HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

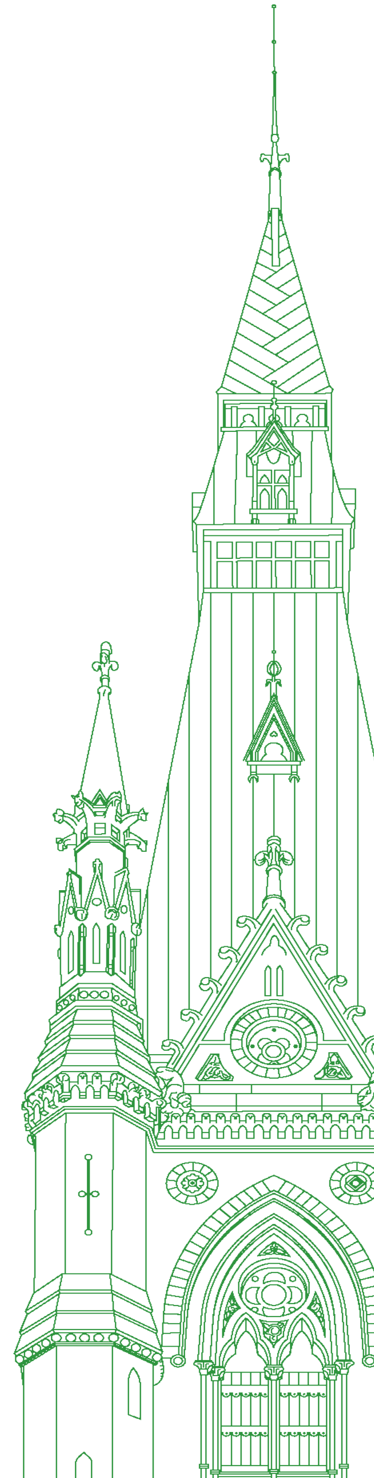
43rd PARLIAMENT, 1st SESSION

Standing Committee on Health

EVIDENCE

NUMBER 018

Wednesday, May 6, 2020



Chair: Mr. Ron McKinnon

Standing Committee on Health

Wednesday, May 6, 2020

● (1555)

[*English*]

The Chair (Mr. Ron McKinnon (Coquitlam—Port Coquitlam, Lib.)): Welcome, everyone, to meeting number 18 of the House of Commons Standing Committee on Health. Pursuant to the orders of reference of April 11 and April 20, 2020, the committee is meeting for the purpose of receiving evidence concerning matters related to the government's response to the COVID-19 pandemic.

In order to facilitate the work of our interpreters and ensure an orderly meeting, I would like to outline a few rules to follow.

First, interpretation in this video conference will work very much as in a regular committee meeting. You have a choice at the bottom of your screen of floor, English or French. If you will be speaking in both official languages, please ensure that the interpretation is listed as the language you will speak. For example, if you're going to speak English, please switch to the English feed, then speak. This allows for better sound quality for interpretation.

Before speaking, please wait until I recognize you by name. That will be a little different once questioning starts, when it will be a bit more free flow.

When you are ready to speak, click on the microphone icon to activate your mike. Should members need to request the floor outside of their designated time for questions, they should activate their mike and state that they have a point of order.

I'll remind you that all comments by members and witnesses should be addressed through the chair.

When speaking, please speak slowly and clearly, and when you're not speaking, your mike should be on mute. If you have earbuds with a microphone, please hold the microphone near your mouth when you're speaking.

Should any technical challenges arise, please advise the chair or the clerk immediately, and a technical team will work to resolve them.

Before we get started, I would like everyone to check in the top right-hand corner and be sure they are on gallery view. With this view, you should be able to see all of the participants in a grid-like fashion. It will ensure that all video participants can see one another.

I would now like to welcome our witnesses. Each witness group will have 10 minutes for an opening statement, followed by the usual rounds of questions from members.

Today we have, from the Canadian Lung Association, Terry Dean, president and chief executive officer, and Dr. Mohit Bhutani, representative and professor of medicine in the division of pulmonary medicine at the University of Alberta.

From the Canadian Cancer Society, we have Andrea Seale, chief executive officer, and Kelly Masotti, director of public issues.

From the Canadian Organization for Rare Disorders, we have Dr. Durhane Wong-Rieger, president and chief executive officer.

From HealthCareCAN, we have Paul-Émile Cloutier, president and chief executive officer, and Dr. Bradly Wouters, representative and executive vice-president for science and research at the University Health Network.

From the Heart and Stroke Foundation of Canada, we have Anne Simard, chief mission and research officer.

With that, we will start with Mr. Dean.

Mr. Dean, please go ahead with your statement. You have 10 minutes, please.

Mr. Terry Dean (President and Chief Executive Officer, Canadian Lung Association): Good afternoon, Mr. Chair, members of the Standing Committee on Health, and invited guests.

Let me begin by thanking you for the opportunity to appear before you today.

My name is Terry Dean, and I'm the president and CEO of the Canadian Lung Association. I am delighted to be joined by Dr. Mohit Bhutani, a respirologist and professor of pulmonary medicine at the University of Alberta.

Today I'd like to tell you about the Canadian Lung Association, how we have adapted to respond to the current respiratory pandemic, provide you with a perspective on the specific challenges of those living with lung disease, and share with you what we need in order to continue to carry out our mission.

The Canadian Lung Association is the country's leading organization focused on helping Canadians breathe. We do this by funding research, leading advocacy and providing up-to-date health information for all Canadians. We represent the one in five Canadians who live with lung disease. These are among the Canadians most at risk for developing a severe case of COVID-19. We also represent the five in five Canadians who simply need to breathe on a daily basis.

This year, we celebrate our 120th anniversary as an organization. Given the current situation, we are compelled to reflect on our founding in 1900 as an organization created to address another respiratory pandemic: tuberculosis, often referred to as TB. We made significant and valuable progress during that difficult time in our history, and we have helped to create solutions for prevention, testing, education and treatment of TB. We are confident we have a similarly valuable role to play now, 120 years later.

However, we find ourselves in the midst of a new respiratory pandemic, COVID-19, and our organization and our work have never been more important.

When you can't breathe, nothing else matters. No one knows that better than the six million Canadians already living with lung disease. We know these individuals are at the greatest risk of severe symptoms with COVID-19, including the need for hospitalization and treatment within intensive care units, and even death.

Beyond the very real increased risk, individuals with lung disease also face increased health anxiety. Many are concerned about properly identifying symptoms of COVID-19 and differentiating them from their existing lung disease. They have questions about how to continue their treatment, access medications and keep themselves in the best health possible. Finally, their caregivers, friends and support networks need to know the best ways of keeping them healthy and safe at the same time.

We've heard their collective voices of concern and have answered the call. We are doing our part to help Canadians understand COVID-19, prevent its spread and protect themselves.

We have created a unique suite of resources and tools to help them get the information they need. We've hosted a webinar, linking patients to respirologists and health care professionals to help them understand the specific impact that COVID-19 may have on them. We've created a series of FAQ videos that address the nuanced questions people have about smoking and vaping, as an example, and COVID-19, advice on medications and use of action plans, as well as how their specific lung disease would be affected by COVID-19. Finally, we deployed more resources so that our toll-free help lines could answer the increased calls that patients have on a daily basis.

As we put the patient first, we find ourselves doing more with less as we adapt our programs and resources to respond. We also fund critical lung health research, and we help develop early career investigators. If we are unable to continue to fund them, we risk not keeping them in the field of research at all, which would have profound long-term consequences on lung health.

From improving treatment options to enhancing quality of life or aiming to reverse or cure certain diseases, our researchers are working diligently to help all Canadians. Together, our programs and their research put the air back into the lungs of all Canadians.

During a time when we are being asked to do more, our sector is struggling. The COVID-19 pandemic has presented unprecedented challenges for the health care system and health charities across the country. The funding the government has provided thus far is greatly appreciated and provides some relief to some health charities. However, it is not enough to sustain them through the pandemic and into the future.

Canadians rely on health charities and will need our organizations to come out of this strong and ready to continue to deliver on the mission we've promised to carry out. The Canadian Lung Association is a member of the Health Charities Coalition of Canada, which represents a $670-million industry with 2,500 employees and almost three million patients. As a coalition, we need more support from the government to help us close the gap of revenue dollars to maintain our operation so we can get back on our feet and ensure that we not only make it through the pandemic, but we remain strong afterwards.

● (1605)

In closing, I want to thank the committee again for the opportunity to appear before you today. COVID-19 is a respiratory pandemic, and the Canadian Lung Association has never been more important. We ask the committee to consider the recommendations on further financial support for the charitable sector to ensure that Canadians continue to get access to the services and support they need today, but also into the future.

Now I would like to introduce you to my colleague, Dr. Bhutani, whom we invited with us today to demonstrate how we work in partnership with medical experts to help meet patients' needs. We'll be happy to answer any questions afterwards.

Dr. Bhutani.

Dr. Mohit Bhutani (Representative, Canadian Lung Association and Professor of Medicine, Division of Pulmonary Medicine, University of Alberta): Thank you, Terry.

Thank you to the Standing Committee on Health for the opportunity to appear today.

I join you today to represent the partnership between the Canadian Lung Association and the Canadian Thoracic Society. The Canadian Thoracic Society, or CTS, is Canada's national specialty society for respirology. We are an interdisciplinary professional association of health care practitioners that includes physicians and a wide range of health care professionals from across the country.

As the COVID-19 pandemic began to spread around the world and in Canada, health care professionals and patients with lung disease began to ask questions about how best to manage their conditions under this new reality. Health professionals asked questions regarding how to manage acute and chronic lung symptoms, which medicines were safe to prescribe to patients, or whether there were any medicines that perhaps they shouldn't prescribe to patients during the pandemic. Similarly, patients were asking us questions about what they could do themselves to best protect themselves during the pandemic. Should they visit their doctors? Should they go to the emergency room or to the hospital in case they need to? How do they know if they have had a COVID-19 infection?

As the medical and scientific authority on lung health, the CTS and its members are ideally suited to guide Canadians through this challenging and unprecedented time. The Canadian Thoracic Society is Canada's leader in the development and dissemination of evidence-based clinical practice guidelines. This work is strengthened by our partnership with the Canadian Lung Association, which then translates these guidelines into public and patient educational materials and programs. Our collaboration allows patients to access the most up-to-date evidence-based information and medical expertise on issues impacting their lung health.

Since the pandemic began, the Canadian Thoracic Society has been extremely active in developing and disseminating documents on best practices for one's health in the time of COVID-19. Thus far, we have developed a website accessible by anyone, and we've developed clinical guidance for the optimal management of asthma, COPD—also known as chronic obstructive pulmonary disease, which is the number one cause of hospitalizations across the country—and sleep disorder and breathing.

We've collaborated with Health Canada, the pharmaceutical industry and various associations, such as the Canadian Medical Association and the Canadian Pharmacists Association, to develop a mitigation strategy for patients and clinicians in the event of an inhaler shortage, primarily speaking about a drug named salbutamol, which is a rescue inhaler used commonly by many patients. We're about to publish recommendations on intensive care unit triage thresholds for lung conditions like COPD and cystic fibrosis to assist health care providers and health systems in decision-making in the event of a major surge in hospitalizations.

The partnership with the Canadian Lung Association has been critical, as they have adapted these evidence-based recommendations and created educational infographics for patients with asthma and COPD to provide, in plain language, guidance on managing their condition during COVID-19.

For Canadians living with lung disease, there has never been a more important time to make certain that their condition is well controlled. This is important not only to them, for their well-being, but also for the well-being and protection of our health systems. Our partnership between the CTS and the Canadian Lung Association really gets the best evidence into action.

I'm very pleased to be here today to help support Canadians during this respiratory pandemic. We need to ensure that health charities such as the Canadian Lung Association can continue to offer these critical services now and into the future.

Thank you.

The Chair: Thank you.

I see that Mr. Thériault has his hand up.

I understand you were having some difficulty with the French. I understand it's being worked on. Are you okay?

I'm not hearing Mr. Thériault at all, or the translation.

● (1610)

Mr. Tony Van Bynen (Newmarket—Aurora, Lib.): Mr. Chair, I'm not hearing anything either.

The Chair: Mr. Thériault, can you try speaking again? We're not hearing you at all.

[*Translation*]

Mr. Luc Thériault (Montcalm, BQ): Good afternoon.

The Chair: Ah yes, that's good.

Mr. Luc Thériault: I was trying to take it off silent mode.

Mr. Chair, I didn't want to interrupt the witness, but the sound from the interpretation is like a microphone being plugged in and unplugged. You can still hear the interpretation, but there's an unbearable sound when the interpreters speak. That should be dealt with. Last time, we talked about moving cellphones away from the microphones. Perhaps people are also talking too close to the microphones, but basically, it's unbearable.

