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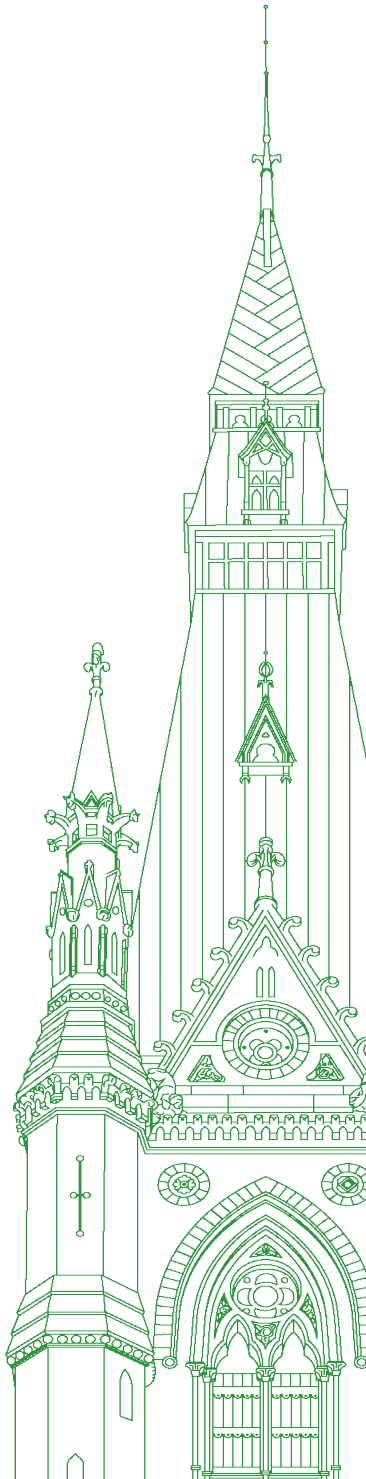

Chair: Mr. Ron McKinnon

Standing Committee on Health

Monday, May 11, 2020

● (1355)

[*English*]

The Chair (Mr. Ron McKinnon (Coquitlam—Port Coquitlam, Lib.)): I call this meeting to order.

Welcome, everyone, to meeting 19 of the House of Commons Standing Committee on Health. We are operating 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.

First, interpretation in this video conference will work very much the way it does 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 before you start. For example, if you are going to speak English, switch to the English feed. If you're going to speak French, switch to the French feed. This will allow for much better sound quality for interpretation.

Before speaking, please wait until I recognize you by name. Once the questioning starts, the witnesses may feel free to respond as appropriate. When you are ready to speak, click on your 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 remind you that all comments by members and witnesses should be addressed through the chair.

When speaking, please speak slowly and clearly. 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 are speaking. Should any technical challenges arise, please advise the chair or the clerk immediately. The technical team will work to resolve them. It may be necessary at times to suspend the meeting in order to deal with such technical issues as they arise.

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

I would like to welcome our witnesses: from the Canadian Cardiovascular Society, Dr. Paul Dorian, representative and department director, division of cardiology, University of Toronto; from the Canadian Health Coalition, Melanie Benard, national director, policy and advocacy; from the Canadian Nurses Association, Michael Villeneuve, chief executive officer; and finally, from Diabetes Canada, Russell Williams, president, and Kimberley Hanson, executive director, federal affairs.

Coincidentally, this week is National Nursing Week, and 2020 is the 200th anniversary of Florence Nightingale's birth. I would like to take a moment to recognize all the nurses working so diligently in the face of this pandemic and doing critically important work every single day, in all areas of care.

I will start the opening statements with Michael Villeneuve, CEO of the Canadian Nurses Association.

Mr. Villeneuve, go ahead for 10 minutes, please.

Mr. Michael Villeneuve (Chief Executive Officer, Canadian Nurses Association): Good afternoon. Thank you, Mr. Chair and members of the committee, for inviting the Canadian Nurses Association to appear today. I have worked in health systems for more than 40 years, 37 of those as a registered nurse, and I have had the honour of serving as the CEO of the Canadian Nurses Association since 2017.

I'd like to acknowledge that I speak to you today from my home in Mountain, Ontario, which is the flattest place in Ontario, I think, despite the name, and I speak to you from the unceded territory of the Algonquin Anishinabe people. CNA House in Ottawa also sits on this territory, and we're grateful to be invited to share this space.

There are more than 431,000 registered nurses, licensed practical nurses, registered psychiatric nurses and nurse practitioners in Canada, the largest number of providers in our health systems. The CNA is the national and global professional voice of Canadian nursing, and we represent 135,000 members across all 13 provinces and territories and, of course, many of our members also live in indigenous communities.

I wish I were speaking before you today about a less sobering topic, but that is not the world we live in right now and, as I saw expressed recently, we went to sleep in one world and woke up in another.

I know that the health and safety of the public and the nation's health care workers are uppermost in your minds and certainly are in ours. The pandemic clearly escalated as broadly and as rapidly as brush fire, and we must maintain our guard in supporting Canada's nurses and all health care professionals who are confronting and mitigating its impacts.

We are in a situation unprecedented for all but the few who can still recall the flu pandemic of 1918 to 1920, and we have all been scrambling in response. The Canadian Nurses Association appreciates the measures that have been taken by all levels of governments across the country to tackle this problem and minimize the spread of COVID-19, and we have particularly benefited from the incredible and courageous leadership of our public health professionals, including the nurses who are so integral to that sector.

We appreciate the strong communication from Dr. Tam, who leads the Public Health Agency of Canada, and we have had good communication back and forth with Health Canada, including with the minister and with Dr. Tam and her team at the Public Health Agency. We thank them all, as we thank you, members of Parliament, who are members of this committee.

We speak with nurses all the time and certainly very purposefully each week we talk with them and poll them. I want to take a few minutes to share with you highlights of a few ongoing issues, and then I want to spend the last five minutes talking about a larger system issue that I think we need to tackle.

What are the ongoing issues of concern for nurses? You've all heard about personal protective equipment concerns, and three months into the pandemic, that still remains a bit inconsistent across the country. It remains our position at CNA that those decisions around the use of personal protective equipment should be driven by evidence and the clinical judgment of the people using the equipment and not by availability or fear of shortage. That's been an ongoing issue that seems fine in some places and less so in others.

The second issue is around testing. The WHO has urged large-scale testing, but we realize that COVID-19 testing in Canada still falls behind some other nations, and nurses are concerned that, without this information, the recovery efforts will not be informed by evidence.

We're concerned about mental health right across society. This has been very scary. Nurses, in particular, are facing significant challenges to their mental and emotional well-being as a result of the COVID pandemic response and recovery. We are continuing to advocate for access for all health care providers to mental health services at no cost to manage their emotional and mental health coming out of this. We're particularly concerned that, just as many of us will have a chance to step back at some point when the pandemic settles, as we assume it will, or in waves, nurses, doctors and people in the health care system are then going to have to pick up the backlog of all undone surgeries and so on, and they will be really be very stressed during that time.

We're working with the Canadian Medical Association and the Canadian Institute for Health Information around determining the impact of COVID-19 on the health of health care workers. We urge governments to fund the tracking of that important data, which is a long-standing issue.

While they talk about concern for their own safety, one of the top issues that nurses mention is vulnerable populations. We're concerned about people who are more at risk for the spread and its impacts, including many indigenous people, particularly in remote settings, and people in congregate settings such as prisons and shelters and the homeless.

● (1400)

My final point, before I speak about long-term care, is that given the lessons of history, we urge a very guarded, evidence-informed, cautiously paced reopening of services across society. We are concerned that the virus is very much alive, still spreading, not well understood, and may sweep across society in successive waves. We understand there are huge economic implications, but that has to proceed very carefully.

Let me turn to a couple of larger issues that are really of concern to the Canadian Nurses Association and to nurses. Due, at least in part, to a very aggressive "flatten the curve" campaign, which Canadians by and large have taken part in, our hospitals have mainly been spared the devastation of our counterparts in China, Italy, Spain and the United States, for example. However, at the same time, the pandemic has laid bare the crippling lack of standardization, funding, strong leadership, appropriate staffing, training, equipping and so on, of people who deliver services in long-term and home care sectors. These vulnerabilities have been well known for 20 years. As a result, just 20% of COVID cases in Canada are in long-term care, but they account for 80% of the deaths. We understand this is the worst outcome globally.

While our health systems have many strengths, a series of robust investigations since 2000, such as the Romanow commission, have generated a now very familiar litany of places we need to shore up. We can all name them all: pharmacare, home care, mental health care, long-term care and primary health care, based on need and not on the ability to pay. We're seeing some of those weaknesses play out now.

The outcomes of COVID-19 in long-term care this spring are in part the result of decades of neglect of that sector and a growing mismatch between the level of care required by people who live there and the human resources deployed to care for them. I've been around for 40 years in the business. Many of the patients living in those nursing homes now with complex, ongoing conditions would have been in a hospital 20 years ago. It's hard for people now to imagine that in nursing homes 20 or 30 years ago, residents still drove their cars. Those people now are managed in home care.

As we've shifted really complex care away, the response in long-term care has not been concomitant with the demand going in there. The rising pace, volume and complexity of care that has been shifted from hospitals to nursing homes also has coincided perversely with a decline in the proportion of regulated nurses in that sector, fewer clinical educators, fewer social workers and fewer occupational therapists. It's a story of fewer and less, and it has a dramatic impact on the people working there, who are largely unregulated, and delivering 80% to 90% of the care. The workforce there is dominated by caring, loving, well-intended health care aides and support workers who are not backed up with the sorts of professional nursing and other resources they desperately need. The sector is heavily dominated by women, often racialized women, who are paid low wages and often are precariously employed. You've heard stories that they have to cobble together two or three jobs or work a lot of overtime to make a living wage. COVID-19 has really exploited those weaknesses.

In the final report of the national expert commission that CNA conducted in 2011-12, we laid out nine practical recommendations to address many of the same issues brought up by Commissioner Romanow, Senator Kirby and others, that could drive better health outcomes, better care and better value for taxpayer dollars. Many of them have gone unheeded.

If there's any silver lining in this, we have certainly seen that we can do things differently. We have flipped around primary care, for example, so that much of it can be done by telephone and virtually. We know that hospitals are partly empty because of cancelled surgeries, but we see the emergency room wait-list problem has declined. Hallway medicine has disappeared. We believe that we have the capacity to address those problems and sustain those results. We can't go back because we know now that we can do it differently.

Meeting demands of older adults requires major changes to the health system and some immediate attention to personal care assistants and nursing expertise in those facilities in particular. We must reimagine aging in this country, including home care, institutional long-term care and end-of-life care, and then put those bold changes in place we know are needed.

● (1405)

To wrap up, COVID-19 has shown us very strangely, in the year of the nurse, that nurses are an important force for delivering better health. They've certainly shown they're dedicated to the people of Canada, even when they're worried about their own health and safety. Clear information, adequate supplies, additional support for the health system and its workers are needed and are going to be needed in the long term. It's not going away tomorrow.

As the chair said, we meet today in the global year of the nurse and midwife, during National Nursing Week and on the eve of Florence Nightingale's 200th birthday tomorrow. Perhaps, ironically, after 200 years, we find ourselves talking like Nightingale saying, wash your hands; clean the environment; gather good information to make your decisions.

This week we've set aside years of planned celebrations, as you can imagine, out of respect for the tens of thousands of nurses who are out there working at points of care this very minute, some of them even coming out of retirement to do so. They've answered the call.

