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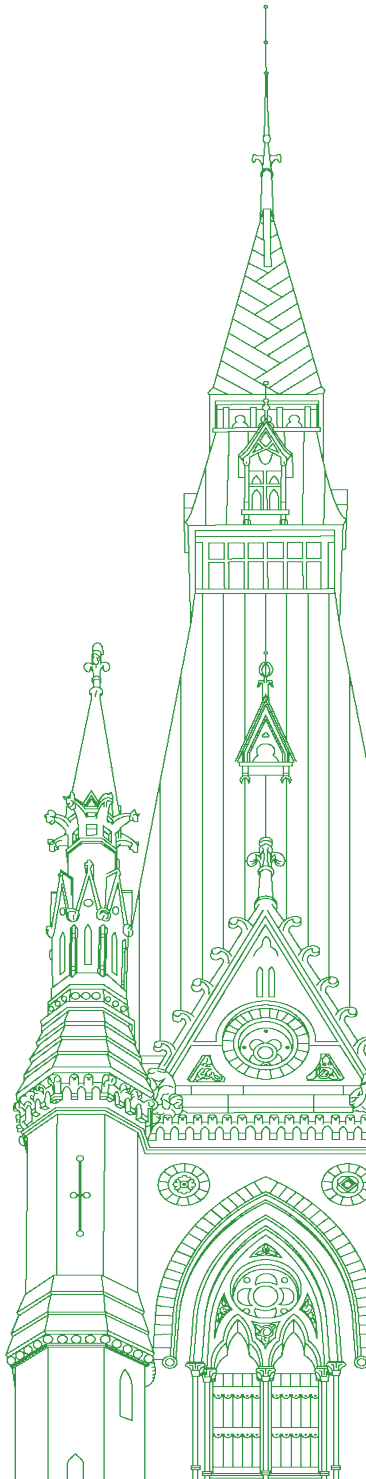

Chair: Mr. Ron McKinnon

Standing Committee on Health

Thursday, April 9, 2020

● (1110)

[*English*]

The Chair (Mr. Ron McKinnon (Coquitlam—Port Coquitlam, Lib.)): I call this meeting to order. I'd like to welcome you all to meeting number 11 of the House of Commons Standing Committee on Health. We are meeting today entirely virtually. Pursuant to the order of reference of Tuesday, March 24, we are meeting for the purpose of receiving evidence concerning matters related to the government's response to the COVID-19 pandemic.

Today's meeting is taking place entirely by video conference and the proceedings will be made available via the House of Commons website. Just so you are aware, the webcast will always show the person speaking rather than the entirety of the committee. I'd also like to note that this is historic. It is the very first entirely virtual meeting of any House of Commons committee. I'd like to thank the House staff, the technicians, and everyone who has worked so hard over this past couple of weeks to bring this together. I know you're on tenterhooks back there and are hoping everything works well. From a long career in IT, with my first computer experience writing Fortran on punch cards, I know that we've come a long way, and I think we'll be fine. I give you all kudos for what you've done in such short order.

I'll carry on with some housekeeping first. To facilitate the work of our interpreters and to ensure an orderly meeting, I would like to outline a few rules to follow. First, interpretation in this video conference will work very much as it does in a regular committee meeting. You have a choice at the bottom of your screen of either floor English or French. Before speaking, please wait until I recognize you by name. When you are ready to speak, you can either click on the microphone icon to activate your mike, or you can hold down the space bar while you are speaking, and when you release the bar your mike will mute itself again just like a walkie-talkie. That may be an old-time reference; I don't know.

All comments by members and witnesses should be addressed to the chair. Should you need to request the floor outside of your designated time for questions, you should activate your mike and state that you have a point of order. If you wish to intervene on a point of order that has been raised by another member, you should use the "raise hand" function. This will signal to the chair your interest in speaking. In order to do so, you should click on the participants at the bottom of the screen, and when the screen pops up, next to your name you can click "raise hand".

When speaking, speak slowly and clearly, and when not speaking, you should mute your mike. We of course encourage strongly the use of headsets. Should any technical challenges arise, for example, in relation to interpretation, or if you are accidentally disconnected, please advise the chair or the clerk immediately and the technical team will work to resolve these problems. Please note that we may need to suspend at times to ensure that all members are able to participate fully.

Before we get started, can everyone click their screen in 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 grid view, and it will ensure that all video participants can see one another. During this meeting we will follow the same rules that usually apply to opening statements and the questioning of witnesses during our regular meetings. Each witness will have 10 minutes for an opening statement followed by the usual rounds of questions from members.

I would now like to welcome our witnesses. We have, as an individual, the honourable David Dingwall, president and vice-chancellor of Cape Breton University; from the Canadian Public Health Association, Ian Culbert, executive director; from the Fédération interprofessionnelle de la santé du Québec, Linda Lapointe, vice-president; and from the William Osler Health System, Dr. Naveed Mohammad, executive vice-president, quality, medical and academic affairs. We will start with Mr. Dingwall.

Mr. Dingwall, please go ahead. You have 10 minutes.

● (1115)

Hon. David Dingwall (President and Vice-Chancellor, Cape Breton University, As an Individual): Thank you, Mr. Chair, and thank you, members. With your permission, Mr. Chairman, I would like to have my written text attached to the proceedings under written proceedings, and thereafter I'd like to make seven brief comments as part of my opening statement.

The Chair: Go ahead with your statement. We can get the written text at some point. We don't have it available at the moment, and of course it will have to be translated into both languages before we can distribute it to the committee. If you'd like to go ahead with your other remarks, you have 10 minutes.

Hon. David Dingwall: Thank you very much, Mr. Chairman.

I did circulate my written text to the committee yesterday, as requested. However, I have just seven fairly quick points.

One is to congratulate members of this particular standing committee for the role you're playing with regard to reviewing some of the aspects of our health care system. As you all know, the issues that relate to Health Canada and the various health-related agencies, particularly the Public Health Agency of Canada, are quite important in view of the situation that we find ourselves in now.

I would hope that when the pandemic comes to a close, or its substantial numbers go down, that the parliamentary committee will continue to review what has transpired to try to ascertain best practices not only in Canada but indeed in other jurisdictions throughout the world so that the appropriate protocols can be put in place and, where necessary, updated from time to time.

The second point I raise is on the issue of governance. I think the Public Health Agency of Canada, as I as a former minister of health understand it, is indeed part of a unique system. It's a federal entity, but it works very closely with provincial entities and with the jurisdiction split between the federal and the provincial governments. It's important for those two entities to share good quality information and to have a frank dialogue among the members.

From what I can see, Mr. Chairman, I think that is taking place as we now speak. The federal agency is regularly meeting with provincial agencies—virtually, that is. They share information, different analyses, and different models. I think this is good for our country and it's good for our health care system.

In my small province, Nova Scotia, I think the system is working well. Chief Medical Officer Dr. Strang issued a health order on or about March 13, followed thereafter by a state of emergency being declared by the province. But they meet regularly with their federal counterparts to exchange information, analysis and best practices.

From a university perspective, the Council of Nova Scotia University Presidents has a working group that meets every day. We are in constant communication with the chief medical officer and his professional staff to share information and to try to address some challenges, particularly for post-secondary, and that has worked well.

The politicians and the political leaders of the three political parties have been very professional, very non-partisan, and very helpful, and I believe the premier, the leader of the opposition and the leader of the NDP are deserving of public praise for the way in which they have handled themselves.

Also, at the senior level in terms of the governance model, or the bureaucracy, we have the deputy minister of health, and of course we have the deputy minister of labour and advanced education, Duff Montgomerie, who has played a particularly helpful role for post-secondary institutions, for universities, in our province.

The third point, which may be perceived by some as provincial in focus, does have a national aspect and that is the need for the governments of Canada and Nova Scotia to address the fact that a lot of international students across the country do not have access to our provincial health care systems. Many international students have to pay a private sector provider to assist them with their health care needs. These can range anywhere between $1,300 and $1,700, and they get limited access to our health care system.

● (1120)

University presidents, student union leaders and many others have called for provincial governments with the assistance—moral persuasion if you will—of the Government of Canada to ensure that all of our international students have ready access to health care in our respective provinces.

The fourth point is that, as I now speak, there is real anxiety and fear among students, family members and friends. There is actually grief, and of course there are mental health challenges. We see those in a variety of ways. They're manifested in such questions as, “What am I going to do to pay my rent?”; “What am I going to do for my food?”; “What can I do about my tuition?”; “I don't have any summer job to go to now”; and if there are summer jobs, they will be limited to those in a few sectors. So there's real anxiety and fear about their future, and universities, I am sure, across the country are attempting as well as they can to co-operate and to address those. I don't want to miss this opportunity to note that the concerns they have are real, and I think Universities Canada has made a submission to the Government of Canada for what it calls “a better future” education investment grants, which would provide, across the country, about $500 million to assist these Canadian and international students in their time of need, in their time of anxiety. I would hope that the committee, in its wisdom, would do this.

Point number five is support for remote Internet access. Some may say that this is a health care committee, not an IT committee. But you need to know that there are real challenges to our health care system to not having good-quality remote Internet access.

If I may, I'll give you a small example. All of our Cape Breton University Bachelor of Science in Nursing students have continued their studies remotely since face-to-face courses were suspended on March 16. As students returned to their homes across Nova Scotia and began remote online learning, many have experienced Internet connectivity difficulties since they live in rural areas across the province. For instance, 77 students had started their nursing-practice placements with the Nova Scotia Health Authority in Cape Breton, and they had completed only two days of their placement when the health authority suspended all student health learners from practice settings across Nova Scotia.

Thinking innovatively, we at the university, and in the nursing program in particular, sought an alternative learning model for students who had to leave their hospital placements. We purchased a virtual sim. A VS uses online learning modules that are interactive and require the students to apply their knowledge and prioritize the care of the patient. There are multiple case scenarios, and the student is provided with feedback on their decisions at the end of the scenario. The student can repeat the scenario multiple times, receiving feedback and a mark each time. The problem is that the virtual sim modules require a strong Internet connection to access and work through each patient scenario. These young nurses are now being asked to join the health care system as new providers in order to support our existing cohort. But a lack of good-quality Internet access is making it very difficult, if not next to impossible, for them to take part and to make a contribution at this difficult time.

● (1125)

The sixth point I would like to raise with committee members is strategic infrastructure investments. A program that could be modelled on the post-secondary institutions strategic investment fund would stimulate the economy and add to our health care science.

Each university is different, but we here at Cape Breton University in rural Nova Scotia want facilities for a collaborative research laboratory, public health applied learning clusters and community engagement hubs, which provide real benefits for the community and the students. Universities Canada, after extensive consultations with all post-secondary institutions across the country, had made that submission to the Government of Canada as well.

Finally, my seventh point is the following. Canada needs a rapid testing module that can be scaled accordingly. Let me be a bit parochial since I represent a university. There are currently 634 students studying in our bachelor of health sciences program in public health, which is one of six programs in Canada accredited by the Canadian Institute of Public Health Inspectors. Students who graduate from this program are eligible to pursue practicum and certification to be environmental or public health officers in Canada, providing a talent pool that is trained and ready to meet workforce demand for rapid testing.

