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Good morning Senator Eggleton and Members of the Committee. Thank you for this opportunity to bring you our experiences and our advice on pandemic planning.

The Canadian Healthcare Association is this country's only federation of provincial and territorial hospital and health associations and organizations. We are a leader in developing and advocating for health policy solutions that meet the needs of Canadians.

While the Canadian Healthcare Association has for almost 80 years represented the interests of the acute care sector, for the past fifteen years we have been equally engaged in matters affecting the community sector such as health promotion and prevention, home care, facility-based long term care. In short, we represent the full continuum of health. Thus, we hope our comments today are meaningful, helpful and relevant to your study.

The Canadian Healthcare Association was involved in the H1N1 pandemic in a number of ways, but primarily as a conveyor of information. We participated in regular teleconferences with federal staff, and relayed this information to our members across the country. Concurrently, we spoke regularly with our members, the primarily non-governmental health representatives of the provinces and territories, and recorded their experiences to share with our national and federal counterparts.

We have chosen to focus our comments today on four key areas of concern, and provide twelve recommendations for your consideration.

1. Communications

Despite the best of intentions of all concerned, and indeed, significant successes, our Members consistently identified communications problems as the number one issue in their efforts to address the pandemic.

Initially, there was simply an insufficient flow of information. As information did begin to be disseminated, what might have started as a single, unified message displayed increasing inconsistency as it was rephrased at various levels of government and health. From the average Canadian's perspective, this signaled 'different' messages, lack of agreement among trusted sources, and inevitably, a lack of trust in all messaging. This was not the time for various governments and

their agencies to flex their independence muscles. This was the time for unified leadership in instilling confidence in our citizens through common messages.

Additionally, a segment of key partners which could have been extremely helpful in sharing information was not included. Since most health providers other than physicians and nurses operate outside the publicly-funded health system, a key source of networking is through their professional associations. Despite efforts on their part to be included, dating back to post-SARS, there has been a lack of success in engaging this network in assisting with information-sharing. Beyond their primary care physicians, many Canadians visit their psychologists, dentists, dietitians, physiotherapists and massage therapists, among others, on a regular basis. All of these health providers were left outside of the 'formal' information loop, unless actions were independently undertaken by their associations – adding yet another level of potential interpretation of key messages.

The Canadian Healthcare Association recommends that:

1. The current communications strategy be evaluated, and assessed for its pan-Canadian reach. In particular, efforts should be made to actively and meaningfully strengthen the relationship between the health care system, and public health.
2. An enhanced *CHA Guide to Canadian Healthcare Facilities* be considered as a vehicle to contact the health system, particularly elements which may be outside other formal networks, such as long-term care homes.
3. Implementation of relevant e-health elements be accelerated for the valuable services they can provide in disseminating information and providing optimal care (e.g. physician/primary health care centres EMRs).
4. Pan-Canadian networks such as HEAL (Health Action Lobby, a coalition of 39 health associations and organizations) be utilized as an important communication mechanism.

2. Health Human Resources:

Inevitably, the response to any pandemic rests with the people behind the action plan(s). The strength of our ability to deal with an urgent situation is dependent upon the capacity of our health workforce, and our ability to support them through the period of urgency. Several issues arose within this context.

Many health care professionals and staff work in more than one setting, which increases the risk of infection spread. Nurses, in particular, tend to be employed in more than one care setting, but many health professionals are mobile in this way.

These health workers are not immune, themselves. They may contract disease, placing an already overburdened health system at increased risk. These same

individuals have family responsibilities and may have to absent themselves from the work place if their loved ones become ill. Canada's surge capacity – the ability to respond to sudden drops in the availability of staff - is fragile at the best of times. At times of epidemic, it can lead to overwhelming situations.

And while it was not as evident a problem for H1N1 as it was during SARS, the ability to request and receive health professionals from other jurisdictions remains a question mark, due to labour mobility issues which still exist.

