)

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

We will now go to Colin Craig, SecondStreet.org president, for five minutes.

Please go ahead.

Colin Craig (President, SecondStreet.org): Good morning, and thank you for the opportunity to speak here today on behalf of SecondStreet.org.

We are a public policy think tank that spends considerable time and resources each year on health reform, working to flesh out policy ideas that could improve the system by drawing on best practices from Canada and peer nations abroad, particularly in Europe. At the same time, we spend a lot of time telling the stories behind the numbers, talking to Canadian patients from coast to coast about their experiences with the health care system, both positive and negative.

In my brief opening remarks today, I would like to share four points with you.

First, I would ask you to put aside your partisan leanings, because patients across the country are suffering right now. Some are even dying while they wait for care, and this is a much bigger issue than politics.

Liberal, NDP and Conservative political parties have each had many opportunities to govern provincially in Canada over the last 25 years, but none of them have managed to fix health care. You could pick your favourite provincial government in Canada over the last quarter century, and the health care they delivered would have failed to stand up to the level of care delivered by many peer nations in Europe. We, therefore, need to ask this question: Why is that?

The answer is that all three parties have largely done the same thing, and that is to throw money at the system and hope something works—but it hasn't.

What we need is structural reform, and that brings me to point number two—the suffering that's happening in Canada right now.

Our organization has gathered government data showing that over 133,000 patients have died on wait-lists since 2018. Over 100,000 of those cases saw patients die before even receiving diagnostic scans. For example, in fiscal year 2024-25, there were 320 cases in which patients died in Ontario while waiting for heart surgery and diagnostic scans, including many who were waiting for angiograms. Nearly 100 of those cases included patients who died after waiting longer than the target time or longer than 90 days. Incredibly, a lot of the data is missing, so the true total is likely higher.

Now, to be clear, a majority of the wait-list deaths we have identified did not occur while waiting for life-saving treatment, but we should not dismiss those cases. How many of you would like to die with extreme knee pain while you wait a year for an MRI scan and then maybe six months after that for surgery? Would you want to spend the final year or two of your life holed up in your apartment, in pain, unable to see your grandkids' soccer games or visit with friends? The answer is obvious.

I'd like you to consider a few patients' stories.

In Manitoba, a patient named Bruce shared his story. After speaking with his family doctor in Manitoba about his heart problems and shortness of breath, he finally got a call back from the specialist's office—after six months—saying that his case was urgent, and they'd like to move it along in six months. That was a year for his urgent heart problem. Thankfully, Bruce had already paid for treatment in Minnesota and was driving to his follow-up appointment when he took that call from Manitoba. Had he waited for government health care in Manitoba, he likely would have been dead.

Leah Costello Rowntree, a British Columbia patient, discussed her cancer fight with us a couple of years ago. She said at one point that she paid for an MRI in the United States to learn more about her case. When she presented the results to her doctor in Vancouver, Leah noted that her doctor was “so excited because she normally [didn't] have those tools”. She was referring to an MRI scan. Leah said, “wow, here's somebody that spent an incredible amount of her life just getting educated enough to become a surgical oncologist, and we're asking her to do her job with one hand tied behind her back.... She was giddy...like a kid in a candy store”.

Jeff Krushell, an Edmonton patient, described how, when he visited a specialist in another country about his back problems, the specialist told him that they often find it interesting when Canadian patients come in, as they're often case studies in terms of the limits of what the human body can endure in terms of pain and suffering.

Needless to say, there are countless other stories in which patients are waiting long times for diagnostic scans. These wait times are especially consequential for cancer patients and those who need cardiac care or other life-saving treatments, when time is not on their side.

The third point I would leave you with is the good news, which is that it does not have to be this way. Our think tank has travelled to Sweden, Denmark, France and Japan to see their systems up close. They have what we want. They have universal systems in which everyone is covered.

● (1120)

Patients receive quality treatment in a timely manner, and when they leave those appointments, no one is facing a massive bill. If we want their shorter wait times and functional systems, we need to put patients first and copy the policies that work well in those countries.

Point four is that in those countries and other better-performing universal systems, one change that is relevant for Ottawa is that their countries give patients a choice. You can use the public system, and if you don't want to, you can pay for private treatment. Unlike the federal government in Canada, they do not penalize provincial governments for letting patients pay for private diagnostic scans or private surgical treatments abroad.

The Chair: President Craig, you are 45 seconds over time. I'm sorry. You can cover it once you're asked the questions if there is time left.

We will now go to Trillium Health Partners with the president and chief executive officer, Madame Farrow, along with Dr. Ivan Diamond.

You have five minutes. Please go ahead.

● (1125)

Karli Farrow (President and Chief Executive Officer, Trillium Health Partners): Thank you very much, Mr. Chair.

To all members of the committee, thank you for the opportunity for us to appear today.

I am Karli Farrow, president and CEO of Trillium Health Partners. I am joined by my colleague, Dr. Diamond, our chief medical director of the Cator family diagnostic imaging program.

Our prescription for Canada is to build the most productive, connected, AI-enabled and high-quality diagnostic imaging platform in the world. Canada performed 16% more MRI and CT scans in 2024 than in 2019, yet median waits increased by 15 days for MRI and three days for CT.

