House of Commons
CANADA

Standing Committee on Health

HESA • NUMBER 058 • 1st SESSION • 39th PARLIAMENT

EVIDENCE

Wednesday, May 30, 2007

Chair

Mr. Rob Merrifield

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● (1545)

[*English*]

The Chair (Mr. Rob Merrifield (Yellowhead, CPC)): We'll call the meeting to order.

We are here pursuant to our order of reference of Thursday, March 29, 2007, concerning Bill C-42, An Act to amend the Quarantine Act.

We have with us, through video conference from British Columbia, Minister of Health Perry Kendall.

Mr. Kendall, can you hear us all right and see us okay? Or Dr. Kendall, is it?

Dr. Perry Kendall (Provincial Health Officer, Public Health, British Columbia Ministry of Health): Yes, thank you.

And yes, it's Dr. Kendall.

The Chair: Okay. I didn't have that in front of me, but I'm glad you corrected me.

We have one other witness who is going to be joining us in a few minutes, but we'll start with you, Dr. Kendall.

There is a problem with some of our microphones, with an echo in the room. Dr. Kendall, could you say a few words to see whether you're coming through all right?

Dr. Perry Kendall: Sure.

I'm Dr. Perry Kendall and I'm the provincial health officer for the province of British Columbia.

The Chair: Okay, Dr. Kendall, we will give you the floor and we look forward to your presentation.

Dr. Perry Kendall: Thank you very much, Mr. Chair and honourable members of the committee.

I thank you for the opportunity to appear on the matter of amending section 34 through Bill C-42. I am the provincial health officer, so I'm the chief medical officer of health for the province of British Columbia. I'm here on behalf of not only myself but the three chief medical officers of health of the public health system for the health regions in British Columbia that have contiguous border crossings with the United States. They are Dr. John Blatherwick of Vancouver, Dr. Paul Hasselback of the Interior Health Authority, and Dr. Roland Guasparini of Fraser.

We want to speak on the matter of amending Bill C-42. I've read the transcripts from your last meeting and I understand the desire to increase security and provide security to Canadians from threats of communicable diseases being imported across the border. But I do not believe that a requirement to mandate an advance notice for land conveyances will actually add any modicum of additional security to the system we have. It will perhaps give the appearance of increased diligence, but it has the potential to divert public health resources away from other tasks they would be doing.

What I think is needed to enhance the general security for public health for importing public diseases is a better and increased public health surge capacity within provinces and territories, and the completion of the build of electronic health records and the communicable disease surveillance system that is currently being developed. I say this because, in all honesty, looking at SARS and our experience with imported diseases, we're most likely to recognize or need to recognize imported illnesses or new illnesses in emergency rooms or hospitals. The chance of picking something up at the border is infinitesimally small.

So our effective public health response is going to require rapid recognition and diagnosis, and then response and referral to an active public health system that can do the necessary contact tracing for persons who have been exposed, so they can be isolated or cases can be quarantined. Despite intensive surveillance for SARS during the period we had SARS, no SARS cases were effectively detected via airport or port surveillance.

I think the historical rationale for quarantine on ships worked because the trip travel time was much longer than the incubation period of any of the diseases we were concerned about. I think this is more dubious for air transport travel time because it is often shorter than most of the incubation periods of the diseases we are concerned about. The chances of somebody actually developing an illness and being clinically diagnosable while on an airplane is relatively small. That is why we pick people up before they get on the plane and stop them from getting on, or pick them up several days after they've landed when they've presented at hospitals.

I worry about the requirement for adverse notification of people who might be symptomatic, particularly in wintertime. I'm concerned that reports of influenza-like illnesses, bronchitis, coughs, fevers, etc., would put so much noise into the system that we'd divert resources away to look for this and wouldn't pick up any of the signals of real illness.

That's essentially a summary of the position or advice I might give or ask this committee to consider. I believe you may have received a couple of letters to that same effect from my colleagues who are medical officers of health.

● (1550)

The Chair: Thank you very much.

Now we'll hear from our second witness today. From the Institut national de santé publique du Québec, we have Monique Douville-Fradet.

Thank you for presenting before the committee. The floor is yours.

Dr. Monique Douville-Fradet (Medical Consultant, Biological, Environmental and Occupational Hazards Directorate, Institut national de santé publique du Québec): If you don't mind, I will be speaking in French, but I may answer questions in English afterwards.

I have prepared some notes and they are available to you. Maybe you have them already or will have them.

The Chair: Just for the committee, they're only in French. We don't have them translated so they're not in front of us, but that's okay. We'll follow along.

Dr. Monique Douville-Fradet: Okay.

[*Translation*]

Your committee is currently studying Bill C-42, an Act to amend the Quarantine Act, in order to make it consistent with the International Health Regulations which will soon come into effect. There is some question as to the government's intention in correcting the problems posed by the wording of section 34 of the Quarantine Act, which has to do with the obligation of conveyance operators to report the death or illness of a passenger when they cross the border. I will not read this section to you, but we may refer to it if necessary.

The Institut national de santé publique du Québec, whose mandate includes support to public health decision-makers, was asked to appear before you in order to give an opinion on Bill C-42, particularly on the relevance of reporting to someone as quickly as possible and whether or not to include land conveyances in this reporting requirement, in the same way as buses and trains. I will therefore give you the opinion of the Institut national de santé publique du Québec.

I would like to say that I am a medical examiner at the Institut national de santé publique du Québec. I am also a medical public health specialist and I work on the monitoring and control of infectious diseases.

We would like the reporting to be done as soon as possible through an intermediary, to quarantine officers, before the vehicle arrives at its destination. We believe it would be judicious to report any problematic situation as soon as possible, before arrival at destination, as that would perhaps allow us to advise on the measures taken onboard in order to minimize transmission, where that is possible, and to be able to properly prepare for arrival. It is particularly in this regard that we know improvements can be made.

