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Chair

Mr. Bill Casey

Standing Committee on Health

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● (1540)

[*English*]

The Chair (Mr. Bill Casey (Cumberland—Colchester, Lib.)): I call the meeting to order.

I hope everybody had a nice week.

I'd like to pick up where we were at our last meeting. Mr. Davies had some issues of concern, and I notice you've withdrawn a motion. I'd like to hear your thoughts on this.

Mr. Don Davies (Vancouver Kingsway, NDP): Thank you, Mr. Chairman.

At the last meeting, I had a motion that would provide the committee with some parameters about when it would go in camera. Mr. Carrie, I think quite thoughtfully, advised us to take some time to consider that motion, which we did.

I had a chance to talk to you, Mr. Chairman, and I'd like to thank you for reaching out and discussing that matter.

With regard to my main concern, it's my belief that the bulk of this committee's business should be conducted in public so that we're accountable to the Canadian public, so that there's a record of our deliberations and our votes, so that we have transparency in government. My main concern was that in previous Parliaments, it was customary for committees to go in camera when they were discussing committee business. I felt that was not an appropriate use of the in camera process. To me, in camera is used for the consideration of draft reports when it's necessary for committee members to be free to discuss things and discuss witnesses' evidence in a very free and open way. It's also for confidential matters or personnel matters or financial matters. However, the consideration of committee business should always be public.

After having a discussion with you, Mr. Chairman, I'm very pleased that you have agreed with that general thrust. On that basis, I have decided to withdraw my motion. I'm happy to leave this in your capable hands and see how it goes. I trust that you will run the committee with the appropriate regard for the public nature of it. If not, my motion hangs like the sword of Damocles over the committee's head.

Some hon. members: Oh, oh!

Mr. Don Davies: By the way, Mr. Chairman, while I have the floor, I also would take this opportunity to withdraw the other routine motion that I did draft and put forward on the agenda for today. It had to do with the 10 minutes allotted to witnesses and allowing eight minutes in certain circumstances. After considering the way in which this committee has allotted the time, I don't think this motion is necessary, so I'll withdraw that motion at this time as well.

The Chair: The chair thanks you for doing that.

I really appreciated the way this all unfolded. I appreciated Mr. Carrie making the motion to give us some time to talk about it. That gave me time to talk to some other committee chairs to understand what your concern was, and then to get back to you. We talked several times on it.

I hope we can resolve procedural issues this way, if we can. That's what my hope would be. It just prevents us from polarizing any more than we have to be polarized. We have a big responsibility here with this committee, and hopefully we can all go forward together—hopefully.

At any rate, thanks very much for that.

The clerk had sent out a memo asking everybody to consider what we might be discussing as we go forward. I guess we should listen to what everybody has to say. I don't think anybody submitted any ideas.

Did the clerk get any submissions? No.

Mr. Kang, let's start with you. Do you have any ideas or suggestions on anything we should study, and why we should do so?

Mr. Darshan Singh Kang (Calgary Skyview, Lib.): I'm not ready yet. I lost my phone, and I was just running around trying to find it.

How about if I pass for now and come back?

The Chair: All right.

Mr. Oliver.

Mr. John Oliver (Oakville, Lib.): Sure. There are two areas, and I'll touch on them briefly.

One of them is that we're one of the few nations with universal health care that does not have pharmacare or medicine included in that definition of "comprehensive". When I was going door to door in my riding, I ran into many people who were now in jobs that were temporary or part-time or contract, and I saw that the historic pattern in Canada, where people were employed and had pharma insurance through their employers, is changing. The cost of pharma when you're unemployed is quite significant. In the case of twentysomethings who are living with their parents—and my riding is Oakville—if a child with diabetes returns to the home, the cost could be $1,000 a month that nobody in the family was anticipating.

There are varying stopgap measures. There are some programs that can be applied for when you can prove you're destitute, bu those are variable across Canada. Different provinces have different rules, so we don't have a universal application for pharmacare, particularly for those who are unemployed and need assistance. I think looking at that would be a very worthwhile study.

We could look at prescription medicine, to start with. What would a national drug formulary look like? How would we go about controlling costs? How would we manage it? Could we make it affordable? I think there are several ways we could study it to look at affordability. There have been a lot of recent studies about the cost of licensed drugs in Canada. Can we, by more competitive negotiating processes, lower those costs to make licensed drugs more affordable?

Finally, there are issues around people misusing some drugs because they can't afford them. They'll take antibiotics for a few doses and then go off them to save them for the next time, and that's leading to inappropriate use of antibiotics. Some people don't use the drugs they're supposed to be using at all because they can't afford them. It would also give us, I think, a national picture of prescription practices, so we could look at over-prescribing, under-prescribing, and how drugs are being used effectively across Canada.

That's one area.

My second one—and these are my top two—is that I really do feel it's time for a comprehensive seniors care strategy. The CMA is calling for it. Most of the medical community is calling for it. It's looking at how we link acute care, primary care, home care, and community services together to provide a comprehensive basket of services focused on seniors.

I have a really good quick story that I'll share with you just to give you an idea of how that might work.

About 12 or 15 years ago, I was down in Rochester, New York. There is a program down there that delivers all-inclusive care for the elderly. It links all of those services together for clients or residents who would be in long-term care facilities here in Canada. These are quite frail, quite compromised people. We went down there in the morning. A call came in from a caseworker—not a nurse—who was working with a woman who was clearly in distress, with trouble breathing. She had chronic obstructive pulmonary disease as a diagnosis, and she couldn't breathe. It was late August and it was about 85 degrees, and she was living in an apartment with one bedroom and no air conditioning. It was a stifling environment. The call came in, and within about an hour a nurse was dispatched to see her in her home. The nurse confirmed the COPD was worsening, and about three hours later—I'm trying to remember the sequence of this—the woman had an air conditioner. A community team came out and installed a $600 air conditioner. By the time we left at around 4:35, a call came back in from the caseworker, who said the woman was fine. Her lungs were clearing up. She was restoring and she was back on track, and they signed off on her for the day.

In other words, for them it was the cost of a caseworker, a nurse's visit, and some calls to some doctors and others at the main headquarters. They averted a very major acute COPD episode for about $600 and maybe another $600 of staff time for the people who were there in the residence with her.

● (1545)

In our system, that woman would have been left on her own and could have had a very serious COPD crisis. When the COPD exacerbated, she would have had to call 911 to have an ambulance bring her in to the emergency room. Usually after an ER stay and an ICU stay, those kinds of elderly, fragile people need time in the in-patient unit to recover before they're sent home. In our system, it would be hundreds of thousands of dollars, but that acute episode was resolved by that interaction as it was happening, through a community team and a home care team.

How do we get that kind of flexibility and responsiveness to seniors, particularly the very frail seniors, in our system? I think that's worthy of study as well for us.

Those are my two thoughts.

The Chair: What was your role there?

Mr. John Oliver: We were looking at different models of how to provide that kind of uniform care. We were watching and observing how they ran that program.

The Chair: Who paid for the air conditioner?

Mr. John Oliver: It was part of the budget of this organization. It was a comprehensive care model. They had a community care element, a home care element, home services, and primary care all situated under one umbrella funding model, and one coordinated service delivery.

● (1550)

The Chair: Well, I think those—

Mr. John Oliver: It's a long way from our models here, I have to tell you.

The Chair: Well, those two subjects could take us a couple of years.