. These realities raise a number of questions:

- Will there be enough professional staff to care for our sick patients, residents and clients?
- Will there be enough support staff to address infection control issues given that cleaning routines will need to be augmented in acute and long term care?

The Canadian Healthcare Association recommends that:

1. Signatories to the AIT need to exert their influence to ensure appropriate labour mobility issues have been addressed prior to a next pandemic situation, and/or that provisions are put in place to allow for a response in an emergency situation.
2. Consideration be given to including the issue of 'emergency preparedness' within the pan-Canadian Framework on Health Human Resources.
3. That all 'national' HHR strategies be linked on human resource needs during a pandemic situation (pan-Can. Framework; Public Health; Aboriginal, etc.)
4. A pan-Canadian HHR Observatory be supported as a means to best address HHR needs during emergency situations.
5. That key related recommendations from the Naylor report, produced following and in response to the SARS situation, be revisited and implemented, including appropriate funding levels.

3. Acute Care Focus

While much of the discussion on pandemic planning has been acute-care focused, we know that infection will most likely spread in the community rather than the hospital setting. For this reason, we particularly applaud this Senate Committee for its attention to this issue.

The vast majority of cases will occur, be treated and recover within a home setting, rather than at a hospital. These recovering individuals will largely rely on the assistance and care of family, friends and volunteers. The opportunity for spread of disease is unlimited. CHA Members, and *their* members – health facilities of all types, shapes and sizes - believe that we need to

address the whole continuum of care and ensure that family physicians, home care and long term care staff, assisted living and independent living environments, and the public at large, receive guidance on how to function in an altered environment.

The Canadian Healthcare Association recommends that:

1. Research be initiated immediately on how to effectively establish durable and meaningful linkages among the multiple parts of the health system, starting with acute care and public health.
2. In non-pandemic times, enhance and implement an educational program for the general public on prevention and immunization.

4. “Non-scientific” Responses

Beyond the more obvious responses to epidemic such as immunization and drug therapies, there are additional measures which can mitigate the growth of infection in the community. These actions need to be fully explained and ‘marketed’ to the public in a manner which allows better uptake, and could include:

- voluntary quarantine,
- cancellation of public events, and
- flexible work place practices which protect employees while providing essential services.

This was a difficult time for all Canadians, and particularly for our health providers as well as the administrators of our various health systems. The Canadian Healthcare Association recognizes the tremendous and valiant efforts everyone put into ensuring the health and safety of our citizens. We welcome this opportunity to ensuring even greater success for ‘the next time’, and look forward to responding to your questions.

Thank you.

Summary of Recommendations:

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1. The current communications strategy be evaluated, and assessed for its pan-Canadian reach. In particular, efforts should be made to actively and meaningfully strengthen the relationship between the health care system, and public health
2. An enhanced CHA *Guide to Canadian Healthcare Facilities* be considered as a vehicle to contact the health system, particularly elements which may be outside other formal networks, such as long-term care homes.
3. Implementation of relevant e-health elements be accelerated for the valuable service they can provide in disseminating information and providing optimal care (e.g. physician/primary health care centres EMRs).
4. Pan-Canadian networks such as HEAL (Health Action Lobby) be utilized as a important communication mechanism.
5. Signatories to the AIT need to exert their influence to ensure appropriate labour mobility issues have been addressed prior to a next pandemic situation, and/or that provisions are put in place to allow for a response in an emergency situation.
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8. A pan-Canadian HHR Observatory be supported as a means to best address HHR needs during emergency situations.
9. That key related recommendations from the Naylor report, produced following and in response to the SARS situation, be revisited and implemented, including appropriate funding levels.
10. Research be initiated immediately on how to effectively establish durable and meaningful linkages among the multiple parts of the health system, starting with acute care and public health.
11. In non-pandemic times, enhance and implement an educational program for the general public on prevention and immunization.
12. Include 'non-scientific responses, including voluntary quarantine, cancellation of public events, and flexible work place practices which protect employees while providing essential services.