As for the limitation on the kinds of conveyances described, I know that an amendment proposed to replace the words "all conveyances" with the words "air and watercraft... and prescribed conveyances". The intent was therefore to exclude land conveyances such as buses and trains. As a result, when we talk about buses and trains, we are only referring to cross-border traffic of conveyances coming from Canada and the United States.

We believe that the obligation to report should extend to all commercial vehicles, insofar as this is possible. I will expand somewhat on this subject—because we went a little bit further in our opinion that we submitted to you—I'm talking to you about the relevancy of having quarantine services at Canada/U.S. border crossings. If they are offered onboard aircraft and in trains, must they absolutely also be operated at border crossings?

First of all, I would reiterate what my colleague Perry Kendall said concerning the assessment of the risk of transmission of a targeted disease in Canada, coming from the United States. You must understand that the wording of the Quarantine Act is not very clear as to the kinds of problems it is targeting. It concerns the reporting on any reasonable grounds the operator may have that a person, merchandise or other things onboard a conveyance might risk spreading a communicable disease that is listed in the schedule, that a person onboard is deceased or that some other circumstance provided for in the regulations exists. In my opinion, this is not very clear.

Schedule 2 of the International Health Regulations is a bit more specific as to the kinds of issues that must be studied. I therefore included this schedule in the document, so that what we are talking about is very clear. Even if you do not have it before you, I will discuss these diseases. You will therefore be better able to follow.

● (1555)

In fact, these would be reportable diseases in every jurisdiction of North America. Among the diseases listed in this schedule, some, like smallpox, polio, avian flu—it says "pandemic" in my notes, but it should say "avian"—cholera, pneumonic plague, yellow fever, hemorrhagic fever, do not pose a major risk. This is because in most cases, the transmission of these diseases is extremely rare if non-existent in North America, given that the absence of causal agents or the public health measures that are already in place. We cannot imagine that this could happen in that way here at home.

Other diseases identified in the regulations are rarely seen, even though they do exist in North America and are susceptible to transmission. Public health authorities in Canada and the United States are well trained to diagnose and deal with these cases, as well with contact with meningococcemia, for example, which we discuss in the document. West Nile virus is not transmitted from human to human. It is only transmitted through contact with the blood or organs of an infected individual or through breast milk, which is not what we are discussing here.

Finally, there may be new entities with a highly contagious potential that could emerge and be added to the list. I am sure that the diseases that are of the most concern are no doubt those that are transmitted by respiratory route, and given the high level of transmission by respiratory route, these are probably the diseases that would most likely be added to the list we are discussing. We must understand that the severe acute respiratory syndrome, or SARS episode, and the efforts that are currently under way to prepare Canada for a potential influenza epidemic, have allowed for greatly improved monitoring of these entities. There are many monitoring mechanisms that have been put into place for severe acute respiratory diseases, both in the United States and in Canada. In English we call them

[*English*]

SRI, severe respiratory infections.

[*Translation*]

Were a patient presenting such symptoms to arrive at a hospital emergency room, the patient would be isolated and public health authorities would be contacted within minutes.

I would now like to talk about our ability to detect and deal with these problems. In order for such a health problem to be detected, one needs to have a sufficient length of time for observation—I would refer you to Dr. Kendall's comments on this issue—and the clear presence of evocative clinical symptoms. The kinds of symptoms one would look for would be fever, difficulty breathing, persistent diarrhea and others. It seems to us that these symptoms are not very specific, which means that one could not identify a potentially contagious disease of such seriousness at the outset that would justify in and of itself having quarantine officers present at every border crossing. You must understand that these are very common symptoms. Dr. Kendall talked about seasonal flu, for example, etc., and that is indeed the case.

Furthermore, it is quite unlikely that a person who is already in such a precarious state would be able to board a conveyance unnoticed. When it is obvious that the state of a passenger is rapidly declining, the vehicle would likely be stopped and transportation to the nearest hospital organized. Given the non-specificity of the symptoms and the available diagnostic abilities, the intervention of quarantine officers is therefore limited, especially since these services are located at many border points of entry. In most cases, a medical diagnosis will be necessary, which makes the transfer of the patients to specialized facilities mandatory.

We have a proven safety net. The illnesses that are of concern to us are already reportable diseases and Canadian medical authorities are well aware of the need to alert the public health authorities, as quickly as possible, of any suspicion of this kind of health problem. In fact, an on-call system covers all public health emergencies 24 hours a day. The system exists at the national level as well as in each of the provinces and territories.

● (1600)

You may have the impression that I was listening to yesterday's news, but I wrote my text well before that. In fact, it does sometimes happen that a person suffering from meningitis or with an acute case of tuberculosis has significant contacts, for example with passengers in an aircraft. When the case is diagnosed at emergency, it is immediately reported to public health authorities. The significant contacts are identified, found, and prophylactic medication is prescribed to them in order to stop any transmission. The cases may be referred to the interprovincial level and from Canada to the United States, or even elsewhere in the world. The Enhanced Severe Respiratory Illness Surveillance Plan represents another bulwark against the transmission of an emerging respiratory disease.

Quarantine officers are placed at border points that appear the most important to us, that is to say airports and ports that could be receiving international passengers coming directly from points of departure outside of North America. It seems a judicious choice to us, given the more obvious risk of presence of this type of communicable diseases, of the significant volume of travellers coming directly from countries at risk and the capacity for the development of an epidemic situation over the course of a long voyage, for example on a ship.

