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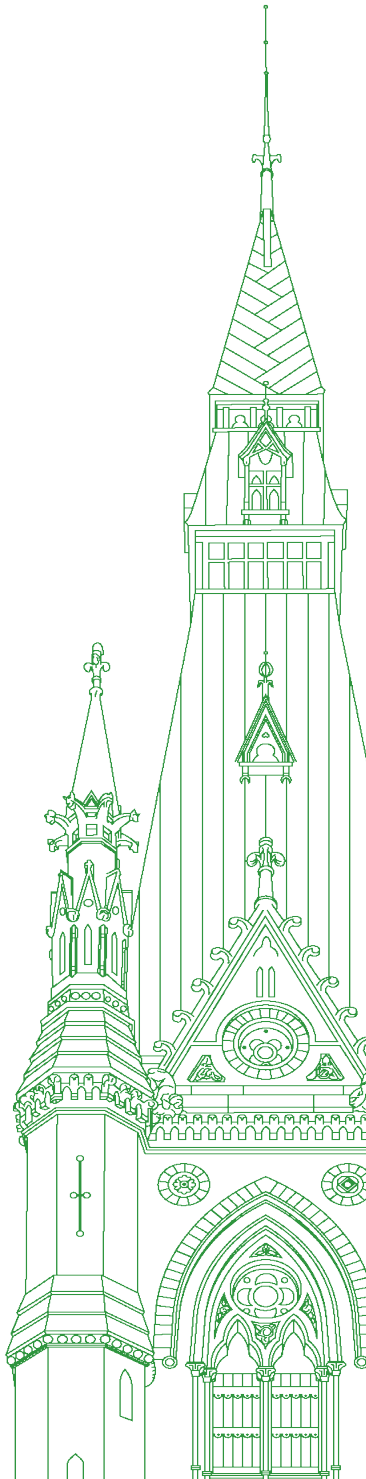

Chair: Mr. Ron McKinnon

Standing Committee on Health

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● (1415)

[*English*]

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

I would like to welcome everyone to meeting number 10 of the House of Commons Standing Committee on Health. Pursuant to the order of reference of Tuesday, March 24, the committee is meeting for a briefing on the government's response to the COVID-19 pandemic. Today's meeting is taking place exclusively by teleconference and the audio feed of our proceedings is made available via the House of Commons website.

Since we can't see who is in the room, I would like to acknowledge who is in the room.

I'm Ron McKinnon, the chair. We have the clerk of the committee, Michael MacPherson. We have the Library of Parliament analysts Karin Phillips and Sonya Norris.

For the Conservative Party, we have Matt Jeneroux, Dr. Robert Kitchen, Len Webber and Tamara Jansen. For the Bloc Québécois, we have Luc Thériault, and sitting in as well from the Bloc we have Martin Champoux. For the NDP, we have Don Davies. For the Liberal Party, we have Tony Van Bynen, Sonia Sidhu, Dr. Marcus Powlowski, Mike Kelloway and Darren Fisher. Sitting in on the Liberal side is Dr. Helena Jaczek. We may have Jenica Atwin from the Green Party on the line as well.

As witnesses, from the Canadian Association of Emergency Physicians we have Dr. Alan Drummond and Dr. Howard Ovens. From the Canadian Federation of Nurses Unions, we have Ms. Linda Silas. From the Canadian Medical Association, we have Dr. Sandy Buchman. From the Canadian Pharmacists Association, we have Dr. Barry Power and Dr. Shelita Dattani.

Once again, everybody, when you speak, if you're reading a statement, please bear in mind that simultaneous translation is difficult in these circumstances. Speak slowly. Speak carefully. I would like to emphasize that you should please wait until I recognize you by name before speaking. When I recognize you by name, please unmute your microphone before you begin speaking. Once again, there is no moderator on the call, so please mute your line when you're not speaking.

During questions and answers, I ask that members identify the witness to whom they are addressing their questions rather than simply directing their question to the entire panel. This will allow me to recognize the witness and give that person the floor. All comments by members and witnesses should be addressed through the chair.

Members, should you need to request the floor outside of your designated time for questions, please unmute your microphone and signal this to the chair. When speaking, please speak slowly and clearly and do not use speakerphone. Should any technical challenges arise, in particular in relation to interpretation, please advise the chair, and the technical team will work to resolve them. Please note that we may need to suspend during these times, as we need to ensure all members are able to participate fully.

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 group will have 10 minutes for an opening statement, followed by the usual rounds of questions from members. We have previously agreed that we will have three rounds of questions.

I would now like to welcome our witnesses.

We'll start with the Canadian Association of Emergency Physicians.

Dr. Drummond, you have 10 minutes for an opening statement. Please proceed.

Dr. Alan Drummond (Co-Chair, Public Affairs Committee, Canadian Association of Emergency Physicians): Thank you, Mr. Chair and members of the committee.

The Canadian Association of Emergency Physicians is the national specialty society for emergency medicine. Our 2,500 members provide front-line emergency care to the millions of Canadians who make over 15 million emergency department visits each year.

In our belief, Canadians have a right to receive timely access to quality emergency care, but the decades-long neglect of our emergency health care system has made this largely an aspirational goal rather than a reality. Emergency departments are crowded because of our inability to transfer admitted patients to the wards and the ICUs in a timely fashion, leading to care routinely given in hallways, with increases in risk of contagion and in unnecessary morbidity or mortality.

The safe occupancy rate of a hospital is known to be 85% to allow for efficient operation and to provide surge capacity. However, Canadian hospitals routinely operate at over 100% capacity. In order to achieve needed surge capacity, our provinces have had to drastically cut back on scheduled surgeries and routine ambulatory care. However, we are now extremely grateful to be at about 75% occupancy across the country. That's a good thing.

The other major chronic challenge is insufficient human resources. We are chronically short of trained emergency physicians and have insufficient residency positions across the country to alleviate that shortage. Our collaborative working group on the future of emergency medicine identified in 2016 that Canada had a shortfall of around 500 emergency physicians, estimated to increase to about 1,100 by this year, and no changes have been made in the intervening years.

With respect to the COVID-19 pandemic that was declared by the World Health Organization in March, the novel coronavirus has lived up to the phrase “novel”. Though we are slowly coming to an understanding of its epidemiology and its transmission, we are already aware of its potential to rapidly evolve and cause serious respiratory illness and death. There is no cure for COVID-19, and management at this point is purely supportive.

It's important to keep a perspective. While it appears to be a mild illness for the majority of people infected, hospital admission rates of over 10% have been reported, with an ICU admission rate of approximately 3%. The overall case fatality rate for the population is estimated to be between 1% to 3%, but the total rises as the individual ages, with a case fatality rate of at least 13% to 14% in those over age 80.

For those who require a ventilator, the case fatality rate is extremely high, and the time on the ventilator is often long, measured in weeks. For survivors, the extent of persistent health problems beyond their time of ventilation is unknown.

The challenge facing us in Canada is that we have been provided with a very precious window of opportunity to learn from the lessons of our colleagues in Italy and New York and those other areas that were hit hard early, and to use that time wisely to maximally prepare for what may befall us should the curve not be flattened appropriately.

In our view, there are three main components of the overall challenge we may face as a nation, but all can be encapsulated by the word “capacity”. This falls, then, into three components: health human resources, technology and physical space.

With respect to health human resources, our first challenge will be to maintain adequate human resources in the emergency departments. Emergency physicians and nurses on the front lines are clearly at increased risk of exposure and thus of being unable to work because of quarantine and/or infection. Staffing, particularly in rural departments with a smaller pool of physicians to draw upon, is tenuous on a good day, and given our overall shortage of emergency physicians, this will undoubtedly be a major issue for them.

The only way to maintain such capacity in emergency departments is to provide sufficient quantities of personal protective equipment to staff. Our members are sharing with us disturbing reports, as you're aware, of insufficient quantity, rationing or uncertain availability. The pandemic has not yet peaked and the virus will be with us for some time, so we need to continue to build our supply and distribution chains coast to coast so that all front-line staff have the appropriate protective equipment to provide care safely.

● (1420)

With respect to technological resources, there are two major concerns: access to adequate and appropriate laboratory testing and screening, and access to ventilators.

By necessity, current testing has needed to focus on the highest-priority groups, including health care workers and patients in hospitals, long-term care facilities and other facilities, but we must radically increase capacity to allow us to expand testing to all who are symptomatic, as well as develop a well-designed surveillance strategy to complement this testing. Public Health will need to increase capacity to react to an increased testing volume to ensure we promptly contact and isolate trace positives. Only when these two steps are in place should we safely loosen current public restrictions on gathering and movement.

The second concern, as you are undoubtably aware, is the availability of life-saving equipment, most notably ventilators. We know, following the H1N1 pandemic in 2009, that the Canada-wide ventilator supply was about 5,000, with regional disparities such that in Alberta there were 10 ventilators per 100,000 people, while in Newfoundland it was as high as 24.

Worryingly, when the Ontario government developed a plan for an influenza pandemic in 2005 and used a standard modelling exercise and an attack rate of 35%, it was estimated that at the peak of an influenza pandemic, patients would require over 170% of available ICU beds and about 120% of the ventilators in Ontario. Sobering also was the estimate that up to 50% of health care providers could become infected. This model envisioned an almost apocalyptic, but now very realistic, scenario in which more than twice as many patients would require intensive care with less than half the usual staff available to provide it, underlining the aforementioned critical need for personal protective equipment, surge capacity and a stockpile of ventilators.

With respect to space, we've talked about ICU space and we've talked about emergency department crowding, but hospitals will also need to provide space for those patients requiring supportive and/or palliative care. No Canadian should ever be allowed to die in a hallway.

We also need adequate space to continue to care for other patients needing acute care. They cannot be forgotten.

I am now going to pass you over to Howard Ovens.

● (1425)

Dr. Howard Ovens (Member, Public Affairs Committee, Canadian Association of Emergency Physicians): Thank you.

Specifically with respect to the role of the federal government, there has been no apparent national coordination of public health measures, leaving a very confusing and differing set of measures on business closures and public gathering restrictions, varying from city to city and province to province. There must be clarity and federally coordinated messaging with respect to strict and uniform preventive public health measures, including public masking, gathering sizes and travel restrictions.

The importance of consistent messaging for effective communication should outweigh potential jurisdictional concerns. Until now, the federal government has only been one voice among many, which has led to conflicting and confusing direction to the Canadian public and to health care providers. CAEP believes that it could have a partnership role in a stronger federal role, in that emergency physicians are generally perceived by the public as knowledgeable and credible, since we are on the front lines of the battle and we're ready to help.

To avoid provinces competing with each other for needed supplies as we approach the surge in the coming weeks, we need the federal government to ensure the rapid and continuous procurement and distribution of vital PPE, laboratory supplies, testing kits and ventilators. Of all these things, right now personal protective equipment is the top priority, in order to secure the health and trust of the acute care and emergency workforce. Expert-based, standardized recommendations for PPE must continue to be developed as we get new knowledge and disseminate it across the country, especially to ensure that rural and smaller centres that may not have local expertise are provided with the same level of comfort and safety as larger centres. To the extent possible, transparency in this is necessary to ensure that recommendations are indeed based on an appropriate abundance of caution rather than the availability of supplies.

During a crisis, it is well established that an effective and lean command and control system is critically important, yet we still do not have an integrated incident management system in place. As a result, we have multiple ministries, departments and agencies involved in a confusing and overlapping span of control. An IMS approach would help implement all of our recommendations and ensure the ability to respond quickly to changing science and circumstances.

Therefore, we see an immediate need for the following: one, create a national incident management system, vertically integrated with provincial systems; two, standardize public health measures and communication nationally; three, use the IMS and the emergency powers act to ramp up domestic production of PPE, equipment and medication, and create a national distribution system to avoid balkanization; and four, ramp up national testing capacity and standardize an aggressive national surveillance strategy to go along with isolation and contact tracing of positives.