[*English*]

The Chair: Thank you, Mr. Thériault.

I'm told that the technical matter has been addressed. Hopefully it has been fixed. If you continue to have problems, certainly you can unmute and indicate that you have a point of order. If necessary, we will suspend and have technical work on it again, but at this point I believe it's rectified.

We will carry on now with the Canadian Cancer Society. Ms. Seale, you have 10 minutes for your statement.

Ms. Andrea Seale (Chief Executive Officer, Canadian Cancer Society): All right, thank you.

Good afternoon. Thank you, Chair and committee members, for having us here today. Thank you to my fellow witnesses.

I'm speaking from Vancouver, from the traditional territories of the Coast Salish people: the Musqueam, Squamish and Tsleil-Waututh.

My name is Andrea Seale. I'm the CEO of the Canadian Cancer Society. I'd like to share with you today the perspective of one of Canada's largest health charities, and to share the experience of cancer patients during the pandemic.

I think it goes without saying that the pandemic is testing us in more ways than we ever thought possible and that we're rising to the challenge on many fronts. It has exposed vulnerabilities and sharpened focus. I'm really happy to see that all the people who support our most vulnerable have taken a rightful place as real-life superheroes, and our health care system is evolving quickly. Elected officials, such as yourselves, and governments across the country have shown incredible leadership for our country.

Canada's charities and, of importance for this committee, Canada's health charities are in a very dire situation. It's estimated by Imagine Canada that registered charities in Canada will lose between $9.5 billion and $15.7 billion, and will lay off between 100,000 and 200,000 staff as a result of the pandemic. Job losses in occupations in the non-profit sector are already 1.4 times higher than in the rest of the economy.

The Canadian Cancer Society is one of the largest charitable organizations in the country. I can truly say that this is the greatest financial challenge we have faced in our 80-year history. We're just youngsters compared to the Canadian Lung Association.

The hundreds of fundraising events that we've had to cancel across the country have led us to forecast a drop in donations of between $80 million and $100 million in the year ahead. That's roughly half of our budget. We've laid off more than one-third of our staff. We've closed community offices across the country. With projections that the downturn will continue for some time, we're being forced to reduce our services and our support for cancer research funding.

The pandemic is also having an incredible impact on cancer patients and the caregivers whom we represent. Of course, the reality is that cancer doesn't stop being a life-threatening, life-changing disease in the middle of this global health crisis.

You may know that more than one million Canadians are living with and beyond cancer. They're among the most vulnerable in our communities right now, because they rely so heavily on a health care system that's forced, at the moment, to turn them away. They rely on community organizations that are overwhelmed. They rely on a support system of their friends and families, who must also stay away right now. In the words of one cancer patient, “I feel like I'm on planet Leukemia, and the rest of the world is on planet COVID. And I am not entirely certain where Earth is anymore or if I will ever get back there.”

For a sense of the scale of this challenge, one in two Canadians will be diagnosed with cancer in their lifetime. When you or someone you love has cancer—and many of you probably know this from personal experience—your sense of time is different. It's measured in hours, or in days or in weeks. It's measured in the visits to your doctor or the number of times you're going to be able to hug someone you love. As we delay these activities in the name of social isolation, imagine how hard it is for someone with cancer to wait.

Clinical trials have stopped, in many cases. Radiation, chemotherapy and surgeries are postponed. There are those who haven't yet been diagnosed and are waiting to find out if they have cancer. Almost a quarter million Canadians are diagnosed with cancer each year, and right now they're left to deal with their anxieties and fears, not knowing when they're going to begin treatment and hoping that their cancer hasn't spread. We know that when the pandemic is over and we're getting to see some light at the end of the tunnel, there will be a backlog to our health care system still to come, of many months or perhaps years.

During all of this, the Canadian Cancer Society is here to help. We're here for everyone, in 200 languages, including 14 indigenous languages. We're only a click or a phone call away. As the only national charity that supports Canadians with all cancers in communities across the country, we're the voice of Canadians who care about cancer. That's why I'm so pleased to speak with you today.

Through our online and telephone services we're hearing firsthand about the worries and anxieties. We're helping people, as well as their loved ones, navigate their new realities by addressing their concerns or separating the facts from all the fake news that's out there about COVID and cancer, and providing them with emotional support and resources to help them cope.

● (1615)

For a sense of what they're telling us, when the pandemic began, patients and caregivers were reaching out for information on COVID and specific information about the virus and cancer. Over time, these concerns have shifted to coping with feelings of isolation and depression, and are now moving toward frustration and fear as their treatments are delayed indefinitely and as people worry this will affect their ultimate prognosis. Some tell us that they feel like collateral damage from the pandemic. Others say that they feel like they're on the *Titanic* and only those with COVID-19 are getting into the lifeboats.

How does the Canadian Cancer Society provide these services? We fundraise almost $200 million a year through grassroots events, donations, sponsorships and online fundraising. We use that to fulfill our mission, which is to provide the support services I described, but also to fund life-saving research on all cancers—we're the largest funder of cancer research outside of the Canadian government—and also to advocate for health policies to prevent cancer.

As a result of the crisis, we estimate a large decline in our revenue and reductions in our research funding and our services. We're doing everything we can to adjust, adapt our fundraising and stay connected to donors across the country, but as you make critical decisions about Canadian health care and emergency funding, we want to ensure that cancer patients and cancer charities are not forgotten.

I ask that you please consider what you hear from the Health Charities Coalition of Canada and from Imagine Canada about the request on behalf of our sector, and please consider the Canadian Cancer Society's submission to the standing committee, targeted to address the needs of people with cancer and their caregivers, and specifically to provide funding to be able to continue our support services for the many Canadians living with cancer. We can help them cope with the pandemic now, and help them cope through the backlog in the health care system that's going to impact their well-being for many months. As we all get through this together, we're here to help.

Thank you very much for taking a few moments to hear from me today.

The Chair: Thank you.

We'll go now to Dr. Wong-Rieger, from the Canadian Organization for Rare Disorders.

Dr. Wong-Rieger, please go ahead. You have 10 minutes.

Dr. Durhane Wong-Rieger (President and Chief Executive Officer, Canadian Organization for Rare Disorders): Thank you very much, Mr. Chair and committee members, for the opportunity to be back before this committee on behalf of the Canadian Organization for Rare Disorders, Canada's national association of over 100 rare disease patient organizations, representing approximately 2.8 million Canadians affected by rare diseases, many of whom have underlying respiratory, cardiovascular and immunosuppressive conditions that put them at high risk for COVID-19.

First of all, I really would like to state without reservation that CORD joins with all Canadians in the fight against COVID-19 and strongly supports the federal, provincial and territorial government actions to protect and treat all Canadians during this pandemic. We empathize with all of those who are suffering. No one knows this more acutely than the rare disease community.

The rare disease community knows the frustration of being unable to get an accurate diagnosis. In fact, it can take seven years or more for a rare disease patient to get a diagnosis. We know the uncertainty of not knowing whether your condition will progress to a serious life-threatening stage. This is the reality for many rare diseases, most of which have highly varied and uncharted disease progression pathways.

Our community knows the urgent need to have a better understanding of a disease. Sadly, many rare diseases cannot be traced to a single virus but have multiple causative factors. We know the despair of having no treatment or cure. In fact, only 5% of rare diseases have any effective therapies, and only a handful can be cured. Finally, we share in that desperate wish to prevent the disease.

CORD applauds the global multisectoral—

● (1620)

The Chair: Excuse me, Dr. Wong-Rieger, can you maybe hold your microphone?

Dr. Durhane Wong-Rieger: Yes. Is that any better?

The Chair: We'll see.

Dr. Durhane Wong-Rieger: CORD applauds the global multisectoral collaborations coming together to combat COVID-19.

Is that okay?

The Chair: Just move a little bit away so you're not speaking directly into the microphone. We get pops and stuff if you do that.

The way you're doing it right now is probably perfect.

Dr. Durhane Wong-Rieger: Okay.

We applaud the global multisectoral collaborations coming together to combat COVID-19: to treat it, to find a cure and to prevent future infections. We're especially heartened by the public-private partnerships, which are essential for getting to successful interventions as quickly as possible.

However, in the same way that COVID-19 has exposed the inadequacies in Canada’s health care system, the experiences of rare disease patients in this time of COVID put in stark relief the lack of a comprehensive integrated approach to rare diseases pre-COVID.

While each rare disease affects only a small number of individuals, there are more than 7,000 rare diseases, which, together, affect one in 12 or nearly three million Canadians. Many of these conditions are associated with lifelong, debilitating symptoms affecting not only the patients, but also those who care for them. For Canadians with rare conditions, as you've heard for cancer and for lung disease, the fight against the disease doesn't stop during a pandemic. Indeed, in many cases, as you've already heard, it has become even more challenging. We have received numerous calls, requests and emails from patients trying to manage with their disease during this time.

In early April, we sent out a survey to our patient community to learn the impact of this. We had about 300 responses in just a couple of days. We were frankly shocked by the extent to which the lack of access to health care and other services is affecting them, and the seriousness of the consequences.

I'll give you a snapshot. Half of the respondents said they had experienced difficulty receiving medical care, such as delayed or cancelled surgeries, no blood work, limited access to dialysis and no physiotherapy. One patient said, “The surgery that is not happening would resolve a problem, in the meantime I am not functional and am bedridden and in a lot of pain.”

Second, about two-thirds were concerned about seeking health care because of the fear of contracting COVID-19. One respondent said, “I've been told should I contract COVID-19 I would be low on the list for treatment due to shortage and [a philosophy of] 'survival of the fittest.'”

Third, half said they could not access rehabilitation or critical services, including personal support care: “House bound/extreme mobility issues/no one able to help because of fears & stay at home in effect.”

About 40% could not access their prescribed medications, not because of drug shortages, but because of logistical issues in health care or pharmacy services, or lack of response to special access requests.

In fact, in a separate survey to the pharmaceutical manufacturers, CORD did receive assurances that the Canadian drug supplies were not in jeopardy and that steps were being taken to meet future supply needs and even to arrange alternative treatment sites if patients were getting infused. Furthermore, we were assured that ongoing clinical trials would not be interrupted, with adjustments made for alternative treatment sites, monitoring and data collection, if necessary.

In summary, it may seem self-evident that we should not neglect patients with serious chronic conditions while we battle a new disease, however rampant it is. Unfortunately, our survey and the calls to our infoline paint a stark and disconcerting picture of limited, delayed or denied access to testing, medical services, surgeries, rehabilitation therapy, supportive care and medicines, all of which inevitably put patients' lives and well-being at risk.

The underlying problem we come back to is that Canada has never approved a rare disease strategy, despite having national strategies for cancer, diabetes, cardiovascular disease and mental illness. Indeed, Canada is the only developed country in the world without an official national rare disease strategy.

Five years ago, in the House of Commons, CORD launched Canada's rare disease strategy, which we had put together and which was developed and endorsed by leaders from all sectors. The strategy outlined five goals: improving diagnosis; providing for expert care and centres of excellence; ensuring community support, including patient organizations; access to treatments; and support for research.

While the strategy has yet to be endorsed nationally, it has nevertheless served as an important framework for a variety of important initiatives, including steps toward the development of provincial plans by Ontario and Quebec. However, it is clear that we cannot adequately and effectively address rare diseases through standalone provincial strategies and other piecemeal initiatives any more than we could conquer COVID-19 if each province were working in isolation. Rare disease needs national commitment, resources and leadership, particularly in this era of COVID-19.

● (1625)

Of course, I would be remiss if I did not acknowledge that the rare disease community is very grateful to see in the 2019 federal budget a $1-billion funding commitment to develop a rare disease drug strategy. Ideally, this would dovetail with the supplemental process proposed by the expensive drugs for rare diseases working group of the provinces and territories. However, I have to reiterate that in order for a rare disease drug strategy to be effective, it has to be imbedded in a comprehensive rare disease strategy.

Moreover, I'm also compelled to point out that the greatest threat to the potential benefits of a national rare disease drug strategy is the Patented Medicine Prices Review Board's regulatory changes that are scheduled for implementation on July 1, 2020, despite the lack of broad stakeholder consultation. This will affect the rare disease community probably more than any other.

To put it in context, the PMPRB changes, in particular the application of the economic factors to set maximum drug prices, would put some chronic disease patients at much greater risk than COVID-19. Ironically, if there were a breakthrough drug therapy for COVID-19, it would be unlikely to meet the new PMPRB pricing restrictions.

We obviously don't believe the government would reject a lifesaving drug for COVID-19 on the basis of the PMPRB economic factors. We simply do not understand why the government is seemingly allowing the PMPRB to deny access to life-saving and life-enhancing drugs for rare disease patients.

I will conclude with two key learnings from our survey results, what we have identified and what we would like to have from the federal government.