This is not only a capacity problem. It is a system design problem, and we see it every day here in serving a region of 2.2 million people across the western GTA. From 2021 to 2022 up to 2025 and 2026, demand at Trillium Health Partners rose 26.5% for CT and 31.2% for MRI, even as we increased capacity and improved productivity.

We see that this is not simply a call for more scanners. At a high level, we are recommending five things.

One, connect every provider and every image to a provincial repository.

Two, build a workforce that can operate as a network.

Three, help health systems adopt proven AI tools that can reduce wait times and increase quality.

Four, make appropriate use a national quality-of-care priority.

Five, invest in a connected platform, not isolated assets, through a diagnostic imaging capacity fund, as we've had in the past in Canada.

Dr. Diamond will describe what this looks like in practice.

Dr. Ivan Diamond (Program Chief and Medical Director, Cator Family Diagnostic Imaging, Trillium Health Partners): Thank you, Karli.

As a radiologist, I'll start with a simple principle. Better access does not mean more imaging: It means the right test for the right clinical indication at the right time. A scanner alone does not create capacity. You need technologists, nurses and radiologists.

Technology can help our health human resources go further. An example is that at Trillium Health Partners we are using AI-enabled MRI reconstruction, together with expanded technology scope, to safely shorten scan times on the scanners we already have. The same equipment and the same team can scan more patients. This is real innovation, running in our hospitals today, and it is the kind of proven AI tool that a national fund should help other health systems adopt.

We are also using governed tools to prioritize urgent cases and support more timely reporting and follow-up. These tools are not intended to replace technologists or radiologists. They free up skilled professionals to spend more time on work that requires their expertise, and they create capacity only when they are validated in Canadian patient populations, integrated into clinical workflow and measured against results.

I'll go back to Karli.

Karli Farrow: Thank you, Ivan.

Our recommendations, we believe, will turn isolated capacity into a connected platform, images that follow the patient, a workforce that works as a network and proven AI put to work with every dollar invested. The test of success is whether every Canadian gets the right test in the right place at the right time, as well as whether every test contributes to better care and better value for Canadians. Here at Trillium Health Partners, we're ready to partner on that as a real-world testing ground.

We look forward to your questions and the dialogue today.

The Chair: Thank you very much.

We're under time by four minutes. We will go to the honourable members now.

We'll start with Madame Dancho for six minutes.

Please go ahead.

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

Thank you to the witnesses for your testimony so far. I appreciate your being here.

I have a few questions for Mr. Craig.

I want to touch on your opening remarks about some of the wait times and the numbers you're seeing of people waiting for care in Canada. Some of your research from SecondStreet.org has documented that over 133,000 people since 2018 have died waiting for some sort of surgery or diagnostic. I believe that was 23,000 last year. Can you just verify that I have the right numbers there?

Colin Craig: That's correct.

Sorry, I would just add this. Those numbers are under-represented because many provincial governments simply don't have all the data. If anything, those are low-ball figures.

Raquel Dancho: You mentioned a good example of someone not dying—Bruce from Manitoba. It's an interesting story. You mentioned in your opening remarks, just to elaborate, that Bruce from Manitoba got a referral to a specialist from his doctor regarding his heart problems and shortness of breath. Six months later, he finally got the call from the specialist, who told him that six months from then, he would have the heart procedure. However, he happened to be on his way to his follow-up appointment in the U.S., following his treatment in the U.S., which he got in short order. Bruce is of the opinion, from the medical information he received, that he would have died if he had to wait for that heart procedure in Canada.

You have also done research on some systems in Denmark, Sweden, France and Japan. Can you elaborate on how perhaps Bruce's case would have been prevented in terms of the one-year wait for heart surgery? How do they operate differently, relative to Canada? My understanding is that they also have universal systems, as Canada does.

● (1130)

Colin Craig: Yes, there are several differences between us and many European countries. One of the most fundamental differences is that they fund services for patients, and we fund health care systems. We throw a lot of money into health care systems and hope that those dollars help patients. They will fund providers after they deliver a service to patients.

As Dr. Whatley mentioned in his comments, that's basically known as activity-based funding. You provide *x* number of dollars to a health care provider when they complete a service to a patient. You do an MRI scan and you might get, say, $1,000. Do a knee surgery and you might get $10,000. That incentivizes their providers to help more patients. We give a large funding envelope—a global budget—at the beginning of a year to, say, a hospital and then tell them, “Good luck. We hope you can help a lot of patients this year.”

I'm generalizing. We have 10 provinces, but in most of the country, this is how it works. For a hospital, every patient who walks through the door is a drain on their budget, so it's set up with the wrong incentives. That's one of the fundamental differences.

A second major one is that they're not as ideological in those countries, so they will partner with government facilities to fund non-profits and for-profits to help patients. That isn't the concern. It's typically a level playing field, and whoever the provider is, they get the same amount of money if they're helping patients. Again, there are some differences.

As one example, we stood in a hospital in Stockholm, Sweden, that is owned by the government, but they pay a private provider to deliver services and run the hospital. The facility delivers care for patients more cost-effectively than the government hospital down the road, so savings can be reinvested in the system to help even more patients. That's a third difference.

Finally, the one that I was alluding to in my opening remarks is that they don't force everyone to use their public systems. They have choice. Some patients—a small number, typically; in a country like Sweden, it's about 7%—have private health insurance. Therefore, the government does not really have to worry about that 7% of the population, so they can take those dollars and use them to help those who can't afford private health insurance. They're not as ideological that way. There is choice and that helps take pressure off their public systems.

