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## Tuesday, November 23, 2004

## Chair

**Ms. Bonnie Brown**

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● (1535)

[*English*]

**The Chair (Ms. Bonnie Brown (Oakville, Lib.)):** Good afternoon, ladies and gentlemen. It's my pleasure to welcome everyone to this meeting of the Standing Committee on Health as we proceed with our review of Bill C-12, short-form title, the Quarantine Act.

We have some important witnesses today, so to not waste further time we will begin with the representatives of the B.C. provincial government, the acting executive director of healthy living/chronic disease prevention, Dr. Brian Emerson.

Dr. Emerson.

**Dr. Brian Emerson (Acting Executive Director, Healthy Living / Chronic Disease Prevention, Population Health and Wellness, Ministry of Health Services, B.C. Provincial Government):** Thank you very much for having me at the committee today.

I think my title sort of belies why I'm here. I'm actually here as a medical consultant. I have two jobs with the B.C. ministry. I'm a medical consultant with the B.C. Ministry of Health, as well as that other longer title. Probably the reason I was invited is because I have 15 years of experience as a medical officer of health in the province of British Columbia, so I can answer questions from the ground level on what happens with public health in British Columbia. For the past year and a half I've also been working with the B.C. government, assisting in a review and rewrite of our public health legislation. So this legislation is of particular interest to me in its relationship to our provincial legislation.

I understand the format is about five minutes of speaking to the committee, and then we'll have questions and discussion. I'll go through my notes fairly quickly, because I think the discussion is probably one of the most important parts.

The vast majority of communicable diseases are actually not intercepted at the border. Imported communicable diseases turn up in the local health districts in communities throughout the country. They cause local cases and local outbreaks. Nevertheless, having a measure of protection at borders is important. It's critical to recognize here that the prevention of the importation of communicable diseases really revolves around the prevention of disease in the countries from which the diseases come.

In British Columbia, 65% to 70% of the tuberculosis cases turn up in people who have come from other countries. So it's important to recognize that in the broad scheme of things, prevention of communicable diseases in other countries is going to be the best measure of protection for Canadians.

On the Canadian situation, however, the primary responsibility for the prevention and control of communicable diseases rests with local public health authorities. These local public health authorities need to be adequately resourced to meet the expectations to be able to control these diseases. The provincial, territorial, and federal roles support those local efforts, and legislation is clearly an important tool in this regard.

A key question I would recommend to keep in mind in analyzing this bill is how do the proposals support local public health activities, and how do they clarify the roles and responsibilities of local, provincial, and federal public health providers? Really, one of the key functions of this bill is going to be to ensure efficient flow of information between those various players to make sure the actions taken are efficient and appropriate. There are only a few clauses currently in the act that speak to this relationship, and I'll talk a little bit more later about some specific sections where that flow of information could be enhanced through some specific changes.

One of the clauses I would like to point out—and we could talk about that certainly in the discussion, is clause 11, which talks about the ability of the federal government to engage in agreements with provincial and local public health departments for the administration and enforcement of the act. The wording in that is somewhat unclear in terms of what the real intent is. That's our interpretation of it, and I think we could probably talk about that in the discussion. That's really an important piece because it provides the opportunity for local public health departments to actually integrate the functions of this bill with the activity they undertake.

I think there are a few issues to keep in mind about what else is happening in the broader picture. One of the challenges will be integrating this legislation with other legislation that's happening. We have initiatives underway to develop supporting legislation for public health agencies, so there are questions as to how this legislation is going to relate to that. There are initiatives on health protection legislation renewal that are also related to this act. The international health regulations are also being rewritten.All these legislative initiatives need to be connected and coordinated so we end up with an integrated legislative framework.

● (1540)

I would like to recognize that we have been engaged in quite a bit of discussion already with our colleagues at the Public Health Agency and Health Canada around specific clauses of this bill, through teleconferences with chief medical health officers, and consultation sessions. That's ongoing, and I'm looking forward to the collaboration that will result from this in creating a seamless public health system.

I have specific suggestions on this bill. The purpose could be broadened to talk about the export of communicable diseases. It talks about the import and spread, but there are actually functions to do with providing for Canada's responsibility not to export communicable diseases. Probably a broader title, such as Communicable Disease Prevention and Control Act, would make more sense as well. The short title Quarantine Act really doesn't speak to the broad nature of this act. That's just a bit of a wording change comment there.

There needs to be some clarity around whether this act will be paramount to other acts, like the legislation supporting refugee and immigration, and Transport Canada. Because there are a number of players, when you get a communicable disease situation in a port or airport, it has to be clear who has ultimate responsibility for some of these things.

This is an opportunity to introduce some roles and responsibilities for the chief public health officer, which seem to be missing from this bill.

The opportunity to talk about the control of communicable diseases across jurisdictions within Canada is another important point, if this is truly going to deal with the spread of communicable diseases. Provisions that talk about cross-provincial, interprovincial control of communicable diseases could also be addressed in this bill.

The specific clauses I'd like to highlight are on the notification of provincial or local public health officials when certain things are happening. We're proposing that a number of notifications be put in so that when the quarantine officer is taking certain measures, those measures are actually notified to local public health officials. This includes such things as requiring a medical exam, requiring compliance with treatment, arresting or detaining a traveller, extending a detention, diverting conveyances, issuing orders with respect to conveyances, and obtaining warrants. These are all quite intrusive and major activities, and it's critical that the local public health officials be informed when the quarantine officers are undertaking any of these measures, to ensure that these organizations immediately work together to deal with the situation.

I'll just summarize—I think I've probably had my five minutes—by mentioning that communicable disease prevention and control are primarily local activities, with provincial, territorial, and federal support to the local action. The legislation really is an important tool for public health practitioners, and the legislation needs to be supportive of their working together. As I mentioned, clause 11 is a particularly important one, as well as that notification piece. There need to be adequate resources at the local, provincial, territorial, and federal levels to undertake the expectations of this legislation.

Finally, there really has to be adequate time allowed for the collaborative development of this legislation with the provincial developments, as well as those other federal and international initiatives I mentioned.

We all want to see the best final product. Taking the time to get this right is very important, because as we all know, we'd like to have an enduring piece of legislation.

I appreciate the opportunity, and look forward to the discussion we'll have today.

● (1545)

**The Chair:** Thank you very much, Dr. Emerson. You bring a unique perspective, having been a medical officer of health who faced some of these questions in your daily role. So thank you very much for sharing them with us.

Our next witness is from the Public Health Agency of Canada, Mr. Frank Plummer, director general for the Centre for Infectious Disease Prevention and Control.

Dr. Plummer.

**Dr. Frank Plummer (Director General, Centre for Infectious Disease Prevention and Control, Public Health Agency of Canada):** Thank you for having me here, Madam Chair.

I think I'm here primarily as an expert in infectious diseases, rather than a representative of the Public Health Agency. You've had a number of presentations from the Public Health Agency, and I don't think I need to reiterate the points they've made.

I'd just like to pick up on a couple of things Dr. Emerson mentioned. Although the Quarantine Act, or whatever it's called, will be an important tool of public health, it will not be a guarantee that we'll be able to keep infectious diseases out of our country. We need to be able to work globally to strengthen public health systems, as well as ensure that our public health system has the capacity to rapidly detect and deal with infectious threats after their importation.

The steps that have been taken by the government to create the Public Health Agency of Canada are important steps along that path, and the introduction of the Quarantine Act is another important step. The changes in the act are really to modernize the act and bring it in line with some of the changes in the international health regulations. As Dr. Emerson mentioned, they are as much about trying to control the export of infectious diseases as controlling the importation of infectious diseases. Part of the intent of the bill is to alter those capacities.

As we move forward with efforts to modernize the public health system in Canada and the various pieces of public health legislation, this is a very important step. The most important thing we need to be able to do is work together across jurisdictions from federal, to provincial, to local, as Dr. Emerson said.

I'll cut my remarks off there, and I will be pleased to answer any questions you might have.

**The Chair:** Thank you, Dr. Plummer.

Our next speaker is representing the Canadian Medical Association, and that's appropriate because he's the president, Dr. Albert Schumacher.

**Dr. Albert Schumacher (President, Canadian Medical Association):** Thank you, Madam Chair. Good afternoon. On behalf of the Canadian Medical Association and our more than 58,000 members across the country, I'm pleased to be here today.

In addition to being president, I'm a practising physician in Windsor. I'm joined today by Dr. Isra Levy, who's a practising physician specializing in community medicine and public health. He's also the CMA's chief medical officer and the director of our office for public health.

Our brief and my comments today will focus on how the proposed Quarantine Act will have an impact on patients and the public. I hope they'll help the committee strengthen this important and much needed piece of legislation.

Our first recommendation is that the proposed Quarantine Act must be part of a comprehensive emergency health measures plan. We understand that the current act constitutes phase one of a long-term strategy to enhance Canada's capacity to respond to public health emergencies. In addition to further legislative initiatives, key to such a strategy will be federal initiatives that facilitate real-time, two-way communication with front-line clinicians, so that when actions are taken, clinicians are rapidly notified with the appropriate information. As the CMA recommended to the Naylor advisory committee, a comprehensive emergency health measures act, administered by the chief public health officer of Canada, is critical to ensure rapid national response to health emergencies.

Our second recommendation is that the chief public health officer of Canada has to have the authority to enforce the proposed Quarantine Act. The recently appointed chief public health officer and the Public Health Agency of Canada must be supported with legislation that allows for moving the powers now vested in the minister under the proposed Quarantine Act to the chief public health officer.

Third, the proposed act should be amended to address interprovincial traffic as well as international traffic. We're happy that the provisions of Bill C-12 apply to goods and travellers leaving Canada as well as entering Canada. This was a deficiency that was identified in the previous Quarantine Act. However, the proposed act must also expressly address goods and travellers crossing provincial or territorial boundaries. Otherwise, Canada is a large ship with no watertight compartments.

Fourth, the public health emergency must be adequately defined. Bill C-12 includes a schedule of specific communicable diseases to which the provisions would apply. We're concerned this schedule may limit Canada's capacity to respond to emergencies. The next public health emergency could be a disease that we have not yet heard of. It could be a bioterrorist attack, a chemical or a nuclear event. The proposed act must enable Canada to respond to new and emerging, as well as existing, threats to health.