On behalf of the CNA, let me close by thanking you for including us. I ask that you place nurses in leading roles in the analyses of the COVID-19 responses lying ahead. Listen to them. They have practical, smart information. Know that we will work with you to identify and deliver the best evidence to help governments and health systems make the changes we need and implement real change.

Thank you very much.

● (1410)

The Chair: Thank you, Mr. Villeneuve.

We go now to the Canadian Cardiovascular Society and Dr. Paul Dorian for 10 minutes, please.

[*Translation*]

Dr. Paul Dorian (Representative and Department Director, Division of Cardiology, University of Toronto, Canadian Cardiovascular Society): Thank you very much, Mr. Chair.

Good afternoon, everyone.

I'd like to begin by thanking all the members of the committee for the opportunity to represent the Canadian Cardiovascular Society. We are grateful for the opportunity to describe some of the challenges in caring for patients with heart disease during this COVID-19 period and to recommend some solutions.

[*English*]

I'm a cardiologist from Toronto representing the Canadian Cardiovascular Society. Our 2,500 members include cardiologists, cardiac surgeons and scientists. We provide specialized and ongoing care for close to three million Canadians living with heart disease. We're very grateful for this opportunity to present to the committee.

What I'd like to do first is to describe the consequences of a pandemic on heart patients and then suggest some recommendations to help improve patient care in the short term as the first wave of a pandemic unfolds, and in the future as subsequent waves of this or other infections hit.

At the front line, what we are observing is that sick people are not seeking the care they should. You heard that just a few moments ago. When the COVID pandemic struck in Canada, we were quick, as a community, to enact strict measures to contain its spread, including widespread stay-at-home messaging. Canadians have been very good at listening and adhering to this advice, so much so that we have seen a significant reduction in patients seeking emergency care for all illnesses, but particularly for cardiac care. Although the numbers of those seeking care are way down, heart attacks and other emergencies have not stopped occurring.

We believe our patients perceive hospitals to be overloaded with cases of COVID, correctly or incorrectly, and they're afraid of coming to hospital and being exposed to the virus. As a result, patients with emergency needs are staying at home and waiting to see if symptoms go away and some, unfortunately, are dying while they wait. When they finally do seek emergency care, they have often delayed so long that their conditions have become more serious and harder to treat. This is something we've observed over the past month or so.

The later patients present for treatment, particularly for heart attacks, the less we can do for them; and we're seeing more complications, which are harder to treat.

Second, while we deal with COVID patients, wait-lists for cancelled procedures have skyrocketed. To be ready for an anticipated surge, hospitals have appropriately, we think, reallocated resources and freed up beds, but in our efforts to be prepared, hospitals have been operating under capacity. Since March, across Canada, a huge number of planned, life-saving procedures were postponed.

As an example, as of March 15 in Ontario, there were about 2,000 patients waiting for valve procedures and 450 for defibrillators. As of May 3, that wait-list had grown to 2,500 valve cases and 680 defibrillator cases. These wait-lists have unfortunately resulted in patients suffering and, indeed, some have died. My colleagues speak of their valve patients who have been accepted for procedures dying at home before the surgery could be done.

We have avoided a surge in COVID patients, but the backlog of heart patients waiting for treatment has surged. Wait times are now longer than they've ever been in years, in some cases.

A major complicating factor, we think, in planning for and delivering care has been the lack of real-time data. Without real-time data, we have no way to understand local health service supply and demand trends and to make regional comparisons to inform decisions about allocation of services and to inform our patients about opportunities to seek care.

Recently we've collected some hospital data where there have been drops as great as 40% per month in several provinces since March in the number of patients coming to hospital with a kind of heart attack called STEMI, the most serious type of heart attack. This has been observed in other countries as well, but we don't have all the information needed to interpret what's happening. Were there fewer heart attacks occurring? We think probably not. Did the patients delay calling 911? Did ambulances make fewer and slower trips? Did patients in the field arrive at hospital already deceased? Was care in hospital delayed because of COVID precautions? We, unfortunately, don't know.

It's frustrating for us to note that much of the data to answer these questions exists and is collected already in real time, but is tracked in data collection systems that don't talk to each other technologically, or that prevent the data from being shared due to geographic boundaries or for legislative, contractual or policy reasons. Collectively, these barriers prevent health data from being used for the very reason it's collected, which is to enable care through evidence-informed decision-making.

● (1415)

We must note that our national resource, the Canadian Institute for Health Information, CIHI, has responded as best it can throughout the pandemic to supply data; however, CIHI itself is limited by the same barriers I've just mentioned. In this moment, we need data in days, whereas the typical time frame for obtaining data is months.

We're eager to help resolve these challenges brought on by the pandemic. In looking to contribute solutions, the CCS has several that we would like to propose.

First, we think we need to refine public messaging in the face of a pandemic. If we can anticipate that stay-at-home orders result in heart attack victims not seeking or delaying care, public messaging needs to be more precise and widely shared. The federal government, through the Public Health Agency and Health Canada, are well positioned to lead this, and the CCS is willing to help develop and spread these messages.

Second, public health officials, health service planners and care providers need shareable real-time data. Current information that can easily be shared would enable more nimble actions in an emergency. We would know where and whether scheduled and essential procedures might still take place, based on need and in balance with local demand. With better access and sharing of data, we can reduce the impact of national health crises on cardiac and other patients, while still providing crisis-related care to those affected.

In the current situation, COVID-19 patients have been appropriately prioritized. The consequences for other patients, unfortunately, have been higher than would have been ideal. Without data, we don't think we can do better next time. Our ask of the government, colleagues and this committee is to take the lead to improve the sharing of real-time data.

This could be done, for example, by forming a national expert working group to oversee coast-to-coast streamlining of data access and sharing. This expert group would work with federal and provincial health data stewards to identify and resolve the long-standing legislative and technical barriers to rapid, shareable information. Their mandate would be to enhance coordination by locating all the datasets and getting them to talk to each other; I emphasize that this data is already being collected.

This committee would also help aggregate data so that it could legally and virtually be “all in the same place”. Through understanding what's going on locally and comparing that to what's happening in other regions or provinces, we can accelerate best care and resource use.

In the long run, we think improved access to data can refine health care system delivery. Care can be more equitably available and higher in quality; care pathways could be more efficient; virtual care could be deployed in the most effective ways; low-value care can be identified and reduced; savings can be reallocated to where resources are needed the most; and, if we get this right, we can expect to see better patient outcomes during but also beyond any crisis.

For those of you on the committee with whom the CCS has met in the past, you will know that the need for access to high-quality data and national comparative reporting is a call that the society has been making for some time, and we are very grateful for the support we've received from our partners and supporters in government.

The COVID crisis has shone a light on access to data as a major impediment in responding to a pandemic. Drawing attention to this at the highest policy-making level is a key contribution that the CCS aims to make. I'd like to just briefly list the actions that the CCS has already taken to support the pandemic.

Thus far, in the last six weeks or so, we have developed, published and shared clinical guidance for health professionals who care for cardiac patients affected by COVID. We've developed and widely shared clear messages stating that people experiencing chest pain or other signs of heart attack should urgently seek care; we've done this in partnership with the Heart and Stroke Foundation of Canada and others, but I think we can do more. We've also funded research to learn more about COVID and its effects on patients with heart disease.

The CCS will undertake to continue to do all we can to help in this crisis, and if we can be of help, I'd like to signal to the committee that in light of this pandemic we're willing and able to consult and provide guidance on any matter concerning Canadians living with heart disease.

● (1420)

We will all have the most success working together if we align our efforts and support one another. *Merci,* and thank you for this opportunity. I look forward to your questions.

The Chair: Thank you, Dr. Dorian.

We go now to the Canadian Health Coalition.

Ms. Benard, please go ahead. You have 10 minutes.

[*Translation*]

Ms. Melanie Benard (National Director, Policy and Advocacy, Canadian Health Coalition): Hello, everyone, and good afternoon.

[*English*]

Thank you for the invitation to appear before you today.

The Canadian Health Coalition has been working for over 40 years to protect and improve public health care in Canada.

We are a national, non-partisan organization made up of health care workers, unions, community organizations, seniors and academics, as well as affiliated coalitions in the provinces and one territory.

Canadians are very grateful to have a universal public health care system that provides care based on people's needs and not on their ability to pay. This system has been put to the test over the past few months. The COVID crisis has highlighted the incredible strengths in our health care system as well as some persistent gaps and challenges. As we slowly begin recovering from this pandemic, we have an opportunity to rebuild our health care system to be even stronger and more responsive to the evolving needs of Canada's population.

Today, I'll be discussing three areas that require the federal government's attention: pharmacare, funding and seniors care.

As you may know, Canada is the only country in the world with a universal public health care system that does not cover prescription medication. As a result, millions of Canadians have been falling through the cracks. Before the COVID-19 pandemic, 20% of Canadian households were struggling to pay for their medication, either because they didn't have a drug plan or because their drug plans were inadequate. One million Canadians were having to choose between putting food on the table and buying the medication they needed. These numbers have increased exponentially during the COVID pandemic. The mass layoffs triggered by the pandemic have left millions more Canadians struggling to afford their medications without work-based drug plans. The need for universal public pharmacare has therefore never been more urgent.

Two years ago, this committee studied this issue in detail. I know a few of you served on the committee at that time. After holding 23 hearings with nearly 100 witnesses, the committee recommended that Canada adopt a universal, single-payer public pharmacare program that would cover prescription medication in the same way as doctors and hospitals.

Over the past 50 years, countless government and academic reports have all made the same recommendation, most recently the government's Advisory Council on the Implementation of National Pharmacare, led by Dr. Eric Hoskins. The Hoskins report from 2019 provides a blueprint for how to build this essential new program. The government must implement its recommendations immediately.

Universal public pharmacare would save money while saving lives. When people skip their medication because they can't afford it, the technical term for which is “cost-related non-adherence”, they end up getting sicker and visiting the hospital and the doctor more often. That's something we want to avoid in normal times, but during this pandemic it's absolutely critical. Research has shown that removing out-of-pocket costs for the medications used to treat just three health conditions—diabetes, cardiovascular disease and chronic respiratory conditions—would result in up to 220,000 fewer emergency room visits and 90,000 fewer hospital stays annually. This could save the health care system up to $1.2 billion a year, just for those three conditions.

Canada's current patchwork of drug coverage is inadequate and inefficient. There are over 100,000 public and private drug plans across this country that each offer different types of coverage. Many plans limit the amount that people can claim per month or per year, and many include expensive deductibles and co-payments that make medications unaffordable.

The current system is also unsustainable. Canada pays the third-highest prices among OECD countries for prescription medications, and spending on medication continues to rise. The number of drugs on the market that cost more than $10,000 per year has more than tripled since 2006. Canada currently spends more on medication than it does on doctors. Universal public pharmacare would allow us to limit this spending by negotiating lower drug prices through bulk purchasing. This new program would allow Canada to save $5 billion every year. Families would save, on average, $350 per year, and businesses would save an average of $750 per employee per year.

Last fall, nearly 200 national and provincial organizations signed a joint statement calling on all parties to work together to implement universal public pharmacare within the current government's mandate. We simply can't wait any longer to implement this program. Canadians are suffering, and some are dying prematurely because they can't access their medication. The government must implement pharmacare immediately as part of its response to the COVID crisis.