Canada faces an unprecedented public health crisis. A national crisis requires national leadership. We need the federal government to provide a steady, clear voice that signals decisive leadership and clear command and control. As emergency physicians, we will stand with you as we embark on this unique challenge and a national enterprise of delivering hope to our citizens.

On behalf of our colleagues, Dr. Drummond and I thank you for the opportunity.

● (1430)

The Chair: Thank you, Dr. Ovens.

We go now to the Canadian Federation of Nurses Unions. Ms. Silas, president, please go ahead for 10 minutes.

Ms. Linda Silas (President, Canadian Federation of Nurses Unions): Thank you very much. I'd like to thank the members of this committee for coming together to tackle what represents our generation's biggest challenge.

I have the honour of being invited here as president of the Canadian Federation of Nurses Unions, but I'm also here to give a voice to the close to one million health care workers across Canada. We're all in this together. Regardless of whether your job is to keep the place spotless or to perform an intubation to a critically ill patient, health care delivery is and always has been a team sport. This means the recommendation your committee will be making to the Government of Canada impacts the lives of not only those who care for the sick in our country but also the lives of the millions of others who live alongside us.

I wish I could be here to recognize the strong work of the Public Health Agency of Canada and Dr. Tam's team, in which I include all the chief public health officers across the country, for what they have done in public awareness and education—and I stress “public”. People across Canada understand that they have an important role in flattening the curve of the outbreak to help the country out of this pandemic.

I wish I could be here to comment on the many initiatives the government has announced to support Canadian workers today and to kick-start our economy tomorrow. Unfortunately, I am not. I'm here to bring light to the sad and scary realities of our health care system.

As you know, the Public Health Agency of Canada was created in the wake of the SARS crisis. Since its beginning, it has taken its public health duties very seriously. 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. That's why I'm here. It's to implore you to take a stand for the health care workforce by calling for the Prime Minister and the government to invoke the measures of the Emergencies Act to help our health care system survive this global pandemic.

The CFNU believes that the current situation in both acute and long-term care settings across Canada fits the law's definition of an emergency that rises above the ability of one province to cope, thereby representing a risk to other provinces. The time for our government to act is now.

You just heard Dr. Ovens say that government is only one voice among many. We are humbled by the gratitude government officials have expressed for our work, but gratitude will not save lives. Given the amount of uncertainty around this novel virus and the real threat to the safety of health care workers across Canada, CFNU is pleading with the government to designate, at a minimum, airborne precautions and the use of N95 respirators at all times in so-called clinical hot spots. These include intensive care units, emergency rooms, operating rooms, trauma centres and units for managing COVID-19 patients. Our goal is to make sure that health care workers are protected 100% of the time when they're providing care to those patients—well, I have to say, as close as we can get to protecting them.

We're also asking that you recognize the critical importance of point-of-care risk assessment: the idea that individual health care workers are in the best position to determine the appropriate PPE required, based on the needs of their situation and the interaction with the individual patient. I find it striking that as recently as a couple of months ago, government, employers and managers around this country respected the clinical and professional judgment of the health care team, both in identifying the most appropriate care for our patients and in determining what health and safety measures we needed to protect ourselves. Today the same governments, employers and managers are locking up personal protective equipment to keep it away from the health care workforce.

Shame on us all. We've clearly failed in our duties to those who care for the sick and the vulnerable.

CFNU's view, and that of numerous experts we've consulted with, is that the government's approach fails to recognize the fundamental importance of the precautionary principle and its guidelines. Nurses and doctors sadly learned from our experience with SARS that the precautionary principle must be applied. We lost two nurses and one doctor with SARS, and that was with 44 deaths in all. Today, between 10% and 15% of those infected with COVID-19 are health care workers.

● (1435)

This is not fearmongering; this is the reality on the front line. We want decision-makers to understand that no infection prevention and control guidelines and PPE measures can be developed and implemented without working with unions and joint occupational health and safety committees. Until the Public Health Agency of Canada's guidance document for acute care facilities for COVID-19 is updated to reflect our various serious concerns, we are encouraging all health care workers to follow the letter of the law when it comes to occupational health and safety, and that is to report any hazard and protect their own health and safety.

I shared with you by email the joint statement issued by the Canadian labour organizations that represent all health care workers. It calls on the Public Health Agency of Canada and all provincial health offices to protect health care workers and their patients by adhering to the precautionary principle. 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.

As members of the health committee, you are all well aware that our health care system is already running over capacity. We simply cannot afford to erode staffing levels any further by having health care workers become sick or having to self-quarantine. Front-line workers across the country who are directly involved in the care of presumed and confirmed COVID-19 patients are not being provided with the PPE they need to do their jobs. This is simply outrageous and unacceptable in a world-class health care system like ours.

However, there are examples of best practices that are beginning to appear across the country. Joint agreements between unions and employers to respect the clinical judgment of health care teams have now been signed in British Columbia, Alberta, Ontario and, last night, in New Brunswick. In Quebec, Newfoundland and Alberta, uniforms are being provided to those caring for COVID-19 patients. In Nova Scotia, we are seeing new measures being developed to assist the long-term care sector.

Some see the shortage of PPE supplies as the driving factor behind regulations advocating the use of surgical masks over N95 masks. CFNU and other health care unions have offered to work hand in hand with government to address the PPE supplies issue and to ensure their appropriate use, but we need transparency, honesty and leadership from our governments.

To conclude, you may be aware that I started my career as a critical care nurse in beautiful New Brunswick. Since then, medical technology has come a long way, but one thing that hasn't changed is that as health care workers, we cannot anticipate and plan for every situation. Patients who are anxious or in respiratory distress cannot be expected to be calm. Patients won't always cough into their elbows, nor will the nurse always have the opportunity to maintain a two-metre distance from a patient. Machines fail, and human error is an unfortunate reality.

Quite simply, unpredictable and unforeseen circumstances are part of working in the health care environment. That is why, as a society, we need to protect our health care teams. Unlike many of us, they don't have the luxury of working from home. As policy-makers, we have to respect their clinical judgment, because ultimately, it's the health care workers who will be providing care for one of our loved ones.

Thank you.

The Chair: Thank you, Ms. Silas.

We go now to Dr. Sandy Buchman, president of the Canadian Medical Association.

Please go ahead, Dr. Buchman. You have 10 minutes.

Dr. Sandy Buchman (President, Canadian Medical Association): Thank you very much, Mr. Chair.

I am honoured to have the opportunity to appear before you today, and I am honoured to appear with my colleagues, Dr. Drummond and Dr. Ovens of CAEP and Ms. Silas of CFNU.

That we are gathered here virtually rather than physically simply serves to further underscore the gravity of the situation we all face as Canadians.

In exploring Canada's response to the COVID-19 pandemic, I am pleased to represent the unique perspective of the front-line workers who are entrenched in the daily battle to defeat it.

Again, my name is Dr. Sandy Buchman. I have over 20 years of experience in practising comprehensive family medicine, with a special interest in primary care, cancer care, palliative care, HIV/AIDS, global health and social accountability. I have spent the last 15-plus years practising home-based palliative care, including providing palliative care to the homeless in Toronto.

Today I appear before the committee as president of the Canadian Medical Association.

I wasn't around for the Spanish flu in 1918, but the CMA was. I wasn't the president when SARS hit in 2003 or when H1N1 came in 2009, but the CMA was there. The organization that represents Canada's physicians has witnessed significant outbreaks during its 153-year history. The Canadian Medical Association represents the interests and well-being of the very physicians who care for our nation's health. I have the humble honour today to speak for our members, those front-line physicians.

As we are all aware, the COVID-19 pandemic is evolving rapidly. We did not get to control if it came to us and we did not get to control when it came to us, but to the degree to which we are equipped, we can control how we respond to COVID-19.

Messages about the health of Canadians and the health of the economy mean nothing without an equal pillar: the health and safety of our front-line workers. At this point, it is of incredible urgency that we support our care providers and that we understand how important it is to be armed with information to make the decisions to make it happen.

We have heard through our members that the inadequate supply of personal protective equipment is even starker than has been reported, so we launched a rapid survey to collect real on-the-ground stories from physicians. On March 30 and March 31, we heard from close to 5,000 physicians. They represented an almost equal split between community-based physicians and hospital-based physicians. This poll was essential to accurately inform us of the situation at the front lines. We now have a clear snapshot of physicians' observations and experiences around the personal protective equipment that is available to them. That equipment includes surgical masks, N95 respirators, face shields, gowns and gloves.

The feedback received shows a dark reality. The results don't just reveal the issues with supply and distribution of PPE; the results unveil the enormous lack of information available about the status of supplies and how health providers can get supplies. The toll that is paid for this uncertainty weighs heavily on health care workers across the country. They are scared. They are anxious. They feel betrayed. They don't know what supplies are available.

More than a third of physicians in community care—that is doctors' offices, walk-in clinics and health hubs—said they believed they would run out of masks, respirators, eye and face shields, and goggles and glasses within two days or less, or indeed they had already run out. That was just seven days ago. Seventy-one per cent of physicians in community care have tried to order supplies in the past month, but fewer than 15% received confirmation that supplies were en route or had been received. In Nova Scotia, only 2% of physicians indicated that their recent order had been received or was being shipped. That's fewer than 50 doctors.

When it comes to alternative supply sources, one in 10 physicians waiting on supplies was aware of a government source of supply. The rate is highest in Alberta, at 26%, and lowest in Nova Scotia and New Brunswick, at 5% and 0% respectively. Physicians who work primarily in hospitals where COVID-19 cases are being directed were largely unaware of how long their current supply will last. A great many respondents are being asked to ration supplies.

Physicians are saying there is lack of information and transparency. They are facing unclear and inconsistent messaging about PPE supply and use. This has become a major concern and source of anxiety.

● (1440)

Ninety-four per cent of those who work in the community responded that they are able to provide patient care virtually over the phone to some degree, over one-third are able to do video conferencing and one-quarter can provide patient care via email or text, but physicians noted that there are many situations where patients must be examined in person.

Canada is known for its health care, but the holes in our system have been evident to those of us working in it for far too long. The delay of measures to ensure greater safety are now even more evident, and to more people. The pressing needs of today, all of them, are those that our nation has thirsted for in times of general health. Too often and for too long, they have all been pushed to the back burner. Even in the best of times, hospitals across the country are at overcapacity, millions of Canadians don't have access to a regular family doctor and countless communities grapple with health care shortages.

There are populations that are especially vulnerable in this pandemic, such as our homeless and those on limited incomes; our elderly, especially those in long-term care; our indigenous peoples; those residing in prisons; people of all ages with complex medical conditions and disabilities—to name but a few. They have challenges in accessing care, and their increased susceptibility to the disease is of grave concern.

Virtual care is in its near-infancy. National licensure is only in discussion.

We appreciate that the federal government is working to make this a priority. We applaud the innovative efforts of our very own industries that are pivoting production to supply PPE. We understand the global competition to supply this protective gear for our care providers. Still, asking health care workers to be on the front lines of this pandemic, without the proper equipment, is unacceptable. Shortages must be addressed immediately, and information about supplies must be disseminated. People's lives are on the line.

Would we expect a firefighter to enter a burning building, risking his or her life, without adequate protective equipment to keep them from harm? Physicians and other front-line health care workers have a call to duty. They're willing to place themselves in harm's way, but they have rights too. It is their right to be protected when they put themselves at risk of harm.

It is not only themselves that they put at risk. It is also their families and loved ones. Society and government have a reciprocal moral responsibility to protect them from harm, hence the critical necessity of adequate PPE at the front lines. We cannot win this COVID-19 war without it.