Additionally, Cape Breton University welcomes students from well over 50 countries to study at our institution. Many of these students arrive in Canada with international credentials, particularly in the health professions. A bridging program would assist the country, let alone the small communities, in meeting its health care staffing shortages, a challenge that is significant in Canada, but particularly in Atlantic Canada. At present, there are more than 150 internationally trained health care professionals studying at Cape Breton University—doctors, nurses, pharmacists, physiotherapists, and the list goes on—but a model needs to be set in motion for rapid testing. If we have the vaccine, whatever it takes in terms of years, I think testing will be here with us for quite some time, and we need to develop that capacity in order to give comfort to the country at large, to the health care professionals and to our first responders in terms of what we may do to address those kinds of things.

That is my submission, Mr. Chairman.

● (1130)

The Chair: Thank you, Mr. Dingwall.

We'll now go to our next witness, the Canadian Public Health Association.

Mr. Culbert, please go ahead for 10 minutes.

Mr. Ian Culbert (Executive Director, Canadian Public Health Association): Good morning, Mr. Chair and committee members. Thank you for the invitation to present to you today.

First, I want to acknowledge that I am joining today's meeting from the ancestral and unceded territory of the Algonquin Anishinabe peoples. The Canadian Public Health Association is committed to working with first nations, Inuit and Métis people and their governments in realizing meaningful truth and reconciliation.

I will begin by expressing our support and gratitude for the efforts of everyone involved in the Canadian response to COVID-19. Throughout this extraordinary situation, people from all walks of life in this country are showing their true grit.

With my time today, I will tell you about how our system has learned from previous responses and how we need to continue to adjust and improve.

This country needs a public health system that can provide a national perspective while supporting the provinces, territories and indigenous peoples with the skills, tools and equipment necessary to meet the demands of this and future disaster or pandemic responses while reducing the burden on the acute care system.

Public health is defined as “the art and science of preventing disease, prolonging life and promoting health through the organized efforts of society”. The core functions of public health systems in Canada include health protection, health surveillance, disease and injury prevention, population health assessment, health promotion and, of course, emergency preparedness and response.

I remind you of that today, because this pandemic has been a classic case study of that definition. From the start of this year, the Public Health Agency of Canada has been monitoring this outbreak, following the evidence and the growing body of knowledge about this novel coronavirus. The agency and public health officials across the country have been following, and contributing to, the science.

As COVID-19 continued to spread around the world, pandemic preparedness plans developed after SARS and H1N1 were refreshed, and the Canadian response began to be formulated. That response is guided by a set of principles embodied in existing pandemic preparedness plans and includes a number of commitments. First, all levels of government and stakeholders are collaborating to produce an effective and coordinated response. Second, decisions are based on the best available evidence. Third, the response to the pandemic is proportionate to the level of the threat at any given point in time. Finally, plans and actions are flexible and tailored to the situation, and evolve as new information becomes available.

Where the “art” of public health comes into play is in the decision-making process for interventions. While it may be tempting to look back and suggest that Canada should have closed its borders and implemented physical distancing measures as soon as the first travel-acquired case was identified in our country, the reality is that there would have been very little public support for those moves at that time. Low public support would have resulted in minimal adherence and a diminishment of support for any future interventions.

For the past few weeks, the message I have been repeating from the Canadian Public Health Association is that how we respond as individuals may be the single most important factor in how well we fare as a country. For both better and worse, this is playing out as we expected. Those who are heeding the advice of public health officials are helping to flatten the curve, while those who do not appreciate the seriousness of this situation continue to endanger others through their behaviour.

The intersection of public health guidance, civil liberties and human behaviour is always a tricky one to navigate. While there has been criticism of the incremental or proportionate approach adopted by public health officials and governments across this country, we believe that this was the most prudent way to navigate this intersection.

● (1135)

Public health officials and politicians alike began with requests for behaviour modification. These requests became appeals, which later became requirements and eventually enforceable requirements with penalties for non-compliance. At each juncture, the request for behaviour modification, be it frequent handwashing or physical distancing, was accompanied by the evidence that predicated that request. This process was and continues to be a perfect example of health promotion in action or the process of enabling people to increase control over and improve their health.

Public health officials across the country understand that if we want our population to change their behaviours, we cannot simply tell them to change. We have to empower them to make the decision for themselves. In times of a public health crisis, health promotion efforts can be hampered by the lack of resources or the time to get people on board and change their behaviours. It is in this situation that enforcement and penalties are reluctantly put into place to safeguard well-being.

It is important to note that there are many in our country who are not in a position to take control of their health or change their behaviours. They may live in crowded housing conditions, are homeless or living in shelters, or they do not have access to clean water. The negative impact of these pervasive social determinants of health are intensified during a public health emergency.

Of course, the Canadian response to COVID-19 to date has amplified some of the perpetual challenges of our federated model and the delegation of authority for health to the provinces and territories. This delegation of authority is a double-edged sword in that it allows provincial and territorial officials to develop responses that are honed to the specific circumstances of their jurisdictions. But in the case of a national public health emergency, it can create the perception that different jurisdictions are taking dissimilar approaches to the outbreak and the perception that there is a lack of coordination. Any differences in public health messaging can be seized upon by the public or the media as signs of disharmony, or worse, incompetence among public health officials.

COVID-19 has once again revealed the lack of surge capacity within our public health systems, mental health support systems, acute care systems and especially in the services available to many if not all indigenous communities. The requirements for testing and contact tracing have pushed public health personnel to the limit, even though all available resources have been redirected toward the COVID-19 response. This redirection of resources will inevitably have repercussions as other core public health functions will be set aside during this crisis.

The lack of surge capacity is directly linked to the chronic underfunding of public health services in Canada. While this issue is not currently within the purview of the federal government to rectify, we are encouraging the development of a legal, regulatory and financial framework in consultation with provincial, territorial and indigenous governments that would provide the Government of Canada with a mechanism to protect and promote the physical and mental well-being of people in Canada through population-based approaches. Such a mechanism will help facilitate the establishment of public health standards and the reasonable provision of public health programs and services. The purpose of this legal and regulatory package would be to provide a national framework of public health functions and activities to inform provincial and territorial activities, accompanied by a resource envelope to support their implementation.

COVID-19 has brought tremendous disruption, hardship and tragedy to the lives of many in our country. It has also resulted in an unprecedented level of scientific progress, non-partisan collaboration and a resolve to triumph over this deadly virus. While we continue to face significant challenges, we inevitably start planning for recovery. As we do so, we have an opportunity to take a longer view of pandemic preparedness with the understanding that COVID-19 will not be the last novel pathogen to disrupt our world and it will most likely not be the worst.

● (1140)

It has too often been the case that a year or two after a public health emergency, public health and political interest in public health wanes. Budgets that were temporarily enhanced are cut back to provide for the immediate needs of the acute care system.

I would ask that you keep one fact in mind as this committee considers recommendations for the future. Public health systems and services in this country are the front line of the health system. If you want to have sustainable acute care systems across the country, you need to have much more robust public health systems to prevent disease, prolong life and promote health both in times of crisis and during normal times.

Thank you.

The Chair: Thank you, Mr. Culbert.

We now go to the Fédération interprofessionnelle de la santé du Québec.

Madame Lapointe, go ahead.

[*Translation*]

Ms. Linda Lapointe (Vice-President, Fédération interprofessionnelle de la santé du Québec): Mr. Chair, committee members, good morning.

My name is Linda Lapointe. I am a respiratory therapist and vice-president of the Fédération interprofessionnelle de la santé du Québec, commonly known as the FIQ. I am responsible for the workplace health and safety of our healthcare professionals. We represent close to 76,000 nurses, nursing assistants, respiratory therapists and clinical perfusionists working in all healthcare settings in Quebec.

We would like to thank you for inviting us to this study on the Canadian response to the pandemic...

[*English*]

Mr. Don Davies (Vancouver Kingsway, NDP): Mr. Chair, if I may interrupt. I'm not getting any translation.

The Chair: Mr. Davies, could you check at the bottom of your screen and make sure where it says “interpretation” that you've chosen English?

There's an icon bar at the bottom of the screen on the Zoom window.

Mr. Don Davies: I see it now.

If I press “English”, it says “language interpretation”.

Should I press “English”?

The Chair: Yes. Go ahead.

Mr. Don Davies: Okay. Thank you, Mr. Chair. Sorry, to the witness.

The Chair: Sorry, Ms. Lapointe. Please go ahead.

Ms. Linda Lapointe: Do you want me to repeat?

The Chair: Yes, please.

[*Translation*]

Ms. Linda Lapointe: All right.

Mr. Chair, committee members, good morning.

My name is Linda Lapointe. I am vice-president of the executive committee for the FIQ, the Fédération interprofessionnelle de la santé du Québec. I am responsible for the workplace health and safety of our healthcare professionals. We represent close to 76,000 nurses, nursing assistants, respiratory therapists and perfusionists working in all healthcare settings in Quebec. We thank you for inviting us to this study.

Over the next 10 minutes, we will briefly discuss federal healthcare funding, and then delve into the issue of safety for healthcare professionals in these difficult times.

As far as federal government funding is concerned, Quebec's health network has been under severe strain since the outbreak of this pandemic. Were it not for the will and know-how of those working on a daily basis, it would have been impossible to provide the high-quality care the public needs in these difficult times. Each day for several weeks now, they have brilliantly met this challenge, despite the many constraints with which they have to cope.

Apart from the magnitude of the pandemic and the speed at which it is spreading, the weaknesses in our network are largely due to the lack of funding, both provincially and federally, in recent years. For several years now, the FIQ has been asking its federally elected representatives from all parties to increase the health transfer to help finance healthcare and services to at least 25% of provincial spending. Unfortunately, this very legitimate request has fallen on deaf ears. Given the severity of the COVID-19 outbreak, adequate funding would undoubtedly have helped facilitate the day-to-day work of the healthcare professionals we represent, and helped provide the public with the care they have a right to expect.

Last week, the Minister of Health, Ms. Patty Hajdu, noted that, over the past decades, various federal governments have underfunded preparedness for public health emergencies. As a result, Ms. Hajdu said, the national emergency strategic stockpile does not have all the equipment needed to deal with a pandemic of this magnitude. We regret that this reserve has not been regularly reviewed and that the amounts invested are still not adequate. A well-provisioned national stockpile would have been useful, especially since Canada depends largely on foreign industry for the supply of personal protective equipment.

Nevertheless, we applaud the federal government's willingness to address this dependency by encouraging Canadian industry to produce this equipment that is essential to the work of our healthcare professionals in the future.

I will now talk about the safety of our healthcare professionals. As we eagerly await Canada's self-sufficient supply of personal protective equipment, we feel it is appropriate to recall the words of Justice Campbell, commissioner of the SARS Commission, which we echo here today. Until the precautionary principle is recognized as a basic principle of workplace health and safety in Canada, our healthcare professionals will be at risk.

Given the timidity of certain recommendations on personal protective equipment by the Public Health Agency of Canada, or PHAC, particularly its refusal to apply the precautionary principle to the risk of airborne spread of COVID-19, the FIQ took the opportunity to express its dissatisfaction on February 7 in a letter to Dr. Tam, the PHAC's chief official. As we emphasize in that letter, we continue to believe that PHAC leadership would have been helpful in the current context.

In Quebec, from the very beginning of this crisis, the FIQ was concerned about the recommendations and the language used in some recommendations issued by the Institut national de la santé publique du Québec, the INSPQ. They did not factor in airborne transmission, as the PHAC did, and the Quebec recommendations expressed concern for a potential shortage of personal protective equipment.