The proposed act must clarify the roles, responsibilities, and training requirements of emergency response personnel. Some provisions of Bill C-12 on the scope of practice of personnel involved in disease screening require clarification, specifically subclause 15(3). What is “any reasonable measure” to prevent the spread of a communicable disease? On clause 26, which officer—screening, quarantine, or medical—might actually prescribe the course of treatment?

The proposed act also does not include any initiatives to deal with the current barriers for qualified health professionals to be deployed across internal borders, for instance, the portability of licensure andcoverage for malpractice and disability insurance. It's essential that this group be covered, if not in legislation, then through the accompanying regulations or other administrative initiatives.

Privacy and confidentiality must be respected and safeguarded. Bill C-12 grants quarantine officers and the minister sweeping powers to arrest and detain people without warrants. Though on rare occasions such measures may be required to protect the public, it's recognized that the potential for abuse may exist.

Clause 51 also authorizes a quarantine officer to “order any person to provide any information or record...that the officer may reasonably require”. Clauses 55 and 56 also appear to give the minister authority to “collect medical information in order to carry out the purposes of this Act” and to “disclose personal information obtained under this Act” to a host of entities. The proposed act must explicitly constrain and spell out the circumstances under which this power could be exercised.

The role of physicians and other health care workers must be respected. To ensure the highest levels of patient care and public safety, the new act should recognize the importance of health professionals having the power, subject to the appropriate constraints, to make vital decisions in response to health emergencies.

In delegating this power, the proposed act or regulations should also address the precautions required to protect quarantine officers and other health care workers from the transmission of disease or the effects of becoming ill.

● (1550)

The proposed act must also allow for compensation and indemnification programs for physicians and trainees whose ability to practise is curtailed due to quarantine being imposed. I should note that in the SARS outbreak in Toronto, there were over a thousand health care professionals who were subject to quarantine at one time or other.

Let me conclude by saying that beyond the issues I've already outlined, we note the crucial components—such as how physical examinations are to be carried out, paragraph 62(a); the medical practitioners' review process, paragraph 62(d); and the protection of personal information, paragraph 62(g)—are left to regulations. This is necessary, but not sufficient. These regulations must be developed as soon as possible.

Bill C-62 is essential and timely legislation; however, on the larger scale, Canada must ensure a sustained and substantial commitment of resources to the comprehensive public health emergency response program. I say we need not just a program, we need a culture of emergency preparedness in Canada. Without this, the best-written laws will be inadequate.

Thank you, Madam Chair.

**The Chair:** Thank you very much, Dr. Schumacher.

Our next witnesses represent the Canadian Nurses Association: Ms. Janet Davies, director of public policy; and Ms. Jane MacDonald, primary health care consultant.

**Ms. Janet Davies (Director , Public Policy, Canadian Nurses Association):** Thank you, Madam Chair.

I'm pleased to be here to represent the Canadian Nurses Association this afternoon.

CNA is a federation of 11 provincial and territorial associations that represent more than 125,000 nurses across this country. CNA maintains a national regulatory framework for nursing in this country and develops national standards, policies, and best practices, as well as publishing a national professional journal.

With me today is Jane MacDonald, who is a registered nurse and staff member of the association and an expert in public health issues.

We welcome the opportunity to participate in the deliberations of this committee as it reviews the legislation related to controlling import and export of diseases. We wish to share with the committee our comments on five particular issues raised in the proposed legislation. The first is professional qualifications, training, compensation, contractual obligations, and ongoing support to screening and quarantine officers. Second is the use of health assessments and screening technology. Third is collaboration and coordination. Fourth is the role and responsibility of the chief public health officer and the agency. And fifth is compensation for individuals in quarantine sites. I will speak to each of these in turn.

With regard to screening and quarantine officers, the designation is dealt with in subclauses 5(1) and 14(1) of the bill. The bill proposes that screening officers be Canada's first line of defence for preventing the spread of communicable diseases through Canada's international borders. We know you will agree that new and changing faces of diseases like Ebola, tuberculosis, and SARS will require screening officers to be current on emerging diseases and knowledgeable about screening issues. Screening officers must then have the knowledge to observe for and identify illnesses and to take appropriate measures.

CNA wants assurances that whoever is responsible for this critical front-line screening is competent, properly educated for this function, and adequately supported in the field. For CNA, there are four questions the bill needs to provide clarity on: who will be designated screening officers, how the screening officers will be trained, what ongoing supports will be provided to these officers, and what guidelines will be developed to ensure that screening officers take appropriate and consistent actions.

As to the designation of quarantine officers, subclause 5(2) states, “The Minister may designate medical practitioners or other health care practitioners, or classes of such persons, as quarantine officers.” CNA recommends that the term “other health care practitioners” be clearly defined. For instance, does this reference include registered nurses? What specific qualifications would be needed?

CNA would also like clarification on how the government plans to operationalize the functions of quarantine officers. The bill is unclear as to the location and supports for those officers. CNA recommends that this information be provided. From our experience with SARS, it will be critical to build the infrastructure to ensure that there are sufficient quarantine officers and screening officers to deal with an outbreak or several concurrent outbreaks.

The second area I want to speak about is health assessments and screening technology. On the matter of actually performing health assessments, clauses 14 and 19 refer to the use of screening technology and physical examination. Dr. Plummer spoke to the need to build capacity to detect. Certainly, in clause 19, reference is made to health assessments, including physical examination, but no specification is made as to who will carry out that assessment.

CNA recommends that the bill define the category or categories of screening technology envisaged. We also recommend that the bill specify that the person carrying out the health assessments and operating screening technology has the necessary training and qualifications to do so.

Third, I want to speak about collaboration and coordination. Dr. Emerson spoke of integration and efficient flows among governments, and certainly in clauses 6 and 7 there is some discussion of coordination of federal–provincial–territorial public health systems. Given the experience of 2003 with the SARS outbreak, CNA recommends that the bill establish a mechanism to coordinate, on an ongoing basis, both governmental and health professional efforts related to emergency preparedness and public health.

The bill should specify requirements for consultation with provincial and territorial governments, as well as with municipal agencies and with national associations of health professionals.

● (1555)

The fourth area that CNA is interested in is around the role and responsibility of the chief public health officer. CNA believes Canadians need a national communications infrastructure to ensure timely and consistent dissemination of technical and public information about disease outbreaks and public health crises. The infrastructure should also carry responsibility for liaison with other countries, with the World Health Organization, and with international disease experts. The committee has an opportunity to articulate the roles of the chief public health officer and the Public Health Agency of Canada in this regard.

Fifth, the issue of compensation is raised at various points in the bill, both in relation to facilities that may be required for quarantine purposes and to the detention of individuals who are suspected of having a communicable disease.

During the SARS crisis, a number of nurses were quarantined along with their families. They lost income as a result. In addition, nurses and other health professionals were affected by administrative decisions to restrict access to their facilities to only those health professionals not working in other facilities. These decisions had two impacts: they reduced access to health services for Canadians; and they resulted in a loss of income for professionals with multiple employment venues. CNA recommends that the bill include recognition of income loss for both groups, those in quarantine and those whose normal opportunities to work are restricted due to quarantine situations.

In conclusion, Madam Chair, CNA is ready to work with governments to ensure that the health system works for everybody.

We would be pleased to answer questions.

● (1600)

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

We'll now proceed to the question and answer section of the meeting. We'll begin with the critic for the official opposition, Mr. Rob Merrifield, who has 10 minutes.

**Mr. Rob Merrifield (Yellowhead, CPC):** Thank you very much for coming in and lending your input on this bill.

It really stems from the experience of SARS and how we can tighten up a piece of legislation to perhaps give us a little more ability to deal with an infectious disease such as SARS. At the time, we didn't really know what it was.

I'm trying to recollect whether this act, the federal Quarantine Act, was ever invoked during SARS. Was it?

Dr. Plummer.

**Dr. Frank Plummer:** The federal Quarantine Act, as far as I'm aware, was not used during SARS.

**Mr. Rob Merrifield:** That was my recollection.

**Dr. Frank Plummer:** There were voluntary efforts to trace people who became ill, to trace contacts of people who became ill after they were in the country, but there was no use of the federal Quarantine Act.

**Mr. Rob Merrifield:** There was no use of it, or no reason for it?

**Dr. Frank Plummer:** There was no use of it.

**Mr. Rob Merrifield:** No use of it. That's right.

On the changes that are being asked for in here, let's go back to before SARS. If SARS hit again, would we use it? Would we have more power under the proposed changes in this piece of legislation?

**Dr. Frank Plummer:** The changes in powers are fairly modest, I think, from what we had previously. It's really modernizing them and having the ability to screen people on exit. All of the screening measures that we put in place were voluntary.

**Mr. Rob Merrifield:** That's right. Really, some of our problem at the time of SARS was that we were exporting it to other countries and we were saying it was voluntary, that you were supposed to take a voluntary card at the airport and fill it in if you felt like it. Yet the World Health Organization actually recommended a personal interview when you checked your luggage.

When I questioned the minister on it at the time, it was that the power was not here in the act in regard to the exporting of SARS. I questioned that. Is it here now, under this piece of legislation? Is it strong enough for you?

**Dr. Frank Plummer:** There is a portion of the bill, as I think you know, that speaks to the ability to screen people leaving Canada and to screen conveyances leaving Canada under certain circumstances when a situation that requires that arises. The intent of the bill is to bring the powers of the minister into line with international health regulations, which are very much moving towards export screening.

To my way of thinking, there is enough there, but perhaps others have other views.

**Dr. Albert Schumacher:** Mr. Merrifield, I'll try to answer that for you.

In the experience of SARS, the major lesson was that the federal legislation lacked the interprovincial tools necessary, and this bill would not help us in that respect. The people moving from Vancouver to Toronto were not in any way affected by federal legislation in place at the time.

That's something that concerns us. There's one chance to catch people, and that's the second they step off the plane, the boat, or the train. After that, the ability to follow them or take other actions later is gone.

● (1605)

**Mr. Rob Merrifield:** Yes, I understand that, and I think that was a shortcoming of it. I'm not sure that's the intent of the Quarantine Act. It may be that the Public Health Agency is now going to put in place some of those mechanisms to be able to coordinate the communications.