These are very exceptional times. I appreciate your recognizing the urgency being felt at the front lines. History has repeatedly demonstrated that times of crisis can define the path forward. We can employ this crisis to guide us towards a healthy future. Despite being in crisis now, we cannot in the future forget these lessons in preparedness. We need to ensure that health care workers are safe.

If we are to do this together, we need the physicians and all health care workers to be kept top of mind.

In conclusion, allow me to thank the committee once again for the invitation to participate in today's proceedings and to share with you the experiences of Canada's physicians. We must apply armour to those who are defending us. Without it, they are defenceless. Without them, Canadians are defenceless.

Thank you. *Meegwetch*.

● (1445)

The Chair: Thank you, Dr. Buchman.

We'll go now to the Canadian Pharmacists Association, with Dr. Barry Power, senior director.

You have 10 minutes. Please go ahead.

Dr. Barry Power (Senior Director, Digital Content, Canadian Pharmacists Association): Thank you for inviting the Canadian Pharmacists Association to appear today, during this rather unusual time.

I'm Dr. Barry Power and I'm joined by my colleague Dr. Shelita Dattani. We are here on behalf of our 43,000 pharmacist colleagues from every province and territory.

We'd like to start today by giving you a quick glimpse into the lives of pharmacists, about 80% of whom are in community pharmacies and close to 15% are in hospitals. We would also like to touch on three issues that are front and centre for pharmacists and their teams at this time.

What are we seeing in pharmacy? The last few weeks have been very intense, to say the least. We have seen an incredible surge of people coming into our pharmacies across the country seeking help and support. They are often scared and concerned that they can't get through to the 811 line or to their doctor's office, which is closed, and they or a family member are sick and need help. We are there for them. We are answering their questions, allaying their fears and providing the care they need.

Pharmacies are also trying to adapt quickly to the changing environment and needs of their patients. To create a safe space for clients, many pharmacies have implemented special hours for seniors and other at-risk individuals. They're adding additional cleaning and disinfecting procedures, often after hours, and are coming up with innovative ways to support physical distancing, like curbside pickup. I've never been so proud of those in my profession who are on the front line and who are showing up every day to work. Unlike many of us who can work from home, they cannot, so we're very humbled to be able to have this opportunity to bring forward some of the major issues and challenges they are experiencing at the moment.

One of the things pharmacists are most concerned about during this pandemic is ensuring all Canadians have access to their medications. We've seen a number of troubling trends over the past few weeks. The first sign came about six weeks ago, when almost overnight the supply of masks, hand sanitizer and gloves were sold out. Then about three weeks ago, as public health officials started to implement social-distancing policies across the country and recommend that people stockpile food and medications, the demand for medications skyrocketed. What we saw was the volume of demand increase by over 200% in March, threatening the integrity of our drug supply chain. If left unchecked, we would have run the risk of running out of medications for our patients.

For fear of medications becoming the next toilet paper, we quickly took action by recommending a temporary 30-day supply limit for medications. This was critical to protect supply chains, address panic buying and most of all to ensure that patients would continue to have access to their drugs in the coming weeks. In addition to the need to manage demand, we are also concerned about the increase in drug shortages. In the months leading up to March, the government's mandatory drug shortage website was listing approximately five new shortages per day. In the last few weeks, the number has increased about 35%, and we are seeing some early signs that those shortages have increased more rapidly in the first few weeks of April. That is in addition to some of the shortages that we've already seen of medications that are being used directly to treat COVID.

Currently, Health Canada has identified three such COVID-related severe shortages. First is hydroxychloroquine, the subject of much press, having been touted by some prominent figures as a cure to COVID. While there is currently no evidence that this is the case, the demand for hydroxychloroquine is now making it difficult for patients who rely on this drug for conditions like rheumatoid arthritis or lupus.

Second is inhalers used for asthma and COPD. The demand for inhalers in the last few months has increased significantly, both from hospitals as they prepare for COVID and in the community setting as people stockpile medications.

Third is medications being used in hospitals, particularly the sedative medications used in ICU settings for ventilated patients, drugs such as fentanyl and propofol.

COVID is and continues to be a threat to Canada's drug supply. We recognize that measures such as the 30-day supply impact patients. Thus, we have been urging governments and private insurers to ensure no patient is out of pocket for the additional costs associated with the 30-day supply. Thankfully, progress is being made to address this concern.

We also want to minimize the risks to patients who might need to refill their prescriptions by visiting pharmacies more often. I'll turn it over to my colleague Shelita to address this issue.

● (1450)

Ms. Shelita Dattani (Director, Practice Development and Knowledge Translation, Canadian Pharmacists Association): Thank you, Barry.

Thank you, Mr. Chair.

We know physical distancing is especially important for vulnerable Canadians such as seniors, people with chronic diseases and those who are at particular risk of coming into contact with COVID, which is why it's critical that we help those people stay at home and why pharmacies have ramped up home medication deliveries in the last few weeks.

In fact, pharmacy deliveries have increased on average 85% to 150% per pharmacy, which translates into an increase of about 36 deliveries per day per pharmacy in this country. For many pharmacies, the dramatic increase in deliveries has been a challenge to manage, from a cost perspective but also from a labour perspective, in making sure that they have delivery staff who are also protected. This is why we've asked the federal government for $60 million in funding to support free medication deliveries for seniors in our country.

Increasing deliveries is just one way to protect people at risk while also protecting pharmacy staff.

I would now like to turn to our final point, regarding access to personal protective equipment, which, as my colleagues have all addressed, is necessary to protect front-line health workers, and pharmacists are no exception.

Pharmacies have been deemed essential services meaning that we stay open when others close. Pharmacists, as my colleague Barry noted, are the most accessible health care workers in the community and even more so now. We are seeing patients every hour of every day, many of whom are sick, without the necessary protective equipment. While many pharmacies have put in place some protective measures, such as plexiglass and other barriers, and are encouraging people with symptoms not to visit the pharmacy in person, there are still many times when we are in direct contact with our patients. We are afraid not just for ourselves but for our families and for our patients—because if we get sick, who will be there to care for them?

In Spain over 50 pharmacies have already closed due to illness. Tragically five of my pharmacist colleagues have died. We have already seen a number of pharmacies close in Canada due to exposure.

Best available evidence suggests that in addition to contact precaution, droplet precaution PPE should be used by health care workers who may be in close contact, i.e., within two metres, of someone suspected of having COVID. We know that droplet protection PPE consists of four elements: a disposable surgical procedure mask, which is used in community pharmacy settings; a full-length, long-sleeved gown; disposable gloves; and eye protection, which can include a face shield or goggles.

Unfortunately, pharmacists and others working in the pharmacy are feeling extremely vulnerable at this time. While pharmacies have been deemed essential, pharmacists and pharmacy staff have generally not been deemed essential health care providers across our jurisdiction in this country, so we have had very limited access to the necessary PPE.

We're calling upon the federal government to recognize pharmacists as “essential” health care providers and to work with all of the provinces and territories to ensure that they have access to the government supply of PPE to be distributed appropriately.

Dr. Power and I thank you very much for your time and we look forward to questions.

● (1455)

The Chair: Thank you, Dr. Dattani.

We'll go now to our first round of questions. We'll start with Mr. Jeneroux for six minutes, please.

Matt, go ahead.

Mr. Matt Jeneroux (Edmonton Riverbend, CPC): Thank you, Mr. Chair. I hope it goes a little bit smoother than it did last week.

I'll begin by thanking all of you witnesses and everyone within your associations for working extremely hard during this pandemic. Thank you from the bottom of our hearts sincerely. I also want to ask questions today in order to better support and better advise the government on gaps. Again, I appreciate everybody being here at least virtually.

The world is facing a supply shortage because every country is planting itself in a position of trying to procure the same items. I'm going to go across the table with this question, starting with the Canadian Association of Emergency Physicians, then the Canadian Federation of Nurses Unions, then the CMA and then the CPhA. When was your organization first contacted by the Public Health Agency and Health Canada to work collaboratively on COVID-19?

The Chair: Dr. Drummond or Dr. Ovens, go ahead.

Dr. Alan Drummond: I'm not sure actually if we were, to be straight thinking about this. We recognize that we had a lead time of several weeks, when we were looking at what happened in northern Italy and New York. Largely this has been an effort based strictly on our own membership trying to streamline our response to the needs of our members, because there was such disorderly and fuzzy communication from all levels of government. Recognizing that this lack of clarity heightened anxiety, we decided that we would ramp up our own research as well as we could, given the limited time span we've been facing, and try to provide the best possible evidence for our members, realizing that what we say one week may change the next.

In terms of personal protective equipment, it really is a concern to our members. The lack of clarity has not helped. Some organizations call for N95s whereas we don't really feel they are really necessary unless we're involved in an aerosol-generating procedure such as an intubation or ventilation or a cardiac arrest situation—

Mr. Matt Jeneroux: I'm sorry to interrupt, but I just want to make sure we get to everybody else as well. If you don't mind, I'll come back to you.

Dr. Alan Drummond: The long and short of it is that we haven't.

Mr. Matt Jeneroux: Okay.

The Canadian Federation of Nurses Unions, go ahead.

Ms. Linda Silas: We wrote to Dr. Tam on January 24 reminding the Public Health Agency of their legal requirement under occupational health and safety. We asked them to be involved in the guidance document, as in the past with Ebola and H1N1.

On February 25, we met with the Minister of Health, because we hadn't had any response from PHAC. On March 5, a week after that, we had a meeting with PHAC, and then a face-to-face meeting with PHAC and all health care unions and other stakeholders on March 13. I'd like to remind others that on March 13 we only had 157 cases in Canada. On March 13, we also came out with our health care national unions' joint statement.

Following this, we're looking at April 7, today, and the second edition of the guidance that came out from the Public Health Agency of Canada, which we denounced earlier this week. It does not represent the precautionary principle. It does not represent the professional and clinical judgment of health care workers at the place of care, so we're—

● (1500)

Mr. Matt Jeneroux: Ms. Silas, I just want to mention that I only have six minutes. I want to make sure we get to—

Ms. Linda Silas: Yes, and we're denouncing their guidance.

Mr. Matt Jeneroux: Dr. Buchman.

Dr. Sandy Buchman: We've had regular communication with the Public Health Agency of Canada now for several weeks. It likely began in January, although I'm not exactly certain, but there has been a regular communication channel. There has been ongoing reassessment, and they have been aware of our concerns for this period of time.

Mr. Matt Jeneroux: You had requested in your latest communication an urgent meeting with Minister Hajdu. Have you received that meeting yet?

Dr. Sandy Buchman: Yes, I was able to meet directly with Minister Hajdu last Friday and again expressed many of our concerns, including what I shared today during my presentation.

Mr. Matt Jeneroux: Thank you.

I'll go to the Canadian Pharmacists Association.

Ms. Shelita Dattani: As others have, we've had engagement with the chief public health officer through the health care professional forums. I think the engagement really accelerated around COVID around late January, early February. We were quite involved before and since that time.

Mr. Matt Jeneroux: Thank you.

I'll go back to the Canadian Association of Emergency Physicians.

Has the government messaging been consistent and clear?

Dr. Alan Drummond: I'll let Howard take that question.

Dr. Howard Ovens: I think it's been pretty consistent and clear, but it hasn't always been consistent with the messaging of provinces and cities, and that's where the confusion comes from. It's been clear and it has evolved appropriately over time as the circumstances have changed, but we're hearing very different things at times on the specifics with provinces and cities.

The Chair: Thank you, Matt.

Mr. Fisher, please go ahead for six minutes.

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

I want to thank all of the folks who are gathered virtually here today to help us assess this situation.

I'll go right to Dr. Buchman.