Mr. John Oliver: Yes. Anyway, those are my two.

The Chair: Mr. Webber is next.

Mr. Len Webber (Calgary Confederation, CPC): Thank you, Mr. Chair. I appreciate the opportunity to be the second person to talk about what we think we should be discussing here.

First, here is a little bit about me and my background, because it leads to what I would passionately like to bring to the table here.

As a provincial minister and an MLA for a number of years in Alberta, working alongside my honourable colleague Darshan Kang, I was involved in a lot of areas with respect to aboriginal relations, and also international relations. I focused for many years in those areas.

For about the last three years of my MLA career, I was focused on a particular issue in health. I met a young lady who approached me one evening at an event, indicating to me that she was dying of liver disease. She saw no way of getting a liver transplant in the near future, and her life was going to be cut very short. It had quite an impact on me. She was asking for help. Of course, what do you do as a politician? You look into the issue when you feel strongly about it. That had a huge impact on my life.

I focused in the last three years of my career on that particular area. I introduced a private member's bill in the Alberta legislature. It was Bill 207. I have the bill right here. I'm quite proud of it. I introduced it as a private member's bill.

I served my last few years as a private member in the Alberta legislature, and I introduced this bill. It was the Human Tissue and Organ Donation Amendment Act, 2013. Mr. Darshan Kang knew it very well. He supported it, along with his caucus colleagues. It was unanimously supported throughout the assembly.

It was a bill that would incorporate a human organ and tissue donation agency in the province of Alberta, which would entail the inclusion of an electronic organ registration system. It incorporated a driver's licence. Anytime you renewed your driver's licence, they would ask whether you would like to be an organ donor. There was an awareness campaign with it as well. It was quite an intense bill. It took a lot of work by a lot of passionate people with whom I worked on this bill.

I was very happy to see it pass and a number of the issues implemented. Of course, there was a change in government, with the NDP Notley government coming into power. I have to give Premier Notley some credit, in that she continues to move forward with progress on this agency. I am very pleased with that.

What I would like to ask the standing committee today is to undertake a study to examine evidence related to the state of the human organ and tissue donation procurement system in the country, to study and focus on the level of awareness by the people of Canada and the level of preparedness of our health care workers throughout the country, in every hospital, to react at a moment's notice when there is an opportunity.

I hear of many, many instances of opportunities that could not be taken advantage of because the infrastructure was just not there. The training of the staff is just not there, and we continue to not do a whole lot about it. Right now, 4,500 people are waiting on organ transplant lists in this country, and, on average, 256 people a year die waiting for transplants. Kidney disease is on the rise. Baby boomers are getting older. I expect there will be many more demands on our infrastructure.

● (1555)

We have 2,000 people waiting for cornea transplants right now. Every year, 1,600 more people are included on that waiting list here in Canada, so the demand continues to increase. I would ask, humbly, that we put together a study on this issue and bring in experts.

I have lists of many experts who can come here to talk to us and to indicate to us the needs and what we need in order to have a robust procurement system here in the country. I think it's very important. I would humbly ask my colleagues around the table here to take a serious look at it. I would be the first to give the chair a list of names of people to come here to speak to us.

Thank you.

The Chair: First of all, congratulations on your private member's bill. What could be more important, really? All the numbers of people you're talking about.... Do we know of countries that have successful programs where they have a good response on this?

Mr. Len Webber: We lag behind countries such as Spain, Portugal, the U.S., France, Belgium, Italy, Australia, Ireland, and the United Kingdom. We lag behind these countries with regard to our human organ procurement and our transplant success.

I have to give a lot of credit to the Province of Ontario, though. They have the Trillium Gift of Life organ donation and procurement system in place here. What they are doing here is a model that other provinces should be encouraged to follow and implement. Here the role of a federal government is to encourage other provinces to get on board, to develop positive systems to put it in place, and to have perhaps an overarching umbrella. The federal government should help these provinces and these silos—basically, these transplant silos—work together in order to have a robust system throughout Canada.

The Chair: Mr. Davies.

Mr. Don Davies: Thank you, Mr. Chairman.

I'll give the committee a wish list of broad issues that I think the committee should look at. Then I will narrow that down and zero in on a few things that I think—

The Chair: Just a second, please. I'm sorry. I thought you wanted to comment on Mr. Webber's idea.

I didn't ask. Does anybody want to comment on Mr. Webber's idea at this point?

Mr. Eyolfson.

Mr. Doug Eyolfson (Charleswood—St. James—Assiniboia—Headingley, Lib.): Yes. I practised medicine for 20 years and could not agree more on what I think we need to do.

I'm sorry. You might have made mention of this point, and I apologize if I missed it. There are jurisdictions that actually have presumed consent. If you don't want your organs donated, you actually have to carry something that says no. That might be something I would be willing to explore to even expand this.

I think you're right. In my own clinical experience, there were numbers of patients that would have been ideal organ donors, but due to systematic shortcomings, we lost organs, and that's a tragedy.

The Chair: Thank you.

Dr. Leitch.

Hon. K. Kellie Leitch (Simcoe—Grey, CPC): I think this is a great thing to take a look at. We do have to be cognizant of provincial versus federal jurisdiction with regard to what we're doing, but that being said, I think it would be very constructive for this group, if people are in agreement, to get Mr. Webber to put pen to paper to provide us exactly what he was talking about.

The awareness part, I think, is outstanding. It's definitely within our realm in the federal jurisdiction. There may be a couple of other items and suggestions, but this may give us some opportunity to have a comprehensive discussion on whether or not we move forward on this idea. My impression is that there seems to be some interest.

The Chair: I think we could have an impact.

Mr. Len Webber: I'd be more than happy to do that. I have a file this thick, Mr. Chair, and I would be more than happy to put something down on paper.

The Chair: Why don't you give us a file about...this thick?

Some hon. members: Oh, oh!

The Chair: No, give us a summary. That's a good idea.

Are there any other comments?

Ms. Sidhu.

Ms. Sonia Sidhu (Brampton South, Lib.): Last week I talked to an organ donor charity fund. They're saying that even though we sign a driver's licence for organ donation, the families don't know. Half the families of these people don't know. There should be an amendment so that they could ask one family member, who would then know that this person wants to do an organ donation. I think we lack that.

● (1600)

The Chair: Mr. Kang.

Mr. Darshan Singh Kang: Thanks, Mr. Chair.

I think there is a lack of awareness, a lack of education. After that bill, there was an organ donation drive in my community, in the Sikh temple. A gentleman took up the cause. Almost everybody he approached signed up for organ donation. I think the committee should look into the education part, on making Canadians aware that they can do this. A lot of people probably don't know that they can sign for it on their driver's licence. People are willing to do it, but there is a lack of awareness.

The Chair: Thank you.

Are there any other comments?

Okay, Mr. Davies, the floor is yours.

Mr. Don Davies: Thank you, Mr. Chairman.

When I was brainstorming big topical areas that I thought would be appropriate for the committee, I came up with a number of them. Of course we can't do all of them, so I'll read out the general list. Then I'll zero in on what I think would be an achievable agenda for the committee.

I thought we should study community care, home care, and palliative care. Sometimes those are connected and sometimes they're subjects on their own.

Mr. Oliver has already pointed out the area of prescription drugs and all the myriad issues around making sure that Canadians can get the medicine they need.

