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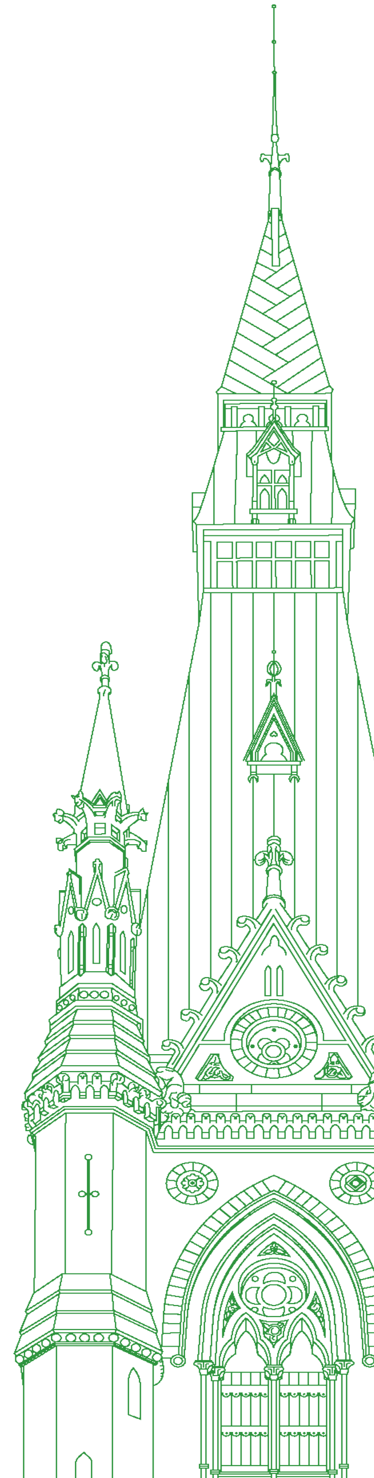

Standing Committee on Health

Tuesday, March 7, 2023

● (1105)

[*English*]

The Chair (Mr. Sean Casey (Charlottetown, Lib.)): Welcome to meeting number 55 of the House of Commons Standing Committee on Health. Today we meet for an hour and a half with witnesses on our study of children's health. We also have scheduled the last 30 minutes, roughly, of today's meeting to do some committee business in camera, so that we can plan for the coming weeks.

Today's meeting is taking place in a hybrid format pursuant to the House order of June 23, 2022. I have a few comments for the benefit of witnesses and members. For those of you—

[*Translation*]

Mr. Luc Thériault (Montcalm, BQ): Mr. Chair, the sound needs to be adjusted. I can barely hear the interpreter and my microphone volume is turned up pretty high. If there's a change, I risk getting a shock. Also, unless people are having trouble hearing your voice, you are drowning out the interpreter.

So, I'd like us to adjust that before we start.

Thank you.

The Chair: Thank you, Mr. Thériault.

We're currently adjusting and hopefully this will be resolved soon.

[*English*]

All right. I think perhaps I will reread the opening until you tell me that everything is okay, and then we'll pick up where we left off.

This is meeting number 55 of the House of Commons Standing Committee on Health. Today we're meeting for an hour and a half with witnesses in our study of children's health, and then for approximately 30 minutes at the end of today's meeting, we will be in camera so that we can plan for the coming weeks. Today's meeting is taking place in a hybrid format pursuant to the House order of June 23, 2022.

I will now make a few comments that have become all too familiar for the members but maybe less so for our witnesses.

We have a couple of witnesses on Zoom today. For interpretation, you have the choice at the bottom of your screen of either floor, English or French audio.

Dr. McLaughlin, you can use the earpiece and just pick the desired channel.

Screenshots and taking photos of your screen are not permitted. The proceedings today will be broadcast on the House of Commons website.

[*Translation*]

As required by our routine motion, I want to inform the committee that all connection tests were done before the meeting and everything is fine in that regard.

[*English*]

I would now like to welcome the witnesses who are with us this afternoon.

We have Dr. Andrew Lynk, chair of the department of pediatrics in the faculty of medicine, Dalhousie University. Dr. Lynk is also the chief of pediatrics at the IWK Health Centre and past president of the Canadian Paediatric Society and Pediatric Chairs of Canada. He is joining us via video conference.

We have with us in the room Dr. Tom McLaughlin, pediatrician and clinical assistant professor at the University of British Columbia. Joining us by video conference is Professor Bruce Verchere, from the departments of surgery and pathology and laboratory medicine at the University of British Columbia.

Thank you all for taking the time to be with us today. Each of you has up to five minutes for an opening statement. We're going to begin with Dr. Lynk.

Welcome to the committee, Dr. Lynk. You now have the floor.

Dr. Andrew Lynk (Chair, Department of Pediatrics, Faculty of Medicine, Dalhousie University, As an Individual): Thank you, Mr. Chair, and thank you for having me today to present. I'm speaking on the traditional and unceded lands of the Mi'kmaq. We are all treaty people, and I know my department of pediatrics and the Canadian Paediatric Society and the Pediatric Chairs of Canada are all committed to advancing the truth and reconciliation recommendations as they apply to children and families and health—

[*Translation*]

Mr. Luc Thériault: Excuse me, Mr. Chair.

I'm really sorry, but the sound is far too loud in the room for me to follow. I can't hear the interpreter at all, despite the adjustments that were made. The sound is too loud in the room.

The Chair: Thank you, Mr. Thériault.

I apologize. The two-week break may have caused new problems. It will be taken care of right away.

[*English*]

Dr. Lynk, we're going to get you to restart. I'll reset the clock. If it comes across too loud in the room, we'll adjust as we go.

Please, go from the top, if you would. Thank you.

Dr. Andrew Lynk: Thank you, Mr. Chair.

I want to thank the committee for inviting me to present today.

I am speaking on the traditional, unceded lands of the Mi'kmaq here in Halifax, Nova Scotia. We are all treaty people. My department of pediatrics, the Canadian Paediatric Society and the Pediatric Chairs of Canada are all committed to advancing the truth and reconciliation recommendations as they apply to families, children, youth and health.

I'm going to build my remarks on some of the September 27 presentations that were made to this committee by my colleagues from the Canadian Paediatric Society, Children's Healthcare Canada and the Quebec association of pediatricians.

In addition to my current pediatric leadership roles, I spent 26 years practising as a community pediatrician on beautiful Cape Breton Island in Nova Scotia. I had the privilege to serve thousands of children from across the island—from first nations communities to children with cancer, children with autism and those who were born prematurely and with dozens of other conditions. I also served the one in four children and families living in poverty there.

I'll always remember a family who came to me. They were a young couple who were probably in their early twenties. Both had lived lives of adversity and were down on their luck. They had a new baby girl. They brought the baby into my office. After I had examined the baby and we had talked a bit, I asked them what they wanted for their daughter. They said they wanted a better life for her than they'd had. I said, “Okay.”

I've thought about that ever since, both as an individual practitioner and as a leader. Obviously I have to rely on my political colleagues to make some of the big system changes to make that happen.

It's quite clear that political discussions around health and health care always get mired in and confused over jurisdictional issues between the provinces and the federal government. It will probably always be like that—at least for the next little while.

I thought to myself, if I'm going to present today and if I were a member of Parliament or a senator, what would be the top 10 things I would focus on if I wanted to try to advance the well-being and health of children and youth here in the country? That's what I'm going to give you. It's my top 10 things in pretty quick succession. You've heard some of them before.

First, when it comes to mental health transfers, commit at least 25% of that, representative of the child and youth population, to services for child and youth health. We still have too many families, children and youth who cannot access mental health services in a timely fashion.