The situation does not seem comparable to us in the case of land conveyances, given the nature of the risk posed by those passengers and the shorter exposure time. These would be very costly measures that would produce very modest benefits, particularly, as is the case here, when the risk is minimal.

In conclusion, we can only support rapid reporting of health problems that arise aboard commercial conveyances, whatever the kind of vehicle, but only where this is possible. Such a measure could allow for a minimization of the spread and for the organization of case management services. The risk of the spread of disease that concerns us exists when an individual crosses an intercontinental border. This is however very rare. The risks of transmission are even smaller when we are talking about a Canada/U.S. border crossing. The quarantine services' ability to detect and manage the case is limited.

The setting up of quarantine services at all border crossings does not seem justified to us, given the rarity of significant cases, the multitude of border crossings that would have to be covered, and the ability to detect and handle these cases and the costs this would incur. There is a 24-hour public health on-call service that is available across Canada and the United States that can respond to this rare demand. The setting up of a communications mechanism between the public transportation authorities and Canadian emergency services would allow the authorities to have access to this on-call system should it be necessary.

[*English*]

The Chair: Thank you very much for your presentation.

We'll now open it up to questioning. We'll start with Ms. Bonnie Brown.

Ms. Bonnie Brown (Oakville, Lib.): Thank you, Mr. Chair.

Welcome to the witnesses. Thank you for your presentations.

Dr. Kendall, you said, I think, that you were not in favour of quarantine officers for land crossings. And you said, I think, that in the case of SARS, even our efforts at airports were rather fruitless and that therefore, probably based upon the incubation period of some of these diseases, the only serious attempt could be made as people come off ships.

Is that right? Is that more or less what you said?

● (1605)

Dr. Perry Kendall: No. Let me clarify. I am in favour of quarantine officers at crossing points, because I understand that the international regulations, as proposed, would have a land-based conveyance report somebody who was sick at the border, if they still had that sick person on board—if they hadn't off-loaded them to a hospital, which I hope they would have done. I support quarantine officers at airports and at ships as well.

My point was that, given the length of incubation periods of many of these diseases, you'll probably only get the disease manifesting itself on board a ship, because of the time the ship is in transit. The chances of somebody developing an illness in the 12 hours that they might be on a airplane, and developing symptoms to the point where they become symptomatic and obvious, is somewhat limited.

Our efforts at detecting people with increased temperatures at airports in Vancouver during SARS, where we had thermal scanners at every airport, didn't pick up a single case of serious illness. They may have picked up a number of people with slightly elevated temperatures, but not a single case of SARS was prevented from entering the country by means of that screening mechanism.

Ms. Bonnie Brown: So now I'm hearing you say you are in favour of quarantine officers in all three ways of conveyance bringing people into the country?

Dr. Perry Kendall: Yes, my understanding is that what we were actually discussing was the requirement for land conveyances crossing the borders to report in advance people who were being transported who may have symptomology of illness, and this is the proposed amendment. My understanding was to remove that to bring the Quarantine Act into consistency with the international regulations, where the advance requirement is just for marine or air transport, which I think makes a lot more sense.

Ms. Bonnie Brown: But in saying that, you just said a minute ago that you thought it was a good idea to have a quarantine officer at these border crossings. You just don't think the bus driver should have to phone ahead.

Dr. Perry Kendall: That's right.

I'm not sure how many quarantine officers we're talking about here. I was more concerned with the issue of the prior notification of potential illness, which I saw as being of little functional utility in terms of actually identifying serious illness or keeping serious illness out of the country—

Ms. Bonnie Brown: Dr. Kendall, I'm sorry, if we didn't have a quarantine officer at each land crossing...and some of these land crossings are grouped, if you think in terms of Fort Erie, Niagara Falls, Detroit, etc.; some of them are fairly close together. But with an advance call, we might be able to get a quarantine officer to that crossing prior to the vehicle that is carrying the sick person coming in.

I think that's more what we had in mind. We didn't have in mind an officer at each crossing. That obviously would be tremendously expensive. It seems to me that the advance warning actually saves the need for that.

Dr. Perry Kendall: It might. You would have to weigh the probability of actually picking up a serious illness and keeping it out of Canada against the inconvenience to passengers in buses and trains who were forced to wait periods of time while the quarantine officers were brought in, and then the cost of moving quarantine officers to the border crossing where somebody was coming in. So it's the feasibility of this.

It's feasible, but I'm not sure you're going to get any benefit from it. That is the point I was trying to make.

Ms. Bonnie Brown: One of the suggestions we were given by the officials who were suggesting that this was the way to go—that is, to take land conveyances out of the bill—was that Americans, people from the United States, for the most part have similar health status to Canadians, and that the real threat comes from third world countries; for example, the SARS infection.

But we've just had a case in the news in the last 24 hours where the person who was putting others at risk was actually an American who was carrying a disease that was not normally thought of as something you would expect to come from the United States. He in fact was told by his doctor not to travel. He travelled anyway, got the results of his earlier tests while he was abroad, knew he would not be accepted into the United States because he was immediately put on the no-fly list, and flew to Canada instead in order to rent a car and drive home.

So it seems to me that this serendipitous—in my view—case, for our purposes, has proven that you can't name which country these germs are going to come from. They could come from anywhere.

● (1610)

Dr. Perry Kendall: Yes, indeed they could, and I think it makes the point that was being made by the doctor from the INSPQ: that our system can track people even if they're asymptomatic. This gentlemen was not coughing. He was presenting a relatively low risk, even though he had a very serious organism. In fact, he was sputum negative on the culture. He wasn't symptomatic, so no symptom watch on an airplane or a boat or a land conveyance would have picked him up in any case. He was picked up because of a good diagnostic surveillance system and good communications, and the keeping of records.