What is even more alarming, however, is that airborne transmission of the virus remains concealed today, even though current research shows that this form of transmission is happening. Moreover, a panel of U.S. experts has just released its opinion on the subject. The INSPQ's recommendations must quickly be adjusted to reflect this scientific evidence. Otherwise, the workers' rights to safety will be violated.

For the past few weeks, the scenarios by the Institut national de la santé publique du Québec have rapidly turned into improvised, last-resort solutions, particularly when it comes to respiratory protection devices. I'm thinking specifically of the prolonged use, or reuse, of single-use disposable masks.

● (1145)

The INSPQ also recommends the use of expired masks and suggests that disposable masks be disinfected, all of which is endorsed by the public health department.

We question these public health directives, which seem to separate public health from the protection of healthcare professionals, or even set them in opposition. We now understand that they are the result of an obvious lack of preparation and that this puts our healthcare professionals at risk and in peril.

We are very concerned that, in emergency situations, the precautionary principle, which must always guide good practices for infection protection and workplace health and safety, is being set aside. No pandemic, no supply issues can justify putting our healthcare professionals at risk of infection.

The picture we want to share with you today is not a happy one; it is raising a great deal of concern among our members. In 2003, during the SARS epidemic, the sheer uncertainty of what we knew about the virus was a source of considerable stress and anxiety for healthcare workers. Today, that same uncertainty is combined with a real global shortage of essential personal protective equipment.

Healthcare professionals were already overworked at the beginning of the pandemic, and they are now facing significant overloads. While many people are seeking care, healthcare professionals themselves or their loved ones may become ill.

Our members are under a lot of stress. They feel unprotected in the face of the virus. Right now, they feel that, if they are not well protected, they may become infected and they may infect other patients, colleagues or family members. Even more worrisome is that this feeling is not unfounded: employers deny them access to protective measures when they could provide better safety.

This equipment is sorely lacking most particularly in residential and long-term care centres, or CHSLDs. Our healthcare professionals are already coping with a staff shortage in these settings, and they must now provide care to very vulnerable clients with minimal protective equipment. These shortcomings largely explain just how fast the virus is spreading in those settings and, correspondingly, they are putting more stress on healthcare workers.

Helping people in need can be rewarding, but it can also be difficult. Healthcare professionals may experience fear, sadness, frustration, guilt and burnout. These are reactions that can be expected in situations of this magnitude and uncertainty.

In conclusion, it must be said that the recommendations arising from the various reports on the SARS epidemic in 2003 do not seem to have been well assimilated. We hope that those that will emerge from the current pandemic will be implemented so that we can be better prepared to deal with other pandemics. It is essential that our healthcare professionals be able to provide quality care to the public in a safe work environment where all the necessary equipment is available.

On a more positive note, we would like to recognize that the federal government moved swiftly to take measures to support workers during this lockdown period. Some of the measures have undoubtedly helped partially reduce the stress of a loss of income for some of our professionals' spouses and enabled them to continue providing quality care to the public.

Thank you.

● (1150)

[*English*]

The Chair: Thank you, Ms. Lapointe. We'll go now to Dr. Naveed Mohammad from the William Osler Health System.

Dr. Mohammad, go ahead, please, for 10 minutes.

Dr. Naveed Mohammad (Executive Vice-President, Quality, Medical and Academic Affairs, William Osler Health System): Good morning, everyone. Thank you very much for the invitation to address the House of Commons Standing Committee on Health today.

My name is Dr. Naveed Mohammad, and I'm the executive vice-president of quality, medical and academic affairs at William Osler Health System, or “Osler”, as we commonly refer to our hospital. I have had the privilege of working on the front lines of health care in emergency medicine for the majority of my career, much of the time at Osler, beginning in 1997. This coming Tuesday, April 14, I will assume the role of president and CEO of our hospital corporation.

Osler is one of the largest community hospitals in Canada, serving our regional population of more than 1.3 million people. We have three sites in northwest Toronto and Brampton: Etobicoke General Hospital, Brampton Civic Hospital and Peel Memorial Centre for Integrated Health and Wellness.

The population we serve continues to grow rapidly, which presents unique capacity pressures for both community health programs and the provision of acute care services. Osler also serves a very diverse population, including a large South Asian community as well as a significant number of new Canadians and international patients. With our close proximity to Canada's largest airport, we are designated as first responder for Toronto Pearson International Airport. This means that while Osler has a primary relationship with the Government of Ontario as a public hospital under provincial jurisdiction, we also serve as an important stakeholder impacted by the policies and legislative directions of the federal government.

In my address today, I would like to provide the committee with a brief overview of how Osler has responded to COVID-19 and give you a sense of what has been happening for health care teams working on the ground. I will also share my perspectives on how the federal government's COVID-19 response has been effective in supporting hospitals and our health care workforce, as well as my suggestions on how Canada and our health care system can be better prepared for future pandemics that we now know are inevitable.

The emergence of COVID-19 in Canada came at a difficult time in hospitals and health care. We were in the middle of a flu surge season, a time each year when most hospitals struggle with higher patient volumes and greater capacity challenges. In fact, when Osler identified its first COVID-19-positive patient, the organization had been in what we call “code gridlock” for some time. As news emerged about a new virus outbreak in China and later elsewhere, it became apparent that our health care system needed to quickly plan, as we feared a similar trajectory in Canada.

Like many physicians, nurses and allied health professionals of my generation, I was in the front lines during SARS, H1N1 and Ebola, as were many members of Osler's senior leadership team. We knew we needed to be proactive.

Also, over the last number of weeks, hospitals, regional partners and provincial authorities, including Ontario's Ministry of Health and the Ontario health agency, have been working together in unprecedented ways to develop and implement a planned and phased approach to critical care and emergency capacity planning. As an acute care hospital, Osler quickly mobilized our focus around COVID-19 strategies and measures. We adjusted our clinical operations and infrastructure to ensure capacity for COVID and non-COVID patients needing hospital care. A core principle throughout has been to protect and ensure the safety of all patients, staff, physicians, volunteers and the community.

Osler's strategies for COVID-19 capacity have included cancelling all elective and non-urgent services, procedures and surgeries and repurposing these spaces within the hospital; where possible, moving or discharging rehabilitation patients or patients requiring an alternative level of care with appropriate home or community care supports; and taking advantage of the natural decline in volume to consolidate our patient activity in new spaces.

● (1155)

To further reduce the number and flow of patients coming in and out of the hospital, Osler has enhanced our virtual care through teleconferencing and video conferencing, and more services are being provided remotely. With this, virtual care has contributed to an overall decrease in patient volumes for non-COVID emergency department visits, and this has allowed Osler to safely take on further COVID-19 capacity. Our virtual strategies also include using iPads and other devices to support virtual visitation between patients and families, as we have needed to make the very difficult decision to implement a no visitors policy.

We are now identifying decanted spaces in our sites to create incremental capacity for more patient beds. Tented spaces are being put up adjacent to the hospital and, if necessary, we will use these and other unconventional spaces for patient care, including our auditoriums, outpatient areas and patient dining rooms.

To facilitate COVID-19 assessment and testing for the public as well as for our staff, physicians, volunteers and their families, Osler quickly brought online three COVID-19 assessment centres, including one of the first to open in Ontario. Operating both within the hospital walls and through an innovative and accessible drive-through model, Osler has now swabbed 5,260 patients. We are currently looking at ways to expedite assessment and testing for community providers and first responders, who experience a greater risk of COVID-19 exposure.

We continue to work with the provincial and regional partners to source and procure personal protective equipment, or PPE. Osler has been blessed with tremendous support from corporate partners, local businesses and donors to source and procure additional PPE. A robust stewardship and conservation strategy has been necessary to ensure a sustainable supply, and this remains a critical priority for the hospital.

It has been an unprecedented time and there have been many hospital policies and procedures we’ve had to create or evolve in real time as information about the characteristics of the virus and its associated clinical implications has evolved. Some policies have meant very difficult conversations for our teams. Decisions such as having a no visitors policy have been informed by ethical decision-making tools; however, the discussions have been difficult and sometimes emotional. We know these changes have been tremendously hard on our patients and their families.

Osler’s people are our most valuable asset. Many hospital staff have been working long hours seven days a week. The health and well-being of our teams has been very much top of mind, and we’ve developed incremental healthy workplace and resilience strategy resources and practical supports along with spaces for respite, reflection and self-care for our staff.

Teams at Osler as well as those at other hospitals and other health care organizations have been genuinely moved by the outpouring of public support for our health care heroes. These gestures have taken many shapes, including sincere and meaningful words of recognition by elected officials, including Prime Minister Trudeau, Premier Doug Ford, local mayors and our municipal and regional councillors. Gifts of financial donations to hospital foundations, words of encouragement on social media and simple gestures of kindness and support amongst neighbours and friends have inspired us and are helping our people through this challenging time. Those of us in health care are sincerely thankful to Canadians for this support.

Having spoken to my colleagues, front-line nurses, physicians and other allied professionals, I can say that the collective sense is that the federal and provincial governments have been working well together to support this crisis on the front lines. Daily updates by the Prime Minister , the premier, as well as municipal leaders have been well executed and have kept people apprised of new decisions and directions. We have been pleased to see the non-partisan way in which governments have come together to expedite high-priority needs, particularly the work on PPE and N95 mask procurement, as significant achievements.

● (1200)

However, as I reflect on what has happened to date and how best to ensure we continue to collectively manage this situation, I ask that you consider the following.

While the government response has been significant and relatively well coordinated, we have collectively been put in a situation, along with the rest of the world, of reactivity. Seventeen years ago when we experienced SARS, and through more recent experiences with MERS and H1N1, we have learned how likely it is that pandemics will continue to occur. The federal government has tremendous expertise in emergency response planning and mobilization, meaning that it is uniquely positioned to ensure that we learn from this experience and do the following:

One, enhance our pandemic stockpiles of PPE and other equipment, as well as diversify the supplier network. Not knowing whether there's going to be enough PPE, ventilators or other life-saving equipment has created significant fear on the front lines.

Two, develop strategies to ensure that we can do more pervasive community testing. Quite simply, we need the ability to do more testing. This will allow us to have a more targeted approach to quarantining staff and physicians, and make it easier to ensure surge planning that better segregates patients with and without a specific virus or communicative disease.

Three, move forward on the national pharmacare strategy to ensure we can mitigate challenges of drug supply shortages and stockpiling.

Four, ensure a coordinated, multi-level and all-party approach to pandemic planning and implementation. This will best leverage federal expertise, ensure resources are best allocated, harmonize policies across jurisdictions, promote the greatest levels of transparency and trust, and ensure that the focus remains on the important work of implementing the plan down to the front lines.

Finally, we hope our levels of government continue to work in the non-partisan way they have been to support all Canadians in putting COVID-19 behind us.

I want to thank all of you for the opportunity to come before the standing committee. I look forward to the discussion and your questions.

Thank you.

● (1205)

The Chair: Thank you, Dr. Mohammad.

We'll go now to our questions. We'll start our first round of questions with Dr. Kitchen.

Dr. Kitchen, you have six minutes.

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

Thank you, everybody, for your presentations. It's greatly appreciated.

Thank you to each one of you who has stepped forward on the ground, Dr. Mohammad and Ms. Lapointe, on all the efforts that you're putting into making certain that Canadians are protected.

Ms. Lapointe, I appreciate your comments. I would like to start with you.

[*Translation*]

I speak a little bit of French. I'm learning a new word every day.

[*English*]

That's all I can do. I apologize.