There's also aboriginal health. From my conversations with the analysts, neither this committee nor the aboriginal affairs committee has actually studied aboriginal health, at least not in quite a long time. I think that's something we could look at.

I'm concerned about privatization, user fees, and just general enforcement of the Canada Health Act. As federal politicians, it's our obligation to ensure that the principles of the Canada Health Act are respected by the provinces. We know there's litigation in British Columbia. I think a private MRI clinic has opened up in Saskatchewan, and Quebec has had some legislation about it as well, so that's another area.

I think antimicrobial resistance is an interesting issue that we would be wise to get a good handle on.

Electronic health records and virtual care are a part of our future that would be interesting for this committee to look at.

Finally, there are issues concerning our blood supply. We have an issue of paid donors at a for-profit clinic opening up in Saskatchewan. We have the Zika issue, where there may be concerns about our blood supply. I thought it would be interesting, basically 20 years post-Krever commission, to see how we're doing on that. We generally wait until there's a disaster or a public health emergency before we look at things.

Those are my issues. They could keep us busy for a decade.

I actually put these in the form of motions. Here's what I would suggest as a digestible process for the weeks and months ahead.

First, I found out that this committee completed a study on mental health in Canada. It was submitted to the House of Commons in May of 2015. That study required a report from the government that never came. It's an outstanding piece of business. I'm not casting aspersions; I think the election may have gotten in the way.

Here's the motion:

> That the Standing Committee on Health formally request that the Minister of Health provide a response to the Committee on the findings of the Mental Health in Canada study completed and submitted to the House of Commons in May 2015.

I think we as a committee should finish off that piece of business so that the good work of that committee is not left unfinished.

Next, I suggest that the committee start with a study on aboriginal health. I'll read my motion:

> That the Standing Committee on Health study the status of health and health care within Indigenous communities in Canada, including status, non-status, on-reserve, off-reserve and urban Indigenous populations, with the objective of better understanding the particular health care needs of this population and the gaps in service delivery, review the effectiveness of the First Nations and Inuit Health Branch of Health Canada, and report its findings to the House.

As part of that, I respectfully suggest that it would be a great opportunity for this committee to put in an application to travel. I myself have never been to an indigenous community to look at health. I've never been to Iqaluit.

Mr. Chair, thank you for circulating the letter from the Honourable Larry Bagnell inviting us to Yukon, where I'm told that 25% of the population is indigenous.

● (1605)

It's a nice way for a committee to.... First of all, we stay within Canada; second, we actually get on the ground and get out of Ottawa and start gathering some information and evidence about the subject first-hand. I think given the priority that Prime Minister Trudeau has placed on the relationship with first nations and given that this issue has not been studied by this committee, it would be a good place to start.

That study would probably take several weeks to even get organized. We would have to get witnesses and all of that. In the meantime, for the next week or two, I suggest, second:

> That the Standing Committee on Health request a briefing from Health Canada officials on the 2015 Canada Health Act Annual Report and the status of Canada's health care system.

We could perhaps all benefit from having a briefing from department officials on the most recent annual report and having a chance to ask some questions. I think that could probably be organized for next week.

Issue number four is something that is happening in other committees. I was substituting in the fisheries committee yesterday, and we did this. The motion is:

> That the Standing Committee on Health request that the Minister of Health appear before Committee at the earliest opportunity to discuss and answer questions concerning her mandate letter.

I recognize that ministers are busy and I certainly don't want to inconvenience Minister Philpott. However, I think we could invite her to come, recognizing that it might take a while. It would be nice to have her appear before the committee to give us her views and priorities from the mandate letter. It would give us a chance to ask some questions of her.

That's where I'll stop. I had some other issues that I think we could also request. I'll finish with number five. That's something else we could do in the meantime if we're organizing a report. The motion is:

> That the Standing Committee on Health request a briefing from officials of the Public Health Agency of Canada, and Canadian Blood Services, on the status of the Zika virus outbreak, the health threats of this disease for Canadians, and the current efforts by the Public Health Agency of Canada and Canadian Blood Services to address the public health implications of this virus.

I'll end there by saying that I know the mosquito is not here in Canada, but the WHO has called this a global health concern. They anticipate 4,000,000 cases next year. Hawaii has just declared a public health emergency. The U.S. is now putting out an alert that this may be transmitted sexually. We don't really know the causal effects or whether it's related to microcephaly or not. Already we're seeing some conspiracy theories popping up on the Internet. Some people think it's Monsanto's fault.

I point this out because the epicentre for this is Brazil, and the Olympics are in Rio this summer. The whole world will be sending a large contingent of people to Rio, and there will be a large contingent of Canadian athletes.

We've had a couple of cases of Zika in Canada. There was an Ontario woman who had to go public to get the testing that she felt she wanted. I think she was pregnant. Of course, the microcephaly affects pregnant women or women who may be considering getting pregnant.

That gives us a couple of briefings to get before the committee relatively soon. It gets a request to the minister out while we get organized on what I think we should study as a first issue, which is aboriginal health in Canada.

● (1610)

The Chair: You have about two or three motions there.

Mr. Don Davies: I can deal with them one by one if you like.

The Chair: Could we deal with those after we get all the subjects on the table?

Mr. Don Davies: Absolutely.

The Chair: Thank you. You had a busy week off.

Mr. Ayoub.

Mr. Ramez Ayoub (Thérèse-De Blainville, Lib.): If I may, I'll speak in French just to balance it a little bit, and if I can practise my English, that would be great.

[*Translation*]

I am interested in two demographics: seniors and younger people —families and children. When it comes to home care for seniors, I would like to know what is being done elsewhere in Canada. In Quebec, certain medical procedures are carried out. We increasingly want our seniors to stay at home. Home care is one way to give them some autonomy, so that they can stay at home longer.

My experience as a mayor allowed me to see those kinds of requirements. People would come ask how they could avoid going to residences, where everything is included, and stay in their community. They live longer, can be in better health and want to stay at home. I am very interested in this issue. What is the outlook for the future regarding this type of care? I would like to know what is being done elsewhere in the world and what the best practices are. What practices could we borrow and implement in Canada?

Attention deficit hyperactivity disorder, or ADHD, is another topic I am very interested in. That disorder was identified several years ago. Children who have been diagnosed with it are prescribed many drugs. That seems to be a modern-day disorder. I am very interested in knowing how it has evolved and how it varies with age. Children are being treated at younger and younger ages, and the treatment continues later on. We don't know when it ends. There are many drugs involved, leading to high costs. I would like to hear from experts on the topic and find out what is being done elsewhere. Is this situation unique to Quebec and Canada, or is it happening everywhere?

Finally, I am very sensitive to what Mr. Webber announced about organ donation. Every province already has programs in place. We will be able to find common ground on how to deal with this issue.

I assume it will be difficult to choose among all the interesting topics available to us, but we will have to do so and start somewhere.

Thank you.

[*English*]

The Chair: Are there any comments on those thoughts?

Mr. Darshan Singh Kang.

Mr. Darshan Singh Kang: I'm catching my breath a little bit.

I just want to echo a couple of points here.

I think we should re-examine the Health Council of Canada. We should look into that and return to the original Health Council of Canada recommendations to ensure Canadians have the means to be engaged to provide input to the government on the operation of our health care system. As well, we should reinstate some of the Health Council of Canada's specific mandate to continue assisting Canadians and different levels of government with regard to various concerns for the nation's health care system.

