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## **Standing Committee on Health**

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**EVIDENCE**

**Tuesday, November 20, 2018**

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**Chair**

**Mr. Bill Casey**



## Standing Committee on Health

Tuesday, November 20, 2018

• (0845)

[English]

**The Chair (Mr. Bill Casey (Cumberland—Colchester, Lib.)):** I call the meeting to order. We're still waiting for our guests. Apparently they're going through security right now.

We do have a bit of committee business. We have to confirm that the deadline for amendments is Thursday, November 22, for Bill C-316, Mr. Webber's bill. I want to make sure everyone knows that Thursday at 4 p.m. is the deadline for amendments.

Mr. Webber, I went to see if I could find you yesterday, but I missed you. Have you been talking to any officials about amendments?

**Mr. Len Webber (Calgary Confederation, CPC):** We have, yes.

**The Chair:** Does everybody think it's all working out?

**Mr. Len Webber:** I think it's working out. I'll be meeting again right after our meeting with CRA just to get some wording on the form. With regard to any amendments, there is just a minor amendment, and that's to the actual title. Up until now I've said "organ donation", but it should be "organ and tissue donation". It's just an amendment to add "and tissue".

**The Chair:** We're all looking for ways to make this happen.

**Mr. Len Webber:** I know you are and I appreciate it.

**The Chair:** That's our total committee business.

I'm going to table the report on motion 132 on November 26. Then we're planning to hold a press conference at approximately 3:30 p.m. on Monday of the same day in the foyer. That's on health care research, Raj Saini's motion 132. I will remind you again as the time draws nearer. If anybody wants to attend that, they can.

There's another issue that we didn't think we'd have time for. We're going to suggest that we propose a deadline to submit witness lists for the study on LGBTQ2 health in Canada. We want the deadline to be Tuesday, December 11, at 4 p.m.

Is that all right with everybody?

**Mr. Ron McKinnon (Coquitlam—Port Coquitlam, Lib.):** It works.

**The Chair:** That's it. Now we're out of committee business.

We might as well suspend until our witnesses get here.

• (0845)

(Pause)

• (0850)

**The Chair:** We'll reconvene the 123rd meeting of the Standing Committee on Health.

We welcome our witnesses.

You're the first ones we've ever had come in the back door, so we're looking for great things from you this morning. We still have one more witness to arrive, but we'll start. We are going to have votes this morning at some time, so we will be interrupted.

First of all, we have Stacey Livitski, regional chair of Diabetes Canada for northwestern Ontario. We also have Charlene Lavergne, a Métis lady who has type 1.5 diabetes, is it, or type 2?

**Ms. Charlene Lavergne (As an Individual):** It's type 1.5.

**The Chair:** You currently live in Oshawa, I understand. We're looking forward to hearing from you.

We're going to ask Ms. Livitski to start with a 10-minute opening statement.

**Ms. Stacey Livitski (As an Individual):**

I didn't prepare anything because I wanted to be able to answer your questions.

**The Chair:** Tell us a story.

**Ms. Stacey Livitski:** I've lived with type 1 diabetes for 36 years now. My grandmother and my mother both had and has type 2 diabetes. I have known no other life than a diabetic life.

I was seven when I was first diagnosed with type 1 diabetes. Seven-year-olds do not understand what diabetes means. It was the first time I saw my father cry, because he understood what that meant for me.

My first few months living with diabetes I spent in hospital. I was there for almost two weeks. I was home for a very short time and was hospitalized again. I got the flu. Unfortunately with diabetes, when you can't control your blood sugar because you're throwing up with the flu and everything else, you get sick with something called diabetic ketoacidosis.

When I got my insulin pump eight years ago, I caught the flu and didn't realize how significant it was, because it was the first time I didn't go into diabetic ketoacidosis. That was a life changer for me.

I have been very proactive on my health. I know what I need. I know what I need to do. For a very small time in my life, I was married to an abusive man and my control subsequently slipped. That was maybe a four-year period of my life. I'm paying for those four years to this day, despite my above average care of myself.

Despite the complications that I have, I still live a healthy, active lifestyle. I work out with my family, despite having peripheral neuropathy. My feet constantly have pain. I don't feel my feet properly and yet I took up running after that diagnosis. I do everything in my power to live a healthy life, with minimal strain to the taxpayers and to society.

I am doing my best every day. My best sometimes doesn't cut it. That's okay, because I cannot control what's happening internally. You know, the weather impacts your hormones and everything. I can't control that, so I just go with the flow.

Being here is stressful, something that I don't do every day, so I'm sure in a bit there's going to be a beep, beep. That's my life. I have had to adjust, and I have. Thirty-six years in I've kind of got it, even on those roller-coaster days.

● (0855)

**The Chair:** Thank you very much. We look forward to asking you questions.

Now we'll go to Ms. Lavergne.

**Ms. Charlene Lavergne:** My name is Charlene Lavergne. I have been living with type 1.5 or type 2 diabetes. Nobody knows what I am because of various.... I have no thyroid, so I have some other issues. I go with type 2 diabetes because it's easier for everybody all around. It's not easier for me, but it's easier for them, especially the medical profession. They really don't know what to do with me. It's been over 43 years. I'm 63 years old this year, and I've been like this since I was 18.

I want to make a little aside. When I was diagnosed, it was in Toronto, but I was born and raised in northern Ontario. When I was down here, their attitude was that I wasn't any type because there wasn't anything like that in my day. You were just insulin resistant. Actually, one doctor gave me Valium and told me I was just having spells and should just calm down, so I was pretty stoned for a long time. Frankly, I don't remember too much about those first diabetic years. Then they made me lose 70 pounds. I wasn't all that big in those days anyway, so it was pretty bad. I lived on soup. It was a really bad time.

They had no types, no typing, no technology, nothing. We peed on a stick. We've come a long way from peeing on the stick. Today they measure blood glucose levels, and there are new insulins and delivery systems. I'm absolutely in love with the delivery system. It's wonderful, but I can't afford what Stacey has. I'm sorry about the walk in, but I have neuropathy so bad that I don't feel my feet, my thighs, my throat or my facial muscles, so I have great difficulty. I'm on disability and every day's a gift for me.

My biggest problem is that I can't afford anything. I live on \$1,500 a month. My insulins are \$1,000. My rent is \$1,000. If you can afford your medication, it's great, but if you can't.... I just beg. I go from clinic to doctor, and I get compassionate care, but I never know when it's going to run out, and I never know when I'm going to get my next batch, so it's really a struggle. I don't know if you realize this, but while drug plans will pay for insulin, nobody pays for lancets and nobody pays for needles. I don't know if they expect us to smoke this stuff. How are you going to get your insulin into your body if nobody will pay for your needles?

Our friends decided that we were going to go down to the meth clinic and see if we could get some needles for me. It's really a struggle every day. For a long time I went without and I nearly died. That's just the way it is. That's what happens with the neuropathy. You have uncontrolled blood sugars. I have heart problems, and there's the weight. Every doctor only sees the weight, but they don't realize that I'm not diabetic because I'm fat. I'm fat because I'm diabetic, and I can't get....

I've had 12 surgeries and two cancers. Five of those surgeries were because I wouldn't heal. I had a surgeon tell me that he didn't believe in type 2 diabetes or whatever my diabetes was, and he wouldn't order insulin. It took me a year and a half to heal. He wouldn't give me insulin. He just didn't believe in it. There are a lot of doctors who don't believe in my type of diabetes. They have no trouble with Stacey. They have trouble with me. I'm the issue. "You're too fat. You don't exercise enough. You've never done the right thing, so it's your fault." I'm telling you honestly, they always blame that. That's their excuse for not treating me. In April, I was refused surgery because I was too fat, and they just didn't even want to talk about diabetes. A lot of surgeons say, "I don't care about your diabetes. It's not my problem, not my issue." It's a constant struggle for me.

● (0900)

There are four areas that most diabetics like me...and there are a lot of us.

Do you realize that it takes a year to get into the diabetic clinic in Oshawa? I have to go to Whitby, which is 40 minutes away. If you don't have a car, it's a two and a half-hour bus ride and then probably a half mile walk to the little hospital there. I get to see my diabetic endocrinologist every four to six months. If you are sick and you miss that appointment, it's another year. My GP has a three-month waiting period to get a doctor's appointment. I saw her in July. I won't see her until December. I manage my own health care. I read as much as I can. Believe it or not, I'm extremely educated. I have a university degree and a college degree. It's in linguistics, but.... What was I thinking? I don't know.

There are a lot of people who don't have the abilities that I have. They don't have the Internet to be able to go and do these things. There are a lot of diabetics who I talk with. I mean, we wait three hours in that diabetic clinic to see our endocrinologist for eight minutes. I've timed her. She gives us eight minutes. She doesn't check our feet. She barely checks our blood pressure, and she doesn't even look up.

It's really difficult. We need a strategy. I need a plan. I want to live. I have four granddaughters. They're absolutely beautiful, and I want to see them get married. Now, mind you, they're eight, seven, seven and five, but I want to see them grow up. I want to give back, and I'm here because I want to give back.

However, I want you to understand this: They pay for nothing. Nobody pays for anything. Everything I have I've actually begged for. If there's any way that you can find it in your hearts to just.... I mean, I've lived here all my life. I was born and raised here. I had one doctor tell me that it is because I am Métis that I am diabetic. I agree, but what am I going to do about it? He just said, "Well, you know, it's your problem." In our family, we don't talk about this. We don't talk about being native or Métis or anything. We were always afraid of getting removed from our families. I'm from up north, from Sturgeon Falls. We don't even go to the A&P.

I have to tell you that it's been very difficult. I'm not the the only one. I'm sure there are other stories like this, but every day is a struggle. If you can find it in your heart to even find a way to do the strategies to get a plan.... We need boots on the ground. I can't wait any longer; I just can't.

Thank you for listening. I appreciate it.