In our last meeting, Linda Silas, who is the president of the Canadian Federation of Nurses Unions, presented. She said, “However, workplace safety has never been PHAC's primary focus, and the agency has unfortunately failed, over and over, to consider and appropriately protect the health and safety of health care workers.”

She went on further to talk about things, but I'll just end here: “In a nutshell, our message to you is this: When faced with this level of uncertainty around the new coronavirus, especially around something as fundamental as how it is spread, we should start with the highest level of protection for health care workers, not the lowest.”

Do you feel from what you've seen that PHAC has actually taken the workplace safety of health care workers seriously, Ms. Lapointe?

[*Translation*]

Ms. Linda Lapointe: I would say that is more or less the case. Our observation today, a few weeks into this pandemic, is that we had the distinct impression that public health guidelines were adjusted based on the availability of personal protective equipment, when public health should be ahead of the game and ensure maximum safety for healthcare professionals and all workers in the health sector.

The guidelines were constantly changing. It was becoming apparent that they were lower than what they should have been under normal, non-pandemic conditions. The guidelines were changing all the time and causing safety to be compromised, or at least sending a message to healthcare workers that it might be compromised. As the guidelines changed, people said that the level of protection was being reduced. For example, the situations for the N95 masks were becoming more and more limited. There were only two situations in which the N95 masks could be used, and the method of transmission has not yet been determined. Over the past few weeks, over the past few days, as time goes by, it's become clearer that there could be airborne transmission. The N95 mask is specifically designed for situations where there is airborne transmission. That is what the big debate is about.

Much like the Canadian Federation of Nurses Unions, we at the provincial level have asked that healthcare professionals be given N95 masks as soon as there is a suspected case, not just for confirmed cases. The latest data show that many patients are asymptomatic carriers of the virus, which is why it's important to protect healthcare professionals, so that they do not leave to self-isolate and deprive people of their services.

Yes, we have major criticisms of the Agency with respect to public health, especially in terms of communications. Documents were continually being updated. It was difficult to get a real-time picture of the adjustments, and things were not concise. It wasn't easy to share the information with healthcare professionals in the field...

● (1210)

[*English*]

Mr. Robert Kitchen: Thank you, and I appreciate that. I apologize for interrupting. I only have a short amount of time.

You mentioned a number of aspects, noting that things are always changing and appearing to change every day. Your comments about the masks are important. The reality is, where are we getting those masks from? We've brought it up with the minister in committee a number of times the question of where these masks are coming from and how quickly can we get them.

Many of you today have talked about the protocols that have been set up. The reality was that after SARS, we developed those protocols. It appears that a lot of times in hospitals, especially in rural hospitals, if you ask a lot of people and where their protocols are from 2005, they don't even know where those are. There is concern as to whether those protocols that were established after SARS are actually being followed.

I'll throw this question to Dr. Mohammad.

Before COVID-19 began to spread across the world, I'm wondering if you or your hospital were aware of the processes and protocols that had been developed previously. I recognize that your hospital is bigger than a lot of ones across Canada, but how often are the health care professionals in your jurisdiction required to review these protocols? How often do you do simulated tests and procedures to make certain that your hospital...? I ask this both from your point of view and also that of smaller hospitals across Canada. How often are those being implemented? Are they done yearly, weekly, monthly?

Dr. Naveed Mohammad: I can tell you what we do at Osler.

We are a larger organization with more staff and more bandwidth. We have a pandemic plan that our emergency preparedness committee is in charge of, and it is reviewed on an annual basis. The pandemic plan includes not only the work that needs to be done inside a hospital but also the partnerships that need to be developed outside with EMS, regional governments and the Ministry of Health when such a pandemic strikes. We do it annually and we review it annually.

As I mentioned, we may be at a bit of an advantage because of our proximity to the airport, but we do have simulation exercises with the local fire departments, local police and the Greater Toronto Airports Authority for various types of issues, whether it be an airplane crash, major trauma or an issue like this one, with the risk of an infectious agent.

I have worked in towns of 1,600 and towns of 2,000 in the past, and I think that with smaller hospitals, it all depends on the administrative bandwidth that they have. Being an accreditor for Accreditation Canada, I often accredit hospitals across the country, and I find that in smaller hospitals, just because of the the workload they have, they may not be reviewing the protocols on an annual basis or even every two or three years. They may just be acting when things like this happen.

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

Ms. Sidhu, you have six minutes.

Ms. Sonia Sidhu (Brampton South, Lib.): First of all, thank you to all the witnesses for being here. Dr. Mohammad, thank you for your leadership.

My first question is for Dr. Mohammad.

How can the government increase our support to the hospitals, the health care providers, to help mitigate the impact of COVID-19? As you know, we have Brampton Civic Hospital and all the health care professionals are doing an amazing job. I just want your views on that.

Dr. Naveed Mohammad: The first thing is that there has been great collaboration between the federal government and provincial governments on some of the things they have put in place right now. The income stability programs for our staff and for all the workers in Canada and things along those lines have been a significant plus and have had a great impact for our community members and the employees we have here at Osler.

As I mentioned in my submission, it's about learning lessons from the past and having plans in place, and specifically having plans in place for personal protective equipment. Suppliers and the supply chain are one of the main things we are challenged with right now.

The other thing is this. I know we spoke about what's happening with international travellers coming to the airport. One of the biggest issues that we face here being so close to the biggest international airport in Canada was that both Canadian and non-Canadian passengers were getting off the plane and telling us that the only people who were asking them questions or screening them were border services agents. I think that was a bit of a weakness in our process, in that smaller countries have public health workers at the gates to check temperatures or ask questions to isolate at-risk patients right at the point of entry.

The last thing I want to talk about is something I mentioned earlier: our drug resource or our supply chain policy for drugs. Right now, because of the number of patients who need to be on ventilators and need to be sedated because they have a large tube down their throat to give them the ability to breathe, I know that across the country and across the province, we're running short on the medications that are utilized to sedate these patients. We're actually quite anxious about that. Therefore, when I talk about the pharmacare policy, not only am I talking about specific drug plans for individual Canadians so that they can have access to medication if we do find one that is working, but I am also talking about a pharmacare policy that creates and opens supply chains for these very important drugs that we may run out of in the very near future in large hospitals.

● (1215)

Ms. Sonia Sidhu: I also want to mention this, if you can answer.

As the member for Brampton South, I represent a highly diverse riding. As you know, many who immigrated to my riding and others are international medical graduates with health care training from international sources. Recently, the federal government has started a recruitment campaign to find those who have medical skills and want to help in the fight against COVID-19.

Dr. Naveed Mohammad, given the recruitment campaign, while credentials recognition is a provincial jurisdiction, how else could the federal government support programs like this, in a pan-Canadian effort to bridge those health care staffing gaps?

Mr. David Dingwall, you can elaborate on this too, please.

Dr. Naveed Mohammad: Do you want me to go first?

Ms. Sonia Sidhu: Go ahead.

Dr. Naveed Mohammad: I can tell you that we have a large number of international medical graduates who reside in Canada. A lot of them are Canadians who have gone to international medical schools. They are not people coming from other countries with education from there. They are people who have grown up in Canada or are born in Canada and have gone to international medical schools.

I can tell you that we have a plan in place right now to staff our organization in a phased manner, because we have shut down surgeries and we have shut down a lot of elective work. Initially, we are going to be using that staff to fill any gaps we may have. After that, we will reach out to the community, to our community physicians or specialists who are practising in the community. They are not practising in a hospital, but they are volunteering to step up.

To answer your question, the College of Physicians and Surgeons of Ontario has worked with the province to allow international medical graduates to have a renewing one-month licence in Ontario. This means that at Osler, if we get to a point where we run out of local resources for physician staffing, we would hire international medical graduates and give them a job letter. When the graduates present that job letter to the College of Physicians and Surgeons of Ontario as a licensing body, they would have a one-month licence to work with us, and then we could renew that on a monthly basis.

I think it's a great idea to put that in place, because it creates a stopgap measure for us here in this province. I would encourage the federal government to recommend that other provinces go down the same path, because most of these international medical graduates would be willing to travel anywhere in Canada to gain that experience. Not only will it help us now, but it will help these international medical graduates to get residencies in the next couple of years, because they will have local Canadian experience.

● (1220)

Ms. Sonia Sidhu: Mr. Dingwall, what are your views on that?

Hon. David Dingwall: I think it's a bit of a tragedy, in that we have a number of professionals within our post-secondary institutions across the country who cannot gain access as doctors or nurses or what have you. There are ways to get around that. I think there needs to be a bridging program for physicians and other professionals, so that they can get into the system and provide the necessary services to the citizens.

In my particular university, last year we had 17 medical doctors from India alone, all willing to participate in the health care, all willing to participate in a bridging program. For whatever reason, the medical societies across the country are not too willing to participate in a meaningful way to make that transition easier.

The federal government can assist by providing some necessary monies for the bridging, but you need the Canadian Medical Association and the provincial associations [*Technical difficulty—Editor*] to a program that will assist. We're not looking for a diluted way. We're looking for these individuals to bridge in and to become family physicians and various professionals in our health care system. With a little bit of will by some of the stakeholders, that can be accomplished quite quickly and it would serve everyone's interests.

The Chair: Thank you, Ms. Sidhu.

[*Translation*]

Mr. Thériault, go ahead. You have six minutes.

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

First, I'd like to speak to all the witnesses. Ms. Lapointe, gentlemen, thank you for your valuable contribution.

I will start with you, Ms. Lapointe. First of all, allow me to point out how clear your presentation was. You have almost answered all of my questions. I still have some, but you have given me an update, and I am very happy with that. Allow me also to commend all members of the FIQ and to recognize their courage and goodwill in these difficult times.

The virulence of this pandemic is quite incredible. On March 13, when Quebec issued the emergency protection order, that decision was made when there were 17 cases of infection and no deaths. About 25 days later, last night at 8:38 p.m., there were 10,031 cases and 175 deaths in Quebec. No one saw a virus of such virulence coming. However, you point out that all the relevant SARS recommendations were more or less acted upon.

At what point, Ms. Lapointe, did you realize there was a problem with the stockpile of personal protective equipment?

You said that people have to be able to do their jobs with equipment, but are you aware of anyone in your organization having to work without adequate protection? Could this explain some of the community spread that we're seeing today in some CHSLDs?

● (1225)

Ms. Linda Lapointe: Thank you for your question.

Yes, the lack of supplies was noticed quite quickly. That is what made us a little angry. In all of his press briefings for two weeks, Mr. Legault was reassuring. He said that there was enough personal protective equipment.

However, in the front lines—we represent 76,000 healthcare professionals across the province—that wasn't at all what we were seeing. Also, we had been told that very restrictive management was in place. We thought there might be enough equipment, but that management was tight in anticipation of a possible shortage. In fact, patients and visitors were stealing masks. We were not sure.

Over time, Mr. Legault had come to recognize that only three to seven days' worth of equipment remained. We had pointed that out. We had been warning the department for two or three weeks. I would send them the names of suppliers who were contacting us at the Fédération. Since we are a union, it's not up to us to provide the equipment, it's up to the employers.

It reached the point that, this week, we had 100,000 masks delivered to the government, and we're expecting another 500,000 next week. We bought them to thumb our noses at the Legault government, even though it has done some good things and implemented some good measures.

How is it that a union could procure over half a million masks in seven to ten days when we had no supply statistics?