The second thing is one you've heard from the Canadian Medical Association. I think there's movement on it, but it's really crucial. The federal government should take the lead on a national health human resources centre. They could collate provincial data on the number, distribution and mix of nurses, physicians, mental health workers and allied health workers like lab techs and respiratory technicians, as well as the ages of those health workers and the number of trainees in various programs. This data would allow for planning to meet the increasing demands of the Canadian population now and in the years to come. We're dropping the ball on this one. We're flying blind. It reminds me of what happened to PPE during the early phases of the pandemic, when the provinces and the feds thought everybody had it under control and we didn't coordinate. This is a major issue.

Number three is that I would support the establishment of a national school meals transfer program, so that all children in schools receive a healthy breakfast and/or lunch without stigma. Currently, about one in five children—this is higher for newcomers and indigenous children—live in relative poverty. This would be a major benefit. Senator Rosemary Moodie and her colleagues have been trying to advance this. We would back this.

Number four is a really important one. In 2016, the federal government and Parliament passed the Canada child benefit. In Nova Scotia, in the year prior to that 2016 date, about one in five children lived in absolute poverty—below the market basket measure. In 2019, which is the last year I have data for, that's gone down to just one in nine. One in nine is still too many, but it has been almost cut in half. It's most likely because of the Canada child benefit. That needs to be indexed to real inflation.

When you look at the UNICEF rankings, right now Canada ranks 26 out of 38 rich OECD countries, with the worst child poverty rates. There's no vaccine for poverty. Doctors can't do this. We need everyone to work on this.

In the United Nations Convention on the Rights of the Child, which Canada passed in 1991, article 27 states that all children should be entitled to adequate standards of living.

• (1110)

Are we really living up to that if one in nine children are still living below the absolute poverty line?

There's another quick point from the Hospital for Sick Children, which was recently published in The Globe and Mail. They're talking about the complexity of the tax forms for poor families and families entitled to apply for some of these measures. They're saying they're difficult for some to navigate and asking if we can make them simpler.

Number five, I would encourage you to pass Bill C-252, which puts restrictions on the advertising of foods high in sugar, fat and salt to children under the age of 13.

Quebec has the lowest incidence of child obesity and children who are overweight in the country, and they have such regulations in law. We know that one in three children in Canada is obese or overweight. They have a higher risk of going on, as young adults and even as teenagers, to have problems with heart disease, liver disease and diabetes—and these are significant problems.

Number six, establish a child-friendly national pharmacare program. One in six families in this country find it difficult and struggle to pay for their children's prescriptions. Also, fund a national, evidence-based and pediatric-sensitive formulary that all practitioners in Canada can use.

Number seven, prioritize housing, water, health and educational opportunities for all indigenous children and youth. I have seen some of the benefits of this among our first nations communities in Cape Breton. When given the opportunity, these children and youth thrive, blossom and make huge contributions to our society.

Number eight, Canada should continue to take a leadership—

The Chair: Dr. Lynk, can I get you to wrap up? There will be lots of time for questions. Perhaps you could make some concluding comments.

Thanks.

Dr. Andrew Lynk: Sure.

The final point, I would say, Mr. Chair, is that we should establish a national child and youth commissioner in Canada to keep an eye on this issue. We have commissioners for grain and the environment and sports integrity. This is really essential. It's been tried before. Senator Moodie is still leading this initiative to include indigenous leadership in communities as well.

That concludes my remarks.

Thank you.

• (1115)

The Chair: You will get lots of chances to build on them through the rounds of questions.

Thank you very much.

Dr. McLaughlin, welcome to the committee. You have the floor.

Dr. Tom McLaughlin (Pediatrician and Clinical Assistant Professor, University of British Columbia, As an Individual): Thank you, Mr. Chair, for giving me the honour of being able to speak to the committee.

I'm Tom McLaughlin, a clinical assistant professor at the University of British Columbia and a pediatrician on the in-patient unit at BC Children's Hospital, where I take care of some of the sickest and most complex patients in the province. I also lead the Canadian Paediatric Society's work on pharmacare. I do research and policy work on children's drug insurance, pediatric formulations and, more recently, drug shortages.

Clinically, I have the best job in the world. Much like Dr. Lynk, I get to help children survive illness, thrive and develop into wonderful people. A big part of how I do that is by prescribing medications. Drugs allow us to easily treat once-lethal infections, help kids focus at school and, more recently, allow children with rare and devastating illnesses to live and lead better lives.

Despite this promise, Canadians struggle to access the drugs they need. Canada is the only rich country with universal health care that is without universal drug insurance. Almost one in 10 Canadians can't afford prescriptions, and almost a million reduce heat or food to afford drugs. This impacts all Canadians, but children face additional barriers to accessing drugs. This is because Canadian policies, largely federal policies, governing the development, approval and reimbursement of drugs, are largely designed for adults.

First, children have unique drug needs. Young children often need liquid medications. However, many drugs are available only as tablets. This means that drugs are compounded, where the tab is crushed and mixed with something by either a pharmacist or a caregiver. Almost 75% of prescriptions for kids are compounded. It might seem trivial to be talking about mixing pills with applesauce on the kitchen table, but this causes real harm. An eight-year-old boy in Mississauga named Andrew died a few years ago from a compounding error, and many more have been harmed by dosing errors.

Another unique issue in pediatrics is the prevalence of high-cost drugs for rare diseases. Despite the name, rare diseases are not rare in children. Almost one in 10 Canadians has a rare disease, and 70% are children.

A second issue is our regulatory system. Health Canada doesn't currently require manufacturers to apply for a pediatric indication or use for a drug, even when studies exist to support pediatric prescribing or where that use is expected—for example, for a new antibiotic. As a result, over 80% of pediatric prescriptions are off-label, meaning they're used in a way that hasn't been rigorously analyzed and approved by Health Canada.

Many drugs that are available in other countries aren't available in Canada at all, requiring importing drugs through our special access program. Even when drugs are approved, they aren't necessarily covered by provincial or federal public drug insurance programs that poorer families rely on.

Currently, federal agencies, or INESSS in Quebec, perform an economic analysis on new drugs, comparing their costs and impact on mortality and quality of life. For many pediatric conditions, this data just doesn't exist, so this analysis is very limited. It also doesn't capture the economic impacts outside the health care system. Treating a child with ADHD medications may help them stay at school and not require expensive educational supports, or it might allow a caregiver to go back to work. The harms of compounding aren't captured in reimbursement recommendations either.

All of this means that public drug formularies, the lists of covered drugs, can and do exclude important evidence-based drugs for kids. As a result, drug coverage for low-income families who depend on public formularies is extremely variable. In my own unpublished research, I show that children with common conditions like asthma and ADHD may have 100% of their drugs covered or 0%, up to $1,500 a year, depending on which province they live in.

What can the federal government do? The Canada pharmacare act, planned by the end of 2023, promises to ensure universal, comprehensive and affordable drug access for all Canadians, but it should also address the unique barriers that Canadian kids face accessing needed medications.

We should modernize Canada's regulatory system to reduce the need for off-label prescribing and increase access to safe liquid formulations. We should implement a pediatric rule, as many countries have done, whereby manufacturers must proactively develop pediatric studies and apply for a pediatric approval when they apply for an adult one.

We should support the national strategy for high-cost drugs for rare diseases with investment proportional to the disease burden in kids and support the pipeline for innovative treatments. I suspect my colleague, Dr. Verchere, will discuss this.

We should develop a pan-Canadian evidence-informed pediatric drug formulary, as Dr. Lynk said, that appropriately values liquid medications and the economic impacts of pediatric drugs outside the health care system. We should also work with provinces to ensure that a child's postal code doesn't impact their coverage for drugs.

