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Mr. Bill Casey

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● (0845)

[*English*]

The Vice-Chair (Ms. Marilyn Gladu (Sarnia—Lambton, CPC)): Good morning. Welcome to the 124th meeting of the Standing Committee on Health. We are continuing today with our study of diabetes strategies in Canada and abroad. Before we begin with our witnesses, there's one item we need to deal with. Our concussion subcommittee has a budget they've proposed to us. We need to approve their budget in order to keep them working. I'd like to have a motion to accept the budget for the subcommittee.

An hon. member: I so move.

(Motion agreed to)

The Vice-Chair (Ms. Marilyn Gladu): We'll now go to our witnesses for the day.

We have with us Victor Lepik, by video conference from British Columbia. From the Horizon Health Network, we have Michelle Corcoran, who is a dietician and diabetes educator. From Universities Allied for Essential Medicines, we have Louise Kyle, who is an advocate with the 100 Campaign.

Thank you all for joining us. You'll each have 10 minutes to give your statements before we go to questions.

Victor, we'll begin with you.

Mr. Victor Lepik (As an Individual): Thank you, Madam Chair and members of the committee.

My name is Victor Lepik and I'm appearing before you as an individual who's lived with type 1 diabetes for more than 30 years. It's my hope that my appearance here today will give you a better idea of the daily challenges I face as a person living with diabetes; some solutions that have greatly enhanced my quality of life; and the need for governments across Canada to improve financial access to important diabetes drugs and services.

Having type 1 diabetes means my pancreas does not produce insulin, a hormone that controls the amount of sugar in my blood. Without insulin, I would have high blood glucose levels, which would affect my major organs, including my heart, blood vessels, nerves, eyes and kidneys, leading to serious, life-threatening complications.

While I'm very conscientious about keeping my diabetes under control, managing my blood sugar is a juggling act. Over the years, I've struggled with low blood sugar and dangerously high blood sugar. Untreated, severe low blood sugar can result in seizures, loss of consciousness and even death. In order to keep my blood sugar under control, I typically require five to seven daily injections of insulin. I also check my blood sugar levels at least 10 times a day to ensure that they're neither too high nor too low.

Late last year, I got a Dexcom continuous glucose monitor and an insulin pump to help manage my disease—decisions that turned out to be life-changing for me.

The continuous glucose monitor helps me manage my blood glucose levels. It consists of a cannula injected into my skin and a transmitter that snaps onto it. I change the cannula every week at a cost of $85. I replace the transmitter every three months at a cost of $389. B.C.'s Fair PharmaCare program does not cover either item.

The transmitter sends a cellphone signal to an app with my blood glucose information. My cellphone sounds an alarm before my blood sugar falls or rises to an unsafe, predetermined level. Unlike a finger-prick device, my continuous glucose monitor tells me whether my blood sugar is rising or falling and at what rate.

I can also share the continuous glucose monitor information electronically with my doctor and diabetes specialists. At a glance, they can easily review my blood sugar management and work with me to make improvements.

I wish I'd had a continuous glucose monitor years ago to prevent severe low blood sugar. In the past, I've often woken up in the middle of the night surrounded by paramedics, firefighters and police officers staring down at me. I have even woken up in hospital without any recollection of how I got there. This has happened to me numerous times.

The continuous glucose monitor allows me to sleep at night without the constant stress and worry that I may not wake up at all. My blood glucose levels are in better control and my physician is happy. An additional benefit is that he is no longer threatening to revoke my driver's licence.

Before the insulin pump, I needed multiple daily injections. Although I worked diligently to maintain tight insulin control to avoid complications, I still struggled with low blood sugar. I sometimes needed to eat in the middle of the night when I was not hungry. Exercise, including neighbourhood walks or playing a game of golf, was difficult, as it typically led to more insulin reactions, more eating and weight gain.

Since getting the insulin pump and continuous glucose monitor, my blood sugar levels are more consistent. I am able to exercise regularly. I rarely have to eat when I'm not hungry, and I've lost 10 pounds and counting. The pump, which typically requires replacement every five years, cost $7,000 last fall when I purchased it. At that time, B.C.'s pharmacare program funded the device only for diabetics aged 25 and under. I am 65 years old. Last July, the B.C. government announced expanded coverage for the insulin pumps by eliminating the age restriction.

While all provinces have a pump program, they are all different and many are pediatric or only up to age 25. Without a national funding program, there are still many Canadians across this country unjustly paying for a device that another province fully funds.

● (0850)

My endocrinologist recently recommended a faster-acting insulin called Fiasp to reduce my high blood sugar levels more quickly. The B.C. pharmacare program does not cover this insulin, and according to Diabetes Canada, no province currently lists it for coverage. It costs $38.49 for a vial that lasts me about two weeks.

While injecting insulin helps me manage my disease, it's not a cure. People with type 1 diabetes often face devastating complications, including heart attack, stroke, blindness, kidney failure, erectile dysfunction, depression, lower-limb amputations, skin conditions, hearing impairment, and an increased risk of Alzheimer's. Preventing these complications would save our health care system millions of dollars annually, yet a major challenge for people like me living with type 1 diabetes in Canada is the cost of medications, devices and supplies needed to manage the disease more efficiently.

The financial burden of managing diabetes can be a heavy one. An insulin pump every five years is $7,000. A continuous glucose monitor transmitter and cannula combined are close to $470 monthly, or more than $5,600 annually. If you include the latest, fast-acting insulin, add another $77 to the monthly cost of managing the disease, for a total of $547 each month or $6,565 annually. To help prevent complications and, most importantly, provide people with diabetes with practical solutions to improve their lives, we need a nationally funded program that is open to all, regardless of age or income.

Thank you.

The Vice-Chair (Ms. Marilyn Gladu): Thank you, Mr. Lepik.

We'll now go to Michelle Corcoran.

You have 10 minutes.

Ms. Michelle Corcoran (Outreach Diabetes Case Manager, Dietitian, Diabetes Education, Horizon Health Network): Thank you.

I would like to thank the honourable members of this committee for inviting me to share my personal experiences and perspective.

I practised for 20 years as a registered dietician, a certified diabetes educator, and now a diabetes case manager in rural New Brunswick. I'm embedded within the offices of 17 community family doctors and nurse practitioners in the Upper River Valley, in my area.

We know that for those who receive diabetes education, diabetes outcomes improve and their complication risk lowers. Many people, for many reasons, do not access the education they need. Access to care should be at the right time and arguably the right place. I would like to share comments made to me by a patient named Anthony: “I prefer to come to my doctor's office. No one knows why I am here. I am just here to see my doctor, just like everyone else. No one judges me.”

Making diabetes education accessible in family doctors' offices is the basis of our diabetes case management program in New Brunswick. It was developed out of a gap analysis that people were not accessing diabetes education at diabetes education centres, so we made it accessible in the family practice office. Our Diabetes Canada clinical practice guidelines and our own New Brunswick diabetes strategy have recommended this model of care. It's known to be as effective in meeting diabetes targets as attending education centres is. Diabetes educators, no matter where they are, make a difference.