If the government knew exactly how much personal protective equipment it had in its possession for three weeks, why weren't those orders made before?

Your second question was whether healthcare professionals had worked without personal protective equipment. The answer is yes, absolutely. We're not surprised that there have been outbreaks of this magnitude in CSHLDs. Our members were crying out to us about this need.

The FIQ website includes a page called “Je dénonce”, where reports on working conditions can be found. Home care and CHSLDs are the two settings where the needs are most pressing and where people did not have equipment. Home care workers would go out to see 12 patients with only one mask. In CHSLDs, there were no masks at all, unless the patient had tested positive for COVID-19. But there may be a period before diagnosis when it is possible to spread the virus. So yes, it has been a problem.

Mr. Luc Thériault: Researchers at Duke University are claiming that, with a sterilization process, N95 masks can be reused.

I understand that it is not your first choice, but do you think that, in the event of a shortage, sterilization in this manner would be worthwhile? Would it be effective?

Ms. Linda Lapointe: I'm no expert, but it should be understood that the instructions clearly indicate that these masks are disposable and, ideally, single-use. Because of the shortage, they're trying to bring in all kinds of means that have not been proven effective. In Quebec, the Association paritaire pour la santé et la sécurité du travail du secteur affaires sociales, the ASSTSAS, and the Institut de recherche Robert-Sauvé en santé et en sécurité du travail, the IRSST, disagree completely on disinfection in this manner.

While not all of the masks come from 3M, the company issued a news release stating that it has been studying disinfection for several years and no method has met their four criteria in terms of the filtration, the elastics and the materials. As a result, they have not approved any method. 3M has been trying to do this for several years.

Some employers in Quebec want to start disinfecting masks, but before we get to that point—again, I'm not an expert—we are advocating extended use of the N95. If a healthcare professional has to go into an intensive care room four or five times, of course, they can't use five different masks. We understand that. If the technique used to remove the mask and put it back on is appropriate, we recommend that the nurse or respiratory therapist use the same mask for a full shift, rather than using masks disinfected with a method that has not been proven effective.

Mr. Luc Thériault: Thank you, Ms. Lapointe.

Mr. Chair, do I have any time left?

The Chair: Thank you, Mr. Thériault.

[*English*]

You have no time left. We've already gone about a minute over.

We go now to Mr. Davies.

Mr Davies, please go ahead for six minutes.

● (1230)

Mr. Don Davies: Thanks, Mr. Chair.

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

My first question is for the Canadian Public Health Association.

In a March 30 article on CBC News, Mr. Culbert, you noted that if people knew more about the COVID-19 outbreak in their particular communities, it would help them to follow advice from public health authorities. However, we're hearing from many health experts across the country that COVID-19 data is of questionable validity due to low testing rates and delays in results. They also note that the data is not gathered, compiled or presented in a consistent manner across the country, and that disaggregated figures are not always provided and inventories of medical equipment and PPE stockpiles are frequently excluded from reporting.

In your view, should the Public Health Agency of Canada mandate that standardized information reporting for all public health authorities across the country be made a reality?

Mr. Ian Culbert: It would be tremendous if the agency had the authority to mandate that, but unfortunately they do not. That is one of the calls we are making in this request for federal legislation that would give the federal government a greater role in coordinating public health efforts across the country.

The lack of streamlined epidemic data across the country is an ongoing issue. We know alcohol sales the next day, but we don't know the impact of alcohol, for example, for 10 years out. It's the same idea with the COVID-19 outbreak. There's a lack of consistency and we're seeing that as the reason for why the federal government had to wait until today to release its modelling figures.

Mr. Don Davies: Thank you.

I'm not quite clear whom to direct this question to, so I'll open it to whomever on the panel wants to answer it.

We've been hearing from the WHO that we need to test, test, test, and I think there's a pretty consistent consensus in the country that testing, tracing and isolating are key factors in helping us deal with the COVID-19 crisis.

My question is on blood serum test kits. I understand that these kits are manufactured in Canada, and they produce very quick results and can at least confirm positively if someone has been exposed to the virus. I understand that they have been approved by the U.S. and the EU, and are actually in use in many countries, but I understand that Health Canada has yet to approve the use of these test kits in Canada.

Should we be making these serum-based home test kits more widely available so that we can get more accurate figures on who's been exposed to the virus in Canada?

The Chair: Anyone on the panel who wishes to respond, please go ahead.

Hon. David Dingwall: I can't respond to the specifics that you're raising, but the World Health Organization is a very reliable and sophisticated partner as it relates to health throughout the world.

It would seem to me that this is probably something the committee would want to take under advisement and to get some specifics from Health Canada as to why they're not, and what conditions would need to exist for them to adopt that. I know from previous experience that our senior officials in Health Canada are a pretty reputable group of men and women who adhere to very high standards. I think we would want to hear an answer from them as to why not, and how they could go to that kind of testing. To me, rapid testing is the most important issue.

Mr. Don Davies: Thank you, Mr. Dingwall. That does provide us with a good question to ask Health Canada the next time they appear, because it seems a little incongruous when test kits manufactured in Canada are being used all over the world and we're not able to use that technology in our own country.

Mr. Dingwall, I want to direct my next question to you.

We know that after the SARS outbreak in 2006 there was a very comprehensive inquiry and report issued by Justice Campbell and for 14 years some have called that a playbook for how to deal with a coronavirus-like pandemic. In fact, that report in 2006 said, “there is no longer any excuse for governments and hospitals to be caught off guard and no longer any excuse for health workers not to have available the maximum level of protection through appropriate equipment and training”.

The stories are legion across this country that governments and hospitals have in fact been caught completely off guard and that our front-line health care workers are suffering from a shocking shortage of personal protective equipment. We know that in 2010 a federal audit flagged problems with the management of Canada's emergency stockpile of medical equipment and that in 2018 an assessment of the H1N1 outbreak showed that Canada had a shortage of ventilators.

Mr. Dingwall, I'm curious as to whether you, as someone with a lot of experience around the cabinet table, can give us any insight into how we can move forward to ensure that 10 or 14 years from now we're not having the same conversation. How can we take the lessons of the current outbreak now and ensure that we follow through with the steps that have been identified? Clearly we didn't do that after 2006.

● (1235)

Hon. David Dingwall: That's an excellent question, and let me try to respond to it in two parts.

The first part is that I think many governments federally and provincially have followed up on the SARS recommendations. Where I think we may have fallen down as a society has been in our failure to put into statute the obligations of the parties who are involved in the process. For instance, provincially under labour standard codes and federally under the federal labour code, those that deal with our indigenous health, the statutory obligations are quite vague in terms of a pandemic. In some jurisdictions they are literally non-existent. However, we need to amplify those pandemic obligations that the state must provide for, whether for the safety of our workers, for rapid communication, or for a host of other things. I think if we put those into statute, people will then be obligated. I think there should be some sunshine laws, in part so that every three years you would have to review your pandemic plan.

Under the occupational health and safety provisions that many of the provinces have, there is reference to a pandemic, but it is very short and the definition is very inexact as to the obligations on the part of the state to do that. I would look at that to see what they have in order to make it a statutory obligation as opposed to a recommendation that may come from a particular commission.

The Chair: Thank you, Mr. Davies.

We'll start our second round and we'll go to Mr. Webber.

Mr. Webber, you have five minutes.

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

I'd like to thank the witnesses for appearing today before our committee. I know that you are likely busier than usual so your time is very much appreciated.

My question is directed to Dr. Naveed Mohammad of Osler.

Dr. Mohammad, I'm currently on the Osler website, and it says:

> As part of ongoing preparations to ensure [Osler] is well positioned to provide emergency care for an increased number of patients in the coming weeks, a temporary triage area is being erected at its Brampton Civic Hospital and Etobicoke General Hospital sites. The temporary structures are part of Osler's escalated preparedness efforts as set out in its Pandemic Plan.
>
> The temporary Emergency Department triage structures, which will remain vacant until they are needed, can be used to provide added capacity for Osler's Emergency Departments should the need arise. They will provide a dedicated space for triaging patients who may require emergency care and will support the safety of patients who do not have COVID-19.

Dr. Mohammad, I want to share with you also a letter from a doctor in my constituency, a quick letter from Dr. Colum Smith. He states:

> ...I simply cannot believe that the local hospitals are receiving patients with fever into their emerg departments....
>
> We need "fever only" facilities opened without delay....
>
> Patients with fever or other signs/symptoms of [COVID-19] infection need to be triaged at the main entrance of our hospitals and directed to a separate assessment area....

Dr. Mohammad, because Osler did construct such a temporary facility, should this not become common practice throughout the hospital system in this country?

● (1240)

Dr. Naveed Mohammad: I'll answer your question in two ways. One is that everything depends on the configuration of the emergency department and the emergency department's isolation capacity. What that means is that each hospital with an emergency department has different types of rooms. We have rooms called isolation rooms that have negative pressure capabilities, which means it's a room where the airflow is suctioned out of the room. There's a separate bathroom for the patient so the patient never has to leave that room, and there's an anteroom so that you have a place to change before you go in so you can change into PPE.

At Osler, one, because of our experience with SARS—we were one of the SARS designated sites—and the lessons learned from it, and two, because we are close to the airport, we have a flow system in our department so that if a patient comes in who is what we call ILI, or influenza-like illness, which is very similar to COVID, he or she gets triaged separately into that area. We have erected a tent outside for that purpose at each site, so if our COVID-positive patients become such high numbers that we have to utilize the whole ER for COVID-positive patients, then the COVID-negative patients would be seen through our tent.

If a hospital does not have a capacity like ours, then it would behoove them to put structures like this up, sooner rather than later, or work within their community so that certain hospitals see one type of patient and certain hospitals see another type of patient.

We have the luxury of having three facilities. We're a corporation of three hospitals. We have talked about maybe having one facility seeing only COVID patients. We haven't gotten to that point yet, but to answer your question, yes, I agree that people should act sooner. However, it all depends on what their innate capacity is to begin with.

Mr. Len Webber: Thank you for that, Dr. Mohammad, and for the work that you do on the front lines. I appreciate it very much.

Mr. Ian Culbert, I have a similar question about your thoughts on these current practices in our health care system here in Canada. Is that something your organization should consider lobbying the government for, namely, funding for triage areas throughout the country?

Mr. Ian Culbert: Yes, thank you for the question.

In fact our organization is focused much more on the upstream side of the health system, looking at actually keeping people out of those triage systems in the first place.

I do want to point out regarding the previous question that Justice Campbell's report was an Ontario-specific report. If you look at the recommendations, most of them have been applied in Ontario.

It was Dr. David Naylor who did the federal report, and many of its recommendations have yet to be implemented fully.

● (1245)

Mr. Len Webber: Okay. Thank you for that.

The Chair: Thank you, Mr. Webber.

We go now to Mr. Fisher.

Mr. Fisher, you have five minutes.

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

I want to thank every one of you for being here. We're so fortunate on this health committee to be able to hear from brilliant people, week in and week out.

Mr. Culbert, modelling isn't data, but data informs modelling. Today Dr. Tam and Dr. Njoo presented modelling based on the best data they could get from the provinces and territories. I'm interested in your thoughts on this modelling and on the measures, whether effective or not, that all levels of government have been pushing on Canadian citizens.

Also, just how important is individual action by Canadian citizens?

Mr. Ian Culbert: You're right that modelling is helpful. It's helpful for the system to be able to anticipate what might be coming down the road. It is not an exact science by any stretch, as so many variables can impact where those numbers go.