Also, with regard to pharmacare, it recommended striking a national public pharmaceutical committee made up of non-partisan experts in the field of national drug plans. We should look into that. We should also look into bringing about national comprehensive bulk buying and pharmaceutical purchasing.

There's also the national mental health initiative. We should....

Then home care is very important.

Also, privatization is my concern. In Alberta, my colleague Len Webber knows there were musings by

Premier Klein about having a third way. There was a push to privatize health care and maybe have a two-tiered system or a three-tiered system. Who knows?

In any case, because the costs of health care keep creeping up, we are trying to find a quick solution. When I was at the doctor, there were 25 or 30 people waiting there. A gentleman came to me and asked why there wasn't a $5 fee to see the doctor. There were lots of people there with colds, sniffles, and all that, who didn't need to be there, so if there was a $5 fee, maybe half the people wouldn't be there. Those kinds of things have come up.

There is also the issue of costs for health care. Because our senior population is increasing, there are more pressures and demands on the health care system. We have to be looking into innovation and technology and how we could keep the costs down. Maybe the committee should bring in experts to look into that and curtail the costs for health care, because I don't think we can keep up, given the way the costs are going up.

Another thing is that we have many doctors from India, Pakistan, and other countries who are driving cabs, and we should look into how we can bring those specialists and doctors to work in the system. When I was in public accounts in Alberta, my suggestion was to let them work in the system with our Canadian doctors here. Let them bring them up to speed in two, three, or four years. Let's pay them some wages so they can make a good living and at the same time work in their profession. They can come up to speed. I'm talking about recognizing foreign credentials. That will, I think, ease the pressures on health care.

We should have incentives for the rural areas of the country, because lots of doctors don't want to go there. We should have some kind of incentive to balance it. Maybe new doctors would go for five or 10 years or whatever. I know maybe it's charged with challenges, but we should look into innovative ways to bring more doctors into the system so they could serve the rural part of the country.

I come from India, and there was a public system when I was growing up. We had clinics. Then, when we brought in the private system, the public education system and public health care system were a shambles. Therefore I think that as a committee, we should be looking into how we can keep costs down and keep health care public. I think once we open the door a little bit here for privatization, everybody will be paying through the nose.

I know what it is like back home. When somebody goes to a hospital, they say, “There's a window; go there.” Then the cost is maybe $200,000 or $300,000. It depends on the severity of the illness. They say, “Go there and deposit the money, and then we will look at you.” I'm afraid that if we open the door even a little crack for privatization, we may end up there.

● (1615)

That's all from me for now.

The Chair: Well, you caught your breath.

Mr. Darshan Singh Kang: Thank you, Mr. Chair.

The Chair: Are there any questions or comments?

Mr. Carrie.

Mr. Colin Carrie (Oshawa, CPC): Thank you very much, Mr. Chair.

I thought it would be interesting to study supervised injection sites. I know there was a recent meeting with Mr. Coderre in Montreal, and that's one issue he brought up with the Prime Minister.

We certainly do have a federal role. I think if these types of sites are going to be considered, we should look into how decisions are made regarding where they're located. In other words, how do they fit into community health and public health ideas at the local level? How do you get input from stakeholders so that if these are going to go forward, you have a willing community?

Maybe we should even look at the facts from the injection site they have in Vancouver. Is this actually something that is working? Is there some science behind it that we could take a look at? I think it would be very topical, and it's something we do have a role in.

● (1620)

The Chair: Very good.

Are there any comments on that?

Ms. Sidhu.

Ms. Sonia Sidhu: Thank you, Mr. Chair.

Actually, I want to talk a little bit about what Mr. Davies said about home care and palliative care to reduce gridlock in the hospitals. As baby boomers age, we need to do something about that. We need more home care services.

I want to give you an example of a 24-hour clinic. In Mississauga there's a 24-hour clinic, and it's just opposite the Trillium hospital. If you go to the hospital for minor injuries, it takes a long time. At the 24-hour clinic, you go there and you get treated. I think it lowers wait times, and also relieves the burden on hospitals. This is something I want to talk about with regard to home care and palliative care for older people. If we increase home care, there will also be an effect on hospital gridlock.

The second thing is that mental health is becoming a challenge. There are so many barriers. We need to address that. Depression also comes into that.

With regard to a pharmaceutical strategy, Mr. John Oliver explained that very well.

Diabetes is becoming an epidemic disease. Every third Canadian, I think, will have a diagnosis of some kind of pre-diabetes condition. Obesity is the main cause, so we need to look into that. We need more awareness.

We need to make some kind of strategy for family doctors. I'm not knocking any family doctors. When a person is pre-diabetic, we should do something about that. When one person becomes diabetic and goes untreated, the person can become a heart patient too, so we need to look into that.

Next is insulin. In some countries insulin is a life-saving drug. Why not in Canada? We should have that life-saving drug too. We should look into that too.

The last government was doing a study on wireless radiation and how it affects our health. We should look into that too.

That's about it.

The Chair: Are there any comments on those?

Mr. Webber.

Mr. Len Webber: Thank you.

I'd just like some clarification, Ms. Sidhu, regarding home care and palliative care. You're from the Mississauga area?

Ms. Sonia Sidhu: I'm from Brampton.

Mr. Len Webber: Are you hearing from your constituents concerns about health care and palliative care?

Ms. Sonia Sidhu: Yes, there are a lot. People don't want to go to the hospital because of the long, long waiting lines, even though we've reduced the waiting period. Still, the old people don't want to go there. It's a big hassle.

For home care, there's a telemetry program through the hospital, but not in all hospitals. We should look into that. The telemetry program is very successful. A nurse can phone the home and say, “Your blood pressure's fine. Your sugar is fine.” The diabetes patients' nurse can phone them and say, “You need to increase your insulin.” Some old people don't know that.

Another thing is that sometimes there's a malfunction. They don't remember which medication to take or whether they already took it.

If we increase home care, we can increase a lot of those things.

Mr. Len Webber: The reason I ask is that I've had personal experience with home care and palliative care in my home. It was absolutely fantastic in Calgary. I can't say enough about the health care system in that particular area. It would be interesting to know what is happening throughout the country in that regard.

Ms. Sonia Sidhu: In Brampton there's a long wait time. Even at the seniors home there are no spaces. We need to make more, or we need to change our strategy.

The Chair: Thank you.

Mr. Davies, you had a comment?

Mr. Don Davies: Yes. Thanks, Mr. Chairman.

I thought it would be helpful for us to review what the committee had recently studied, so I went through the briefing book.

Starting in June 2015, we studied lung cancer in Canada. Mental health in Canada was studied in May 2015. “Health Canada Safety Code 6” was looked at in March 2015. In 2014-2015 the committee studied “Best Practices and Federal Barriers: Practice and Training of Healthcare Professionals”. There was a statutory review of the Pest Control Products Act in January 2015. E-cigarettes were studied in late 2014. There was a study of marijuana's health risks and harms in May and October 2014. Government's role in addressing prescription drug abuse was in 2013-2014. We looked at technological innovation in health care in 2012-2013. In October 2012 the committee studied vaccine priority lists during pandemics, and in March 2012, neurological diseases. We looked at the role of government and industry in determining drug supply in Canada in March to June of 2012. Finally, there was a study of chronic diseases related to aging and health promotion and disease prevention in 2011-2012.