About 80% of diabetes care is done within the family practice or family doctors' offices. Almost half are not meeting any of the targets we've set out in our clinical practice guidelines. Family doctors, as you know, are overwhelmed, not only with diabetes but with everything else they have to deal with in their practice. As a case manager, I am their specialist resource right in their office, and I can help them provide a collaborative model of care for the patient, the family, the physician, as well as a learning tool and making timely changes to patients' care.

We have significant and growing evidence that current diabetes therapies can keep people healthy and save lives. Unfortunately, many people live with untreated or inappropriately treated diabetes. They ration or don't take their medications, their insulin; they don't test their sugar; and they reuse their insulin pen needles.

I'm going to share another story with you. Helen is a senior and she has our New Brunswick seniors medical plan. She has type 2 diabetes. She is on insulin and metformin, and she had a heart attack about four years ago. Because she is already on insulin, I cannot help her get a medication with evidence of cardiovascular risk reduction, which may prevent her from having another heart attack, improve her blood sugar and lower her risk of hypoglycemia as well as weight gain. Adding these medications is recommended by our clinical practice guidelines, but our government has chosen not to abide by those guidelines as recommended, or even use the product monographs, which are evidence-based as well. If she had a private plan, we would not be having that conversation.

Standard diabetes care is accessible in New Brunswick, but it's not available to everyone. For diabetes foot care, you have to have coverage or you have to be on income assistance to equitably access it, and cost is a barrier. Many people have to pay up front for their supplies, their insulin and their medications before they are able to access coverage. This is a barrier. I will tell you that many people say —and I hear it every day— that they haven't picked up their medications yet because they have to pay up front and they have to wait for money to do it. Credit cards are not an answer.

Mental wellness specialists have long wait times, and diabetes eye exams, which can help reduce the risk of retinopathy through screening, are not always accessible. Family practice eye doctors certainly are accessible; however, you have to pay for the diabetes eye exam there. If you go to a specialist, it is free, but you have to wait for that. Who can wait?

Fear of hypoglycemia can affect life, and I think Victor outlined that very well. It can be a barrier to your own productivity. I'm not sure if any of the members here have ever had low blood sugar, but I will you tell you, and I know Victor will attest to this, that you feel like crap. You don't feel productive. You are not able to do the things you need to do because you're trying to eat to fix that low. Sometimes you overeat and end up with a sugar that's three times the height it should be. You don't want to wake up your spouse at night for help, so you fall down the stairs because you've had a low.

I've also heard this stigmatizing statement: “So what if they have low blood sugar? They can eat sugar. That's great.” It's not always the most appropriate thing. There are medications and insulins that can reduce the risk of hypoglycemia but are not readily available. Devices can make a difference.

● (0855)

Should I have to ask people living in my area, “What medical coverage do you have?” We've created a have and have-not system of access to diabetes care, medications and insulin. It is a system that festers with discrimination against those who have not.

If they have a private plan, I can help them with more options. If they don't, I'm sorry to say that I tell people every day, “I'm sorry, your plan doesn't cover a medication that I know can help you. It will cost you $200 out of pocket in order to actually have that medication.” We have compassionate programs and samples from doctors' offices, but that's not sustainable.

I would ask you this: Why are we able to provide people suffering from drug addiction with the coverage, free syringes and paraphernalia they need to stay healthy and safe, but we can't do this for people living with diabetes?

I've told people to move out of the country or out of the province to get better coverage. Some people have done this, and I'll tell you that people who have moved to New Brunswick have said, “I'm appalled. I can't believe I had coverage for this elsewhere. I can't believe I have to pay for this insulin. I can't get what I need.”

Should I have to make people choose between picking up insulin or getting groceries? Should they have to shop pharmacies to get the best price for insulin? These are things I deal with every day. It's frustrating, as well, when I have a plan that can provide some coverage but still people are denied that coverage, not because they didn't meet the criteria set out by our government, but because the people who are advising this plan have wrongly read the forms, or they inexplicably say that this is denied when it shouldn't be.

I shouldn't have to advocate for patients. There shouldn't be this issue.

Insulin is essential for life. People living with type 1 diabetes need insulin or they will die.

I'm going to share with you another story. Jeremy lives with type 1 diabetes. Now he's 42 years old. He's a seasonal worker, so of course he had spotty coverage for anything he needed for his diabetes. Now he has retinopathy, and he has nerve damage. He's on peritoneal dialysis. Why are we paying 100% of the cost of peritoneal dialysis for this person when we could have helped him and perhaps prevented this other chronic disease that he now has to live with?

Insulin and arguably all diabetes medications are essential for life. As a diabetes educator, I stand firmly behind that. I'm going to ask you this: Would Banting, Best, Collip and Macleod have thought that their discovery would be only for the rich people of this country, those with money or drug coverage? Would they have wished Canadians not to have access to the medications, supplies and devices needed to help keep them healthy and, of course, ultimately reduce health care costs?

We need to stop failing at what we are doing. We need to create a unified strategy, so that no matter where you live, who you are or what you are doing, you have access to what you need to live well with diabetes. It's crippling our country's health care costs. Diabetes needs to be treated with urgency and promptness, just like other life-threatening diseases. Of all diseases, diabetes is treated when we screw up, when we fail and when blood sugars are uncontrollable.

Let's prevent what we know is going to happen. Let's not react.

These are my asks to you: Support access to the model of diabetes case management, so that more people can gain access to the education and care they need; close the gap between the haves and have-nots to keep people healthy and make things accessible; and support the diabetes 360 strategy from Diabetes Canada, which also outlines a national and unified strategy to improve the lives of Canadians living with diabetes.

Thank you.

● (0900)

The Vice-Chair (Ms. Marilyn Gladu): Thank you very much.

Now we're going to go to Louise Kyle for 10 minutes.

Ms. Louise Kyle (North American Coordinating Committee Member, Advocate with the 100 Campaign, Universities Allied for Essential Medicines): Good morning. Thank you for inviting me here again to speak to diabetes strategies in Canada and abroad. This is an area of significant importance for me and more than 425 million other people living with diabetes in Canada and around the world.

My name is Louise Kyle. I am a law student at the University of Ottawa, a student leader of Universities Allied for Essential Medicines, an advocate with the 100 Campaign, a runner, a skier, a daughter, a sister, a partner, a friend. I also live with type 1 diabetes.

In 2013, I was in the Dominican Republic with AYUDA, an organization that empowers youth to become agents of change in diabetes communities around the world, in conjunction with a local diabetes organization.

On the day of the youth camp, which coincided with a 10-kilometre race to raise awareness and reduce stigma about diabetes, I met a father who was registering his three-year-old daughter for camp. He could see that I had my race bib on and realized that I had run the 10K. He asked me how it went, and I shared that it was tough, very hot, but that I love to run and it is an important part of my life.