•(0905)

**The Chair:** Thank you for your presentation. I'm sure that we'll have some interesting questions.

We're going to start our questioning with Mr. Ayoub for seven minutes.

[*Translation*]

**Mr. Ramez Ayoub (Thérèse-De Blainville, Lib.):** Thank you, Mr. Chair.

[*English*]

I'm going to ask the question in French.

[*Translation*]

**Ms. Charlene Lavergne:** That's fine.

**Mr. Ramez Ayoub:** I'd like to thank you both for your testimony. Personal testimony is always more touching and appreciated.

I'll start with you, Mrs. Livitski.

You told us your story briefly. You were diagnosed at the start of your life, or close to it. What do you expect from your government and health services? How do you rate the services you received as a young child and those you receive now, as an adult? What services would you like to see offered to young people who are diagnosed with type 1 diabetes and who, as you said, do not really have control over it? They don't really know what's happening to them, even though their parents usually accompany them.

What more would you like from health services? I'll prompt you by saying that this could even affect schools. What do you see on this side?

[*English*]

**Ms. Stacey Livitski:** You have to understand, too, that, like Charlene referenced, when I was diagnosed at age seven, I was peeing on a stick. This gave us outdated information about what was going on in our bodies. Technology has come a long way, and that really has improved our ability to self-care.

I actually expect a little bit more from my doctors. Like Charlene was referencing, there are specialists out there, and we know more than our specialists do about diabetes. We're going for appointments and essentially getting nothing in return from our health care professionals. When Charlene was talking, it made me upset, too, because I've actually, because I'm an adult, had doctors who don't understand that I'm still a type 1 diabetic, that this does not change just because I've aged.

**Mr. Ramez Ayoub:** From the beginning, have you ever had any doctor who understood your situation and diagnostic—

**Ms. Stacey Livitski:** I would say no. I do not feel like I've ever—

**Mr. Ramez Ayoub:** No? Not even now?

**Ms. Stacey Livitski:** Not even now.

In Thunder Bay, we have one endocrinologist and that is it. He has already told me, "You know far more than I will ever know". That is because I've been involved with Diabetes Canada, so I know the strategies that they've put out to the doctors, even though the doctors don't necessarily follow them. That's something that I can ask and I can expect my government to say to the doctors that there are guidelines that have been researched and set out and that they should be followed.

My husband is lucky that he has me in his life. He was adopted, so he does not know his family medical history. Even though the doctor was doing the tests, he never said anything to my husband. I watched his A1C, which is the blood test that they do to determine if you're a diabetic. I was watching his A1C level go up and up and up. I said to him, "Do you realize that, at this moment, you are sitting at a pre-diabetic level and if you don't get your act together, you're going to cross that?" His doctor never said anything, yet that number is in the guidelines and he was almost there.

I expect our health care professionals to actually be following those guidelines. They're there for a reason. Diabetes Canada does not put in hours and hours of work with leading specialists for that information to sit on the shelf, without being used to implement better care.

• (0910)

[Translation]

**Mr. Ramez Ayoub:** Thank you, Mrs. Livitski.

Ms. Lavergne, you told us your story and mentioned the high cost of drugs and access to treatment.

What exactly would you like to achieve? For you and other people with type 2 diabetes, what would be a viable treatment option?

**Ms. Charlene Lavergne:** In urban centres such as Toronto, Vancouver and Montreal, people with type 2 diabetes have access to everything. That's where all the money goes. In Oshawa, I have access to nothing, and the same is true in Sudbury and Barrie. If you are not in a—

**Mr. Ramez Ayoub:** You said you have nothing. By that, do you mean that you have access to absolutely nothing? Don't Ontario's health care services support you?

**Ms. Charlene Lavergne:** There is absolutely nothing. As I said, it takes a year to be accepted by a clinic that treats everyone. It takes hours to get there. There are no doctors. If you don't organize yourself, you get sick.

I haven't been to the hospital in three years because I took my time and take care of myself, but many people don't and end up ignoring their situation.

**Mr. Ramez Ayoub:** Are you saying that there is no service to treat diabetes or, rather, no service for health problems in general?

**Ms. Charlene Lavergne:** There are no services for health problems in general.

**Mr. Ramez Ayoub:** So people who don't have diabetes like you or other members of your family who need to see a doctor don't have access to one.

**Ms. Charlene Lavergne:** That's right.

My sister lives in Cobourg, and when she has to go to Oshawa to see a doctor there, she has to travel an hour and a half. It doesn't make sense.

**Mr. Ramez Ayoub:** Have you ever had a family doctor in your life?

**Ms. Charlene Lavergne:** I have a family doctor, but it takes two or three months to get an appointment.

**Mr. Ramez Ayoub:** Okay. There aren't any emergency appointments or anything like that.

**Ms. Charlene Lavergne:** No, there's nothing.

**Mr. Ramez Ayoub:** Thank you.

[English]

**The Chair:** Now we go to Ms. Gladu.

**Ms. Marilyn Gladu (Sarnia—Lambton, CPC):** Thank you, Chair.

Thanks to the witnesses for joining us today.

Ms. Livitski, how much does your treatment cost every year?

**Ms. Stacey Livitski:** That is a number that I am terrified to actually look at. This is sad that I have to admit that I am fortunate that my aunt passed away last year. I was maxed out on my credit card to pay for my continuous glucose monitor to keep me safe because I do not feel when my blood sugar goes low. Right now, I'm actually borrowing one from my health clinic because I have a nurse who does not follow procedure. I have a nurse who has been willing, many times, to get into trouble for my sake. She has gone against clinic policy to ensure that I get what I need because she cares.

**Ms. Marilyn Gladu:** I heard that the glucose meters cost about \$8,000. I think that was the number we heard in previous testimony.

Ms. Lavergne, you mentioned that it costs about \$1,000 a month for your drugs.

**Ms. Charlene Lavergne:** Get ready for this. Because I'm such a wacko diabetic, I take probably 260 units of insulin per day, plus an enhancer, plus oral medication. Then you need your statins, and if you have an antibiotic, because we catch every bug going by, it's constant.

It's approximately \$1,000. Test strips are \$1.50 each and I use eight a day and that is with a lancet, which we have to pay for. Pen needles are \$75 for 100.

• (0915)

**Ms. Marilyn Gladu:** I took your point about the fact that...it just seems unusual to me. We pay for all these safe injection sites for drug addicts to get their needles for free. We give prisoners their needles for free—

**Ms. Charlene Lavergne:** And I can't.

**Ms. Marilyn Gladu:** —but we have Canadians who are suffering with this disease, and honestly, if you don't control your disease you will end up having a much worse condition and taking advantage of really expensive services.

We heard testimony about the emergency room calls, 70,000 amputations—

**Ms. Charlene Lavergne:** Oh, I don't go to emerg.

**Ms. Marilyn Gladu:** —and all of those things, yes.

**Ms. Stacey Livitski:** Amputations are huge, and where I am from we have some of the highest rates.

**Ms. Marilyn Gladu:** Do you get the disability tax credit, Ms. Livitski?

**Ms. Stacey Livitski:** I do. I just had to reapply and I am very thankful that this time I got it my first go-round. The last time I had to fight for it.

**Ms. Marilyn Gladu:** We heard that originally 80% who were previously accepted began to be rejected last year, and then there has been a reapplication, and of that, I think 58% were approved, but still 42% were rejected.

Ms. Lavergne.

**Ms. Charlene Lavergne:** My doctor won't fill mine out. She said that I won't get it because I am diabetic.

I had it before for other reasons, the cancer.

This 14-hour idea, are you guys kidding me? It's 24-7, 365 days a year.

**Ms. Marilyn Gladu:** Yes, and I think the amount is \$1,500, which when I hear all the testimony of how much it costs to live every day, it's not the right amount to cover what you're experiencing.

One of the things I'm interested in is the doctor shortage. I've been watching across the country and I have seen incidents in Cape Breton where they're missing 52 emergency room physicians and nobody has a family doctor and they don't have a vascular surgeon. If you cut an artery there, you die or lose a limb. In my own riding 20% have no doctors, and it's going to be 50% next year when everybody retires because of the tax changes brought in by Finance Minister Morneau.

We're seeing this across the country and your circumstances don't seem different. Could you make a recommendation to the government on what we could do to try to fill that need?

**Ms. Stacey Livitski:** I think there needs to be a little more incentive to come to the northern communities. Charlene and I are still a distance away. We're still in northern Ontario.

Despite getting the early notice from my doctor because I just happened to be there when he made his choice, I went over a year without a family physician after mine retired. I had the applications going in to the doctors already, and it took me a year of badgering before I was able to get a doctor.

That's bad because I get to see my endocrinologist twice a year and that's it. If anything happened in that time, I was having to go to walk-in clinics. I would not go to emerg; I went to the same walk-in clinic where I was able to build that rapport with that physician. They understood that I knew what I was talking about, because if doctors don't realize that, I end up getting poor care because they think they know more, and they say it's just my diabetes and I'm not taking care of myself.

I know my diabetes is not well right now because I have an underlying issue that's making it impossible for me to take care of myself.

**Ms. Marilyn Gladu:** Ms. Lavergne, do you ever ration your insulin because you can't afford it?

**Ms. Charlene Lavergne:** Oh yes, I've done that. I do it all the time.

I have to say, though, I have managed to beg enough that I'm doing pretty well for right now, but I never know when that's going to change. It depends on the mood of the doctor.

The other problem I have is that I also ration pills. I reuse needles, which just makes me ill. What do you do? You reuse the needles, reuse lancets and you're all alone. I'm all alone. I have nobody to help me. I live alone. My husband's dead. I don't have anybody to help me. If I have a problem in the middle of the night, I'm going to die. There's nobody.

Nobody understands. My favourite is when you do go to the doctor at an urgent care clinic. I love it. "Oh, another diabetic. Here we go." They don't see past the fat anyway.