Raquel Dancho: That's interesting, Mr. Craig. Often the Scandinavian countries are upheld as socialist-type countries, yet my understanding is that even the most far-left parties in those countries support this sort of option for health care underpinning their universal systems.

I want to get your comment on this. My understanding is that in Denmark, they give patients a statutory right to diagnostic assessment within 30 days of hospital referral, when medically feasible. If the region cannot provide the service within the required period because of capacity constraints or other reasons, eligible patients can choose a contracted private hospital at public expense. I believe Australia does something similar, also in a universal system very similar to Canada's.

Can you comment on that at all?

Colin Craig: I'm not as familiar with the Australian model.

Yes, guarantees are very common in Europe. Across the European Union, they have what's known as the cross-border directive. It was implemented in 2011. If a patient has a need to avoid a long waiting list in their own country for whatever reason, this allows them to go to another EU country, pay for treatment and get reimbursed by their home country, up to what the home country would have normally spent. That covers the entire EU. There's some variation among countries, but from 10,000 feet up, that's how it works. It's an accountability measure. Individual EU members have their own measures as well, as you mentioned regarding Denmark. They have those features in place. If you can't get care in the public system, you can go private and the government will fund your treatment.

This is something that is missing.

● (1135)

Raquel Dancho: Yes. I think it provides certainty for individuals in Denmark and other countries. Our governments don't do anything if they miss these benchmarks, and they're missing them by months and years, in many cases. It's an interesting case study.

Thank you for sharing that.

The Chair: Thank you very much, Madame Dancho.

We will go to Parliamentary Secretary Chi for six minutes.

Please go ahead.

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

Thank you to all the witnesses for appearing before committee today and enriching our study.

When someone is looking for a scan to find out whether they have cancer, what matters to them is how soon they can get an answer.

My first couple of questions are for the Trillium team.

What caught my attention in your opening remarks is how your team has looked at the whole process, from the moment a referral comes in to the time a patient spends in the scanner. You've been able to book patients more quickly and get more out of the scanners you already have.

If you could take us into the imaging department and show us one change that makes a real difference, what would you show us, and what does that look like for a patient today versus a few years ago?

Karli Farrow: I'll pass it over to Ivan to define that for the committee.

I will say that part of what we describe is the productivity we're creating today. Our recommendations link into how we're building a platform that can unleash even more productivity within the system. This is very important, because when we look at total spending in health care—which was just reported by CIHI—our position is this: Wherever that spending comes from, private or public, we need to do a much better job of tapping into all the available capacity.

Dr. Diamond.

Dr. Ivan Diamond: I'll highlight what we've been doing around the use of MR reconstruction algorithms.

This is software that lives on the MR scanner. An MRI sequence can typically take up to four minutes to acquire. This software, using advanced AI reconstruction, has the potential to decrease those sequences by up to 50%, depending on the time. Every single MRI exam is made up of a series of those sequences. Not only does this allow us to shorten the exam, but it also—during those times that patients need to remain still and sometimes hold their breath for periods of time—provides a much better patient experience. This has equivalent diagnostic quality and allows us to leverage additional time on our scanners using the same resources.

It requires no net new resources to expand capacity through MRI reconstruction. Similar tools exist in CT reconstruction. We truly believe this is an opportunity to expand overall system capacity without net new resources, in terms of scanners and technologists.

Maggie Chi: Thank you so much for that.

In your opening remarks, you talked about how AI is enabling a lot of these new technologies and new approaches. One of the ambitions behind the government's AI for all strategy is to put Canada's strength in AI to work in ways that benefit Canadians.

At Trillium, you've been testing how AI can help at different points in a patient's care journey. Now that your team has experimented and worked with these tools, where has AI proved to be useful in a way that you weren't expecting and that really surprised you?

Dr. Ivan Diamond: I don't think it surprised us. We truly believed that AI gave the opportunity to make care safer and faster.

One of the tools we've deployed is an algorithm to detect intracranial hemorrhage. In our workflow, patients have scans. Many in the emergency department may have bleeds detected by the AI. The AI flags that case to be immediately looked at by a radiologist. We know that there will be false positives, even with AI, and the final validation is done by a radiologist. It allows us to make those diagnoses more quickly, allowing the patient to get more advanced care quickly.

The other area is this: We, like most hospitals, read outpatient exams after the patient has left the hospital. By leveraging our advanced AI tool screening, we have these scans looked at before the patient leaves the hospital. We've had patients with brain tumours and brain bleeds, unexpectedly, on outpatient studies, identified right away and redirected to the emergency department as a consequence of leveraging that technology.

There's really an opportunity at every single part of the diagnostic imaging journey to leverage AI to improve bookings and appropriateness, to improve how we perform exams, to improve how radiologists report exams and, ultimately, to make follow-up safer and more robust, using these tools that do not require additional health human resources.

● (1140)

Maggie Chi: Thank you for that.

Karli Farrow: If I could just add....

Maggie Chi: Go ahead.