Ms. Bonnie Brown: Both of our witnesses, Mr. Chair, have said that it's better to detect these illnesses before someone is allowed to embark, and indeed, this particular man who's been in the news in the last 24 hours had been to the doctor, had been tested, and had been told not to fly. What do you think we can do about those kinds of situations?

The Chair: Mr. Kendall.

Dr. Perry Kendall: Sorry. Were you asking me that question?

Ms. Bonnie Brown: Maybe Dr. Douville-Fradet might answer.

Dr. Monique Douville-Fradet: That's part of the point I wanted to make.

It's not a full guarantee, if you have quarantine agents in an airport, that some people like that will be picked up. But what I was saying is that to get this guy and get the proper diagnosis it took specialized services. That was one of the points.

The other point was that he was diagnosed, and then reported to public health. Right now, everything is being done to get all the contacts and everything. For TB, and for meningitis, we're really used to that. These are the two major, I would think, threats that could come back and forth. I'm not talking about a pandemic flu. That's another thing. But with TB and meningitis, there are not that many. I was the provincial epidemiologist for the province of Quebec for eight years. In those eight years, in Quebec, we may have had fewer than five or six of those cases. But when they come, we're fully trained to reach out for contacts and do the thing. There are liaison between provinces and territories in Canada and the U.S. That's what is happening right now.

Ms. Bonnie Brown: Thank you.

The Chair: Thank you very much.

Madame Gagnon.

[*Translation*]

Ms. Christiane Gagnon (Québec, BQ): I agree with you that we should not go beyond what the current bill provides for the surveillance of travellers. I think that individuals have some responsibility. Perhaps they do not want to disclose the fact that they are suffering from a dangerous infectious disease. In many cases, they are aware of that fact, but they do not want to declare their disease. If this cannot be determined at boarding time, then all the passengers of the aircraft would have to undergo a diagnosis even before boarding, which is impossible. It would be extremely complicated to do this for ground transportation.

Why are the United States not asking for the same kind of protection? As Canadians travel South, the United States does not seem to be worried about certain infectious diseases. As you were saying, we are not talking about ordinary diseases. When passengers move between the United States and Canada, why do the United States not feel vulnerable?

Canada feels more threatened by a potential epidemic introduced by a traveller. As you said earlier, we do have some protective measures. Moreover, individuals are expected to declare such diseases. If someone does not comply, it is his responsibility. Basically, it would be very difficult, very expensive, and I think, practically impossible to apply measures that go any farther than the current measures.

● (1615)

Dr. Monique Douville-Fradet: A bus only has one driver. He has to sit up front and drive. He does not have the time to mind the health of his passengers. A passenger would have to be in very bad shape before anyone said that someone onboard was severely ill or dying.

We would need a link or a mechanism to take care of persons who are found to be seriously ill on trains. If a passenger is found to be seriously ill, his case could be reported to the Public Health Agency of Canada, describing his symptoms, and so on. to ensure that the person is taken to a place where he can undergo diagnosis. I think that such a procedure would be good.

Nonetheless, if a passenger is seriously ill at the border, there may not be adequate facilities to perform a diagnosis. It would require physicians and other resources such as tests.

It would also depend on the type of problem. If someone comes down with a fever caused by the Ebola virus, it is obvious that he is seriously ill. He might not even get into the country alive. If he gets in, he will really be in bad shape because the disease has gone beyond the incubation stage. Rapid transportation does not leave enough time for incubation to take place during a trip.

I think that in any case, there will be have to be a diagnosis along with specialized care. There is already a system in place, because the Public Health Agency of Canada is in charge of infectious disease prevention and control for the entire country.

Ms. Christiane Gagnon: I have no further questions. I am inclined to support the bill as it stands. It could be improved by making two amendments, but I do not think that we should go beyond the current provisions. There are safeguards in place for air travel and overland travel. However, the responsibility lies with the travellers especially overland travellers. Practically speaking, I do not think that we have all the tools and resources that we need to detect how many individuals have come down with a given disease. As you said, this is very unlikely.

Dr. Monique Douville-Fradet: Precisely. I entirely agree with what Dr. Kendall said when he emphasized that for SARS, intensive surveillance was implemented in airports. It was very expensive. Even in the regions where SARS was present, the number of potential cases was very small as compared to the number of people who had some type of fever that had nothing at all to do with SARS. It is a disease whose symptoms are not very specific.

Ms. Christiane Gagnon: Thank you.

● (1620)

[*English*]

The Chair: Thank you very much.

Ms. Davidson.

Mrs. Patricia Davidson (Sarnia—Lambton, CPC): Thank you, and again thank you very much to both of our witnesses today.

I just have a couple of questions.

We talked a little bit about—maybe it was Ms. Brown who talked about it—the no-fly lists and the gentleman in question being placed on the American no-fly list. Are those no-fly lists shared? That's one question. Would we know that as a Canadian group?

And what established relationships do you have, Dr. Kendall, or would Canada have with the border states to address reportable diseases crossing the border? Is there a good system in place to address that? And does B.C. have similar relationships with other countries, for example, Asian countries? I would think that you probably have a fair amount of travel between Asia and certain areas of B.C.

The other question I had for anybody who can answer is this. It's my understanding that section 34 of the new Quarantine Act is currently not in force, waiting for adoption of Bill C-42. So how does that affect Canada's ability to respond to a public health threat at the border?

The Chair: Go ahead, Dr. Kendall.

Dr. Perry Kendall: British Columbia has good working relationships with our colleagues in public health in the contiguous states south of the border. We have regular twice-yearly public health emergency planning meetings, either in B.C. or in Washington, in Portland, Oregon, or in Idaho. We have good relationships with Alaska to the north, as well. We share databases and information between laboratories and public health physicians.