Sandy, it's so nice to hear your voice, even if it's virtually. I understand that you've recently met with Minister Hajdu to discuss your members survey on PPE. I want to take a second to thank you and your organization for what I think is such an invaluable survey. It really helps inform us as we work so hard with the provinces and territories.

Sandy, based on that survey, is there a particular jurisdiction or jurisdictions that you're more concerned about than others? I noted yesterday that news reports said that Manitoba and Alberta were sharing their PPE stocks with Ontario and Quebec. I think of this as very good co-operation, but I thought maybe you could touch on particular jurisdictions that you may be very concerned about.

Dr. Sandy Buchman: Thank you very much for the question.

Yes, we're concerned about the jurisdictions where the rise in the number of COVID cases is happening exponentially, particularly in Ontario and Quebec.

In looking at the amount of PPE and as we try to import more PPE and try to manufacture our own domestic supply, we think it's important to have coordination at the federal level between the federal government and the provincial governments and through the different regional health authorities to be able to deploy the equipment to the areas of the country that need it the most.

Right now we're seeing the most rapid rates of rise in Ontario and Quebec, and I think it's really important to see the appropriate distribution in those places. If the curve is a little flatter in other jurisdictions, they may have a little more time and they may not exceed their capacity to handle the number of patients who are presenting. As more PPE is manufactured or imported, equipment can then be distributed appropriately to those regions as well.

● (1505)

Mr. Darren Fisher: Sandy, what are your thoughts on the PM's update today on Canada's plan to mobilize Canadian industry to fight COVID-19 and to help provide that vital made-in-Canada protective gear and medical equipment? How are you feeling about that effort?

Dr. Sandy Buchman: We're encouraged. We've been encouraged all along by the efforts that the federal government has taken to procure the equipment and to work with businesses to repurpose manufacturing facilities to produce PPE. We don't think we can let up, so yes, we are encouraged by that.

However, as we're all aware, we're also facing a critical crisis point, particularly in certain areas of the country, which is that we may exceed the capacity of our system to handle it. If we start seeing physicians, nurses and other front-line care workers getting sick or becoming emotionally or mentally exhausted and dropping out, it leaves increasing burden on the remaining health care workers on the front lines. We can't state urgently enough that the development and the manufacture of this PPE has to occur now, and we have to get it out to those areas as quickly as humanly possible.

Mr. Darren Fisher: Sure. I totally agree.

Sandy, you talked about the CMA and how it was around for H1N1 and for SARS, and I'm pretty sure the CMA was around for the Spanish flu, but probably you were very young.

Could you just talk to some of the...? We're talking about different pandemics from different eras. We've talked about what we've learned from SARS and we've talked about what we've learned from H1N1. Do you see our being in the same position in a time frame down the road, when we're going to say that we learned some lessons from what I think you called a rapidly evolving pandemic?

Dr. Sandy Buchman: I think there will be lessons learned. I think the first and foremost one is that we were caught flat-footed. We didn't have adequate supplies of personal protective equipment for health care workers and we had drug shortages, as has been mentioned.

I think in particular that we don't have enough ventilators and other necessary equipment and beds. They were cut short in our health human resource planning. As mentioned, we don't have an adequate number of emergency physicians or other physicians and other health care workers available, particularly if they get sick or burnt out or, might I add, refuse to go to work, which is their right if they are put in harm's way without personal protective equipment. I think there are a lot of lessons that we didn't learn from SARS or H1N1 in appropriate planning.

However, I also think this was a global problem. I don't think there was a health care system in the world that was adequately prepared for the magnitude of this pandemic and the rapidity with which it has fallen upon us.

In sum, yes, I think we've already learned some of those lessons for the next time around, and I hope for dealing with the second and even third waves of COVID-19 that are likely to come.

Mr. Darren Fisher: Sandy, how does your organization work with the provincial and territorial governments to make sure they have the protections they need to do their work?

Dr. Sandy Buchman: Right now we're working with the federal government, as I mentioned earlier, to ensure there is transparent information that will come down the pipes to advise the provincial and territorial governments with regard to the supply of PPE and other equipment.

We work through our provincial and territorial medical associations, specifically within their jurisdictions as they deal with their local, provincial or territorial governments. It's by working together with our provincial and territorial counterparts.

The Chair: Thank you, Mr. Fisher.

Mr. Darren Fisher: Thanks, Sandy.

Thank you, Mr. Chair.

The Chair: We go now to Mr. Thériault.

Mr. Thériault, go ahead for six minutes.

[*Translation*]

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

I thank all of the speakers for their enlightening comments.

There are some constants in what you say. I've noted the issue of the lack of personal protective equipment supply, but before I address that, I'd like to talk about something that I'm struggling with. I'm going to speak first to the representatives of the Canadian Association of Emergency Physicians.

At one point, you said that in order to have more cohesion and leadership, an emergency measures act would have to be invoked. On March 17, there were 460 cases of COVID-19 in Canada, and five deaths. Now there are 17,063 cases, and 365 deaths. Quebec was one of the first to implement much stricter measures. On March 14, it declared a state of health emergency. Yet Quebec is one of the places with the highest number of these 17,063 cases. However, when we look at the ratio of deaths, hospitalizations and intensive care patients, we can see that the system's ability to take care of people is working. What would you have done more than what we have already done in Quebec, with emergency measures legislation? That's my first question.

Second, why should the supply of personal protective equipment, which is the responsibility of the federal authorities, not simply be added to the jurisdiction of Quebec and the provinces? In a crisis like this one, it seems to me that everyone should look to their own skills and expertise. If we need to get things moving, if we need to approve more products, if we need to allow companies to retool, let's do that. The federal government must do its job. How would emergency measures legislation solve the problem?

● (1510)

[*English*]

Dr. Howard Ovens: From what I know, Quebec has done a very good job in its response to the situation, with some of the more stringent precautions being put in place very quickly and some very good communication from your premier to the public. I think the problem is that, when we have people listening to media that go beyond our borders in any one city or province, and in some places you're allowing gatherings of 250 people, in other places gatherings of 50 people and in still other places gatherings of 10 people, and when the biology of the virus is the same in every one of those locations, it becomes very confusing for people and they start to lose a little trust in what they're being asked to do.

Our request was not a criticism of anybody's efforts. It's more a desire to make sure that the public is getting clear and consistent messaging.

Obviously, PPE is a shared responsibility. Our concern is that, at a time of great demand, we—

[*Translation*]

Mr. Luc Thériault: I'm sorry to interrupt, but Quebec is currently using the containment strategy that was implemented in China. Our least affected regions are under containment. You raise a public safety issue, but earlier you mentioned a leadership problem with respect to the ability to protect first-line workers. I understand that, but you have to look at it from a public health perspective, not a public safety perspective. You didn't address that earlier. I'm asking the question from a public health perspective. I'm wondering about our ability to provide equipment to the health care community to really protect them and to ensure that the health care system can hold up in the face of the strength and virulence of the pandemic.

From a public health perspective, how would emergency measures legislation improve the situation in our health care environments?

[*English*]

Dr. Howard Ovens: If we look at what has happened internationally, we can see the danger if we don't have a coordinated approach in Canada. Just as we've seen in the U.S., where governors have been competing with each other for available supply and driving up the cost, or where one jurisdiction—as the U.S. tried to do to Canada—prevents export, imagine if Ontario said that its businesses could not sell masks to Quebec, or if Quebec could not sell gowns to Nova Scotia, or if the supply chain became interrupted because of provincial boundaries. I think that would be a tragedy under the circumstances. It's that type of maximum co-operation that I think is in the best interests of our country.

Thank you.

● (1515)

[*Translation*]

Mr. Luc Thériault: It is the federal government's jurisdictional prerogative to do exactly what you say. It doesn't need emergency measures legislation to be able to exercise its jurisdiction competently.

[*English*]

Dr. Howard Ovens: I'm an emergency physician, not a constitutional lawyer. The intention of my comments, I think, are clear. I'll leave it to other people to interpret them in the most appropriate fashion from a legal and constitutional perspective.

Thank you.

[*Translation*]

Mr. Luc Thériault: If I understand correctly, aside from emergency measures legislation, and after what you have seen of Quebec's management of the pandemic, you are not suggesting anything different from what Quebec has already done to deal with the current pandemic.

[*English*]

Dr. Howard Ovens: Once again, I'm not trying to criticize anybody. I think even Quebec would benefit if Ontario, Nova Scotia and other jurisdictions on your boundaries were as aligned as possible. In fact, at one point we were asking that the rest of Canada align with the excellent steps that were being taken earlier and more stringently in Quebec. The question is not who's right or who's wrong. The question is how we can all get to the safest place together.

The Chair: Thank you, Dr. Ovens.

We go now to Mr. Davies for six minutes.

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

Dr. Buchman, I would like to begin with you, please.

Four days ago, on April 3, the CMA was quoted on CTV News as asking the federal government for direct communication to physicians and nurses about the types of medical equipment and supplies coming into Canada, when they will arrive and where they're going, as well as contact information to order that equipment.

Dr. Buchman, you're quoted as saying, “We want to know the availability of what's coming down the pipeline and when it will arrive. If we know we're going to receive an adequate supply of equipment in a certain period of time, it allows us to plan and decide how much we have to ration.... It buys us some time and as we're trying to flatten the curve—which is the goal here so that we don't reach the surge that will overcome the health care system's capacity to handle it....”

I have a quick question, Dr. Buchman. Has the federal government responded to your request as of yet?

Dr. Sandy Buchman: Thank you for the question, Mr. Davies.

No, I haven't heard any response as of yet, but we do know that what we requested is being considered very highly.

Just to reiterate your point, what has not been clear to physicians and other front-line health care providers is what PPE is coming down. How can we plan appropriately? As a result, the experience of anxiety is considerable.

It also has other implications, like everything we're seeing about the resterilization of personal protective equipment, such as N95s. In an ordinary time we wouldn't even consider this kind of alternative, because we just don't know. We really are requesting the full information and full transparency of that information. To this point in time, it really hasn't arrived, but I'm confident that the government is aware of our concern and our ask.

● (1520)

Mr. Don Davies: I do note that Prime Minister Trudeau comes out every single day and gives a briefing to the Canadian people, so certainly, there are lots of opportunities for the Prime Minister to give that information if he chooses to.

Dr. Drummond, is your hospital currently rationing personal protective equipment and, if so, can you give us a brief picture of what that looks like?

Dr. Alan Drummond: The answer.... That's a loaded question. I think what is happening in my hospital, as an example of what's happening across the country, is preservation of personal protective equipment. Some would call it rationing. Certainly, our nurses are being told to use two surgical masks on a shift basis, which can go from eight to 12 hours. That seems like rationing.

By the same token, I think we have to be a little bit careful. I believe the promises of government that equipment and help is on the way. I think there is a little bit of concern about excessive anxiety and perhaps limited science. We know the N95, which is what a lot of people are calling for, really is for aerosol-generating procedures, such as intubations or code blue cardiac arrests.

Given the prevalence and the circumstances, I'm not really sure that's exactly what we need at this point in time, so we need to be protective of that supply until we are guaranteed its certainty. For the most part, just using droplet precautions, I think, should serve most of us quite well.

Mr. Don Davies: Thank you.

I'll move to you, Ms. Silas.

You were quoted two weeks ago as saying that front-line nurses across the country "are frustrated and insulted that many of them are being denied N95 respirators and other safety equipment they know they need" and that they want "the federal government to guarantee access to the protective equipment they need when their professional judgment tells them to protect themselves."

Has the federal government responded to that concern as of yet?

Ms. Linda Silas: Politicians do, but not the scientists, and then hearing Dr. Drummond, I'm shaking my head. When you do not know for certain how the virus is transmitted, that is when you up your personal protection equipment. It is not when you bring it down.