Karli Farrow: One of the most important uses, as Dr. Diamond just pointed out, is this: If we're really trying to tap all the available capacity, these are tools that can help us prioritize. When we use the whole network to the effect of best outcomes for patients, that means not just within our hospital walls but also in those centres that are delivering radiology outside our walls. It's how we can jointly work on prioritization and ensuring access to care, which are a huge priority and one that we do very well in terms of those people who require—and who we've identified as requiring—urgent diagnostic imaging. Where we have seen longer wait times is in those lower-priority areas. If we can use AI to help, within a network, prioritize cases, we can move those wait-lists along in different ways.

The Vice-Chair (Raquel Dancho): Thank you very much.

We'll go to our next questioner.

[*Translation*]

Ms. Gaudreau, you have the floor for six minutes.

Marie-Hélène Gaudreau (Laurentides—Labelle, BQ): Thank you to the witnesses for being here. We always receive valuable information from experts such as yourselves. As you know, I'm a Bloc Québécois member. Earlier this week, I met with my counterparts in Quebec City and mentioned that I have the privilege of serving as vice-chair of the Standing Committee on Health. The first thing they asked me was whether the committee understands its role and, indeed, the limits of its jurisdiction.

That's precisely why you're here today. We have before us a motion dealing with problems of access to magnetic resonance imaging, or MRI. The motion contains two elements that relate directly to the role of Health Canada: first, identifying innovative approaches to implementation in Canada and in other countries with respect to technologies such as MRI; and second, determining what the federal government can do to support health data.

Whenever we discuss challenges, I think of another study we're conducting on HIV/AIDS and syphilis, particularly in Manitoba but also across all provinces and territories. Once again, the discussions have been extremely interesting, but the reality is that, even if I were to raise these issues with the minister here, she would tell me that those matters fall under Quebec's jurisdiction.

The challenge we face is this: When I hear in opening remarks that we should try to set partisanship aside, I would say that health care shouldn't be partisan. That's important. What matters is identifying needs, and I'm sure you've heard discussions about health transfers. I've been here for seven years, and throughout that time the primary objective has been to ensure that growth in health transfers never falls below 6%. Yet the proposal in the 2026-27 budget is reduced to 5%.

When we consult provinces and territories across the country, they tell us that this was the lesson the previous government failed to understand. There was unanimous agreement that growth should not fall below 6%, but now it stands at 5%.

We're told that there's a shortage of data, health care workers, specialists and MRI machines. Last week, in my riding, I met with the Sainte-Agathe hospital foundation. It is working tirelessly to raise funds for an MRI machine because people currently have to drive at least three hours to obtain that service. Imagine dealing with an emergency situation under those circumstances.

The reality is that we need services. That's why, while I find these discussions extremely worthwhile, I'd like to hear more from you about models that exist elsewhere and that could be adopted without encroaching on provincial jurisdiction.

My question is for the representatives of Trillium Health Partners.

Ms. Farrow, I understand that you oversee a large hospital network. When Ottawa increases or decreases the growth rate of health transfers to the provinces, does that have a tangible impact on your ability to expand MRI operating hours, hire staff or operate equipment?

In other words, if the goal is to reduce wait times, how important is the predictability of federal health transfers to day-to-day health care planning?

Dr. Diamond, I'd also invite you to respond.

● (1145)

[*English*]

Karli Farrow: Thank you. To answer the question, Trillium receives the majority of its funding from the provincial government.

I don't think it would be appropriate for me to answer questions about the predictability between the federal government and the provincial government. We have a high degree of engagement with our provincial government and the agency that oversees the administration of health care for Ontario.

[*Translation*]

Marie-Hélène Gaudreau: In essence, my question is this: If you had greater resources and were able either to hire more staff or acquire additional equipment, would that improve the situation?

Put simply, if health transfers were increased, would you be in a position to allocate those funds where they're most needed?

[*English*]

Karli Farrow: We've included in our submission a part of the proposal suggesting that additional funding to support capacity building for diagnostic imaging equipment would be very useful for Trillium Health Partners. We recommend that such a fund should come with a complete plan that would see high-quality appropriateness, as well as an interconnected system of care.

The short answer is that, as per our proposal, we believe that funding would be helpful for our organization.

The Vice-Chair (Raquel Dancho): Thank you very much.

Ms. Konanz, you have five minutes. Please go ahead.

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

Thank you to the witnesses for being here.

My first question is for Mr. Craig.

You touched on wait-list deaths. In the communities I represent, we have a severe shortage of specialists and doctors. If they can get a referral...patients are dying on wait-lists, waiting for critical scans. It's not just anecdotal. It was reported through freedom of information from your organization, SecondStreet.org, that 4,620 people died in B.C. alone between April 1, 2024, and March 31, 2025, while on wait-lists. Some never find out the illness they succumb to.

You said that the data here is incomplete or unrepresented. Those numbers are incomplete. Why is this data incomplete? What might be a reasonable estimate for the true size? Could it be incomplete because, with the shortage of doctors, citizens can't even get their referrals on time?

Colin Craig: Thank you for the question.

This is a problem right across the country, generally speaking, as you have governments simply not tracking this data.

It's interesting when you compare the high bar governments set for the private sector versus the bar that is lying on the ground for themselves. You will find provincial health departments going into restaurants across this country every day and finding the smallest of mistakes. Those are often reported quite publicly. Maybe a restaurant has a mouldy soup can in the fridge. It's not a good thing, but that will get reported. We saw an example of a day care that was missing a paper towel holder. That was reported online for the world to see.