There are four things we need. We need affordable housing. We need to be able to afford our medications. We have real problems with food insecurity. I can't afford to eat. I don't know about you guys, but my budget to eat every month is \$89. I don't know how you guys do it, but I'm telling you, it's fun.

Basically what I'm trying to say is that it's difficult outside the urban areas. I can't get around without a car. I can't do anything.

What we need from the government... I just don't want to be alone anymore. I feel I have given my country everything I needed to give. I gave you three beautiful daughters who are not criminals. They are taxpayers. They're struggling. I have grandchildren. I've always done everything I needed to do, and now I just feel like I've been abandoned. I feel like I'm not getting the help I need.

The doctors I do see don't have the time or energy to listen or care.

● (0920)

**The Chair:** The time is up.

Mr. Aubin, welcome to our committee.

**Mr. Robert Aubin (Trois-Rivières, NDP):** Thank you very much.

**The Chair:** I want to introduce our new presenter, Karen Kemp. Karen is a diabetes life coach practitioner working in partnership with Diabetes Canada. She's also an event planner for World Diabetes Day and a director with the Diabetes Action network.

We have your advance notes. We've distributed those.

We're just going to continue with questions.

Mr. Aubin, you have seven minutes.

[Translation]

**Mr. Robert Aubin:** Thank you, Mr. Chair.

I'd like to thank both of you for being here this morning.

I'd like to welcome the three witnesses. Ms. Kemp, I'm including you in the discussion, even though you didn't have an opportunity to make your presentation.

I often see committee meetings televised on CPAC where they hear from ministers. However, if there is one committee that deserved to be broadcast on television, it's this one. Indeed, your testimonies are direct and touching, and they shed light on a little-known reality. I have the impression that many Canadians who, like me, don't have diabetes, make themselves feel better by thinking that this disease is regularly and easily treated with insulin. However, this study is allowing us to discover a completely different reality, which your testimony is expressing so well.

That said, the committee is meeting today to make specific recommendations to the government so that it can move things forward in your favour.

There are two questions I would like you to answer in turn. The first concerns the funding of health services. As you know, health care is largely managed by the provinces. Do you think that a better transfer of funds from the federal government to the provinces would mean better services for your communities?

**Ms. Charlene Lavergne:** Only if we receive it. It's all well and good to say that we'll be given money, but if I don't see it, it's not worth it. I need help right now. I can't wait.

**Mr. Robert Aubin:** What do you think, Ms. Livitski?

[English]

**Ms. Stacey Livitski:** The money is given to the LHINs and then it gets divided. That still stays in Ottawa and Toronto, the bulk of it.

Where Charlene and I are, we need more doctors. We need more specialists. We need more access. I don't know how you transfer that down so that it actually gets disbursed equally. Actually, it wouldn't be disbursed equally. We need more in the areas that are hit more. We need better access. We need better solutions.

● (0925)

[Translation]

**Mr. Robert Aubin:** All right. That's one possibility. The federal government is transferring more money to the provinces in the hope that they will make the best possible use of it.

Another solution might be more direct, and I'd like to know what you think about it.

According to Statistics Canada, 30% of Canadians living with diabetes like you don't have insurance to cover blood glucose monitors. They don't have prescription drug coverage, either. Isn't it high time that, after putting in place a universal health care system, we add a universal pharmacare system?

**Ms. Charlene Lavergne:** Yes, absolutely.

**Mr. Robert Aubin:** You'd see that money because you'd be able to submit your own claims.

**Ms. Charlene Lavergne:** Exactly.

**Mr. Robert Aubin:** Ms. Livitski, do you have anything you'd like to add?

[English]

**Ms. Stacey Livitski:** Yes, I do. I totally agree. At this moment, I am married and my husband, thankfully, has a job with insurance, but I still have to pay a large sum. They pay 80%. When you look at how much medication I'm taking, that 20% is still a heck of a lot of money that most people don't have to pay. I am lucky because I'm in this situation and I can pay that, but it's still a heck of a lot. That's taking away from everything else I have to do to live healthy and maintain that health so that I'm not being a drain.

I'm draining myself and essentially killing myself working so hard to try to stay healthy for the sake of everyone else. My daughter is 16. Like Charlene said, I want to see her grow up, man. She's 16 and I've been at this for 36 years.

What else can I do? What else do I have to give? The stress is just immense. We need help. We've been suffering in silence.

**Ms. Charlene Lavergne:** For a long time.

**Ms. Stacey Livitski:** For a long time, yes, to the detriment of our own mental health and that's hard too.

**Ms. Charlene Lavergne:** You know what? I'm terrified because I'm going to be 65, and at 65 they're not going to pay for the special insulin I need, the tailored stuff. They won't pay for needles again. Sixty-five isn't going to be good for me. They're going to claw back my CPP down to.... I'm going to live in a cardboard box underneath the Oshawa railway tracks because there's just nothing. There's nothing for us. There's no support and there's nobody to talk to. We're always alone.

[Translation]

**Mr. Robert Aubin:** Ms. Kemp, would you like to add anything?

[English]

**Ms. Karen Kemp (Diabetes Advocate, Diabetes Canada):** You have my notes, and people have read them.

I'm going at it a bit differently with regard to CGM. It helps me because my blood sugar fluctuates; it's called hypo-unawareness. With type 1 diabetes, your blood sugar can just plummet and go low. You have no signs or symptoms. It's very dangerous. I can be somewhere and not even recognize my husband. You need to have your blood sugar.... It's on my phone because of this transmitter that I wear. It costs me \$3,000 a year, and it's not covered by extended medical insurance.

I brought some to show you and to pass around. In order to put this on, you need a needle—like this—to insert that. It has a copper wire that reads your blood sugar, which is a sensor. It has a transmitter attached to it. It's very high tech. In the notes you can see that, at any time, you know what your blood sugar level is. Then you know how much insulin to take and what to eat. It's showing on this that you want to be within the grey line, but it could go down or it could go up. Because I was panicking getting here—I left at seven in the morning from Kanata—my blood sugar went low. I could see on here that it was going down so I just drank a juice. However, if I didn't have this, I wouldn't know that it was low. I could pass out.

Not everyone with type 1 diabetes—that's 10% of the 11 million Canadians with diabetes—needs to wear a CGM. It's the 2.5% or about 275,000 Canadians who have hypo-unawareness. You need to test before you drive. You test when you wake up in the morning. If you don't have this, you set your alarm for 2 a.m. and you test, because you often go low in your sleep. What happens is then an alarm goes off.

It's a great system. It's like magic. Imagine having a diabetic child, and the parents have to keep going in to prick their finger and test because they don't know if their blood sugar is going high or low.



You prick your fingers about 42 times a week, whereas this is one needle a week. That's like 2,000 finger pricks. It hurts. Mine are calloused.

What I'm asking for is to have this covered. The key point is that the CGM system, the continuous glucose monitoring system, can prevent life-threatening emergencies. Also, it can put less financial stress on the family, less burden. It would help people with type 1 diabetes hypo-unawareness have a healthier, confident life, because you don't feel confident if you don't know what your blood sugar is.

Here's the best way I can explain it. What's your blood pressure right now? You don't know. That's what we live with. We live in fear. The reality is that we live in fear. We don't know if our blood sugar levels are high or low. This is perfect because it will show me. When I got here, it had two arrows going down. That was like "Get some juice into you quickly", right? You like to have it nice and even, but things happen in life. Everything affects your blood sugar. I'm just saying that this would save money in the long term because of all the complications with type 1 diabetes.

You had another person listed to speak today, Michelle Sorenson. Unfortunately she wasn't well. She ended up in the hospital.

I don't know what else I can say. It saves money.

• (0930)

**Mr. Robert Aubin:** Okay.

**Ms. Karen Kemp:** I also brought an insulin pump to show you. You use this needle to inject the infusion set, and then you attach this cannula. You can see what's in here. There's a cartridge of insulin. If I'm going to eat something, I'll look to see what my blood sugar is. Okay, it's six. I put in my blood sugar level. How many carbs am I going to have? I'm going to have two pieces of toast, so I put in 30 carbs. Then it does the math and figures out how much insulin I need.

It's a fair amount of work, but this has saved my life multiple times. Not every person with diabetes needs this because they have signs and symptoms. The unawareness means that you simply go low and you have no symptoms, such as perspiring, headache, dizziness, mood changes, extreme fatigue or turning pale. You don't have any symptoms. I ran into Costco once to get some flowers and boom—I went low. I would love to have seen that videotape. I was walking around and I didn't expect to go low. I didn't have anything with me. I had my Costco card and my debit card. I needed food, right? They always hand out samples and someone gave me one. I opened it and it was a bar of soap. I was going to eat it, but I smelled it and thought, "Oh, God, I can't eat that." You're so low your brain is shutting down. You can't ask for help. It's hard for others to imagine. I couldn't find the door because my brain was shutting down. I just kept walking around and around. You can have this right next to you but your brain has shut down and you don't even know you need to drink it. I finally found the way out, but I didn't know where my car was. Luckily a beep, beep did this. My car was full of food and juice and all sorts of things. I finally found it. I sat there, drank three juice boxes, ate some food and I was okay. You live like this.

• (0935)

**The Chair:** I have to go to our next questioner now.

**Ms. Karen Kemp:** Sorry. Yes.

**The Chair:** Dr. Eyolfson, you have seven minutes.

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

I thank all of you for coming.

Ms. Lavergne, I was distressed in particular to hear of your interactions with the medical profession. I have been a physician for 20 years. On behalf of my profession, I'm sorry. Certainly your experience goes against everything we were taught in medical school. However, I'm not surprised to hear that account. That in itself is also unfortunate.

We were talking about the costs of things. Did you just say that your insulin costs \$1,000 a month?