That is where the frustration lies. If you don't call having two surgical masks given to you at the beginning of your shift to wear for 12 hours or more rationing, we have a problem here. If there's miscommunication between the federal and provincial levels and then every employer in the country is doing it differently.... Even in Ontario, where they have very specific agreements with the health care unions and the government and employers on the PPE, there are still differences.

We have stories of nurses being given a paper bag to put their masks in to bring back home for the next day. We're in 2020 and we are not in a shortage today. We're worried about tomorrow and we need to protect our workers today and get the equipment in for today, because they will be dropping like flies, just like physicians, just like the rest of the health care team.

Mr. Don Davies: We hear a lot about lessons learned. Of course, we've been through pandemic-like issues before. In 2006, 14 years ago, the final report of the independent SARS commission made a number of recommendations. I want to take you through a few of them. One of them was:

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

Ms. Silas, you've said that you believe we should start with the highest level of protection, not the lowest. In your view, do the current federal guidelines respect the recommendations from the SARS commission in 2006?

Ms. Linda Silas: No, nor did they in 2007-08 with H1N1 or Ebola. The precautionary principle was engraved by Justice Campbell with the SARS commission report. We worked with the Public Health Agency of Canada. CMA was there. The ER doctors were there also during H1N1 and Ebola, and again today.

To say that we were surprised by this.... It is hard to accept when you're on the front line because we knew what we had to do.

The Chair: Your time is up now. Sorry.

Don, did you want to say something?

Mr. Don Davies: No, I understand my time is up, Mr. Chair.

● (1525)

The Chair: We'll start the second round now with Dr. Kitchen.

Dr. Kitchen, you have five minutes. Go ahead.

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

Thank you, everybody, for being here today. It's greatly appreciated that you're taking the time to do this, to discuss these issues.

I'm going to follow on a bit more with what Mr. Davies was talking about on the issue of what was a step forward back in 2003. Basically, after SARS we developed the Public Health Agency to monitor all across Canada. What I'm hearing from you, Ms. Silas, as well as you, Dr. Drummond, is that we have some gaps here. There appears to be no apparent public health measures being put forward, or the ones that are there are not being followed.

I believe, Dr. Buchman, you said that we were caught "flat-footed". I'm wondering where the guidance is here. Is there any guidance at all, and do you see it that way?

Dr. Sandy Buchman: Yes. I don't think we were adequately prepared or we wouldn't have found ourselves in this situation. As mentioned, the rapidity and magnitude of this pandemic wasn't anticipated, but that's what you have to prepare for, these crises. I think even our Minister of Health explained that public health has been underfunded in this country for quite some time, so yes, we weren't prepared, and hence we're scrambling at this point in time.

I think we are getting up to speed. We just hope that we can flatten the curve enough so that we don't exceed the capacity of our system to handle it, in addition to the risk health care workers are exposed to and, of course, the vulnerable and more at-risk parts of our population. We are scrambling right now. We shouldn't be in that position and we need to to do whatever we can to ensure our system has the capacity now.

Mr. Robert Kitchen: You would agree that the Public Health Agency—not only in communications across the country—should be in a position to administer and ensure that we have those PPE supplies ready, the ventilators ready, the health care workers that we need and the medications prepared for such a situation, and should be regularly monitoring this aspect. Is that correct?

Dr. Sandy Buchman: It should be, but this is in conjunction with the roles and responsibilities of the federal, provincial and territorial governments. Each jurisdiction, right across the country, should have all these measures in place. I think that's a joint responsibility within our whole system.

Mr. Robert Kitchen: Thank you.

You mentioned the aspect of basically ramping up national testing policies. I'm assuming when you talk about that, you're talking about the testing to say whether someone has COVID. There's a lot of discussion going on right now. As we start to hopefully flatten that curve and try to transition out of that, and get Canadians back out into the public and get the economy back rolling, what measures and steps are going to be needed to make certain that the people who are actually out there have developed immunity such that they can be out in public?

Do you see value in the expansion of more of the immunity testing as well as the testing we're doing right now to determine whether somebody has the virus?

Dr. Sandy Buchman: Yes. Our ability and capacity to test is absolutely critical to responding to this pandemic. It's really the testing that allows us to know who is potentially infectious or who is immune, and will, therefore, guide the public health response of what we should do. We are seeing our testing capacity increase day by day. Again, that's kind of where we got cut short as well, but we're seeing it increase now day by day as we sort of.... It also reflects the increasing numbers of positive cases.

I'm encouraged actually by the recent announcement about the government's actions, but we're not where we need to be yet. We should really ramp up our testing as much as possible. We should also get serological testing. We need to know what our level of immunity is out in the community, and that will help guide the public health measures we need to take.

● (1530)

Mr. Robert Kitchen: Along that line, as we have seen and as we have heard from the nurses and doctors, a lot of our health care workers are becoming sick. My wife was an emergency nurse, and I have family who are emergency nurses, etc., and the reality is that these people are the ones going into the crisis. They are the ones stepping forward, and they want to do that. Not only do we need to make certain that we are protecting them, but they desperately want to get back, so is that a process that we need to be ramping up more for our primary care workers?

Dr. Sandy Buchman: I would defer to my public health expert colleagues in that regard.

I do think that it would be important for health care workers to be tested and also to know what their immune status is. If they are immune already, hopefully they are safe within those environments, but there is still very much that is unknown about the coronavirus and how long immunity might last, for example. We are in an experiment in real life now. We have to continue to do these studies right as we're in the middle of it, so yes, I think it's critical to ramp up testing as much as possible.

The Chair: We go now to Dr. Jaczek.

You have five minutes, please.

Ms. Helena Jaczek (Markham—Stouffville, Lib.): Thank you very much. I want to thank all the witnesses for coming today. Obviously they represent so many of our front-line health care workers who are doing such extraordinary work. I'm so glad that we have the opportunity to hear you today and learn from you.

I want to make sure that everyone has understood that our government is extremely interested in hearing from everyone. I see in some of the background information with which I've been provided that apparently there was a meeting with the Canadian Association of Emergency Physicians in March. Obviously, neither of our witnesses today was present, since they mentioned that, but every effort is being made, as I understand it, and this was reinforced last week when we heard from officials from the various agencies involved in this pandemic that they were extremely anxious to listen, learn and adapt in this rapidly evolving situation.

I would like to clarify a point from Dr. Ovens. In terms of the consistent messaging that you were asking for, it seemed to particularly involve public health messaging, in terms of the advice that should be given across the country. I was wondering if you could clarify, exactly, the piece about the need for a national standard.

Dr. Howard Ovens: Thank you, Dr. Jaczek.

Just to clarify, Dr. Drummond and I were aware of the meeting with the ministries of health. The question for us was whether we had been contacted by the Public Health Agency of Canada. Perhaps we were overly specific.

In terms of the public health messaging, there has been quite a variation over the last month about the allowable size of gatherings, which businesses are essential and non-essential and whether it's appropriate to be outside exercising, and in which fashion and where. Now we have some inconsistency about public masking.

The problem is that if you've heard these things are different in different communities, yet you know the virus is the same, it erodes your trust in the strategies that you're being asked to follow, and unfortunately that leads to a potential erosion in public co-operation.

That was the concern we were trying to express.

● (1535)

Ms. Helena Jaczek: I see.

Of course, some of the epidemiology has varied from province to province. We have [*Technical difficulty—Editor*] across the country, and of course we do have a division of powers between the federal health ministry and its agencies, and the provincial and territorial jurisdictions. However, it's a point that you've made clearly. As every effort to [*Technical difficulty—Editor*] I can hear, and knowing that there are some new guidelines that are going to be coming out shortly in terms of the use personal protective equipment, your suggestions are clearly very well heard.

If I have a little time left, I would like to ask Dr. Buchman about pandemic—

The Chair: Dr. Jaczek?

Ms. Helena Jaczek: Yes?

The Chair: Dr. Jaczek, your voice is breaking up. Make sure you're speaking very clearly into the microphone and you're not using a speaker phone.

Sorry, go ahead.

Ms. Helena Jaczek: I will do my best.

Dr. Buchman, in terms of pandemic exercises, since SARS.... When I was back in public health, certainly after SARS, in my jurisdiction in York Region we did hold specific exercises getting all the players involved and so on. Could you explain the involvement of the Canadian Medical Association, through your provincial association...? What role has the CMA been playing in terms of perhaps looking at potential gaps through these last many years?

Dr. Sandy Buchman: Thank you for the question. We've always taken the approach that we should have an adequately supported and funded public health care system. There have been so many pressing issues that we've undertaken and continue to undertake that, when we saw that the Public Health Agency of Canada was created and developed, this was one thing that was perceived to be actually doing quite well. We were very glad to see the differences from, say, the SARS days.

There are so many serious issues now in our system, for example access to care. Five million Canadians don't have access to a family doctor. We have inadequate access to mental health and addictions services. Seniors care is an issue. Palliative care is an issue. We have problems with our health human resources in remote and rural areas, with the remote and rural distribution of physicians across the country. There are so many issues that, once Public Health seemed to be in place, yes, attention was changed to these other pressing issues of the time, thinking that the public health system that had been set up was robust.

The Chair: Thank you, Dr. Jaczek.

Ms. Helena Jaczek: Thank you.

The Chair: We go now to Mr. Webber for five minutes.

Go ahead, Mr. Webber.

Mr. Len Webber (Calgary Confederation, CPC): All right. I hope you can hear me okay.

The Chair: Yes, speak up, speak slowly, speak clearly.

Mr. Len Webber: All right.

Let me begin by thanking all of you for presenting here today, and all the health care workers in Canada for working day and night to help Canadians.

I want to address my first question to either Dr. Drummond or Dr. Ovens. It's regarding the uncertainty of all this. It's regarding the separation of fever and infection patients from the general population in the ER and in the ICUs. Is there separation of these patients from the general population? You talked about a lot of care being provided in hallways and about crowded ERs and crowded ICUs. Are there steps taken to separate these COVID-19 patients from the general population?

Dr. Howard Ovens: It's Howard Ovens. I'll take that one.

Yes, as we mentioned, our hospitals and our provinces have taken extreme measures to create adequate capacity in our hospitals. It's at the expense of a lot of people who've had their care delayed, but it has been successful, and most of our emergency departments are very efficiently being emptied of new cases. There are infection control procedures right from when you enter the hospital and go to the emergency triage desk through to admission to the wards or the ICU. The proper isolation techniques, I believe, are the norm and are being followed.

The concern, if we're unable to flatten the curve, is that as our hospitals fill, our ability to do that well may become compromised. But as of today, I think everywhere in Canada we have the capacity to do proper spacing.

● (1540)

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

That is my concern. If you're not able to flatten that curve and cases continue to grow, will we have facilities in place to accommodate that so we can separate these patients from the general population? That is a concern, for sure.

To Dr. Drummond or Dr. Ovens, with regard to the usage of personal protective equipment, we all know that the government shipped 16 tonnes of personal protective equipment to China back in February. It said we are getting millions of masks soon, but it really is not clear what our daily consumption of PPE is. Do we know? Does the government know how many masks and gloves and gowns and face shields are required on a daily basis here in Canada? Has the government communicated with you to ask these questions? What is the requirement?

You alluded also, Dr. Drummond, to the usage of masks on a daily basis and being asked to use two masks on a shift. I'm curious to know, too, with respect to the gloves, how often you change these gloves. Is it per patient or is it per shift?

Those are the two questions I'd like to ask Dr. Drummond or Dr. Ovens.

Dr. Howard Ovens: I'll take the first shot at that.

The Chair: Excuse me, Dr. Ovens, before you respond to that, I'd just let everyone know that I'm getting word from the technical people to remind people to mute their microphones when they're not speaking. We're getting a lot of noise. It's difficult for the interpreters and so forth to work that way.