I know a lot of you asked about the coordination of the different local, provincial, and federal jurisdictions. I think that's fair comment. I'm just not convinced that it should be in a Quarantine Act. Not that there's a problem with it being there, but it's more the Public Health Agency. That would be my assessment of it.

**Dr. Albert Schumacher:** Let me tell you something that's in place. Every time you come back to Canada, on the customs form they ask you whether you will be visiting a farm in the next 14 days. I think perhaps there's some temporal provision in the act such that the act would have a measure for people having entered the country during the past two weeks, let's say. It's already there when we're talking about agriculture. There's probably no reason it can't be extended into this area.

**Mr. Rob Merrifield:** Exactly. And I would agree with all of that.

I believe the last time the Quarantine Act was invoked federally was on bamboo coming from South America or something, and we invoked it at a blink of an eye. Yet with SARS, it seemed we didn't feel it had enough power to be able to do us any good, and there was some resistance coming from the airline industry and so on.

That being history, we're looking at a piece of legislation. Are the changes here going to help us as we move further along? I think that's the question before us, and we look for your input in that area.

The other area in this bill that we have questioned—and you have, as well—is compensation for individuals who are, in an extreme case...which is the only time the Quarantine Act, in my estimation, should ever be used. It should be used very sparingly, but it should be used aggressively when it's done. And when it's aggressively used to protect society, there should be some compensation for those who are impacted by it.

Now, should we have it in the act or should we have it in the regulations? We asked the minister these same questions, and there was a sort of very fuzzy answer that we “may” compensate.

Should we put “shall” in, and should we specify?

I know this may put Mr. Plummer in an awkward position, but I'd be interested.

**Dr. Frank Plummer:** My answer, I think, would be as fuzzy as the minister's. I think that's really....

**Mr. Rob Merrifield:** We're the politicians here. You can speak freely.

**Dr. Frank Plummer:** I think others have views on it.

**Ms. Janet Davies:** From the perspective of the nursing community, there is an obligation to compensate. There were significant numbers of nurses and other health professionals whose income was affected because of the SARS situation. On whether it's best articulated with a "may" or a "shall" in the legislation, I bow to your superior knowledge.

On the other hand, as to whether it should be in regulation or not, I think you probably need to introduce the flexibility that's necessary to make sure the compensation is adequate to respond to the actual situation.

**Mr. Rob Merrifield:** Well, many of you have commented on the compensation part of it. I concur and I think this is one of the concerns we identified initially. Hopefully, we'll be able to address that with some of the amendments we may be putting forward.

**Dr. Albert Schumacher:** Mr. Merrifield, if I could answer, I guess you have to look backward to last year and decide if you would have declared SARS a national emergency or a quarantine emergency level 1, where federal funding would have kicked in to compensate those people. Now, the federal government did move to give the provinces some extra funding, so I guess the answer is yes.

How would you signify that in the future? What kind of declaration would be necessary to make those kinds of funds flow? Should that be in the regs or in the legislation? I'm not sure. But clearly, SARS would have triggered it. How is it best set up in legislation to make that trigger happen again in the future?

**Mr. Rob Merrifield:** Yes, fair enough. We'll examine that as we move forward and look at some of the amendments in the language.

I have one further question. I don't know how much time I have left.

**The Chair:** Quite a bit, actually.

**Mr. Rob Merrifield:** Oh, really? We're just scooting along, you know. She's actually lenient every once in awhile.

**The Chair:** No, it's actually that the witnesses are rather succinct, compared to the normal set.

**Mr. Rob Merrifield:** She usually blames me; now she's blaming you. I like that reply.

**The Chair:** No, no. I was complimenting them.

**Mr. Rob Merrifield:** This isn't so much a question with regard to the piece of legislation, but it is with regard to the issue. It's to you, Mr. Plummer.

From your expert vantage point of infectious disease control, are we at greater risk today than we were two years ago, when SARS hit, of an infectious disease impacting Canadians, or is it a lesser risk?

● (1610)

**Dr. Frank Plummer:** I think we've learned a lot from SARS and are much better prepared than we were. We've put in place a number of enhanced surveillance systems across the country, sentinel surveillance systems in hospitals. We have quarantine officers at airports who weren't there before. Information systems that allow alerts to go out are being rolled out. So yes, we are better prepared.

Are we at greater risk? I think in some ways we are, because of new threats. Avian influenza in Asia is an ongoing issue and puts us at greater risk of pandemic influenza than perhaps we've even been before.

I think we are better prepared than we were. We're continuing to work on enhancing that preparedness, but there are other factors that go into changing the risk in addition to our preparedness.

**Mr. Rob Merrifield:** Yes, and I think that's what Canadians are really quite concerned about. Are we at a potentially higher risk from an infectious disease perspective, looking globally at infectious disease? And then we look at how we can prepare the best we possibly can, and obviously, we can't prepare 100%. There are no guarantees at all in this area. But I think it's important for us to understand that to add fuel to where we're going in this whole area of an agency and the Quarantine Act.

**Dr. Frank Plummer:** I think, if I might just add to that, another factor that has sort of altered the risk is the lessons learned globally from SARS and the willingness of countries to be more open about their situation. If China had been more open to the global community initially, we might have been able to avert the whole SARS thing, or at least mitigate it greatly. That's another factor that's changed.

**Mr. Rob Merrifield:** Thank you.

**Ms. Janet Davies:** I wonder, Madam Chair, if I can respond.

**The Chair:** Go ahead, please, Madam Davies.

**Ms. Janet Davies:** The member asked whether we were better prepared or not. Of course, there was the National Advisory Committee on SARS and Public Health that issued its report last November, which Dr. David Naylor led. Until we begin the implementation of the recommendations out of that report, I don't think we can speak with confidence that we're better prepared or able to deal with SARS or a like outbreak in this country. He made a number of significant recommendations, not the least of which had to do with making sure we had adequate numbers of human resources in the health sector to support the activities that need to go on. He also spoke about the need for a communication infrastructure to make sure we had the efficient flows of information, both technical and to the public, and to support coordinated and consistent actions across the country.

So there is a gap that was identified in terms of our ability, as a country, to respond.

**Mr. Rob Merrifield:** Thank you very much. I couldn't agree with you more.

**The Chair:** Thank you, Ms. Davies.

Thank you, Mr. Merrifield.

We'll move on now to Mr. Ménard.

[*Translation*]

**Mr. Réal Ménard (Hochelaga, BQ):** My first questions are for the Canadian Medical Association.

I think two points in your submission need clarification. First, you are looking for a comprehensive emergency health measures plan. What do you mean exactly by that. What additional legislation would make you happy and would you need to implement such a plan? Of course, I am convinced the jurisdictions of all levels of government would be respected.

[*English*]

**Dr. Albert Schumacher:** The difficulty right now with provincial jurisdictions is that there are large gaps even in the jurisdictions of the provinces. In the province of Ontario, for example, provincial medical officers of health do not have jurisdiction on a number of federal pieces of property, including armed forces bases, national parks, and first nations reserves. In fact, the jurisdiction at airports and even on railroad lands is shaky. You in fact have provinces that look like Swiss cheese when it comes to the authority of the provincial medical officers of health.

There are two parts to what the federal chief medical officer of health needs to deal with. One is to take care of the federal jurisdictions that are there—the ports, the airports, the prisons, and so forth. The second is the coordination role. I see it largely as a coordination role among the provincial medical officers and even down to the local medical officers of health.

We've talked about the communication strategy. Part of that communication strategy should not be the chief medical officer of health communicating just with the 13 provincial and territorial counterparts, but also and at the same time getting out to the 80 or 100 medical officers of health in each of the districts. That's how quick it has to be. You can't have information sit on somebody else's desk for an hour or two hours or a day before it goes on to the next level.

● (1615)

[*Translation*]

**Mr. Réal Ménard:** In your submission, I noticed an argument which is definitely sovereignist in tone, if not autonomist. I was amused and pleased. It looks as if you wished each province to be considered a separate entity, and there would be some interprovincial control, as if people going from one province to another were foreign travellers.

When the officials appeared before us, their first point was that this legislation applied to foreign travellers. Why would you like to have this kind of control? I am sure you did not write this in your submission out of sovereignist convictions, and that is fine. But do you not think that this is a bit strange, since we always praise the value of the Canadian common market, and the mobility of capital and people? Is this not somewhat regressive?

[*English*]

**Dr. Albert Schumacher:** The concern is that in our system, we have no other natural borders. Canada is a very large country. In the United States, effectively, with their infrastructure response use—with the National Guard, and so forth—they can close and contain their interstate borders much more readily than we can. It's something that I think would rarely have to be done; nonetheless, in times of an epidemic or outbreak it's something that potentially you will have to do. We don't have large numbers of soldiers who can move to the border and close the highway. This would count upon police forces, public health forces, other emergency forces to help out.

There are probably smaller units even within the large provinces that would need to do this. I don't think a provincial border is necessarily the be-all and end-all. With provinces of the size we have, you may need to draw other lines of convenience in order to contain problems in the future. This is something we need to think about as we give the authority up the chain for isolating, closing, shutting down transportation systems.

[*Translation*]

**Mr. Réal Ménard:** I have two questions for the Canadian Nurses Association.

I asked the first one to the officials when they appeared at this committee's first meeting. From your own point of view, what type of training should the screening officers have? I know Health Canada will be responsible for training plans. I was also wondering whether they should be physicians or nurses, for example. I know the term “health professionals” is really vague. We agree with you. But, from your own point of view, what kind of training should they be given? Do you think nurses could be quarantine officers or screening officers?

[*English*]

**Ms. Jane MacDonald (Primary Health Care Consultant, Canadian Nurses Association):** Thank you for the question.

You have two levels of people, the screening officers and the quarantine officers. I guess we would see this committee or the government trying to figure out what's most important for each of those levels. You have the screening officers, who are really the front line. They're the ones who are going to get people coming into the country. For those people—if it's going to be somebody like a customs official, which seems to be in the bill right now—we would want to make sure they have adequate training. It's not sufficient just to have the questions. They need to have an understanding of what kinds of illnesses and symptoms they're looking for, so they can know when to refer up the line.