● (1425)

Now is also the time for the federal government to reaffirm its commitment to public health care. Public health care is our best defence against the COVID pandemic and other health crises. Regrettably, our health care system has been eroded over decades through systematic funding cuts and privatization. Even in normal times, the system is functioning at capacity.

The federal government must increase health transfer payments to the provinces to expand the capacity of public health care across the country, both in normal times and in times of crisis. The 10-year health accord from 2004 guaranteed the provinces an annual 6% increase to Canada health transfer payments. When that accord expired, the federal government reduced the annual increases to nominal GDP or 3%. We've known for years that this is simply insufficient to keep the system running effectively. At least a 5.2% escalator is needed just to maintain existing services.

In addition to long-term increases to the CHT, extra funding will be needed to handle the backlog of surgeries and services that have been put on hold during the pandemic. Instead of turning to the private sector to address this backlog, the federal government should support the provinces in implementing inexpensive public innovations to reduce wait times such as centralized wait-lists and team-based care.

The government must also protect our public health care system by actively enforcing the Canada Health Act. Many private, for-profit health care companies have taken advantage of this crisis to expand their markets, particularly in the area of virtual health care. Many of these companies are violating the Canada Health Act by charging patients out of pocket or billing private insurance companies for virtual doctors' visits.

In addition to raising concerns about the privacy and security of patients' medical information, this is draining resources from the public health care system. It is also threatening the foundational principle of equity that underlies our public health care system. The government must take action to prevent further erosion of this system and ensure that patients always come before profits.

I think we would all agree that one of the greatest tragedies of this pandemic has been the widespread devastation in our long-term care homes. The suffering of residents, staff and their family members in recent weeks is simply unfathomable. According to recent estimates, approximately 80% of all COVID-related deaths in Canada have been in long-term care facilities. Our deepest sympathy goes out to all those who have lost loved ones during this crisis, and we express our ongoing gratitude to all front-line workers who are putting their lives at risk every day to help care for patients in need.

Although we may not have been able to prevent the COVID pandemic, we could have limited its devastating impact in our long-term care homes if we had implemented fundamental changes to this sector sooner. My colleagues from CUPE testified before you last week on this issue, so my recommendations here will be relatively brief.

To ensure equitable access to safe, high-quality care, we must bring long-term care and home care into our public health care system. Over the past several decades, we've seen widespread privatization in this sector, in part because these services aren't currently covered under the Canada Health Act. We need new, dedicated federal funding for long-term care that is tied to national standards of care. These standards must include things like minimum staffing levels. The federal government must support the development of more public long-term care facilities and home care services, since abundant research shows that public not-for-profit facilities provide higher quality care than private for-profit facilities. All public funding should go toward patient care, not corporate profits.

We also need a national health human resource strategy to help recruit, train and retain high-quality care workers. These workers must be paid decent wages and guaranteed stable, full-time employment. We can significantly improve patient care by improving the working conditions for staff. The seniors and people with disabilities living in long-term care facilities and relying on home care are counting on us to rapidly make these changes. We must not let them down.

We can't undo the harm that has been caused by this crisis, but if we implement these changes, we can help prevent similar harm from occurring in the future. Let's learn from this experience and rebuild a public health care system that we can all continue to be proud of, a system that provides the high-quality care that everyone in Canada deserves.

● (1430)

Thank you.

The Chair: Thank you, Ms. Benard.

We go now to Diabetes Canada.

Mr. Williams, please go ahead for 10 minutes.

Mr. Russell Williams (President, Diabetes Canada): Thank you very much for the opportunity to present today.

I thought I would start off sharing some of the calls we are receiving on our information line from people looking for help.

One example is a woman who phoned us about her father, who is an insulin-dependent, type 2 person with diabetes. He was living in a long-term care home, and she had concerns, as we've heard today, as a result of the COVID-19 pandemic. Our caller wanted to bring her father home to live with her, but she needed advice on how to manage his diabetes.

Another woman with type 1 diabetes who struggles to keep her blood sugar within the recommended range reached out to us. She works in maintenance in a hospital and she and her physician were worried about her risk. Despite the advice of her medical team, her employer refused to modify her work arrangements so that she could reduce the risk of catching COVID-19. We needed to help her convince her employer to make accommodations.

We also heard of someone who had just been diagnosed with diabetes and had been released from hospital. A new diagnosis of diabetes is overwhelming at the best of times, but especially in this environment. Discharged with insufficient information and support, this person was scared and confused and uncertain of what to do with their diet, their medications and glucose monitoring.

Countless other people have reached out to us, people who have problems with their injection site or have to manage their diabetes with added problems, such as kidney disease.

[*Translation*]

What I'm saying is that we've seen a significant increase in demand for Diabetes Canada's services.

[*English*]

Diabetes is a large and growing burden in Canada. Diabetes, as you know, is a leading cause of heart attacks, stroke, kidney disease, vision loss and amputation. Treating the disease will cost our health care system over $40 billion a year. It's a disease that disproportionately burdens vulnerable Canadians, including newcomers, indigenous peoples, seniors and those with lower incomes.

In a moment, we'll talk about how the pandemic has posed an even larger threat to people living with diabetes and associated conditions, but I want to share with you some of the examples of how it has impacted Diabetes Canada.

Physical distancing measures and the economic impact of the pandemic have reduced Diabetes Canada's revenue by more than 50%, like a lot of charities. We had to temporarily lay off more than 50% of our staff. Some of them we've been able to bring back because of the CEWS program, and we appreciate that, but we won't be able to keep them. Our revenues will continue to be negatively impacted by the pandemic for the foreseeable future. That directly affects our ability to serve people affected by diabetes.

However, the needs of people with diabetes for trustworthy information, education and advocacy are even greater than ever before, and we are rising to meet that challenge. We are providing timely and evidence-based resources and tools to our community about diabetes and COVID-19, including a frequently updated website, weekly "Ask the Experts" videos, webinars in 12 of Canada's most commonly spoken languages and educational webinars for health care providers. We are providing patient resources and supports via our 1-800-BANTING line, where people can get personalized, expert medical advice from diabetes educators.

We are also collaborating with governments at all levels during this pandemic to support health policy development and implementation, to ensure that diabetes medications, supplies—

● (1435)

The Chair: Sorry, Mr. Williams, your sound is very choppy, so you might want to speak extra slowly. Thank you.

Mr. Russell Williams: I hear it as choppy when I listen to you, too. My apologies.

We are collaborating to ensure diabetes medication, supplies and devices remain available and affordable. We are amplifying announcements from provincial governments that support people with diabetes, and we continue to work on our national strategy, which Kim will talk about later.

We continue to work with governments on prevention, nutrition policy and pharmaceutical policy, which affect the daily lives of people with diabetes. We must ensure that the total ecosystem of the world of diabetes is balanced going forward, and there are no effects caused by policies that negatively impact our [*Technical difficulty—Editor*].

In these respects, like most other charities, we are stepping up during this time despite dwindling resources.

Health charities in Canada are a $670-million sector, supporting 2,500 employees and almost three million patients. We support well over $155 million of research and 1,300 investigators. Supporting research through this is going to be very important. Patients need services and supports more than ever as a result of capacity and the stress you've heard about today on our health care system. Charities must increasingly meet these needs without the help of volunteers, who are prevented from serving by physical distancing, and with reduced donations from households and businesses as they grapple with the economic impacts of the pandemic.

For these reasons, we are united with other health charities in calling for direct investment from the federal government of up to $28 million per month, which represents the monthly revenue decline of our members that we've been witnessing since March 2020. This investment would allow staff and volunteers to focus first on patient support, restarting our fundraising efforts and protecting our gains in research.

I ask for your support in calling for greater federal investment in this vulnerable sector. We desperately need increased support. For example, the emergency rent assistance program is not geared to help charities at this point. Many of these charities have facilities across the country, and other programs do not seem to respond to the day-to-day operational needs of charities. Many of our charities have had to increase care and are filling gaps in the health care system caused by physical distancing and isolation.

Now I'd like to ask my colleague, Kimberley Hanson, to speak about the impact of COVID-19 on people with diabetes.

Thank you.

● (1440)

[*Translation*]

Ms. Kimberley Hanson (Director, Federal Affairs, Government Relations and Public Policy, Diabetes Canada): Thank you very much.

[*English*]

Many people with diabetes are at high risk for COVID-19, but as we are learning more about this new virus, research is showing that while having diabetes doesn't make someone more likely to catch COVID-19, it makes the consequences more serious if they do.

Early research shows that people with diabetes are approximately twice as likely to require hospitalization and intensive care as those without and about three times as likely to die of COVID-19. Because of this many Canadians with diabetes are very worried about the pandemic.

Like diabetes, COVID-19 is a disease that exploits health inequities. The more socially and economically disadvantaged a person is, the more likely they are to suffer from diseases like diabetes, heart disease and high blood pressure which put them at greater risk to COVID-19.

People in poorer socio-economic circumstances can also be more exposed to infection. They may be unable to self-isolate due to insecure labour conditions which do not allow for teleworking or provide statutory sick leave. They are more likely to experience overcrowding in their living arrangements. The pandemic has brought out in even sharper relief the critical necessity of addressing underlying health inequities to preserve the health of our citizens.

COVID-19 has also highlighted serious gaps in data and challenges that can exist due to unintegrated health systems across provinces and territories. The critical necessity of making evidence-informed decisions about allocating limited health care resources and implementing health policies during the pandemic has highlighted the lack of health data sharing and systems integration that has plagued our health care system for years.

A lack of easy ways to share best practices and harmonize health care across provinces and territories has contributed to the burdens of COVID-19 being shared unequally among different provinces and their citizens. Conversely, the tremendous progress that is being made to close these gaps in response to the pandemic shows how collective will and a sense of urgency can produce real results in record time.

Provinces are leveraging and sharing medical information as never before and planning to use apps and digital tools to share and track chronic medical conditions. From coast to coast doctors are offering virtual consultations that would have been considered impossible just two months ago, and which are a key tool in preventing the overload of our emergency health care system.

Practices such as these—leveraging virtual care, establishing and using medical data repositories and registries, optimizing and continuously improving patient care pathways—are all key tenets of diabetes 360º, Diabetes Canada's nationwide strategy, which this committee has recommended for implementation.

Developed by 120 stakeholders over more than a year of rigorous effort, diabetes 360º contains evidence-based recommendations aimed at improving patient outcomes. It will enhance the prevention, screening and management of diabetes to achieve better health for Canadians. It will reduce unnecessary health care spending by billions of dollars, improve the lives of millions of Canadians and protect Canada's productivity and competitiveness.

We believe, in light of the pandemic, that diabetes 360º is more relevant than ever. It's implementation will support public health and deliver on the need for collaborative, value-based health care models and a multidisciplinary comprehensive approach to health care. The billions of dollars in savings that will be realized by our health care system when we implement diabetes 360º is an example of the effective use of public dollars to combat chronic disease.

Given that diabetes is one of the most empirically measurable chronic diseases, implementation of a comprehensive strategy to prevent, diagnose and treat diabetes, based on data on patient health outcomes, can serve as a useful test case for managing other chronic diseases.

With the 100th anniversary of the discovery of insulin in Canada in 1921 being right around the corner, we urge governments to embrace diabetes 360º now.

In summary, Diabetes Canada, like all Canadians, is pivoting rapidly to adapt to the new reality we are faced with, given the COVID-19 pandemic. We are serving people with diabetes now more than ever and will continue to strive to do so even with limited resources, but we, along with other health charities, need additional support from the federal government to do so. A key measure that the federal government should take in response to the pandemic and in anticipation of 2021 is to implement a nationwide strategy to address diabetes and the burden of chronic disease in Canada in general.