Having said that, Dr. Ovens, please go ahead.

Dr. Howard Ovens: Thank you for that.

First of all, on the glove question, gloves so far have been in very good supply. We do change gloves between every patient contact and wash our hands.

As for the issue of demand, I can't speak for what information the federal government in Ottawa is receiving. I can speak most informedly about Ontario, where I'm quite familiar with the arrangements. We are continuing to improve our modelling of what the demand for PPE will be in various scenarios as the outbreak may worsen. We were really overusing PPE early in the outbreak, when the actual risk to our colleagues was quite low. The danger was that we would run out of it before we even got to the most dangerous part of the wave.

The other thing is that we don't know long this will last. If we flatten the curve, it will actually extend the period of active treatment. Do we have enough data on how much we need? Probably we need to continue to refine that, but I believe there is a lot of activity going on, from hospitals up through the provinces, which are hopefully channelling that information to Ottawa, on not just how much we're using right now but how that models into our needs for the future.

The Chair: We go now to Mr. Kelloway.

You have five minutes, please.

● (1545)

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

I'd just like to echo what everyone has said here today. It's a real honour and a privilege to talk to the witnesses today. I thank them and all the health care professionals who may be listening to this discussion today.

My focus, for at least one question, will be the Canadian Pharmacists Association. We know that there was more of a push, pre-COVID, for collaborative health care teams. Now we know even more so that's the case. There's an “all hands on deck” approach here.

Do you feel that pharmacists could be better utilized in the fight against COVID-19? If so, how?

Ms. Shelita Dattani: Thank you for that great question.

Absolutely. As I alluded to in my remarks earlier, pharmacists are doing everything they can and working within the full scope of current practice across the country, which is unfortunately quite fragmented.

In our province, Alberta, pharmacists are being immensely utilized. They are able to prescribe for many conditions. They are able to extend therapies, and they're able to do a lot of different things in terms of scope of practice. As primary care environments are more and more burdened, pharmacies are going to start becoming almost the sole universally available primary health care provider.

Being able to help patients and fill those gaps in primary care right now—obviously still in a collaborative way and interacting with our physician and nursing colleagues, but having the ability to exercise some of those things more independently, in a harmonized way across the country—is very much needed.

Mr. Mike Kelloway: Thank you for that.

I see that your organization—and you referenced this in your 10-minute statement—recently released guidance to pharmacists to fill prescriptions for only one month at a time. Can you go a little deeper as to why you decided to issue this guidance?

There is a reason I am asking. I am getting a lot of calls in my riding, predominantly from people over the age of 60 or 65. A good chunk of my electorate is made up of seniors, and they are becoming concerned about this filling of prescriptions only once a month. I just wonder if you could elaborate a little more on that for us.

Dr. Barry Power: Sure. Thank you, Mr. Kelloway.

This is Barry Power speaking.

Actually, I was speaking to a pharmacist in Sydney last week about this very issue. She was explaining some of the concerns that have been brought back to them from patients.

The situation in Canada is that we get about 80% of our prescription drugs from China and India, with the bulk of them coming from China. China has been in shutdown since January, and the manufacturing processes and the shipping of medications into Canada have pretty much come to a standstill. As a result, we had double the normal volume in March, and we've seen drains on the warehouses and the stockpiles of medications we have in Canada.

We already have a system that's very fragile. We have drug shortages, and we were very concerned about pharmaceuticals going the way of toilet paper and hand sanitizer, with those very constituents having to go from pharmacy to pharmacy to try to fill a prescription, so we had to make a decision quickly.

We decided that 30 days would give people enough prescription drugs to allow them to shelter in place for two full 14-day quarantine periods, and we would be able to make any subsequent deliveries to them. We did reach out immediately to drug plans, provincial drug plans and private payers, to try to get them to come on board as part of the COVID-19 response in Canada to cover some of the co-pays that people are seeing.

We absolutely recognize that this is a burden on people, and we continue to advocate for all payers to help offset some of the costs that people are being faced with.

Mr. Mike Kelloway: Thanks so much.

How much time do I have, Mr. Chair?

Ms. Shelita Dattani: Maybe I can just—

Mr. Mike Kelloway: Sorry, my apologies. Go ahead.

Ms. Shelita Dattani: Maybe I could just reinforce what my colleague Dr. Power was saying in terms of what we've done.

We're also really trying to alleviate the burden on many of the seniors we serve every day. The points that I made in my remarks about deliveries are part of that, recognizing that we want these folks to stay at home and we want to give them the access to medications they need. That's part of our plan to dramatically increase our deliveries happening every day.

● (1550)

Mr. Mike Kelloway: Thank you, both, for those answers.

Mr. Chair, how much time do I have left?

The Chair: You have one minute.

Mr. Mike Kelloway: Okay.

We're hearing some troubling reports that pharmacies in Canada are running out of hydroxychloroquine, which I understand is commonly used to treat illnesses like lupus and malaria.

Have you heard from your members that there are surges in prescriptions or demand for this drug, and what steps is your organization taking to ensure that the people who have non-COVID prescriptions for this are able to get the medication they need?

I know we have just a limited amount of time, so a short answer would be best.

Dr. Barry Power: As soon as we heard about surgeons prescribing hydroxychloroquine, we contacted regulators across the country. We put out a statement advising pharmacists not to fill these prescriptions and to reserve those medications for people with rheumatoid arthritis and lupus.

Most regulators around the country now have similar statements, in some cases a joint one between pharmacy and medicine, if not pharmacy, medicine and nursing, to make sure that these medications are safeguarded for people who are stabilized on them for chronic conditions, or that they are used in an acute care setting such as a hospital where it's under a tight protocol.

Mr. Mike Kelloway: Thank you.

The Chair: Thank you, Mr. Kelloway.

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

[*Translation*]

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

I'd like to speak to you, Mr. Power. First of all, I want to tell you that I'm pleased to see that you have not waited for the government guidelines to take action and to give direction to your members to address the drug shortage, including the 30-day prescription measure.

We know there's a supply problem. We were just talking about it. India has imposed export restrictions on several active ingredients used in the manufacture of medication. There is also a problem in getting them to Canada because of a lack of personnel and containers, not to mention the problems with the commercial flights that carry these drugs.

India is one of the main suppliers of raw materials. This country is being hit by the pandemic and its containment measures are very severe.

What are our options for dealing with raw material supply problems?

We talked about hydroxychloroquine. Are there any alternatives? Are there any other drugs that can be used instead?

Can you tell us about the situation so people will be reassured?

[*English*]

Dr. Barry Power: Thank you very much for the question, Mr. Thériault.

We've been in contact with a number of the manufacturing associations, and I believe that, as of yesterday, India has agreed to lift some of the restrictions on the export of the active pharmaceutical ingredients. We are hopeful that this will start the flow again, especially in combination with China coming back online. We still don't have a good timeline in terms of when the supplies are going to start flowing into Canada, but we are hopeful that it will pick up over the next coming weeks.

In terms of hydroxychloroquine, there is another drug, chloroquine, that can be used. Most of the focus has been on hydroxychloroquine, but they're both anti-malaria drugs and may have a similar effect. The supply for that will really depend on the ability of various companies around the world to supply the ingredients for hydroxychloroquine tablets to administer to patients.

We're definitely in a situation where there's an increased global demand for hydroxychloroquine and chloroquine as a result of all of the focus on COVID-19, and we do need all governments to encourage increased production of these medications for that reason alone. To date, the data are still somewhat questionable as to whether or not hydroxychloroquine has a clear benefit in COVID-19. Some of the research that has come out is promising, but it is not clearly showing that it has a major effect in improving the outcomes for people infected with COVID-19.

● (1555)

The Chair: Thank you, Mr. Thériault.

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

Go ahead.

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

Ms. Silas, I take you back again to 2006 and the final report of the independent SARS commission. It said:

> [T]here 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 [reasonable] level of protection through appropriate equipment and training.

On the principle that if we don't know how we got here we won't know where to go, can you explain to us how we got caught so off guard with respect to personal protective equipment after that clear warning from the SARS commission? What advice would you have to deal with this on a go-forward basis?

Ms. Linda Silas: Justice Campbell was clear: We had never put occupational health and safety, the safety of workers, in our health care system. And we didn't. I was educated as a nurse. For a lot of doctors, it was always, “Put patients first.” Today, since SARS, we've been faced with the reality that we have to put workers on an equal footing. You heard the example from Sandy about a firefighter going into a fire without his or her equipment. We don't do that in health care.

What the Public Health Agency of Canada needs to do is separate completely public health, public security and occupational health and safety. Occupational health and safety is under provincial and federal laws. It's an employer's responsibility to provide the training and equipment that workers need, and health care is no exception.

That's what we're trying to drive here. We are not respecting the health care workplace as a workplace. It is not an area where things will just go well if we pray enough. It is a workplace that can be very dangerous, and we need to protect our workers.

Mr. Don Davies: You know, an alarming memo was recently sent to front-line health care workers in Hamilton, Ontario. It stated, "Staff should be keeping their first surgical mask on until grossly soiled or wet, or until an N95 respirator is needed for an aerosol generating procedure.... After the procedure, the N95 will be kept on until grossly soiled."

Do you have any comment on that memo?

Ms. Linda Silas: Sick, sick, sick. It goes against all our training in disease prevention. Any training that we ever got is that you have to derobe after you leave the patient. You have to throw away anything from one patient to the other. And of course, as soon as it is soiled, never mind grossly soiled, you have to discard it.

We are looking forward to new studies around resterilizing some of the N95s, for example. When and if they prove to be safe for health care workers, we will be supporting that. In the meantime, we are going to stand ground that health care workers are going to be protected against this vile virus.

Mr. Don Davies: Thank you.

Dr. Drummond, quickly, you mentioned that you would like to increase testing to all who are symptomatic.

Yes, Mr. Chair. I'll just finish the question—

The Chair: Sorry, your time is up.

Mr. Don Davies: Oh, okay. Thank you.

The Chair: Thank you.

We're starting the third round. We'll go now to Mrs. Jansen.

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

Mrs. Tamara Jansen (Cloverdale—Langley City, CPC): I want to start by saying a tremendous thank you to all the witnesses, as well as all the workers on the front line—the witnesses, most especially, for their honesty and transparency here today.

I've been so worried. I've had many constituents calling me who work in the health care field. They feel such a tremendous anxiety for themselves and their families when they're being told to change the way they're using their PPE in order to make sure they don't run out. As you just mentioned, it's sick, sick, sick. It's very difficult for them to say, "I have to wait till my mask is soiled to change it." It's been very, very concerning. I'm thankful that you've all been so open and honest with us.

I have a question for Dr. Ovens. When I had constituents calling, they would be saying to me that the information that was being shared at the briefings, whether they were provincial or federal, didn't really reflect the experiences they were seeing on the ground. In the interim report of the national advisory committee on SARS and public health, which was released back in 2004, it was noted that Canada needs a real-time alert system in place for a proper pandemic response.

Do we have some sort of software for data entry at hospital level so that we can report to the local public health in real time, so that the information shared is real-time information?

● (1600)

Dr. Alan Drummond: There is no national real-time system that I'm aware of. Data gathering varies a lot from jurisdiction to jurisdiction. Some data elements in some places are automated, but at least some data elements are manually reported, I think, pretty much everywhere.

Mrs. Tamara Jansen: In your view, then, do you believe that the discrepancy with what's being reported in media briefings would be improved if we had a better system for that?

Dr. Alan Drummond: That's a broad statement. Obviously, the more accurate the data is and the faster we can get it up to the leadership groups, the better it would be.

Mrs. Tamara Jansen: Okay. I appreciate that.