● (1120)

Children deserve the same access to safe, effective and available drugs that adults have in Canada. I hope this committee can help us get there.

Thank you.

The Chair: Thank you, Dr. McLaughlin.

Next, from the University of British Columbia's departments of surgery, pathology and laboratory medicine, by video conference, we have Dr. Verchere.

You have the floor, Dr. Verchere. Welcome to the committee.

Dr. Bruce Verchere (Professor, Departments of Surgery, Pathology and Laboratory Medicine, University of British Columbia, As an Individual): Thank you, Mr. Chair.

I'm joining you all from Vancouver, where I live and work on the traditional and ancestral and unceded territories of the Musqueam, Squamish and Tsleil-Waututh peoples.

I'm a diabetes researcher at the BC Children's Hospital Research Institute, and I'm grateful for government support of my research through the Canadian Institutes of Health Research and through national networks such as the Stem Cell Network.

I'd like to talk to you today about diabetes in children, its huge health burden and impact, the importance of research, and the opportunities we have in Canada as world leaders in diabetes research and care.

Diabetes is currently an incurable disease and a tremendous burden on children and families. Children who develop diabetes have it for the rest of their lives. They face a lifetime of checking blood sugar and administering insulin every day, all the while living with fear, in danger of low blood sugars. It's a life-changing disease.

There are two main forms of diabetes, type 1, in which the insulin-producing cells of the pancreas are destroyed by the immune system, and type 2, a metabolic disease associated with obesity and aging.

While one can develop diabetes at any age, children are particularly impacted by type 1 diabetes, as it is most commonly diagnosed in children and youth. Canada has one of the highest incidences of type 1 diabetes in the world, and it is increasing in prevalence each year. Type 2 diabetes impacts more than three million Canadians and is normally seen in adults but is disturbingly being found increasingly in youth, associated with the rising prevalence of obesity. This form of the disease disproportionately affects children of certain ethnic groups, including those of South Asian descent and, in particular, indigenous youth.

Because children live with diabetes for many years, they are at a high risk for complications later in life, including kidney failure and blindness. Children with diabetes are also at an increased risk for mental health problems, including depression and anxiety. The burden to children, families and our health care system is immense.

I have two main messages for you today about addressing the burden of diabetes in children and the important role government can play. The first relates to the implementation and funding for the national framework for diabetes, and the second is regarding continued support of diabetes research in Canada.

First, speaking to Canada's national diabetes framework, which was tabled just a few months ago, this is a huge milestone for all people living with diabetes in Canada, including children. I want to acknowledge the vision and effort of those who brought this to reality, including the health minister; MP Sonia Sidhu, chair of the all-party diabetes caucus; and many stakeholders who've contributed.

The diabetes framework provides a strategy for government to improve health outcomes for people with diabetes, including children, through several mechanisms. These include ensuring Canadians have access to resources for disease management, increasing awareness of diabetes for all Canadians, and funding and promoting innovative and impactful research.

The national framework for diabetes has the potential to have a tremendous impact on the lives of thousands of Canadian children living with diabetes and their families. I urge the government to ensure the resources are provided to fund and implement this framework, beginning in 2023.

Second, I'd like to talk briefly about the importance and promise of diabetes research to children's health. Canada has a truly remarkable research history in diabetes, and Canadian diabetes research has never been stronger. In 2021 we celebrated the 100th anniversary of the discovery of insulin by Banting and Best, a miraculous Canadian medical research discovery that allowed children with type 1 diabetes to live long lives. However, even Sir Frederick Banting said that insulin is not a cure for type 1 diabetes. More research is still needed.

Since the discovery of insulin, Canadian diabetes researchers have made pioneering contributions, including the development of drugs in common use today for type 2 diabetes and weight loss, and pancreatic islet cell transplantation in type 1 diabetes and, more recently, in stem cell-based therapies for type 1 diabetes. It's important to point out that the development of these therapies builds upon foundational research and took many years to move from discovery in the lab to the clinic. Tri-council funding, particularly from the CIHR, ensures that the best diabetes research is funded across the country, that the diabetes research capacity in Canada remains strong and that new discoveries will find their way into new therapies.

In 2021 the Canadian government invested in diabetes research through the CIHR Institute of Nutrition, Metabolism and Diabetes, in partnership with other funders, including the JDRF, the Stem Cell Network and Diabetes Canada. This investment has had a transformative impact on diabetes research in Canada, including the creation of national teams and networks working together to understand the cause of diabetes and find new treatment. I feel it's important that the momentum built by these national diabetes research teams not be lost. I urge government to continue to support diabetes research through these special initiatives and innovative partnerships, while maintaining and increasing tri-council funding for foundational research.

To conclude, diabetes is a life-changing disease and a tremendous health burden, affecting thousands of Canadian children. I encourage the government, through implementation and funding of the national diabetes framework and increased research funding, to continue to address this significant child health issue.

● (1125)

Thank you for allowing me to speak to you this morning. I'm happy to answer any questions.

The Chair: Thank you, Professor Verchere.

We're going to begin with rounds of questions now, starting with the Conservatives.

Dr. Ellis, you have six minutes.

Mr. Stephen Ellis (Cumberland—Colchester, CPC): Thank you, Mr. Chair, and thank you to the witnesses for being here today. As you all may or may not know, we are coming close to the end of our study on children's health, which has become very large. As all of you pointed out, it's a very complex topic in terms of the breadth and the actual number of things that can influence children's health.

That being said, Dr. Lynk, I will start with you. You talked a bit about mental health transfers and 25% of those transfers coming to children. Certainly, that's been part of our difficulty. The Canada mental health transfer has not been forthcoming from this government, even though it was promised, but that's a whole other kettle of fish.

Maybe you could talk a little about resiliency in kids. Is there an opportunity to speak about that in the education system, as well?

Dr. Andrew Lynk: That's a great point. Mental health care is just one aspect of mental health. Obviously, families that are functioning well, schools that are functioning well and all those support systems are really important, too.

UNICEF does a very good job. If you look at its 2020 report card for Canada, it had about 125 different indicators. It measures some of these specific things around resiliency and how kids are doing.

I was a little shocked, actually. A quarter of children are feeling sadness or hopelessness for long periods of time. Only 50% rate their lives high on life satisfaction. A quarter of kids go to bed or school hungry, at least sometimes, because of a lack of household food. They go through all those different things.

If I'm understanding your question correctly, Dr. Ellis, resilience is more than just health care. It's the family income. It's how well you're supported at school. It's how well communities function. It's about the environment. It's complicated, obviously, but that's why I think I was trying to make sure that at least if there were mental health transfers going to the provinces, the provinces should be accountable to make sure some of that money is dedicated to child and youth services.

With that—and I agree with the current government that provinces are responsible—if they are going to get the money, I think they need to publish outcomes, wait times and how people are doing. That's a wonderful opportunity for us to compare between provinces, because provinces that are doing better—and most provinces are doing better in something than other provinces, for various reasons.... It's an opportunity to learn, to share and to scale things up.

I don't know if I have answered your question completely, but you're right. Resilience is important, and it's supported in many different ways.

Mr. Stephen Ellis: Thank you very much, Dr. Lynk.

Dr. McLaughlin, you talked a bit about children's medications. I will just focus on that. There's another topic I will come back to later, perhaps, if we have time.

Certainly, when we look at the drugshortagescanada.ca website, we still understand that children's Tylenol and children's ibuprofen are short, and in my estimation every first-line antibiotic that would be given orally to children is also in short supply in Canada.

I am wondering if you have any comment on that. Have we seen this before? Do you have any ideas around the solutions?