Diabetes Canada stands ready to collaborate with governments to end the diabetes epidemic once and for all.

[*Translation*]

Thank you.

● (1445)

[*English*]

The Chair: Thank you, Mr. Williams and Ms. Hanson.

We will start now with our questioning. We will do three rounds of questions.

I would also like to remind everyone that the committee is meeting for the purpose solely of receiving evidence concerning matters relating to the government's response to the COVID-19 pandemic. I would urge members to do their best to stick to that area.

We start now with Mr. Jeneroux.

Mr. Jeneroux, please go ahead for six minutes.

Mr. Matt Jeneroux (Edmonton Riverbend, CPC): Thank you, everybody, for joining us today. Also, in celebration of National Nursing Week, certainly from our side of the table, we want to recognize that and appreciate the chair's comments.

The first question is for Mr. Villeneuve. Is there a protocol that's consistent for PPE for nurses across the country?

Mr. Michael Villeneuve: In theory there is, Mr. Jeneroux.

If we look at the advice coming, say, from the World Health Organization and then the Public Health Agency of Canada, it's quite consistent. The advice has been very, very helpful. The challenge we have is when you filter it down through however many lenses—at the regional health authority level, the employer, the organizational level, the level of the manager within an organization—that seems to be where things fall apart a little bit. It's not unusual in a federation, in a profession with multiple regulated categories and lots of people influencing it.

In theory, yes, I think it's pretty clear. Our advice has not really changed. I can tell you from my own experience in a neurosurgical intensive care unit, that if I go to do a procedure, the nurse and the doctor are educated in terms of knowing what is needed for that procedure. We expect employers, governments and everyone to have the materials there. You get what you need for that procedure and you use your clinical judgment. We think nurses are quite capable of making those decisions.

What we have been concerned about in some cases is the interpretation of what seems like a fairly straightforward "if this, then that". Part of it is that with 430,000 nurses, 13 jurisdictions and hundreds of employers, it gets a little bit mired.

Mr. Matt Jeneroux: We had the head of the Ontario registered nurses union indicate that they need nine million masks a week. Is that unique to Ontario, or is that pretty standard across the country to keep them safe and healthy?

Mr. Michael Villeneuve: I don't know the exact number, Mr. Jeneroux, but the issue with it is that typically, in a situation of plenty, you would change that material quite frequently. You don't leave it on for very long. You've seen some of the pictures of nurses with some damage to their faces and so on. As for nine million, I don't know if that's the right number or not in each province and territory.

What we have heard from physicians, nurses and so on is some concern about using PPE for too long and not being sure if they can use it again. What happens when you don and doff it, and do that sort of thing safely? That's where we've heard, and you've heard, probably, the same thing, "I was told to wear one mask for four hours", whereas when I was in the ICU many years ago, I changed it room to room to room, and so on, throughout the day.

Our concern has been that decisions should always be based on evidence and need, and not on the fear that there will be rationing if there is a shortage in the future.

Mr. Matt Jeneroux: As the chair indicated, we're looking at the government's response to COVID-19. Obviously, in preparation for any potential other pandemic, we want to make sure that we get everything right and are able to present that back to the government and to the particular individuals involved.

When was the first time your organization was contacted by the minister or the Public Health Agency with regard to a response, whether it be in terms of PPE or any other issue at the time, from that January-February time frame?

● (1450)

Mr. Michael Villeneuve: I actually made the first call myself, and I'm going to say it was around January 20. I should have checked this. It was about the third week of January. We were watching and asking the great question of science: What is going on here?

I called Dr. Tam's office—I happen to be a member of her advisory committee of health professionals—and said, "Could we just talk with someone?" I had a very good meeting, within 24 hours, with her team, and asked questions: Is there something we can do? How can CNA be helpful here? What do you think is going on? We had, from that day forward, excellent communication with the Public Health Agency of Canada and with Health Canada.

Mr. Matt Jeneroux: At that point in time, we were hearing stories already about the lack of personal protective equipment. Was that something that you raised in that January 20 phone call?

Mr. Michael Villeneuve: It didn't come up in that first call, Mr. Jeneroux, but that was because what the Public Health Agency said was the same thing that the minister said, which was helpful. When we asked what we could do, the answer back was, "Please tell us what nurses are telling you so that we have a very good sense of what is going on at points of care across the country."

No, it was not in that very first conversation, but I have to say it was very prominent in many conversations thereafter, although now I see it seems to be shifting. We haven't been hearing quite as much about it in the last three or four weeks as we were in the first four weeks. There are still pockets of it. In other places though, I can tell you that I happen to be board chair of a hospital in Ontario and was told by the nurses that they had every single thing they needed and that it was not a problem.

It's the unevenness of it that seems to be playing out. Of course if Nurse Betty in Saskatchewan hears that Nurse Dave in New Brunswick has something different, it's confusing, or as we heard in a case in another province, a paramedic and a nurse showed up to do some kind of care, whatever they were doing, and the paramedic had the N95 mask and the nurse was told she didn't need it. It's that unevenness in practice settings that causes anxiety for people.

The Chair: Thank you, Mr. Jeneroux.

We go now to Dr. Powlowski for six minutes.

Mr. Marcus Powlowski (Thunder Bay—Rainy River, Lib.): Thank you.

My first question is for Mr. Villeneuve of the Canadian Nurses Association.

By the way, I fully support everything you're trying to do with respect to PPE. I'm a long-time emerg doctor. Keep hammering away on that, please.

I want to talk about chronic care homes and the situation faced by people in those homes. Obviously this crisis has really highlighted the plight of people working in those homes and people living in those homes, as so many of the deaths have been in those homes.

Mr. Villeneuve, you talked about the need for bold changes. You didn't mention it, but would you support the call by CUPE last week for a universal, publicly funded chronic care program for all elderly in this country?

Mr. Michael Villeneuve: Yes, it has been our position for a long time, Dr. Powlowski, that long-term care and home care, when required, should be provided based on need and not the ability to pay. That patchwork, which one of my colleagues just testified about, as to the way long-term care plays out across the country has not done well for seniors in this country.

Our concern is that we might jump immediately to inquiry or just funnel a lot more money in there and put more registered nurses in there, or whatever the solution would be. We need to step back and look at that population. What is aging in Canada going to mean? Long-term care and chronic care don't just happen, as you know, inside bricks-and-mortar walls. It's in community centres, in primary care. It's part of end-of-life care.

I think we've had a terrible outcome. We need to analyze it and inquire, of course, but we need to step back, take it up a level and consider what aging in Canada is going to mean for the 21st century and how we are going to pay for it.

Mr. Marcus Powlowski: Yes, I totally agree. I think part of doing better in the future in managing a crisis like this means doing better in terms of providing services for chronic care.

I want to direct my next question to Ms. Benard from the Canadian Health Coalition.

Advocating for both universal, publicly funded pharmacare and presumably universal, publicly funded long-term care, the questions arise: Can we afford one? Can we afford both?

I'm not an economist, but I gather, having listened to her, that some of the arguments made were that for one thing, there are economies of scale and buying in bulk reduces the costs of medications. She also made the argument that it's cheaper to have people take their medications and thus avoid going to the hospital than not taking their medications and going to the hospital. That actually costs a lot more money. Presumably a nationally funded pharmacare system would also allow the money that a lot of people don't get from their employer, because it's going into their drug plan, to go into a nationally funded system. I think the argument you would make is that it is affordable and maybe it's even cheaper to have a nationally funded pharmacare program.

How about a universal, publicly funded long-term care program? Is that something that's affordable? Again, presumably some of the money going into that system is money that individuals currently pay out of pocket as they become older, and if they have money, they have to pay to be in these institutions. Do you think a national, universal, publicly funded long-term care program is financially feasible?

● (1455)

Ms. Melanie Benard: To the first point, yes, as I mentioned, pharmacare would save us around $5 billion every year. We would be spending $5 billion less with a pharmacare program than we are currently spending without one. It's not a question of can we afford it; it's can we afford not to have it.

Mr. Marcus Powlowski: That means collectively, through our company plans, through drug plans or through the government plans that already exist, if we add those all together, we would pay $5 billion less if we had a national universal pharmacare program.

Ms. Melanie Benard: That's right. We didn't just come up with those numbers ourselves. A report by the Parliamentary Budget Officer had some conservative estimates in it. Some people say it would even be upwards of $11 billion a year. It depends, I think, on the discounts we could get on the prescription medications, but the savings would be substantial. In part, as you highlighted, it's because we would be saving money in other areas of the health care system as well, so the government would be saving money in that way.

In terms of a universal public long-term care and home care program, I'm not an economist either, but I would say that it really is a question of priorities. I think we've seen the consequences of the current state of long-term care in this country. I don't think anyone would think that this is acceptable. There's some early data suggesting that there are more deaths in for-profit long-term care facilities than publicly run not-for-profit facilities.

Again, it's a question of priorities. I do think that when the government decides it's an issue that it's going to take on and make a priority, which I think is what seniors really deserve here, then we can find the funding for it. Where there's a will, there's a way.

Mr. Marcus Powlowski: Do I have time for another quick question?

The Chair: No. Thank you, Dr. Powlowski.

We go now to Mr. Thériault for six minutes, please.

[*Translation*]

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

I'd like to thank all the witnesses.

It would be very interesting if you could submit your speeches today and, if you wish, add comments in light of the questions you'll be asked.

My first question is for Dr. Dorian.

My blood ran cold as I listened to your testimony. It goes without saying that cardiology treats a vital organ. A number of witnesses have come to tell us that the health care systems that were weakened before a pandemic such as the one we are experiencing, given its severity, were in bad shape. Before this pandemic, the system was barely able to properly treat and care for people.

I understand your concern about collecting information, but based on what you know today, how long do you think it will take to restore the situation and resume care for patients with acute and chronic cardiac problems?

● (1500)

Dr. Paul Dorian: Thank you very much for your question.

We are ready to resume all acute care immediately, just as for a heart attack that must be treated right away. It's possible to resume treatment today, if patients come in when they are in crisis. For chronic problems, for procedures such as non-acute angioplasties, valves and defibrillators, unfortunately, there was a fairly long waiting list, even before the COVID-19 crisis. I don't know exactly how long it will take because we still don't know when we'll be able to resume treatment. In fact, we'll probably resume elective procedures very slowly. However, “elective” doesn't mean that we can wait years to perform these kinds of procedures because, unfortunately, there are deaths among patients who are on a waiting list.

It depends a bit on when we can do more elective procedures than we did before the COVID-19 crisis. Otherwise, since we were already working at full capacity before the crisis, I admit that I don't know how we'll be able to add patients who haven't received care for one, two or three months. At the very least, we'll have to increase the number of procedures we perform by a few percentage points, which will take months or maybe even years.

Mr. Luc Thériault: I'm not sure if you're aware of the situation in Montreal, including some health care centres where there have been outbreaks. I'm thinking in particular of Hôpital du Sacré-Cœur de Montréal. Don't these outbreaks complicate the delivery of cardiac care to patients who don't have COVID-19?

Dr. Paul Dorian: I fully agree with you.

First, we had to reduce the total number of medical procedures we could perform. We can focus more on certain procedures, such as angioplasty for people with acute heart attacks but, in principle, we had to reduce the total number of procedures.