Nationally, I think you would have to address that question to Dr. David Butler-Jones or Dr. Howard Njoo. My understanding is that there are very good channels of communication between the Public Health Agency of Canada and the Centers for Disease Control in Atlanta, Georgia.

Mrs. Patricia Davidson: Are you able to address the no-fly lists?

Dr. Perry Kendall: I don't know the answer to the no-fly list. I'm sorry.

Mrs. Patricia Davidson: Okay.

Dr. Monique Douville-Fradet: I don't have an answer to the no-fly list, either. What I understand of the case in the news is that his doctor had told him not to fly. But I don't know about a no-fly list. Again, maybe Dr. Butler-Jones could answer that.

Mrs. Patricia Davidson: Thank you.

The Chair: Thank you.

Go ahead.

Dr. Monique Douville-Fradet: I want to say that the relationship we have with United States is one that often goes through the Public Health Agency of Canada and then to the United States, or to France or England or Asia or wherever.

Mrs. Patricia Davidson: Thank you.

The Chair: Thank you.

Ms. Priddy, go ahead.

Ms. Penny Priddy (Surrey North, NDP): Thank you.

Welcome, to the witnesses. Dr. Kendall, it's nice to see you.

Dr. Kendall and I have worked together in other lives.

I have to say as I begin, Mr. Chair, that I'm a little concerned that some of the witnesses we had identified to be here today, such as bus transport, motorways, and so on, are unable to be here. This is the second meeting in a row that the witnesses I anticipated would be here are not. That is notwithstanding the skill and knowledge of the witnesses who are here today. But earlier on we had discussions about having motorways and other kinds of land conveyance providers here, and they're not here.

The Chair: For the committee, they were all asked to come, and these were the two we could get.

Ms. Penny Priddy: You're not taking anything off my time, are you?

The Chair: I'll add it on to your time.

Ms. Penny Priddy: All right.

We had some questions last week, which I think Ms. Brown raised, around what relation our discussion had to the SPP. I also wonder a bit about what relation this has to SPP. I am concerned that witnesses we really need to talk to are not available to come and talk with us. That gives me not enough information sometimes to make the kind of informed decision that I think I should make.

Having said that, I want to ask both witnesses, Dr. Kendall and Dr. Douville-Fradet, a question. This wording, "land conveyances", has been removed. I've heard Dr. Kendall say that you wouldn't be on a plane long enough. Fair enough, but if you get on a bus in Florida and decide you're going to visit Vancouver, I'll bet you're on a bus long enough for something to display itself. Or if you get on a train in Arizona and you're going to northern Ontario, I'll bet you.... If you go to northern Ontario from southern Ontario you could be on a train long enough for disease symptoms to display themselves. Given that we are also seeing an increase—although we hoped we never would—in the incidence of tuberculosis, certainly in Canada, and I assume in the United States, I want to know if you think that removing or not removing "land conveyances" is a sound public health decision—in your opinion, yes or no.

● (1625)

Dr. Perry Kendall: Yes.

Ms. Penny Priddy: You think it is a sound public health decision to not have "land conveyances" included.

Dr. Perry Kendall: Yes. I could spell my rationale out very simply. I don't think it adds any additional protection to what we currently have, and it has the downside risk of diverting public health resources to an activity that wouldn't have any additional benefit.

Ms. Penny Priddy: I'm not talking about having quarantine officers at every crossing. I'm just talking about having some kind of notification for the border that somebody on a bus or a train is extremely ill.

Dr. Perry Kendall: I'm thinking that if anybody is extremely ill on a bus or a train, they ought to be taken off the train or the bus whenever they go through a city with a health facility before they get to the border; or rather than stopping them at the border, as Dr. Douville-Fradet suggested, make sure they get some care immediately upon arrival at their final destination.

Ms. Penny Priddy: That's why it would be interesting to have motorways and so on here to know what their legal authority is to do something like that.

Dr. Douville-Fradet, would you agree that it is sound public policy to remove this wording from the Quarantine Act?

Dr. Monique Douville-Fradet: Our opinion was that—

Ms. Penny Priddy: I just need a yes or a no.

Dr. Monique Douville-Fradet: No.

Ms. Penny Priddy: Thank you.

Have you ever seen any infectious disease cross the border—either one or both of you—by a land conveyance, in your medical experience? Perry?

Dr. Perry Kendall: I haven't seen—

Ms. Penny Priddy: All right. Have you heard of it, read about it—whatever?

Dr. Perry Kendall: I'm sure it must have happened, because people travelling backwards and forwards across the border would be carrying or incubating influenza, potentially measles, and perhaps even mumps. Across the border by a land conveyance, it's entirely possible that it could happen. People travelling from Nova Scotia to the rest of Canada have carried mumps with them. We've had Japanese tourists flying in recently developing measles when they got here, and we've quarantined 120 people in the party. So it's entirely conceivable that somebody who is incubating a disease could use a land conveyance to cross either an international border or a provincial or territorial border.

Ms. Penny Priddy: But you still think it's sound public health. Okay.

Dr. Douville-Fradet, have you seen any infectious disease cross a border?

Dr. Monique Douville-Fradet: I think if you're talking about any infectious disease, probably. I have exactly the same answer as Dr. Kendall. But if I may expand a little bit, what is happening here is that whenever there is mumps or measles, or TB right now, or meningitis or whatever, public health gets into the loop. And from that we can assure good control.

What I was saying just a little bit earlier was that if it's possible to have advance notice of a person really not doing well, it's okay, but as you can see with TB—

[*Translation*]

it is not necessary.

[*English*]

When a person is really sick, the person will go to the hospital and we will catch it there.

Ms. Penny Priddy: If they're taken off.

Am I out of time this time?