The first is that while you deal with the crisis, don't sacrifice those with other health care needs. Set up a parallel team to identify, prioritize, triage and resolve the needs of those with chronic and other health care conditions. This extends, obviously, beyond the rare disease community, but it really does impact those with rare diseases disproportionately.

The other big learning is that Canada needs an innovative pharmaceutical industry. Companies in Canada are stepping up to ensure adequate supplies of emergency drugs and medical devices, and are partnering with researchers to develop new tests, therapies and vaccines for COVID-19. At the same time, they are ensuring that Canadians with rare and common conditions have continued access to the drug tests and other technologies that are needed. Perhaps this is truly the opportunity to develop effective public-private partnerships.

The problems experienced by the rare disease patients and families were not directly caused by COVID-19. Sadly, it has taken a pandemic to bring the pervasive deficiencies and dysfunctions in our health care system to the surface. We urge governments to address those issues now. We in the patient community are ready and wan to work with you, along with our clinicians and our researchers.

I would just add parenthetically that CORD has not applied for any of the support funds because we are, quite frankly, a very lean organization. We know how to work with limited resources. We have instead hoped that the funds would go to our hundred-plus patient groups, many of which are small, many of which are very much volunteer-led, and rely on fundraising events that are obviously not happening now.

Thank you very much.

● (1630)

The Chair: Thank you, Dr. Wong-Rieger.

We go now to HealthCareCAN.

Mr. Cloutier, please go ahead for 10 minutes.

[*Translation*]

Mr. Paul-Émile Cloutier (President and Chief Executive Officer, HealthCareCAN): Thank you very much, Mr. Chair.

[*English*]

HealthCareCAN is an organization that represents Canadian research hospitals, regional health authorities and health organizations. My thanks to the committee members for the opportunity to present to you today with my colleague, Dr. Brad Wouters, of UHN, with whom I will split HealthCareCAN's presentation time.

[*Translation*]

The research community, regional authorities and the Canadian Institutes of Health Research actively contributed to the responses to the COVID-19 pandemic.

[*English*]

The COVID-19 crisis has already exposed the gaps in the public health system, and the health care system more broadly. One of those gaps is the fact that Canadian health care facilities, designed for another time and place, are among the oldest public infrastructure in use today, with approximately 48% of facilities being over 50 years old. The picture in bigger cities is even worse, where 69% of health care institutions are over 50 years old.

[*Translation*]

Our hospitals are facing enormous budget constraints, which very often force them to postpone important maintenance work that is sorely needed to ensure quality patient care. We haven't adequately funded the maintenance of our health care facilities.

[*English*]

Once COVID-19 is behind us, we must complete the unfinished business of medicare by closing the gaps in long-term care and our traditional institutional health care system. As health care leaders now turn to addressing the backlog created by the huge numbers of cases and procedures delayed in the face of the pandemic, our focus must be on the building of surge capacity into our health care. This will require much more strategic support from the federal government as we work to addressing the coming surge of patients waiting for different types of care due to COVID-19.

Another area of deep concern for Canada's health care organization is the very fragile state of Canada's health research enterprise. Much of Canada's health research talent is employed by research institutes based in health care facilities. That talent drives a $3-billion annual sector of our economy, employing nearly 60,000 highly skilled researchers and staff nationwide. This not-for-profit sector accounts for the majority of the biomedical research that is conducted in Canada, including current essential research and clinical trials around COVID-19.

Hospital-based research drives improvements in disease prevention, diagnosis, treatment and care for Canadians. Here are two examples. Vancouver Coastal Health Research Institute has nine major centres, known internationally for their research excellence. It employs over 1,500 personnel engaged in research, 900 principal investigators, and graduate and post-graduate training conducting clinical and discovery sciences. The other example is the Research Institute of the McGill University Health Centre, which is also world renowned, with over 1,200 graduate and post-graduate trainees, and 440 researchers and staff. It is recognized for groundbreaking work relating to health outcomes in transplantation, infectious diseases and patient self-monitoring applications, among many others.

That workforce is paid through a combination of public and private research grants, charitable donations, allotments from foundations, and contracts for clinical trials which are almost all funded privately by biotech and pharmaceutical companies. That revenue base has all but evaporated in view of the COVID-19 pandemic. All research and clinical trials not related to COVID-19 have been either suspended or cancelled, with severe implications for the sector's capacity to employ essential research staff and contribute crucial research toward improving Canadians' health outcomes.

● (1635)

[*Translation*]

The health research institutes welcomed the announcement of the Canada emergency wage subsidy, but they were very disappointed to learn that, under Bill C-14, they wouldn't have access to it.

[*English*]

Mr. Tony Van Bynen: Mr. Chair, the translation is overriding.

Mr. Paul-Émile Cloutier: Last Friday, Dr. Kevin Smith, the CEO of UHN in Toronto, testified to the Standing Committee on Government Operations—

Mr. Tony Van Bynen: Point of order, Mr. Chair.

The Chair: Pardon me, Mr. Cloutier.

Mr. Paul-Émile Cloutier: —warning that Canada's research councils will likely see 10,000 to 15,000 jobs lost in the next few weeks if they are not granted access to some form of federal support. The federal government can avoid those layoffs by granting the research institutes based in health care organizations access to the Canada emergency wage subsidy on the same terms and conditions as other industries.

This is why we are urging the government to do this today and to treat us equally. This could be done by a simple change of regulations, a minor change that would give Canada's health researchers the security they need to weather the storm of the present crisis.

Now I'll pass it on to my colleague, Dr. Brad Wouters, to say a few words from his perspective.

Dr. Bradly Wouters (Representative and Executive Vice-President for Science and Research at the University Health Network, HealthCareCAN): Thank you.

The Chair: Before you start, I'd like to remind everyone that it really helps with the translation if when you speak French, you go on the French channel, and when you speak English you go on the English channel. I know it's kind of awkward when you have both languages integrated into your speech, but otherwise the sound levels on the translation come through at the same level as the floor and it's very hard to hear.

Thank you very much.

Please go ahead, Dr. Wouters.

Dr. Bradly Wouters: Mr. Chair, thank you for the opportunity to speak today.

As Paul-Émile mentioned, on March 15, nearly all hospital-based, non-COVID-related research across Canada was suspended. At that time, our organization had budgeted $460 million for our hospital's research operations for the fiscal year, a sum which employs 1,000 scientists and 4,000 other highly skilled research staff, including clinical research associates, research nurses, laboratory technicians, biostatisticians, data managers, graduate students and post-doctoral fellows.

Our organization is the largest research hospital in Canada. It is one of the top centres in the world. It includes the Princess Margaret Cancer Centre, ranked in the top five cancer centres in the world. It also includes the Toronto General Hospital, ranked this year by Newsweek as the fourth best hospital in the entire world.

We perform more organ transplants than any hospital in North America. We have over a century of research accomplishments that include the development and application of insulin to treat diabetes and the discovery of stem cells. But never in our history has our research future been more at risk than it is today.

The majority of our industry revenue has been lost because the clinical trials and research projects they support have been suspended. Charities, as you've heard today, have also begun to cut their giving, resulting in forecasted losses of revenue for our institution alone of more than $10 million per month. We have managed to stretch our resources for the past seven weeks without job action and layoffs in hopes that the federal government would provide us access to support programs like the Canada emergency wage subsidy.

We operate in an extremely competitive environment with other health academic medical centres around the world. It has been important for us to keep our staff engaged, part of our institute and ready to relaunch and compete for funds when we come back.

Many of our researchers and scientists have also jumped in and contributed to a rapid response to COVID-19, bringing their unique skills and talents to the treatment and prevention of this disease. We have launched new clinical trials in patients. We are exploring the fundamental biology of the virus and we are developing new vaccines and therapies. However, 80% of our staff remain unable to continue essential research into cancer, lung disease, cardiovascular disease, Alzheimer's disease, rare diseases, diabetes and many other key diseases that kill the majority of Canadians.

Since our suspension, we have had numerous contacts with officials in several government departments. All of them have been extremely responsive and understanding of the situation we are in. We have asked to have the same opportunities as other businesses and not-for-profits, but have been excluded from these key programs because we are located inside a public hospital.

On May 1, we were forced to begin the process to identify roughly 1,500 staff for a first round of job layoffs because of the suspension-induced loss of revenue. If we continue to be unable to access these federal supports, we will face large end-of-year operating deficits, additional layoffs and insufficient revenues to support our cause.

Honourable members, institutions like mine all across the country are currently ineligible for the wage subsidy based largely on a technicality. Because these health research institutes are physically based in public hospitals they are designated as public institutions and are excluded from eligibility.

Our hospital and the care of patients is funded by the provincial ministry of health. However, we are legislatively prohibited from using any of that provincial support for our research. Instead our research is funded by a wide mix of over 900 different organizations. For the most part we are not funded out of public sources. To the extent that those funds do come from public sources through competitive research or innovation grants these have also stalled since March.

I would also mention that eligibility for these programs would come at a marginal cost to the government. The staff, if we are forced to lay off, will have access to the Canada emergency response benefit, but it is clear that it would be much more effective to keep those employees part of our organization. If we are forced to lay off that staff, they will be unproductive. They will be unable to contribute to COVID-19 research, and we will be at risk of losing them. This jeopardizes our ability to restart research and to compete for international industry and other funding when we come back.

● (1640)

Without urgent support from the federal government, we run the risk of setting back health research in Canada by decades and undermining patient outcomes in Canada in the future.

The Chair: Thank you.

We go now to the Heart and Stroke Foundation.

Ms. Simard, please go ahead for 10 minutes.

Ms. Anne Simard (Chief Mission and Research Officer, Heart and Stroke Foundation of Canada): Thank you very much, Mr. Chair, committee members and co-witnesses.

The Chair: Your sound is very weak.

[*Translation*]

Ms. Anne Simard: I'll make my comments in English, but I can answer your questions in French or English.

[*English*]

At our organization, the Heart and Stroke Foundation, there is a lot that echoes what other witnesses have said. In my testimony, I am going to highlight for you the impacts of COVID-19 on those with heart disease and stroke, and their caregivers, and how we have been responding and supporting them through this time. I will also address the financial toll the pandemic has brought on us within this sector and, to echo some other comments, specifically the issues regarding health research, at a time when science and research are incredibly important.

I will first focus on COVID and the intersection in our understanding. We know that it has worse impacts on people with underlying conditions, such as heart disease and stroke. We know that people with heart conditions are four times more likely to die if they have the virus than those with no underlying conditions, and those with previous strokes are three times more likely to die. As some of the other witnesses spoke about, we know that it has devastating respiratory impacts, but underlying and emerging evidence is showing that it actually has a significant involvement with the cardiovascular system and serious consequences like clotting, stroke, cardiac arrest and heart attack.

Right now, as others have talked about, people with heart conditions and risk factors are very much adhering to the physical distancing and self-isolation precautions, but what is really happening—and it is a very worrisome, unintended consequence of the pandemic—is that people experiencing signs and symptoms are not seeking medical attention for fear of coming into contact with the virus, or are justifiably worried about overwhelming our health system.

We at Heart and Stroke have just done a piece of data analysis with the Canadian Cardiovascular Society. We found that in Ontario there's been a 30% reduction in ER visits over the period of March and early April for STEMIs, which are the most serious type of heart attack, and a similar reduction for stroke-related visits. At Vancouver Coastal Health, they're seeing a 40% reduction in STEMIs.

We're very quickly mobilizing to continue to draw attention not only to COVID but also to the importance of really treating medical emergencies as such and seeking care. I also very much echo what some of my colleague witnesses have spoken about. People with heart disease and stroke are managing complex, chronic conditions with a lot of medications and rehabilitation, and a lot of them now are not getting the kind of support and care that they need, in addition to things like delayed surgeries and delayed treatments.

In fact, for us at Heart and Stroke, the number of people seeking guidance and support has been a bit overwhelming. In the last two months, we've had one million people coming to our website and nearly 100,000 accessing our COVID-specific resources, webinars, supports, online—

● (1645)

The Chair: Excuse me, Ms. Simard. Could you hold your microphone a little closer to your mouth, please?

Ms. Anne Simard: Certainly. Is that better, Mr. Chair?

The Chair: That's much better, thank you.

Ms. Anne Simard: Heart and Stroke produced the best-practice guidelines for stroke, and we have adapted them to work with how clinicians and institutions can treat stroke in this very challenging time. One of the realities is that despite all the quick action during COVID, we know there are going to be very significant lasting impacts, and for organizations such as ours, quite a reduced capacity to provide the kind of support we have always provided.

Like other health charities, we have had significant impacts from the pandemic. All our fundraising activities, except online, are largely on hold. We have already had an immediate revenue loss of $25 million, and have accordingly made many difficult decisions, including laying off nearly half our staff. At the same time, however, we recognize that heart disease and stroke affect nearly 1.6 million people every year, so we still need to be focused on going forward.