I just thought it would be helpful for us to know what had been studied. This was triggered by Sonia's reference to mental health. I agree it's an important thing, but it was just studied by the committee, so we may not want to—

● (1625)

Ms. Sonia Sidhu: Wasn't it incomplete?

Mr. Don Davies: We haven't received a response from the government.

Maybe it would be good for you to look at that report to see if there are areas in there that you think aren't covered well. Maybe we could zero in on them.

The Chair: Mr. Kang.

Mr. Darshan Singh Kang: I think long-term care is a big issue too. That's where the problem comes in the hospitals. Lots of the people there have long-term illnesses. In the hospital they use the term “bed-blockers”, but if there was long-term care in hospitals or nursing homes or whatever, it would reduce the pressures on the hospital itself in terms of reducing wait times in the emergency department. I think the committee should look into that.

Home care is great. I know from personal experience that home care works. If you put more money into home care, I think the pressure on hospitals will be reduced as well. I've had personal experience with home care. It works wonders. It would also reduce the overall costs in health care. Lots of seniors want to be in their homes. They don't want to go to a nursing home. They want to be looked after, and with a little bit of home care, I think we can keep them out of the nursing homes and out of the hospitals.

Another thing is the one-stop shop, the clinic where a person can go in and get a blood test and an X-ray. As Sonia suggested, if we had 24-hour health clinics where they do the X-rays and blood tests and all that, that too would reduce the pressures on the hospitals.

I'm wondering, Mr. Davies, what came out of those studies by the committee. Were the recommendations implemented? Did anything come out of those, or are the reports sitting and collecting dust? What happened with those recommendations?

I think we should follow up on that, as a committee, and see where we're at. Maybe those recommendations could be implemented, and maybe that would be a step in the right direction to maybe cut costs or improve health care.

Thanks, Mr. Chair.

The Chair: Thank you, Mr. Kang.

Mr. Davies.

Mr. Don Davies: When the reports are done by committee, they're issued, they're filed in Parliament, and their work is done. They remain available to government. Government looks at those reports as they wish. I'm not sure it's the committee's role to....

We do our work, provide those recommendations to government, and then hope they pick it up, I guess. That's why I think it would be helpful to have the minister come here. I mean, that would be a good question to ask the minister: of the reports that have been issued, is there a process for the government to review the recommendations and maybe implement them? I'm not sure.

Mr. Darshan Singh Kang: I'm new here too, so I don't know how the process works. We all have to come up to speed.

I think if a committee has no teeth, if we do something and nothing gets done with it, then that work is not really.... That makes me wonder why the committee is there if we bring in the stakeholders and do all the work, and then those reports just sit there and nothing happens. I think it's just lip service.

● (1630)

The Chair: Mr. Oliver.

Mr. John Oliver: I was going to raise that question as well.

I think we should finish our work. I don't think Doug has stated his priorities yet, so we should finish that. We need to see what the members of this committee would like to do.

I also think it's worthwhile reviewing the past work of the committee to see if there are any standing items that didn't get through. As a committee, we don't need to repeat those items, but if we think they are important, we can move them forward as well. I think that should be one of the things we could do. When we look at our agenda and what we're going to put on it, that's one area.

I know the issue of radio frequency electromagnetic radiation and health of Canadians died just as the House rose. I think there was more to be done at the House level.

There are a few that we probably need to consider. They are something else to put on the agenda for what we look at in the future.

The Chair: The process would be that when we conclude a direction, then our research department would see what has been done before. If it's out of date, we can still consider going ahead. The research department will lay out a work plan and indicate possible witnesses. We can choose our own witnesses, but they'll come up with a plan for us. It takes a little while, but not long.

Mr. John Oliver: This would be when all that's been done. The previous committee did all of that and completed all that work, and then it just died.

I think it's worth doing a quick check. We could ask the staff that question. Are there outstanding things to be completed by the previous committee, and do we as a committee choose to see those through, to finish the work of our previous colleagues?

The Chair: When we're done with this subject, Mr. Davis is going to move that we ask for a report on the mental health report that the government was supposed to reply to. We could add yours to it as well. That's appropriate.

Go ahead, Mr. Davies.

Mr. Don Davies: I have a list here—I think it was in the briefing—and perhaps the analyst can reissue the last five years of reports to all of us. There are not that many, about 15. Then you can actually see the reports and read the recommendations.

I would caution about looking backwards, because we're in a different Parliament with a different committee and a different majority. I'm not sure how helpful that would be. I would rather start in this Parliament and look forward. However, I think it's helpful to be familiar with those reports and what's been recommended. It may give you some ideas. I don't suggest that we block that off.

I think we should take a clean slate in front of us and decide what we want to do, going forward. After we work collegially together to get a good report with recommendations, then we can stand right behind Mr. Kang as we try to get them implemented.

The Chair: Okay. Are any other comments?

Dr. Leitch, you're up.

Hon. K. Kellie Leitch: I have a few things.

First, I know Mr. Davies was going to come forward—and it's listed here—about having the Public Health Agency of Canada and Health Canada officials come to present. I think that would be very valuable. There are some of us who have worked in the system and have some ideas about the system, but I think the overview of the departments would be extremely valuable to all the committee members, especially to those who haven't been here on Parliament Hill for a long period of time.

Second, I think we should have a full discussion with respect to marijuana and its impacts on individuals under the age of 18. I'm happy to discuss the impacts it also has on adults.

I am a pediatric orthopedic surgeon. I have met children in the emergency department who are under the influence. It's exceptionally concerning to me. I think this committee should be aware of what those impacts are, both in the short term and in the long term. There is now documented evidence that exists, at least from the medical profession. I can't speak for others who would like to pontificate on this issue, but I think it's important that at least this committee be well aware of it.

The Chair: Do you mean the side effects of marijuana on young people, or the actual impact?

Hon. K. Kellie Leitch: I think there's a wide range of things, but most importantly.... You may call them side effects; I call them complications. You can talk about both. I'm sure Dr. Eyolfson has the same viewpoint as I do, that we categorize those differently.

I think it's important that people go in with their eyes wide open on the impacts that marijuana can have on Canadian kids.

The Chair: Mr. Davies.

Mr. Don Davies: Thanks.

Here's what I would suggest, Kellie. I haven't read the report, but it appears that from May 2014 to October 2014 the committee did a study called “Marijuana's Health Risks and Harms”. I'm not familiar with that report, but I'm wondering if that would be a good place to start. We could just pull that report and see if it gets at the issues that you think ought to be got at, or if you think that's some—

● (1635)

Hon. K. Kellie Leitch: I have read the report. I guess, in keeping with what you said in the comment before this one, that we should be forward-looking. I would encourage everyone here to read the report, absolutely. I think that would be of value.

Mr. Darshan Singh Kang: Well, I think that when you say “forward-looking”, marijuana is marijuana, and that report would be as good as we would get, probably, unless there are new issues that have arisen out of marijuana, such as genetically modified marijuana and the effects of that or something. I think that marijuana is marijuana.

Hon. K. Kellie Leitch: I would hesitate to say that. Similar to pharmaceuticals and other hard drugs that are currently illegal on the market, they are changing it on a daily basis. I can tell you that meeting a young person in 2010 who said they had been on marijuana is a quantifiably different experience from meeting a child who comes through the door and says they had marijuana last month.

Mark my words, in the same way that our colleagues are doing their best to update, modify, and make more effective cardiac drugs every day of the year, there are individuals out there making more potent marijuana, changing the consistency, and looking at the other places it can be placed. It's not just about smoking it, but whether they can make it an edible product or something else. I think these are important things to look at.