Then there's your question about the quarantine officers. Would the quarantine officers be somebody like a nurse, like a medical practitioner? Who will it be? That's why we're saying the committee needs to very carefully define and think about that level: because it'll be the quarantine officers, from the reading of the bill, who decide what needs to be done. As far as we're concerned regarding training, in the case of a quarantine officer or someone like a nurse, for example, you would want those people to have a basic preparation, want them to be prepared and sufficiently knowledgeable to know what they're doing.

So you would need the basic preparation. You would need ongoing training and supervision at all levels across Canada, you'd need to figure out how many people across Canada you want to have and where you want to have them, and you'd need to have other skill sets. For example, if you have a large airport where a whole group of people are coming in at once, those people who are going to be responsible—the quarantine officers in that area—may need a certain set of skills that those in smaller border crossings don't need.

Where are you going to get those people? Are they going to be on call? Are they going to be people who are already employed in health units, hospitals, old age homes? They could very easily be nurses; they could be of different professions. But the committee needs to be very clear, and the bill needs to be very clear, about what's expected of those people. They're the people who are going to be screening people coming in. They're going to be screening you and me and our visitors coming in from different places, and we want to ensure those people have the skill set to do it.

● (1620)

**Dr. Frank Plummer:** If I might clarify, what is intended as screening officers would be customs officials who are screening for other things. The quarantine officer would be a qualified health practitioner, a nurse or physician.

**The Chair:** Thank you, Mr. Ménard.

We'll move on now to Mr. Savage.

**Mr. Michael Savage (Dartmouth—Cole Harbour, Lib.):** Thank you, Madam Chair, and welcome to our panellists.

My first question is for Dr. Emerson. Dr. Emerson, I'm intrigued by your long title. On another occasion I'd love to talk to you about what B.C. is doing on healthy living and chronic disease prevention, but that's not for today. Perhaps we'll exchange business cards later.

You mentioned you have had conversations with a number of other levels of government about this piece of proposed legislation. You mentioned specifically taking the time to get it right. I wonder if you can tell me the kinds of discussions you've had and whether you think there's been enough of them in the process.

**Dr. Brian Emerson:** The first discussion was a forum held in Edmonton to introduce the proposed Quarantine Act as well as to discuss emergency public health legislation. That was a two-day forum hosted by Health Canada, with good representation from the provinces and local public health officials. That was in September. Subsequent to that, there has been a teleconference with chief medical health officers of all the provinces to talk about the outcomes of some of the ideas that came out of that conference. There is another teleconference scheduled. In addition, there has been exchange of ideas and information between medical health officers, chief medical health officers, and representatives of the Public Health Agency, as well as with Health Canada. There's an ongoing discussion as well as those two specific sessions.

The question was, has it been adequate? From my perspective, we're really at the start of a collaborative process of developing this. As more and more analysis is done, ideas are generated. As these committee meetings happen, proposals may come up. This is a bit of an ongoing process in terms of getting it right. As I mentioned specifically, there are some sections that still need some work.

**Mr. Michael Savage:** You had talked about the fact that this also includes Canada's role not to export communicable, contagious disease. Do you think this bill does a good job in that way?

**Dr. Brian Emerson:** I think the clauses that talk about screening and allowing to prevent exportation do appear to be reasonable measures. As I mentioned, stopping diseases coming in through the quarantine officer screening scenario is going to catch very few diseases. The diseases will arrive; people will come in well and develop diseases afterwards. The same thing will happen; people will leave the country and get sick afterwards. So it's a very limited measure in order to stop either import or export. But from the measures that are proposed in the bill, I think it's a reasonable approach. The characteristic of communicable diseases is that you can't always pick them up on a quick pass-by of a traveller. The volume of travellers coming and going is huge. It would be completely impractical to really set up an iron-clad way of catching people coming and going.

● (1625)

**Mr. Michael Savage:** Obviously, our number one priority is in people that might be coming into the country with something, but we do have a reciprocal responsibility to ensure that it doesn't go the other way.

I have a question for Dr. Plummer. The lab in Winnipeg is the only level-four laboratory in the country. I wonder if you could talk a little bit about how information is traditionally collected and shared with other levels of government in other labs and in the infectious disease community and what impact that would have on this piece of legislation.

**Dr. Frank Plummer:** Essentially, you're right. There are two level-four labs in Canada, but they're both in the Canadian Science Centre for Human and Animal Health. There's the Food Inspection Agency lab, which handles animal diseases, and the Public Health Agency lab.

We work extensively through national and international networks. The national microbiology lab is one of two Canadian laboratories that are members of the laboratory response network of the Centers for Disease Control in the United States, so we exchange information, particularly about response to bioterrorism, through that network. The lab in Winnipeg is also the chair of the laboratory network of the Global Health Security Initiative. This is an initiative that was set up by the ministers of health of the G-7 countries plus Mexico, and part of that is a laboratory network that, as I mentioned, we're chairing. That group seeks to exchange information about best practices, to communicate emergencies, to do exercises together. For instance, that network organized a smallpox diagnosis workshop, hosted by the CDC, in which lab people from around the world were able to work with actual smallpox material to validate their diagnostic tests, which are impossible to do in another way.

In addition to that, we have developed a network called the international high security laboratory network. The reason for this is because within the G-7 plus Mexico, these are the health labs, but there are agriculture labs, national defence labs, and so on in other countries that have level-four capacity and are important players in the scene. In addition, there are level-four labs that are outside of the G-7 plus Mexico—Australia, South Africa, Russia, for instance. That network is working along the same lines—standardizing lab testing, exchanging information, working on making sure regulations don't hamper our ability to do our job.

Finally, within Canada we have the Canadian Public Health Laboratory Network, which is chaired currently by the director of the provincial public health laboratory in Saskatchewan. It is a table of equals—the secretariat is at the national microbiology lab—at which we sit down to work through common problems and share information and try to enhance each other's capacity.

Those are the main ways in which we interact with other levels of government and other governments.

**The Chair:** Thank you very much, Mr. Savage. I'm sure there's a natural follow-up question to this, but perhaps you'll get another chance. Right now it's Mr. Lunney's turn.

**Mr. James Lunney (Nanaimo—Alberni, CPC):** Thank you, Madam Chair.

I'd first like to acknowledge, Dr. Plummer, that we had a chance to have an exchange over another issue of public health not too long ago concerning *C. difficile*, and I appreciated your briefing at that time on an important health matter.

I just want to also compliment the CMA for bringing forth its concerns today in a very concise manner and for raising some very specific concerns here.

One of the concerns you raised is about the schedule itself, which lists some 25 diseases, I believe. You said "that this schedule may limit Canada's capacity to respond toemergencies. The next public health emergency could be a disease we have not yet heard of, abio-terrorist attack, or a chemical or nuclear event".

You are wondering about the ability to respond to new and emerging as well as existing threats. We know that the act does give the minister power to name new diseases. It does leave us with a little bit of concern when you take a name like SARS, sudden acute respiratory syndrome, that doesn't really define a specific agent. In essence it's a syndrome, isn't it, that could apply to any number of organisms? In this case, we've taken that now to apply to one specific organism.

Would you care to comment on your concerns that way, or do you feel they are adequately addressed by the minister's power?

● (1630)

**Dr. Albert Schumacher:** I think it's addressed and you've caught onto the concern.

We don't know what's going to happen next. In fact, things like nuclear, chemical, and biological events aren't particularly addressed or mentioned. I have to tell you that this is in total contradistinction to when I was 16 and a member of the Canadian Armed Forces in the armoury corps for the summer. An entire week of my summer was spent on nuclear, biological, and chemical warfare training. In fact, I got more training in that one week when I was 16 than I did in the entire rest of my medical career.

Part of it is what you see in the bill, but part of it is changing the culture out there. Your second line, your second tier, is not built up. You have less than 100 physicians with Dr. Levy's qualifications in public health. You have a small number of infectious disease specialists, and we saw a good chunk of those in Toronto get SARS themselves when it came out. It is the tip of the iceberg that you've touched on—those diseases that are listed, the other things that can go wrong, and the kind of culture and training we have out there. Other countries are ahead of us. In the United States, for example, a significant number of physicians and nurses and other health care workers got their experience and payment through the armed forces and they come from a culture of mass casualty, mass trauma, emergency preparedness, national disaster—get the National Guard out. We don't have the same thing here.

That's a long answer to your question, but in addition to the words on the paper that need to broaden that scope and definition, we need to broaden how we're going to deal with this on the ground—the whole emergency measures as well as the quarantine. We need more people at the second level, the volunteer responders, the ones who are going to fill in when the medical officer of health is busy. That needs to be incorporated and addressed here as well.

**Dr. Isra Levy (Chief Medical Officer and Director, Office for Public Health, Canadian Medical Association):** If I may just add to that, one place to look for how things have been done is indeed in the international health regulations, where the WHO has identified exactly the same dilemma and has looked at ways to move beyond schedules of diseases by broadening, if you like, the syndromic surveillance concept and allowing, in an equivalent type of context, the screening officer in our Canadian context to trigger things at a syndromic level rather than at a disease-specific level. It seems to be something worth exploring, at least conceptually.

**Mr. James Lunney:** I appreciate your raising that concern. It may not have been what was on our minds when we started this meeting. I know the United States has put a lot of money into training people, or at least it is beginning and is making some very significant steps in raising awareness and expertise to respond to a bioterrorist attack of some kind.

I was witness to a discussion about this in Israel at the Hadassah Hospital, where they're making some very significant preparations in case that kind of event should happen. In Canada we don't like to think we might be a target for such an attack, but that's a public health emergency on a whole other range and perhaps worth considering in the Quarantine Act. Maybe we should be thinking that way a little more seriously. One of the issues they raised, for example, was that the number one thing you want to do is make sure your first line responders are not carrying the infection to your primary treatment facilities, by arranging a facility for disinfecting outside the primary treatment facility for primary contact personnel, so they don't carry infection right into the primary treatment facilities and so on.

Is that the kind of measure you are talking about, Dr. Schumacher?