Within all the things we talk about in information and support and working with the health care community, the other function we also perform is funding. After the federal government, we are the second-largest funder of research into cardiovascular disease. We support some 700 researchers across the country, and our funding for them is quite precarious.

I think the challenge we're all quite concerned about is that health charities like ours have delayed or cancelled our competitions, and we're wondering about delaying payments. However, as COVID does create some research opportunities, many researchers and tremendous innovation, there are also hundreds of other research projects with years of money invested, millions of dollars, that are nearing completion and are now in danger of being wasted if we can't continue.

I think of all the partnerships among health charities that are more public and vocal and talking about the change that needs to happen, working closely with research institutions, researchers, scientists, clinicians and translating that science into action. Those partnerships are very successful, but they are at risk, and if we can't continue, not only is that knowledge translation at risk, but there will also be an erosion of expertise and a loss of progress on experiments and clinical trials. It's a very beautiful thing when it works, and a complementary piece that is so fundamental to caring for the many people with chronic disease in Canada.

Our focus and our appreciation of being able to speak with you today is to speak to the partnership among health charities. We've heard reference to the Imagine Canada partnership and the Health Charities Coalition of Canada that are asking for broad support for not-for-profits' and charities' operating costs. If we just focus on the research component of the help we need, we fund about 155 million dollars' worth of health research every year and are at a period where we're wondering if we're going to be able to continue to do so.

A way we could come forward and sustain that decades-long partnership—century-long partnership if you're the Lung Association; we're a mere 70 years old—is sustaining our ability to be part of that research and then to translate that research into impacts on patients.

I would mention two other small points. The federal government has made huge investments, $1.1 billion, in COVID. I think one of the questions is how much of that will look at the intersection between underlying medical conditions and compromised and vulnerable people and what those outcomes are. I think there's a real sense that it will be much worse for them, and we know that already.

● (1650)

The last point is that we as health charities have for a long time had many partnerships, including with the federal government. We're very open to solutions, and one idea is to do a partnered model by which we could match donor dollars with federal dollars, public dollars, to sustain some of those research investments.

At the Heart and Stroke Foundation, we've been very grateful to the federal government for the five-year, $5-million investment into research on women's heart and brain health, in which we matched donor dollars to federal dollars to really push women's health equity.

In closing, I would just echo not only my comments, but the comments of other witnesses. This is a precarious time for health charities, as it is for other organizations, but the intersection between the patient experience, the caregiver experience and health research and the translation of that into awareness, information and action is really a unique place in which the health charities operate.

We thank you for your consideration and attention to our requests.

The Chair: Thank you, everyone, for your presentations.

We'll start our rounds of questions at this point. We want to have three rounds, and we will start round one with Dr. Kitchen.

Dr. Kitchen, you have six minutes.

Mr. Robert Kitchen (Souris—Moose Mountain, CPC): Thank you, Mr. Chair.

Everybody, thank you for your presentations. Hearing from you is greatly appreciated.

Definitely we have heard across this country how COVID-19 has consumed everything, and other diseases or illnesses have been totally forgotten. As we've seen and have heard, patients are not seeking care from hospitals or are not seeking care from their doctors when they're presenting with signs and symptoms, because of their fear that they might contract COVID-19 in some manner.

Dr. Wouters, thank you for your statement, when you talked about the exclusion of your researchers on the issue of the wage subsidies program. That's something we had tried to point out. When this program was brought out, a number of issues were missed, in particular small businesses that were sole practitioners, and so on. This is another one that we definitely need to be focusing on, because our health research is paramount for this country to progress and for the safety of all Canadians.

I thank you for your comment on that. We will bring that forward, or at least I will anyway.

Dr. Bradly Wouters: Thank you.

● (1655)

Mr. Robert Kitchen: This committee has heard, time and again, that PHAC was not adequately prepared to deal with the spread of COVID-19 in an efficient way, in part due to the underfunding and mismanagement of health care preparedness. In fact, just yesterday we heard from the Canadian Manufacturers & Exporters, who had a plan put forward in 2009 after the SARS epidemic, dealing with an influenza pandemic program. Basically what they said to us was "We forgot about it; governments forgot about it." That seems to have happened when PHAC actually started in 2003 to develop these things. It seems to have been forgotten about.

Mr. Cloutier, in a recent article in The Hill Times, you said a couple of things that struck me. One was that given Canada's experience with SARS, Canada "should not have experienced the critical shortage of medical supply in its health care system". Further in that interview you said that PHAC's visibility and access to cabinet should be increased, even outside a disease outbreak, through the establishment of a "pandemic preparedness council".

Given that PHAC was established as a result of the SARS epidemic and given that we have seen significant gaps in preparedness by PHAC, what would a pandemic preparedness council do differently to address the shortcomings in Canada's COVID-19 responses? If you could comment on that, please, I'd appreciate it.

Mr. Paul-Émile Cloutier: Thank you very much for that very important question. I certainly would hope that, as I wrote in my article, SARS was really a wake-up call, and I think that COVID-19 is now seen as a clarion call.

I think what you have to look at is the power that's given to the Public Health Agency. When I used the word “council”, I pointed out that it would be important for the person who's head of the Public Health Agency to have access to cabinet and to present his or her views as to the state of our nation in terms of a pandemic.

At this moment I feel that it's a bit too bureaucratic. It is reporting to a number of people, when in fact we know that in Ottawa the decisions are really made at cabinet. I used the word “council" hoping that in this situation—and it's only in this situation because of the model that we would have—this person could actually be reporting to the Deputy Prime Minister through a committee that would be established at cabinet to discuss a pandemic or any major challenge that would be coming up rather than just staying in their offices and looking at what is being done.

The other thing is that the sharing of information and delegating of powers that there should be between the provinces and Ottawa, in my view, needs to be worked at and needs to be reviewed as we go forward.

I don't know if I've answered your question.

Mr. Robert Kitchen: I appreciate that. It was something that caught my eye. Having you here gave me an opportunity to ask that question.

Further on in that article there was talk about the funding for PHAC. It has decreased over the past few years, with its budget declining by 7% in the fourth quarter of 2019. That equates to about $47 million being cut. What reforms need to be made at the federal level with respect to ensuring the sustained and adequate funding of PHAC, especially in terms of preparedness? Where do some of the gaps lie? Can you identify those?

Mr. Paul-Émile Cloutier: You may recall that a few years back we did have a minister of state for public health. We no longer have a minister of state for public health. At one point, the level of delegation and reporting authority that person would have had were much higher than it is at this moment.

I believe that if you really are serious about public health in Canada, you need to give them the tools. There can't just be a tool box that's not open and not used. I believe it's important that the person or the agency have the authority not only in Ottawa but also across the country to conduct research and analysis.

When you look at the PPE, the stockpile and the ventilators, these are things that should have been managed in a much better way. I think this is where the Public Health Agency, if it had been granted the authority, probably could have done a better job.

● (1700)

The Chair: Thank you, Dr. Kitchen.

We go now to Ms. Sidhu.

Ms. Sidhu, you have six minutes.

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

Thank you to all the witnesses for taking part in this meeting.

On Sunday I hosted a teleconference with seniors in my riding. The major concern I heard from them was the pharmacy dispensing fee. We need to ensure that all Canadians have access to their medications. When restrictions came into play there were changes in the frequency of prescription refills, and those who used to have three months' worth dispensed were restricted to only one month at a time. That is also tripling the dispensing fee.

I would like to hear from Heart and Stroke or the Organization for Rare Disorders. What are your thoughts on how this is impacting Canadians?

Maybe the Organization for Rare Disorders can answer first.

Dr. Durhane Wong-Rieger: Thank you very much.

We have also heard many concerns around dispensing and dispensing fees. As well, as you said, they could get only a small supply of the medicines. Some of them could not get them from their normal pharmacies, and when they went to another pharmacy there were huge issues, especially for some of the rare disease patients, in that the medicines they were getting were not routinely listed in all dispensaries.

We also had a lot of problems with people who, because of COVID and because of the impact on them, were actually having to use more of their medications during that time of infection. They could not get an understanding from the pharmacy that what they were given was actually not a 30-day supply, that it was now a 10-day supply. This was a huge issue.

We also—

The Chair: Pardon me, Dr. Wong-Rieger. Would you please hold your mike a little further away.

Dr. Durhane Wong-Rieger: Yes. I'm sorry about that. I forgot.

We've heard a lot of those same concerns. Again, as I said, we had 50% of the people say that they could not get their regular medication. In almost every case, it had nothing to do with not having the drugs there, though in some cases it was, and it was actually the more routine medicines that were not there, such as amoxicillin. In some cases, we had a number of patients who reported they couldn't get access to, interestingly enough, chloroquine. This was something they used normally, and in several cases they were told, “We're holding on to the supply because we want to save it for COVID patients.”

Ms. Sonia Sidhu: Do you think the recent investment of $240 million the government has made in the provinces and territories for virtual care will ease this issue? Do you have advice for these Canadians? Does any other group want to comment?

Ms. Andrea Seale: I could speak briefly to it. Among the top concerns we hear from cancer patients, I think they relate to financial strain overall. When you have chronic health conditions, such as cancer and others, there are burdens placed on patients depending on where they live and what kind of access to health care they have, and there's the financial strain it places on people in having to get to treatments or losing employment. Any of these changes that add to financial stress are the kinds of things we hear about and that patients feel very deeply.

Ms. Sonia Sidhu: Thank you.

Ms. Anne Simard: If I may add to that, the other piece in terms of virtual care is that what has actually been a success story is how not only many health care provider clinics but also patients have responded to virtual appointments, renewing prescriptions by email and getting consent by video conference. There is a lesson in here that is a success story. It's about how there has been a fair bit of resistance and many challenges for so long, and there's been a bit of a breakthrough in this period around accessing different modes of care, and an acceptance that wasn't there.

I'm not diminishing the challenges presented, but there is a piece about the virtual appointments, telemedicine and the adaptiveness that patients and caregivers and the health care providers have shown that I think is an important go-forward strategically for the health system.

● (1705)

Dr. Mohit Bhutani: I'm going to add to that for just two seconds, Mr. Chair.

I would echo those comments. In Alberta we've been using telemedicine for a long time for rural and remote communities, and it's worked very effectively. To see it gravitate into the more urban centres has been a real positive. I think the investment in the virtual care is good for now, but is also going to be helpful for the future.

Dr. Durhane Wong-Rieger: I don't mean to take up all of your question time, but I have to put in a very strong word about rare diseases. For our patients, because they don't normally have a good plan of care and their specialists are oftentimes isolated far away, we have patients who say, “I can get a meeting with my family physician, but they know nothing about my disease.”

We come back to needing to have comprehensive plans of care for patients with rare diseases, plans that they can own, that they can hold. This is what many other countries do. We need to have the ability for patients to manage their care, and then they can actually have access to what we hear is happening in cardiovascular disease, in cancers and in other conditions. For us, this is something that has actually turned into a nightmare for most patients, because they can't get access to others who would actually know anything about their disease.

The Chair: Thank you, Ms. Sidhu.

Mr. Cloutier, I would point out that when you're answering a question, you can leave your headset on so we can talk to you if there are translation issues or sound issues and so forth. Thank you.

Also, Dr. Wong-Rieger, try to remember your microphone, okay?

We go now to you, Mr. Thériault. You have six minutes.

[*Translation*]

Mr. Luc Thériault: Thank you, Mr. Chair.

I'd like to thank the witnesses for their very informative testimony.

Ms. Seale, experts have come to tell us that this will not be the only pandemic, that there will be others in the coming years. I have read your brief carefully, and it's quite comprehensive. Other witnesses have also come to tell us that the underfunding of the health care system has weakened it. As a result, when we are faced with a pandemic as virulent as the one caused by COVID-19, the system is unable to take care of its patients. The system was already overburdened and, in terms of diagnosis, we know how important it is to diagnose in a timely manner, especially with cancer, which is the leading cause of death. It's clear from your brief that right now patients and caregivers feel left out, and they are.

It seems that we have learned nothing from SARS. In your brief, you make it clear that, this time, perhaps we need to be aware of the long-term effects of this pandemic and its impact on the treatment of our patients. We didn't collect that information during SARS. I was looking at everything you do, and I thought your organization would certainly be interesting, important, and relevant enough to do that kind of research. What would you think if we did put the money forward so that your organization could take the lead on this kind of research? Do you think it would be in a good position to do this follow-up, which wasn't done during SARS?

[*English*]

Ms. Andrea Seale: Yes.

I'm sorry. I missed the very beginning of your comments, but I think the rest was directed to me. Is that correct?

[*Translation*]

Mr. Luc Thériault: Yes, absolutely.

[*English*]

Ms. Andrea Seale: Thank you.