The question we ask is this: Okay, government, if that's the high standard we're going to meet, how many people died on waiting lists the previous year because you did not provide care and treatment on time? No province tracks that or discloses it. We have to gather this data through freedom of information. It's an imperfect process—

● (1150)

Helena Konanz: I don't want to interrupt you, but I have only a short bit of time.

Why do you think it's not being tracked? It's a simple question, but this is a life-or-death situation. Why isn't it being tracked?

Colin Craig: I think there are a couple of reasons. First, which politician in the country wants to stand up and release this data each year? It's not good data to have to disclose to the public: People are dying because care is not being provided. That's part of it.

I think the second part of it is that the government doesn't think of health care this way, that this should be tracked. The data is tracked, as far as I can tell from conversations with current and former staff, almost by accident. Someone managing a wait-list hears that a patient has passed away and no longer needs a scan, surgery or whatever. They click a box to cancel the procedure. It asks them why it's being cancelled. They choose from a set of options, and that's it. The data is never analyzed. We know this because governments have to gather the data for us and provide it. If they had already gathered it to analyze it, then they wouldn't charge us for the information. It would all be in a nice, neat little report they could hand over.

I think those are the two reasons.

Helena Konanz: Thank you.

You referenced the story of a surgical oncologist in British Columbia who had to work with one hand tied behind her back. First of all, we're short on oncologists, and for the ones we do have, it looks as though they have their hands tied behind their backs. This doctor is saying that this is because of a delay in diagnostics.

How might some of the reforms you suggest help the burden and workload of physicians at a time when there is so much concern regarding burnout and, as a result, a loss of access to health care services and a shortage of doctors and specialists?

Colin Craig: I think multiple things need to happen all at once.

The big picture point that I would respectfully submit to this committee is that you're not going to spend your way out of this problem. We spend a lot, as a nation, on health care. We are not getting good quality in terms of the volume of care delivered to patients. The question is, why is all this money being wasted in the system, instead of reaching the front lines—doctors, nurses, buying diagnostic equipment, etc.?

Part of this goes back to what I talked about: activity-based funding. If you fund output, the dollars get spent in the system on output, instead of being spent on distractions. Quebec has had some very positive success with this in experimenting with activity-based funding. They call it, I believe, patient-focused funding. They have seen the cost of different surgery diagnostic scans coming down per procedure because they are funded under an activity-based funding model. B.C. has tried this in the past. They had some positive success there. Many other countries use that approach as a default. It helps ensure that more dollars are spent on care for patients, rather than on hiring more vice-presidents and being wasted on this side or the other—

The Chair: Thank you, Mr. Craig. We are 40 seconds over time.

We'll go to Dr. Eyolfson.

Dr. Eyolfson, you have five minutes. Please go ahead.

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

Mr. Craig, you hit the nail on the head when you said that we can't just throw more money at it. That's a frustration we've had in the federal government. I've said this for years: Provincial governments just want the federal government to give them more money, but they don't want a peep out of us if we even suggest what they do with that money. Quebec, as you said, has some good outcomes. It would be good if we had some way of giving such direction to all the provinces.

In regard to your comparison with Australia, I've read about Australia's system and its change. Australia had a single-payer universal system like Canada's up until the 1990s. They went to a two-tier system. The National Institutes of Health in the U.S. looked at this. Although you're correct that, overall, they have good outcomes provided for less money, they also found that patients in the private system did much better. Patients in the public system were having longer waits and worse outcomes. The waits got worse and the outcomes got worse in the public system.

If we were to add this dual system, in which you give patients choice, how would we ensure that care does not suffer in the public system as it did in Australia?

● (1155)

Colin Craig: I didn't raise Australia. That is a country we plan on exploring further. My understanding is that, yes, typically, the care provided in that country exceeds what you find in this country.

To answer your point about allowing choice and your concern about protecting the public system, we have, as I mentioned, travelled—as an organization—to Sweden, where there is choice; to Denmark, where there is choice; to France, where there is choice; and to Japan, where there is choice. In those countries, when we describe the wait times that Canadians face, they look at us as though we're a bit crazy. “What is going on in Canada? In a developed nation like Canada, why are so many patients suffering?” They look at us as though something crazy is going—

Doug Eyolfson: I'm sorry to interrupt you, but I have limited time. That's leading to my next question regarding the countries you mentioned: Denmark, France and Sweden. Yes, they have better care in both systems, provided for with less money.

However, all three of these European nations spend much more than Canada on their social safety net. They spend more on addictions treatment. They spend more on relieving poverty. They spend more on making sure that the unhoused have homes. They have a much healthier population overall because of these investments. All of these things together would save money for the health care system without being direct investments in the health care system.

Another comparator of all three of these countries is that they all pay significantly higher taxes than Canadians do. If we're going to compare on this, we need to compare all the facts. To say in a vacuum that Denmark, France and Sweden all have dual-payer systems and they provide better care for all in spending less money, is incomplete, considering, as I've said, the robust spending they have on their social security net, which is far more than Canada's. The fact is, if we wanted their system, Canadians would need to expect to pay significantly higher taxes.

The Chair: You have 15 seconds, Mr. Craig.

Colin Craig: You make a good point about apples to apples. Compare their health care system with our health care system, and they get better results. They and many of those countries are spending less than or about the same as what we are. They're getting better bang for their buck.