I asked his daughter if she wanted to check her blood sugar, and when she told me that it hurt and she didn't like to, I asked her if she wanted me to do it first. Shocked, the father said, “Do you have diabetes?” I told him I'd been living with diabetes for 20 years. He was almost in tears as he told me that he had never met another person who had lived as long as I have with type 1 diabetes.

As you've heard, type 1 diabetes is a condition in which the body no longer produces insulin. Therapy requires insulin administration and regular blood glucose testing. Without insulin, someone with type 1 diabetes will die in a matter of days, and it will be painful. With insufficient access to insulin, a person with type 1 diabetes is at risk for longer-term complications. As you've heard, these complications massively impact the overall quality of life and ultimately can cause premature death.

Type 2 diabetes is a condition where the body still makes insulin, but the insulin is insufficient for what the body needs. This means that some people will need to take medicine to make their insulin work better, or they may need to administer insulin as well.

That father in the Dominican Republic hadn't met anyone who had lived as long as I have with type 1 diabetes, because in many places around the world, access to adequate treatment and support is out of reach for people who depend on it for their survival. Shockingly, today—and you will have heard me say this before—despite the fact that the first use of insulin to treat someone with type 1 diabetes, here in Canada, was in 1922, one out of two people globally who require insulin do not have access to it.

Diabetes is challenging. It requires a constant balance of activity, food and insulin. I was diagnosed in 1993, when I was two and a half. I don't remember much about this part of my life. I remember that when I was first diagnosed, I used test strips that gave me a range: less than four, four to 10, 10 to 16, or over 16. I used human insulin: NPH and R. This didn't last long.

I have seen huge technological improvements over my 25 years with diabetes: from test strips that took only 60 seconds to provide a reading, to test strips that spit out a result in five seconds, and now we have flash glucose and continuous glucose monitoring, which provide trend arrows, as you heard Victor mention. My NPH and R were replaced with analogue insulin, and ultimately with an insulin pump, which I use today.

Growing up in Calgary, Alberta meant that I had access through our health system to an amazing team of doctors, nurses and dietitians. Despite not having public benefits, my parents were always able to purchase insulin, test strips and other supplies that I needed—even an insulin pump. These are decisions that my parents were able to make because of privilege. Not everyone has access to these options. This is a very important distinction to make.

I don't remember a life without diabetes, and for me it's just been another part of life. This is not the case for everyone who lives with diabetes. Today, 57% of Canadians cannot follow their prescribed therapy due to cost. As you heard from Michelle, individuals living in New Brunswick, as well as in Quebec, Saskatchewan, Nova Scotia, and P.E.I., who use an insulin pump and have an income of less than $15,000 all spend more than 25% of their income on out-of-pocket diabetes costs.

● (0905)

These are people who are forced to make decisions about whether they will spend money on medicines and technology that will save their life or on other basic necessities. It is worth noting that nearly one million people go without food and heat in order to pay for medicine in our country.

Furthermore, a study published just this Tuesday by UBC researchers found that 731,000 people in Canada, primarily young people with chronic conditions and no prescription drug insurance—doesn't that sound familiar?—borrow money, give up necessities or go into debt to pay for their prescription medicines.

Low-income Canadians are disproportionately affected by the high costs of treating diabetes. They have a higher risk of cardiovascular complications and death compared to individuals with higher socio-economic status. A study estimated that 5,000 deaths in Ontario alone could have been prevented with universal drug coverage for diabetes supplies.

Diabetes-related mortality is as much as three times higher for indigenous populations in Canada than for non-indigenous populations. A recent policy round table found that these challenges can be linked to “variability across the country in terms of public and private insurance coverage for medications and supplies for those managing their diabetes.”

As you know, insulin was discovered here in Canada by Frederick Banting and his team of researchers. Banting wanted to see insulin mass-produced and distributed to those who need it. He chose to sell the patent rights to the University of Toronto for a symbolic $1, famously saying, “Insulin does not belong to me, it belongs to the world.” That was in 1921.

Despite the fact that insulin was synthesized in Canada nearly 100 years ago, a lack of affordable insulin remains the leading cause of death for young people living with type 1 diabetes. I will repeat that today one in two people who need this medicine to live does not have access. The reasons for this lack of access are multi-faceted, but a major issue, as you've heard, is that insulin and other supplies are priced at a level that is above what many people can afford. The cost of insulin alone—just one piece of the complicated diabetes picture—can eat up 25% of a family's income in low- and middle-income countries.

Despite current list prices of analog insulins like Humalog and Lantus sitting around $300 U.S. per vial, a recent study in the journal BMJ Global Health found that the cost of producing one vial of analog insulin is between $3.69 U.S. and $6.16 U.S. In Canada, one year's supply of analog Lantus, which is just one half of a typical insulin regimen, costs about $1,800. Researchers in the same study contended that analog insulin could be sold for $133 per patient per year, and the manufacturers would still make a profit.

Despite insulin being nearly a century old, the insulin market hasn't played by the rules of a normal competitive market. We have three big insulin manufacturers who dominate 90% of the insulin market, and prices have been increasing in lockstep. The price of insulin tripled between 2002 and 2013.

These statistics should make us question what happened in our system. We should be asking why we're living in a time when more than one person died last year rationing their insulin in the United States, and only 1% of children living with type 1 diabetes in sub-Saharan Africa will live six years past diagnosis.

Canada is the birthplace of insulin. We should be the ones to amplify the insulin access movement. Canada can, and should, be a leader and hold other states to account to ensure that human rights for all people are upheld. All provinces and territories in Canada should lower out-of-pocket costs for people with diabetes. Vital diabetes supplies, including insulin and other supplies that you've heard mentioned today, should be free at the point of delivery at all pharmacies across the country.

We should be using Canada's standing on the international stage to advance non-communicable disease treatment, including that for type 1 and type 2 diabetes. Canada could spearhead a World Health Assembly resolution on diabetes or on insulin access. Global Affairs Canada should fund projects and programs that will improve access to insulin worldwide. This could include incentivizing biosimilar production of insulins and other diabetes medications. Then we should impose price controls on off-patent medicines.

● (0910)

We should be improving transparency within our drug pricing system. Canada should provide the procurement prices of insulins to Health Action International to inform their access study.

Diabetes is a complicated disease. It has disastrous effects if not treated properly. In 2016, 1.6 million deaths were directly caused by diabetes. Without consistent insulin access, no matter how much we invest in prevention strategies, this will not change.

The demand for insulin is only growing. In fact, a study published just yesterday estimates that the number of people living with type 2 diabetes who require insulin will rise to 80 million by 2030. More than a half of these people will face challenges accessing the insulin they need. Comprehensive access to insulin would avert over 260,000 disability-adjusted life years just this year. By 2030, this could increase to 331,000.