**Ms. Charlene Lavergne:** That's all of the meds.

**Mr. Doug Eyolfson:** That's all of the meds. Okay.

**Ms. Charlene Lavergne:** Just the insulin is \$800.

**Mr. Doug Eyolfson:** Just the insulin is \$800. Okay.

How long ago were you diagnosed with diabetes? When did you first have insulin?

**Ms. Charlene Lavergne:** I was on and off insulin during pregnancies and infections. I was on and off insulin for 40 years, but I've been on it full time for about 25 years.

**Mr. Doug Eyolfson:** Do you recall, when you started on full-time insulin 25 years ago, how much you were spending on it per month?

**Ms. Charlene Lavergne:** Well, I'll give you an idea. Up until last year, I was still using a syringe and a vial. I was mixing my own insulin because I'm good at it and nobody else knew how to do it. It was \$26 for a vial a year and a half ago, and for the cartridges, it was \$133 for 10 days' supply. The first vial I remember using was \$5. So it's come a long way. It's very pricey now.

**Mr. Doug Eyolfson:** The price is going up quite substantially.

**Ms. Charlene Lavergne:** I can remember from last June to this June, it started at \$18 for a vial and within six months it went up to \$28.

**Mr. Doug Eyolfson:** Is it the same form of insulin you've been taking the whole time or have they changed it? Is one of these a newer form?

**Ms. Charlene Lavergne:** No, up until a year ago, it was just the old stuff, good old NovoRapid and....

**Mr. Doug Eyolfson:** These price increases were not with any new insulin. Was it just going up?

**Ms. Charlene Lavergne:** Whenever you went to the pharmacy, you said, “Please God, please God, I've got so much in my purse.”

**Mr. Doug Eyolfson:** I've been asking that, because it's been a common theme in these discussions and other discussions, and certainly in our discussions on pharmacare. This drug is a century old.

**Ms. Charlene Lavergne:** NovoRapid has been around.

**Mr. Doug Eyolfson:** The person who discovered it did not make any money off of it. He gave it to the world for free and this is happening. This is one of the things we realize that is broken in our system.

**Ms. Charlene Lavergne:** The stuff I'm on now is really expensive. I'm on Tresiba and Fiasp, and they are really pricey.

**Mr. Doug Eyolfson:** Ms. Livitski, you talked about the insulin pump you're on. How much does that cost? What's the upfront cost, and what do you pay per month for it?

**Ms. Stacey Livitski:** I'm lucky because I live in Ontario. I get funding through the assistive devices program, but it doesn't cover everything.

I can't use that same Inset that Karen showed you. That's a little bit cheaper than what I have to use. I do pay more. I do not track it, because just like tracking my time, that's taking more away from me, and it would really make me [*Inaudible—Editor*] fast.

● (0940)

**Mr. Doug Eyolfson:** Did anyone give you an idea of what that cost would be for someone who had no coverage at all?

**Ms. Stacey Livitski:** The pump is what, six—

**Ms. Karen Kemp:** Well, no. You have to qualify for an insulin pump through the government, and then the assistive devices program. A pump is \$7,000.

**Ms. Stacey Livitski:** It wasn't an option until that program became available in Ontario. In 1997, my doctor told me I really needed to be on an insulin pump, but I had no coverage. That was when I was with my ex-husband, and I had no access. It was unattainable.

**Mr. Doug Eyolfson:** You said that it's an employer plan through your husband that is paying, but you're paying a 20% co-pay, is that right?

**Ms. Stacey Livitski:** Yes, 20%.

**Mr. Doug Eyolfson:** Is that new? Has that gone up or has it always been that way since you've been on that plan?

**Ms. Stacey Livitski:** He's just switched jobs, so he's only been where he is for a year. The job he has now has a much better plan and coverage.

That's the thing. Employers don't necessarily know what their employees need. Plans are tailored not knowing the needs of the plan members. That's an issue in itself. It's a pick and choose kind of menu plan.

**Mr. Doug Eyolfson:** I'll ask everybody this question.

Have you ever applied for any private insurance or through an employer? Have there ever been difficulties due to the pre-existing conditions clauses?

**Ms. Stacey Livitski:** I tried right out of college and was denied right off the bat. Even with my husband's insurance, I actually was denied for life insurance despite my below average A1C. I am doing everything in my power—

**Mr. Doug Eyolfson:** I meant an insurance plan for covering medications. Were you excluded from those?

**Ms. Stacey Livitski:** When I got out of college, so everything.

**Mr. Doug Eyolfson:** Were you excluded from everything?

**Ms. Stacey Livitski:** Pretty much. Anything you wanted to get, “Oh, no, you have type 1 diabetes. No, sorry, we're not going to touch that.”

**Mr. Doug Eyolfson:** Are you saying people should apply for work insurance at the age of five just in case they're diagnosed with diabetes after that?

**Ms. Stacey Livitski:** Essentially.

**Mr. Doug Eyolfson:** Ms. Lavergne, would you say you've had similar experiences with the private insurance industry?

**Ms. Karen Kemp:** Currently, my husband has insurance with Great-West Life. We've been asking GWL, because the government insurance has coverage for CGM, if it would cover CGM, and it is just not answering. We keep trying by sending letters and it is not going to cover it.

**Ms. Stacey Livitski:** I don't think insurance companies understand a lot of the technology either.

I heard of people who made a request for coverage, and they were told that the CGM would be covered. Then, when they put that in, they were denied because they lived in Ontario and the company confused this part, with this, and said, “Oh, no, you have coverage already, and we're not paying for it.” They're two totally separate things that do totally different functions, but we need them both equally.

**Ms. Charlene Lavergne:** You have to remember that I take more insulin than they do. I take three times more insulin than they do, and I get nothing. Nothing is covered for me. I don't exist.

**The Chair:** The time's up.

**Mr. Doug Eyolfson:** I think that's my time. Thank you very much.

**The Chair:** We now go to our five-minute round.

I believe we start with Ms. Gladu.

**Ms. Marilyn Gladu:** Indeed, thank you, Chair.

One of the Conservative members, Tom Kmiec, has brought forward a private member's bill, Bill C-399, the fairness for persons with disabilities act. It tries to make sure that everyone who has diabetes and is, as you say, worrying and calculating and taking all these actions 24-7 has access to the disability tax credit, which then also gives them access to the pension that's related to it to try to help when they turn 65 to pay for all of these medications and things going forward. I think that's a good idea, but my concern is that today, even with the disability tax credit, 40% of the people who should qualify aren't able to get it.

Ms. Kemp, you weren't here when we had this discussion. Do you get the disability tax credit?

**Ms. Karen Kemp:** I do.

**Ms. Marilyn Gladu:** You've never been refused?

**Ms. Karen Kemp:** No.

• (0945)

**Ms. Marilyn Gladu:** That's excellent.

**Ms. Karen Kemp:** My doctor fills out the form and submits it.

**Ms. Marilyn Gladu:** All right.

After all the testimony I've heard, it sounds to me that it would be terrific if, when a person is first diagnosed, it would be recognized what type of diabetes it is and what the best method would be long term to control it. For example, if when you were young, you needed a glucose pump and you were able to get one, that would offset....

It's going to cost \$7,000 for that pump, and I'm not sure how often you'd have to replace it, but that would preclude some of the emergency room visits, the amputations, the very expensive procedures. I think we heard something about \$70,000 for serious diabetes intervention in hospital. It would be ideal for the person's life if they were able to have the technology and they were on a plan where it was paid for—needles, etc. That would be good.

Is there anything else that is needed in order to really address this issue that is affecting...? I guess one-third of Canadians have diabetes or prediabetes.

**Ms. Stacey Livitski:** There is something with the disability tax credit that I didn't get to mention. When I was denied the last time I applied, I called the office and was told that as long as my file went across that agent's desk, she would never approve my claim because she felt I did not deserve it.

Like Charlene, I have peripheral neuropathy. I am in shape because I do work out, but every time I take a step, that step hurts, and that was not taken into account. It was really a blast for me to be told by this agent, "I don't feel you deserve this, and as long as your file goes across my desk, I will not approve your claim." Do you know how heartbreaking that is?

I wrote a letter and sent it to the appeals office, which is located elsewhere, and to the office in Sudbury, across the desk of this lady who told me I wasn't approvable on her account, and I explained the mental impact, because that is what's huge.

I get blamed, just like Charlene does, because I'm diabetic. I did nothing wrong. As I said, we're fighting every day. There are small

system breaks that just need to be fixed so that we don't get blamed for everything we do and we get credit and are acknowledged for doing everything that we do to try to stay healthy.

**Ms. Marilyn Gladu:** Yes, we've heard quite a number of horrific stories of how Canada Revenue Agency has treated people with type 1 and type 2 diabetes over this whole disability tax credit.

Ms. Livitski, you seem to know quite a lot about Diabetes Canada. Do you know about their 360° plan, and do you think just implementing that plan would be the answer?

**Ms. Stacey Livitski:** It's going to help a lot.

As Charlene said, she gets blamed because she's Métis. I mentioned my 16-year-old daughter, who has status as well. There's a pediatrician in town she will not speak to because when she mentioned that she works out, the physician said, "Why do you work out? You're tall and slim. What do you have to do to work out?" She also has ADHD, and she said, "Well, I do it to stay healthy. I have ADHD, and this helps. I'm at risk for developing type 2 diabetes." He looked her up and down and asked why she would say a thing like that. Well, it's on both sides of her family. She has that genetic disposition, and it's likely going to affect her. The 360° plan would help my daughter in the future.

Prevention of limb.... As I said, it's huge in northwestern Ontario, especially in Thunder Bay, and I am very afraid of it.

Yes, the plan is still high level, but I think it's going to help us slowly get down to those root issues.