Dr. Buchman, one of the recommendations in the document was that we need a better emergency preparedness response system, which would include a national emergency stockpile system. Your survey of the 5,000 physicians showed that information regarding that stockpile was pretty scarce.

Would you say that this national emergency stockpile system is inadequate?

Dr. Sandy Buchman: As we've heard, there are significant shortages. I'll give you an example. I'm a palliative care physician, and we're trying to ramp up our response in palliative care, because no patients should be abandoned if they are not suitable for a ventilator or if they're not going to survive on a ventilator.

There's a procedure called "palliative sedation" that allows a patient to be sedated and pass away comfortably and peacefully, but we know that some of the medications are now in short supply, in particular one called Midazolam, and some others. Another one is called methotrimeprazine. That's just a very small but important clinical example of these drug shortages that we have on an ongoing basis, as has been previously referred to. We see them—

Mrs. Tamara Jansen: Sorry. I have a very quick question.

Is there such a thing as a national emergency stockpile system as you see it? Is there something that actually exists?

Dr. Sandy Buchman: I could be wrong, but to my knowledge we don't have adequate stockpiles or emergency medicines. It might be a better question for my colleagues from the Canadian Pharmacists Association.

Mrs. Tamara Jansen: It wasn't specifically about drugs. It was also about PPE and stuff like that. I think that's what the emergency stockpile system was for.

Dr. Sandy Buchman: Yes, there are adequate supplies for that.

Mrs. Tamara Jansen: In regard to the surge capacity that we heard the Prime Minister talk about, has it been made available by cancelling other medical procedures, or is there another, better way to create surge capacity, such as having a plan for pop-up hospitals, instead of taking away services for regular patients?

Dr. Sandy Buchman: That's a very good question. I feel that I don't have the expertise to answer it carefully, but I do know that in other countries of the world, there are pop-up hospitals that are separating regular patients from COVID-19 patients. I'm presuming there is evidence to support that. Again, I would defer to my colleagues, maybe Dr. Drummond or Dr. Ovens, who might be able to respond to that.

● (1605)

Mrs. Tamara Jansen: Is that possible, Dr. Ovens?

Dr. Alan Drummond: Actually, I'd be happy to respond.

We have talked extensively of lessons learned from previous issues such as SARS, H1N1, Ebola and MERS, and, quite frankly, I think there are some lessons that have gone unheeded.

One of the major ones is about the consistent lack of surge capacity in our hospitals. We know that a safe occupancy rate is 85%. Most Canadian urban hospitals try, and sometimes fail, to provide decent levels of care at over 110% of capacity, and that's routine. We have suggested to all levels of government that this is something that needs to be taken care of, both from a basic human decency perspective and also for pandemic planning.

Now we are in a situation in which cancer surgeries are being postponed and radiologic investigations are being delayed because hospitals have had to take extraordinary measures to get surge capacity down to a reasonable level, so shame on them.

This is not really the time to point fingers, but this is the one lesson we must learn. These pandemics are not going away. In the last two decades, how many have we faced? This is something that we really must learn.

Is there a role for field hospitals? There is going to have to be, if this becomes more than just a passing thing. I could see a role for the army, particularly in rural communities, where hospitals may rapidly become overwhelmed and field hospitals will be needed. Let's hope that the military and the Canadian Forces medical services are considering an active role in the provision of patient care.

Mrs. Tamara Jansen: Thank you.

The Chair: Thank you, Mrs. Jansen.

We go now to Dr. Powlowski.

Dr. Powlowski, you have five minutes, please.

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

For the witnesses who may not know, I'm a long-term emergency room doctor. I would like to compliment everybody on their great presentations. You all did an excellent job.

In support of what you have all been saying, let me also lend my support to a lot of people's emphasis on the importance of transparency at the federal level, provincial level, local level, hospital level and even the ward level, especially with respect to PPE. If we're asking health care workers to risk their lives and their families' lives, we ought to be telling them what we are doing in terms of procuring PPE.

I know that our federal government is doing absolutely everything it can in order to make sure that, as much as possible, we're getting the PPE to the people out there. I spoke to the parliamentary secretary responsible for this yesterday. They're leaving no stone unturned to try to get those things to you and to get them to you as soon as possible. I think that, at every level of governance, whether it's at the hospital level or at the federal level, we need to be forthcoming and transparent with the front-line workers as to how many masks, how many N95 masks, how many gowns and when they're going to come.

Having said that, let me get to the actual question, and it's regarding the controversy over whether the virus is transmitted by droplets or also aerosolized. Listening to the head of the nurses speak, I know that a lot of nurses are really worried about the possibility of it being aerosolized, and I think for good reason. Some of you and the doctors may have looked at that study out of Nebraska on the 10 patients with COVID-19. They tested their rooms to look for where the virus was, and it was everywhere. It was under the bed. It was on the toilet seat. It was in the air. It was outside the rooms, even though the rooms were negative pressure rooms. In addition, I think there are infectious disease people who have also speculated or believe that it is aerosolized.

The CDC is now suggesting that people consider wearing masks, partly with the idea that asymptomatic people or mildly symptomatic people may be transmitting it and wearing the mask may help to prevent their transmitting it.

Dr. Buchman from the CMA and the ER guys are kind of saying, no, it's droplet spread. To lend a bit of support for the nursing position, I'm a little curious about the precautionary principle that she talks about. Certainly, as doctors, isn't that the way we operate? We don't dismiss the worst-case scenario. We have to first prove that it isn't the worst-case scenario. As ER doctors, we don't go in and look at a 35-year-old and say, “Yeah, your chest pain is just heartburn.” No, we're always thinking about the worst-case scenario: It's an MI, a PE, a pneumothorax or whatever.

Why are we so quick to dismiss the possibility of it being aerosolized? Isn't it better to consider it aerosolized and act according to how the nurses want us to?

● (1610)

Dr. Alan Drummond: I don't mind weighing in.

Nobody is discounting for a moment the concerns of our nursing colleagues, who are the backbone of the emergency health care system—truly, no argument.

The reality of it is that we need to keep a bit of perspective on this, and I think that may be a little bit lacking. Ninety per cent of the people who get this disease are going to have a cough, a cold and a runny nose. Between 7% and 10% will end up in hospital and certainly some will end up in the ICU, and the case fatality rate is going to depend on their age. If we choose to go with N95s and all manner of maximum protection at an early stage of the disease when we're not sure of the disease prevalence, are we going to end up putting somebody at risk when they do go to intubate or perform chest compressions if we've burned out all of our available supply?

You're a physician. I'm a physician. We know that the science on this is a little sketchy. This is a disease in process. It's rapidly evolving and our understanding is evolving, but we have to protect to save lives. To be sure, we have aerosolization concerns during invasive ventilation, intubation and cardiac arrest, but do we really want to burn through our precious supplies at this point in time to prevent somebody from getting a cough or a runny nose?

I don't want to be flippant. I'm just trying to be very straight here. We have to keep our perspective.

Mr. Marcus Powlowski: Let me suggest that maybe a better thing would be not to dismiss the nurses' concern about it being aerosolized, but to say, “Yes, maybe it is, and when we have enough N95 masks, we're certainly going to get them to everyone, but at present, we think the risk is low. Because we think the risk is low and we really need to preserve those N95s for those aerosolized procedures, we're going to suggest that, but as soon as we have enough N95s, we're going to be there for the nurses to give them those N95s, as they're suggesting.” We know some hospitals are suggesting to leave it to the individual to determine, but at the moment maybe we have too much of a shortage.

Let me go on to—

Dr. Alan Drummond: Excuse me. Nobody is being dismissive of our nursing colleagues, not for a moment. We work side by side. We are a team, but we have to let a bit of science into this discussion as we know it and as we understand it going forward, unless we want people to actually contract a fatal disease while trying to intubate a 25-year-old. I understand your point, but I think that science is probably a little more in favour of, at this point, preserving our capacity.

Mr. Marcus Powlowski: I don't think the precautionary principle is contrary to science. There's a bit of—

Ms. Silas, are you jumping in? I guess I'm still on.

Dr. Howard Ovens: It's Dr. Ovens. May I comment briefly?

I want to say, in addition, very briefly, that just because you can find the virus on a surface, that doesn't mean it can be transmitted. When we look at the R-naught, it really suggests that the majority of the spread is by droplet contact. There's really very little clinical evidence that this is being spread in an aerosol fashion.

The argument about this can distract from what's really very effective, which is good hand hygiene and very dedicated use of droplet contact precautions with careful coughing.

Ms. Linda Silas: It's Linda here. May I interrupt?

We're not asking permissions here. We're asking our employers to respect our professional judgment when we're in front of the patient.

The Chair: Dr. Powlowski, your time is up.

We'll now go to Mr. Jeneroux, for five minutes, please.

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

I want to reiterate the first question I asked about two hours ago.

I asked the Canadian Association of Emergency Physicians if they had been contacted by Public Health to work collaboratively on COVID-19. They said they hadn't. Then one of the Liberal members indicated that they had talked to the minister in March, two months after we had been raising that this was an urgent issue. The response from the emergency physicians was that it wasn't actually a meeting on COVID-19 or the public health aspect of it.

To the members on the other side, this is a non-partisan committee. This is something we're trying to do collaboratively with each other to better support and better advise the government. I just ask the members on the other side, when the minister's office sends them an urgent email to read into the committee record, that they certainly don't have to do that. All it does is that it ends up essentially embarrassing them and the government at hand, because, quite frankly, this is a committee that's trying to better support and get better advice for the government so we can work together to do better for Canadians.

I appreciate at least the clarification from the emergency physicians on that.

My last question before my time is up, Mr. Chair, is for Dr. Buchman.

We've been hearing that there has been a lack of modelling data provided. I'm just curious as to whether your association has been receiving any of the national modelling data to know what to prepare your association and your members for.

● (1615)

Dr. Sandy Buchman: We haven't received any differing or different modelling data than anyone else has received, so we haven't been partial to receiving anything particular that no one else has.

Really, what's available in the public realm is available to us.

Mr. Matt Jeneroux: Are you aware if the government has internal modelling data that would be helpful at all to your association?

Dr. Sandy Buchman: I'm not really able to comment on what data they have or they don't have, but we are hopeful that any data that governments have, federally or provincially, would be shared publicly. That is, again, within the principle of transparency that we were talking about earlier. We think it would be critical to share anything that is known or available.

Mr. Matt Jeneroux: In my final few seconds, I'm going to quickly jump over to the Canadian Pharmacists Association.

We spoke a little about the limited refills for one month. Are there any exceptions being considered, particularly in rural and remote communities, where we know it is often more difficult for individuals to get the medication?

Dr. Barry Power: Thank you, Mr. Jeneroux. It's Barry Power speaking.

Absolutely. They are in the recommendations and in many of the directives that we've seen come out from many of the colleges. There is a recommendation that the pharmacists exercise their clinical judgment. Absolutely, if somebody has to drive two hours to get to a pharmacy, it's not reasonable. They could be provided with a larger quantity—if somebody has an extreme immunodeficiency, for example, as well. They could be provided with an additional quantity. It really is intended to be an individual decision. For the broad majority of the Canadian public, however, we strongly recommend that there be a 30-day limit.

Mr. Matt Jeneroux: Great.

Mr. Chair, I cede the rest of my time—

Ms. Shelita Dattani: If I could just add one more point to Dr. Power's point.... The other way we're mitigating that and helping seniors and people who cannot come into the pharmacy is managing that through delivering out to those communities—those rural communities and places where those people might be—and discouraging those vulnerable populations from coming into the pharmacy any more than they need to. We will bring medication to them.

The Chair: Thank you, Mr. Jeneroux. Did you say you were done?

Mr. Matt Jeneroux: Yes. I cede my time, Mr. Chair.

The Chair: Thank you very much.