Many claim that diabetes is no longer a death sentence thanks to Banting. But 2022 will be the 100th anniversary of the first use of insulin to treat a person with type 1 diabetes, and half the people worldwide do not have access.

I challenge Canada to be a leader to ensure that, by 2022, we can say with confidence that diabetes is no longer a death sentence for anyone around the world.

Thank you.

The Vice-Chair (Ms. Marilyn Gladu): Thank you very much.

Now we're going to begin our first round of questioning. We'll start with my colleague Ms. Sidhu.

You have seven minutes.

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

Thank you all for being here and giving us valuable information.

This is the last meeting of the diabetes study. We have heard a lot.

We know that Canada has a higher rate of type 1 diabetes than the majority of OECD countries. We all heard that for lack of insulin people are dying out there, and there are other problems. We heard that obesity is the number one risk factor for type 2 diabetes in children. In Canada, 95% of children diagnosed with type 2 diabetes are obese. Dr. Mélanie Henderson stated that before the committee.

Michelle, you said that healthy living and access to diabetes education are a factor for the diabetic population. Can you explain that? What is the effect on people in rural areas who are not coming to your clinic and don't get diabetes education? Can you explain how they are impacted by that?

● (0915)

Ms. Michelle Corcoran: I live in rural New Brunswick. To give you a bit of background, when I worked in the diabetes education centre, I thought that, over 15 or 16 years of practising, I had seen most people living in my area with type 2 and type 1 diabetes who needed help. When I moved into family practice, I will say that three-quarters of the people I saw in family practice had never seen a diabetes educator before. They were not accessing care at an education centre, whether it was because of the stigma of going to a hospital, or they didn't want to go there because they were sick, or they couldn't get there because they lived in such rural areas that it took them an hour to get to the education centre, making that inaccessible.

Ms. Sonia Sidhu: This year, diabetes cost health care $27 billion in direct costs. Diabetes 360 is evidence-based and supported by the whole diabetes community, and it saves $36 million.

How do you see that diabetes 360 can help the diabetic population? I want to ask Louise and Michelle. Victor, if you have any comments, you can say them too.

Ms. Louise Kyle: Could you repeat the question?

I'm actually not very familiar with the diabetes 360 strategy.

Ms. Sonia Sidhu: Okay.

Michelle, you could start, then.

Ms. Michelle Corcoran: The diabetes 360 strategy has four different types of pillars: that 90% of Canadians are living well and having access to care that prevents diabetes and preserves wellness; that 90% are aware of their diabetes status; that 90% of people with diabetes are engaged in their care; and the last piece is that 90% of people are engaged in appropriate interventions and have access to care.

Ms. Sonia Sidhu: Do you recognize the needs of Canada's diverse regions, people and populations? Access is a challenge, especially in the winter months when roads and communities are separated. Do you think it works in that area as well?

Ms. Michelle Corcoran: I think it does. It helps provide that access. The program I work within, the case management model and even the extramural program we have in New Brunswick, which can go to people's homes to provide them with education and care, make it more accessible.

Ms. Sonia Sidhu: Thank you.

Across the country, medical cost coverage needs to be standardized when it comes to pumps, lancets and strips. Do you, Victor, think it will help the diabetic population? How do you think the federal government can step into that?

Mr. Victor Lepik: I live in British Columbia. Two years ago, I moved out here from Ontario. There's quite a bit of difference between what's covered in Ontario and what's covered in British Columbia. I was quite surprised at that.

In my own life, for instance, my continuous glucose monitor has been a life-changing device. I have one here on my arm. You can see it. I change it every week. It sends a message to my phone, and I can see right there that my blood sugar is 7.8, and it's steady across.

In the middle of the night, when you are asleep for eight hours, you can't be finger-pricking every hour or whatever. You'd be exhausted. Instead of waking up in a coma, or not waking up, an alarm will go off. I have mine set at 4.5. The alarm will wake me before I fall to a low sugar level and into an unconscious state leading to death. This is especially important if I'm home alone and there's no one there to check on me.

Access to these sorts of devices just changes your life so greatly and really gives you a chance to start living like a normal person. However, the cost of all these things—insulin pumps, insulin, syringes and what have you—is just enormous for so many people. I myself struggle with it, and I'm a person who has a pretty good life here in Canada. For somebody who's on a low income, or for children.... For somebody who has their child in school, the teacher can have an alarm on their phone. The mother can see what the child's glucose level is.

The technology is there, but the coverage across Canada is just not available, if that answers your question.

● (0920)

Ms. Sonia Sidhu: Thank you.

Louise, you mentioned 500 deaths in Ontario alone. One in two people cannot access insulin. Do you think access to education for the family physician can be a useful tool in helping those people get access? I think public education is the main tool for those people. How do you think it can be beneficial to those populations?

Ms. Louise Kyle: It's a good question. I don't devalue education, but it's important to recognize that you can't prevent everything.

Ms. Sonia Sidhu: Also, stigma's out there. How can we reduce that stigma?

Ms. Louise Kyle: Stigma is out there, for sure. I know a lot of people talk about type 1 and type 2 diabetes becoming conflated, and a lot of people with type 1 are upset hearing that a poor diet caused their condition. It's not true that a poor diet really caused anyone's condition. It's a factor that goes into it, but there's a lot that goes into a diagnosis of diabetes. There are lifestyle factors on top of genetics on top of poverty on top of food insecurity. These are all social issues that go to a diagnosis of type 2 diabetes, but stigma is a problem for both conditions, and public education could be a tool there, certainly.

The Vice-Chair (Ms. Marilyn Gladu): All right. That's your time for that question.

We're going now to my colleague Mr. Kmiec.

Mr. Tom Kmiec (Calgary Shepard, CPC): Thank you, Madam Chair.

I have a lot of questions for Victor, especially on cost, but I'll just start with you, Michelle.

Can you tell me about the different types of insulin? I'm not a diabetic, so I don't know, but I've heard people talk about the costs associated with manufacturing. There are also distribution, marketing and all the things that go along with it.

I have spoken to Diabetes Canada, and people keep talking about different insulins, so tell me how many different types there are and, just very quickly, who uses which type.

Ms. Michelle Corcoran: It doesn't matter which type of diabetes you have; all insulins are accessible for both type 1 and type 2.

There are long-acting insulins, short-acting insulins, and rapid-acting insulins. I'll give you some examples of long-acting insulins: Toujeo, Tresiba, Humulin N and Novolin NPH. They are long-acting insulins that give you coverage for an extended period of time, 24 hours or longer.

There are insulins that are short- or rapid-acting that you would take with a meal, based on what you are eating at a meal, the carbohydrate content or other factors, things like how well you are, whether you have exercised, or whether you have done anything else that could cause changes to your blood sugars. Those insulins give you the two different things.

Mr. Tom Kmiec: Can either one be used with a pump?