Second, we aren't ready to reopen yet.

Third, there will be an increase in the number of patients waiting, even after all the doors have been opened.

Mr. Luc Thériault: Should there be a special protocol to reassure patients who have appointments at these health care centres where there is an outbreak? Should those patients be redirected elsewhere? How is that going to happen over the coming weeks?

Dr. Paul Dorian: I fully agree.

What the patient is told about the appointment will vary from one hospital or group to another, and will depend on the location and the workload whether it is possible or not.

That's why I wanted to emphasize that, as much as possible, hospitals and health care centres across Canada need to work together to know exactly where to send patients when they can't be treated locally.

● (1505)

Mr. Luc Thériault: Earlier, you seemed to tell us that this could be done fairly quickly. Is the IT infrastructure already in place to do that? How and in what time frame could it be done?

Dr. Paul Dorian: Almost all hospitals already collect the necessary data. This data is collected on site but isn't shared among hospitals, regions or provinces.

The challenge is to collaborate and find a computerized way to share data between hospitals. This will require willingness, discussion and resolution of patient data security issues. Patient data is, in principle, personal data, and patients must first be allowed to share and discuss it.

So the problem isn't so much that the data isn't collected, but rather that it remains local and isn't discussed between regions.

Mr. Luc Thériault: Could you give us a very quick example—

[*English*]

The Chair: Thank you, Mr. Thériault.

We go now to Mr. Davies for six minutes, please.

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

Thank you to the witnesses.

Dr. Dorian, I'd like to pick up on that last point. You're one of, it seems, a long lineup of witnesses who have commented on the frustration of not having national standardized data. Would you support the call for national leadership, backed up by federal legislation, to make national standardized data collection mandatory?

Dr. Paul Dorian: Absolutely. I could not emphasize more exactly what you've just said.

Let me give you a specific example about frustration. There's been a lot of discussion, for example, on our lack of understanding whether patients.... Let's take acute heart attacks, for a moment, or cardiac deaths. We know from places that collect this data in real time and publish it immediately there's been about a 40% increase in the number of people dying outside of hospital—in Italy, in New York and in other jurisdictions that have this data where they measure it reliably.

Every time somebody dies outside of hospital, that information is collected in vital statistics, because a death certificate is issued, or it's collected by the 911 paramedics. That data is available in electronic format within four hours of the event. We know where it sits: in the individual's emergency medical system's data repository in each individual municipal jurisdiction. When patients arrive in hospitals we know that data is collected in the emergency department. It's immediately abstracted and uploaded to a computer. That's how we know, for example, how many patients have COVID at any one time. For patients who are admitted to hospital, we have that data within weeks, but we potentially could have that data within days.

The problem is not that highly skilled individuals are not collecting the data; rather, it isn't aggregated. Inability to aggregate the data in 2021 is less an informatics problem than it is a problem of the willingness to share data and the ability to break down regulatory and privacy-related silos. We obviously have to be conscious of the need for privacy protection, but the 21st century privacy protection universe allows us to do that.

Mr. Don Davies: I take it you're also speaking about metadata. Surely we can find a way to extract the raw anonymized data so we can access the raw numbers and protect privacy.

Dr. Paul Dorian: I totally agree.

To give you an example of metadata, in the last two days I have received metadata—it's not privacy protected—from Alberta, British Columbia, Ontario and some from Quebec. This is from colleagues, but of course I have to be on the Internet, make phone calls and send emails.

The numbers I gave you are accurate from the last 72 hours, but an individual sending emails is not a very efficient way to gather data, as you can imagine.

Mr. Don Davies: Thank you.

Ms. Benard, a Toronto Star analysis released just two days ago of public data on long-term care homes in Ontario found that residents of for-profit nursing homes in Ontario are far more likely to be infected with COVID-19 and die than those who live in non-profit and public municipally run homes. In homes with an outbreak, they found that residents in for-profit facilities are about twice as likely to catch COVID-19 and die as residents in non-profits, and about four times as likely to become infected and die from the virus as those in a public municipal home.

In your view, what factors may explain this discrepancy?

● (1510)

Ms. Melanie Benard: That is the data I was alluding to that suggested for-profit facilities have higher fatality rates in their long-term care centres.

An obvious example is staffing levels. Even at the best of times, when corporations are trying to increase their profits and they're accountable to their shareholders, one of the easiest places to reduce their cost is to have lower staffing ratios and fewer staff on shifts all the time. We've heard of equipment and supplies being locked up so staff members can't access that equipment for basic things, such as cleaning, toileting, basic personal hygiene. Again, this is an attempt to increase the profits and reduce the expenses in these for-profit facilities. That's in normal times. One can only assume that in a time of crisis like this, these problems would be exacerbated.

Mr. Don Davies: I'm wondering if there's some international experience.

A recent study by the International Long Term Care Policy Network found that Canada has the highest proportion of deaths in long-term care settings among 14 comparable countries, including Belgium, Denmark, France, Germany, Ireland and Norway. Dr. Brian Goldman of CBC's *White Coat, Black Art* has called this "a statistic that should leave Canadians mad as hell".

Ms. Melanie Benard: That's a good question.

We have Dr. Pat Armstrong on our board who is one of the leading experts on seniors care in Canada. She would be in a better position than I am to answer that question. She just released a book in the fall that is looking at the privatization of seniors care in several different countries.

I know, for example, that Norway is a good example to follow. They've had success in bringing long-term care back into the public system after it had been privatized for a long time. I would assume it is in large part due to the vast number of private, for-profit, very large chains that have taken over this sector in Canada.

The Chair: Thank you, Mr. Davies.

That brings round one to a close. We'll start round two with Dr. Kitchen.

Please go ahead for five minutes.

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

Thank you, everybody, for being here today. It's greatly appreciated.

Mr. Williams, as I know you're aware, diabetes is a contributing factor in approximately 41,000 deaths in Canada per year. We've heard many times on this committee that the health research has fallen by the wayside, especially with this current focus on COVID-19. In fact, some clinical trials have been halted indefinitely.

Do you see any concern with respect to future diabetes research?

Mr. Russell Williams: Yes, we are quite concerned about our ability to continue supporting. As you know, we are committed to advancing diabetes research, and we're working with a number of research partners to advance it. We're concerned about the research environment and the gains we've been making, given that there's a pullback in both private and public support.

Everybody is trying to work through this, but as you look at 2021 being the 100th anniversary of the discovery of insulin, this is the time we should be focused very much on continuing to support diabetes research through partnerships. We have a great partner with CIHR. We have great partners with some of the private corporations and private donors. However, this is being challenged right now given the negative economic impact of COVID-19.

● (1515)

Mr. Robert Kitchen: Last week we heard from Dr. Wouters from HealthCareCAN who stated that 80% of their staff remain unable to continue essential research into cardiovascular disease, rare diseases, diabetes and many other key diseases that kill the majority of Canadians. Part of it is because the training is all done in hospitals and they aren't able to access the benefits from the programs out there.

Have you heard from any of your researchers on whether there are funding issues when they're working within hospitals?

Mr. Russell Williams: We're hearing that, and we're talking to them on quite a regular basis. We're trying to figure out the impact throughout the country on that, because I think different people have been affected in different ways. We are pulling together a number of key leaders on that to have a discussion to get a better understanding of it. I could forward some of our data to you following this meeting.

Mr. Robert Kitchen: Thank you.

I have one last question, just quickly.

I've seen issues, for example, where there are shortages in ramipril and metformin, the medications that are used a lot by type 1 and type 2 diabetics. Are you aware of any other drug shortages that are of concern?

Mr. Russell Williams: In the beginning of this pandemic, we started to hear some concerns. There was some anxiety from people who were thinking about spending time in lockdown and isolation. We monitored that very quickly, very regularly. We have talked to Health Canada, to suppliers, distributors and pharmacists, and people are working through this.

I'll ask Kimberley to add an answer, but our sense is at this point there is not a problem. There have been a few problems at a few pharmacies, but that seems to be working out right now for some of the medications we're dealing with.

Mr. Robert Kitchen: Right.

I apologize, Kimberley, but I'm wondering if you could send that comment to the committee. I'm short on time, and I just want to make sure I get some more questions in, if I can.

Mr. Villeneuve, I appreciate you being here. I can tell you that when I first met my wife, she was a pediatric intensive care nurse with the Hospital for Sick Children. She became an intensive care nurse and flew on the air ambulance at Sunnybrook in Ontario. She has extensive experience and spent a lot of time training, as did I. I realize and recognize all the training that goes into our health care workers, in particular when we are looking at long-term care.

The Minister of Employment, Workforce Development and Disability Inclusion stated this:

> We may create, working with the Homecare Workers Associations of Canada, some kind of training so that people who aren't in those jobs now—maybe people who are at home and unemployed—can take a shortened version of this training and be able to perform the less complicated tasks that are required at these homes.

I'm wondering what your thoughts are on that and where you see that with health care workers in these long-term care facilities.

Mr. Michael Villeneuve: Thanks, Dr. Kitchen. I am an old Sunnybrooker too, so I appreciate the reference to your wife's work there.

I think we want to be careful that we are not putting people into positions where they put themselves or residents at risk. The danger in the fast-turnaround course is that they expose the residents to COVID or they themselves get it. If we're talking about simpler functions, for example, what a volunteer might do, such as pushing someone from a bedroom to a common dining room or something, I think that makes some basic sense. However, when it comes to short-cutting the orientation and training time for something as important as very complex continuing care, I think we want to be careful.

The Chair: Thank you, Dr. Kitchen.

We go now to Ms. Sidhu for five minutes, please.

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

Thank you to all the witnesses for joining us.

I want to recognize that it is National Nursing Week, and I want to thank the thousands of nurses who are working on the front lines to protect all Canadians.

First, turning to Diabetes Canada, it's nice see you, Russell and Kim. I really want to thank you at Diabetes Canada for the work you do for Canadians living with diabetes.

Kim, you will know that a few weeks ago we did a webinar for Canadians living with diabetes. During the webinar we received many questions and comments from patients about an increased risk of diabetes complications due to COVID-19. They are concerned about different provincial and territorial approaches to protecting Canadians living with diabetes, resulting in health inequities.

How can we ensure that efforts to protect Canadians living with diabetes continue, given the difficult circumstances? Do you think leveraging virtual care is helping people? As Russell mentioned, in long-term care he receives calls. What are your thoughts on all of that?

● (1520)

Ms. Kimberley Hanson: Thank you so much for the question, MP Sidhu. We really appreciate your support for diabetes, always.

As I mentioned in my remarks, we know that diabetes is a disease, as is COVID, that really exploits health inequities. Responding to COVID as well as ensuring the health of people with diabetes will necessitate fundamentally addressing things like food insecurity and job insecurity in a general sense, ensuring that people don't have to choose between taking medication and feeding their children. We know that leveraging things like virtual health, as we have out of necessity the last couple of months, can make care much more accessible to all Canadians, regardless of where they live, and can help reduce wait times significantly. I had an appointment with my specialist over the phone just recently. Instead of taking more than an hour, it took 10 minutes and was very, very helpful. I think that can be a model for us moving forward.

What we're fundamentally learning here is that the more we can act in coordination, one province to the other—learn from each other's best practices, leverage data, analyze it and use it to make decisions about health care—the better that health care will be and the better the health outcomes will be for Canadians. Those are, as you know, all behind our diabetes 360º nationwide strategy.

Ms. Sonia Sidhu: Thank you.