We need to be thinking about the same thing. How do we get better bang for our buck, but also other changes...? As we mentioned, the importance of choice can take pressure off our public system. The public system doesn't have to worry about treating everyone, just those who actually need help from the government.

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

Please go ahead.

[*Translation*]

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

For goodness' sake, could we at least compare apples to apples? When we refer to the governments of Australia or Germany, the comparison is relevant because their federal systems are similar to ours. However, we can't compare ourselves to unitary states, where a single national government is responsible for the entire system. That's not our reality. Otherwise, we wouldn't have provinces and territories with responsibility for areas such as education and health care. I would encourage our analysts to clearly distinguish among the jurisdictions being compared, because we're not there yet, at least not here. As for us, we may eventually get there when we become a country of our own.

What we continue to hear, and I heard it very clearly from Mr. Craig, is that our population is aging, that increasing life expectancy is creating additional pressures and that people need more and more care.

I used to work in a health and social services centre. The first consideration from an administrative standpoint is always the need to balance the budget.

Can we imagine how low priority levels P4 and P5 were on our list of concerns? Frankly, I can't believe I'm discussing this here in Ottawa. What this highlights is that we're talking about access to a resource, system or piece of equipment directly linked to specific needs.

Perhaps the central question is whether we can at least establish comprehensive data collection and share that information more broadly. My question is for Mr. Craig. Perhaps he can tell me whether having access to all the data would, in fact, be beneficial in supporting innovation and decision-making and in enabling provinces to learn from each other's experiences.

● (1200)

[*English*]

The Chair: Madame Gaudreau, your time is up.

I'll give 30 seconds to one witness. Does anyone want to respond, or should we go to the next one?

Dr. Shawn Whatley: Yes, I'd like to respond. It's a fascinating discussion, and I appreciate the question. I think the unique value proposition for this committee is to look at what you can control.

We keep talking about things outside the federal government's jurisdiction, which I find interesting. It's fun to talk about forms and functionalities and IT, but it's the wrong question to be discussing.

Furthermore, we don't need to look around the world for solutions. In 2017, the Manitoba auditor general report on MRI wait times showed that access was next day for athletes; same day or next day for “government officials, donors, or people working in the health care system”; 20 days for people in WSIB; and 23 weeks for everyone else.

We don't need to look around the world, folks. We have great solutions in Canada.

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

Just one second, please.

Mr. Craig, you have your hand up. Is there something you want to say?

Colin Craig: I was hoping to respond to the question.

The Chair: I know, but we're way over time; we're already one minute over time. I can't go that far.

We'll give you the time once Madame Dancho asks her questions. She's going to speak next.

Madame Dancho, you have five minutes. Please go ahead.

Raquel Dancho: Thank you, Mr. Chair.

One part that we'll need in our report from the analysts, after we put all this together, is some definitions of different terms in health care around the globe, because there's a bit of a misunderstanding.

I was listening to testimony from Mr. Eyolfson from the Liberal side regarding universal health care, but he wasn't quite accurate in his description.

For example, the U.S. does not have a universal health care system. It does not have a system that covers everyone publicly. Most other countries in the world—developed countries—have universal systems similar to Canada's, but they are different in certain key ways. “Universal health care system” means that a country has a publicly funded system that everyone can access, but that does not preclude private options for treatment or insurance in addition to that system. In fact, most high-performing universal health care systems are not strictly single-payer, and Canada's is really the only one in the world like it—in the developed world, anyway.

Part of the study has to have some of the definitions so that we're clear on what we're talking about.

I want to ask some questions of Mr. Whatley.

You've written a lot about health care governance in Canada, and we've heard some very interesting testimony from you over the years. I wanted to ask you about some OECD statistics. I believe you've touched on them from time to time. The OECD reports that Canada has about 26 diagnostic imaging scanners per million people, whereas the OECD average in the developed world is 51—double what Canada has—never mind the high performers in the OECD.

From your perspective, is it a governance issue? Is it a funding issue? Why is Canada such an underperformer when it comes to diagnostic imaging scanners per million people compared to the rest of the developed world?

Dr. Shawn Whatley: That's a great question.

We often focus on capacity and funding, but it's the wrong place to focus on. We should focus on how our capacity is being used.

For example, in 2012, the Ontario auditor general, in their report on independent health facilities in Ontario, noted that there was a 20% to 40% savings for the same procedure and/or scan when it was performed in an IHF versus a public hospital. This is understandable, because public hospitals are large; it's just a completely different apparatus.

Our focus needs to be on finding ways to use the current capacity we have. It would be lovely if we could get up to OECD averages. That would be wonderful, but my assumption for this committee is that you don't have new money to spend.

● (1205)

Raquel Dancho: Also, according to the OECD, we pay some of the most per capita, yet we are such an underperformer on things like diagnostic scanners per million. I see you nodding. Money, as others have mentioned in their testimony today, is not necessarily the answer; it might be part of the answer, but more money may not solve the problem.

One concern we have heard at this committee—and that I've heard elsewhere and agree with—is that if we all woke up tomorrow with double the number of scanners, let's say...would that not take scarce resources like technicians and others who help operate the scanners away from the public system? You've argued in some of your writing that we shouldn't be worried about that.

Can you go into some detail about why that wouldn't be a concern?