As I say, I still practise medicine. I'm still at CHEO here in Ottawa. I think it's important that everyone here have a complete understanding of the impacts of marijuana.

The Chair: Thank you very much. That's really meaningful.

Mr. Ayoub.

[*Translation*]

Mr. Ramez Ayoub: Regarding marijuana, you are saying that there are different levels and that it changes with time, and I understand that well. How will we be able to decide what kind of marijuana we are talking about? Although that drug is currently illegal, we know the government wants to legalize it at some point, but for people of a certain age and not for youth, so as to make the use safe.

How will we be able to find out what that drug's effects are on young people, what its potency is, where it grows, and so on?

[*English*]

Hon. K. Kellie Leitch: I understand your concern, but that's like saying that we shouldn't study the drug formulary at this table, as was recommended before, because drugs are changing every day. I think we have a responsibility here to take a look at these issues in totality, whether that be a drug formula, as others of your colleagues have suggested, or whether that be looking at diabetes, which again is an evolving disease entity that we have different treatments for. I think this should be treated in the same manner.

Mr. Ramez Ayoub: I'm not saying not to study it—

Hon. K. Kellie Leitch: No, no, but recognize, I think, that all of these things will change, potentially even in the course of when we're studying them. That's not a reason to not look at something.

Mr. Ramez Ayoub: Absolutely. I agree.

Mr. John Oliver: It's still up for debate, but if we were to look at this, I think it would also be important to look at what regulation does to improve things and to reduce the risk to children. Regulation allows licensed manufacturing. It allows potency to be identified on labels, much like production of alcohol, so that you understand what you are absorbing. It's released through controlled environments, rather than the black market and the uncertainty of that. I think the regulation aspects of how it's prepared, licensed, and regulated may mitigate the risks of children being exposed to it.

I think we could probably all quickly agree that children using marijuana is completely unacceptable and that there are health risks. There are a lot of studies that show the long-term consequences of underage young Canadians using marijuana, so how do you better restrict access? I don't remember the exact numbers, but I think the WHO study—the World Health Organization—said that right now Canadian teens are the highest or second-highest users of marijuana globally. How do we reduce access, or limit access, or have zero access to marijuana, while at the same time regulating the production of it and licensing its release?

● (1640)

The Chair: I'm not sure, but we may end up with this subject anyway, as the legislation comes forward. In the meantime, it's a valid issue to talk about and it would be good to find out what the government's plan is to regulate the quality or the aspects of the product.

Mr. Davies.

Mr. Don Davies: Mr. Chairman, you read my mind.

This issue is going to come before this committee sometime in the next four years. All indications are that the government is going to proceed with some sort of legalization framework for marijuana. If and when that happens, that legislation will come before this committee, or if it doesn't come before this committee and it goes to justice, perhaps there will be a joint justice-health committee, or maybe this committee will look at the health impacts.

Yes, it could be a...joint committee.

Some hon. members: Oh, oh!

Hon. K. Kellie Leitch: I was just waiting for that one. I could see you chomping at the bit on that one.

Mr. Don Davies: At that time it will be appropriate for this committee to have a comprehensive and thorough look, as Kellie suggests, at the full health impacts and ramifications of marijuana. I have no doubt that this will be coming at some point. Of course, if after two years there isn't anything from the government, then maybe we can revisit the issue at that time.

The Chair: We'll have it on the list for the steering committee to look at and see what the steering committee decides.

I don't know whether we're going to get marijuana and physician-assisted dying. I don't know whether or not that will end up at this committee. It may, or maybe some aspect of it will come to us. Again, it might be a joint committee, as you were saying, of justice and health.

Are there any other questions on the subject?

Mr. Eyolfson.

Mr. Doug Eyolfson: I forget which minister I talked to, but Kellie brought up this question at the last meeting, and it didn't look as though this committee would be dealing with physician-assisted dying. It would be justice and the special committee, so we likely wouldn't be dealing with it. That's just as a point of information.

The Chair: When I was getting my hair cut yesterday, one of the members of the committee was there, and he said that he thought we would get it, so I don't know.

Mr. Doug Eyolfson: I may have been misinformed.

The Chair: I don't know. This is barbershop talk, so I'm not sure.

Anyway, you have the floor, Mr. Eyolfson.

Mr. Doug Eyolfson: Thank you for putting me in this part of the order, because you're making my job far easier. Many of the things that were on my list have been discussed, so I can just go through some of them to reiterate my feelings on them.

We talked about universal pharmacare. I agree. I spent 20 years of my career as an emergency physician, and I saw people come in sick because they couldn't afford their medication. It's a regular occurrence. If you consider a plan that will make sure that everyone can get their medication, people might say that it's awfully expensive, but it's much more expensive not to. If you look at the cost of one patient who has to come to the emergency department for diabetic ketoacidosis and who ends up in the intensive care unit, you could have probably paid for a lifetime of that patient's insulin for the cost of that one visit.

That's just one example, but I think it's a very, very important example. We might be able to show that there's a net financial benefit in the long run in addition to it being the right thing to do.

Also, with regard to the interplay of seniors care, home care, and homelessness, I agree. It was said by a couple of people that hospitals are often bed-blocked by seniors who don't have any acute medical problem but who cannot go home. They have mobility issues, they become demented, and they don't need to be in a hospital, but there aren't proper home care supports or personal care home beds for them.

It's become so critical that sometimes people like this are brought into the emergency department by concerned family members, and internal medicine departments won't admit them because there's nothing medically wrong with them. In some appalling situations, we've seen patients stuck in our emergency department for in excess of a month. Again, you'll save substantial amounts of money by making sure that seniors have adequate housing and adequate home care.

This plays into homelessness as well. There are people who are homeless who are not seniors, and they are very expensive to the health care system. Given the large numbers, hospital admissions for frostbite and hypothermia in Winnipeg among the homeless, as you can imagine, are very, very costly. Again, dealing with homelessness would take a big burden off the health care system and probably ultimately save money.

As for other issues, I agree on the organ donation strategy.

Antimicrobial resistance is something for which I think there might be a bit of interplay between departments. I know we have a very long list, but something that has come to my attention, which might be worth looking into if we have the time, is re-emerging antibiotic resistance. We're dealing with this in the medical community and we're trying to educate health care providers on their prescribing practices.

Another significant source of antibiotic resistance is the agricultural community, which uses antibiotics in animal feed. For people who aren't familiar with this practice, when you feed antibiotics to healthy animals, they tend to grow faster, so basically you get a more profitable cattle operation. Somehow, and I don't quite know the mechanism, members of the ranching community are able to obtain antibiotics without a prescription from a veterinarian in response to an illness, and they are able to routinely feed them to their cattle. That practice looks as though it may be a significant source of antibiotic resistance, and it's a practice that I would certainly like to see banned. It's banned in many countries in the world, and I think banning it would help to ameliorate an evolving public health crisis.

There are other things on this list that I wanted to speak to. I agree that we need to take a closer look at supervised injection sites and at harm reduction in general. There is some science supporting it, but I think we need to look at all aspects of it, including the science behind it, the social issues behind it, and the justice issues behind it. I think it's a very important thing. There's tremendous potential to improve health outcomes by properly looking at this issue.

That's all I have so far.

● (1645)

The Chair: That's not bad. I think what we did here today is incredible in terms of all the things we've come up with and the issues we've discussed, and we haven't even got to me yet.