Absolutely, I think there are going to be many lessons to be learned. From the patient perspective, I think there has been a great deal of understanding that the health care system is in an impossible situation and that we've had to prepare for the worst. At the beginning of the pandemic, when you looked around the world, it really looked like of course Canada needed to avoid the worst that we saw in other countries. Perhaps our preparation has meant that we won't see that in Canada, which I think cancer patients, like all of us, would be very grateful for.

Absolutely, there are lessons to be learned here about the impact. One of the things that's a great challenge for our Canadian health care and that applies to cancer very specifically is the lack of access to data about patient experience, which is held in different pockets across the whole country and makes it quite difficult to understand in real time what people are going through and adjust. I think there are great lessons to be learned.

There's absolutely research that should be done to understand not just how we would deal with another pandemic, but also how we could create a health system that can be more responsive to people's needs on a very timely basis. We would think that would be another good outcome from what's been such a challenging situation, just as Ms. Simard mentioned virtual care as being something that's been a real, positive leap forward that the pandemic has caused. I think we could apply the same...to understanding the impact of strain on the system on different types of diseases and patient groups.

● (1710)

[*Translation*]

Mr. Luc Thériault: Thank you.

Would you like to add anything, Mr. Cloutier?

Mr. Paul-Émile Cloutier: Mr. Thériault, I find your question very relevant. I would just like to add a new dimension to it, without, however, contradicting what you said.

Today in Canada, most of our hospitals are operating at a capacity beyond what should be the norm. Often hospitals are operating at 110% or 120% capacity, and there are no beds or space left for patients. The COVID-19 crisis has put additional stress on the system, forcing hospitals that were already operating at overcapacity to let some patients return home and to convert some rooms, such as operating rooms, to intensive care units. This problem is caused by the lack of adequate infrastructure to meet Canadian needs.

Mr. Luc Thériault: How should—

[*English*]

The Chair: Thank you, Mr. Thériault.

[*Translation*]

Mr. Luc Thériault: I'll continue in the next round.

[*English*]

The Chair: Mr. Davies.

Mr. Don Davies (Vancouver Kingsway, NDP): Thank you, Mr. Chair. Thank you to all the witnesses for being here.

My first question is to Ms. Seale.

Ms. Seale, you've talked about the profound impact on the finances of the Canadian Cancer Society. I know that you requested emergency funding of $16.4 million from the federal government for a few things: to protect vital services, reduce isolation, support mental health, expand navigation resources and provide practical supports for cancer patients. Has the federal government responded to that funding request yet?

Ms. Andrea Seale: We've had numerous positive conversations about the request and, I think, a great deal of understanding of the needs of cancer patients and the role that we could play in supporting them. But those conversations are still ongoing and we haven't had any confirmation of funding.

Mr. Don Davies: Thank you.

Mr. Cloutier, you gave some pretty sobering statistics about the age of hospital infrastructure in Canada, and apparently the majority of it is well over 50 years old. You've also written that Canadian hospitals are forced to defer much-needed maintenance due to budget constraints in order to maintain front-line care for patients, and you've noted that we have not adequately funded the upkeep of our health institutions. In your view, what does the effect of this deferral of needed maintenance have on infection control in our hospitals?

● (1715)

Mr. Paul-Émile Cloutier: It certainly has an impact, and especially an impact on patients who are either vulnerable or older. It also has an impact on our ability to introduce new technologies within our hospital sector. I'm always reminded that one of the hospitals which I visited was receiving a gamma knife, but the infrastructure for receiving the gamma knife did not allow that to be placed within that hospital. So it has an all-around impact on the organization.

We had estimated a few years back the number of projects and we had gone to many of our institutions, which are members of HealthCareCAN, and asked them what projects they would put in place to allow them to really upgrade their institution. I believe that number is in the billions of dollars. I don't have the exact number.

This leads me to my last point on this. At this moment, hospitals are not allowed to access any infrastructure funds, and again it's a simple regulation that does not allow hospitals and schools or universities to apply for the competition within the government's infrastructure fund envelope. I believe that's unfair, and I believe that hospitals—

Mr. Don Davies: Thank you, Mr. Cloutier. I'll move on to another question.

You've also written that once COVID-19 is behind us, it is imperative that we complete the unfinished business of medicare by closing the gaps in long-term care and traditional institutional health care systems. There's been some talk lately about establishing national standards for long-term care, perhaps bringing them under the Canada Health Act or establishing a federal transfer to the provinces and territories, but tying that money to observing higher standards of care for long-term care for seniors. Is that something your organization would endorse?

Mr. Paul-Émile Cloutier: Yes, it would be something our organization would endorse. I find that the long-term care organizations have been left behind. They should be enshrined in the Canada Health Act. I think that would be a first step. They need to be a partner in the delivery of health care. They can't just be put on the side, thinking they will organize by themselves. We saw the complexity with COVID-19; what was happening among hospitals, long-term care and the delivery of the care.

To me it would be an appropriate move, and I think a political move that would be welcomed by all Canadians.

Mr. Don Davies: Thank you.

Dr. Wouters, I want to make sure I understand this. You're saying that non-COVID-19 research in Canada is not being funded right now purely because the CERB criteria that has been set by the federal government excludes hospital or clinical-based research.

Do I understand that correctly?

Dr. Bradly Wouters: Yes, the main issue around the reduction of revenue is because when research is suspended it means that much of our revenue also gets suspended. We do a large amount of clinical research, clinical trials, funded by external industry, pharmaceutical companies and biotech companies. Because of what the hospitals have done to prepare for COVID-19, as you heard from the other witnesses, a large number of those clinical trials have been stopped. That revenue has also been stopped.

For us alone, our single institution, that represents a drop of over $6 million per month in revenue.

Mr. Don Davies: The remedy for that is what?

What advice would you give us to recommend to the government to fix that?

Dr. Bradly Wouters: Access to the wage subsidy program for our 700 people would allow us to keep them employed and bridge through this suspension so they can participate in COVID-related research and can be there and ready for us to come back when research gets turned on and we can compete for those dollars again.

It's a very competitive environment. Health hospitals all over the world compete for those funds for those clinical trials. We want Canadians to have access to those trials but it means we need very strong clinical research and clinical scientists here who are able and ready to carry out those trials.

● (1720)

Mr. Don Davies: Thank you.

The Chair: That brings round one to a close. We'll start round two at this point with Mr. Webber.

Mr. Webber, please go ahead for five minutes.

Mr. Len Webber (Calgary Confederation, CPC): Thank you, Mr. Chair.

I will continue with Dr. Wouters on that specific topic of the suspension of research.

Have other countries suspended their research as well in these areas?

Dr. Bradly Wouters: Yes, they largely have. Every academic health science centre, like those in Canada, has largely been suspended whether this is Harvard or Stanford or Johns Hopkins in the United States, anywhere in Europe; they're all very much in that same situation.

How they all respond is a little different because they are in different jurisdictions.

Mr. Len Webber: Okay, thank you.

Dr. Bhutani, have we seen any evidence of permanent or long-term lung damage in those who have contracted COVID-19?

Dr. Mohit Bhutani: Currently, the evidence is building in regards to what the long-term effects are going to be. There's going to be a multi-tiered response or an expectation of that. If they have had mild symptoms, probably at the end of the day, probably not a lot of damage. But there's a potential for the patients who get admitted to hospital and ultimately go to intensive care units and are put on ventilators to develop some long-term consequences.

Currently in Canada and around the world we are trying to carefully follow these patients in clinics after their discharge from hospital, seeing what the natural history or the progression of this disease is going to be. Once they get discharged from hospital, at least in our institutions, a lung specialist will follow up on them longitudinally, taking a look at their lung function over time.

The question is uncertain at this point. I think the length of stay in the ICU, the type of care they get in the ICU for complications they develop in the ICU will all impact the expectations we have.

Mr. Len Webber: Is that potential damage because of the actual COVID disease or is the ventilator the issue there?

Dr. Mohit Bhutani: That's a great question. I give a lecture to medical students on this every year. If you have an hour, I can take you through all of it.

The reality is that there is the acute problem and a chronic problem. The infection itself results in massive inflammation within the lungs, and the lungs harbour a lot of inflammatory cells. That inflammation, in the short term, becomes very severe and can lead to permanent damage to the lungs. The infection can lead to that problem.

It can be complicated with what we call ventilator-associated complications. When the lungs get inflamed like that, they become very stiff. Lungs are normally very pliable. They're like a balloon: They inflate and deflate very easily. When the inflammation sets in, they become very stiff. When you're trying to drive air into this stiff bag, there's a chance of developing complications like a collapsed lung or a punctured lung. Those are ventilator-associated complications. Those are very well studied, and there are strategies within the ICU to prevent the frequency or occurrence of them, but at the end of the day, there's still a potential risk of ventilator-associated complications.

Mr. Len Webber: That's interesting.

Dr. Bhutani, you talked a bit about some medicines that should not be prescribed during this pandemic. Are you aware of patients who are being denied prescriptions because of COVID, prescriptions for conditions other than COVID? Am I making sense?

Dr. Mohit Bhutani: Yes, one hundred percent.

In the pulmonary-lung world, the two primary conditions are asthma and chronic obstructive pulmonary disease, COPD. For both of those diseases we use a medicine called, as a broad term, an inhaled corticosteroid. It is a very minute dose of steroid introduced into the lungs to help deal with the conditions.

The concern that patients and other practitioners have had is that steroids suppress your immune system. If you have asthma or COPD, does taking this inhaled steroid put you at any higher risk of potentially acquiring the infection? There's no evidence to suggest that is the case. In fact, it's the opposite. We really want patients with those two conditions to optimally manage their lung condition to prevent them from developing some of the more serious complications of the infection, if they were to acquire it. In fact, we tell them to be more compliant with it.

The only issue we've run into relates to dispensation. Because of the pandemic and the preparation for a potential hospital surge, Health Canada recognized, through a report from the pharmaceutical industry, a need for salbutamol, a rescue inhaler also known as Ventolin. You might recognize it as the blue inhaler, as it's the one most commonly seen around. It's meant to be used in a rescue circumstance. There's going to be a potential shortage of it because hospitals have acquired a large quantity of it in anticipation of a hospital surge.

Health Canada and the partners we identified in our notes got together and developed a strategy. The comment earlier about dispensing one month at a time, really, from our world, has come from that standpoint. We weren't sure what was going to end up being needed and required as the industry tries to replenish its supplies.

Right now there's no concern. I think we've developed a really nice mitigation strategy to deal with that, should it happen.

● (1725)

The Chair: Thank you.

Mr. Van Bynen, please go ahead for five minutes.

Mr. Tony Van Bynen: Thank you, Mr. Chair.

I want to thank the witnesses today for bringing a lot of important information forward for us.

My wife volunteers at the cancer centre at Southlake Regional Health Centre, but since the outbreak of COVID-19, she hasn't been able to do so. I know that the work of volunteers is important to patients, their families and the centre.

Mr. Cloutier, I'm wondering if you could share how the centres that rely on helpful volunteers are coping with their absence during COVID-19.

Mr. Paul-Émile Cloutier: I think they're managing it with a lot of challenges and difficulty. I think they're trying to get help through other health care providers within their own community. I know for a fact that within hospitals, staff who were assigned to a particular floor were reassigned to another position within the COVID-19 area, so there is some flexibility but sometimes it's very difficult. I'll give you an example.

I'm a resident of Ottawa, so I try to offer my help at the Ottawa general hospital because of my work. I believe there are challenges there. You have to be careful with how many people you bring into the system, because if you do this, there's a higher risk that you may get the virus.

A lot has to be done to manage the situation in the system, but I would certainly encourage your wife to continue to offer her services, maybe in an area where there's less risk to her life.

Mr. Tony Van Bynen: Thank you.

The idea of greater pan-Canadian collaboration has been a recurring topic of conversation throughout these committee meetings. I'm wondering if the organizations and the hospitals that HealthCareCAN represents across Canada have been collaborating during the pandemic.

Specifically, what is the process for identifying existing health resources and gaps in health equipment and resources in hospitals? How is this information being communicated at the federal, regional and provincial levels?

In your view, how could communications between hospitals and different levels of government be improved, such that the provincial and federal governments have a better understanding of the needs of the health care provider organizations?

Mr. Paul-Émile Cloutier: Within each of the provinces, there are a lot of communications and meetings that are happening among these various hospitals to discuss PPE, ventilators and how best to deal with some of the patients who have come through the hospital. That's done at the provincial level, and it's very similar to the other provinces: They do the same and then they usually report their findings to the government, to their ministry of health.

● (1730)

Where I think there was a lack or where there was a gap, it was at the federal and provincial level, where sometimes I felt that the federal government did not have the appropriate information to actually assess and then follow that by making a decision.