**Dr. Albert Schumacher:** That's exactly the kind of measure and training I mean, and I'll tell you the sad note there. In early October, the Red Cross ran a weekend course for emergency responders—your volunteer fire chiefs, your other critical emergency personnel, or whoever wanted to sign up if they were interested. That course cost $900. If I or any other health providers attend that, it's not something we're going to make money on.

This is a place where I think the federal and provincial governments have a role. It's to bring this kind of thing out there to the people, because sometimes the leader in the crisis is not necessarily going to be the person you think it will be, because they're going to be sick, quarantined, or dead.

● (1635)

**Mr. James Lunney:** Thank you.

**The Chair:** Ms. MacDonald.

**Ms. Jane MacDonald:** I just wanted to intervene on the same point and say that the Naylor report made similar recommendations around the preparation of health workers, nurses, and physicians coming out right now who may need different kinds of training to be able to deal with emergency preparedness, with surveillance, and with new public health issues. It goes back to the issue around implementing the Naylor recommendations and looking at that committee report. In nursing particularly, the federal government could play a huge role as far as supporting that kind of training and education and ongoing education for nurses is concerned.

**The Chair:** Thank you, Mr. Lunney.

Mr. Thibault.

**Hon. Robert Thibault (West Nova, Lib.):** Thank you, Madam Chair.

I thank you all for appearing and for bringing this invaluable information to the committee. As I listen to you, both in your presentations and in response to the questions, it brings to mind that this isn't the last piece of work we have to do on this matter. It's an interim measure. It's an improvement on what we had, but I don't think it's the total answer.

One is the question of the designation of the public health officer or the minister. In statutory regulations, it's impossible now to designate the public health officer because there isn't the legislative framework to do that. That would have to be done as we introduce a bill creating the public health officer or legitimizing his powers, so that there might be an interplay with this one.

The second question is that question the Canadian Nurses Association brings about, as to designation of the professions and the training. It's difficult to do in law. The training changes or requirements change, but when I look at the regulation or the power to regulate, that's not listed there. I'll ask you to comment in a moment on whether it should be listed there, whether that would be an area. When it says “medical practitioner”, it seems to me that it's talking about a doctor and it may include other professions, but it's difficult in screening officers and what their training would be. When I read it, it seems to me that it is the customs officers with additional training, generally speaking. That might suffice, but it might not always suffice.

The last point I wanted to touch on and that some of you had mentioned is something we're going to have to grapple with, and that's the “shall” and “may” on the compensation. In looking at it, there are a lot of different levels. If we look at the SARS crisis that we had and we look at loss of income to medical doctors, loss of income to nurses, at practitioners who were practising, then to me there's no doubt that they should be compensated. If you look at secondary loss of income, tertiary loss of income, loss of opportunity because there were no people in my restaurant, is that at the same level? Is that, at that point, a “shall” or a “may”?

If I look at conveyances, generally speaking the conveyances are the responsibility of the conveyor. But at some point, mistakes can be made because we may, as a government or as public health officers, be overcautious and destroy things that would not necessarily have to be destroyed. So is it a “may“ or a “shall” in that instance? I think that's going to be very difficult. If we want to be responsible financially and protect what we want, perhaps it has to be a “may”, but perhaps there should be more direction in the regulations.

I'd encourage you to respond on any and all of those, if you wish.

**The Chair:** Dr. Emerson.

**Dr. Brian Emerson:** On the chief public health officer question, you're right, there's a piece missing in the puzzle, and related to that is the question about actually compelling reporting of events to the chief public health officer. It was one area that we suggested could potentially be in legislation, just as we have medical practitioners report to medical officers, and medical officers report to provincial health officers. There's no avenue for requiring reporting of an issue to the chief public health officer. So that's an area that could be covered off.

On the power to regulate training, you're right, it's difficult to enshrine training and regulation, because qualifications and expectations change. So you need to be flexible.

In British Columbia, we have empowered the provincial health officer to establish standards for medical officers of health. The standards themselves are outside of regulation, but the provincial public health officer can establish the standards for the training of medical health officers and their performance. You can empower the establishment of standards without actually listing the training requirements in regulations. So that's one way to deal with that issue.

On the compensation, I think you hit the nail on the head. Clearly we want people to cooperate with requirements to be quarantined or isolated, and if it means a personal loss, then part of the compliance with that request is that they will be compensated in some way, that the loss they suffer will be covered. But you're right that who all has been affected by a public health measure can be quite a far-reaching thing and you don't want to necessarily tie yourself into a situation where you're compensating the whole chain if you have a very strict requirement. So that's a challenging one.

But I think the key area is that, as part of the control measure, those who have been affected certainly need to be looked at. I think you identified them as the primary individuals.

● (1640)

**The Chair:** Thank you, Mr. Thibault.

Mr. Carrie is next.

**Mr. Colin Carrie (Oshawa, CPC):** Thank you, Madam Chair.

Thank you very much for coming today.

We touched on the issue of importing and exporting these diseases. We talked a little bit about in and out of provinces, and you mentioned interprovincial regulations so that health care professionals can move from one province to another. Does the CMA have anything in place right now?

I know in chiropractic I'm registered to practise in Ontario, and only in Ontario. Does the medical profession or nursing profession have anything where you can go from province to province?

**Dr. Albert Schumacher:** There's currently no magic federal licence to practise medicine. Even in the armed forces, each of the medical officers there is licensed by a province or territory, and that's how they practise on bases across Canada. It does make a problem, so the regulatory college in whatever jurisdiction you went to would have to grant you a special temporary licence.

Obviously we need to do some of that ahead of time. We should be able to do it ahead of time for these teams or these special people, quickly and at really no extra cost.

The other issue is not just with licence, but with malpractice insurance. In Canada, for physicians anyway, there are three regions of malpractice, Ontario being the most expensive and Quebec being the least expensive. You can't practise or have coverage outside of the province unless you're adequately insured for that. So if you're from B.C., you cannot automatically come to Ontario unless you upgrade your insurance to the Ontario level. It doesn't take long, but it's another hurdle, and when you're trying to get on an airplane in Vancouver to come to Toronto to help out, it's more red tape at the time.

**Mr. Colin Carrie:** You're coming up with some really good, common-sense solutions for us on things that are missing in the bill.

Have you heard of anything internationally, as well? In Canada, we don't seem to have these professionals trained. You mentioned the United States, and my colleague mentioned Israel. Are you aware of anything on international cooperation between specialists such that they could come and help us out?

**Dr. Frank Plummer:** I'm not aware of any. I know there are such agreements, mutual aid agreements, in the firefighting arena, for instance, and elsewhere, but not, as far as I'm aware, in the medical field.

**Mr. Colin Carrie:** We seem to be missing the boat, and that's what I'm concerned about here with this. You're bringing up some really important things that we haven't addressed before.

**Dr. Isra Levy:** Yes. In the international context, actually, it was the Canadian experience with trying to bring physicians and nurses into Toronto where we ran into exactly the problems Dr. Schumacher has outlined, both in bringing in American infectious diseases specialists and in cross-border movement, and you've correctly identified the barriers there, at least some of them. Others are things as mundane as hospital privileges, which become overwhelming challenges in an emergency situation because there's a time delay in getting them through.

But in the international context those agreements don't exist. The World Medical Association actually took a close look at the CMA's experience with two things in mind. One is trying to work with the WHO to address exactly that point for easy, rapid transfer of health professional mobility. The second is a global type of rapid two-way communication. As Dr. Emerson and our colleagues from the nursing association have both pointed out, right across the spectrum, the rapid communication of whatever decision is taken, for example, in this context by a quarantine officer, to a whole array of people who need to know would need to go beyond the national boundary, or the pan-Canadian boundary, into the international context.

● (1645)

**Mr. Colin Carrie:** On that, I want to throw another question out too. Is there anything you would see as a common-sense measure, like screening? We have the questionnaires, of course. But there was talk of these things at airports that could catch temperature variations in people coming in and out of the country, or even interprovincial, because these diseases know no boundaries. Have you thought of any recommendations of any good screening techniques you would do en masse?

**Dr. Isra Levy:** I know Dr. Plummer was intricately involved in those thinkings and conversations. But certainly I think the short answer is that there is no easy answer to that.

The screening technologies that were touted for SARS in fact turned out, in retrospective analyses, not to have been that useful. At least, they turned out not to have been that useful from the point of view of picking up disease. They were very useful from the point of view of reassurance to a worried population, which adds the dimension of risk communication. An important component of public health is also appropriate confidence building and maintenance in the public.

These technologies can be used for different reasons. But in short, in terms of preventing the spread of infectious disease into the country, there's no easy answer to that one. It would depend on the specific medical issue at hand.

**Dr. Frank Plummer:** I would support that. There is no evidence that thermal scanning for fevers did anything to detect SARS cases. This question of public confidence always came up. In my mind I was wondering how can doing something completely ineffective inspire public confidence? But maybe it does.

**Ms. Janet Davies:** I would also like to add something. I agree with both Dr. Levy and Dr. Plummer. But I'm wondering too about the image that's been created in my mind this afternoon, having heard that screening officers could be customs officers. It seems to me that these are now gun-carrying people. I'm wondering about the risk communications and interviewing skills of people with guns who are asking people about their health status.

**The Chair:** Excuse me, I have to intercede here, because our customs officers don't carry guns. American customers officers do, but Canadians do not, although we don't know what's going to happen with the new Public Safety Act.

**Mr. Colin Carrie:** But the manpower issue is so important.

**The Chair:** Mr. Carrie, your time is up.

We'll move on to Ms. Dhalla. Thank you.

**Ms. Ruby Dhalla (Brampton—Springdale, Lib.):** I want to take the opportunity to thank everyone who has come here today.

My question is for you, Dr. Plummer, in terms of your experience and so forth with the lab in Winnipeg. You mentioned that you're working with a variety of the G-7 countries in infectious disease. How does this bill put us at an international level compared to what countries have abroad?

**Dr. Frank Plummer:** I'm not an expert in quarantine law, but as I understand it, this is very comparable to what many other countries have and would bring us in line with what's being contemplated for the international health regulations.

To come back to a point somebody made earlier, I think it is important to have the capacity to screen for syndromes. Although we talked about SARS in the schedule, SARS started off as a syndrome but became a very specific diagnosis. Now it's thought of as a very specific infection, very much like influenza is.