Dr. Shawn Whatley: Your question, I assume, relates to this discussion about the public and private offering of services.

As far as we can tell, for example, over 2,200 nurses travel from Windsor to work in Detroit every day. We have unemployed orthopaedic surgeons in Canada, and 31 out of 100 nurses under the age of 35 who graduate do not practise nursing. They leave within five years.

We have oodles of data showing that our health human resource capacity, which is the broader term for your question, is being underutilized, and in many cases, we're giving them no option other than quitting what they trained to do.

Raquel Dancho: That's interesting. I appreciate that.

I wasn't aware that there are Canadian nurses travelling to Detroit to work in the U.S. rather than in Canada.

Dr. Shawn Whatley: That's correct; there are.

Raquel Dancho: I see multiple people nodding.

I didn't realize that. This is interesting and, I'm sure, disappointing for some of the nurses working with the shortages we see in Canada.

I want to conclude with this in my remaining time.

One thing I have heard on capacity issues is that if there were more private diagnostic clinics, for example, it wouldn't be that people wouldn't want to work in a hospital during daytime hours. It's those 2 a.m. shifts in the ER that people may struggle with, and consistently still struggle with right now, without an alternative option for work. I have had some people suggest to me that hospitals need to top up the pay for those evening shifts or provide other incentives should other options become available in a private system.

Do you have any comment on that?

Dr. Shawn Whatley: In my experience, based on working in one of the largest emergency departments in Canada and working for a number of years on boards in hospitals, you can't pay nurses to do something that requires them to go against other incentives in their lives. For example, you can't pay them an extra $100 to work an unsociable shift.

We have to allow local institutions to be creative and pull in people without forcing them to work a certain ratio of nights or a certain ratio of weekends. The solutions are there if we allow people to find them on their own. It's the rigid structures and ratioing. Often these are driven by professional associations that won't let hospitals find innovative solutions to staffing.

Raquel Dancho: That's great.

Thank you very much.

The Chair: Thank you very much.

Mr. Craig, you can send a response to Madame Gaudreau's question in writing. That would be appreciated. You didn't get time to answer.

Now we will go to Mr. Sawatzky for five minutes.

Please go ahead.

Jake Sawatzky (New Westminster—Burnaby—Maillardville, Lib.): Thank you, Chair.

Thank you to all the witnesses for being with us today.

My first question is for Ms. Farrow.

Your annual report indicates that Trillium Health Partners delivered about 800,000 diagnostic services from 2025 to 2026. That's an increase of nearly 21,000 from the previous year.

What's driving this increase in demand, and how are hospitals expanding diagnostic imaging capacity to keep pace?

Karli Farrow: Thank you for the question.

Trillium Health Partners serves one of the fastest-growing regions in the country. We deliver end-to-end care, including regional specialized services, such as neurosurgery, cardiac care and cancer care.

What we see is that the increase in need comes primarily from our patient demand, which is a combination of population growth and the complexity of what people in our community are dealing with. We see there's an increase in people who are living with two or more chronic diseases regularly.

At the same time, this is why our submission advocates for the appropriateness of diagnostic imaging, as well as better connectivity. As for Mr. Whatley's point about the ability to deliver care under the Independent Health Facilities Act, which has been a long-standing reality, we can see that there is a need to prioritize this care across the community, whether you deliver care in an IHF or in a highly specialized centre like ours, in a way that maximizes capacity and ensures that there is no duplication of tests once patients have arrived at the hospital. The compounding pressure of population and patient demand is what increases the need.

However, we see that there's variability in the clinical appropriateness of using scans. This is not just a Canadian issue; it is a worldwide issue, because populations are aging around the world. The complexity of care because of medical discovery means that people live longer, and they live with more chronic disease, which leads to more diagnostic imaging being required.

● (1210)

Jake Sawatzky: Thank you, Ms. Farrow.

Could you drill down more into avoiding the duplication of tests? How can we ensure that we're avoiding duplication?

Karli Farrow: Let me pass it to Dr. Diamond and get him to walk through exactly what that looks like.

Dr. Ivan Diamond: Thank you, Mr. Chair.

One challenge is that there is a significant opportunity to provide imaging through IHFs by leveraging the entire platform. The challenge is that, at least within our region, not all IHFs are connected to the provincial imaging repository. It is not uncommon for a patient to present at Trillium Health Partners for the follow-up to a finding that was made with outside imaging and for us to be able to see the report but be unable to see the outside imaging in a streamlined manner. This results in our needing to repeat the imaging and creates additional patient anxiety as a consequence.

One of our recommendations, along with targeted funding, is to incentivize these additional clinics to onboard onto provincial repositories to ensure that, irrespective of where a patient obtains imaging, it is available throughout the platform.

There's another opportunity to use AI at the time of intake to check provincial repositories for patients who have recently had similar exams outside a hospital system, for example, to avoid duplicate imaging.

Jake Sawatzky: Thank you.

This technology has immense potential to help with a lot of the issues that we're facing and to help diagnose a lot of people. Could you expand on, in terms of the implementation, some of the barriers that our health care system faces when it comes to implementing these new technologies?

Dr. Ivan Diamond: One needs to be able to afford the technology, but as much as the promise of AI is there, these are also tools that need to be appropriately validated to ensure that they work within our local system. Also, it's not just the implementation of the tool itself. It's thinking about how that human-tool interface works and redesigning our workflows in a way that maximizes the benefit of the tool in terms of patients and capacity. It's about looking at workflow, monitoring that and then picking which tools have proven benefit.