As I said in my remarks, I still believe that the individual behavioural change we're seeing among Canadians is probably the most important factor. It's not the only factor, but it's certainly the most important factor. If we maintain physical distancing and working from home—all of those different factors—to keep people healthy, first and foremost, all of that is focused on keeping people out of emergency rooms. If we reduce the number of people who become infected, we reduce the number of people who become seriously ill and therefore reduce the number of people who need to go into an ICU.

Mr. Darren Fisher: To talk about PPE for just a moment, normally provincial and territorial health authorities or provincial and territorial governments would order it and stock it and distribute it to their health authorities.

What are your thoughts on what the federal government is doing right now, whether it be speedy procurement or any of the efforts to invest in Canadian companies to retool to do this made in Canada approach to provide PPE for the amazing health care workers we have in this country?

Mr. Ian Culbert: I think the government is fundamentally pulling out all the stops to get as much PPE out to communities as necessary.

It does speak to the issue of the national emergency stockpile and how it is managed. I think closer collaboration among the federal government and provincial and territorial governments is key in this regard because it's extremely wasteful to have a national stockpile of equipment that has expiry dates. We could have reciprocal arrangements for the provinces and territories that, on a yearly basis, we sell that equipment to the provinces and territories so that we can keep renewing the emergency stockpile and don't have a complete waste of resources of just throwing stuff out once it becomes expired.

I think we can improve that system dramatically if there is greater collaboration.

Mr. Darren Fisher: Yes, and Mr. Dingwall spoke about the collaboration between PHAC and the various health authorities, and I agree with Mr. Dingwall on that.

We always talk about the rapidly evolving pandemic. Can you tell us a little bit about how it's evolved, how science has responded and maybe how the government has responded? How have we learned, or should learn, from countries that are maybe a little bit ahead of us in the pandemic?

Mr. Ian Culbert: Certainly. I'll contrast it to SARS.

SARS we knew very little about. We didn't know it was airborne until the crisis was fundamentally over. In contrast, with COVID-19 we've done the genomic sequences in an incredibly fast turnaround. We have a variety of diagnostic tests and we have made them available in a very short time. However, unlike what happened with H1N1, we're not able to produce a vaccine in a similarly short time, because it's a novel coronavirus. It's not something we've seen in our environment before.

The international collaboration around knowledge sharing has been tremendous. The international publishing houses that control the scientific journals around the world have been very open in sharing all of that data, even pre-published materials, so I think the level of scientific advancements in this period of time has been tremendous, but we're always catching up because we've never been here before with this particular virus.

● (1250)

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

The Chair: You have 20 seconds.

Mr. Darren Fisher: I have a quick question, then.

Mr. Culbert, the federal government has an important role in the health care of Canadians, especially in this pandemic, but can you confirm for me that guidelines for health care workers generally fall to the provinces and territories?

Mr. Ian Culbert: Generally speaking, yes. It is the role of the Public Health Agency of Canada, in an emergency like this, to develop supplementary guidelines so there is some consistency across the country.

Mr. Darren Fisher: Excellent. Thank you so much.

The Chair: Thank you, Mr. Fisher.

[*Translation*]

Mr. Berthold, you have the floor for five minutes.

Mr. Luc Berthold (Mégantic—L'Érable, CPC): Thank you very much, Mr. Chair.

Mr. Culbert, my question will be quite direct. You said in a CBC interview that the fact that people know more about pandemics helps them make the right decisions for their own protection. Do you consider that Canada was quick enough in conveying the magnitude of the pandemic and the risks, since it is only today that we have learned about the expected health effects?

Do you not think that Canada should have acted much more quickly to convey the risks to the public?

[*English*]

Mr. Ian Culbert: My view is that the government has been extremely transparent with the number of cases and the type of spread that we've been seeing.

I think everyone wants to see the modelling numbers, but they are so variable, based on how we as individuals respond. It's good for the system to know what we might be expecting, but it can also be fear-invoking for a lot of people. This is a period of high anxiety for Canadians, so we have to provide modelling figures very carefully.

However, I do believe the government has been transparent in—

[*Translation*]

M. Luc Berthold: Mr. Culbert, in an interview, you said this:

[*English*]

“Knowing more about the outbreak in their community could help people to follow advice from public health.”

[*Translation*]

I think people have been slow to react and protect themselves. You can't say one thing and then say the opposite. The sooner people are aware of the threat, the sooner they will protect themselves.

[*English*]

Mr. Ian Culbert: In the CBC interview you're referring to, I believe I was being asked about how much information should be shared, as in how many cases there were and how specific the information should be, as opposed to protecting the anonymity of individuals and their confidential health information. I was saying that information should be shared as much as possible without compromising confidentiality. I do not think it's a disconnect from saying—

[*Translation*]

Mr. Luc Berthold: I agree with you. Thank you very much, Mr. Culbert.

I'd now like to ask Ms. Lapointe a question.

Ms. Lapointe, first of all, I tip my hat to all healthcare staff currently working in hospitals. You are indeed at the centre of the crisis, it's important to say that. I was absolutely flabbergasted to hear that people are still working without protection in establishments, particularly in CHSLDs, where there are outbreaks. We can see that the problem lies in those establishments.

Work is currently being done on technologies that will allow the manufacture of electronic devices to protect healthcare workers. Each healthcare worker could have their own device to filter the air they breathe in and out.

Do you think the government should consider this solution, given that we have learned today that the situation could go on for several more months?

Ms. Linda Lapointe: As I said earlier, public health guidelines in Quebec are constantly changing. It's been determined that there is sustained community spread throughout Quebec. That was problematic, because in previous days they claimed that there was provincial community spread, but the INSPQ documents still contained a paragraph that said regional epidemiology had to be taken into account. We were still in a grey area.

As of yesterday, the INSPQ has changed its message on community spread. Indeed, the surgical mask or procedure mask—I am not talking about the N95—is required for all healthcare professionals and workers when within 2m of a patient or colleague, whether they are a presumptive case or have tested positive or negative. This is brand new. It took province-wide community spread to adequately protect workers.

There is still the dilemma of...

● (1255)

Mr. Luc Berthold: If there was a technological solution allowing each employee to have their own mask and not have to take masks from others, disinfected disposable masks, should we choose this option?

Ms. Linda Lapointe: That would be a potentially very interesting option, but the type of equipment has yet to be determined. We are only asking for N95 masks and we don't have them. You understand, I will wait for the technology to arrive before I consider it.

Mr. Luc Berthold: Thank you, Ms. Lapointe.

Mr. Chair, do I have any more time?

[*English*]

The Chair: Yes, you have 20 seconds.

[*Translation*]

Mr. Luc Berthold: Okay.

I'd like to take this opportunity to thank all healthcare staff for their extraordinary work. I thank them for being there, on the front lines, for us.

I think all members from all parties recognize your fine work. We're here to help you and support all your requests, if you have any.

Ms. Linda Lapointe: Thank you.

The Chair: Thank you, Mr. Berthold.

[*English*]

We go now to Dr. Jaczek.

Dr. Jaczek, go ahead for five minutes, please.

Ms. Helena Jaczek (Markham—Stouffville, Lib.): Thank you, Mr. Chair. I hope you can hear me; I do not have a microphone.

My first question is for Mr. Culbert.

If I heard you correctly, Mr. Culbert, you said that there were criticisms that perhaps the public health measures were not stringent enough early on in the pandemic, and you also made reference to the difficulty of changing people's behaviour: If they're not convinced that there is a real risk, they may not comply with those public health measures.

I was wondering if you could expand a little on that, and perhaps tell us what the conversations were between the Public Health Agency of Canada, your organization and various provincial public health authorities. Could you just give us a sense of those deliberations?

Mr. Ian Culbert: Certainly, and thank you for the question.

I want to clarify that as a non-governmental organization, we aren't privy to many of the conversations to which you refer, although I co-chair, with Dr. Theresa Tam, the CPHA's health professional forum, which brings together health professional associations. We have been receiving briefings and having consultations with the agency on a biweekly basis on a wide range of issues, and we have been able to give feedback on some of the guidance documents.

Human behaviour is challenging when you're trying to get people to change their behaviours. When you have an epidemic that starts halfway around the world, there is a sense of insulation; there's "them and us". Then you see some cases in B.C. or in Toronto; it's a "them and us". You slowly have to change people's thinking so that there is no "them and us", so that it's a "we" situation, but that takes time and it takes evidence. You have to prove to people that this is serious. That's where public health is often challenged, because when we're successful, nothing bad happens, but if we're unsuccessful—if we don't change people's behaviour, if we don't change our systems for the future—bad things do happen. It is a process.

I'll leave it at that for now.

Ms. Helena Jaczek: You talked about a national framework that you think would be desirable in terms of public health practice across the country. We've heard a little bit about the authority for the federal government to actually require data collection coordination, and that rather than it being more on a voluntary basis, the federal government would have the authority to collect data nationwide.

What else in that national framework would you like to see in terms of perhaps better coordination of activities among the federal government, the provinces and the territories?

● (1300)

Mr. Ian Culbert: Well, certainly the establishment of national public health standards across the country would be a wonderful development out of something like that. In the case of immunization, we have different immunization schedules in different jurisdictions, and so you would have the ability to bring all of the parties together to come up with a harmonized immunization schedule and also the funding envelope to be able to support the provinces and territories in adopting those schedules. It really is about creating a rising tide so that we can raise the level of health and well-being for all Canadians equally and fill in the gaps where necessary across the country.

Data is a consistent problem in terms of the ability of provincial and territorial governments to collect what the federal government would like to have, but then there is that sense of not always wanting to share information about problems because, unfortunately, it is politicians who make those final decisions as to what information gets shared, and so there are challenges there. If we had that national framework, I think it could improve things dramatically.

Ms. Helena Jaczek: Perhaps I could ask this to the Honourable David Dingwall, in terms of his experience as a former minister of health.

Hearing Mr. Culbert, what is your opinion of having more of a national framework when it comes to public health?

Hon. David Dingwall: I think timing is of immense importance in the process going forward. I think if you would call upon all of the various stakeholders, they would probably agree that some clear national standards that we all buy into would be very helpful for those who are on the front lines.

I also believe it requires some statutory obligations, as I said in responding to one of the earlier questions. I don't think we can just have a framework; I think we need a framework that has statutory teeth, such that people are going to have to report on a regular basis in terms of what is transpiring and what is not transpiring. It's all well and good to have the framework, but someone has to exercise it to see that the stockpiles are renewed, that we don't have antiquated equipment, that people are trained, that we're looking for the best practices worldwide and that we're taking into consideration the practices of the World Health Organization in terms of all of their abilities. From that perspective, I say yes to the national framework, but it needs to have some teeth, and I think the teeth are the statutory obligations of the parties going forward.

The Chair: Thank you, Ms. Jaczek.

We go now to Monsieur Thériault.

[*Translation*]

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

My question is for Mr. Culbert.

You said earlier that everything was going according to plan and that, to that extent, the measures had to be proportional to the threat, because there might be a low level of buy-in and support for the measures being taken.

However, when Quebec declared a health state of emergency, there were only 17 cases of infection and no deaths. In Canada, there were 176 cases and only one death. Right now, Quebec is considered one of the champions of lockdown measures and adherence to lockdown and social distancing. Nevertheless, we are the leader in terms of the number of infections and cases, and deaths are concentrated in living environments such as CHSLDs.

