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Chair

Mrs. Joy Smith

Standing Committee on Health

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● (1530)

[*English*]

The Chair (Mrs. Joy Smith (Kildonan—St. Paul, CPC)): Good afternoon, ladies and gentlemen.

I want to welcome all our guests to committee today. It is indeed a pleasure to have you here. We're certainly looking forward to your insightful comments on this very important topic. I was noting the fact that we've never had this topic at the national health committee for Canada, so I think we're breaking new ground here today. This is great.

Before we start the meeting, I want to adopt the budget for this afternoon's briefing on sodium. A copy of the proposed budget has been distributed to the members of this committee. The motion states that the proposed budget in the amount of $16,500 for the briefing on sodium consumption in the Canadian diet be adopted. Do I have agreement?

(Motion agreed to)

The Chair: Thank you.

We're going to begin right now. We have quite a complete panel today, so we're going to ask that the presentations be for five minutes each just so we can cover everybody. The clerk has informed me that because of the number of people presenting, we do have to do it that way.

We will start with the witnesses from Blood Pressure Canada and begin with Dr. Norman Campbell, president.

Dr. Norman Campbell (President, Blood Pressure Canada): I'm Dr. Norm Campbell, the president of Blood Pressure Canada. Blood Pressure Canada is a coalition of 29 national organizations dedicated to the prevention and control of hypertension in Canada.

My colleague, Dr. Kevin Willis, is with the Canadian Stroke Network. The Canadian Stroke Network is one of the more important partners of Blood Pressure Canada in the effort to reduce dietary sodium.

If one looks at World Health Organization reports, one will see that they believe elevated blood pressure is the leading risk for premature death in the world. Elevated blood pressure damages the blood vessels and causes strokes, heart attacks, heart failure, kidney failure, and other blood vessel damage such as dementia. In Canada, approximately one in four Canadian adults has hypertension and 90% of us are estimated to develop hypertension within our life spans.

Importantly, hypertension, or increased blood pressure, is preventable. One of the major factors in increasing blood pressure as we age is high dietary sodium. In Canada, it's estimated that Canadian adults are consuming around 3,500 milligrams of sodium per day. Most of this is added to our diets in the processing of foods.

We have done some analyses. About three in 10 Canadians with elevated blood pressure have high blood pressure because of high dietary sodium. This translates to between one million and two million Canadians with high blood pressure who would have normal blood pressure otherwise. That's estimated to contribute to about 10% of the cardiac and stroke events that occur in our country.

The cost savings of reducing dietary sodium from its current 3,500 milligrams today down to levels that are recommended, which is around 1,700 milligrams per day, would save the health care system about $400 million to $500 million per year in direct hypertension costs and about $2 billion per year if one takes into account the reduction in cardiovascular events that would occur.

From our organization's perspective, about 75% to 80% of the sodium in the diet is coming from the processing of foods. Therefore, we believe that strong government action and resources are required to address this issue, in particular by setting targets and timelines for food categories to reduce dietary sodium, with close government monitoring, such that Canadians are eating a healthy quantity of dietary sodium.

This should be supplemented by secondary activities such as regulations to facilitate reduction in dietary sodium that may enhance industry compliance, education of Canadians, and addressing certain research needs to evaluate the success of the program in particular, but also the challenges faced in reducing dietary sodium.

I'll end my comments at that. Thank you.

The Chair: Thank you very much.

I was just asking the clerk, Dr. Campbell, if you had brought a presentation with you, and the clerk informs me that you haven't.

Dr. Norman Campbell: I didn't write my notes down, if that's what you're asking.

The Chair: We just want your sage words in writing, sir. It would be very nice if you could now distribute your notes among the group here.

We now have, presenting from the Canadian Restaurant and Foodservices Association, Ron Reaman, vice-president.

Thank you.

Mr. Ron Reaman (Vice-President, Federal, Canadian Restaurant and Foodservices Association): Thanks. I'm going to hand it over to my colleague, Joyce Reynolds, who will begin. We'll share the presentation time.