That's where it is, and some of this is really about building expertise and capacity across the country and then sharing best practices across the country so that all Canadians can benefit from the promise of this technology.

Jake Sawatzky: Thank you very much for your answers.

The Chair: On behalf of the committee members, I would like to thank the witnesses for their time. Thank you for your valuable input to the committee.

With that, I will release the witnesses.

I see, Madame Sidhu, that you have your hand up, so please go ahead.

Witnesses, you can log out. Thank you again.

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

On September 19, 2025, I put a motion on notice. I have resent it to the chair and to the clerk to ensure that all of my colleagues are aware of it.

Today, I would like to move the following motion:

> That, pursuant to Standing Order 108(2), the committee undertake a four-meeting study on the current and potential uses of artificial intelligence in diagnostic and triage tools within primary care and emergency settings; that the study examine frameworks to support evidence-based deployment and equitable access, including the economic impacts of improved diagnostic efficiencies such as cost savings to the healthcare system, reduced patient wait times, and optimized allocation of medical resources; that the committee present its findings and recommendations to the House; and that pursuant to Standing Order 109, the committee request a comprehensive response to the report by the government.

Thank you, Mr. Chair.

● (1215)

The Chair: Thank you.

Is there any discussion on this? I see none.

Do you want the vote counted? Okay, we'll have a recorded vote.

Our clerk will take the vote.

Please go ahead.

(Motion agreed to: yeas 10; nays 1)

The Chair: Madame Gaudreau, it's your turn.

[*Translation*]

Marie-Hélène Gaudreau: Mr. Chair, I also gave notice of a motion on November 10. I believe all members have received it.

It reads as follows:

> That, pursuant to Standing Order 108(2), the committee undertake a study of at minimum four meetings, on access to, advertising of and the online sale of drugs and health products in Canada, as well as the associated public health, regulatory, monitoring and enforcement issues; and that the committee report its findings and recommendations to the House.

Mr. Chair, that stems directly from our first meeting, during which we discussed opioids in particular, as well as issues related to HIV/AIDS and syphilis, including access to data. This is where we see that a study could generate findings that would clearly contribute to strengthening public health.

[*English*]

The Chair: Thank you, Madame Gaudreau.

We now have Madame Dancho.

Raquel Dancho: Thank you, Mr. Chair.

We are open to this motion. We feel that the department officials should be brought forward as well and included explicitly in the motion. It's Health Canada and others within that department who currently govern, as we heard during the natural health products bill, a lot of this enforcement and regulation, so it would be good to have them come.

I'm putting forward an amendment to include “department officials”.

The Chair: It seems there is unanimous consent to add that.

(Amendment agreed to [*See Minutes of Proceedings*])

Are we all in favour of the motion as amended? Is anyone against?

(Motion, as amended, agreed to)

The Chair: Go ahead, Madame Dancho.

Raquel Dancho: Thank you, Mr. Chair.

I'm moving the following motion:

> That the committee undertake a consideration of the Supplementary Estimates (B) 2026-27, referred to the committee; that the Minister of Health be invited to appear before the committee no later than Monday, December 7, 2026, for at least one hour, accompanied by departmental officials; and that the departmental officials be invited to testify for at least one additional hour, for a total of at least two hours of testimony from departmental officials.

It's a particularly standard motion, Mr. Chair. At most committees, we are able to question the minister and department officials on government spending. This is an accountability measure.

One last point I would make is that we have invited the health minister several times. It is now approaching mid-November, so we've been at this for two months now, and she has yet to appear. I would ask, Mr. Chair, that you come back at our next committee meeting with an update from the minister's office on when she'll be appearing.

Thank you.

● (1220)

The Chair: Madame Dancho, in answer to your question, the minister's appearance is in process. I see that she will appear within the first 10 days of December. That's what I'm hearing.

Raquel Dancho: That's great.

The Chair: Somewhere in the first 10 days they will give me the final date, and I will give it to you as soon as I get that date finalized.

Madame Gaudreau, you have your hand up. Please go ahead.

[*Translation*]

Marie-Hélène Gaudreau: I am reassured to hear that planning is already under way. Naturally, I support this motion, since it's customary for ministers to appear before the committee to discuss the budget.

That said, if we look at items 2, 4, 6 and 7, I'd like us to take into account the fact that there are only seven meetings available. Obviously, the minister must appear for two hours. If we adopt this motion, that will take up two hours, and we also have other studies under way. I believe there are still two meetings remaining for one of those studies.

Therefore, I would like us to take the time, perhaps in camera, to establish our work plan. Ultimately, however, I agree with the proposal.

[*English*]

The Chair: Are all in favour? Is anyone against?

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

The Chair: Before I go to the in camera meeting for the committee business, if I suspend the meeting, then I cannot call the meeting back until 10 minutes after the vote is concluded unless I have unanimous consent from the committee members that, if a vote is called during suspension, I can come back as soon as we are ready. Is there unanimous consent?

Some hon. members: Agreed.

The Chair: I have unanimous consent, so I will not follow that rule of 10 minutes after the vote conclusion.

Thank you. I'll suspend the meeting to go in camera.

[*Proceedings continue in camera*]

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