Dr. Tom McLaughlin: That's an excellent question.

You're right. Drug shortages actually have existed beyond this current round of, specifically, pediatric shortages. That relates to some of those regulatory issues that I talked about.

There are many drugs that are not widely available in Canada, so through our special access program we essentially import and do one-off importation for them as a routine matter. That is something that continues to this day. It has been worsened by the pandemic in terms of common children's medications like Tylenol, Advil and antibiotics. I think it gets back to, in large part, what I was talking about related to regulation.

We struggle with having child-friendly drugs available in Canada, because our regulatory system doesn't push manufacturers or support manufacturers to make those drugs widely available, so there's more we can do on that through incentives and through mandates to be applying for needed drugs.

● (1130)

Mr. Stephen Ellis: Thank you very much for that.

You talked a bit about rare diseases. Certainly, we know very clearly that Canada is the only G7 country that doesn't have a rare disease strategy, and this disproportionately affects children. It's probably not exactly in your area of expertise, but I'm wondering if you might have some comments around rare diseases, the definition and how you think Canada might proceed with a rare disease strategy.

Dr. Tom McLaughlin: The reality is that pediatrics, as a field, has evolved. We have largely become a specialty of rare diseases. At my hospital, I work on the in-patient ward. It's the tertiary referral centre for the province of British Columbia. A quarter to a third of all patient beds are filled by a child with a rare disease. Clinically, this is in every pediatrician's wheelhouse.

I agree. We need to have dedicated leadership. This is a role for the federal government. It can serve an important coordinating role, as it does in many other areas of health care. We should have a national strategy for rare diseases. It should involve work on our drug development pipeline, our regulatory system, and how best to support and reimburse these medications, which can be very expensive.

I certainly agree that we need a national strategy.

The Chair: Thank you, Dr. McLaughlin and Dr. Ellis.

Next, we have Mr. van Koeverden for six minutes.

Mr. Adam van Koeverden (Milton, Lib.): Thank you very much, Mr. Chair, and thank you, witnesses, for coming today. Your testimony has been very interesting and valuable in producing a report to Parliament on children's health.

Dr. Lynk, you started listing your top 10 priorities, but I think you got through only eight. Before I ask a question, I'll provide you with an opportunity to list the other two. I was taking notes, and my list is incomplete.

Dr. Andrew Lynk: I appreciate that. I submitted my notes.

I'm sorry. Perhaps I should have cut it down to eight, but here are the other two.

Firstly, we need to continue to take a leadership role in global climate change and greenhouse gases. If we don't address that one, the next generations are going to be in big trouble, I think.

Secondly, I'll go back to what Dr. Verchere was talking about: Invest in health research. Keep an eye on those budgets. Canada has a stellar record of contributing globally to new innovation and knowledge that are actionable and make a difference to people's lives. Through our CIHR, there's a specific institute of human development, child and youth health. Make sure we are well funded, so we can support some of the world's best scientific minds and mentor the next generation of clinicians and scientists.

I remember being in Cape Breton, when I started as a medical student, and looking after kids with cancer who died or had a high chance of dying. By the time I started practising and was well into my first decade, these kids sometimes had 90% survival rates. That's all because of clinical trials and research. It's the same for diabetes, to Dr. Verchere's point. We have all these new tools because people are doing research to help us, as a health care community.

Those were the other two things I wanted to mention.

Mr. Adam van Koeverden: Thanks. It's a very good list. There are a couple that stand out for me. There is current work on this committee around marketing to kids and a national child and youth commissioner—that one is spoken about on this committee, around health care for children, as well. Thank you for underscoring them. I would say it's a very comprehensive list of suggestions.

I'll move on to Dr. McLaughlin.

We talked a bit about rare diseases. February 28 was the rare disease advocacy day. I used to participate with a friend named Simon Ibell, who started something called “Be Fair 2 Rare”, and it got me thinking more about rare disease advocacy prior to becoming a politician. I think I've mentioned him before on this committee. He was a special guy who left us too soon. His work was exceptional.

I'm wondering to what degree you've been engaged in Canada's rare disease strategy and rare disease drug strategy. I spoke at the CORD conference last year. I had an opportunity to hear from advocates directly. They mentioned that work is ongoing, but it's complicated, obviously, because it's so far-reaching.

Do you have any comments on Canada's future rare disease strategy, as it pertains to drugs or treatment?

● (1135)

Dr. Tom McLaughlin: That's an excellent question.

The future of pediatric drugs is going to be something we all have to grapple with. It's in the name. These are expensive drugs for rare diseases.

By and large, these are drugs for a very small population. It is relatively difficult to get high-quality evidence in the way we used to do it, through randomized controlled trials and that sort of thing. We often have imperfect evidence as part of our development strategy, and that also impacts reimbursement. Should we be paying $100,000, $1 million or $2 million for medication for a child with a significant rare disease?

It's important to balance lots of different things. The magnitude of the disease matters. If it is a child whose life is threatened, I think it makes sense to have more focused and specific end points that may be about that child. It might be that we cover a drug and then we monitor that child's symptoms. We need to develop the evidence infrastructure on how to follow evidence for a very small population.

That also impacts reimbursement decisions, again. Our current systems, CADTH and INESSS, account for patient perspectives and for the magnitude of diseases. That needs to be further fleshed out.

At a federal level and at a governmental level, there are lots of dollars involved. What amount of funding should we be supporting this with? I would say this is something that should be commensurate with the disease burden.

All those things should be part of a rare disease strategy. I would encourage everyone to look up CORD and other national advocacy organizations that have very fleshed-out positions on this.

Mr. Adam van Koeverden: Thanks, Dr. McLaughlin.

Yes, CORD's an awesome organization. We should maybe consider adding it to the list of witnesses.

You mentioned the cost of drugs for rare diseases. I think your average Canadian feels that pharmaceutical companies.... They sense this degree of uncompassionate profiteering when it comes to the lives of kids. Do you have any insight into how or why these drugs, which are so critical in...?

I think of a couple of kids in my riding. Statistically, there shouldn't be more than one, but there's more than one case of spinal muscular atrophy in Milton. The cost for those drugs was completely inaccessible. It was more than any family could afford, virtually. In working through the rigamarole.... I forget the name of the drug, because I'm thinking of the cystic fibrosis one, Trikafta.

Dr. Tom McLaughlin: It's nusinersen, or Spinraza.

Mr. Adam van Koeverden: It's Spinraza. Thank you.

Do you have any insight as to how these drugs get so completely unaffordable? What role can the government play in levelling that playing field or making them a bit more accessible?

The Chair: Answer as succinctly as you can, Dr. McLaughlin. We're out of time here.

Dr. Tom McLaughlin: Of course.

Any profit-making company's motivation is to make profit. That's a good thing. That's how society has become wealthy and developed innovation. It's on us, as a society and as governments in particular, to balance that with appropriate regulation and controls on those prices.

I think it is a very important government role to be involved in how much drugs cost and what their prices are.

The Chair: Well done. Thank you.

[*Translation*]

Mr. Thériault, you have the floor for six minutes.

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

First off, I think it's exciting to hear from witnesses who are making very meaningful contributions to our study. We could talk for an hour with you alone, Mr. McLaughlin.

Dr. Lynk, you presented 10 ideas or solutions to improve children's health, without regard to jurisdiction. I understand all that.

You talked about breakfasts earlier. You know very well that that's a universal practice across Quebec.

What do you mean when you say we shouldn't worry about jurisdictions because you're just throwing some ideas out? However, after you do that, we have to work it out between the various levels of government.

Are we hampering children's health with our federal health care system, with Canada's federal and political setup?