Ms. Michelle Corcoran: No, the rapid-acting insulins are the only ones that can be used with a pump: Humalog, Apidra and NovoRapid.

Mr. Tom Kmiec: I'm guessing those are the most expensive ones.

Ms. Michelle Corcoran: No, they are not.

Mr. Tom Kmiec: That's interesting.

The next question, then, would be the cost. Victor, you talked a lot about the cost, and so did you, Louise. You're both type 1 diabetics. Are you applicants for the disability tax credit as type 1 diabetics?

Mr. Victor Lepik: Are you directing that to me?

Mr. Tom Kmiec: We could start with you, Victor.

Mr. Victor Lepik: Am I eligible for the disability tax credit? No, I'm not. I applied for it, and I was refused.

Mr. Tom Kmiec: When were you refused?

Mr. Victor Lepik: That was probably within the last three or four months.

Mr. Tom Kmiec: Were you informed that you had a right of appeal?

Mr. Victor Lepik: No, I don't recall that. I'll just ask my wife.

Did they say we had a right of appeal for that tax credit?

A voice: I'm not sure.

Mr. Victor Lepik: We're not sure, but I don't believe so.

Mr. Tom Kmiec: How about you, Louise?

Ms. Louise Kyle: I have never applied for the disability tax credit, partly on principle. I have never felt that my diabetes is a disability. I think that, as long as one has the proper tools to manage it, then it shouldn't be a disability, so I've never applied for it for that reason.

● (0925)

Mr. Tom Kmiec: So if there's a—

Mr. Victor Lepik: Could I just add something? When I asked my family physician to sign the form for this, he said, “We'll give it a go, but I don't think we'll have much luck”.

Mr. Tom Kmiec: Did he explain why?

Mr. Victor Lepik: I vaguely remember it now, but I do remember him saying, when he filled out the form and gave the reasons for it, “Good luck, but I don't think we'll succeed with it”.

Mr. Tom Kmiec: CRA has been en masse refusing type 1 diabetics from having access to the DTC and also not informing people that they have a right of appeal, which is why I asked whether that is what you two have lived through in your experiences.

Mr. Victor Lepik: I understand.

Mr. Tom Kmiec: The University of Calgary has made a calculation that there are about 1.8 million Canadians who could apply for the disability tax credit, but only 40% do, and a lot of it is associated with stigma or not knowing about the DTC. A few of the groups that presented as witnesses before this committee mentioned that they don't promote it to the people with whom they interact.

It's worth for an adult with an average income of $45,000. You're talking about $7,600 a year off your taxes. In their case, that is a substantial amount of money. That's for the pump and lot of the things that go with it.

Thank you, Victor, for providing a lot of the costs associated with monitoring your condition and making sure you are healthy and able to have quality of life and be productive, too, to the level that you want. How much time does it take you in a week to take care of your condition?

Mr. Victor Lepik: One of the factors in the application for the tax credit was how much time it takes. I don't think they calculate into that or allow on that tax credit calculus the time it takes to check your finger prick 10 times a day and to change.... I don't use that system anymore, since I have the glucose monitor, so my time frame is much less in that respect, but the actual time it takes to monitor and look after your diabetes, especially with type 1, is 24 hours a day, because it can never, ever, leave your mind. My phone is always buzzing, and, my God, the thing I used to fear the most before I got a continuous glucose monitor was going to bed at night, because I would be stressed every night going to bed wondering if I was going to wake up or not.

The way they calculate it for the tax credit is actual physical this, that and whatever, but the mental stress is a 24-hours-a-day calculation that doesn't come into the equation whatsoever.

Mr. Tom Kmiec: The juvenile diabetes research foundation and Diabetes Canada are supporting a private member's bill that I've put forward to actually reduce the hours from 14 to 10 and include the dosage time—the time it takes you to calculate your dosage—because that's one of the most stressful things. That's what I'm hearing from you, Victor. I'm guessing the dosage is something that most type 1 diabetics worry about: “Do I have the right amount? Am I feeling well enough at the moment I'm in?” Maybe Michelle can jump in here, with her experience.

Reducing the hours and including the dosage are only one part of it. My private member's bill also proposes to include a lot of people with different types of rare diseases in being eligible for DTC, but they still have to apply for it. It's always saying, “Okay, I'm going to apply for this to get that tax relief.” The CRA is really good at chasing down what I would call vertical taxation equity, which is when a person makes more money. They're very good at making sure they calculate how much you owe. But they're very bad at horizontal tax equity. I would say that someone with type 1 diabetes who is dealing with a $45,000 average income should not be taxed at the same level as a healthy person who doesn't have to manage this condition and live through the stress every single evening.

Michelle, in your experience, how many people take advantage of the DTC? Do they even know about it?

Ms. Michelle Corcoran: Many people don't know about it. Many people talk to their friends about the tax credit. I can't give you exact numbers, but I can find that out for you. Most people talk to their family doctors, and the doctors will say, “Well, you're going to get denied, because you don't spend 14 hours a week looking after your condition.” Maybe they do, but it's not in the inclusive criteria that are listed or outlined in that tax credit.

I will argue that it's not just type 1 diabetes. It's type 2 diabetes, which can be equally complicated for those who are taking insulin and medications and have other co-morbidities and other chronic diseases. That comes into play when they're managing things like their chronic kidney disease risk or they're managing their blood sugars. They're managing all of those things in their life as well—every day. I'm not sure that even the 10 hours.... Certainly, reducing it from 14 to 10 would make a considerable difference. Refining the criteria for that would help many people get access to that.

I would agree with Louise as well. It's not a disability, but it would certainly help with living with a chronic disease.

● (0930)

The Vice-Chair (Ms. Marilyn Gladu): Very good.

Now we're going to Mr. Davies for seven minutes.

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

Thank you to all the witnesses for being here.

I think it is so profoundly important that we conclude our study on diabetes by hearing from patients and people who deal on the front lines with patients. We've heard a lot of academic and interesting policy information on diabetes, but you're bringing home to this committee in the most powerful way possible what we need to hear as policy-makers to address this chronic, widespread and, frankly, growing problem.

Ms. Kyle, I want to start with you and pick up on something I heard you say. You don't view diabetes as a disability. We know that individuals with type 1 and type 2 diabetes can face diabetes-related stigma. I'm curious what your comments might be on that, because I think that may have emerged from your very clear statement.

Ms. Louise Kyle: Yes, I think that plays a role, certainly. For me, a big frustration is seeing that we don't have consistent coverage for all the tools that someone with type 1 or type 2 diabetes needs in order to live a healthy and happy life with their condition. Instead, we are put through the burden of having to apply for a tax credit. It's a lot of paperwork. I've talked to my physicians and my educators about it. It's a huge burden to put on someone who is already dealing with something 24 hours a day—to be put through this sort of administrative process of coming up with 14 hours a week of things that don't even scratch the surface of what someone with diabetes has to deal with.