My next question is for the Canadian Nurses Association.

As we know, there are outbreaks in long-term care centres. In Brampton South, one example we have is Holland Christian Homes' long-term care Grace Manor. Due to the labour shortage this year, Canadian Armed Forces are helping now during the COVID-19 situation.

I heard from the Canadian Nurses Association that we need fundamental changes in long-term care. I want to know how the federal government can work with the provinces and territories and with organizations such as yours and others to ensure that more nurses are able to help in our health care facilities, because our seniors deserve a high standard of care.

Mr. Michael Villeneuve: Thanks very much, Ms. Sidhu, for the really great question.

It's very complicated, so it's hard to answer in a short couple of minutes, but there are a couple of things. First of all, Canadians, and certainly nurses and CNA, do look to the federal government for strong leadership, and one of things that federal government has traditionally done well is convene. I think there's a convening function to bring people together. We're a bit leery of five more years of talk, because we've identified many of these problems for years. Some of them are as simple as four-bed rooms or single-bed rooms with a Jack and Jill bathroom. It spreads like a brush fire through those kinds of places.

Some of it's old, outdated infrastructure, so if we had a modernization of the idea of what long-term care looks like.... In places like Sick Kids and many other hospitals, now they're going to basically all single rooms because of this very problem. The infrastructure of long-term care looks like 1955. It just has not kept up, and it might have been fine when people were walking around in their clothes and driving to do their shopping from those facilities, but it's not now.

I think we turn to the federal government for the convening functions, the strong sense of levelling the playing field and the standards across the country. As a Canadian, what can I expect in Saskatchewan that I should also expect in New Brunswick? It's a bringing together, development of standards function to set the expectations.

● (1525)

The Chair: Thank you, Ms. Sidhu.

Mr. Webber, go ahead for five minutes, please.

Mr. Len Webber (Calgary Confederation, CPC): Thank you, Mr. Chair, and happy National Nursing Week to all of you, in recognition of all our heroes out there: all our nurses and health care workers.

Dr. Dorian, you mentioned in your presentation that procedures for heart valve replacements, defibrillators and such have been delayed significantly, if not even cancelled. Are people actually dying because of their inability to access heart surgeries and procedures due to the prioritization of COVID-19?

Dr. Paul Dorian: The short answer is yes. We don't have the exact numbers, but we have a number of cases. I just talked to a colleague from Sunnybrook hospital yesterday, who is in charge of data for the province of Ontario, and they've had four deaths on their waiting list in the last month, so the answer is yes.

Unfortunately, these are quite ill patients, and we use the term “elective procedure” very carefully. These are individuals who need a procedure not immediately, for example, an acute heart attack or somebody who's at death's door. These are individuals who normally would be expected to have a procedure within somewhere between four and eight weeks and are now potentially facing a waitlist of months and perhaps even longer.

Mr. Len Webber: We hear that quite often. Even with an area that I'm quite involved in, which is organ and tissue donation, the fact that those have been delayed as well is causing people to die, and that's just a shame.

You mentioned research briefly in your presentation and how COVID-19 has affected heart patients. Can you talk a little about the research that has been going on, if any, that you've heard of regarding the long-term effects on the heart due to COVID?

Dr. Paul Dorian: Those are superb questions. Absolutely, we would like to be able to help our patients understand, both in the short term and the longer term, what the consequences are to the heart of having COVID. We know that if you already have heart disease, then your chances of getting sicker, or sadly, not surviving COVID are higher. This is, of course, no news to anybody.

We also know that a substantial proportion, probably a minority, but a large number of patients who have the COVID illness not only have respiratory illness—they have troubles breathing and they have lung problems—but they also develop acute heart damage. We call that myocarditis. There are at least five or six different kinds of heart problems that can happen with COVID.

What we don't yet know is, in addition to what the best way is to treat the heart during COVID, what the long-term consequence is, what we should be looking out for, and how we should treat these patients to prevent worsening of their heart problems after they're discharged from hospital. There are some active research programs going on in Canada, sponsored by the Canadian Cardiovascular Society, and indeed worldwide, to answer those questions.

I might just emphasize that the only way to do that type of work is to have rapid access to all of the data that we require to answer these questions; otherwise, we're extremely inefficient in going patient by patient.

Mr. Len Webber: Thank you for that, Doctor.

Ms. Kimberley Hanson of Diabetes Canada, you also mentioned research and how the diabetes patients are three times more likely to die of COVID.

You mentioned early research. Can you elaborate on that, on what you've heard about early research on diabetes and the effects that COVID-19 has had on diabetic patients?

Ms. Kimberley Hanson: Mr. Webber, the data we have are quite early on. We have data that unfortunately doesn't distinguish between whether patients had type 1 diabetes or type 2 diabetes. The research doesn't give us well-segmented data in terms of how many complications the patients had and perhaps what their ages were, and so on.

However, what we see from countries that had the pandemic earlier than we did and therefore are farther along in their journey is that when somebody who already has diabetes catches COVID, they're more likely to experience that cytokine storm that can result in the type of COVID that needs hospitalization; they are much more likely to end up in the ICU than somebody without diabetes and consequently, they're more likely to experience a death as a result of it. We need to learn a lot more about that in order to fully understand what that means.

We're trying to send Canadians with diabetes a clear message, that they don't necessarily need to be afraid right off the bat, that they just need to take precautions, as do all Canadians, in order to reduce the risk that they'll catch COVID-19. However, it's important to recognize that diabetes does predispose people to a greater likelihood of a poor outcome if they do catch it.

● (1530)

The Chair: Thank you, Mr. Webber.

Mr. Van Bynen, you're up next, please. You have five minutes.

Mr. Tony Van Bynen (Newmarket—Aurora, Lib.): My first question is for Ms. Benard of the Canadian Health Coalition.

We've seen the need for a radical change in long-term health care, because of the devastating effect we've seen with COVID-19. I understand that your organization has been looking at national standards for long-term care facilities. How would you propose implementing and regulating these measures, recognizing that there are a number of layers of jurisdiction involved in providing health care and long-term health care?

Ms. Melanie Benard: Thank you for the question. It is a bit of a complex question because of this overlapping jurisdiction.

As we have seen in other areas of health care, there is a really critical role for the federal government to play. In the Canada Health Act, we have some criteria that the provinces must meet in order to access federal funding. There's no reason we couldn't do something similar for long-term care, having dedicated funding for that specifically and then including these national standards that the provinces have to meet to access that funding.

Mr. Tony Van Bynen: I understand, and we've heard a lot about funding.

My concern is that we seem to be pointing at organizational change, structural change, in order to improve the lines of communication for things like providing PPE on a national basis. Is there a need for a different type of organization or for structural change in the delivery of health care to make it more efficient and more effective, particularly in relation to these national emergencies, these pandemics? How would we go about implementing that?

Ms. Melanie Benard: That's a big question. The kinds of standards for long-term care and home care that we're calling for would be really broad principles that, as I mentioned, the provinces would be expected to meet. When it comes down to operationalizing those principles, that would most likely be done at the provincial or municipal levels. We would be looking for things like staffing levels and the number of hours of direct care that each resident should be getting per day. It would be really those kinds of broad principles and criteria that could be implemented at the federal level.

Mr. Tony Van Bynen: My next question is for Mr. Villeneuve.

Many nurses have been helping on the front lines of provincial telehealth programs, for example. I'm interested in hearing your thoughts on the Prime Minister's recent announcement to expand virtual care during this pandemic, and how initiatives like this can help nurses and other health care professionals during this time.

Mr. Michael Villeneuve: Thank you very much, Mr. Van Bynen.

It's been amazing to watch—just as an observer, let alone being an RN in the job I'm in—how quickly we were able to make that transition. When we surveyed nurses, polled some of our members, 70% had moved to virtual care options in their practices. We've known in nursing for quite some time that nurse lines, nurse-led care and nurse-led models of care, for example, are very satisfying to the public and have great outcomes. They are the same as or better than traditional models, have the same or less cost and are as satisfying to the public. We would absolutely strongly encourage more virtual care.

There are not enough of us to do it all, so it does extend our reach. The visits are shorter. We would absolutely strongly support it. One of the issues, though, that's been brought to us by our own members is that you need a reasonable amount of bandwidth to do some of that, and that's become a problem across the country.

One of our nurse leaders in Nunavut, for example, told us that just to do a Zoom meeting they use up their entire month's worth of bandwidth, and then they are paying by the minute, and so on. The other pieces have to be put in place, but we would strongly advocate for more virtual care.

● (1535)

Mr. Tony Van Bynen: Thank you.

My next question is for Dr. Dorian.

I understand your desire to make sure that we have leading indicators in data. What type of organizational barriers are you encountering in getting access to data in order that you can start using data as a leading indicator rather than a lagging indicator, so that we can be more proactive in how we deal with the changes that we're observing?

Dr. Paul Dorian: Thank you very much, Mr. Van Bynen. It's a very important question.

The only organization that I'm aware of in Canada that is allowed to receive data that's transported across provincial barriers is CIHI, the Canadian Institute for Health Information. Different provinces have different strategies for collecting data from hospitals and individual practices and aggregating them intraprovincially. CIHI is a very effective organization with some limitations in terms of what it is able to do, particularly in early or just-in-time data provision. They're doing it for COVID, but it would be useful for them to be able to do that with other kinds of data. Some of the limitations are regulatory, such as the challenge of sending data across provincial lines. Within provinces, there are different kinds of challenges, and they're related to the sensitivity around data privacy.

The fact is that the data custodians are the individual agencies that hold the data. For example, for cardiac data in the realm of COVID, we have data that's collected in ambulances, as I mentioned earlier, and housed inside emergency medical systems. These data are not easily interoperable, but the biggest hurdles are not the operability in terms of the IT challenges; they're that the data custodians are not in a position to talk to other data custodians to share data. They just don't feel that they have the regulatory and privacy wherewithal to be able to share data.

Mr. Tony Van Bynen: Thank you.

The Chair: Thank you, Mr. Van Bynen.

We go now to Mr. Thériault for two and a half minutes, please.

[*Translation*]

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

Dr. Dorian, some children are returning to school and will therefore be exposed to potential sources of COVID-19 contamination. The Heart and Stroke website explains that some symptoms associated with Kawasaki Syndrome may be similar to those caused by COVID-19 and that it isn't always easy to distinguish between the two diseases. The standard treatment for Kawasaki Syndrome has been used in Europe for COVID-19, and some doctors believe that this treatment may even be useful for COVID-19. What's your opinion on this?

Dr. Paul Dorian: Thank you for your question.

[*English*]

I apologize, but I'm going to answer in English to be more succinct and more accurate. My deep apologies, but I do this for the sake of accuracy and brevity.

Kawasaki disease is a rare disorder. It manifests in the heart as what's called coronary artery aneurysms and sometimes inflammation of the lining of the heart. We see this so rarely in Canada we don't have a good sense of the best therapies, particularly for the COVID version of a similar illness. The standard treatment would be steroid therapy, like a cortisone variance. We have absolutely no idea if this would work in COVID. From some early reports in China where it's been used, there's some limited evidence that this therapy may be harmful to COVID patients.

As a community we're unfortunately flying a little blind. We feel very bad that there are children who are affected, but these individuals are so infrequent that we really don't have any good data to help guide their therapy.

If I may be permitted, I think this is yet another example where to be able to give the best possible advice to our patients, whether it's pediatricians or adult physicians, it is absolutely imperative that we have access to the most comprehensive, accurate and real-time data on all aspects of COVID as we can so we can aggregate this information and not be dependent on our individual minor experience.