**Ms. Charlene Lavergne:** But it's a plan. It's something.

**Ms. Stacey Livitski:** It's a start.

**Ms. Charlene Lavergne:** It gives you hope. It says, "Hey, we care about you."

**Ms. Karen Kemp:** If people living with diabetes aren't able to take care of themselves and properly manage it, it's extremely dangerous, and it's life-threatening. If you have read my notes, you will know that my sister passed away at the age of 29. Her blood sugar went low. It's a reality. It's something we all live in fear of, that when we go to sleep, we might not wake up. That's just what we live with.

To give us the proper supplies we need to survive, is that asking too much?

• (0950)

**The Chair:** I have to go to Mr. McKinnon now.

Mr. McKinnon, you have five minutes.

**Mr. Ron McKinnon:** Thank you, Chair.

Thank you all for coming.

Ms. Lavergne, you mentioned in your story that you're rationing insulin. You're holding off, not taking insulin and so forth.

Does that cause your other consequential things, like your neuropathy, to advance? Has that been made worse because of that?

**Ms. Charlene Lavergne:** I think it's true that it does. I think there are studies that show neuropathy is inevitable for type 2s. The problem is that I really don't know what kind of type I am. I'm kind of in between. I think it makes it really bad.

I started out just having sore feet, and now you can see I have trouble with my facial muscles. It really is getting to be quite a handicap for me. It's really difficult.

**Ms. Stacey Livitski:** I don't know about Charlene, but I know when my blood sugar is higher that I do feel the pain a lot more severely.

**Ms. Charlene Lavergne:** It's not just the insulin. You get depressed. You can't get help. There are no psychiatrists. There are no psychologists. There is nothing out there. There's nobody to talk to about our issues.

I swim five nights a week. I try not to drown in the pool.

**Ms. Karen Kemp:** Fifty per cent of people living with diabetes, whether it's type 1, type 2, or type 1.5, suffer from depression. Fifty per cent.

**Ms. Stacey Livitski:** And anxiety.

**Ms. Charlene Lavergne:** It's really good some days.

**Ms. Karen Kemp:** To answer your question regarding the pump, you need a new pump every four to five years.

**Mr. Ron McKinnon:** I don't remember which one of you was talking about the agent who turned you down. What agent was that? Was that an agent with the federal government or the provincial government?

**Ms. Stacey Livitski:** It was CRA when I did the disability tax credit. When you get your denial letter, you get a nice little form letter signed by an agent with their extension, which says, "If you have any questions, please call", so I did.

**Mr. Ron McKinnon:** That sounds like a bureaucrat out of control. That's the sort of thing that needs to be taken up the line, because that's not the way they are supposed to be doing their job, as far as I'm concerned.

Were you able to advance that claim?

**Ms. Stacey Livitski:** As I said, what I did was I wrote a letter explaining how I didn't like filling out forms because that again was taking away more time from my life than what I have already missed because I'm spending time taking care of my diabetes. I don't want to have to sit and calculate and time myself doing everything, wasting more time, to fill out that form to prove to them that I'm doing everything plus more.

I know that on that one, I had way above 14 hours accounted for. As I said, I'm always fighting. I'm Pavlov's dog. Without my CGM, that buzz, I don't feel it. I am Pavlov's dog. That bell rings, and then it's, "Oh, I should be feeling this", but if I don't have this attached, it makes no difference. I don't have that bell. I don't have that warning.

**Mr. Ron McKinnon:** Ms. Lavergne, you said that your physician would not fill out the forms because you have diabetes.

**Ms. Charlene Lavergne:** She just refused me three weeks ago. She said, "You're not going to get it. You have diabetes. It's not going to happen."

**Mr. Ron McKinnon:** That, again, seems to be people who are not doing their jobs, because having diabetes is not a contraindication to getting you this funding. It's a matter of time required for looking after your condition.

I put it to you that your physician is not acting in your interests in this case.

**Ms. Charlene Lavergne:** Considering I see her only every three to four months, it's—

**Mr. Ron McKinnon:** That brings me to earlier discussions and conversations. I think all of you mentioned that there seems to be either apathy or unawareness among the health care professions.

**Ms. Charlene Lavergne:** There's stigma. There's a big stigma. In my family, there are 35 diabetics and we don't talk about it. I have to do my blood sugar under the table when I visit my mother. We don't discuss it, and they don't treat.

Last year I lost my uncle to it because they just won't treat. They won't admit to it. They don't want to deal with it because the stigma is so bad.

● (0955)

**Mr. Ron McKinnon:** What's needed in terms of education?

**Ms. Charlene Lavergne:** Well, the 360° would address a lot of that, because I think that a lot of people don't understand just how bad this is.

I was at the forum last February and I spoke for world health. They have this wonderful paradigm that they want to introduce here in Ontario that would give us one-stop shopping. We would be able to go into this centre, and everything would be there. There would be foot doctors and all the specialists that we need. The problem is that they just want to do it in Toronto. So, hey, what the heck, the rest of us don't exist? That was my big beef: It was only in Toronto.

**The Chair:** I'm sorry, Mr. McKinnon, but your time is up.

We're going over to Mr. Lobb.

**Mr. Ben Lobb (Huron—Bruce, CPC):** Thanks very much.

My first question is for Ms. Livitski.

You mentioned about the benefits package, I think, for your husband's job. That's a pretty tricky one, because from the business standpoint, it's part of the policy with the insurance company that it has to be confidential. You can't know which one is, but it does make it tricky when the person in the business is trying to figure out what package of benefits would be best suited for the company.

I wonder sometimes, when there are a lot of dollars invested in advocacy and lobbying by different agencies like Diabetes, etc., if they shouldn't spend more time talking to the CFIB and other businesses to convince them to enhance those specific things. A lot of times they come to government and say they need this, that and the other, and they have about a 50-year history of being disappointed. I also wonder, if you're fortunate enough to have benefits, if they shouldn't talk to the businesses to improve that.

**Ms. Stacey Livitski:** For sure. I am so thankful, because I wouldn't be able to do half of what I do to be able to take care of myself. As I said, even with my husband's insurance with his old employer, I wasn't covered for it, and I went into immense debt because, as Karen said, I don't feel those lows. It's hard. You just don't know.

Sometimes, too, it depends on who you talk to in the company who knows the plan. Sometimes they don't understand what the plan covers, because they don't understand the diabetes lingo. They see all these words, and they don't know which is which, so it's hard to even talk to them about it to see what's covered, because they don't understand.

**Mr. Ben Lobb:** One question I have for you—any of you, because I think all three of you are from Ontario—is what about your medical records? This province, I guess, should be at the forefront of e-medical records. Do any of the three of you have access to your medical records?

**Ms. Stacey Livitski:** I have some on a stick, because my doctor retired, and that's about it. I have a 14-year span of medical records, and that's all I have. I don't have back to when I was diagnosed, even though—this is funny—I was diagnosed at the same clinic where my last GP was, but I don't have that record either.

I know in Thunder Bay there has been talk that e-records are not always shared and accessed properly. You have to be a part of that clinic to be able to have access to their EMR, but if you don't go to this clinic, they don't converse, so it's still an issue.

**Ms. Charlene Lavergne:** I have no access at all.

**Mr. Ben Lobb:** I think that's a big issue, too, because I don't have access to mine. The only thing I know is that someone else looked at my records and got charged for it. That's the only thing I know about e-medical records.

**Voices:** Oh, oh!

**Ms. Charlene Lavergne:** I just know that I'm always another diabetic. I know that when I come in the door it's, "Oh, another diabetic".

**Mr. Ben Lobb:** Do you think, perhaps, we need to take a longer look at nurse practitioners?

**Ms. Charlene Lavergne:** Yes.

**Mr. Ben Lobb:** You mentioned about eight minutes, and I agree with you. I'm just wondering if the provinces should look at providing more resources to nurse practitioners. They can spend more time. They can delve into if there are any personal issues as well.

I had a procedure, I guess, with a nurse practitioner, and she asked me, "How are you?" I was blown away by that, because I had never

heard that before. I'm not criticizing the doctor; I'm just talking about the nurse practitioners.

**Ms. Stacey Livitski:** My doctor actually started as a nurse and then became a nurse practitioner and is now a physician. She actually spends that time and sits and talks and has that discussion, "How are you? What can I do to help you today?" versus "What's your problem? You only have five minutes and it better be only one problem," because that is.... There are signs in the offices that say, "one problem".

• (1000)

**Ms. Charlene Lavergne:** The thing is diabetes isn't just one problem. It's like an onion. You just keep peeling it.

What's really funny is I can't get any help anywhere except for one place. You're not going to believe where I get it. The City of Oshawa has a RAMP, recreation access membership program, which means that I can swim at any of their pools and walk on any of their tracks for free, as long as I can prove I have the Canada pension plan disability. I haul in my income taxes every year and I show it to them. They encourage me. They really encourage me. They help me get in the pool. They help me get out.

Why is it that they can do that and they recognize that we need it and they know it's important, but nobody else does? It's so weird.

**The Chair:** Okay, the time is up.

Now we go to Ms. Sidhu.

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

Thank you, all, for being here and sharing your story. We know there are 11 million people living with diabetes or prediabetes, and every three minutes another person is diagnosed with diabetes.

Early detection is important for both type 1 and type 2. You share in your stories the stigma out there. There are so many other problems. We need a national strategy. Diabetes Canada's diabetes 360° strategy could save \$36 billion if we implement that strategy.

You also mentioned a one-stop shopping centre.

**Ms. Charlene Lavergne:** The world health, yes. The paradigm is really interesting.

**Ms. Sonia Sidhu:** I know there are gaps that exist. I just want to ask everyone how we can fill that gap on what the federal government cannot do. We need to have, as you said, programs such as RAMP. Municipalities have to come in on that too, and provincial governments have to share the responsibilities as well.

Can you explain how we can fill those gaps and how we can reduce that stigma out there?