We go now to Mr. Van Bynen. You have five minutes. Go ahead.

Mr. Tony Van Bynen (Newmarket—Aurora, Lib.): Thank you, Mr. Chair.

I would like to start by saying that a genuine statement about close collaboration across all health care providers is important, and it's critical that we recognize that everybody is contributing. I also agree very much that we shouldn't be making partisan statements, and to portray that kind of genuine statement as a partisan statement is totally inappropriate.

On behalf of my constituents, I would like to thank all the health care professionals whom the witnesses represent for their tireless work in this unprecedented and historic pandemic. I certainly hope that doesn't become portrayed as a partisan statement.

Having said that, we are hearing that there are a lot of retired doctors, nurses and other health care professionals who are coming back from retirement to assist in the fight against COVID-19. Our government has also opened up a recruitment campaign for those with medical education and experience.

Now, I would ask Dr. Drummond whether he believes these initiatives will ease the burden and the risk of burnout for the health care professionals who are working on the front line around the clock. Is there any new training these professionals need to do before joining the front lines?

● (1620)

Dr. Alan Drummond: Thank you for the question.

I think it's all hands on deck in the coming weeks, as we expect a bit of a surge. We have concerns that elderly physicians, out of a sense of social conscience, good citizenship or community spirit, will feel compelled to go back to work. We have to be very clear that it's a choice that depends on one's own personal circumstances and one's own comfort as we get older. I'm 66. As we get a bit older, our exposure is the same but our risk is worse.

We are saying that if you're going to go back, just make sure you understand what you're asking of yourself and your family, because you may end up a fatality, and you have to weigh that up. If you do go back, perhaps it's not on the front lines in the emergency department, but doing something else that is necessary.

Absolutely, the government freeing up the workforce is helpful. Clearly, our residents are concerned that there may be some restrictions on entering practice because of a delay of examinations that needs to be considered. As a matter of fairness, if we are going to recruit foreign doctors, we must then make sure that they have access to working in the Canadian workplace beyond COVID-19.

Yes, I salute the government for that. It is all hands on deck, but we do need to be careful about what we are asking. Linda Silas's comment about personal protection is really important, and we would expect nobody to place themselves in harm's way without adequate protection on the front lines.

Mr. Tony Van Bynen: Thank you. I appreciate that. I appreciate your concern and I appreciate your candour. I've heard a lot about gaps that seem to be present today.

Rather than looking through the rear-view mirror, I'd like to put our focus on going forward and what your suggestions are as part of the solution after COVID-19. For example, I've heard there is a limited number of health care professionals and that's a concern, but in the long term, what can be done? Should there be programs to increase the inventory of health care professionals? How can that be accomplished?

Dr. Alan Drummond: Is that a question for me?

Mr. Tony Van Bynen: Yes.

Dr. Alan Drummond: Okay, thank you.

Yes, I think there is. We've been very clear. For five years now, we've been saying we have a critical shortfall of emergency physicians, and that's going to get worse at a time when the population is getting older and not necessarily healthier. We're talking about a shortage of 1,100 emergency physicians, as we speak. That problem is certainly going to be worse in rural environments. They are always tenuous in terms of their capabilities, which is why we have emergency departments closing down in P.E.I. and Nova Scotia after midnight, and in British Columbia, because of limited physician supply.

I think we also have to look at our colleagues as physician assistants, as nurse practitioners in community paramedicine to help in the future, in terms of preparing not only for the day-to-day emergencies but also for any future pandemic. We have a workforce of people who are really willing and able to help, but there may be restrictions. I'm talking about physician assistants and community paramedicine in that particular light.

Dr. Sandy Buchman: Mr. Chair, it's Sandy Buchman. May I just add something here?

In the long term, we need national health human resource planning, so I echo Dr. Drummond's words, but we have no national plan of how many physicians, nurses and other health professionals are needed. We have data, but we have no national entity that can put that together.

We have to plan for 10 and 20 years hence. We have a growing seniors population, of course, but we have about 10 times the number of pediatricians graduating versus geriatricians. It's really just to say that we have before us a major challenge, and that is national health human resource planning and introducing these innovative interprofessional models.

Mr. Tony Van Bynen: Thank you. That's a great segue to my next question.

Are we suggesting that there should be a restructuring in the way health care is being delivered at the federal, provincial and municipal levels? Should there be a change in the roles of the different levels of government to address some of the gaps that seem to continue to exist?

Again, I put that out to the doctors.

● (1625)

Dr. Alan Drummond: I would echo Dr. Buchman's call for a national health human resources strategy.

What can happen is that Nova Scotia trains an emergency physician who suddenly finds himself up in southwestern Alberta. We need to get a handle, especially in the emergency department, on the number and types of providers that we need for the various practice locales, whether it be Sunnybrook hospital in Toronto or Sundre in Alberta. We need to start thinking about who is going to practise in our emergency departments and what level of training they are going to require. For sure, that's true.

Is the practice of medicine changing? Well, from a family practice perspective, this may be the dawn of a new era, as many family physicians learn to practise or try to practise medicine innovatively through the use of Skype, FaceTime, teleconferencing and video conferencing, so yes, it's time. The health care system is going to be under some level of siege over the coming years as our elderly population dramatically increases.

Yes, this is the time, and yes, there is a role for the federal government, in my view.

Dr. Sandy Buchman: I would just add that virtual care has already changed the health care system. For years, we've been trying to get virtual care on. We have just completed a task force with the Royal College of Physicians and Surgeons of Canada and the College of Family Physicians Canada on advising regarding the policy, regulation and governance of virtual care.

It's taken off just through COVID-19. The genie is out of the bottle. There's no going back, so the health care system will fundamentally change as a result of virtual care. It's just the beginning, but once this pandemic is over, we need to reassess virtually everything about our health care system.

The Chair: Thank you, everyone.

We go now to Mr. Thériault. Mr. Thériault, you have two and a half minutes. Please go ahead.

[*Translation*]

Mr. Luc Thériault: I'll be brief. I'll continue in the same vein with Dr. Buchman.

In times of crisis, we see the emergence of innovative practices. We know that access to primary health care is a daily difficulty, especially in rural areas. I'm curious to know how well things are going so far.

Next, how do you feel about remote consultations, that is to say by videoconference or teleconference? Is it adequate and effective for diagnosing COVID-19, among other things, and for providing care to people with this and other problems?

[*English*]

Dr. Sandy Buchman: Thank you for the question.

Even at the present time, pre-COVID and pre-pandemic, our system does not have the appropriate capacity to serve our remote and rural communities. This is a huge problem. This would be part of the health human resources planning picture.

Specifically with regard to COVID-19, just as we are testing the more urban population or the part of the population that is better served, we need to get testing out for rural and remote communities. It is possible to provide virtual care for the mild illnesses, the 80% or so of people who will only have mild illness, but we have to be prepared, as we are, to evacuate those with more serious illness to centres that would be able to handle them.

Again, a lesson that needs to be learned is that we don't have the full capacity yet to serve our remote and rural populations. The pandemic should be a wake-up call. We are gravely concerned that people will get sick in our remote communities, particularly in our first nations communities, where the social circumstances would predispose first nations communities to the development of significant illness, given, say, the number of people who live in a particular dwelling.

To your point, I think it's very important to look at that issue critically. We'll take lessons from this to ramp up resources for remote and rural communities as much as possible, including the increased use of virtual care.

● (1630)

The Chair: Thank you, Mr. Thériault.

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

Mr. Don Davies: Thank you.

Dr. Ovens, you spoke eloquently about the need for transparency and for us to make science-based decisions. Would it be helpful to the medical community for the federal government to release its modelling of the various potential outcomes of the development course of COVID-19?

Dr. Howard Ovens: Within limits, yes. At its most simplistic, we can all extrapolate a line on a curve. The interesting thing is what assumptions they're currently building into their model and how they anticipate it playing out. In the end, we're going to have to see what happens. I think it would be of interest, but I don't want to put too much importance on models.

Mr. Don Davies: Right. Thanks.

Dr. Drummond, I think one of your recommendations was that you'd like to see increased testing for all who are symptomatic. It looks to me as though we're testing about 1% of the population right now. We're certainly not testing everybody who is symptomatic. Can you give us an idea of what we would be looking at to get to the levels of testing that you think we ought to be doing?

The Chair: Is that for Dr. Drummond? Dr. Drummond, are you there?

Dr. Howard Ovens: If he is taking a biology break, I could try to take that, if you like. It's Howard Ovens.

Mr. Don Davies: Okay. Mr. Chair, I'd like my time to please be adjusted because of that delay, if that's okay.

The Chair: Yes.

Mr. Don Davies: Thank you.

Go ahead, Dr. Ovens.

Dr. Howard Ovens: From international experience, a winning strategy is that you test aggressively everyone who is symptomatic, as well as carry out a random surveillance of key populations. That's so you know the prevalence of the disease, but more importantly, so you can follow that up by isolating the people who are positive and tracing their contacts. It's a chain that starts with testing but ends with isolation and contact tracing.

I can't give you, off the top of my head, the exact number that will be required, but it would definitely include everyone who is symptomatic, as well as a well-designed surveillance program.

Mr. Don Davies: Thank you. I take it we're not there yet. Is that your point?

Dr. Howard Ovens: We are not there yet.

Mr. Don Davies: Thank you.

Finally, to the Canadian Pharmacists Association, I've been contacted by seniors who are concerned about conflicting messages. They're being told to stay home, but of course the result of having to go every month for their pills is that they have to go every 30 days instead of every 90.

Second, there's a financial issue. A senior couple told me that they pay a $10 dispensing fee. Between the two of them, they have 12 prescriptions, so their fees have gone from $120 every three months to $120 every month. Is there any talk in the Canadian Pharmacists Association about adjusting dispensing fees to help seniors who are on fixed incomes in light of the requirement to get their pills more frequently?

Dr. Barry Power: Thank you for the question.

We are exploring a number of options for helping these people. We are working with the provinces and payers, and we're having discussions within the profession as well about the best way to approach it.

We knew it was going to be a difficult situation for a lot of people. We had to make a decision quickly due to the incredible spike that we saw. We're now starting to have discussions with a number of stakeholders, both to figure out when we can roll back the recommendation to go with 30 days and also to figure out ways to help people.

Mr. Don Davies: But would pharmacists consider reducing their dispensing fees as a contribution to the extraordinary circumstance right now?

Dr. Barry Power: That's a discussion that would have to happen with the pharmacy owners, but it's a discussion that we can entertain with some of the stakeholders within our community.

● (1635)

The Chair: Thank you, Mr. Davies.

Mr. Don Davies: Thank you.

Ms. Shelita Dattani: Could I—

The Chair: Go ahead.

Ms. Shelita Dattani: I could add to Barry's point about the mixed messaging, which I think was the start of that question.

Certainly we talked about the 30-day supply, but we are definitely discouraging patients, particularly if they're vulnerable, symptomatic or don't feel comfortable coming into the pharmacy. Many pharmacies actually have seniors' hours for patients if they feel more comfortable coming in when there are fewer people, but again, if they're symptomatic or sick or don't want to come in, we are more than willing to deliver, and we continue to deliver.

As I mentioned earlier, pharmacies across the country have committed to a dramatic increase in deliveries so as to reduce the number of patients coming in. Also, pharmacies are taking phone calls. They're talking to patients over the phone and putting up signage, and they're definitely, in every way, discouraging symptomatic, vulnerable or senior patients from visiting their pharmacies. We want to protect their health and ours, and I think the messaging has been very clear on that.

The Chair: Thank you.

I would like to thank everyone. I certainly thank our illustrious panel for their very valuable contributions and their excellent answers to our many questions. I would like to thank the members of the committee and the MPs in the meeting for their time and contribution.

I thank you all. The meeting is now adjourned.