● (1140)

Dr. Andrew Lynk: Thank you very much.

[*English*]

It's a very good question.

One of the most startling examples of where children fall through the cracks would be in our indigenous children when they need special services, and who pays for it.

There was something a few years back, as people will recall, called “Jordan's principle”, whereby the children would get the services and we could fight over whether the feds or the provinces paid for it first, but there was a lot of red tape. One child by the name of Jordan passed away prematurely because there were jurisdictional battles over who was going to pay for his complex care. That stuff can't happen anymore. We need to sort out things like that.

Clearly, the provinces have a lot to do with social and health well-being. They run schools. They run hospitals and clinics. They run roads. They do a lot of environmental things. My point was on what is clearly in the federal wheelhouse, and that's why I've listed these 10 different ideas. If I were a member of Parliament, that's what I would focus on. If I were a member of the Nova Scotia legislative assembly, I might focus on some different areas within the provincial jurisdiction.

It's to keep our focus on things federally, to share best practices and best evidence from across the globe so that Canada is the best place to raise a child. That's why I was finishing on highlighting the need for a national child and youth commission or commissioner, in concert with our indigenous leaders as well, to keep a focus.

As you know, there are so many things you have to deal with as MPs, and so many national issues of importance, but I just don't want this to get lost. That's where that national commissioner or commission could help keep us focused on this important issue and share best practices from different provinces and jurisdictions.

[*Translation*]

Mr. Luc Thériault: Some of the programs you brought up already exist in Quebec. Therefore, some solutions are already in place.

Basically, you're saying that practitioners must be able to share their best practices and that the federal government facilitates the sharing of best practices. I guess that's what you mean. In Quebec, we already have the equivalent of a child and youth commissioner.

It's all well and good to say that 25% should be invested in young people's mental health. However, by the same token, when you look at what the government recently put on the table, which is totally inadequate, how can we accomplish all that?

Everyone who comes to see us here wants to tie investments to their area of expertise. How do we mediate that?

[*English*]

Dr. Andrew Lynk: It's an excellent question.

One of the things we need to do a better job of is measuring outcomes. There's a lot of data across the country on wait times for adults waiting to receive knee, hip and cataract surgeries. There's very little on children. We're starting to establish some wait times for surgery, for example, but how well do we focus on outcomes in terms of resilience, well-being and access to services for children across the country? Again, that's where a national commissioner can collate that data.

If Quebec, for example, or P.E.I., is doing really well in one area, why is that? Why are your obesity rates lower? Why are your diabetic complications lower? Why are your surgical wait times for children lower? Why are children doing better in school in your particular area? There are all sorts of things to share, but I don't think we have one area and one group that's bringing all of this together to help you folks—who are going to design policy, legislation and budgets—to really make informed decisions, especially with competing priorities, with an aging population and with all sorts of external threats to Canada and other things. That's why I'm—

• (1145)

[*Translation*]

Mr. Luc Thériault: I'd like to ask you one last question.

Do you feel that the federal government is investing enough in pediatric care and research? Don't you think it has a lot of catching up to do?

[*English*]

Dr. Andrew Lynk: Yes, I agree with that. Dr. Verchere may also want to jump in on that.

In my faculty here at the department of pediatrics in Halifax, we have about a 12% success rate when we're applying for research funding, and I can tell you that maybe that's getting the *crème de la crème*, but there are probably another 20% or 30% of people who aren't getting funded—and who have excellent ideas and things that will make a difference in people's lives—because there's not enough money. There's a cut-off line. I realize that in life there have to be cut-off lines, but is a 12% acceptance rate good enough? I don't think so. I think we could invest better in that as well, and that's an important investment for the future.

The Chair: Thank you Dr. Lynk and Mr. Thériault.

Mr. Davies, you have six minutes.

Mr. Don Davies (Vancouver Kingsway, NDP): Thank you, Mr. Chair, and thank you to all the witnesses for being here today. I'm particularly pleased to see two from British Columbia.

Dr. McLaughlin, I would like to start with you.

Are Canadian children facing socio-economic barriers in accessing affordable medications?

Dr. Tom McLaughlin: Yes, definitely.

Medication access varies immensely between provinces and jurisdictions. This is particularly important for families living in poverty. Depending on what province you live in, you might have almost all of your children's drug costs covered, or you might have to pay out of pocket, even if you are below the poverty line.

Mr. Don Davies: Do you see actual cases in your practice where kids show up and can't afford medication or are maybe even in hospital because they haven't had access to medication?

Dr. Tom McLaughlin: Yes. I work on an in-patient ward, predominantly. It's not an entirely infrequent situation. In hospital, all drugs are paid for by the hospital, so patients are not bearing costs. We will prescribe a medicine for when the child goes home, and then an hour or a day later, the ward will get a call back when the parent is surprised to see what it costs. They'll sometimes say that they can't afford it and that they need a different medication.

That really does happen.

Mr. Don Davies: Thank you. I'm going to come back to you.

Dr. Verchere, I want to ask you the same question. Do you see any socio-economic disparities for.... I was going to say in insulin uptake, but I will expand that to glucose monitors, test strips, syringes and pumps.

Is there restricted access to those, dependent on income disparities in Canada, in your experience?

Dr. Bruce Verchere: The answer to that is yes, Mr. Davies.

That's left to the provinces. Insulin is largely covered, but devices.... If you're looking at a pump or continuous glucose monitor, that can be $7,000 to $8,000 out of pocket—it depends on the province that you're in for the coverage—and then it's a few hundred dollars per month.

Of course, that means that access to these devices.... We know they have an impact on health because they improve control; they relieve the stress of the disease, and they reduce complications because the glucose control is better. Because not everyone can afford that out-of-pocket cost, there's definitely a socio-economic disparity in the access to that.

Mr. Don Davies: Thank you.

Dr. McLaughlin, in 2020 you co-authored a position statement for the Canadian Paediatric Society, entitled “Pharmacare in Canada: The Paediatric Perspective”. You included a recommendation that I'm going to quote: “Federal, provincial and territorial governments should develop and implement pharmacare plans that mandate universal, comprehensive, portable prescription drug coverage for children and youth.”

The health committee in 2017 and the Hoskins advisory committee appointed by Prime Minister Trudeau in 2019 both recommended exactly that, via a single-payer system. In other words, it was to expand the basket of covered services in our single-payer system to include essential prescription medicines.

Do you agree with that recommendation?

Dr. Tom McLaughlin: A single-payer system would certainly be the simplest way to have the federal government serve the same coordinating role as it does in other areas of health care. That would still mean that provinces have jurisdictions and are responsible for the delivery of health care, including prescription drugs.

There are other options. We have a patchwork system; we can have more patches. That would probably marginally improve the situation. In Quebec, there's been mandatory insurance, which is subsidized.

There are different ways of getting there, but I think we should and probably do all agree that children should be able to get the drugs they need and not have to face cost barriers.

• (1150)

Mr. Don Davies: Dr. Verchere, I want to ask you about the connection between healthy diet, sugar consumption and other things.

I understand that it's probably more of a type 2 diabetes question, but there are currently legislation proposals before Parliament to restrict the marketing of poor nutritional items to children—sugary beverages, etc. There's a proposal that both the Liberals and the NDP ran on in the last election, which would devote a billion dollars over four and five years to establishing a school nutrition program.

I'm wondering if you could give us your position on the connection between nutrition and the development of diabetes.

Dr. Bruce Verchere: You're correct in that type 1 diabetes has a different etiology, but certainly, in terms of type 2 diabetes, diet is an important contributor. There are genetic and environmental components to type 2 diabetes in both a sedentary lifestyle and an unhealthy diet, which contribute to obesity and the risk of type 2 diabetes. It is increasing in prevalence in kids, particularly in certain ethnic groups and, certainly, in indigenous persons.