Victor, I think you would probably feel the same way. There are a lot of things I do to manage my condition that don't fall into that. I exercise; I make food choices when I'm grocery shopping; I make food choices when I'm out purchasing lunch or when I'm making food at home. Those are things that don't go into this basket.

For me, I guess it is a bit of a principle thing. It's also a burden. It puts a burden on people who are dealing with a chronic condition 24 hours a day.

Mr. Don Davies: I want to follow up. If I heard you correctly, you said that the price of insulin has tripled between 2003 and 2013. Do you know why?

Ms. Louise Kyle: It is a complicated problem. In Canada, we don't have the same problem that other countries are facing. We have other issues with access, but our insulin prices have not seen the same kind of skyrocketing increases that the United States, for example, or other places around the world have seen.

To be truthful, we don't completely know why this is happening. It is a multi-faceted issue. We are lacking a lot of transparency in terms of the way things are priced, which is a major issue. We don't know where along the supply chain these price increases are always happening.

Mr. Don Davies: Ms. Corcoran, do you know why insulin prices are going up?

Ms. Michelle Corcoran: I would hazard a guess, and this is a professional guess. Research costs do contribute to some of these things. As industry sets their points of pricing, I know that the costs do vary from one company to another. I did some analysis of what it would cost for 50 units of one type of insulin, which could be $40 per month in comparison to $169 a month. The price is considerably variable.

Yes, there is technology that goes into developing these resources, these medications and insulin; however, in terms of a disability tax credit, I think access is the bigger issue. We should be providing this as a basic necessity of life.

Mr. Don Davies: On the disability tax credit, I have many constituents who have conditions. When their physician fills out the paperwork saying that they have the condition, they qualify for the disability tax credit and other programs—not because of the amount of hours they spend each week dealing with it, but simply because they have the condition. It strikes me that this is how we should be treating diabetes.

If you have type 1 or type 2 diabetes, just on its own, leaving aside the stigma of the word “disability”, the point is, should there be some sort of tax relief issued to recognize the extra burdens or barriers of dealing with this simply because you have the condition, as opposed to trying to measure how many arbitrary minutes or hours a day you deal with it? Would that not be a wiser policy approach to this?

● (0935)

Ms. Michelle Corcoran: It would be brilliant.

Mr. Don Davies: Ms. Kyle, go ahead.

Ms. Louise Kyle: Yes, I agree. Also, I think a wise policy approach is to make sure, in the first place, that everyone has access to the tools they need that make this condition easier to manage.

Mr. Don Davies: Mr. Lepik, I want to turn to you. That was very powerful testimony. Thank you for detailing with such precision what your monthly expenses are.

By my figures, the blood glucose monitor, the insulin pump and the insulin itself add up to—if you add in the $7,000 replacement every five years—over $7,000 a year. That's $900 a year for insulin and $5,600 annually, I think, for the blood glucose monitor pump. Maybe I'm getting them mixed up, but it's certainly $6,000 or $7,000 a year. Do you know people with type 1 diabetes who are going without their medication, monitoring or any other tools or resources because they can't afford it?

I think we have lost Mr. Lepik.

While we're waiting, I'm going to come back to this. I think we have a very clear picture here. We have provincial variation. We have patients who are rationing or going without what they need to manage what is a life-threatening if not potentially fatal disease. We have the issue of more expensive complications down the road if this is left untreated, whether that's amputation, blindness, kidney failure or stroke down the road, which obviously costs the system much more money.

Would the answer not be that we should be moving to a universal public pharmacare system whereby patients get their necessary medication provided through our public system, just like any other medically necessary service? Would that be your position, Ms. Corcoran?

Ms. Michelle Corcoran: That would be my position.

Mr. Don Davies: How about you, Ms. Kyle?

Ms. Louise Kyle: Yes. We are the only country in the world that has a universal health care system that doesn't include pharmacare. We absolutely need to move towards that.

Mr. Don Davies: I'm not sure, Madam Chair, how I'm doing for time or with Mr. Lepik.

The Vice-Chair (Ms. Marilyn Gladu): You have one more minute.

Mr. Don Davies: I would like like to direct some questions to Mr. Lepik.

The Vice-Chair (Ms. Marilyn Gladu): We'll go to the next round, but we will come back to you for the one minute you are owed.

Mr. Don Davies: Thank you.

The Vice-Chair (Ms. Marilyn Gladu): Let's go to Monsieur Ayoub.

Mr. Ramez Ayoub (Thérèse-De Blainville, Lib.): Madam Chair, I would suggest that we wait for Mr. Lepik, because I will have some questions for him also. We could wait for him if it wouldn't take too long.

The Vice-Chair (Ms. Marilyn Gladu): We will suspend until we get Victor back.

● (0935)

(Pause)

● (0940)

The Vice-Chair (Ms. Marilyn Gladu): We're back now. We have Victor with us by teleconference.

We will pick it up with Mr. Davies for his remaining minute.

You had a question for Victor.

Mr. Don Davies: Hello, Victor. I don't know how much of my question you heard before, but I was really struck by your itemization of the costs. If I added them up correctly, it basically comes to an annual cost of about $7,000 for you to manage.

Mr. Victor Lepik: Yes. The insulin pump is $7,000 every five years, but the cost of managing the diabetes is $6,565.

● (0945)

Mr. Don Davies: Right. I was calculating if you had to set aside $1,000 a year to replace your monitor.

I have two questions, and I will turn it over to you.

First, do you know other people who are not able to afford the medication or tools they need to manage their diabetes?

Second, do you think it's time we moved to a universal public pharmacare system so that every person with diabetes would have access to the medication and tools they need to manage their resources through our public system?

Mr. Victor Lepik: I have been out in B.C. for only two years now. Even when I lived in Toronto, a couple of guys I worked with had type I diabetes, but we had a pretty good drug program there through our union, so the cost wasn't really a factor for us.

Now that I'm retired and living out in B.C., it has just become so obvious that we need a universal health care program, not just for me but for everyone, and especially for diabetics. Listening to the other people speak, it's just so obvious.

That would be my answer to that question.

The Vice-Chair (Ms. Marilyn Gladu): Very good.

Mr. Don Davies: Thank you.

[*Translation*]

The Vice-Chair (Ms. Marilyn Gladu): Mr. Ayoub, you have the floor for seven minutes.

Mr. Ramez Ayoub: Thank you for joining us again, Mr. Lepik.

I want to continue along the same lines as my colleague, Mr. Davies. We're talking about universal drug coverage across the country, but we're noticing differences between the provinces. You've travelled, and you've even moved to British Columbia in the past two years.

In your opinion, what barriers must a government overcome to provide universal drug coverage across the country and to ensure consistent coverage?

[*English*]

Mr. Victor Lepik: If I understand the question, to have universal health care equal throughout the country.... We're the nation of Canada. Why should something be available for one person's illness, living in Toronto, and not be available for somebody living in Vancouver or New Brunswick? It just doesn't make sense.