I think within the province, within the regions at least, those members of our organization were in constant conversation with their neighbours to discuss issues, practice and lack of ventilators, and see where they could actually get some PPE and ventilators. That conversation was also done on a frequent basis at the provincial level, I know that for a fact. Sometimes even some of our major hospitals would have conversations at the international level only to be able to have access to additional PPE and ventilators. That is done at the provincial level.

I think we need to strengthen the coordination and the information from the provinces to the federal government, and the federal government to the provinces. That's what I would suggest.

Mr. Tony Van Bynen: Thank you.

The Chair: Ms. Jansen, please go ahead for five minutes.

Mrs. Tamara Jansen (Cloverdale—Langley City, CPC): I'd like to direct my first question to HealthCareCAN, to Dr. Wouters. Just for clarification's sake, your organization represents health researchers across Canada, correct?

Dr. Bradly Wouters: Well HealthCareCAN represents health researchers across Canada, research hospitals across Canada. We're one of those.

There are more than 40 such organizations.

Mrs. Tamara Jansen: You mentioned the fact that all research and clinical trials in Canada that are not related to COVID-19 have been suspended or cancelled, and that, I understand, if trends hold the pandemic will cripple Canada's overall research capacity.

In light of this information, what do the Canadian research members think of the $850 million research grant announcement made by the Prime Minister on Monday, of which $840 million will go to the WHO, according to a tweet by WHO Director-General Tedros.

Dr. Bradly Wouters: I think the investment in COVID research is welcome. This is clearly a huge, worldwide pandemic that needs to be solved, and I firmly believe that science and research are going to be our path out of the pandemic.

The investment is good, but it's a piece of it. I think what we're here for today and what we're talking about today is that the larger research infrastructure, what we're hearing from all the charities and the other parts of the research investment, has not been addressed, and is in a very fragile moment.

Mrs. Tamara Jansen: Yes, so that money could have possibly been better used here in Canada is what I was hoping you would say, but maybe not.

I'm going to now move my questions on to Mr. Terry Dean from the Lung Association. I've been hearing that there is some pressure on doctors to put COVID-19 down as cause of death when comorbidity issues are much more the reason for a patient's death. I'll just give you an example. My grandfather had COPD, but he died of pneumonia. My dad was the same, he had COPD and also died of pneumonia.

Do we have any idea how many deaths currently attributed to COVID-19 should more likely be attributed to comorbidity issues?

Mr. Terry Dean: At this point I'm not aware of the specific answer, other than to say we know that many of these patients are older, and that they suffer from many different diseases, many different comorbidities. To be able to specify COVID-19, I think it would be very difficult.

Mrs. Tamara Jansen: Okay.

Mr. Terry Dean: We spoke earlier about some of the surveillance that's needed in Canada to help us understand what's happening, and I think this is a great example. Data can inform the decisions we want to make down the road, and I think an investment in that particular area should be something the government considers.

Mrs. Tamara Jansen: You think that if we had the right kind of investigative technology, we'd eventually be able to sort through those questions?

Mr. Terry Dean: The hope is that the information will help us make better decisions. Right now, I don't think we have a solid enough base to be able to give that confirmation.

Mrs. Tamara Jansen: Thank you.

My last question is for Dr. Wong-Rieger. I really appreciated the information from your survey results, which showed that many non-COVID patients are having a hard time accessing health care right now. I heard of a farmer in Ontario who had a staph infection. He called the hospital to ask if he could come in because he wasn't feeling well, and they told him, no, call Telehealth Ontario. He didn't receive a callback right away and was eventually found dead in his home.

I know that in B.C. here, they'll be studying causes of excess deaths that were not directly blamed on the coronavirus since it appears that we had about 170 deaths in March and April, which would not normally have been expected.

Has your organization seen any evidence of excess deaths due to lack of medical care for anything other than COVID-19 over the past two months?

● (1735)

Dr. Durhane Wong-Rieger: I think there is certainly the immediate death that can occur. We definitely have gotten notices around immediate death, where people could not get access to an intervention that would have in fact been life-saving. That definitely has happened.

What we're more concerned about—and we're trying to figure out a system to track this maybe also internationally—is the death that will occur later on because there was a therapy that was not provided. We've had patients who say, “I need to get regular infusions, but I'm afraid to go in for an infusion, so if I skip the infusion, what's going to be the impact?” I think we definitely need to continue to track that. Unfortunately, certainly for rare diseases, we do not have a very good system to do that. That's why we are also pushing very much for data registries and the ability to do that.

Then, yes, there are the cases of immediate deaths and further disabilities as a result of it, but I think down the road we will see much more serious disabilities and progressive diseases that will also be, at the end of the day, caused by COVID and not being able to access.... I don't know exactly how we can track that, but I think we need to because if we have more waves of this, as everybody says, information is king.

The Chair: Thank you.

We go now to Mr. Fisher, for five minutes.

Mr. Darren Fisher (Dartmouth—Cole Harbour, Lib.): Thank you very much, Mr. Chair.

Thanks, folks, for being here.

You can't think of COVID-19 without thinking about folks with underlying health conditions. In the age where information is king—well, accurate information is king—we did hear some witnesses today use words like “fear” and “frustration”, and speak about patients' fear of even going to the hospital. We know about blood infusions and MRIs and that people are not being referred to neurologists or oncologists. These things can add to an already sky-high level of stress for some of these patients.

I'm interested in some of these folks with respiratory issues and the cancer patients. What is life like for some of these folks during this time of COVID-19? How are they connecting with health care professionals? I know Dr. Bhutani talked about telehealth. Is it through online sessions? What is life like during COVID-19 for these folks?

I'll start with the Lung Association, and then if there's any time left maybe go to the Cancer Society.

Mr. Terry Dean: That's a great question. We're hearing—and we talked about it earlier—that telehealth is a great tool. I know a number of physicians who are making themselves available for telephone and video conferences. I mentioned earlier that we have hosted a number of webinars and Q&As on our website, in which we have had respirologists and health care professionals answer the questions of those on the video. For remaining questions, because the webinar was only an hour, we actually had them respond to the questions we received, and then we sent the answers directly to those patients.

We're encouraging them to use the tools, but we're hearing the same thing. There is some stress. There are some mental health issues. We're encouraging them to manage their overall health by making sure they're exercising if they can, getting enough sleep and eating properly. If they are on medications, we encourage them to make sure they're complying with their plans to best manage their health.

Dr. Mohit Bhutani: I'll just add to that. I've done a number of telehealth clinics and phone clinics with my patients. The respiratory patient is like any one of us. There's a lot of anxiety about what they should and shouldn't do and how they are going to manage the activities of life like going for groceries, getting their prescriptions and adapting to this.

I think that the stress and anxiety of that is certainly as much as it is for anyone in the country, but I'm going to say that, with the resources the Lung Association and the Canadian Thoracic Society have provided, a lot of them cope as best as they can. There are videos we've developed for at-home exercises and online resources for them to read and maybe become more educated about their lung disease.

We've also promoted lots about how, for people who are considering stopping smoking, this might be a good time. The social circumstances aren't there when you may want to go and have a cigarette. If you're ever contemplating going to consider smoking cessation, maybe this is the right time to do it.

We're trying to work with them on an individual basis, but I would say that, at the end of the day, they're like any one of us. They're nervous. They want life to go back to normal as much as possible, but they've been very compliant with what the Public Health Agency is saying. They're trying to avoid social circumstances that might put them at higher risk. I'm very impressed with some of the responses that I see from my patients.

● (1740)

Ms. Anne Simard: I think the other piece, if I may jump in—

Mr. Darren Fisher: Okay. I know we were going to go to Ms. Seale, but if you have something quick you want to say, go for it.

Ms. Anne Simard: I just also think the way that they're getting care is very different, even when you show up at the hospital. Today, for example, when you're talking about stroke, we talk about door-to-needle time. If you are a candidate for the clot-busting intervention, what we would aim to do in 45 minutes, to save as many brain cells as possible when you have a major stroke, now can take twice or three times as long with a number of serious consequences.

To the questions earlier about never minding the impact of COVID, but with the way that hospitals are managing—very beautifully with precautions—there are still other consequences that may have knock-on effects of more disability, more death and more complexity.

Mr. Darren Fisher: I'll go to the Cancer Society.

Ms. Andrea Seale: Yes, thank you. I would echo everything that's been said.

There's such a feeling of powerlessness when you are diagnosed with cancer that you need support in the best of times. What we've been hearing through our helpline—we have a community called cancerconnection.ca where patients and caregivers go to support each other and share their experiences—is a frustration that they can't get answers about what's going to be next for them, which is very understandable, because the health care system right now is trying to determine how it's going to reopen, resume services and get back up to the levels of care that people need.

The anxiety is very high. For us it's meant that we're more relevant than ever to people. We're not part of the health care system; we're not funded as part of the health care system. We're funded purely by donations that people from across the country contribute to help each other. I think that's really pointed out the importance of that second part of the health care system that keeps a lot of things going, that takes the pressure off government-funded health care, but that is really a lifeline for people when they have nowhere else to turn and they have to deal with the inadequacies of our system.

The anxiety is there, and I think it's going to be there until we start to see the backlog being dealt with.

Mr. Darren Fisher: Thank you.

The Chair: We go now to Mr. Thériault.

Mr. Thériault, please go ahead for two minutes and a half.

[*Translation*]

Mr. Luc Thériault: Thank you, Mr. Chair.

Ms. Seale, on December 9, two cancer survivors, Ms. Dubé and Ms. Sansfaçon, joined us in challenging the government. We organized a meeting with the Prime Minister regarding employment insurance sickness benefits. This seems to me to be fundamental for anyone who wants the least financially stressful treatment possible. At the beginning of the discussions, we were talking about at least 26 weeks, but we were proposing 50 weeks because, after all, these people have paid into employment insurance.

I'd like to hear your perspective on that. I imagine that you would agree to increase the benefit period to 50 weeks?

[*English*]

Ms. Andrea Seale: We've been advocating for an increase to the employment insurance sickness benefit for a number of years now. It currently provides 15 weeks of coverage, so when someone needs to take time off work, 15 weeks are covered.

From a cancer point of view—and this, of course, is different for different diseases—we know that's not adequate for the average length of time that a person needs to be off work to receive cancer treatment. We have asked for at least 26 weeks of sickness benefits and would see that as being very helpful to those with cancer. Of course, more time would provide for people who are not the average and have much longer experiences and need support.

The extension of employment insurance sickness benefits would be very meaningful to people with cancer and other diseases and would help address what I described earlier, that incredible financial strain people feel when they're ill, and the strain that then puts on families and caregivers and their extended support network around them.

So, yes, we would absolutely be very supportive of an extension to the sickness benefit.

● (1745)

The Chair: You have 15 seconds.

[*Translation*]

Mr. Luc Thériault: This can also be useful in the event of relapse. Of course, when you're undergoing treatment and you're under stress, the results aren't necessarily always there.

[*English*]

Ms. Andrea Seale: Yes, you're right. It's very often complex. It's not just a matter of one course of treatment; this is sometimes many years of impact on a person's life.

The Chair: Thank you.

Mr. Davies, please go ahead. You have two and a half minutes.

Mr. Don Davies: Thank you.

Mr. Cloutier, two weeks ago, you wrote in Policy Magazine the following:

> The Naylor report charted a clear course forward, but we only followed the roadmap partway. We created PHAC but failed to maintain the necessary resources and processes to deal with an outbreak of the scale and scope of COVID-19.

In your view, in what ways did we fail to implement the recommendations of the Naylor report and what can we do going forward to remedy those?

Mr. Paul-Émile Cloutier: I made reference in my article that there was a report in 2006 that outlined a number of recommendations. If you look at the list of recommendations that were made and how many of them were implemented, you'll see that many of them have not been implemented.

That's why I said that if SARS was not the wake-up call, I would hope COVID-19 will be that clarion call where you are going to address not only the failures and the gaps that existed during SARS, but also the same gaps that might still exist during COVID-19.

I'm particularly pleased that a task force has been put together, again with Dr. Naylor, who is well versed and well capable of analyzing this situation. I hope this time that the governments—not just the federal government—will take this report seriously and try to implement all of the recommendations from this report.

Mr. Don Davies: Of that itemized list of suggestions that were not moved forward with, do any stand out to you that you could advise this committee would be priorities for us to address this time?

Mr. Paul-Émile Cloutier: One was funding and one was better coordination between the provincial governments and the federal government. Those are the only two I have at this moment, but I could get back to you with the list and say which ones we thought could be done better.

Mr. Don Davies: Thank you. That would be helpful.

Mr. Dean, this is a good segue, because you spoke of the need for information.

Previous witnesses have called for federal legislation establishing mandatory standardized information sharing between provinces, territories and the federal government in cases of national health crises. Is that something you would support?

Mr. Terry Dean: Absolutely, and beyond crises, there is obviously ongoing care and management of chronic disease.