But I think this will modernize the act that we have and bring it close to what everybody else has.

**Ms. Ruby Dhalla:** Dr. Levy, you had also mentioned some of the work that's being done at the WHO. How involved has the CMA been in that in relation to the Quarantine Act?

**Dr. Isra Levy:** Thanks very much.

We were consulted by Health Canada's international health group, which is still within Health Canada, I believe, not within the agency, before Health Canada went across to Geneva to negotiate. In fact, we did prepare a response to Health Canada in terms of how the physicians of Canada, at least, would see the lessons from SARS and our experience before SARS as needing to be built into international health regulations.

In many respects, our comments on this bill mirror the comments that we suggested Health Canada take into the international context.

● (1650)

**Ms. Ruby Dhalla:** Thank you.

**The Chair:** Thank you, Ms. Dhalla.

Madame Demers.

[*Translation*]

**Ms. Nicole Demers (Laval, BQ):** Thank you, Madam Chair.

Ms. Davies, you told us that, unfortunately, we would probably not be ready to face a new SARS outbreak. Do you think the implementation of Bill C-12 would help change your mind? Do you think this bill affords adequate protection to nursing staff and other workers in healthcare who are in contact with communicable diseases?

**Ms. Janet Davies:** Answers that have been given up to now indicate that we might be better prepared, but not completely, to face another SARS outbreak.

I think we are still facing the challenge mentioned in last year's report of the advisory committee on SARS. Its recommendations have not been implemented yet. We should also address the lack of health specialists who have the knowledge required to prepare us as a country and protect us from this kind of problem.

**Ms. Nicole Demers:** Ms. Davies, do you think the number of quarantine officers we have now is enough to cover the whole Canadian territory?

**Ms. Janet Davies:** I could not tell. I do not have any qualification in that regard.

**Ms. Nicole Demers:** Could you answer this question, Dr. Plummer?

[*English*]

**Dr. Frank Plummer:** We have enough quarantine officers to cover the major ports of entry for international flights. That's where quarantine officers are stationed. But not all international airports in Canada have quarantine officers.

[*Translation*]

**Ms. Nicole Demers:** Would you have more to say about this, Dr. Emerson?

[*English*]

**Dr. Brian Emerson:** On that question of capacity, I think that's why I alluded to the importance of clause 11, which allows agreements to be made between the federal government, local public health, and provincial public health.

By allowing such agreements to be established, one can be better prepared for the potential surge capacity that is needed. We don't want to have too many resources and we don't want to have too few, but by having agreements established with local public health and provincial public health, we would be better prepared to cope with episodes of increased need.

[*Translation*]

**Ms. Nicole Demers:** Thank you. Dr. Levy?

[*English*]

**Dr. Isra Levy:** Thank you very much. Thank you for the indulgence.

Apologies, but my French is not as sound as yours, so I'll make comments in English.

To address some of your questions and Monsieur Ménard's earlier question about whether Bill C-12 will really help with SARS, it strikes me that it's important to remember that a lot of the pressure for modernization of the Quarantine Act predated the SARS experience. The modernization is indeed a very strong step forward. I think this is a good bill in general.

In fact, the degree to which this bill would make our situation different is an interesting question. If we look at the way SARS entered Canada, it was not deficiencies in the old Quarantine Act that prevented us from allowing SARS into Canada. But certainly the experience of the chief medical officers from across the country—and I was fortunate enough to be able to participate in their daily teleconferences during that experience—really highlighted the fact that the one tool that was not available to anybody was a tool to prevent interprovincial travel. I think it has been widely recognized and acknowledged today that this is an important thing and that we'll deal with it. If I may make the point, I think it needs to be dealt with urgently. Perhaps it could be dealt with through interprovincial agreements, and it could be dealt with through enabling legislation for the chief public health officer. But it must be dealt with, because that is the one thing that could have made a difference.

With respect to provincial authority and the plan that the Canadian Medical Association put forward to Dr. Naylor, and which Dr. Schumacher explained today, I'd refer you, Mr. Ménard, to the material in your background package that we submitted to Dr. Naylor and to the five-step emergency preparedness legislation that's proposed. It very much builds upon provincial autonomy and provincial responsibility in the context of Canada's system. But it says that it's not always enough; it's very explicit in its suggestion on the kinds of tests we would bring to bear as to when provincial autonomy could reasonably be breached, if you want to go as far as using that word.

I'll end it right now, but the specific example in the SARS experience was when there was a scare in Montreal during SARS, which turned out not to be related to SARS. But the dilemma that faced the Quebec chief public health or chief medical officer was precisely the fact that he had no way of preventing importation from Ontario with the legislative tools in his hands at the time.

So I think those are a couple of points I've tried to bring out in response to both your question and Monsieur Ménard's earlier question.

Thank you.

● (1655)

**The Chair:** Thank you.

Thank you, Madame Demers.

Mr. Thibault.

**Hon. Robert Thibault:** Thank you.

When we were discussing the international health regulations, it reminded me of the time when free trade was being discussed and somebody said it's amazing the free trade now when there were barriers...available in the 52 states and four Canadian provinces. I guess we have a little bit of the same dilemma here, where the interprovincial negotiations or regulations are probably going to be more difficult than doing the international ones.

But I think it's an important step that we have to face, and I think it is the natural phase two of this bill. I think the advent of a public health officer for Canada provides an important tool to negotiate and work with the public health officers from every other province, as well as the district and regional ones, as mentioned by Dr. Schumacher earlier.

What I'd like you to explain to us is that in a case like SARS, or in any other biological or chemical problem of this nature, the communications from your lab or from another country to us, to the provinces, to the districts, to the health practitioners, to the remote stations where it might appear.... I can catch a communicable disease in Montreal, but it's not going to show up on me for three days when I'm in Lower Concession, which is quite a remote area.

So how would we improve that? What is the natural, logical conclusion to do what you're suggesting, Dr. Levy, to prevent interprovincial travel? What would be the natural conclusions to this?

**Dr. Albert Schumacher:** Perhaps I can start.

Since SARS, one of the recommendations we've made is that every front-line health care provider's office needs to be wired into the federal government, the chief public health officer's office. That means the federal government needs to invest in broadband DSL satellite communications so that every nursing station, emergency room, nurse practitioner, and physician's office has that communication ability. Then you have the e-mail address and can send it back and forth in real time.

That doesn't exist right now. When the scare of anthrax happened, after 9/11, Health Canada was literally paralyzed for two days. The only communication to the public and providers was on the CMA website. That's not an acceptable way to run the health of a country.

We need the basic infrastructure in place so we know it's there, and nobody has the excuse that the office isn't wired and there's no computer. This is part of the government's obligation to the patients, and your obligation to the patients as the provider. We're going to make it as easy as possible for us to communicate.

● (1700)

**Hon. Robert Thibault:** Would I be right in saying that every physician's office would have a computer now? There is computerized billing, and 99.999% of them would be connected to the Internet.

**Dr. Albert Schumacher:** No, that's not true. I would say that probably half, or less than half, of physicians' office computers, which are usually used for scheduling and billing, are hooked to the Internet. We only have about half of the e-mail addresses in a best-case scenario. You need to have that in place, and it's not there.

The worst part is that the isolated ones, the ones that are off the grid and aren't in New Brunswick, where everything's cabled, need satellite to bring it in. That's a greater investment than many of the practitioners in a small town are prepared to make. They need assistance.

**Hon. Robert Thibault:** Dr. Plummer, on that point or a previous one, I think you wanted to talk about compensation and that element when my time ran out.

**Dr. Frank Plummer:** I was going to come back to that.

You're right that compensation is a very complex issue. It covers everything from people losing income because they're in quarantine, to a person losing a business opportunity because the plane doesn't fly. Where do you draw the line?

I think many of the issues of compensation that were talked about concerning SARS were really areas of provincial jurisdiction. The federal government chose to help out with compensation, but I don't think it's directly affected by this bill. I would only point that out.

**Hon. Robert Thibault:** Do I have one minute left?

**The Chair:** No, you're actually finished.

**Hon. Robert Thibault:** Okay. Thank you.

**The Chair:** Mr. Lunney.

**Mr. James Lunney:** She rules with an iron rod, Monsieur Thibault.

Thank you, Madam Chair.

In the CMA presentation, you made some remarks about privacy and confidentially being respected and safeguarded. I agree with you, and I think we all agree, that the quarantine measures are measures that we hope would be used very rarely, even though we know they're necessary. You acknowledge that it's recognized that the potential for abuse may exist, but I think the public has a legitimate interest in making sure that we put in as many safeguards as possible.

In that light, I want to go back to subclause 15(3), which you raised, about the proposed act clarifying roles and responsibilities. You asked a question on subclause 15(3). What is “any reasonable measure” to prevent the spread of communicable disease? I only want to pursue that for a minute.

If we look back to subclause 15(3), it's any measure: “Every traveller shall comply with any reasonable measure ordered by a screening officer or quarantine officer for the purpose of preventing the introduction and spread of a communicable disease”. How do we define that?

There are some very specific consequences to that subclause that appear repeatedly. Arrest without warrant and the health assessment requirement hinge on subclause 15(3), as does further detention by the quarantine officer, and so on. There are some serious consequences that come out of that subclause. Remember that people could be detained simply for having been in the vicinity. They may not show any sign of the disease, but they were in the vicinity.

I would be concerned whether, for example, it might be recommended that you should have a vaccination for something such as anthrax, which was mentioned earlier. We had an interesting incident with armed forces personnel and one healthy soldier who refused the vaccine. Is that the type of measure that is foreseen? Would people be compelled to receive a vaccination that may not in fact be adequately tested or proven to the satisfaction of a whole segment of the population? Is that the type of concern you might be raising?

**Dr. Albert Schumacher:** I think those are exactly the kinds of things that need to be thought about ahead of time. How long can you detain someone? What's a reasonable quarantine period? What's the review process going to be to get you out of quarantine? I speak from a position of self-interest, because it's health care workers who are going to be half or more of the people you're going to lock up or contain. So what's the process of getting out, and who is going to make those decisions?

I think we need to give some thought to that, rather than making up the rules on the fly as we go, because people doubt about what we should do when we do that. The problem in Canada is that we always try to do the nice guy thing instead of being hard and tough like Madam Chair is today with time. You can't make the wrong decision when you have one chance.