Especially with regard to the rationing of personal protective equipment, how do you explain the fact that after the SARS crisis we were unable to cope with the pandemic, with our national stockpile depleted? What role did your association play, from the SARS episode to the present day, to put us in such a situation?

● (1305)

[*English*]

Mr. Ian Culbert: Certainly many of the lessons of SARS have been learned, and I think we would be in a much worse situation if we had not followed those recommendations as closely as we did. We have the Public Health Agency of Canada, which is really doing a tremendous amount of work, and the coordination work that they're doing is incredible.

Have those lessons been learned—

[*Translation*]

Mr. Luc Thériault: Is everything really going according to plan with respect to the shortage and the availability of equipment in the national emergency strategic stockpile?

[*English*]

Mr. Ian Culbert: Absolutely not. I would say that the national emergency stockpile is probably the largest failure in our response to date. As I mentioned, it is one of those things that require much greater collaboration between the federal government and the provincial and territorial governments.

[*Translation*]

Mr. Luc Thériault: How much time do I have left, Mr. Chair?

The Chair: Thank you, Mr. Thériault.

[*English*]

We go now to Mr Davies.

Mr. Davies, you have two and a half minutes, please.

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

[*Translation*]

I am sorry, but I'm going to ask Ms. Lapointe my question in English.

[*English*]

Madame Lapointe, Quebec's COVID-19 cases far exceed those in any other province. The numbers that came out today show a rate of 110 positive cases per 100,000 and no other province is above 50 cases per 100,000.

I'm wondering if you could tell us why that is.

[*Translation*]

Ms. Linda Lapointe: We believe this is largely due to the number of tests that have been done. In Quebec, we have been at the forefront of testing people. That is probably the main reason why we have so many positive cases.

[*English*]

Mr. Don Davies: Thank you.

One of the other profound observations of the Campbell SARS report said:

> That in any future infectious disease crisis, the precautionary principle guide the development, implementation and monitoring of worker safety procedures, guidelines, processes and systems.

Now many people are expressing that they think the reaction of the Public Health Agency of Canada may have been too slow and too cautious—too slow to close borders and impose travel restrictions, too slow to acknowledge community transmission, too slow to acknowledge asymptomatic transmissions, too slow to recommend the potential that masks may have in helping to reduce transmission. You identified as well that perhaps the agency was too slow in identifying potential airborne transmission.

What is your sense, Madame Lapointe? Are we fully displaying the precautionary principle, or do you think we are being too slow in getting ahead with measures that may help in slowing the spread of the virus?

[*Translation*]

Ms. Linda Lapointe: I will speak for the healthcare professionals we represent. We have been slow to protect them. It's something we have noticed in the field for several weeks now.

With regard to contamination in CHSLDs, once family visits were stopped, it's possible that healthcare professionals may have infected patients, but we will never know. There were also healthcare professionals visiting several healthcare establishments. We're in the process of correcting that. If an asymptomatic infected person visits two or three establishments, there's no question that this can lead to further contamination.

[*English*]

The Chair: Thank you, Mr. Davies.

That ends our second round. We go now to our third round. We begin with Ms. Jansen.

Ms. Jansen, you have five minutes. Go ahead.

● (1310)

Mrs. Tamara Jansen (Cloverdale—Langley City, CPC): Thank you so much, everybody, for joining us as we try to understand what's working and what's not working.

I wonder if I could address my first question to Mr. Ian Culbert. You mentioned that Dr. Tam was taking an incremental approach to the restrictions because Canadians wouldn't be willing to comply and it had to be done slowly.

For me, I'm about an hour outside of Vancouver. On January 21, I hosted a Chinese New Year event, and the Langley Chinese Arts and Cultural Association did a beautiful presentation for us. It was fantastic. Then by January 25, it cancelled its much larger presentation that was going to happen in Langley due to the COVID crisis. They were begging me to get the government to be more proactive. They themselves as a community began to pick people up from the airport who were returning from China to ensure they didn't take cabs. They were buying them groceries so that they wouldn't go to grocery stores. This was all done on a completely voluntary basis.

I'm just wondering—is it possible that it was because of a misjudgment of the willingness of Canadians to self-isolate that this didn't go quicker?

Mr. Ian Culbert: I would say that you're talking about a highly sensitized community in that situation. They had a direct connection to what was happening in China and were very much aware. I think many Canadians were not that connected and were thinking of it as a problem on the other side of the country.

Mrs. Tamara Jansen: Thank you. I appreciate that.

I have a question now for Linda Lapointe.

You mentioned that there was a stockpile failure. You mentioned it in your presentation in regard to PPE and said that reuse was a real disaster. I know Linda Silas mentioned it was “sick, sick, sick”. That was what she said at our last meeting. Then you mentioned at the end of your presentation that the government was really pulling out all the stops, so that's fantastic to hear.

Does that mean that you have been able to stop the reuse of PPE? I have not heard that here on the western side of Canada.

[*Translation*]

Ms. Linda Lapointe: No, we have not halted reuse of equipment. For the time being, in Quebec, we are not at the point of having to reuse equipment, particularly masks, but we know that healthcare establishments are considering this practice. Apparently, one establishment in Quebec City has found a way to disinfect equipment. However, we don't know what disinfection methods that employer intends to put in place. At the moment, we do not reuse or disinfect equipment, but if we were to run out, it could be a solution.

[*English*]

Mrs. Tamara Jansen: Then I'm not exactly sure what you meant by “pulling out the stops”. I know that here in B.C. we're actually begging community organizations and businesses to donate PPE. I believe that's helping, but it's hard to tell.

I have a third question, and it would be for Dr. Naveed Mohammad.

At our last meeting, Dr. Alan Drummond said there was a lesson that we absolutely haven't learned. We started out talking about the surge capacity, and I think you've made it clear that surge capacity was created in your area by cancelling other medical procedures. Dr. Alan Drummond mentioned the fact that we're actually cancelling cancer surgeries to make way for that surge capacity.

The lesson he felt we hadn't learned was the idea of field hospitals in order to be able to take care of COVID patients separately from the regular needs. I wonder if you could speak to that, because you obviously have a field hospital, but you are actually creating surge capacity by cancelling regular and necessary health procedures.

Dr. Naveed Mohammad: I'll answer it in two parts.

Surge capacity is not a new problem in Canada, or in Ontario, or certainly in our region here in the Central West LHIN. This is being highlighted right now because of the COVID crisis, but every year during the flu season, hospitals across Canada and across the U.S. suffer significant surge issues, which is where hallway medicine comes from. I think that's the lesson. If we can use this opportunity to learn that lesson, it will be great, because even if we control COVID, we're still going to have surge capacity issues next year during the fall flu season and in the year afterward.

● (1315)

Mrs. Tamara Jansen: Would you disagree with Dr. Alan Drummond about the idea of having field hospitals where we could keep the COVID patients isolated, then?

Dr. Naveed Mohammad: I wouldn't disagree with that, but what I'm trying to say is that there are field hospitals that are now being set up at our peer hospitals in Toronto, and we're also looking at a bigger field hospital plan. However, I think it is a shame if a first world country that most of the world wants to immigrate to is using field hospitals to meet its annual surge.

Yes, right now we need to use field hospitals, but I think the federal and the provincial governments have to work together to realize that the number of beds that we have to serve our population on a daily basis is currently significantly below what we actually need.

Mrs. Tamara Jansen: Okay—

The Chair: Thank you, Mrs. Jansen.

We go now to Mr. Kelloway.

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

Mr. Mike Kelloway (Cape Breton—Canso, Lib.): Thank you, Mr. Chair.

Hello, colleagues.

To the witnesses, thank you for coming today and thanks to all the essential workers from coast to coast to coast.

My first question is to President Dingwall.

We know that our government will be launching a mental health portal for Canadians, as the Minister of Health has said in press conferences, and I would like to know if you're hearing from your students about the impact this has had on their mental health. That's my first question. Also, is your university taking measures to support students during this time?

Hon. David Dingwall: Thank you for the question.

With regard to mental health, I think the number of cases has significantly increased in terms of the numbers of questions and students reaching out for forms of comfort and attention. The anxiety level is beyond what we've all seen in the past, and we have a number of students who find it quite difficult to concentrate on studies and practise social distancing. They're worried about their families, wherever they may come from, and they have very little access to the kinds of necessities of life that we just take for granted.

When you take all of those things together, the mental health and anguish are real. We at the university, through our student services, through consultations with student representatives and through parents, are trying to put some different packages together, whether it be with regard to food, tuition or meaningful dialogue.

Our faculty have reached out to the student body, in terms of…

This is exam time as we now speak. Students are writing, so faculty have reached out to try to accommodate them through remote learning. It's gone reasonably well; there are always gaps, but there is a concerted effort by the faculty, the administration and student services to be helpful to our students who find mental health to be a real challenge.

Mr. Mike Kelloway: Thank you, Mr. Dingwall.

I have another question, and it is around student employment.

The Prime Minister announced new changes regarding the Canada summer jobs program to ensure that students could still work and get the experience they need during this tough time. I would like to hear your thoughts on this announcement and on how applicable it is at this time in terms of perhaps even changing the scope of what we traditionally know as summer work.

Hon. David Dingwall: As all of us who have gone to university know, students would like to work during the summer months to help to pay for their tuition and for their finances going forward. The program is certainly welcome, but what are employers going to do? Are they going to be reaching out to have students come to their place of business and work if they have other citizens and workers who are laid off? We will have to wait and see, but it's certainly a welcome addition, particularly for our student body, because most of them do like to work during the summer months in order to gather that kitty for the tuition in their academic year, but it is still a wait-and-see situation.

I hope employers—public sector employers, private sector employers, government agencies—will take advantage of this new program that the Prime Minister has announced.

● (1320)

Mr. Mike Kelloway: Thanks very much.

Mr. Chair, how much time do I have?

The Chair: You have one minute.

Mr. Mike Kelloway: Okay. I'm going to stick with President Dingwall for my last question.

You were an MP for, I believe, 17 years, and a cabinet minister, a minister of health, as has been mentioned during this session. Do you have anything you can compare this to during your time in government, or around the cabinet table as a minister of health or a minister of public works? Was there anything comparable that you dealt with during your time? Obviously this is unprecedented, but are there some similarities or some terms of reference you can call upon and share with us?

Hon. David Dingwall: Not really. We had to deal with the blood crisis and we had an inquiry into that. We had the AIDS issue and we had the smoking programs, but in terms of this particular virus that has hit us as a country, that has hit the world, I haven't seen anything like it.

If you go back in history and look at what the World Health Organization has studied, whether it be smallpox or whatever, this is quite rare in terms of Canadian society. I think there are so many lessons that we're going to learn as a result of this particular virus hitting us the way it has, but I don't think we can miss the opportunity.

We can talk about framework; we can talk about consultation; we can talk about programs, but unless there are statutory obligations on individuals and providers and health care organizations, it will be all for naught. When people have to lay a report before the Parliament of Canada and tell members of Parliament what they have done with that $250 million on research, or whatever it is, that's an obligation they take quite seriously.

I'm all in favour of better frameworks and better communications, but without statutory obligations, we will not hit our objectives.

The Chair: Thank you, Mr. Kelloway. We will go now to Mr. Jeneroux.

Mr. Jeneroux, please go ahead for five minutes.

Mr. Matt Jeneroux (Edmonton Riverbend, CPC): Thank you, Mr. Chair.