This said, we want to make data-informed decisions. That's the best use of our allocation of resources. I think we need to start by building the database.

The Chair: Thank you.

That brings round two to a close.

We'll start round three with Ms. McLeod.

Ms. McLeod, please go ahead, for five minutes.

Mrs. Cathy McLeod (Kamloops—Thompson—Cariboo, CPC): Thank you, Chair.

This is the first time I have subbed in to this committee or any virtual committee, and of course my first disappointment is that it doesn't have all the power we would normally have. Certainly if we did, I'd be making a motion right now and supporting Dr. Kitchen's thoughts around the issue of the CEWS and the CERB.

You're paying money for one versus the other, and you get so much value out of the other. I would have loved to be able to make a recommendation to the government that they need to perhaps broaden that criteria.

I really appreciate that testimony, because you spelled out the case very clearly. It can't be a motion of committee, but certainly I think that as independent MPs, if we feel strongly about it, we should all take the opportunity to move that forward.

My first question would be perhaps to Ms. Seale of the Canadian Cancer Society.

It's very tragic. There's a young woman who is dying of cancer and receiving care at home, but of course no one is visiting her because of COVID. Is there any mechanism or is a system in place—and do you have access to PPE, proper equipment—whereby people in palliative care, in their home environments or others, can have visitors? What a terrible thing to be dying alone at home without people coming to visit.

Is there a system in place? Is there adequate protective equipment so that we can have those sorts of visits?

● (1750)

Ms. Andrea Seale: Yes, it's very tragic. We've heard the same kinds of stories of people having to be isolated from each other at times when they want to connect and, of course, we've all seen the situation in long-term care homes.

The patients we speak to and the families we speak with are very respectful of the instructions from Public Health to self-isolate and protect our health and protect each other. They haven't been looking to access PPE that would otherwise be needed in the health care system. Even in spite of how tragic and difficult it is, I think that for the most part we've seen a great deal of support for wanting to ensure that the health care system has what it needs to care for the most numbers of people.

Mrs. Cathy McLeod: If we had had adequate PPE, if we'd had the storerooms that should have been filled with updated equipment across the country and if we had had adequate protective equipment in place for the health care workers, including in our long-term care facilities, is this something that as an organization you might have wanted to support?

Ms. Andrea Seale: I think any kind of support we can give to allow people to connect with each other right now is vital. It's what we're trying to do when it comes to our online and telephone support, where people are able to connect that way. We've really augmented the kinds of offerings we're making right now in terms of our website resources and our phone support, and people are certainly accessing them.

I think that in the absence of being able to connect in person, this is.... People are accepting it and turning to those more virtual ways, but of course it's not the same as being able to be there in person with the people you care about.

Mrs. Cathy McLeod: Again, had Canada been well prepared, then it might have been a little easier.

For my next question, you talked about everything being on hold in terms of chemo, radiation and surgery, and diagnoses all being delayed, which of course is very difficult. Have you been able to do any quantification of that yet? Or is it going to take time?

Ms. Andrea Seale: Yes, it's definitely going to take time. As we have talked about in a couple of circumstances here, the data is not there. It's hard to get a picture of the experience. It's also very much varied across the country. Different jurisdictions are providing different levels of care right now.

There was a study from the Quebec Cancer Coalition. They surveyed patients and found that 61% reported that their treatment or their care has been interrupted to some degree. It's certainly something that we've heard on a fairly widespread basis, but we also know that some of the most urgent surgeries have been going forward as they need to, and that depending on the resilience of the local health system, they're starting to reopen and treatments are starting up again in some places. That's very good to see.

Mrs. Cathy McLeod: Okay.

The Chair: Ms. McLeod, you have 10 seconds.

Mrs. Cathy McLeod: I won't say anything more. Thank you, Chair.

Dr. Mohit Bhutani: Mr. Chair, may I make one comment?

● (1755)

The Chair: Sure. Please go ahead with a quick answer to Ms. McLeod's last question.

Dr. Mohit Bhutani: It's actually more toward her PPE question. I think COVID-19 has created a lot of complexity in health care and the situation you described is very tragic, obviously. The one thing to keep in mind is that with PPE is that there's donning of it, putting it on, and doffing it, and understanding these processes takes a skill set. You have to be very careful about who has access to these things, and how they have access them, because it's actually in the doffing, in the taking off of the PPE, that most of the errors happen, resulting in the transmission of infection. To make it available to the general public is an idea, but it has to be done with careful thought.

The Chair: Thank you, Doctor.

We go now to Dr. Jaczek.

Dr. Jaczek, please go ahead. You have five minutes.

Ms. Helena Jaczek (Markham—Stouffville, Lib.): Thank you very much, Chair.

Monsieur Cloutier, I'm not sure if you remember, but we were supposed to meet on Friday, March 13, when essentially all hell broke loose, and obviously we were not able to hold that meeting.

I would like to pursue the line of questioning that a number of my colleagues have been pursuing. It's essentially this. You have recommended a pandemic preparedness council and a greater role for the federal government. You've referenced the fact there was a minister of state for public health; in fact it was the Hon. Carolyn Bennett, from 2003 to 2006, post-SARS. I was the medical officer of health for York region at the time, so I remember that vividly.

In an ideal world, how would you see our going forward, given all of your experience in government, in organizing this pandemic preparedness council? What sort of authority would it have? It's all very well to talk about coordination and collaboration with provinces, but what compels provinces to comply? Could you describe what, in an ideal world, you would like to see take place?

Mr. Paul-Émile Cloutier: Good question, and I'm sorry we missed our meeting on the 13th.

First, you have to start by saying to yourself that at this moment the Public Health Agency of Canada is often considered the poor cousin of Health Canada. It has very little money; it has very little influence. If it has a major issue during a crisis like this, it has to report to two or three people before actually getting to report to cabinet. My proposal for a council is that it should not be reporting only to one or two people, but also reporting to a body of people who can actually make decisions very quickly about the country, not just about a province or a problem. It would be reporting to the Prime Minister or even reporting to cabinet. That would give it the authority and the visibility and allow it to have access to decision-makers across the country.

The other thing, too, is I think there has to be a review of the relationship of the Public Health Agency of Canada with the various provinces and how they work. I have to admit, very politely, that I think the communications and the coordination exchanged this time was much better than during the time of SARS. When the government wanted to really act, it did very well by trying to get all the people around the table to discuss issues such as ventilators and PPE.

However, I would like it to be given more power and some visibility and access to decision-makers, and also the authority to be able to speak to the person who has to make the decisions, and not have to go through a number of levels before reaching the top individual in government.

Ms. Helena Jaczek: In a post-COVID-19 world, assuming all has gone well with the enhancement to PHAC, as you suggest, what federal role do you see in health care more broadly? You've talked about hospitals across the country being at capacity already and that wait times for procedures are lengthy in many provinces. How would you see the federal government perhaps wanting to ensure, should there be another pandemic, that we at least have the ability to have some sort of surge capacity locally within hospitals, within public health units?

● (1800)

Mr. Paul-Émile Cloutier: They would have to look at the picture at this moment in terms of surge capacity, because we are lacking. We had problems in the area of surge capacity even before COVID-19. The federal government, with the provincial government, would have to look at that carefully and say, what is the normal world that we have and our needs in terms of surge capacity?

In addition to that, as I said earlier, there's going to be another surge capacity for all those patients who have not received care or have not received their surgery. That is going to be an added surge capacity, so you may see hospitals having the same problem or the same challenges that they have had with COVID-19, but maybe double, because COVID-19 patients will continue in any case. It won't stop tomorrow morning. It will only stop if there's a vaccine, and that won't happen for 18 months.

My concern would be for the governments to come together and discuss how we address surge capacity in each of the provinces, because it does vary from one province to another. Surge capacity is the biggest problem that a hospital faces every day when they're trying to treat patients.

Ms. Helena Jaczek: Therefore, you would—

The Chair: Thank you, Dr. Jaczek. We'll go now to Dr. Kitchen.

Please, go ahead. You have five minutes.

Mr. Robert Kitchen: Thank you, Mr. Chair. I would like to share my time with Mr. Webber.

Dr. Bhutani, you talked about COPD and asthma, and in particular about inhaler shortages. You mentioned salbutamol, and then you explained a little later why that was the case, because there are actually people storing it in hospitals in preparation for a second or third wave.

We've also heard of shortages of drugs such as hydroxychloroquine, which we know is a malaria drug, but because of its use with RA patients and lupus patients, issues have been brought up about that.

Are you aware or have you heard of any other shortages of drugs? Would they be related to this type of situation where it's being overused, or is it maybe a supply disruption?

Dr. Mohit Bhutani: There are two parts to that question. The first is whether I am aware of any other shortages.

Drug shortages are very common within the country. Health Canada has a website called drugshortagescanada.ca, where all the up-to-date information is applied. These are commonplace. What the pharmaceutical industry has historically done is order or procure a certain number of units of medicines based on historical norms. Things moved very quickly between January and March in regard to the pandemic and a lot of the purchases from the hospitals increased in anticipation of what Mr. Cloutier talked about in regard to the surge planning. I think what ended up happening with the salbutamol MDI, which we use for patients on a ventilator, was that the hospitals stockpiled them. From what we can understand from the information, it wasn't really patients, it was more hospitals stockpiling them, which was the appropriate response from a planning standpoint.

The other complication with salbutamol is that when you're on a ventilator you actually have to use double the dose of the salbutamol, because a lot of the medicine is lost in the tubing of the ventilator. Therefore, for what you need to get down there, you actually have to administer double the amount. That created a perfect storm between requirements from the hospital in terms of what they're planning for and then non-availability for patients.

Working with the pharmaceutical industry, Health Canada and the partners I've identified, we've done a really good job in trying to resolve this, so the concept of the salbutamol shortage is a bit nuanced. Yes, they're only getting one month's supply of it, and I think there was a discussion earlier regarding the dispensing fees resulting from getting only one month's supply. However, in all honesty, if you're ideally managed with your asthma and your COPD as an outpatient, you should theoretically, by current standards, only need one inhaler per year. In reality, if you're using more salbutamol as an outpatient, you should probably talk to your doctor about your chronic management because it probably needs to be improved.

Mr. Robert Kitchen: That's great. Thank you very much.

Dr. Wong-Rieger, I realize that you cover a whole bunch of rare diseases. I'm going to focus on just one and ask for your comments, particularly on cystic fibrosis and the medication Trikafta.

On the issues with the PMPRB, how do you see that impacting our CF patients?

● (1805)

Dr. Durhane Wong-Rieger: Certainly cystic fibrosis has been front and centre in the effort to try to get access to Trikafta, which has been considered the A+ therapy for patients with cystic fibrosis. Unfortunately, because of the PMPRB, the company has been very clear that it cannot bring it into Canada at this time. The impact on our pricing would be such that it would not only not be affordable for us, but it could also damage us further.

I think that has created a huge problem. They're not the only patient-to-organization, not the only disease, that's impacted in that way, but they've definitely been able to raise public awareness, and the fact that a young woman died in Nova Scotia.... Again, we have no clear evidence that she would have been saved by Trikafta, but she was definitely of the patient profile that would have benefited from it.

The other thing that happened, of course, is we didn't get the clinical trials in Canada. Again, early on there was the recognition that this was not going to be a country where we were going to bring this in early. Unfortunately, because of the way the system is set up, if you've got the patient on the clinical trial, you can't just drop them. I think companies are unwilling to risk the fact that they may have to keep a patient forever, or for many years, and this is reverberating through many of our rare diseases, including cystic fibrosis.

Mr. Robert Kitchen: Thank you very much.

Mr. Webber, let's move over to you.

The Chair: You have 10 seconds.

Mr. Len Webber: Thank you very much, Dr. Kitchen.

Very quickly—10 seconds—Dr. Wouters, you alluded to organ transplants very briefly. Are you seeing people dying because they're unable to get organ transplants because these have been postponed? I would think people are dying because of that.

Do you have any comment on that?

Dr. Bradly Wouters: It's having a consequence, like all the consequences of stopping elective activity. We have a very large lung transplant program that has essentially been put on hold. Lots of people are waiting for lungs; lots of people are on those waiting lists, and with every day that goes by, there's a risk to everyone who's there and waiting for those.

It's a secondary consequence of COVID; it's not limited to transplantations, but they are definitely part of that collateral damage.

Mr. Len Webber: Thank you.

The Chair: We will go now to Mr. Kelloway. Please go ahead for five minutes.

Mr. Mike Kelloway (Cape Breton—Canso, Lib.): Thanks, Mr. Chair, and hello, colleagues.

Thank you to the witnesses for some great testimony today.