● (1540)

The Chair: Thank you, Mr. Thériault.

We go now to Mr. Davies for two and a half minutes.

Mr. Don Davies: Thank you.

Dr. Dorian, we've already spoken of deaths because cardiac surgeries weren't performed. Toronto's University Health Network recently estimated that 35 people may have died in Ontario alone because their cardiac surgeries weren't performed. We know that thousands of other surgeries have been postponed or cancelled to ensure enough acute or critical capacity in our hospitals for a possible surge of COVID-19.

Given those estimates, do you feel we have the balance right between providing continuity of essential care for non COVID-19 patients and freeing up the hospital capacity needed to respond to the COVID-19 pandemic?

Dr. Paul Dorian: That's a very important question that we talk about a lot, Mr. Davies.

In retrospect, I think it would have been reasonable to have less surge capacity and have continued doing some therapies, but I think I would absolutely not criticize health care planners and public agencies. I think we did the best we could as a community, given the information we had available.

What's really important is that we have accurate planning from today going forward. I think we understand much more now than we did eight weeks ago. It's been a very short period of time since we started this journey.

What's really important on a go-forward basis is that we use whatever information we can get. The more information we get, the better we can predict what the consequences would be of what I think we all agree now must be a ramp-up of cardiac and other needed procedures, cancer surgeries, other kinds of surgeries.

To get the balance right will not necessarily be easy, but it will be made better by having the most accurate and comprehensive data possible. This is not just looking forward for the next two or three months, but I think we have every reason to believe we're going to have to have this careful balancing act for months and possibly years.

It puts quite a bit of pressure on public health planners, epidemiologists, so we need now more than ever to have a community-based, fact-based, evidence-based response to health care planning.

Mr. Don Davies: Thank you.

I have a quick question for Mr. Villeneuve.

Approximately how many Canadian nurses have been infected with COVID-19 to date?

Mr. Michael Villeneuve: I don't know the number today, but I can get that information for you.

Certainly, we've been concerned by any infected, and it seems to us, here in Ontario, that it has been in the long-term sector that the support workers have been unduly affected. However, we're working with the CMA, as I think I mentioned earlier, and CIHI to try to gather that data and report it in a reliable way.

One of our problems, as you can well imagine, is this: Did the worker get it at work? Did they get it from a child outside? How are we going to distinguish those sorts of outcomes?

I will look for that information for you when we put our brief in this week.

The Chair: Thank you.

That ends round two. We start round three at this point with Mrs. Jansen.

Mrs. Jansen, please go ahead for five minutes.

Mrs. Tamara Jansen (Cloverdale—Langley City, CPC): Thank you so much.

I would like to direct my first question to Dr. Dorian.

As you mentioned, all of this data is already being collected, and yet we don't have access to that information. In this day and age when everyone is concerned about making science-based decisions, it does seem surprising that we do not have access to that information. It's even more surprising, of course, since the 2006 SARS report was clear that we needed a real-time, information-sharing system in place to help with tracking cases in a situation like this. Even here in B.C., we're looking at excess deaths that can't be attributed to COVID-19. That sort of data would help us better understand if our COVID-19 response was appropriate.

Do you think that some regions are afraid to share that data for fear of liability issues perhaps?

● (1545)

Dr. Paul Dorian: I don't think it's necessarily a fear of sharing the data because of liability, but there are certainly lots of appropriate questions about data privacy.

I think individual data custodians, the individuals who hold the data, whether it's within hospitals, regions, provinces or agencies like emergency medical care systems, for example, are understandably and appropriately concerned with exporting their data without being assured that the data, which involves individual patient information, will be kept private. One of the concerns is privacy. Another concern is data interoperability.

A third concern, and not a concern but a limitation, is that data tends to be siloed within jurisdictions and we just don't have, today, the structures. It really needs to be an overarching structure, provincial or federal, in my opinion, that brings together all of these individual custodians and has them work together so that they trust each other with their data and the data can be federated in one location.

We know it's technically possible. The hurdles are jurisdictional and informatics-based.

Mrs. Tamara Jansen: Wonderful. Thank you very much.

I have a question for Ms. Benard.

You suggested that public long-term care facilities provide better care than private. Amanda Vyce from CUPE made a similar bold statement a few meetings ago, which I also challenged.

I'm wondering what science-based information you're using to make that suggestion, especially since we just heard from Dr. Dorian that there is no pan-Canadian data collection system to support that kind of an assertion. Is this just one of those cases where if you say it long enough and hard enough it becomes true? Here in B.C. we've had a private long-term care facility ban public health nurses from entering due to the fact that they were only given two masks and two gloves to ration for the month by our regional health care authority.

Clearly, the challenge that long-term care facilities have is far more complicated than just being either public or private. Access to PPE has been one of the biggest fiascos our public health authority has had to deal with. Our national emergency stockpile system was severely mismanaged, making it very difficult for all nurses, including long-term caregivers, to be able to protect themselves and their patients from infection.

Protecting our seniors should be our top priority. Do you think that the Toronto Star article you cited has been sufficiently peer reviewed to be able to extrapolate such a bold assertion?

Ms. Melanie Benard: Respectfully, I mentioned that the private, for-profit or public, not-for-profit is a factor in terms of providing higher quality care, and that is not simply based on the Toronto Star article that Mr. Davies cited earlier. It's based on decades of academic research. The office of the seniors advocate in B.C. also published a report, I think, a month before the COVID crisis began, and it looks—

Mrs. Tamara Jansen: So it's not just private versus public. I appreciate that. That's what I was hoping to hear. That's awesome.

I have a question for Mr. Villeneuve.

In regard to telehealth, I've tried before to call in to get test results and I always have to go in to the doctor's office to get my results because of billing. Also, when I had kids and I was going to the emergency and called to see if I should go in or shouldn't go in, they would often say, “Well if you don't know, you should come in.”

I'm wondering if there might be a certain situation that we have in front of us that will hold us back from using telehealth more in the future.

Mr. Michael Villeneuve: I think that if we cling to old patterns, that will be an issue.

We've certainly seen here that the public seems willing to do this and seems satisfied with it. We've heard in many regions across the country—not just from our polling but from regional health authorities—that they've also moved to 70% virtual, and more than half of that by phone. I think that if we can get the billing right, because I do believe physicians need to be paid just as nurses and others are paid, and if they're adequately compensated, I think we can make that shift.

I have to say that I'm an aging baby boomer now. I'm at the bottom end of the trail, and we want those kinds of services. We want those sorts of changes, so I believe we can make them.

The Chair: Thank you, Ms. Jansen.

Mr. Fisher, please go ahead for five minutes.

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

Thank you to all the witnesses who are here sharing their expertise as usual.

Dr. Dorian, you gave incredibly thoughtful remarks, and your responses to the questions were equally thoughtful, and I want to thank you for that. I've changed my direction and I'm going with you because of some of the thoughtful things you've had to say.

I think we've been very fortunate in Canada. I think the Canadian public has generally bought into the public health message and done a pretty good job.

You talked about refining the public message, and your organization has offered to help or would offer to help develop and spread the public health message. I'm putting words in your mouth here, but I think you said we need to find a way to balance medical needs with coronavirus needs. You've acknowledged that the coronavirus patients are appropriately prioritized. Again, I'll repeat my belief that we've been very fortunate in Canada that Canadians have bought into public health.

Again, because of your thoughtful comments, I'm fascinated and I would rather we could sit down and have a cup of coffee or a beer and talk for an hour and a half on this, but we have five minutes, and I know you're only going to be able to touch on this.

If you were developing and spreading the public health message, what would it look like? Would it be similar or would it be vastly different? I would feel confident if you were in that role based on the things you've said today, but maybe you could just touch on some of the things you might have done if you had been crafting that public health message for Canadians.

● (1550)

Dr. Paul Dorian: Thank you very much for your kind remarks, first of all.

I think we have a task to do as a community, and this includes physicians, nurses, all the health care workers and representatives of government, and that is to help patients figure out whether the symptoms they have warrant emergency care or not. That is true for COVID-like symptoms and that is true for cardiac-like symptoms.

The major challenge we have, for which there is no easy answer, is to make sure that we educate all members of the public that, if they have severe symptoms—this could be shortness of breath, a cough or a high fever in the case of COVID, or it could be chest pain or it could be paralysis in the case of strokes—they seek emergency care immediately.

We have the extraordinary good fortune in Canada of having a very well-functioning emergency health care system. It would be an extreme shame—which is why it's so frustrating for those of us on the front lines—that patients who could benefit from immediate care in the fortunately infrequent situations where immediate care is necessary were forgoing that care.

What that message should sound like exactly, I'm not exactly sure. The Heart and Stroke Foundation has come up with some specific instructions to patients, but the requirement, I think, would be to come up with something simple, straightforward and available in all the languages that all our Canadian citizens speak. It would be messaging that would be widely spread to reassure individuals that emergency care is available if they just want to seek it.

Mr. Darren Fisher: Thank you, Doctor.

Mr. Villeneuve, telehealth fascinates me. I know we had some pioneers in Nova Scotia who were pushing for this for a long time and see it maybe as one of the only good things to come out of the coronavirus thing, which is that we are now talking about telehealth and doing telehealth.

Is it here to stay? Is telehealth going to expand? Are we going to utilize our medical health care professionals in a bigger way through telehealth in the future after coronavirus says goodbye?

Mr. Michael Villeneuve: Mr. Fisher, I can't imagine us going back. I can't imagine the public would be satisfied going back.

Ms. Jansen mentioned it a few minutes ago. I think we're going to have to learn to manage how much risk we're willing to take on. When nurse Mike is on the phone talking to someone in the public, what is the balance of "I can't see you, so I can't tell," but now we can see you? We're doing it right now.

The public has learned to work like this. Offices are closed and the country has sort of shut down, but society has gone on with great communication. When we ran the national expert commission almost 10 years ago, I can remember one of our business leaders saying, "Why do you people spend so much time trying to describe a wound when we all have a camera that we could show the doctor and click it?"

We've made that leap and I can't imagine now that the public, or even doctors and nurses, will want to go back.

Mr. Darren Fisher: Mr. Chair, do I have any time remaining?

The Chair: You have 10 seconds.

Mr. Darren Fisher: Thank you. I'll pass.

Thank you, folks.

The Chair: Thank you, Mr. Fisher.

We'll go now to Mr. Jeneroux.

Please go ahead. You have five minutes.

Mr. Matt Jeneroux: Thank you, Mr. Chair.

Mr. Villeneuve, would you agree with me that one of the most significant challenges that nurses are facing right now is the lack of PPE?

● (1555)

Mr. Michael Villeneuve: It's uneven across the country, but it is an ongoing concern for all health care workers.

Mr. Matt Jeneroux: Going back, when was it first raised by your association, the importance of having PPE, and enough PPE, on the front lines?

Mr. Michael Villeneuve: You raise a great question, because we sent a joint letter with the Canadian Medical Association and the Canadian Pharmacists Association fairly early on. I'll find that for you. It was the first public statement we made in an open letter saying that we were concerned about mental health issues, as many of us talked about, but also about PPE.

It was early on, because of the SARS experience. It wasn't really so much a complaint as beware that this is coming, it's spreading across the country, and people need the right equipment to protect themselves in this situation. We were on it very early.