Thank you, witnesses, for being here today, and thank you as well as to your accompanying associations for all the work you're doing on this pandemic.

We on the opposition side are looking to ask tough questions, but largely in the role of better supporting and advising this and future governments on any sort of pandemic planning, so I appreciate your being able to weigh in.

My first question will be for Mr. Culbert.

Correct me if I'm wrong. The national emergency stockpile, you said, could have been in better shape prior to this. Is that a correct statement?

Mr. Ian Culbert: Yes.

Mr. Matt Jeneroux: Great.

Follow me as I walk through some of this timeline. We saw that the minister was advised in a February 10 memo to work with the provinces and advise the provinces on stockpile information only if asked. February 10 was past the date on which, I believe, 16 tonnes of PPE materials were shipped to China.

Could you comment on where there could maybe have been better planning? Maybe the optics of that aren't so good when you're speaking about having the stockpile in better readiness for when the virus eventually did hit Canada.

Mr. Ian Culbert: Certainly.

First, I don't think it was ever imagined that the national emergency stockpile would be able to supply all of Canada in this kind of an outbreak. Keep in mind that SARS was limited to Ontario and B.C. predominantly. H1N1 was a different kind of outbreak, so the types of supplies required were different.

First and foremost, we have to rethink what the national emergency stockpile should look like in the future to respond to the evolution of pandemics.

At the point the shipment was made, I believe it was ascertained that the risk to Canadians was still very low and that this was a way of moving the front line of the pandemic outside of Canada. If we were able to stop transmission in China, we might be able to reduce the numbers here. That's what public health policy tries to do: keep that containment circle as large as possible.

In hindsight, was it the best decision? Possibly not, but I think it was made in good faith, with the best information available at the time.

● (1325)

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

For Madame Lapointe, I have a similar question.

Again, the 16 tonnes of material was sent to China days before the minister was advised about this and sharing this information with her colleagues. I'm curious if you can comment from the perspective of your members—the nurses, the assistant nurses and the respiratory therapists—on what the optics of that look like and perhaps some better planning that could have been in place.

[*Translation*]

Ms. Linda Lapointe: Absolutely. I want to believe that the decision was made based on the situation at the time, but we knew very well that the snapshot on February 10 was not going to be the same. Epidemiologists and experts did not seem to think that Quebec in particular would see such a significant surge. In my opinion, we should not have taken the risk. I understand that we wanted to reduce the spread, but we should have at least made sure that our healthcare professionals across Canada had the necessary equipment.

We now find ourselves with healthcare professionals having been unprotected for the past three weeks. We're not there yet, but in other countries about 14% of healthcare workers have been infected by the virus and there have been deaths, particularly in Italy and Spain. I would hope that there will be no deaths among our healthcare professionals in Canada, that would be unfortunate.

[*English*]

Mr. Matt Jeneroux: Just out of curiosity, Madame Lapointe, was your association consulted on any of that? Has it been consulted on the emergency stockpile by the minister herself?

[*Translation*]

Ms. Linda Lapointe: No, we were not consulted at all with respect to the national stockpile. Even at the provincial level, we asked questions regularly about the amount of equipment in each facility and overall. We never received any answers to our questions.

[*English*]

The Chair: Thank you, Mr. Jeneroux.

We'll go now to Dr. Powlowski.

Dr. Powlowski, go ahead for five minutes, please.

Mr. Marcus Powlowski (Thunder Bay—Rainy River, Lib.): I have a quick question for Dr. Mohammad. Woody says hello, by the way.

You mentioned the lack of medications for sedation and anaesthesia. I would think you were talking about maybe propofol and Midazolam. I'm not sure of the jurisdiction in terms of procuring medications. I would think, as with most things in curative medicine, that it's the Government of Ontario. I would also think that our federal government, as with all kinds of procurement, has pulled out all the stops and tried to do its best to get these things.

Do you know specifically what's being done to try to expedite access to propofol or Midazolam? I know Ventolin is another one.

Dr. Naveed Mohammad: You're right that the medications that I'm referring to are propofol and Midazolam. There's also fentanyl. What's happening is that people who are presenting with COVID-19 and have significant respiratory distress, when we've had to sedate them and put them on ventilators, many of them have had to be on ventilators for much longer periods of time than we usually have people on ventilators, so that has increased not only the length of time we use the medications but also the volume of patients that we now have in our ICUs.

Ventolin is also in short supply. That's more of a community issue right now. In hospitals, we're okay with Ventolin.

We're basically working through our usual partners. The Ministry of Health and its sources is one of the partners, but we have significant relationships with our supply chain, with our drug companies, because of the large amounts of purchasing that we do, as many hospitals do throughout Ontario. Right now, just as with PPE, since the issue is not localized to Canada and China, or to Ontario and China as in the case of SARS, but is a worldwide issue, the suppliers are probably not able to create it as fast as they need to.

Once again, this goes back to what we can do to prepare and have these things on hand. I know that unlike PPE, drugs will expire, so that is something that we'll have to go back and look in a more innovative way at how we can cycle these through our warehouses so that if an event like this occurs again, or if and when an event like this occurs again, we can be much better prepared.

● (1330)

Mr. Marcus Powlowski: Thank you very much. We'll do whatever we can at the national level to push this same issue and access those medications.

I want to quickly change gears and ask a bit of an academic question to Mr. Culbert. He mentioned that our approach from a public health perspective with respect to this crisis was first to try to suggest things to people, to educate the public. We were left coercive actions only as a last resort. I think the Public Health Agency of Canada and the Ministry of Health have been criticized as being maybe too slow in doing this.

However—and I would throw this back at the public health community and public health academia—I would suggest that this approach only reflects the prevailing attitudes of public health and public health academia. Having myself gone through a bit of public health university and also having been involved in writing public health legislation, I think there's been a tremendous swing in the pendulum, away from what used to be a heavy emphasis on coercive action to control the spread of infectious disease while giving scant attention to impeding individual liberties. Over the years, because of a lack of infectious disease, we've become a lot more concerned about doing everything possible not to infringe on individual liberties, and we've been very reluctant to use any sort of coercive action to control the spread of infectious disease. This is public health academia. Although our government was criticized for it, it is the prevailing attitude in public health academia and public health circles in the western world.

I'm throwing it out to you that this was perhaps a mistake on the part of the public health community.

Mr. Ian Culbert: Thank you for your question. I would suggest that we have some evidence to show that coercive actions can only be used as a last resort. For example, forcing people living with TB into sanatoriums earlier in the 20th century resulted in their avoiding public health authorities, going underground and actually continuing the spread of TB.

We have had a massive cultural change as well over the last 100 years in the public's attitude towards science and authority. We only have to look at the growth of vaccine hesitancy and vaccine denial to see that just telling people the right thing to do does not work anymore. We have to convince people and bring them along that path. It takes time, unfortunately, and we don't always have time to do it, but it is actually what works.

The Chair: Thank you, Dr. Powlowski.

We go now to Mr. Thériault.

[*Translation*]

You have two and a half minutes.

Mr. Luc Thériault: Thank you, Mr. Chair. I'm going to go to Ms. Lapointe.

In conclusion, I would like to summarize your message to us today. If we want to counter such a virulent pandemic by applying the precautionary principle in terms of public health and workplace health and safety, that means we cannot continue to make health networks weak and precarious by underfunding them. Adequate funding would be particularly useful for front-line services, as well as for applying the precautionary principle, which is so important in public health.

You also tell us that we could have been better prepared and that the precautionary principle should not vary according to the amount of equipment we have in reserve to protect the public. You also said that we need to work on this, in order to become less reliant on wheeling and dealing in the global market.

In the end, you want us to not come out of this episode with recommendations put aside as we did after the SARS episode, when we weren't thorough enough.

● (1335)

Ms. Linda Lapointe: Absolutely. It's not only in Quebec, it's like that everywhere in Canada. Working conditions for healthcare professionals are not easy, and it's not just during a pandemic. They have an enormous workload all the time, not to mention the medical complexity of patients' problem and the staff shortage.

We have long advocated for an adequate nurse-to-patient ratio precisely to provide safe care. In a normal setting, we're always short-staffed. Healthcare professionals work overtime and do not necessarily work in the best conditions. This is particularly the case during a pandemic when the collective agreement is suspended. We send our professionals from one activity centre to another and we don't systematically verify whether they have the required expertise or whether it's the priority of their activity centre. We are all over the map with our healthcare professionals. This does nothing to attract and retain healthcare professionals.

When this crisis is over, people will be tempted. There's a good chance that people will leave the profession. They will change careers. The situation doesn't make professionals want to stay or the public want to study in this field. This must be addressed since it will be an issue over the short and medium term.

Mr. Luc Thériault: Thank you very much.

The Chair: Thank you, Mr. Thériault.

[*English*]

We go now to Mr. Davies.

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

I'd like to focus on what we can do moving forward to better prepare our country in the future.

It's quite clear now that hospitals are routinely operating above the capacities that they were built for. I note that the Brampton hospital, where Dr. Mohammad works, was built for 90,000 patients per year. It routinely sees 140,000 patients per year. Obviously there is concern about our hospitals' ability to deal with surges. We're having to set up tents and field hospitals.

Mr. Culbert, you spoke of chronic underfunding of our health care system and you said that's primarily outside federal jurisdiction. In 2014, the federal government reduced the health care escalator from 6% to 3%, and that decision was confirmed again with the present government, even though we know that health care costs are rising by about 5.2% per year.

Is this an opportunity for us? Would you advise the federal government to take a look at that escalator and see if we should be increasing it to keep up with inflation?

Mr. Ian Culbert: My comment was speaking specifically to the federal government's role in public health, which is the prevention and health promotion side of the equation, and it doesn't have a role. I will reassert that the more we keep people healthy, the more likely we'll have a sustainable health care system and keep people out of hospitals except when urgently necessary.

Obviously we need to look at funding across the board, but consistently we don't fund the preventive side of the equation sufficiently. Two to five per cent of the overall health budget is spent on keeping people healthy. That means we put an emphasis on sickness and not on health.

Mr. Don Davies: Dr. Mohammad, one of your four recommendations was that we move forward on national pharmacare. I wonder if you could expand on that and why you think that's an important policy for the federal government moving forward.

Dr. Naveed Mohammad: The first thing is that right now there is talk about certain medications that may or may not work with COVID-19. I know that the evidence is preliminary, but many people who have drug plans or are able to afford it have gone out and stockpiled those medications. Many of those most vulnerable people who may have the highest exposure rate cannot afford these medications. I think that a national pharmacare strategy for all of our citizens, especially those who are most in need, is significantly important, not only for issues like COVID-19 but for any illness.

I know of people who have to pay out of pocket, and when we give them medication that's prescribed for four times a day or twice a day, they only take it once a day or at half the recommended dose to make it last longer, because they can't afford it, and that's under normal circumstances. The vulnerable populations are much more exposed to issues like this. They are sometimes forced to work because they need to work, and they expose themselves to COVID-19. For them, this is of the utmost importance.

● (1340)

Mr. Don Davies: Thank you.

The Chair: Thank you, Mr. Davies.

That wraps up our questioning. I would like to thank our panel, all of you, for giving us so freely of your time and your valuable perspectives. It has been most helpful.

As we bring this meeting to a close, I'd like to compliment the House of Commons staff and technical personnel for a great job in this very first House of Commons committee meeting by video conference. As far as I'm concerned, it's a great job. Well done. Thank you.

With that, the meeting stands adjourned.