[*Translation*]

Mr. Ramez Ayoub: I understand the philosophical aspect of it. I don't want to put you on the spot or focus on your specific case. However, we're talking about a situation that affects the entire country. There are various types of private or public coverage. Some provinces don't have any coverage at all.

Would you be willing to pay more for people who don't have access to any coverage? Nothing is free in this world. In the end, someone always pays.

Was this an issue for you when you lived in Toronto? It seems that you had good coverage at that time. Is that correct?

[*English*]

Mr. Victor Lepik: I had coverage with my employer, so that made a huge difference for me. My unionized health care program filled in all the gaps. I imagine that somebody in Toronto or elsewhere in Ontario who didn't have that would be enormously out of pocket, as much as somebody in Vancouver.

When you look at the health improvements from being able to manage diabetes, I'm sure that the program would be much more than self-funding.

[*Translation*]

Mr. Ramez Ayoub: I agree that we should draw attention to the consequences of failing to treat either type 1 or type 2 diabetes and emphasize that this will generate health care costs in the future.

My next question is for Ms. Corcoran or Ms. Kyle.

We studied the issue of drug coverage recently, and recommendations were made to the government. In your view, what major barriers must a government in power—in this case the current government—overcome if it wants to establish national drug coverage?

[*English*]

Ms. Michelle Corcoran: One thing that I think could be a barrier is the access to pharmacies and the costs at the pharmacy level, because that is not equal. Even within my own province, you can shop from one pharmacy to another and you can see up to 30% difference in cost. A universal care system may be able to provide equitable costing. That barrier may be an issue that you come across, if that answers your question.

[*Translation*]

Mr. Ramez Ayoub: Ms. Kyle, what's your opinion?

[*English*]

Ms. Louise Kyle: Can I just ask for some clarification? Are you talking about logistically or currently, what are some barriers province to province?

● (0950)

Mr. Ramez Ayoub: From my perspective, it's mainly over money and the equality of chance to access medications across Canada.

Ms. Louise Kyle: When you're looking at a national program, you're talking about bulk purchasing, which, to me, makes sense. You negotiate lower prices across the board, and perhaps you don't run into the same issues with different prices from pharmacy to pharmacy. Also, we should be looking at the fact that we currently have a patchwork of systems that provide coverage for different pieces of diabetes care.

I moved from B.C. to Ontario to study. When I moved here, I was shocked, to be frank, at the systems in Ontario, at the amount of paperwork and the different programs that are available for coverage. We have the Trillium drug program, which covers diabetes test strips and insulin. Then we have the assistive devices program, which covers insulin pumps and pump supplies. Those are different systems, so you have to apply for each of them individually.

This is, again, to the point about putting a burden on people who are already dealing with a chronic condition. The amount of time that I spent on the phone and filling out paperwork to deal with these programs was.... These patchwork systems need to come together and become more cohesive.

[*Translation*]

Mr. Ramez Ayoub: The answer to my last question may already be obvious, but I'll ask it anyway.

In your view, as part of a possible coverage strategy, should cases of type 1 diabetes be treated differently from cases of type 2 diabetes?

[*English*]

Ms. Michelle Corcoran: No.

[*Translation*]

Mr. Ramez Ayoub: I simply needed to hear the answer.

[*English*]

Ms. Michelle Corcoran: They should all be equal.

Mr. Ramez Ayoub: The answer is pretty obvious, but I just need the answer.

Madam Kyle says no. How about you, Victor?

Mr. Victor Lepik: No.

[*Translation*]

Mr. Ramez Ayoub: Thank you.

[*English*]

The Vice-Chair (Ms. Marilyn Gladu): Now we go to Mr. Lobb for five minutes.

Mr. Ben Lobb (Huron—Bruce, CPC): I'm going to turn my time over to Mr. Kmiec.

Thank you.

Mr. Tom Kmiec: Let's talk more about taxes. The regular committee that I sit on is the finance committee, but this is a particular interest of mine. One of the problems that I've heard is that after your diagnosis of diabetes, you have these ancillary costs. You might have access to your insulin, but then you don't have access to the strips that you need or the pump that you need.

All three of my living kids have a chronic kidney condition. Eventually it will result in their losing their kidneys and requiring transplants. In their cases, when I looked into the cost, they will have the same situation. They will need all the stuff that comes with.... The public health care system will provide them, at end-stage renal disease, with dialysis, but everything that comes with that—the tubing and everything else—you have to pay for, so the Kidney Foundation does that. It's a lot of the same costs that I find here, and it changes from province to province. I think only Canadians who move to different provinces get to fully experience how different the health care system is.

I grew up in Quebec, moved to Ontario for work, and then moved out to Alberta for love. I represent Calgary. Every single system is totally different. What is it about them? Is it that when you move you should be warned ahead of time? Could it be done through the foundations? Could the foundations tell you the differences that will happen? There are costs associated with it, too.

That's why I like the DTC, because that's where the federal government, through the tax system, can get involved and try to level the playing field as best it can so that there's horizontal tax equity, at least. Everybody presumably pays some taxes at some point, and the income tax system is a unique way to try to get to that goal.

Michelle, since you're with the health network, how much information on the tax portion of it do you give to your patients, clinicians and others who are accessing the system?

Ms. Michelle Corcoran: Very little, only because I know very little. I tell them to find out, to call the person who does their taxes or call the 1-800 number to find out more about it. It would be great if clinicians had more information on how to direct people, but we don't have that readily accessible unless we dig for it.

The only thing I can tell people who are moving from one place to another is that, before they move, they'd better call and find out what coverage they're going to get when they get there.

Mr. Tom Kmiec: They should call ahead of time. So, they have to do their homework before they start moving around.

Ms. Michelle Corcoran: A lot of people perhaps don't have the capacity to do that, nor should they have to.

Mr. Tom Kmiec: It's not a question for Victor, but Victor mentioned that he was working and had a union before. Part of unions' collective bargaining agreements is that they negotiate access to a private insurer. Typically, public sector workers and members of large unions in the private sector have access to health insurance, which is also a way of gaining that equity across Canada. As you move across the country, your union will still cover you, and the health coverage that you receive will come with you to whatever province you go to.

Is there a solution for diabetics there?

● (0955)

Ms. Louise Kyle: Why should I be forced to make a decision about where I work in order to have the coverage I need? I should be able to start my own business. I should be able to choose a job that doesn't come with benefits and not have to worry about what coverage I have. We should have a national pharmacare program that covers all these supplies. It's a no-brainer to me.

Ms. Michelle Corcoran: We shouldn't have to make people choose between working and not working. Some people are not able to work and, therefore, have no access. A large proportion of people living in New Brunswick, upwards of 40% or so, have either the public plan or no plan at all, not because they haven't tried. They just don't have that access to coverage, and they can't afford it, because it's inequitable. They can't get access because they have a pre-existing condition, so it will cost them too much.