Some hon. members: Oh, oh!

The Chair: I compliment everybody on their work on this and their thoughtful approach to it.

I had occasion to talk to my own doctor. I asked him what the big issues are that he runs into. He said, “Wait times and lack of home care.” He said that 30% of our hospitals have people in them who shouldn't be there. Thirty per cent of the beds are occupied by people who shouldn't be there.

On another issue, I agree with Mr. Davies on indigenous health. It's come up from some members in talking to me. I haven't had any direction at all from the minister, by the way. I've not had one ounce of direction from the minister on this, and I'm pleased that we haven't. Eventually we will have, because there will be legislation, and hopefully she'll come here and make a presentation and tell us her direction, but nobody is trying to direct this committee. We're on our own, and I hope we stay that way. I appreciate that.

I did talk to the Minister of Indigenous and Northern Affairs because the aboriginal issue had come up, and I wondered if it would be a problem for her if we did this. She said, “No, I'd love you to do a study on aboriginal health.” Just to let you know, she said that to me, and I was very pleased to hear it.

I really like the idea of organ donation, because it's something that I think we can have an impact on very quickly. I think we could.

Another one that didn't come up is veterans' health. I don't know whether that's an issue for us, but it's certainly an issue in my province. Veterans are homeless. There's a lot of post-traumatic stress. I deal with them all the time. I don't know if there's a role for this committee in veterans' health, but it's an amazingly frequent issue that I run into as a member of Parliament.

Anyway, those are my thoughts.

On pharmacare, about two weeks ago the Province of Nova Scotia announced a whole new pharmacare program. They announced it and then had to withdraw it about two days after they announced it, because it was not well thought out, I don't think, and it ran into a wall instantly. Pharmacare is a big issue. It's on people's minds. It's on Canadians' minds for sure.

Actually, I think we're going to have to take these and give them to the steering committee—

Mr. Eyolfson.

● (1650)

Mr. Doug Eyolfson: I apologize. I was thinking at the end that there's just one more thing on my list that might bear looking into, at least from a cost-benefit analysis. It's something that has only been in the news a bit, but I'm sensitive to it.

I had many jobs concurrently with emergency medicine. In one of them, I spent several years as a medical director for Manitoba's Emergency Medical Services system. There is a lot of concern regarding the role of EMS and ambulance service in the health care system, particularly with the inconsistency of fees charged for this service and when all the other parts of the health care system, other than drugs, are paid for. You do get an ambulance bill, and it can be very expensive. It depends on where you are and how far you have to go. It can be a couple of hundred dollars if you're in a major city, but it can be several thousand dollars if you are in a rural area.

One of the problems is that as it stands right now, for some reason, emergency medical services are not really part of the Canada Health Act services. They're considered a municipal or provincial service and are paid for out of those budgets. Every jurisdiction has to come up with ways to recover costs, because, as you might imagine, it's an expensive service to provide.

We do know that there are people having some adverse outcomes because they're not calling an ambulance. They know they can't afford the bill. In particular, these are people with chronic medical conditions who have frequent hospital visits.

Some of the calls that I received personally during the campaign were about this, so it might be worth looking into seeing if there's a way to put EMS under the umbrella of health in Canada.

The Chair: Thank you.

Mr. Kang.

Mr. Darshan Singh Kang: I'll take it a step further. I know this is a provincial issue, but parking at the hospitals is another big issue that I hear about. It costs so much to park. If you have a loved one sick in there, you're paying $25 to $30 a day for parking. It's very expensive, as you know. Maybe we can look into that somehow. Maybe ambulances and parking could go together.

The Chair: Well, it's probably not going to be a priority, but we'll have a look.

Does anybody else have anything else they want to put on the table?

Mr. Davies.

Mr. Don Davies: It's just a question of process, Mr. Chairman.

We've had probably two dozen good ideas here. How do you see us moving forward? You've made reference to this being referred to the steering committee. Is it your view that the steering committee will meet and then decide this, or will it come back with recommendations to the main committee?

Also, I think we could deal with a couple of my motions today, either up or down. We could at least deal with whether or not we want to get some briefings or ask for the committee's report. Is it your desire to deal with those? I'm just curious about how you see this moving forward.

The Chair: I'd say that other than the ones you have particular motions on that you want to deal with today, we should refer the subjects we talked about today to the steering committee. We might find that when we do a little research and when the analyst has a look at things, maybe the committee has done some of this work before and maybe that will affect us. We'll home in on the items that we think are the best, and we'll come back to the committee.

Is that normal? Is that how we do it, Mr. Clerk? Do we come back to the committee? I want everybody to agree. The steering committee will weed through the pros and cons. Some subjects can be done very quickly and some will take longer. Some we can actually have an impact on quickly, and some we can't. We'll look at those and talk about what we can do. I am sure the analyst will also have some thoughts on what can be done, how long it will take, and who we need to have. Then we'll come back to the committee with our recommendations and we'll decide. How's that?

● (1655)

Mr. John Oliver: The other lens I would put on things is whether they are under provincial or federal jurisdiction. A lot of what we've talked about is under provincial jurisdiction, and quite frankly there are provincial governments at work studying some of these issues already. I think the lens of whether something is really our work needs to be applied. I think that's what Len mentioned.

The Chair: I think if we come to them with a consensus on something that's a provincial issue, we could at least make a comment. We can't do much in the way of making recommendations, but we could make comments and send them to the provinces. Is that okay with everybody?

All right, we will refer those to the steering committee.

Now, have you reserved a room for tomorrow?

Are all members of the steering committee available? Mr. Davies, are you available tomorrow afternoon?

Mr. Don Davies: I think so. What time?

The Chair: Sorry, it's at nine o'clock tomorrow morning. We thought you weren't available, for some reason.

Mr. Don Davies: That would be close. Could we make it 9:30?

The Chair: That's fine with me. How long will the steering committee meeting last? Is that a two-hour meeting?

Mr. Doug Eyolfson: I have House duty at 10.

Mr. John Oliver: I have House duty at 10.

The Chair: You both have House duty? I wonder if we could get the Speaker's room. Can we do that? Is that possible?

Mr. Doug Eyolfson: I could do 9:15.

The Chair: What time does your House duty start?

Mr. Doug Eyolfson: It starts at 10.

The Chair: Can you do 9:00?

Mr. Doug Eyolfson: I'll do my best.

The Chair: All right, let's do it at 9:00. That will give us an hour.

Mr. John Oliver: Will there be enough time in one hour to consolidate the ideas that are here, digest everything that's been suggested, and try to understand what our committee agenda will be?

Maybe we could have a meeting of this committee first to say what the top five are and what is involved in doing the top five, and there might be a second meeting so we can come back with a more detailed plan of how we're going to approach this work. I don't think one hour is going to be sufficient to come back to the committee.

The Chair: No, I don't think so either, not for what we've discussed.

Mr. Carrie.

Mr. Colin Carrie: Perhaps I could make a suggestion, Mr. Chair.

Don has a couple of motions, and perhaps we could deal with those. I think he has some good suggestions here as to where we could get officials. We could have a briefing for the new members just to get an overview of what Health Canada actually does. Perhaps the Minister of Health would like to come by. We could deal with those motions, and if that's the case, we have two meetings next week. The planning committee could do another meeting next week at a more convenient time. I agree with what John says, that given the great input we had today, it will probably take longer than that to make a decision on what we want to do first.