The Chair: Yes, and I gave you an extra minute and a half when you only needed 30 seconds. But that's okay.

● (1630)

Ms. Penny Priddy: The goddess will bless you.

The Chair: Patrick Brown, you're next.

Mr. Patrick Brown (Barrie, CPC): Thank you, Mr. Chairman.

I have two questions. My first question is for Mr. Kendall.

In terms of British Columbia, do public health officials there have established relationships with other international countries? Being close to the Pacific, obviously you'd imagine there'd be some relationships with some Asian countries.

And I have a general question for both witnesses. In your professional opinion as public health experts, what are the greatest communicable disease threats facing Canada?

Dr. Perry Kendall: To the first question, official linkages between British Columbia health officials and health officials of governments outside of Canada would be through PHAC. But in fact, our public health officials at the B.C. Centre for Disease Control do have ongoing relationships with other public health officials and scientists in other institutes of infectious disease in China, Hong Kong, Vietnam, Taiwan, and other countries. So there is, in addition, a global public health surveillance network and unofficial networks of disease reporting. So there's a very active global communicable disease surveillance network.

What is the most serious infectious disease not currently in existence facing Canada? It is probably the emergence of a pandemic strain of influenza.

Dr. Monique Douville-Fradet: I have to agree with that. This is why SRI surveillance has been very much strengthened in Canada and in the U.S.

Mr. Patrick Brown: Okay, thank you.

The Chair: Thank you very much.

We'll move on now to Ms. Kadis.

Mrs. Susan Kadis (Thornhill, Lib.): Thank you, Mr. Chair.

Welcome to our witnesses today.

This is a somewhat general question, which I think Ms. Priddy asked in her way as well. Do you believe, both of you, that the health of Canadians is just as safeguarded with or without the requirement for reporting by land conveyances?

Again, this is somewhat broad, but I think it's a very important idea to pose to you. When we're dealing with the serious nature of communicable diseases and the changing global environment, and the increasingly closer global environment that we do currently live in with the dynamics that exist now, should we not be erring on the side of caution, even if, yes, it may be somewhat costly or definitely not foolproof? We know that even air and sea are not foolproof. No one would say they were. But we still believe, and the proposal is to continue this element, that it is still important enough and essential enough to keep that in the act.

So I would just ask both of you, regarding this particular amendment, do you not believe we should be erring on the side of caution when it comes to the health of Canadians?

The Chair: Go ahead, Monique. We'll give Dr. Kendall a few seconds to think about it.

Dr. Monique Douville-Fradet: Okay.

Well, maybe this is why we were saying that if it is at all possible for land transportation to be able to reach the normal way of doing so with the 24-hour duty of public health, then, if it's possible, why not? But it doesn't justify—to us, at least—putting people or quarantine services everywhere.

There is this 24-hour duty list. It's all around Canada. It's in the United States also. And anyway, people will go through where exactly this thing comes into, which is a hospital, and from a hospital to public health.

The Chair: Dr. Kendall.

Dr. Perry Kendall: We would be just as safe without this. I agree with Dr. Douville.

As far as erring on the side of caution goes, my concern would be that if we set up a process that had many advance calls to quarantine officers or others, which then required public health professionals to be diverted from what they were currently doing or to get up at 2 o'clock in the morning, the downside risk is that we would take away scarce resources and basically be diverting them for no additional benefit. I think we'd end up with a net loss to the system rather than a net gain.

● (1635)

Mrs. Susan Kadis: Thank you.

The other issue I want to have addressed is the issue of provincial reporting and communication. Unless I'm mistaken, I'm not seeing it addressed appropriately here, in my opinion, in terms of mumps and other things that have been raised.

Do you feel that is an element that should be put in here or strengthened in here in terms of land conveyance within Canada and communication?

Dr. Perry Kendall: I think all medical officers in provinces and territories have the abilities within their acts and exceptions within their protection of privacy acts to enable them to make the appropriate communications to other public health officials in other provinces and territories or indeed at the federal level. I believe they routinely do that at the present time, with our current information-sharing agreements and with our public and territorial health acts.

Mrs. Susan Kadis: You believe the federal government does have a role to play in that coordination of information.

Dr. Perry Kendall: Yes. We're attempting to develop specific and official memoranda of understanding through the public health network, with sign-off by ministers of health at the federal, provincial, and territorial levels so that everybody is very explicitly clear that we have that ability, that we have practised it, that we have particular protocols for respiratory outbreaks or gastrointestinal outbreaks or any other kind of outbreak. We're developing the protocols to enable us to do routine, regular cross-jurisdictional reporting and communication.

Mrs. Susan Kadis: Maybe I could just finalize with Madame Douville-Fradet. I thought I heard, perhaps, you suggesting that you think it would be appropriate if there were not quarantine officers at every single border crossing but perhaps a practical mechanism to ensure prior knowledge in terms of possible communicable diseases, that that's something you would possibly support.

Dr. Monique Douville-Fradet: Well, that was the idea, but I do agree that it would have to be a type of mechanism that would not put in too much burden on public health resources. By that I mean that if someone is having trouble, or whatever, we need a diagnosis. This cannot be done without going to a hospital and having the proper tests.

Before we can say that this is very transmissible, that this is a big thing, that we have to go and look for contacts and everything, we need a diagnosis. It's not possible to have that without proper consultation of specialized resources.

The Chair: Mr. Fletcher.

Mr. Steven Fletcher (Charleswood—St. James—Assiniboia, CPC): Thank you, Mr. Chair.

Dr. Kendall, you mentioned that British Columbia has a special arrangement with the states along the 49th parallel. Is there any such arrangement with Alaska?

Dr. Perry Kendall: Yes. Alaska is included in our meetings.