It's a real privilege to be here to listen to a lot of the recommendations from the witnesses today and the past witnesses via Zoom. We've heard, over the course of the last six or seven weeks, that research matters and health investment matters. MP Jaczek talked about the theme of a stronger role for the federal government, and that's coming from the witnesses. Even among us as parliamentarians, hearing from many that investing in health care is essential is just great to hear.

My questions will be focused on the cancer society. This one is close to my heart.

My mom has had stage four cancer for six years, and she was a former volunteer for the Canadian Cancer Society. I know vividly how the disease affects individuals, especially during this pandemic, in the impact it can have on a compromised immune system. It's a double anxiety.

Can you tell the committee what kind of COVID supports you're offering to Canadians and their families impacted by cancer? You talked a little about it, but I think it's important to talk about some of the specific things you're doing right now with respect to those families and those individuals impacted by cancer, as it relates to COVID-19.

Ms. Andrea Seale: I'm really sorry to hear about your mother. It's lovely that she was a volunteer with us. We have 100,000 people a year volunteering with the Canadian Cancer Society; it's an amazing grassroots network of people who all care about cancer and who do a lot to support each other and all the million-plus Canadians living with cancer.

Because we've had to switch away from some of our offline supports that we typically give, we've augmented the online support during the pandemic. Our cancer helpline is probably the simplest way for people to access support, and our online community called cancerconnection.ca has so many amazing conversations happening among cancer patients themselves and their caregivers—people who are going through things right now who are giving each other tips and support.

As some of the other organizations have mentioned, we've also created things like webinars with specific information about what COVID means if you have cancer, how to navigate the health care system, how to understand the impact on you and how to protect yourself from the virus.

We've created all of these added services specifically during the pandemic, giving people more facts and a helping hand, and we're seeing a lot of uptake.

● (1810)

Mr. Mike Kelloway: Absolutely, and I'll preface my comments by saying that my mother is actually doing very well. Even with stage four cancer, she can outwork me on any given day.

While my next question is also for the cancer society, it's also open to anybody who would like to answer it. As part of the provinces' and territories' response to COVID, many hospitals obviously had to cancel or postpone non-essential surgeries. How does this impact Canadians with cancer or heart disease, whatever the case may be? I'm looking for priorities and recommendations for hospitals that are now resuming these cancelled procedures. What would you recommend as a priority for hospitals as they gear up to take on those non-essential surgeries?

Ms. Andrea Seale: I think opening up the levels of care as quickly as possible is what's going to help our cancer patient community most of all. As for the decisions that are being made about how to prioritize, I will leave them in the hands of the health care leaders to do that well and to follow some of the guidance that has been created by organizations like the Canadian Partnership Against Cancer and the surgical oncology associations that have provided more prioritization guidance.

I just want mention that the thing that really helps people in the long term is research, so while we have these immediate needs that people face, there is also the larger question of research and what's happening with it, which we've talked about today. Here, I just want to say that, as a funder of research, the request for the wage subsidy program to cover researchers is very important because we see the investment that we make in research and the donations that people have given to us that go towards research. Maintaining those research teams is vital to that long-term outcome.

We've also been part of the more than 40 organizations who've been calling on the government to please consider opening up the wage subsidy program to cover hospital-based researchers. We see it as essential for that long-term health outcome for Canadians.

Mr. Mike Kelloway: That's fantastic.

The Chair: Thank you, Mr. Kelloway.

Dr. Durhane Wong-Rieger: If I could just jump in here, I think it's such an important question, but also one that, for the rare diseases community, has become disproportionately difficult. I mention this because you get treatment guidelines for the more major diseases, but at the same time, for instance, we will have a patient who has been waiting for a kidney transplant, but who gets put aside because he's not in the same category as other transplant patients. We have another patient who's waiting for a micro-radiation therapy. Again, it took a lot of advocacy to get her in in the same way as a patient with another cancer has.

We have recommended that there be a parallel task force that would be made up of experts but also include, from our point of view, many of our specialists who are able to put the patients into a proper triage. As we anticipate another wave, I think we really want to do the things you're recommending.

How do we set up the ability to handle these other patients so that we don't end up with a backlog? Our fear is about what happens a lot of times, that the more common and better-known conditions always end up getting prioritized because people don't know the others and don't recognize the risks of those others, so we need to have a task force that can put all of that into perspective.

Mr. Mike Kelloway: Thank you very much.

Dr. Mohit Bhutani: If I can jump in on this, I think one thing this committee needs to know is that, as we start to loosen up the criteria and start to go into elective surgeries, we've got to be prepared, because COVID is not going anywhere. Let's not fool anybody: We need to be prepared with testing and contact tracing, because if the load starts to increase and we start seeing signals of increased hospitalizations and increasing numbers, we're going to set ourselves back significantly, and all the things we've talked about today are going to be set back even further.

I think we want the testing and contact tracing, and every province needs to be prepared for that and do it in the right way to prevent this from recurring.

Mr. Mike Kelloway: It's a marathon, not a sprint; that's for sure.

Thanks for the answers, folks. I appreciate it.

● (1815)

The Chair: Thank you, everyone. We go now to Mr. Thériault.

Mr. Thériault, please go ahead for two minutes and a half.

[*Translation*]

Mr. Luc Thériault: Thank you, Mr. Chair.

My question is for the representatives from the Canadian Cancer Society, Ms. Masotti and Ms. Seale.

In recommendation 6 in your brief, you call on the federal government to show more leadership and address the inequalities in funding for take-home cancer drugs.

Could you elaborate on that?

[*English*]

Ms. Andrea Seale: Yes, thank you.

I think I'll ask Kelly to speak to this one.

Ms. Kelly Masotti (Director, Public Issues, Canadian Cancer Society): Hopefully my audio will work this time.

We face inequity across the country in how cancer patients have access to their cancer drugs. We know that patients today want to be in their homes. We hear this over and over again. Take-home cancer drugs—and I here I would love the physicians to jump in on this—are available to patients across the country to pick up at their pharmacy and take at home, specifically oral chemo cancer medication.

We don't see this adequately addressed across the country. For example, in some provinces, if you pick up your medication at the pharmacy and take it at home, that is covered. In the province of Ontario, for example, if you are taking your oral chemo in the hospital, it's covered, but if you go to the pharmacy and pick it up yourself, it's not. Again, it speaks to that financial burden on cancer patients.

We see a role for the federal government to work with the provinces across our country to address this issue of take-home cancer drugs. We don't want cancer patients to have to pay out of pocket, but want this to be covered equally across the country so that all Canadians have access to take-home oral cancer medication without having to pay out of pocket for it.

The Chair: Mr. Thériault, you have 30 seconds.

[*Translation*]

Mr. Luc Thériault: I imagine that in pandemic times, this problem is even more acute.

[*English*]

Ms. Andrea Seale: I think anything that we can do that keeps people out of hospitals is beneficial at this time. We've certainly seen that people have self-selected to stay away from hospitals. Given the strain on hospitals, more at-home support and more virtual support make sense.

The Chair: Thank you, Mr. Thériault.

We go now to Mr. Davies.

Mr. Davies, go ahead for two and a half minutes, please.

Mr. Don Davies: Thank you.

Dr. Bhutani, there is talk across this country about reopening parts of our economy and our society. I'm wondering what advice you would have for the committee.

What are some of the considerations we should be looking at? What are the guidelines or guideposts that should guide us in having a health-based, rational approach to reopening?

Dr. Mohit Bhutani: What I alluded to earlier is that testing is really the key piece here. Until a vaccine becomes available and we can inoculate the population to help resist the infection from being developed, we really need to be able to identify very quickly and accurately who has had it, who they've been exposed to, and work within a parameter of public health to quarantine those patients if that's the scenario that's needed.

I think it's very clear. I think we need to go at this very methodically and very slowly. As you remember, everything we've gone through over the past few months has been to save lives and to prevent our health care system from collapsing. We won't be any farther ahead if we open the doors too quickly. We have to do it in a very methodical way. I think testing and contact tracing is really critical to all of this. We really need to be prepared for this.

I think we've alluded to this conversation a little bit throughout the afternoon, that every province has a bit of a different strategy. I echo Mr. Cloutier's comment that there should be a national strategy where everyone is treated the same. We need to be working towards that.

Mr. Don Davies: Last word to you, Mr. Cloutier. There has been reference in this meeting and at others of drug shortages in this country. Canada at one time had a public drug company, Connaught Laboratories.

Is it time for the federal government to look at re-establishing a national public drug company that could work with academic institutions, which, after all, provide a lot of the research that goes into new chemicals to help Canada perhaps address the chronic problem of drug shortages?

● (1820)

Mr. Paul-Émile Cloutier: I think that it would be important to do that, but I think before actually establishing a company you would have to have a national drug strategy, to which all of the parties would be—and I'm not saying political parties, but all of the players involved in this—at the table. I think it would be premature to establish a company without having that strategy ahead.

The Chair: Thank you, Mr. Davies.

Thank you to all of the witnesses for sharing your valuable time with us and for all of your even more valuable experience and expertise.

I would also like to thank all the members for being here. It's good to see all of you day by day.

I would like to draw everyone's attention to the purpose of these meetings and remind them that what we are mandated to do is to receive evidence concerning matters relating to the government's response to the COVID pandemic. I know that we've touched on a lot of wide-ranging health issues today. It's not uncommon for us to do that, but I would really encourage the members to focus on the mandate we have, which is to receive evidence relating to the government's response.

Once again, that said, thank you, everyone, for your time and your excellent questions.

I declare the meeting adjourned.

Published under the authority of the Speaker of the House of Commons

SPEAKER'S PERMISSION

The proceedings of the House of Commons and its committees are hereby made available to provide greater public access. The parliamentary privilege of the House of Commons to control the publication and broadcast of the proceedings of the House of Commons and its committees is nonetheless reserved. All copyrights therein are also reserved.

Reproduction of the proceedings of the House of Commons and its committees, in whole or in part and in any medium, is hereby permitted provided that the reproduction is accurate and is not presented as official. This permission does not extend to reproduction, distribution or use for commercial purpose of financial gain. Reproduction or use outside this permission or without authorization may be treated as copyright infringement in accordance with the Copyright Act. Authorization may be obtained on written application to the Office of the Speaker of the House of Commons.

Reproduction in accordance with this permission does not constitute publication under the authority of the House of Commons. The absolute privilege that applies to the proceedings of the House of Commons does not extend to these permitted reproductions. Where a reproduction includes briefs to a committee of the House of Commons, authorization for reproduction may be required from the authors in accordance with the Copyright Act.

Nothing in this permission abrogates or derogates from the privileges, powers, immunities and rights of the House of Commons and its committees. For greater certainty, this permission does not affect the prohibition against impeaching or questioning the proceedings of the House of Commons in courts or otherwise. The House of Commons retains the right and privilege to find users in contempt of Parliament if a reproduction or use is not in accordance with this permission.

Also available on the House of Commons website at the following address: https://www.ourcommons.ca

Publié en conformité de l'autorité du Président de la Chambre des communes

PERMISSION DU PRÉSIDENT

Les délibérations de la Chambre des communes et de ses comités sont mises à la disposition du public pour mieux le renseigner. La Chambre conserve néanmoins son privilège parlementaire de contrôler la publication et la diffusion des délibérations et elle possède tous les droits d'auteur sur celles-ci.

Il est permis de reproduire les délibérations de la Chambre et de ses comités, en tout ou en partie, sur n'importe quel support, pourvu que la reproduction soit exacte et qu'elle ne soit pas présentée comme version officielle. Il n'est toutefois pas permis de reproduire, de distribuer ou d'utiliser les délibérations à des fins commerciales visant la réalisation d'un profit financier. Toute reproduction ou utilisation non permise ou non formellement autorisée peut être considérée comme une violation du droit d'auteur aux termes de la Loi sur le droit d'auteur. Une autorisation formelle peut être obtenue sur présentation d'une demande écrite au Bureau du Président de la Chambre des communes.

La reproduction conforme à la présente permission ne constitue pas une publication sous l'autorité de la Chambre. Le privilège absolu qui s'applique aux délibérations de la Chambre ne s'étend pas aux reproductions permises. Lorsqu'une reproduction comprend des mémoires présentés à un comité de la Chambre, il peut être nécessaire d'obtenir de leurs auteurs l'autorisation de les reproduire, conformément à la Loi sur le droit d'auteur.

La présente permission ne porte pas atteinte aux privilèges, pouvoirs, immunités et droits de la Chambre et de ses comités. Il est entendu que cette permission ne touche pas l'interdiction de contester ou de mettre en cause les délibérations de la Chambre devant les tribunaux ou autrement. La Chambre conserve le droit et le privilège de déclarer l'utilisateur coupable d'outrage au Parlement lorsque la reproduction ou l'utilisation n'est pas conforme à la présente permission.

Aussi disponible sur le site Web de la Chambre des communes à l'adresse suivante : https://www.noscommunes.ca