**Ms. Charlene Lavergne:** I think one of the things I'd like to see is a recognition of—I don't know how to put this politically correctly—ethnicity. I'm French Canadian. You guys all know that, but I'm also native. I eat a little differently from other people. When I go to the nutritionist at the clinic, they're this big. They eat two apples and an orange and that's it. That's their life. They don't understand that I like poutine, and I like *pattes de cochon* and I like meat pie. I was raised on venison and various other things. They just don't understand.

I spent 43 years trying to adapt myself to their box. They've never recognized the Métis in me. They never have. They've never taken the time to say.... I'm in English Canada really in southern Ontario. It's a constant struggle.

**Ms. Stacey Livitski:** It's hard.

**Ms. Charlene Lavergne:** It is.

**Ms. Stacey Livitski:** We need everyone, all levels of government, to actually work together to help us work together better too and recognize that even though.... You have three people here who are all living with diabetes, but we're all different people and our diabetes impacts us differently. Even though we have the exact same condition, our lives are impacted differently by it.

We make different choices. We have different hormones, and that's the thing. Even the doctors don't always grasp it. Insulin is a hormone that your body normally produces. When you have something else going on, that hormone imbalance impacts your diabetes, and I've had to tell doctors that. There are gaps in education.

I brought that up with the College of Physicians and Surgeons of Ontario at a meeting at the beginning of the month. I was fortunate enough to be invited to that. I'm always bringing up where I'm able that there needs to be more education. Nurses get maybe a day if we're lucky. Not enough time is spent on education. There are researchers out there. Why aren't they being embraced, and used and taught. Let's put the shame away.

**Ms. Charlene Lavergne:** Yes, please.

**Ms. Stacey Livitski:** We did not do anything. You have examples here of three women who are strong, independent ladies. We are fighting all the time. Why are we getting harassed when we go in for something that's not diabetes-related and being told, “Oh, well, it's just your diabetes”?

• (1005)

**Ms. Charlene Lavergne:** You get chemo and they say, “We'll worry about the diabetes later.” I'm thinking that I'm not even 36 here.

**Ms. Stacey Livitski:** Right. It's together. We need to be treated as a whole person. This disease encompasses every aspect of our lives. It's 24-7. I did not know I had anxiety until I got my first sensor.

**Ms. Charlene Lavergne:** She brought me in this morning. I'm freaking on Sparks Street.

**Ms. Stacey Livitski:** These are things that we're being impacted by, and it's not recognized and being treated as if all of these things connect together. I find it odd that I, as a 43-year-old lady who has no medical training, recognize that every part of my body impacts the other. I'm terrified to go for my next blood work because my

A1C is not going to be where I want it to be because I've just had major mental health issues. I saw the impacts. I felt horrible.

This is how bad it is, right? I'm now stressing and hard on myself, and I don't want to go to get that next blood work, because it is not going to be where I want it to be. To me, that just gives that physician the right to say, “You've done this to yourself. You've brought it on yourself. Look at what you did. You didn't have control. How dare you?”

Well, you know what? I was trying. I didn't have my sensor. I was suffering from depression and anxiety. I have PTSD. It all has an impact on me. I'm trying, but I can't do it. I need my city, my province and everyone to work together to help me get the resources that I need because I live in the middle of nowhere.

**Ms. Charlene Lavergne:** Yes, you do, don't you?

**Ms. Stacey Livitski:** I do. It's hard.

**Ms. Karen Kemp:** I empathize with your concerns. It's frustrating because the tools are there. They're readily available for the physicians.

A doctor told me once, “I love it when you come in, Karen”, because I tell her all sorts of things about diabetes. When I first moved to Toronto, I went to a physician. I told her I have diabetes, and she said, “No, sorry. I won't see you. You'll have to find someone else.” I said that I'm only here for a year and I understand diabetes. I won't be high maintenance; I just need a doctor if I have a cold or something. She said, “No, I won't take you.”

One doctor told me she loves it when I come in because she learns about diabetes. I said that there's all these conferences you can go to and there's literature, but she doesn't have time.

**The Chair:** We have to go to Mr. Masse now for the final question.

Welcome to our committee.

**Mr. Brian Masse (Windsor West, NDP):** Thank you, Mr. Chair.

I'm sorry that I'm switching with Mr. Aubin. I had a bridge issue—people know me around here as the building person.

Before, when I had a real job, I was a PSW. I used to work on behalf of persons with disabilities as an employment specialist. We recently had a juvenile diabetes group lobby the Hill here. One of the things was the disability tax credit. What's interesting about that was in 2002, when I arrived here, it was to be cut by the Treasury Board at that time. John Manley was the finance minister who was being advised to cut it. We ran a long campaign with Malcolm Jeffries, who has passed away by now. He was wonderful. We were able to stop it.

Can you highlight the difficulty about the disability tax credit? Even saving it from being cut, it really doesn't cover very much of your costs. Could you especially connect that to how that type of access and resources for prevention could be really worthwhile for our health care system, where we'll make more money—let alone the ethics of doing the right thing—with a little bit more support for people to be preventative in their daily and working lives?

**Ms. Stacey Livitski:** Prevention is the total key.

Having a CGM pump for myself, I don't ever have to go to the hospital. I did once, right when I first got my pump. Because I knew so much, they said, "Okay, we're going to stick the IV in you because yes, you're dehydrated and you need that," but they spent no time on me. They just said, "There you go. We'll take it out when you're done."

Since then, I have not been in the hospital because I am working my butt off to keep myself...but it costs. If you've been watching me, how many times have I looked at this thing and actually made changes to the insulin that's going into my body because I'm going low and trying to prevent it? Prevention is everything.

I call it little money and you guys look at it as big. I look at it as it's a little money up front to save a whole heck of a lot of money down the road. I was diagnosed with peripheral neuropathy when my daughter was two and a half and she's now almost 17. By rights, I should probably have had an amputation by now.

•(1010)

**Mr. Brian Masse:** We had one person from my riding, Angelia Lapico, 14 years of age, who is now becoming an advocate. It seems a little rough to turn a 14-year-old into an advocate and champion at that age. It's very inspiring, but at the same time...

**Ms. Stacey Livitski:** It's a need. We have to. As Karen was saying, we're educating our doctors on a daily basis.

**Ms. Charlene Lavergne:** We're training them.

**Ms. Stacey Livitski:** My mom is type 2 and I've actually had to go in with her and fight with her doctor to change her insulin. I shouldn't have to be telling the doctor how to do his job so that my mom can have the same level of control that I do. I was looking at hers, and I said, "Mom, this is not good. There is something better out there", but the doctor was not comfortable with that something better—

**Ms. Charlene Lavergne:** I know, I remember that.

**Ms. Stacey Livitski:** —and refused, but I have that education. I had him previously and thought I had trained him. I gave him lots of books to read, talked to him, but he wasn't comfortable so he refused.

**Ms. Charlene Lavergne:** I think with the tax credit, the doctors are really afraid to fill them out. They're very complex. They're not

clear, and they have this 14-hour rule that if you have to do more than 14 hours a week.... Well, it's 24-7, 365 days. We're constantly checking.

I don't have pumps or anything because I can't afford that, so I have to use ye olde test strips, but I'm like a criminal. I couldn't even get fingerprints because there's nothing left of mine.

**Ms. Stacey Livitski:** I can't use my finger for my BlackBerry. I have to use my thumb. It's the only one that doesn't change.

**Ms. Charlene Lavergne:** Yes, because we don't have fingers....

I think the forms need to change. They need to be more adaptive. I think it would help if we had a tailored form for just diabetes, and maybe even somebody who knows what they're doing looking over these instead of just going across anybody's desk.

**Mr. Brian Masse:** You have to apply, too. We do a lot of public education because if you don't know about it, you don't get it, so that's a big problem. On top of that, you could have the same condition medically all your life and still have to reapply for it. We have people who have spina bifida who have had to reapply for the....

**Ms. Charlene Lavergne:** I get asked every year, "Are you still alive?" I have to call them and I have to get a signature proving that I'm still alive because they basically can't believe that's happening.

The thing is that I'm diabetic for life. It's not going away, although I'd like it to.

**Ms. Stacey Livitski:** Even with our technology, though, I'd say I spend more time because I have the technology, not less. I've had it said to me, "You have a pump and CGM. You don't spend that time now." Well, no, I'm looking even more because I can look even more, and not damage my fingers and use all those dollar test strips. I'm using technology to its maximum.

**Ms. Charlene Lavergne:** Dollar test strips?

**Ms. Stacey Livitski:** I'm actually spending even more time because I have stricter guidelines because I am trying to stay healthy. I am trying to not give that doctor that ammunition to say you've done this to yourself.

**Mr. Brian Masse:** I would argue that—

**The Chair:** I have to wind up. We're way over.

**Mr. Brian Masse:** It's all really good testimony. Thank you.

**The Chair:** Your testimony is so compelling and meaningful to us. We're really grateful.

I'm looking at the clock. I understand there might be a vote this morning.

**Ms. Marilyn Gladu:** It's at 11:13. The bells are at 10:43.

**The Chair:** Okay. I'm going to propose to the committee that we do one first round again, if the committee is prepared to do that.

**Some hon. members:** Agreed.

**The Chair:** We'll have a round of five-minute questions. We'll start with the same schedule we had before.

I wonder, Ms. Sidhu, if you would like to start. I'm surprised you're here. This is your issue here that you raised so strongly, and I thought maybe you'd like to....

**Ms. Sonia Sidhu:** Thank you, Chair, for giving me an opportunity.

Ms. Lavergne, you said your doctor did not fill out the forms. I think CRA has changed the rules. A nurse can fill out the forms now.

**Ms. Charlene Lavergne:** We don't have a nurse in our current practice.

**Ms. Sonia Sidhu:** You don't have a nurse.

Two weeks ago, with Diabetes Canada, we had a mobile cardiovascular unit here, a screen unit.

Do you think in a remote area that mobile unit could be a big help?