Mr. Steven Fletcher: We have you, Dr. Kendall, saying yes, it is reasonable to not have land conveyances included, and we have our other witness saying no, it's not reasonable. Is there a compromise here that would address your concerns, Dr. Kendall, or those of our friend from Quebec? Is there a compromise here that will meet the needs of Canadians while dealing with the public health issues?

Dr. Perry Kendall: I think, on Dr. Douville-Fradet's proposal, with very specified mechanisms of transportation such as a train, one wouldn't necessarily need to stop it at the border, but then if you had concerns that someone on board that conveyance was ill and needed medical attention, if you hadn't put them off to give them medical attention before they got to the border, then rather than putting them off at the border where there aren't diagnostic or care facilities, it would actually make more sense to arrange for them to be met by an ambulance and transported to a hospital at their closest point of destination.

● (1640)

Mr. Steven Fletcher: So if the act were able to include something that says “best efforts”, to recognize that there is a possibility over land but that the probability is low, if we could incorporate that in such a way, would that alleviate your concern, Dr. Douville-Fradet?

Dr. Monique Douville-Fradet: I agree pretty much with what Dr. Kendall has said. I don't think our position is that we need quarantine people everywhere. What I've said is that I'm thinking of a way, just a way, to have a heads-up, if it's possible, to be able to reach what is actually already there, which is

[*Translation*]

physicians in hospitals and a public health prevention and control system.

[*English*]

Mr. Steven Fletcher: I've finished. That's it.

The Chair: Ms. Bennett.

Hon. Carolyn Bennett (St. Paul's, Lib.): Hi, Dr. Kendall.

Thank you very much, both of you, for coming. As you can tell, the committee is still somewhat unpersuaded that what was put in the bill—

Ms. Penny Priddy: Well, you are.

Hon. Carolyn Bennett: Well, we're talking about consensus, not unanimity, madame.

I think there is a concern that what we had once thought we needed as a tool.... Why wouldn't you just leave it in the tool box, even if you never used it, as opposed to getting rid of a tool you might need?

I see the argument that when you're coming by land, you can hop off before you get to the border. But could there not be a situation where the person has hopped off before they get to the border, but the rest of the land conveyance is all now exposed?

I guess I'm still not understanding how international health regulations are not, as I had thought, a minimum standard rather than a maximum standard. Even though the international regulations don't make us do it, what has changed between the original bill and now, that we all of a sudden have decided we don't need any more?

I understand Dr. Kendall's concerns about resources: that if this is there, it shouldn't just be a piece of paper but should actually be the capacity to do it. But is there some way, as the parliamentary secretary asked, whether through a communications strategy or infrastructure, whereby you can...? Is there a compromise or something that would allay the fears of this committee that at some point there'll be a situation where we'll wish that we, in terms of our due diligence, had left the tool in the tool box?

The Chair: Go ahead, Monique.

Dr. Monique Douville-Fradet: I think what we've proposed is a communication strategy, but

[*Translation*]

we must keep in mind that a proper intervention takes a diagnosis. Therefore, we need some way to communicate so that we can pick the individual up and take him away for diagnosis. Only then can we intervene. As I said, very serious problems would be extremely rare. However, we can deal with them if they come up.

Moreover, if there is a case of tuberculosis, every person who was in contact with the case in an aircraft long enough to risk contracting the disease must be traced and given the necessary care. We are organized for doing this. We have powers that allow us to obtain the names and addresses of all the travellers in the aircraft. We know that every individual onboard the plane does not run the same risk of contagion, but we have the names of all the passengers who were onboard. We will specifically track down those who were close to the infected person and give them chemoprophylaxis if need be.

● (1645)

[*English*]

Hon. Carolyn Bennett: Dr. Kendall, what—

[*Translation*]

Dr. Monique Douville-Fradet: I think that we already have a safety net.

[*English*]

Hon. Carolyn Bennett: Dr. Kendall, why did we ask for this before, then?

The Chair: Dr. Kendall?

Dr. Perry Kendall: Answering the same questions?

My concern would be that if it did stay in the act, it would have to be acted on, and then, I would say, there could be unintended consequences that could weaken our existing system.

The Chair: Can you speak up a little bit, Dr. Kendall?

Dr. Perry Kendall: I'm sorry.

If it were left in the act, I would be concerned that it would then need to be acted upon, with the potential downside of the unintended consequences of weakening the public health system and draining away resources to no benefit.

As to whether you might need such a tool, I understood from reading the transcripts of your last meeting around this that the potential exists for a regulatory change immediately if one should discover an epidemiological situation in which a disease, whose characteristics I can't imagine at the moment, did make it necessary or desirable that we stop someone or have advance notice of their carrying the disease from a particular place in the United States to a particular destination in Canada. We could implement a way to block them or stop them at the border if such powers didn't exist in the existing public health, though I think they might.

For example, suppose somebody exposed a theatre full of people in Bellingham to smallpox, and we knew about it. If we knew about it in time, American authorities might be able to put a cordon sanitaire around Bellingham, or we might decide that we would stop land transport coming across the border at that time. In the absence of a defined epidemiological event like that, I don't think we need to have the tool in the tool box. I think we have enough tools, or could put additional tools in if we found a situation that merited them.

The Chair: Your time is gone.

Hon. Carolyn Bennett: Are you speaking on behalf of the public health network? Are all your colleagues across Canada—

The Chair: Just one question I'll allow, but not two.

Hon. Carolyn Bennett: Does the public health network of Canada have a consensus on this?

The Chair: Okay, go ahead, please, quickly.

Dr. Perry Kendall: I have consulted only with the public health officials in B.C. who have a responsibility in health areas next to or very close to the border and who would be impacted by this.

The Chair: If the committee will allow it, I have a quick question.