Mr. Tom Kmiec: Is it that they don't have access because they're not eligible, or is it that they're eligible but don't have access because they can't afford it or don't know about it?

Ms. Michelle Corcoran: All of them.

Mr. Tom Kmiec: So when you look at the statistics, and I'm not sure who mentioned it here, the 30% or 36% of Canadians who don't have access for costing reasons, that's based on the survey. If you look at it, it's an impression.... It's not just they themselves, but it's others, members in their direct circle. That's the impression that you may have, but if you look at the numbers themselves, about 1.8% of Canadians, mostly in Newfoundland and Ontario.... This is more broadly, beyond just persons with diabetes. These are people who were not eligible for anything. They've kind of fallen through all the different cracks of the different programs, and they see this very often in the tax system as well. People will fall through different cracks. I think type 1 diabetics should have access to the DTC.

You mentioned your support for national pharmacare, but I want to take it back to the tax system itself and my private member's bill.

The Vice-Chair (Ms. Marilyn Gladu): I'm sorry, but that's your time.

We're going now to Dr. Eyolfson for five minutes.

Mr. Doug Eyolfson (Charleswood—St. James—Assiniboia—Headingley, Lib.): Thank you, Madam Chair.

Thank you all for coming.

Ms. Kyle, that was very refreshing, what you said about recognizing coming from privilege and not having to struggle in the way many people do. I'm in a very similar boat. I was raised by a lawyer. I'm a physician married to another physician. I will never have trouble making ends meet if I have a catastrophic diagnosis of any sort. Whatever else I have to worry about, how I pay for it is never going to be an issue.

However, for 20 years I was an emergency doctor, and for the last eight years it was in an inner-city hospital. If you spend time in a hospital like that, you understand.... I understand how truly privileged I am when some of my patients literally didn't have homes, never mind that they couldn't afford medications.

One of the things I've been passionate about is national pharmacare. Again, I know we're talking about diabetes, but this folds into it because it's such a major disease.

One of the things concerning me of late is the amount of very organized push-back we're getting from certain interests in the community. At another meeting, a representative of Johnson & Johnson claimed that our strategy to decrease drug prices is going to make Canada a non-competitive environment for the development of new medications.

There's some information out there claiming that if we decrease the price of our medications, it's going to inhibit development of new drugs, and this will put the lives of Canadians at risk. Could you respond to that statement? I'll ask all three of you in turn.

Ms. Kyle, go ahead.

Ms. Louise Kyle: Yes, I would be happy to respond to that statement.

The last time I was here, we were talking about federally funded health research. Some of you may remember that we talked about different models of incentivizing research and making sure that the products of research are available to all who need them at the end of the day.

Part of the rhetoric you talked about is that it costs so much to bring a new drug to the market that we have to recoup those costs, and if we don't invest and we don't sell these drugs for an arm and a leg, innovation is going to die. We know that's not true. We know there are models that are working and producing drugs on a different model from the one we're looking at right now. We know a lot of drugs are publicly funded, so that rhetoric is inaccurate and false.

It's not surprising to me that you're getting that organized push-back.

● (1000)

Mr. Doug Eyolfson: Thank you.

Ms. Corcoran, go ahead.

Ms. Michelle Corcoran: I would agree with Louise's comments. As you say, many research studies are publicly funded through grants and monies, for which they apply, available from the Public Health Agency of Canada and so on. They have money that is helping them do the research they are doing, so I question that comment.

Mr. Doug Eyolfson: Thank you.

It's easy to forget about you, Mr. Lepik, because we can't see you right now, but do you have anything to add to that?

Mr. Victor Lepik: That's all right.

In regard to the push-back from the drug companies, I think that's a natural thing on the playing field. As the national health care system goes, they should really take a look at a country like New Zealand. I lived in New Zealand for many years. What New Zealand pays for drugs is so much less than what we pay in Canada, because they negotiate as a country. They don't have 10 different provinces and regions negotiating separately.

With a national pharmacare system, we have a pretty good population in this country, and I think the push-back by the drug companies would be insignificant. You know, everybody wants to sell something. If we had a national system, the bargaining power would be huge.

Mr. Doug Eyolfson: Thank you very much.

I have only 10 seconds left. Thank you so much to everyone for coming.

The Vice-Chair (Ms. Marilyn Gladu): Very good.

Now we go back to my colleague Mr. Kmiec for five minutes.

Mr. Tom Kmiec: Thank you, Madam Chair. You're always so fair.

Is any insulin not covered by a public drug insurer?

Ms. Michelle Corcoran: Yes. There are some long-acting insulins that are not covered by publicly funded plans. There are concentrated insulins, as well as mealtime or rapid insulins, that are not covered by publicly funded plans.

I will add that most times we can get coverage for some type of insulin, but it's difficult for people to give insulin without the pen needles that go with it. They may have to be paid for up front, or they may not be covered at all.

Mr. Tom Kmiec: Why are those insulins not covered by the public drug insurers?

Ms. Michelle Corcoran: I assume it's related to the cost to the province. In terms of our negotiations, they negotiate a cost of availability. In all honesty, that's the only thing I can think of, that it's related to cost.

Mr. Tom Kmiec: So the public drug insurers chose not to cover that particular type because of the cost associated with it. But they are approved for use in Canada. Is that right?

Ms. Michelle Corcoran: Absolutely.

Mr. Tom Kmiec: So insulin generally is approved, but specific types of it, manufactured in different ways, fast- or slow-acting, are not covered, even by the drug insurer.

Do you know if private insurers cover them?

Ms. Michelle Corcoran: Private insurance has much more liberal coverage of those types of insulin. Depending on the plan—a group plan versus your own personal private plan—there will be much better coverage. Usually we can get it if they need it. If they have a private plan, it's covered.

Mr. Tom Kmiec: I'd like to go back to the 14 to 10 hours. It's a lifetime condition that you have to deal with. Just as a comparison, based on StatsCan and other publicly available information, the average Canadian spends about 14 hours a week on their cellphone. That's what we're talking about here. The average Canadian spends 16 hours a week playing video games. We all know people who spend way too much time doing something that is not healthy for them.

In comparison, diabetics are trying to stay productive and have a quality of life they enjoy. When we make that comparison, going from 14 to 10 hours, as I'm proposing, including the time to calculate and the stress relief that comes with it, how much of that do you think would help diabetics?

Ms. Louise Kyle: I think I've made my thoughts fairly clear on this topic. I don't know if I need to belabour that point.

● (1005)

Ms. Michelle Corcoran: I would agree that whatever we can do for people living with diabetes to enhance the criteria to meet that 10 hours would give them the benefit of the credit.

The Vice-Chair (Ms. Marilyn Gladu): I'm really sorry, but that concludes our time for testimony. We have a vote to get to.

Thank you so much for coming. Please excuse us while we do our parliamentary duty.

The meeting is adjourned.

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