•(1015)

**Ms. Charlene Lavergne:** My problem is we're in the GTA. We're in the greater Toronto area, but we don't get serviced at all. How can I put it? They think because we're in the GTA or we're officially part of the GTA that we get all these services, and we don't. We're completely ignored. Even Global News won't give us our weather in Oshawa. Basically what happens is we fall in the crack and we don't get anything out there.

**Ms. Sonia Sidhu:** You said you had 35 family members who are diabetic. There's a stigma out there.

**Ms. Charlene Lavergne:** Yes. Oh, it's big time.

**Ms. Sonia Sidhu:** How can we educate those family members?

**Ms. Charlene Lavergne:** The thing is, even in my own family, we won't discuss or talk about it. It's like being native. We don't want to admit to it, because we're afraid. Everybody is afraid. They're afraid of the stigma. It's terrible.

**Ms. Stacey Livitski:** It's the blame. The doctor that I fought with over my mom was like, "You're fat and lazy. It's your fault. I'm not going to change it. You have to change."

**Ms. Charlene Lavergne:** They can't get past the weight. That's another issue that they should—

**Ms. Sonia Sidhu:** Can we educate the coming generation in the schools? Do you have any idea about that?

**Ms. Charlene Lavergne:** That would be lovely.

**Ms. Stacey Livitski:** It's where it starts.

**Ms. Charlene Lavergne:** I taught school for years and what I did was—I was a diabetic in that classroom—I took care of the diabetic children sneakily, secretly. I had kids in my classroom that nobody else wanted because they were diabetic and I took care of them. That's probably so illegal nowadays, but I did it because I needed to do it.

We need to educate this new generation. There are more type 2 diabetics now than there were in my day. We're diagnosing 20-year-olds and 15-year-olds with type 2. We have to look at our food. It's a whole bunch of things.

One of the things I would love to see is a focus on nutrition. Look at juice boxes. Look at pop. There's just so much going on that it's just scary.

**Ms. Sonia Sidhu:** How can we educate our health care professionals?

**Ms. Charlene Lavergne:** There's nothing better than the Government of Canada for advertising. You guys are really good at it. You really are—and you have the cash, so personally, I'd say advertise. But find a way that you don't blame us for a disease that I didn't have anything to do with.

**Ms. Stacey Livitski:** It's hard because it's not only advertising. You look at some of the TV shows that portray diabetes and half of them...it's just like, "Are you for real?"

**Ms. Charlene Lavergne:** They make jokes. I've had people in restaurants come up to me and they watch me take my insulin and they say, "You're having a piece of cake? How dare you. You're a diabetic." You don't know this person. This is somebody you don't know. I am sorry, but I just look up at them and I say, "Well, that's why Dr. Best and Dr. Banting invented insulin." There is a real stigma out there. With Banting and Best inventing it in this province, and we're this badly behind, I'm kind of embarrassed.

**Ms. Sonia Sidhu:** You said that you have a hard time with insulin. I know that 830 diabetic patients die in Ontario every year because of a lack of access to insulin. If insulin were covered in a national pharmacare program, would this mean that no patient would die due to a lack of access to insulin?

Do you think this is the best idea?



**Ms. Charlene Lavergne:** It is if they don't make it too difficult. You have no idea what I do to get my insulin.

**Ms. Stacey Livitski:** It's the hoops and the procedure to get it, right?

**Ms. Charlene Lavergne:** I go to one doctor and get a card. Then I go to another doctor and get another card. Then I go to another clinic. I have to do that every month and run around.

**Ms. Stacey Livitski:** It would be fantastic—

**Ms. Charlene Lavergne:** It would be wonderful.

**Ms. Stacey Livitski:** —as long as it was accessible. There are lots of programs around but they're impossible to get and use. They're not user-friendly.

**Ms. Sonia Sidhu:** Prevention is the key. A lot of diabetic patients don't know they are diabetic. How can we reach out to them?

**Ms. Charlene Lavergne:** Education, I think. I think it's about educating Canadians, but don't forget people who are new here and not necessarily born and raised here. As I said, you have to reach everybody. You have to talk to everybody. You have to make it clear to them that it's not a bad thing and you can live with it. You can survive this.

• (1020)

**The Chair:** I have to move now to Ms. Gladu.

**Ms. Marilyn Gladu:** Thank you, Chair.

I want to ask a question about this mobile thing we had here on the Hill that does screening for diabetes. At the time, it looked to me like it was a great way, especially for rural and remote communities, to screen children.

Could you each describe to me how they knew you had diabetes when you were young? What was the signal that you had it?

**Ms. Stacey Livitski:** I remember that my teacher called my parents and basically—excuse my language—said I was being a pain in the ass and disrupting the class. One of the signs of diabetes with high blood sugar is frequent thirst and urination. Every five minutes I had to go to the bathroom. I would go and pee, stand for five minutes at the water fountain, then go back to class for a couple of minutes and say, “I have to go get a drink now; I'm thirsty,” and then I would do the exact same thing over and over again.

I was seven. I was well beyond being potty trained, and I started wetting the bed at night. I remember playing down in the basement with my sister, and I could not get up to the bathroom in time. Everyone just thought I had a urinary tract infection. I was very fortunate that the doctor tested me, because otherwise...I wasn't really sick; I was just drinking all the time and feeling a little blah and going to the bathroom.

That's my diagnosis story.

**Ms. Marilyn Gladu:** Ms. Lavergne.

**Ms. Charlene Lavergne:** I was 18 and I was in Don Mills, I think. I had just got married and I think I went to the doctor to get the pill. The doctor did some blood work and he said, “Oh, you know what? Your blood sugar's really high. You must be diabetic.”

Then he sent me for—oh, you guys are going to love this. I did a jellybean test in those days. You ate 11 jellybeans and then they

tested your blood sugar. Well, I don't want to be mean, but your blood sugar would be high after 11. Then he retested me, but his treatment plan was to lose 70 pounds, and I did it.

**Ms. Marilyn Gladu:** That's horrific.

Ms. Kemp.

**Ms. Karen Kemp:** I had planned a trip halfway around the world for a year, which I did take. There is diabetes in my family, but type 2, and so prior to going, my doctor wanted to do a test. She did the test and then she went on holidays, and the doctor who was filling in for her looked at my report. My blood sugar was 11. The normal range is between 4 and 6. She had the nurse call and tell me everything was fine.

So I went. I travelled for a year all through Southeast Asia, New Zealand, Australia, India, backpacking, but occasionally I wouldn't feel well. Then I was getting really sick, but in India a lot of people didn't feel too good anyway. I was thirsty, as she said, and I lost 30 pounds in 10 days. So I hopped on a plane and flew home, but I went into a coma on the airplane, a diabetic coma. The cells that produce insulin, the islet cells, were rapidly being destroyed, which I wasn't aware of. Actually, I was in the airport in Japan for two days because I was so ill they didn't want to put me on the flight. Finally they said they would take me. I lived in Vancouver and I went into a coma on the plane. They made an emergency landing in California, and got me off the plane. My blood sugar was 58 and they gave me six hours to live, because you just can't survive with high blood sugar like that.

Anyway, I made it, and that's how I found out that I had diabetes.

**Ms. Marilyn Gladu:** Wow, that's quite a story.

We definitely need to do a better job of screening because otherwise it's hit and miss, right?

The other thing I thought of with this mobile idea is the difficulty in getting a doctor, and a doctor that's experienced in diabetes, and getting the right devices. If you had a mobile doctor, the diabetes doctor, for a given area, who had all of the devices and was informed, it would be a great way of improving the service and getting that prevention in place, I think, in a good way.

Is there any comment on that?

**Ms. Karen Kemp:** With the annual physical, just check everyone for diabetes. Everyone, when they have an annual physical, should be checked for diabetes. I love the idea of covering insulin and people not having to pay for it.

**Ms. Charlene Lavergne:** I don't know what I'd do with myself if I didn't have to pay for insulin.

•(1025)

**Ms. Stacey Livitski:** I think everyone should be tested, exactly, regardless of family history or whatever. Things are changing, and we need to change with them.

To go back to what was said, free insulin would be amazing. I mentioned diabetic ketoacidosis and Karen just covered it, but the people who have died in the past, I think of them. It's not a fun death. I think of just the short times that I've had it. It is painful, excruciating. I know the warning signs now, if I go into it, because being on the pump we're actually at higher risk of that. It's not a pleasant thing. Diabetes is not a pleasant feeling, and having that is just horrific.

That would be amazing. You don't even understand.

**The Chair:** We have to move along to Mr. Masse, but we have one more Liberal question. I'm not sure if somebody would like to ask that question after Mr. Masse. If someone has a bank of questions they'd like to ask, let me know.

Meanwhile, Mr. Masse, you have five minutes.

**Mr. Brian Masse:** Thank you, Mr. Chair.

If a national pharmacare program covered insulin, make the case for what would change in your life. If you were trying to convince the general population of the need for a national pharmacare program that would cover insulin, tell us how that would change your life.

I'll leave it open.

**Ms. Charlene Lavergne:** How would it change my life? It would be like Christmas. It would be everything rolled into one. What would it mean for me? I'm 63. It would mean that I could look forward to seeing my four granddaughters and I could live with less anxiety and less stress. I would know that it was there for me. I wouldn't have to scramble. I wouldn't have to just about sell my socks for stuff. Having the right insulin too; that's the key. I need to have the right insulin, not the cheapest stuff on the market.

Basically it would give me hope, and it would give me a little bit more cash so I could eat.

**Mr. Brian Masse:** No, there's nothing wrong with that, but I think it's important to recognize the income level of people. You aren't going to take the money—

**Ms. Charlene Lavergne:** I'm not going to Hawaii.

**Mr. Brian Masse:** —yes, and go to Hawaii or invest it in the New York Stock Exchange.

**Ms. Charlene Lavergne:** No, but I lived in New Zealand. I had my first daughter in New Zealand, and they had national pharmacare then, years ago.