Mr. Matt Jeneroux: Again, we want to make sure that we're getting the best response possible for any future potential pandemics, so knowing that these sorts of things are being raised early and often is exactly what we're trying to get at.

Mr. Michael Villeneuve: Yes.

Mr. Matt Jeneroux: That brings me to what we've understood with the national emergency stockpile and how that was mismanaged.

Was that something on the Canadian Nurses Association's radar at all? Until it was in the news, did you know about that?

Mr. Michael Villeneuve: Our concern was the unevenness of it. For example, we had heard from one source that there were masks sitting at an airport, blocked, that couldn't get through some customs hurdle, or something such as that. I don't remember the specific date or details. However, it seemed to us as though there was an unevenness about it. Of course, part of that, we assumed from our own research and talking with people, is because some of these products come from places in other countries that themselves are shut down.

A key lesson from this going forward for all of us coming out of this is for personal protection, just as we do for firefighters and others, so that the stockpile is there when we need it.

Mr. Matt Jeneroux: Help me understand the unevenness. Are you talking about within jurisdictions or within products? What do you mean by unevenness?

Mr. Michael Villeneuve: I'm particularly thinking of personal protective devices, masks here and in different jurisdictions, different employers and different rules on different shifts.

I'm not trying to dodge the question at all. It's a problem we often have in health care: I think we should do it this way on the surgical ward, whereas this leader thinks we'll do it that way on a medical ward. Even within institutions, practices can be quite different.

Mr. Matt Jeneroux: One of my colleagues, Mr. Davies, asked a question about how many nurses have been diagnosed with COVID-19. We'd also be very interested in that.

Can you confirm, and I think you did, but just to clarify, that most of the confirmed cases of nurses diagnosed with COVID-19 are in long-term care homes?

Mr. Michael Villeneuve: No, I don't know that. I'm sorry, I don't know. I checked with my colleague while we were talking and we will get that information for you this week.

Mr. Matt Jeneroux: Do you have any ballpark numbers, just to tide us over until then?

Mr. Michael Villeneuve: I would totally be guessing. However, we noted in Ontario that among what I believe are seven deaths of health care workers, not that it should come to death, but if we're counting the worst outcome, five were personal support workers in home care and long-term care and two were custodial workers in hospitals.

Mr. Matt Jeneroux: Touching on mental health, I know you touched on it already, but what support measures for the nursing profession should be provided now that weren't necessarily provided before and should be considered in light of COVID-19?

Mr. Michael Villeneuve: We know from, I believe, the Pollara research last week that both anxiety and depression have risen across society. The level of burnout was about 40% among nurses before this even started, and I think it's pretty high among a lot of physicians.

We're taking part in a rapid review of the research, Mr. Jeneroux, coming out of the University of Toronto to define the top-level mental health interventions that work. Is it a phone line or is it one-to-one counselling? Then we can identify which among those we think works the best. The issue then will be: Can we get it to people quickly and without a high cost or without any cost? Mental health care in this country is expensive. It was hard to get before all this.

● (1600)

The Chair: Thank you, Mr. Jeneroux.

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

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

In view of the fact that it is National Nursing Week, my first question will be for Mr. Villeneuve.

I will have my T-shirt at the ready. Tomorrow is International Nurses Day and I will wear it with enthusiasm to celebrate our wonderful front-line nurses.

Thank you so much for giving that shout-out to public health nurses who are not quite as visible as the nurses on the front line. I know here in the York region that our public health nurses have been working around the clock on contact tracing which, as you know, is a very detailed type of activity. It's very time-consuming and requires considerable skill as, obviously, some people really do not want to disclose exactly what they have been doing for the previous 14 days.

Going back to the issue of mental health, there's a strain on our front-line workers, which I think is self-evident. My recollection post-SARS certainly in the GTA was that a number of nurses did take early retirement following the SARS epidemic and the work and stress that they had been involved in.

I know the Canadian Nurses Association has been concerned about shortages in the nursing profession, so are you thinking ahead to consequences post-COVID as to what that's going to look like from a labour point of view?

Mr. Michael Villeneuve: Yes. I'll give a very brief answer around SARS. I happened to be stationed out of the country that year, so I wasn't very close to it, but I have colleagues who worked right in the middle of it at Mount Sinai who, even now when you talk to them all these years later, are so traumatized they can hardly talk about it.

In our long-term care sector here, we have a colleague who reported from one of the homes. She volunteered to go in to help. Sixty of the residents out of the 170 had died in the previous three weeks, and eight had died that night. She looks completely haunted, and this is a 32-year-old, I guess; she's young. Everyone looks young compared to me, but she's just a young woman, a doctoral candidate, full of energy, and she just looks defeated. Then she got COVID herself as a result of the experience and feels she doesn't even know if she can go back into it.

We haven't had the ICU decision-making where I have to decide if you get a ventilator or you don't, or we're taking you off one because this one might do better and all that horrible stuff that came out of New York, Italy and Spain. We may have it hit harder in the long-term care sector, and I don't think that even at CNA it was so much on our radar that we thought it would sweep through there.

Yes, we are concerned about what comes out of this. We're really concerned that, for example, in Ontario it was suggested.... I think it was Mr. Ford on Thursday or Friday who suggested that the estimate for the catch-up for the surgeries that Dr. Dorian mentioned is two years. Who is going to do that? If all of these people are already working full time, where are those surgeons, techs and nurses going to come from?

We are concerned and we are also working with a different research team to measure some of the impacts of this on the workforce. Does it cause people to retire, to move and change? It's all sort of, at this point, a bit of a messy middle, but it's on our radar.

Thank you very much for that question.

Ms. Helena Jaczek: Thank you.

My next question is for Dr. Dorian.

I think many of my colleagues have been questioning the whole issue of why the data isn't much more readily available. CIHI has that responsibility, in order, hopefully, to create some sort of national database that makes sense. You have referenced privacy concerns. I remember, when I was commissioner of health services and medical officer of health for York region, I was the health custodian for six different datasets, and according to our legal counsel, I couldn't talk to myself. In other words, I couldn't cross-reference patient X in one dataset with the same patient in another dataset.

To what extent have you talked to privacy commissioners to ensure that they understand that aggregating data analysis is just so vital for us to understand the science behind disease patterns, etc.? Have you as an association had those types of conversations?

● (1605)

Dr. Paul Dorian: We've had some of those conversations. We work very closely with CIHI, and I just want to make sure that there's no misunderstanding. CIHI has been extremely collaborative and supportive of the kinds of efforts we make. It's limited by its budget, its bandwidth, and its ability to collect and aggregate information. That's a challenge we face together.

It's also limited in that it has access to some data, which is collected inside hospitals, but CIHI doesn't have the mandate to collect, for example, emergency department data or data from long-term care homes, at least some data in physicians' offices, laboratory data and so on.

I think you hit the nail on the head when you said it's a challenge to even be allowed to talk to yourself. My sense is that the firewalls that are up there are not because of anybody's ill will but because of levels of concern—perhaps appropriate, perhaps not appropriate—that will only be surmounted if we can get all of the individuals, groups and custodians into one room at one time with some leadership and direction from public health agencies, at either the provincial level or national level, who will help adjudicate between these various concerns and come up with a single type of strategy.

I think we have tried to have individual conversations with individual privacy commissioners, but I'm not sure that is the most fruitful way of trying to solve this problem.

Ms. Helena Jaczek: Thank you.

The Chair: Thank you, Dr. Jaczek.

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

[*Translation*]

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

Ms. Benard, I can't go into the origins of the CHSLD situation in two and a half minutes, but you've put your finger on a problem that has had structural effects on the organization of care in our CHSLDs. You talked about underfunding and, in particular, the fact that the increase in health transfers has been reduced from 6% to 3%. That's one of the great lessons of this pandemic. Experts tell us that a weakened system means that, when such a medical situation, such a contagion, occurs, weaknesses and problems emerge catastrophically.

I'm doing the same analysis as you. I think the years of delay in funding have had a structural effect on a temporary situation, the pandemic. It is said that more than 80% of deaths are occurring in long-term care centres, particularly in Quebec. This is serious. I agree with that part of your analysis. I think it would be complacent not to draw the conclusion that we must find funding that exceeds system costs, which are at 5%.

Personally, I presume that everyone in the system is benevolent and caring and that they have done what they could despite the underfunding. That justifies nothing.

How would a national standard make a difference because what is needed is money on the front lines, not a system of organization or normativity that will be a drain on the government's finances?

Why is there a need for a standard, and if there is a need for standards for public long-term care facilities, what are they?

Ms. Melanie Benard: Thank you for your comments.

[*English*]

I'm glad we're in agreement on the issue of funding.

I think the question was what the role would be for standards. If we just need increased funding, why would we need standards? I would say that we need to have some consistency. People across the country need to know they can rely on a certain standard level of care.

Of course, there is a huge role for the provinces in terms of the delivery of that care, but to meet these basic standards is something that, as I said, we'd see under the Canada Health Act for other areas of health care.

We're calling for similar standards to be in place for long-term care and home care.

● (1610)

The Chair: Thank you, Mr. Thériault.

We'll go now to Mr. Davies for two and a half minutes, please.

Mr. Don Davies: Thank you.

Dr. Dorian, we've heard that one of the gaps the COVID-19 crisis has exposed as well is the chronic drug shortages which occur at all times but have been particularly pronounced here in British Columbia. They've limited refills on all prescriptions to 30 days.

I'm just wondering what you could tell the committee about your experience with drug shortages, if any, in your field of expertise.

Dr. Paul Dorian: This will have to be entirely anecdotal. I'm not aware.... I apologize again for coming back to data, but we don't have any really solid data on the full spectrum of drug shortages.

In my own practice, I work out of St. Michael's Hospital in Toronto. I've had more than a handful of situations where the medication I've prescribed was unavailable at the pharmacy that issued the previous prescription. We asked them to look around at other pharmacies. They couldn't find the medication. These were cardiac medicines and I was asked to think of a substitute. Often the substitute medications are not as effective.

We're not talking about generic versus non-generic. We're just talking about medication type A versus medication type B. It is happening. I'm not sure within the cardiac realm that it's been a situation where the medication was completely unavailable in any place. We've had relative shortages inside hospitals. We've had information from our hospital pharmacy that we need to be very careful on the use of certain in-hospital medications, particularly some pain-killing medications used in anaesthesia, medications used in acute cardiac care, but I don't have any information to tell you that this has resulted directly in patient harm. It's just something that we need to be very careful about in terms of future planning.

Mr. Don Davies: Ms. Benard, there has been a bit of a question about what relationship universal, single-payer public pharmacare might have to the present COVID-19 crisis.

I leave last words to you to explain to the committee why you think there's a connection.

Ms. Melanie Benard: Sure. Thank you.

As I mentioned in my testimony, we've seen millions of Canadians losing their jobs during this crisis. Since the majority of people who do have drug coverage have it through private insurance through their employer, people have now lost that coverage, in addition to people trying to function on reduced incomes as well.

All these problems have been exacerbated during this crisis which makes this need for universal, single-payer public pharmacare all the more urgent.

The Chair: Thank you, Mr. Davies.

Thank you to all the committee members for all the great questions. Most particularly, thank you, witnesses, for sharing so much of your time with us today and also your expertise.

I'd like to advise the committee that for our meeting on Wednesday, the Canadian Association of Retired Persons will be added to the panel. They will be sharing the time slot with the Council of Senior Citizens' Organizations of B.C., so this won't add on any time.

Thank you everybody.

The meeting is adjourned.