I'm trying to get a handle on what we're really looking at. With the SARS situation, the federal Quarantine Act was not invoked; it was only the provincial quarantine act. Each province has its own act. I don't really know exactly how powerful or how different each provincial or territorial jurisdiction's quarantine act is.

Nonetheless, we have this piece of federal legislation before us. I'm trying to envision a ground conveyance. Let's say a Greyhound bus is going from Seattle to Vancouver in the middle of a pandemic—and we know, or hear from experts around the world that it's not a matter of *if* it will happen but *when* it will happen—and somebody is deathly ill. The Quarantine Act, to me, would be invoked not necessarily to deal with the ill person, but to make sure the disease or whatever it might be is contained within that bus at either a border crossing or a hospital. That's the thing I envision.

My concern with the testimony here is that you have to think of the worst-case scenario. Why would we weaken something, thereby not allowing for the opportunity for us to contain it in that worst situation? The Quarantine Act has never been abused or overused in my mind, even in the worst situation we've had in the country.

I guess that's my position on it. As a chair, I'm neutral, but either one of you might want to answer and convince me otherwise.

● (1650)

Dr. Perry Kendall: Monique, it's up to you.

Dr. Monique Douville-Fradet: You don't want to go there?

Dr. Perry Kendall: I'm willing to go there, but I want you to talk to this.

Dr. Monique Douville-Fradet: Okay, no problem.

I'm going to talk in French to be very specific.

[*Translation*]

A flu pandemic clearly involves an infinitely transmissible disease, by definition. A virus that would cause a pandemic would be very virulent and very easy to transmit. Currently, when such cases first appear, we can try to quarantine the people involved and stop the disease from spreading. Nevertheless, sooner or later, it is very likely that despite all our attempts, the disease will keep on spreading.

Let me come back to your example. We are riding on a bus and a passenger is incubating the pandemic flu. He might not yet be extremely ill, but he can be contagious. This is how pandemic flu behaves. Patients may not show clear symptoms and be contagious nonetheless. In such cases, we can do something, of course, but when the disease is highly contagious, it is very difficult.

It was discovered that SARS was not very contagious unless you got very close to a patient. As a matter of fact, if we look at the places where the disease spread the most, we realize that those places had many problems with hygiene, even in hospitals. When we look at the results of the attempts to monitor fever in order to detect SARS, we realize that this procedure was ineffective in airports, trains and buses.

[*English*]

The Chair: Okay, fair enough.

I don't know if Dr. Kendall wants very quickly to add to anything in there or not.

Dr. Perry Kendall: I would agree with Dr. Douville, and it is the opinion of the public health network and the folk who are working on our Canadian pandemic influenza plan that the Quarantine Act is not going to keep pandemic influenza out of Canada. In all likelihood, the first cases we actually identify are going to be second-, third-, or fourth-generation cases, and by the time we pick it up, it's going to be spread in our communities.

The Chair: So we throw our hands in the air and give up.

I don't have any more questioners, and we don't want it to go very much longer.

Now I see three. That's what I was afraid of.

Let's try this. Pat has asked for a very quick question and then... another very quick question, and then we'll call it.

Mrs. Patricia Davidson: Okay, thank you.

Just quickly, Dr. Kendall, this is a question for you.

I'm told there has been a group of about 130 to 140 Japanese students who arrived in Canada, with one individual diagnosed with measles, and apparently that person had the disease when they got here. I think some of the people are in Alberta and some are in British Columbia. Is that correct—a person in hospital in B.C. and some quarantined in Alberta?

So how does this work, then? The provinces are working together, I guess, but is there a federal quarantine implication in this type of instance?

● (1655)

Dr. Perry Kendall: I don't believe there is. We're consulting with the Public Health Agency of Canada to coordinate communications. The Japanese student who was incubating measles when she arrived with her tour group became clinically ill and was hospitalized, and the diagnosis of measles was made. The 122 people who were in her tour group were isolated in Banff and were checked for their vulnerabilities. I think about 30 of them were shown to be vulnerable and were offered immunization.

The public health officials in both B.C. and Alberta have tried to track down the places where that tour group went with the girl when she was infectious. They are trying to find out those people who would be most at risk and basically give them information about the symptomology of measles. If they were in those places and they haven't had two doses of the MMR vaccine, they're advised to get their second dose of MMR.

Mrs. Patricia Davidson: Thank you.

The Chair: Thank you.

Okay, Penny, very quickly.

Ms. Penny Priddy: Thank you.

For some reason this conversation, or the whole discussion, is much bigger than I understand. We're talking about a piece of legislation with wording saying there is a duty to notify the nearest public health officer, or the nearest...whatever it says. It's not that there's to be a quarantine officer at every crossing—not anything like that—just a duty to notify the nearest public health officer, or whatever it says. So why we would feel this need to take it out is a bit beyond me. I am puzzled about why this discussion has grown this big and why we would just not leave it there, since we are not talking about the resources, we're not talking about a quarantine officer, but just about leaving the current wording that there's a duty to notify the nearest person, period.

The Chair: All right, that was more of a statement.

Ms. Penny Priddy: Sorry, there was a question in it, but it escaped me.

The Chair: Does anyone want to quickly look at the question on that, or are we fine with it?

I'm not seeing any bites. All right.

We're going to call this part of the meeting over. We want to thank you very much for being here through video conference, Dr. Kendall, as well as Dr. Douville. Thank you for being here and for your presentations.

With that, we'll just have a quick break in our meeting as we go in camera to discuss some of the upcoming report on CDR.

Thank you very much.

[*Proceedings continue in camera*]

Published under the authority of the Speaker of the House of Commons

Publié en conformité de l'autorité du Président de la Chambre des communes

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