In the earlier part of your question, you addressed the privacy concerns. I would suggest that currently my medical officer of health locally can phone me up and ask me questions about my patient, and that goes to him. Nobody else can do that, and it's only within the context of that disease. We would see the same thing happen, so that if I get a phone call at my office about somebody who has been back for a week but had seen me when they were ill, I don't think it's going to be the customs officer or the second-tier screening officer; I would think it would be the medical officer. It would have to go up to that second or third level before I could divulge that information. I think that's fairly easy to set up, but it has to be the same kind of relationship that I would have with my local medical officer of health now.

● (1705)

**Mr. James Lunney:** So at the present time, you don't see the provisions here are adequate in the bill. Perhaps that's something you're suggesting should be addressed in regulation, or do you feel it should be in the bill itself, specifying a chain of command or who is responsible for confidentiality?

**Dr. Albert Schumacher:** I'd like to know who I'm answering to, because right now, to disclose that kind of information, by default I'm only going to disclose it to another physician. It's just as if it were an insurance exam and the insurance company was hounding me about something. If I really have to tell someone, I want to tell the medical director of the insurance company. I don't want to tell the clerk, I don't want to tell the next person. We then have that professional relationship to protect the patient. I think the same thing is going to have to happen with the Quarantine Act with some of that disclosure, especially when it's over the phone: “I want to see your records”, and so forth.

**The Chair:** Thank you, Mr. Lunney.

Mr. Thibault.

**Hon. Robert Thibault:** There are two points I'd like to make.

First, to the members of the Canadian Nursing Association, Madame Davies and Madame MacDonald, you're concerned with training. I understand that very well. In my riding, in some of the remote areas, we've had very good luck with nurse practitioners, with extra training for ambulance drivers. They can do a lot of these screenings in communities where we can't possibly hope to have a physician resident. Do you see some of these skill sets or professions being used in some of these posts or positions?

**Ms. Jane MacDonald:** Yes, and in addition to the registered nurses as well, that's exactly what we do see. We also see the additional training and the supportive training all along the way with that, which could be a very good adjunct.

Could I go back to your point about communications, the one you raised before? There are a couple of issues, and they actually go to Dr. Emerson's point, too, about capacity at the local level. If you look at public health nurses who are working in a health unit or in a hospital, for example, their access to computer technology may not be very good. Also, in the north, with the first nations and Inuit health branch, you may also want to look into their access to computer technology and whether they're online at the nursing stations, because as far as we know, their access to computer technology isn't very good. When you're talking about instant communications and easy communications, we may need to look there first in order to get them online and to get their skill set up to date as well.

**Hon. Robert Thibault:** I'd like to ask one final question to Dr. Schumacher, on perhaps medical ethics.

One of the areas I was looking at in this bill suggests that if a client gets the opinion of a medical practitioner or screener and wants a second opinion, then that person, at their own cost, will have to get that opinion at the location of detention. I would presume that could be very expensive, and there's no position of financing by the federal government or being paid by the federal government. It's silent on that. As you know, it's at the cost of the detainee.

The question I would ask is whether there are cultural or religious reasons, in your opinion, for why people would specify the physician they would ask for? It could be a physician of the same sex, same culture, or same religion. In your understanding, would there be situations in which that could happen?

**Dr. Albert Schumacher:** I don't think there's an ethical problem. I think they're asking for a physician to at least equal the opinion of another physician there, or to trump what the customs officer's initial thought was, especially if there's a delay in getting a further or more fulsome opinion or examination to rule something out. I think that provision's useful.

Now, can we make it practical at all the entry points into the country? Literally, you almost have to somebody like the public defender on call to come in for that second opinion. That's going to be a tough one. You're going to inject someone into a potentially high-risk situation of infectious disease, they're not necessarily going to be paid for it, and.... There are all kinds of issues around there. This is going to be a tough one to actualize. It's nice to say that everybody has a right to it, but let's make it practical. That's going to be kind of tough.

In the meantime, you're sitting around detaining one person and usually the person's whole family. Talk about the roadblocks in our emergency rooms. You're going to have roadblocks at your airports and ports like you've never seen before.

● (1710)

**Hon. Robert Thibault:** Thank you.

**The Chair:** Thank you, Mr. Thibault.

Mr. Ménard.

**Mr. Réal Ménard:** Merci. No more questions.

**The Chair:** Oh, you've pulled it, okay. You did ask.

Mr. Carrie.

**Mr. Colin Carrie:** Thank you very much.

My colleague did touch on the question I was going to ask, but I was hoping to get a little bit more detail.

We were talking about manpower and how if something were to happen there doesn't appear to be an adequate level of training here for a major outbreak. I was wondering if the CNA or the CMA has developed any programs for their members to take to get better educated on what to do if this were to occur.

**Dr. Isra Levy:** Well, we've done two things. Much of what we've done has in fact been precipitated by SARS, though we had started planning for smallpox before the SARS experience. We're confident that it will carry us through into the pandemic influenza that we know is coming, but we will need government support to do this.

The first thing is that we recommended to the Naylor committee the notion that Canada really needs a health emergency response service that involves both a government-centred, intramural set of teams—interdisciplinary, multidisciplinary teams—who are essentially government employees.... The new agency seems to be moving ahead with a health emergency response team concept, and that's more or less what we're talking about, though we're not too sure exactly how that's going to be working. We certainly think that's a good first step, and the training that will go into that, we'd be very interested in participating with, watching, just making sure that it makes sense.

But as a corollary to that, we also think there's a tremendous opportunity to develop volunteer lists of health professionals who are not employed by government. We certainly did that within the CMA during the SARS situation. We put out a call for volunteers and we essentially created the beginnings of a volunteer physician corps. The interesting thing was that we had nurses calling to say that they'd like to volunteer too. So there really is a tremendous well that we began tapping into in that sense.

That speaks to the development of the human resource, but the other side of the question that's very relevant and important is the training that will need to be done for these people. That would be part of an ongoing, forward-looking approach.

We've had some difficulty getting ahead with that within the profession because it takes resources, and resources coming from membership dues are not always sufficient for the demands that are being spoken about here in terms of bringing physicians up to speed in areas in which, as Dr. Schumacher pointed out, many of us were never trained—in bioterrorism, for example. Very few physicians practising in Canada have ever seen smallpox. The need for training resources is certainly an area where there's a tremendous opportunity for further progress.

The one place where this has been done quite well is in the United States. The American Medical Association and the CDC have a number of partnerships—and I'm sure the ANA also does, I'm not as familiar with them. But certainly, in terms of partnerships between government and national medical associations in the States and resource flow for the purposes of training, the trend has been set.

**Dr. Frank Plummer:** I would add for clarification that the Public Health Agency of Canada is moving ahead with the implementation of a health emergency response team system. An office has been established and money was received in the last budget for this activity.

It does very much mirror what Dr. Levy has outlined as a core federal capacity of health professionals, a coordinating body, but then teams of volunteers across the country who would be able to assist in an emergency and in fact possibly be deployed to other jurisdictions to assist with an emergency. Training is a part of that plan, but it's going to take some time to roll out.

● (1715)

**Mr. Colin Carrie:** I like what you were saying about an ongoing, forward-looking approach, because this manpower issue, with all the shortages we hear about—nurses, doctors, hospitals.... We actually had the minister in here. I tried to nail him down on the manpower issue, and it was very hard. These politicians are hard to tie down.

**Ms. Jane MacDonald:** Can I respond to that?

In addition to what Isra was describing, the CNA is actually working with our community health nurses specialty group now to develop a certification exam for community health nurses and a specialty for that.

The other thing that's going on that you've probably heard about before is that Health Canada is actually running online surveillance courses. It's being developed by Health Canada for health workers at the grassroots level. As far as public health nursing goes, and for a lot of the other workers who are at the grassroots level, ongoing continuing education is a huge issue. The resources aren't there for it, the time isn't there for it, and the ability to travel isn't there for it, particularly for the people working at the grassroots level.

Health Canada is working quite closely with the Public Health Agency to develop this surveillance training program, which could be enhanced, looking at emergency preparedness and other themes. It's a very good way to get at people who don't have the opportunity to travel or to take six months off to take a course.

It gets back to that local issue and the importance of supporting that as well around emergency preparedness and communicable diseases. It's not just up here. It's the people who are at the grassroots level that we need to be looking at as far as training and continuing education goes.

**Mr. Colin Carrie:** On this issue you've brought up, I've been talking to firefighters and emergency response people. They have the exact same issues. Thank you very much for bringing this forward.

**The Chair:** Thank you, Mr. Carrie.

I think everybody has had a turn, and some people have had two. I have a couple of questions, with the indulgence of the committee, I'd like to put forward.

Did I hear correctly, Dr. Plummer, when you suggested that Health Canada is looking at customs officers as screening officers?

**Dr. Frank Plummer:** That's what's contemplated in this legislation, yes.

**The Chair:** Can I just say I agree with Ms. Davies that this is not going to be sufficient unless you have some way of proving to us that customs officers, who have a police-like quality to what they do, can suddenly be in the health care field? I can't see it at all.

I don't want to get into compensation, but it surprised me to hear that 50% of doctors, or members of your association, are not connected to the Internet. Has the CMA tried to encourage them to be connected?

**Dr. Albert Schumacher:** Absolutely.

**The Chair:** Why are they resisting?

**Dr. Albert Schumacher:** I think it's an issue of connecting at home and then connecting at practice—usually at more than one practice site. The other big issue, of course, is contamination of your computer at work with viruses. You have confidential patient charts, billing information, and so forth on your computer that does your scheduling and your billing. You don't want that corrupted by exposure to the outside world. That's been the other reason for keeping that off-line and safe.

You're talking about reduplicating a computer system and then putting it on-line. What I'm suggesting is, the reduplicating of the computer system, fine, I think that should be the responsibility of the profession, but perhaps the online part we could have some help with, especially since it's a two-way deal with the chief public health officer and with Health Canada.

**The Chair:** In most businesses that have confidential material on their computer, are they not also worried about viruses contaminating it? Do they not usually feel that being connected is more valuable and try to protect themselves against those viruses? I find this a very strange situation.