I think measures that would lead to healthier food intake, food choices and food security could have an impact on the incidence. I should point out that many kids who are obese but haven't perhaps developed full type 2 diabetes are at very high risk for developing type 2 diabetes early in their adult life. The potential impact of that in children is really important.

Mr. Don Davies: Dr. McLaughlin, we also have the shortage of pediatric pain medication that occurred this fall. This committee heard evidence that there are literally hundreds of drugs that achieve shortage capacity every year, so we have a problem with drug shortages in this country.

Specifically, what steps do you recommend the federal government take to help address shortages of pediatric medication?

Dr. Tom McLaughlin: In particular, with many of the pediatric medications we're talking about, we're talking about shortages of child-friendly liquid formulations. There's actually lots of Tylenol out there; it's just that it's tablets. It's hard, when you're a parent at 2 a.m., to be responsible for the last step in the manufacturing process, which has errors and dangers.

It again goes back to the regulatory issues that I talk about to support and incentivize manufacturers to have child-friendly formulations available in Canada, and there are a number of steps to get there.

The Chair: Thank you, Mr. Davies and Dr. McLaughlin.

Next, we have Mrs. Goodridge, for five minutes, please.

Mrs. Laila Goodridge (Fort McMurray—Cold Lake, CPC): Thank you, and thank you to all the witnesses.

That's a good place to jump in at. As a mom, I was actually the first person to bring forward the idea of the Tylenol shortages in the liquid formulations, because I remember just feeling crazy. I thought I was crazy. I thought I was alone and it was just an issue that I was seeing. I've come to learn that this is something that happens with a lot of children's issues.

I'm not sure if it's that we don't have all the right regulations in place or that we're not putting enough emphasis on this. One of the most alarming pieces that's been brought to my attention in the last few weeks, and it's resurfaced, is the shortage of baby formula. We're seeing this from coast to coast to coast, with parents struggling, going on social media platforms to try to find basic food to feed their children.

Could you comment on how important it is to have adequate access to pediatric formula?

Dr. Tom McLaughlin: That's an excellent question. I'm also a parent and can certainly relate to what you're talking about.

I'm not an expert in formula regulation and availability. For many children who can't breastfeed, or whose parents choose not to, formula is a key form of nutrition. For some children, who require specialized formula because of an intolerance to proteins, in particular, access to that can be difficult. I suspect there are similar availability and regulatory issues, but I would have to look into that and get back to you.

● (1155)

Mrs. Laila Goodridge: I appreciate that. I know it's something that's challenging. I went back onto the Health Canada website here today to do more research, because it's been brought up that this is missing, yet again.

There is a big piece on breastfeeding. While many do acknowledge that breastfeeding is a very good option, and is a natural option, it's not an option that works for everybody. Not everyone can, and not every baby can have breast milk, so when these kinds of pieces aren't available, it just adds a lot of extra stress onto the parent, which intrinsically puts it on the child.

You were talking a bit about how the adult formula Tylenol wasn't available, and trying to get your kid to eat it at midnight. I know I've struggled to get my son to have any children's medication that's not grape-flavoured. I've had cherry-flavoured spit in my face.

Could you expand a bit on some of the other oral children's medications where, currently, there's a shortage?

Dr. Tom McLaughlin: Thank you.

You're absolutely right regarding feeding. Breastfeeding does have unique benefits, but that should not mean that mothers, in particular, should face an additional burden or expectation, as they are already facing the hardest job in the world. My wife went back to work at two months after our son was born, and she had difficulty with pumping, so we used formula. I'm totally okay with that.

Now, in terms of drug shortages, I think there are different pieces to it. With the pain medication, we're talking about shortages of drugs that are generally available and were acutely not available. There are also many drugs that are just never available in child-friendly formulations. There's a list from the Goodman Centre in Montreal of over 20 drugs available in other countries that are commercially made liquid formulations that are not available in Canada because their drug maker just hasn't applied for approval. This includes a key epilepsy drug, and it includes many others, so it's a mix of products that are generally available—the availability does vary and that has been the cause of the recent shortages—and products that are not available at all in child-friendly formulations but might be available in other countries.

Then there are drugs for which there aren't pediatric formulations in any country. For some of our HIV medications, if you have an infant who is born with HIV.... You know, we laugh about not taking grape-flavoured medicines, but these medicines are important. If you have to take a medicine every day—if your infant has to do that in order to not develop resistant strains of HIV—that is serious business, and these medications can be extremely unpalatable, because they're not available. As a result, some children can develop drug resistance to that, so that is something that happens.

There are actually several different layers of having the right medications for children, including some that you touched on.

Mrs. Laila Goodridge: Thank you. I appreciate that.

I'm sorry I didn't get to ask questions of any of the other presenters.

The Chair: Next up we have Ms. Sidhu, please, for five minutes.

Ms. Sonia Sidhu (Brampton South, Lib.): Thank you, Mr. Chair, and thank you to all the witnesses for their valuable testimony.

My question is for Dr. Verchere.

Dr. Verchere, I saw first-hand the diabetes excellence hub and diabetes research program at the Child & Family Research Institute. Thank you for the work you are doing on that.

Can you tell us about the mini med school initiative and how it is encouraging and promoting science outreach and education? I know you have a different topic every month to engage youth. Can you elaborate on that?

Dr. Bruce Verchere: Yes, I'd be happy to.

Where I work—and Dr. McLaughlin does, too—at the BC Children's Hospital Research Institute, we have a unique program to try to bring science, research and medical research—pediatric research, really—to bounding young scientists, to encourage high school students of all backgrounds to consider careers in research. To do that, twice a year we host a mini med school. It's usually around one topic. We've done diabetes three times. It's held over six evenings over a month and a half, and it reaches, when we do it in person, about 250 students. They come into the hospital, and they learn with some lectures and hands-on work with our pediatricians and our scientists at BC Children's Hospital.

Interestingly, during the pandemic, when we went virtual, we were even able to expand our reach, because we wanted to reach other parts of B.C., and people find it hard to come down to the Lower Mainland. The results have been really remarkable. I should say that the mini med school spans cancer, transplantation, immunology, infectious disease, mental health and diabetes.

We've had high school students come back from that program to become summer students, and a few have even gone on to Ph.D.s in medical school. The program has been in place for some 20 years now, and some have even come back to do further research training at the institute as Ph.D. students and post-docs. That's been, I think, a remarkable success, and I would love to see it happen elsewhere in the country.

● (1200)

Ms. Sonia Sidhu: Thank you. I have two follow-up questions.

This month is nutrition month. Nutrition and an active lifestyle play a big role in the prevention of diabetes. What are the most promising areas of research in childhood diabetes, and how might they lead to new treatments and therapies? Can you tell us?

Dr. Bruce Verchere: It's a really exciting time in diabetes research. When we talk about childhood diabetes we're usually talking about type 1, although, as I said, there is an increasing prevalence of type 2. Most exciting is that we have access to such incredible technology in regenerative medicine and stem cell biology in gene editing.

One area of research that has a great Canadian story that's gone from the laboratory to clinical trial is in the transplantation of insulin-producing cells into people with type 1 diabetes. It started with pancreatic islet transplantation in Edmonton. It has gone from our ability now—and some of this work was done at UBC—in being able to make insulin-producing cells from stem cells, and now that's in clinical trials in adults with type 1 diabetes, with sites in Edmonton and Vancouver.