We don't want to waste time, but I think that for things that are very simple, officials can come and utilize the committee's time quite effectively.

The Chair: I was thinking that we'd choose a subject and then let the analysts work out a plan. Actually, if we hear from the minister, that may change our focus at the steering committee. I think it's not a bad idea that we hear from them first, if we can.

Do we know when the minister might be available?

Ms. Sonia Sidhu: Can we put a motion for her to come at her convenience?

The Chair: I beg your pardon?

Ms. Sonia Sidhu: Can we put a motion to have the health minister come at her earliest convenience?

The Chair: Yes. Would you like to move that motion?

Ms. Sonia Sidhu: Yes.

The Chair: Okay. We've moved a motion to have the minister come at her earliest convenience. How's that?

That's good.

Mr. John Oliver: Yes, and to follow through on Don's motion that said, “to discuss and answer questions concerning her mandate letter”, I would like to add to that “and her expectations of the committee”.

The Chair: Excellent.

Does that cover you off, Mr. Davies?

● (1700)

Mr. Don Davies: Yes.

The Chair: I'm sorry that we stole your motion.

Mr. Don Davies: That's okay. I'm happy to have that done.

When ministers appear before committees, if they come at estimates or to discuss a mandate letter, it's always interesting. You can ask the minister almost anything, because there's what's in the mandate letter and there's what's not in the mandate letter. It's pretty broad. I think the way it's written would be broad enough to ask the minister for her expectations, but using the mandate letter as a guide for the minister and a template would help focus the discussion. I'm happy to move that, although I'd be surprised if you can get the minister here that fast.

What I would suggest is that we do meet tomorrow, and I'll tell you why.

We've had probably 20 good ideas. I think what we have to do is figure out the next three years, and we have to figure out the next three months at this point. I think all we have to do tomorrow is get a good jump, even in an hour, by picking two or three issues that we'd like to work on right away, so that we can at least give the analysts some direction. We'll have to come back to the committee, I believe, on Monday or Wednesday to make the decision to ratify the suggestion of the steering committee. That means next week is pretty much a wash, except for these other two things that I'm going to suggest in a moment.

I think we should get a start tomorrow, even if it's only for an hour. Is that okay?

The Chair: I like it. I'd like to keep moving if we can—that's my nature—but the clerk has just suggested that we could take Monday's standing committee meeting and turn it into a steering committee meeting. We could have just the steering committee meet on Monday instead of the entire committee, and that gives us two full hours and a scheduled time. Really, in an hour, the way it is, we'd only be partway into it. I like that suggestion.

Thank you, Mr. Clerk.

Mr. Don Davies: I have a self-interest. I won't be here next week. I'm travelling to Vienna with Hedy Fry and David Tilson, but that's okay, because we'll have someone cover it.

The Chair: We'll just take your page and tear it out, then.

Mr. Don Davies: I'll have someone cover it.

The Chair: Okay.

Mr. Don Davies: Can I move the other two? I'm going to move motion number 3 on my list:

> That the Standing Committee on Health formally request that the Minister of Health provide a response to the Committee on the findings of the Mental Health in Canada study completed and submitted to the House of Commons in May 2015.

The Chair: Just a second. We should deal with Ms. Sidhu's motion first. We didn't really do that.

Your motion was to ask the minister to come...?

Ms. Sonia Sidhu: Yes, at her earliest convenience.

The Chair: Okay.

Are there any questions?

Mr. Carrie.

Mr. Colin Carrie: If I could, I'll make a friendly amendment. Normally if you have the minister in front of the committee, you also have it televised. If the clerk can get a room where it's possible to televise it, that's always good.

The Chair: All in favour of the motion to invite the minister?

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

The Chair: Mr. Davies, you have your motion number 3.

Mr. Don Davies: Yes. There's no time limit on it. It just asks the government to respond to the Mental Health in Canada study, as they ought to have to the original request.

The Chair: The analyst has just slipped me a little note here. Her value is already demonstrated.

The committee started the study, but didn't report. The committee never did report on mental health, and that's unfortunate.

Mr. Don Davies: Does it need to be reported, then, or can it be reported?

Mr. John Oliver: This is the question that I had around the electromagnetic radiation issue as well. They were both finished, and then they didn't get to the House.

Ms. Karin Phillips (Committee Researcher): With respect to the mental health study, the committee started the study. They had four meetings, but the committee didn't actually produce a report. The one study that was started and for which there was a report that the government didn't table a response to was the e-cigarette study. That could be one where there's a follow-up.

Mr. Don Davies: Maybe I mixed them up.

Is the e-cigarette study the one for which we're waiting on a response?

Ms. Karin Phillips: Yes.

Mr. John Oliver: Did the electromagnetic one get something?

Ms. Karin Phillips: With regard to the electromagnetic one, there was no government response to that.

Mr. John Oliver: Was it submitted, though?

Ms. Karin Phillips: It was. There was a report tabled.

Mr. John Oliver: We could ask for reports on the ones that have been tabled, then.

Mr. Don Davies: I apologize for that error.

Could we ask for reports, then, on those two studies?

Ms. Karin Phillips: Yes.

A voice: I so move.

● (1705)

The Chair: All in favour?

The motion is carried. The system works.

(Motion agreed to)

Mr. Don Davies: Finally, Mr. Chairman, on my motion number 2, if we're not being too optimistic, we could maybe aim for Wednesday of next week. I move:That the Committee request a briefing from Health Canada officials on the 2015 Canada Health Act Annual Report on the status of Canada's health care system.

That would give us a chance before the break to have a report and a chance to ask questions.

I don't know if it's feasible to have that done in a week, but we can ask.

The Chair: We can ask.

Hon. K. Kellie Leitch: Can we also add the Public Health Agency of Canada? They're two separate entities.

The Chair: Okay, we will add the Public Health Agency of Canada.

All in favour?

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

Mr. John Oliver: Motion number 5 is also more of an update.

I appreciate this list, by the way, Don. It was a thoughtful way to get us oriented and moving on the Zika issue.

Mr. Don Davies: Given the time, we would not be able to have that done until after the break, but if it were the committee's wish to do it, we could maybe arrange a briefing for the week after the break week.

I'm happy to move the motion if people would like to get a briefing on that situation.

The Chair: We have a motion on the floor.

Mr. Don Davies: It's number 5.

The Chair: Number 5 is that we request a briefing from officials of the Public Health Agency of Canada and Canadian Blood Services on the status of the Zika virus outbreak.

I have people calling me about it. I know people are concerned.

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

Mr. Don Davies: We're on a roll; we should just keep going.

The Chair: No problem. This is good.

All right, so where are we now?

Next week, on Monday, is the steering committee. On Wednesday, if we can get the health officials here, that will be the agenda. When will the steering committee report to the standing committee?

A voice: Wednesday.

The Chair: The steering committee will report, one way or another, if we have a decision or not on Wednesday.

The steering committee meets on Monday. That will be interesting.

Is there anything else that anyone wants to bring up today?

An hon. member: Healthy food.

The Chair: Oh, yes, food.

The clerk asked me if we wanted to invest in food. I said we would just get beverages, but how does the committee feel about that? Is the committee in favour of having a little food here?

Some hon. members: Beverages.

The Chair: Okay, we'll see if we get hungry.

Thanks very much, everybody. I really appreciate it.

The meeting is adjourned

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