**Dr. Albert Schumacher:** That may be the case, Madam Chair, but thus far, in my profession, with the amount of interpersonal time expected between the physician and patient, that hasn't necessarily made economic sense yet.

**Dr. Isra Levy:** Perhaps I may add to that as well. There are two issues that seem to come together here, and they're probably best kept apart.

One is physician connectivity or health care worker connectivity generally, and that would differ. Not all front-line health care workers are in offices, and indeed some physicians are at the bedside as well, so the connectivity implications are very varied. But the underlying issue is that the online connectivity is really only one source of communication medium.

I'm no communications expert, but I'm fortunate to work around some. Certainly our experience with communicating with our members...and we've done that in the past on behalf of what is now the Public Health Agency very successfully. We know a couple of things from multiple sectors.

First, we know that the membership will look to a trusted source, and the trusted source is usually another professional rather than a government entity, if we just limit ourselves to those two examples. Secondly, at least in a physician membership in Canada, we also know that not all physicians want to receive their communications through online communications even if they have the facility. There are many who prefer faxes. There are many who prefer direct mail.

We are discovering that you really need a multi-pronged approach if you want to actually hit the brain cell, which is the ultimate target, as opposed to the desktop.

It's really an interesting phenomenon, because when we took that into the international context and we had discussions with our colleagues, the first thing we learned was this. Not necessarily in most countries in the world, but in those countries most in need of a communications infrastructure like we're talking about in terms of a government being able to communicate directly to professionals through professional bodies or not, it's radio that does the trick. Indeed, I haven't checked out the Israeli scenario recently, but certainly a few years ago in Israel it was radio. The unique frequency channels were really the place people went for specific sources of information.

All this is to only make the point that connectivity is one component, but the broader underlying issue is how you actually get the communication out in a way that it will be used by the specific user.

● (1720)

**The Chair:** I have to react to this idea of radio. In a public health emergency where you're trying to keep the fear down, surely the last thing you want is this on the public airwaves, to scare all the citizens. There may be situations in Israel, particularly, where they have to alert the citizens, but to me that's building on this culture of fear that we see permeating the world in the last number of years.

**Dr. Isra Levy:** I think that risk communication theory would argue exactly the contrary, that the last thing you want to do in a public emergency is to be perceived as not sharing all of the information you have available with the public.

Now, I'm not suggesting that in a Canadian context radio is necessarily the best mechanism to do that, but I think we're highlighting in the discussion the complexity of the communication challenge, certainly in the emergency context. We know that this is only really the telescoped version of the communication challenge that is out there every day, and I think that speaks to the advantage of preparedness in advance.

Another point that several of my colleagues on this side of the table have made is that the best legislation isn't enough if you're not resourcing the program that supports the legislation adequately. Certainly the health professional groups, I think, felt very strongly, coming out of the SARS experience, that resourcing of the communications infrastructure just between government and the health professionals, never mind the public, needed to be really seriously looked at in terms of a renewal of the system.

**The Chair:** Thank you.

Mr. Lunney has a short question.

**Mr. James Lunney:** Just to touch base on an issue that Dr. Plummer briefly alluded to way back in the discussions, I want to ask a question on the avian flu. It's been a huge issue in British Columbia where, as Dr. Emerson will attest, we had the CFIA out there ordering the destruction of millions of birds in the Fraser Valley, most of which weren't sick. Some of them were organic. Of course, the fear is that a recombinant virus will get into the farmer and combine with a human virus and spread to the population.

My question is specifically about precautions in terms of our public health response in producing our flu vaccine. We take the two or three most virulent viruses we can find in the universe and we grow them in the egg medium, i.e., not just any old eggs, but fertilized eggs or chicken embryos with chicken cells in them, which contain an unknown quantity of chicken viruses. Now, as I understand it, they will screen for some 40 known viruses, but my question is, if we're worried about a recombinant virus, and we then take the vaccine produced in these fertilized eggs and inject those into the most vulnerable people, and now into babies themselves, what measures are being taken to screen those eggs to make sure we're not creating a recombinant virus in the process of producing the vaccine? Are there public health measures being taken to screen these things and to make sure that in fact we're not actually spreading what we're trying to combat?

● (1725)

**Dr. Frank Plummer:** I'll try to answer that.

A pandemic influenza strain could emerge from an avian ancestor, and the way in which we plan to make a vaccine to deal with that is actually to use recombinant techniques to produce a recombination between the very virulent strain and a very mild human strain, so that the virus would not have the characteristics of the very severe pandemic strain or its avian ancestor. Those vaccines would then be produced in embryonated hens' eggs, and the virus is inactivated or killed before being administered to humans. That vaccine would undergo extensive safety testing in animals first, and then phase-one clinical trials for safety in humans, and phase two, which are the largest safety trials, and then would ultimately come into use. So it would go through the normal vaccine manufacturing process that's used for influenza annually and has been proven to be very safe.

**The Chair:** Thank you very much, Mr. Lunney. You can pursue this afterwards with Dr. Plummer. I think only the two of you are really getting it, anyway.

First of all, committee members, I'd like you to stay for a minute. We have a question we have to resolve.

But on behalf of the committee members, I would very much like to thank the witnesses for their expertise, and I reserve the right to perhaps call you again, maybe just by phone, to find out any more thoughts you have on this bill. Thank you for the thinking you've already done, and thank you for the time you've allotted to us to present your ideas. Thanks very much.

Now, for the committee members, the clerk had prepared this statement for me to remind me of our plan, that the final meeting with witnesses would be this Thursday, and then we had planned to embark on clause- by-clause. If we follow our plan, the amendments would have to be in by this next Monday, November 29, at 5 o'clock. Based upon what I've heard today, which is that the consultation process so far has been one two-day meeting in Edmonton, one or two conference calls, and a few exchanges of notes between those players who were in Edmonton, and based upon your questions, where you and the witnesses are raising concerns, I'm wondering if we're moving too fast and if we need to hear more.

Do you think you're ready to submit amendments for Monday?

Mr. Thibault.

**Hon. Robert Thibault:** Madam Chair, perhaps, with the indulgence of all parties, what we could perhaps do is that after we've heard the last witnesses, which I understand could be a relatively short meeting for the number of witnesses presenting, we could have an informal discussion amongst all of us to see where we see this going. From what I've heard from the panel, I think that while there are concerns, they have also said this is a good first or interim step. So I don't know that we would want to leave the country without this bill if it is better. And it matches up to the bills we see in other countries, from what I've heard.

But there are questions, for example, on the financing and all those other things, and we might want to have informal discussions among ourselves on those things to see where we'd like to see it going before coming to clause-by-clause.

● (1730)

**The Chair:** Can I ask the clerk a question?

Supposing we did get our first batch of amendments in and we started clause-by-clause, is there any way we could reserve the right to stop if we got to a question that we felt we hadn't heard enough about, call witnesses again, and then start again?

**The Clerk of the Committee (Ms. Carmen DePape):** Yes, we could do that.

**The Chair:** I'm pretty concerned about this. I don't know. I'm just hearing so much.

The other major question is, what's in the bill vis-à-vis what's in the regulations? It would seem to me that a lot of the things that affect individual Canadians who are maybe flying home from some other location, who might be stopped, forced to have a medical examination even though they feel perfectly well, then quarantined.... On that whole aspect of it—their rights—we have to really understand whether we're going to allow it to be done in regulations that we have no control over or whether we should get at least the human rights of people into the bill.

Anyway, these are just some thoughts that I've had over the last couple of meetings.

Mr. Merrifield would like to comment.

**Mr. Rob Merrifield:** Yes, I think there are three parts to this. First of all, the testimonies today were good, although a good part of the testimony today was about how public health should be organized and how the agencies should be coordinating and so on. So that's part of it.

**The Chair:** I forgot that point.

**Mr. Rob Merrifield:** The other part is the actual bill itself and how it's going to be applied. Some of the testimony with regard to.... We've mentioned this, and I think both sides of the table are a little wound up on the compensation. Is that compensation in the bill or is it in the regs? And that's what you just mentioned.

Much of the detail that you're concerned about needs to be really looked at and addressed in the regs more than the intent of the bill. This bill wasn't even invoked in the SARS outbreak.

I don't know if we need so much time here. I would be more comfortable putting our amendments in here to point to the regs, but making sure in this bill that the regs come back here, and then we can deal with it from that perspective.

**The Chair:** Yes, we could comment on the regs, but as we found in other situations where we commented, nobody paid any attention to our comments. They didn't change anything because we commented. I take you back to reproductive technology.

**Mr. Réal Ménard:** We can adopt a motion.

**Mr. Rob Merrifield:** We still have to work on the regs on reproductive technology, and hopefully that will come forward.

But I'm wondering if there's some language, then, that we can put in the bill. Maybe we need the researchers to do that.

**The Chair:** But we have to approve the regs.

**Mr. Rob Merrifield:** Yes, approval of the regs.

**The Chair:** I see, okay.

Mr. Ménard, quickly.

[*Translation*]

**Mr. Réal Ménard:** I tend to think we should now look at amendments, and not hear more witnesses. I think two important things should be done. First, we should want to examine the regulations, as was done for tobacco. You asked yourself our researcher to do some work on this.

Secondly, we should task ourselves with examining the amendments as soon as next Monday. Personally, I am more concerned about the submission of the Dalhousie University professor who suggested 11 amendments. I do not quite agree with two of them. Some amendments are technical in nature, and some others deal with the implementation of this legislation.

You could tell us who is supposed to appear on Thursday, but I do not feel hearing more witnesses would bring us anything new. We could examine the regulations right here.

[*English*]

**The Chair:** In answer to your question, we had invited a number of people, but the only person who has agreed to come so far is someone from the Canadian Airports Council. And there might be somebody from—

**The Clerk:** Human Resources.

**The Chair:** —our own Department of Human Resources. There might be somebody from there. But it does look like a short meeting.

I've raised these concerns with you. The general reaction seems to be let's at least get started on the amendments and maybe we can protect ourselves by a couple of amendments we add that give ourselves another look at it later. But anyway, we'll continue this discussion after the witness or two witnesses on Thursday and we'll carry forward from there.

I thank you very much, ladies and gentlemen.

The meeting is adjourned.

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