**Mr. Brian Masse:** I know. They're way ahead of us here.

**Ms. Charlene Lavergne:** You paid \$5—

**Mr. Brian Masse:** It's embarrassing.

**Ms. Charlene Lavergne:** —and they were better at managing my diabetes than Canada ever was.

I paid \$5 to go to the doctor. You just went to the chemist then and got all your meds. It was absolutely heavenly. You went in and presented your scrips and no questions, no problems. If you had any

issues, they dealt with them right there. That daughter will be 41 years old in two weeks. They're 40 years ahead of us.

**Mr. Brian Masse:** That's incredible.

**Ms. Stacey Livitski:** It would be amazing.

**Mr. Brian Masse:** Would you feel you would be a more productive contributor to society in general, not only in your family, but also in your lifestyle?

**Ms. Charlene Lavergne:** Oh, yes. I could do a lot more. Hopefully, it would help with the other disabilities I have, but the fact that I didn't have to worry about where every little bit was coming from, I can't begin to tell you what that would do for my life. It would just lift a big burden.

Right now I live every day to survive to get the next...I'm like a drug addict.

**Ms. Karen Kemp:** For insulin.

**Ms. Charlene Lavergne:** For insulin. It would be nice not to feel so criminal. I just want to be able to function.

**Ms. Stacey Livitski:** Charlene's story is not solely hers. I think most of us have been in that position at one time or another. We have scrounged and not done what we needed to do because we knew we could not afford the amount of insulin we needed to get by.

**Ms. Charlene Lavergne:** I went bankrupt.

**Ms. Stacey Livitski:** It's sad, and the drain on society is that we end up with these complications. It's not right at that time either. It's years down the road, because that relationship I was in for those four years was well before my daughter. Those issues are compiled and get worse. Every bit like that helps to improve and makes us not have to struggle and feel that pain and that anxiety and the helplessness—

**Ms. Charlene Lavergne:** —and the embarrassment.

**Ms. Karen Kemp:** I can relate to that because I worked in a pharmacy for 10 years. I'm very fortunate. My husband has a plan. It only covers 80% for the insulin, so still there's the 20%. Working in a pharmacy I came across several people who didn't have the money for insulin.

I would speak to the insulin reps on the side—they were numerous—and also speak to them about test strips and say I had four people who needed insulin and couldn't afford it. Because of the relationship we had I was able to get insulin and test strips for them, but that doesn't happen very often.

As Charlene said, it would be like Christmas. It would be magic. It would just be amazing to cover insulin for patients who need it. As someone said, there are different types of insulin. We're all on NovoRapid.

•(1030)

**Ms. Charlene Lavergne:** Yes. I'm on Fiasp, which is the NovoRapid.

**Ms. Karen Kemp:** The newer one. I want to go on that one.

**Ms. Charlene Lavergne:** I have some in my...I'm like a drug dealer.

**The Chair:** We have to move on to the next questioner, Dr. Elyofson.

**Mr. Doug Eyolfson:** Thank you, Mr. Chair, for the second opportunity.

Ms. Lavergne, I appreciate what you said about New Zealand. This is one of the systems we looked at when we were studying national pharmacare. We were impressed that they have a truly universal system.

**Ms. Charlene Lavergne:** They really do very well.

**Mr. Doug Eyolfson:** Exactly, yes.

One of the things we found with their system and one of the challenges we have is what the country pays for drugs. You might not know this, but Canada pays the third highest in the world for its drugs.

**Ms. Charlene Lavergne:** I didn't know that.

**Mr. Doug Eyolfson:** Yes, in the world.

**Ms. Charlene Lavergne:** Is there a reason for that?

**Mr. Doug Eyolfson:** There are many reasons for that.

**Ms. Charlene Lavergne:** All right. We're not going into that.

**Mr. Doug Eyolfson:** If you had another two hours, I might tell you more.

**Ms. Charlene Lavergne:** I'm sorry I asked, sir.

**Mr. Doug Eyolfson:** It is a very good question, because we spent weeks asking that same question.

One of the reasons they and other countries with universal pharmacare make it sustainable is they're paying much less. We're getting a lot of push-back; I'm seeing it indirectly. I think all advocacy groups and all patients need to be aware. We're getting push-back from the pharmaceutical industry. Never mind pharmacare; they are saying right now that if Canada goes through with its plans to decrease what we pay for drugs, it's going to inhibit research and development. It will decrease the number of new drugs, and in their very words, will put Canadians' lives at risk. We are hearing that.

**Ms. Charlene Lavergne:** The next time they say that to you, you say, "Listen, pumpkin. I peed on a stick." Forty-three years ago, I was peeing on a stick. The first glucose monitors were like cases. You had to put your whole hand in. We have really come a long way.

Look, insulin was invented in this province. We are not going to take that lying down. That's not going to happen. I don't believe that for a moment; I just don't. It doesn't make sense. It's not a logical conclusion.

Another thing I'm very worried about with pharmacare is I'm terrified that the insurance companies are somehow going to get in there.

**Mr. Doug Eyolfson:** It's funny you should say that, because that is another one of the groups that has been lobbying very heavily—

**Ms. Charlene Lavergne:** I know.

**Mr. Doug Eyolfson:** —against universal pharmacare. That's something we've had to manage.

They're not just lobbying the government. I will tell you that they're lobbying chambers of commerce. I've been shown documents. The Canadian Chamber of Commerce, in one of their position

statements, contends that there'll be fewer new drugs, and it will jeopardize the lives of Canadians. It also says that universal pharmacare will add crippling payroll taxes and inhibit small business.

**Ms. Charlene Lavergne:** We didn't die with OHIP.

**Ms. Stacey Livitski:** No, and we're already there. If you look at it, Karen and I.... She wasn't here when I made the statement about my husband's.... We said the exact same thing. I don't know if any of you realized that.

**Ms. Marilyn Gladu:** Yes, you said you were 80% covered.

**Ms. Stacey Livitski:** Right. Also, we both looked at it not as a blessing. We're still paying 20%. Charlene doesn't have that luxury. We're already at the point where we can't afford to live on what the pharmaceuticals are giving us now. What's the difference? I don't want us to be in a situation like the Americans are. They're paying \$500 for a vial of insulin that I'm paying \$30 for. Let's get real. We can't afford to live now.

• (1035)

**Ms. Charlene Lavergne:** You know what? I'm sorry, but I think Canadians need to get smart and realize that our best ally is our government. I would much rather have you control all that, because I have faith that you will be fair. I don't have that faith with insurance companies or pharmaceuticals. I know you guys will be fair. I'd rather have you control it and take care of it. That's just my opinion.

**Mr. Doug Eyolfson:** Thank you.

That's what many of us have felt as well.

Would you say that, on the bulk of it right now, the current scheme we have is endangering the lives of many Canadians?

**Ms. Stacey Livitski:** When we're having to not give our medication and then suffer the consequences of the pain of being in ketoacidosis and the pain of living with neuropathy.... If it were that easy, and we had everything up front and didn't have to put ourselves in those positions, I think everyone would be a heck of a lot better.

**Ms. Karen Kemp:** You are endangering lives. One in eight admissions to the hospital is diabetic-related, and that's just increasing. The system right now—

**Ms. Charlene Lavergne:** It's broken.

**Mr. Doug Eyolfson:** Also, after 20 years as an ER doctor, I can tell you that was my lived experience. It reflects pretty much what the statistics are on that.

**The Chair:** Okay. That completes our time.

On behalf of the committee, I want to thank you for your testimony. It's been really compelling. It's really hands-on and exactly what you're living with. It's actually testimony that could have been heard at the pharmacare hearings we had as well. It's also very helpful for our diabetic study.

Is there anything we can help you with? The CRA application...? It seems unfair that you have not been able to make an application. Is there something we can do? Does anybody have any idea of how we can help her to just make the application? We can't help you with the decision.

**Ms. Charlene Lavergne:** My doctor has to do it, and unless I can convince her that it's worth her while and her time—

**The Chair:** Ms. Kemp and Ms Livitski, do you qualify for the CRA disability?

**Ms. Stacey Livitski:** We qualify, but I still had issues. It's not—

**The Chair:** You do qualify, though.

**Ms. Stacey Livitski:** We qualify.

**Ms. Karen Kemp:** The doctor is holding back. When I got the form in, she was kind of like, “Oh, another one.” I said, “What do you mean?” She said, “Every third patient's bringing in these forms now to sign.” However, she signed mine, because she knew I have type 1 diabetes and I need this.

She feels, as she told me, that people are trying to take advantage of this. You mentioned maybe having a different form for people who have diabetes. I don't know about that, because then everyone will say, “Well, we want a different form.”

**Ms. Charlene Lavergne:** Or maybe just a section?

**The Chair:** Mr. Masse, did you have a question or maybe an answer?

**Mr. Brian Masse:** Yes. Your physician needs to fill out the form. Sometimes physicians charge for those as well.

**Ms. Charlene Lavergne:** It's \$44 or \$46.

**Mr. Brian Masse:** My suggestion, Mr. Chair, although it's not my committee, is that you perhaps ask your researchers to come back with the process that one goes through for the disability tax credit application and the potential fees and cost structure for it. Then you can disseminate that.

**Ms. Stacey Livitski:** That is a great point.

**Ms. Charlene Lavergne:** They're paying for those.

**The Chair:** We'll do something.

Another thing is that if we have three witnesses, and two qualify and one has said that she can't even apply.... Perhaps you should be able to apply.

**Ms. Charlene Lavergne:** It would be nice.

**The Chair:** We'll think about this. We'll talk about this afterward.

**Ms. Charlene Lavergne:** I could really use it.

**The Chair:** Thank you very much, everybody.

**Ms. Charlene Lavergne:** Thank you for having us here.

**The Chair:** Thanks to the witnesses and thanks to the committee. It was another wonderful meeting.

The meeting is adjourned.

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