The big issue for us is that we really want to see some of these therapies being able to be given to children, and there are issues with that. For example, with stem cell therapies the recipients still need the immune suppression, so ethically they're not in a position to do that with kids; we need more safety studies. However, this is a very promising area of research that looks like it could lead to people with type 1 diabetes being insulin-free. I'm not sure I'd call it a functional cure, as they would still need to take immunosuppressive drugs, but we could give them better sugar control, and they could potentially be free of insulin.

Ms. Sonia Sidhu: Lastly, what role can community-based organizations and advocacy groups play in supporting families and raising awareness about childhood diabetes and how we can prevent it?

Dr. Bruce Verchere: This is really important, I've learned. I think it has been mandated by CIHR funding that we have an element of patient engagement whereby we interact with persons with lived experience of diabetes with our funded investigators and our trainees. We've had a lot more interaction with people in the community, both with type 1 diabetes and type 2 diabetes. That's inspired and helped instruct our research and how we communicate it.

Importantly, it's critical that we get out to the community, particularly those who are in lifestyle intervention research—especially with people who may not live, for example, in the Lower Mainland in B.C. but in more remote areas—just to learn about diabetes awareness, about the potential impact of effective diet and lifestyle. We can do much more there, and I think the research is showing that it works. One example is our BC Diabetes Research Network, which we formed now as a van that allows us to go out into the community and interact with groups, for example, in Surrey, in the South Asian community. We are hoping to do more of that.

The Chair: Thank you, Ms. Sidhu and Dr. Verchere.

[*Translation*]

Mr. Thériault now has the floor for two and a half minutes.

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

Dr. Lynk, you talked about social and economic determinants. Our health care system was weakened before the pandemic and many people have come here to tell us that the pandemic exacerbated the problems related to child and youth health and well-being.

As my grandmother used to say, an ounce of prevention is worth a pound of cure, and prevention starts with education. Even before the pandemic, the system had been weakened a great deal and we were barely able to meet the demand. So we do emergency medicine. On top of that, we're moving at breakneck speed, so Canada is having trouble ranking well with UNICEF. To get a good report card from UNICEF, we would need to invest in prevention.

With respect to infant mortality, obesity, suicide and immunization, Canada ranks in the bottom third despite the fact that it's a wealthy country. Do you believe the health transfer offer will cover the next 10 years and be enough to turn the tide from emergency medicine to preventive medicine, the key to restoring our health care systems?

● (1205)

[*English*]

Dr. Andrew Lynk: It's an excellent question. There are probably never enough dollars for health care or health as compared with all the other competing priorities that we have in governments, I'm sure. I'm sometimes conflicted, as a pediatrician. I have a child, like Dr. McLaughlin, and I also work on the wards for children with rare diseases. The drug costs can be enormous for one family, versus that same money going to help children who are living in poverty. How do you make those decisions? It's not easy, that's for sure. They are both deserving.

I would add also that when my colleague, Dr. Verchere, was talking about diabetes and prevention and control for type 2 diabetes, obesity is a major contributing factor. More children who are living in poverty have problems with their weight, because the foods they can afford to buy are usually high in carbs. They can't afford healthy foods, and they often can't afford to participate in healthy activities like sports teams and things.

To me, poverty is at the root of a lot of our issues in terms of the social determinants of health. The federal government has made a big contribution to that in the last five years. The provinces and the feds have to continue to do that, so that those one in 10 kids living in families below the absolute poverty line are given a hand up. That will go a long way in settling not everything, but a lot of things when it comes to our health.

You also mentioned education. There is a tremendous opportunity to share best education practices across the country, including in learning to read. The Ontario government just had a “right to read” program, using new evidence-based methodologies to teach kids to read. One in three kids is below the standard in Nova Scotia, and probably many other provinces, by the time they are in grade 3 or grade 6, because we are using old methods.

There are so many good things that contribute to health and resilience and children having the best shot, and we can share them across this country. Again, I would focus on this. We need one group or body to be able to bring this all together to advise the feds and the provinces on best policies we can share, to measure outcomes, to do better and to make Canada the best place to raise kids.

The Chair: Thank you, Dr. Lynk.

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

Mr. Alexandre Boulerice (Rosemont—La Petite-Patrie, NDP): Mr. Davies changed to Monsieur Boulerice.

Voices: Oh, oh!

[*Translation*]

The Chair: I'm sorry, Mr. Boulerice.

You have the floor for two and a half minutes.

Mr. Alexandre Boulerice: Thank you, Mr. Chair.

Dr. McLaughlin, I really wanted to hear from you as a pediatrician, because late last year in Montreal we had a crisis in our emergency rooms, including a major one at Sainte-Justine Hospital. We saw a resurgence of childhood respiratory diseases, and they were quite virulent at the end of the year.

I learned recently that it was also caused by the pandemic, because many children had poorly developed immune systems, having been isolated for several months, even years.

In your opinion, when will we be back to normal in terms of our children's immune systems? Is this going to continue?

[*English*]

Dr. Tom McLaughlin: That's a fantastic question. I don't know that I have or that anyone has the answer to it. If I've learned anything—if we've learned anything—from the last several years of the pandemic, it's that making predictions about what's going to come next is hard to do.

I agree that we all faced the same crisis in our children's hospitals, and that was related to not having exposure to viral illnesses. How that will play out over the coming years, I think, remains to be seen.

[*Translation*]

Mr. Alexandre Boulerice: I have a question for Dr. Lynk.

When we spoke of the socio-economic determinants for children's health, you talked about poverty and education.

Can you tell us how important quality housing is?

● (1210)

[*English*]

Dr. Andrew Lynk: That's also one of the major determinants of health. It's not just your genetic code; it's your postal code that is so important. A lot of families are living housing-insecure. In a lot of cities across the country, rents are going up. It's a big issue. I would just say that all those issues around poverty....

I haven't lived in poverty, but I certainly deal with families every day who do. The stress that puts on parents—what that causes between partners and between parents within families—contributes to discord and conflict. We know that when children are raised in stressful households, especially as young children, that constant stress and pressure actually affect how their genetic code gets expressed, and probably brain development. You can imagine that if there's not enough food in the house, or if there's not enough money for winter jackets or rent, the stress is huge.

I'm just going to go back again to poverty, then, which to me is one of the root causes of a lot of issues that the federal government has both done something about and can continue to do something about, as can the provinces. We need a strategy; we need targets and we need outcomes. It's not acceptable to have one in 10 children living below the poverty line in this country—not at all.

The Chair: Thank you, Dr. Lynk.

Dr. Kitchen, you have five minutes.

Mr. Robert Kitchen (Souris—Moose Mountain, CPC): Thank you, Mr. Chair, and thank you all for being here. Congratulations on your hard work in becoming pediatricians. I know the big challenges for all of you and the hours you put in just get to that stage, so I appreciate that.

My wife was a pediatric intensive care nurse at the Hospital for Sick Children. We got to know Dr. Tony Addison, a good friend and the pediatrician who delivered our first two children. Unfortunately, we then moved to rural Saskatchewan. That said, we had a fantastic doctor at the time.

That's a big challenge that lots of Canadians have, because they don't have access to pediatricians and they don't have the benefit of getting that education and knowledge from the mindset that you have and what you can provide to that.

I want to ask a very quick question without getting too long-winded answers. The reality is this: How do we educate Canadians?

When I look back to ParticipACTION, I see they put out the advertisement for a 70-year-old Canadian to get out and exercise. That was a fantastic ad.

How do we educate Canadians to get the best evidence, best practices and education out there, so that they understand how to look after their children so they're not clogging up our emergency wards because of things that maybe they could do at home?

I'll start with you, Dr. McLaughlin.

Dr. Tom McLaughlin: That's a very good question. I agree. In particular for folks who don't have easy access to subspecialists or to specialists like pediatricians, I think it can be particularly challenging to get good, high-quality information.

Governments can have a role in ensuring that information is available. I think specifically of emergency departments as well. That relates to having a really strong primary care system and having options other than emergency departments.

In British Columbia we've actually developed a virtual pediatrician on-call system whereby anyone in a family doctor's office or a nursing station anywhere can actually contact a pediatrician, who can speak directly to a family. That's called CHARLiE, which is an acronym.

There are lots of different things.

Finally, we should ask Canadians and work with them. What is the best way to get information? I'm in the ivory tower, and I certainly have my ideas, and I think some of them are good, but I think we should also be engaging with people. How do you get information? How can we meet you where you are?

Mr. Robert Kitchen: Thank you.

Dr. Lynk, I'm going to ask you the same thing, but before that, I'm going to throw another question at you quickly that you might want to touch on.

Your number two point was on the national health human resources centre and the collection of data. I'm interested to hear a bit more about that data on practitioners. My wife is now retired, and I recognize that many practitioners have basically felt that they got burned out with COVID-19, so a lot of them have retired at this point in time. How do we get that set up?

● (1215)

Dr. Andrew Lynk: Those are both great questions.

I would just say that the Canadian Paediatric Society has a wonderful website, called Caring for Kids, which is written for families, at basic levels, and has all sorts of wonderful information. I'm just going to put that plug in that some of that information is out there. We also have to contend with a lot of misinformation and disinformation around vaccines and other things, and that's another huge issue.

To the health human resource issue, it's huge, and the pandemic exacerbated everything. In lots of pediatric departments—and I can just speak for pediatrics across the country—maybe a third of the pediatric health workforce is doing okay; a third is doing so-so, and a third is struggling with well-being and feeling burnt out, often because people don't have enough colleagues and supports to help them and because of the moral distress of knowing they have long wait times and can't do all they want to do for their patients.

The big thing is just planning. Are we going to be in the same position five or 10 years from now? Again, we're flying blind right now. We don't know. How many pediatric neurologists do we need in the next five or 10 years? I can't even answer that—and I was president of the Pediatric Chairs of Canada—because I don't have that data readily at my fingertips to plan. How many should we be producing? Who might be retiring? Who's thinking about that?

This is where I think the federal government, on the advice of the Canadian Medical Association, the Canadian Nurses Association and others, can have a centre to collate all this information and help us plan, so we don't get burnt on this again.

The Chair: Go ahead, very briefly.

Mr. Robert Kitchen: Thank you.

Dr. Verchere, I'm not leaving you out. Very quickly, on the issue of T1D and, in particular, the high cost of some of the medications, I'm going to use Jardiance as an example, which is being looked at from the point of view of kidney failure. In fact, you probably are aware that they've discontinued the research on it because of the great evidence they've seen on it. That's a huge cost to families in utilizing the value of that medication. I'm just wondering what your comments are on that aspect.

Dr. Bruce Verchere: I'll preface it by saying I'm not a clinician, so the pediatricians here on the call may be better equipped, but I think it's an interesting class of drugs. They lower blood sugar quite effectively, and the clinical trials have shown improvements in kidney and cardiovascular diseases, alleviating those complications of the diseases.

It speaks to the importance of research, the need for clinical trials and partnering with pharma on these trials. Eventually, evidence will drive the decisions that we make around drugs.

There are members of that class of drugs that are still being used and are thought to be safe, but with any drug there are concerns about side effects. There's always a balance.

The Chair: Thank you, Dr. Verchere.

The final rounds of questions for today's meeting will come from Mr. Jowhari, please, for five minutes.

Mr. Majid Jowhari (Richmond Hill, Lib.): Thank you, Mr. Chair, and thank you to all the witnesses for your testimony today. It was very insightful.

I'm going to focus my line of questioning on data, starting with Dr. Lynk.

A number of times in your opening remarks, when you talked about the national health human resource data.... Recently, you responded to my colleague Dr. Kitchen's question on a planning tool whereby you would be able to see where the supply is, what the situation of supply is and where the demand in the future is going to be. As well, you responded to the role that a national youth commissioner could play in using data to be able to look at jurisdictions where they're producing some really good results and being able to compare them.

Can you expand on where you think the data for children's health should come from? I'd really like to get an understanding.

If you're going to develop a children's health data strategy, who should be developing it? What should be the element of that strategy? Who should be monitoring it? What jurisdictions need to collaborate together to be able to collect that data, and how will that data be able to help us form the policy that we need in the future?

• (1220)

Dr. Andrew Lynk: It's a great question. I think we all agree that we need to measure things. What gets counted counts. We need to measure outcomes. We need to see who's doing well and who's doing less well, so that we can share and scale things up.

Should that function and that repository sit with the national child's commission or commissioner? That's one. It could be Health Canada. UNICEF collects this data as well. The key thing is to have all these things in one place, so that when you're making decisions as policy-makers, which you have to do, you have easy access to it—as will the provinces—to share and scale things.

All I can do is agree with the importance of it. I'm not sure, from an efficiency point of view, where it should actually sit, but it's somewhere nationally, with national leadership.

Mr. Majid Jowhari: What would be some of the data that we should be collecting as it relates to children's health?

Dr. Andrew Lynk: If you look at the UNICEF 2020 report card, there are all sorts of measurements of graduation rates, poverty rates, food security, housing security and well-being. Look at Children's Healthcare Canada, which represents the 17 children's hospitals across the country. They collect data on their wait times, including mental health, surgery, children admitted for mental health issues and suicides, etc.

There is a whole range of data that I think you could probably get a consensus on fairly quickly with your child life and health colleagues across the country and that we could put together in a concise, easy-to-find report.

Some of that's already being collected. It's just putting it in one spot that's easy to access. Again, there's a discussion that needs to be had as to where that should sit and who should be responsible for it.

Mr. Majid Jowhari: Thank you.

I'll go back to you again, Dr. Lynk. On a number of occasions today, you talked about the fact that we need accountability.

I'll give you an example. Back in 2017, the Liberal government allocated $5 billion over 10 years to mental health and spent that money. Today, we still don't know how that money trickled down and which services were improved.

A number of times, you talked about clear accountability measures. What are your thoughts around the new round of conversations that are being had with the provincial and territorial health ministers and the premiers around the fact that we are adding a dimension of accountability through measures and clearer outcomes?

Dr. Andrew Lynk: I'm 100% for it. We have to have accountability. We have to have outcomes. We have to measure stuff, and if we're going to spend our tax dollars wisely, taxpayers, whether they live in Chicoutimi; Sydney, Nova Scotia; Comox, B.C.; or up in Iqaluit, have the right to expect that money is being used for the best possible impact.

It is quite right for the federal government to ask the premiers to be accountable, and to have comparable, measurable outcomes on all sorts of different things as they relate to health. It is absolutely necessary if we're going to get better and healthier as a country and be a better place to raise children.

Mr. Majid Jowhari: Thank you. Mr. Chair.

The Chair: Thank you.

To our witnesses, that concludes our round of questions, and we want to sincerely thank you. I can just imagine that you are all extremely busy people. Your patience and professionalism in handling the questions today was greatly appreciated, as was the expertise you brought to the topic.

We're approaching the finish line in terms of hearing testimony, and then it's a matter of putting it all together and formulating recommendations. This will be of great value to us in that regard.

Thank you so much for being with us. You are free to go.

For the MPs in the room, we'd like you to stay. We have some committee business to attend to, and we need to switch over to in camera for that.

Thanks again, everyone.

[*Proceedings continue in camera*]

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