Ms. Joyce Reynolds (Executive Vice-President, Government Affairs, Canadian Restaurant and Foodservices Association): Thank you for the opportunity to speak to you today about the issue of sodium and the active role of Canada's restaurant and food services industry in playing a part in the solution.

The Canadian Restaurant and Foodservices Association is the largest hospitality association in the country, with 33,000 members. We comprise the quick and full-service restaurants, hotels, social and contract caterers, clubs, coffee shops, and pubs, as well as institutions such as hospitals, schools, and offices. We represent a $60 billion industry that employs over one million Canadians. Every dollar spent at a restaurant generates an additional $1.85 in spending in the rest of the economy, well above the average of all industries in Canada.

Food service is a very competitive business that operates on razor-thin margins. Rising food and labour costs reduce the pre-tax profit margin of the average operator to only 4.4% of operating revenue in 2007. In contrast, the average business in Canada enjoys a pre-tax profit of 7%.

Canada's restaurant and food services industry recognizes the challenges Canadians face managing busy, active lifestyles in a complex, modern world. That's why the restaurant industry offers a wide range of menu items to satisfy an increasingly diverse set of consumer demands.

● (1535)

The Chair: Ms. Reynolds, I'm sorry to interrupt, but we can't keep up to the translation. I know you only have five minutes, but perhaps condensing it would be a better idea. If you could do it so the translation could prevail, we'd appreciate it.

Thank you.

Ms. Joyce Reynolds: Okay. I will try.

Restaurants are responding to a growing number of dietary concerns and eating preferences, including low-fat, lactose-free, vegetarian, and locally sourced. Restaurant operators have diversified their menu mixes to ensure that Canadians have choices in menu offerings to meet their many needs.

We've established a nutrition and fitness round table. We've established voluntary nutrition disclosure through our nutrition information program, so many of our members with standardized menu items are able to provide nutrition information at point of sale as well as on their company websites, and can meet the many dietary concerns of our customers.

The restaurant industry has been a leader in addressing other nutrition and food safety related issues. For example, extensive work has been undertaken by the restaurant and food services industry to dramatically reduce and eliminate trans fats in the Canadian food supply.

In addition to committing a tremendous amount of resources to trans fat reductions, the industry has also begun the process of exploring opportunities for sodium reduction. We recognize that sodium is a serious and complex issue and that we are part of the solution. We commend you for studying it and look forward to working with you and other stakeholders on effective and workable solutions.

I will turn it over to Ron Reaman now.

Mr. Ron Reaman: Thanks again for the opportunity to speak with you today.

I want to assure all the members of this committee that Canada's restaurant and food services industry recognizes the importance and challenge of reducing sodium intake levels for Canadians. Many of our member companies are already working on product reformulation and testing of sodium-reduced products.

As you know, a process has been established in which government, industry, and the public health NGOs are working together under the aegis of Health Canada's multi-stakeholder working group on sodium reduction. We're fully committed to that process that is already under way, and we are hoping to play an active role in collectively achieving our shared goal, which is to reduce the overall intake levels of sodium by Canadians.

My industry has been working very hard to identify opportunities for success on a number of health-related reforms, as Joyce has already noted. While the industry is committed to doing our part and working collaboratively to achieve the reduced dietary sodium intake levels of Canadians, it is imperative to note some of the key challenges that face the food service industry as we move towards that success. You'll hear from some quarters that reducing sodium is a simple matter and that the food industry should just get on with doing it. While the industry has already begun to reduce sodium and develop lower sodium projects, the fact is that sodium plays a multi-faceted role in food, and we should not be misguided and oversimplify the complex. Among other things, we need to know that sodium is used as a stabilizer. It's used as a flavour enhancer. It's also used as an antimicrobial agent in support of food safety protocols.

I can't underscore strongly enough that the restaurant industry in particular is, above all, a consumer demand-driven business. We supply what our customers want, and we respond to meet those demands. For any sodium reduction strategy to be successful, we first need to educate the general public so they are able to shift their demand and acceptance of sodium-reduced products. This is a critical point in the overall equation of sodium reduction.

For the food services industry, sodium is a critical component in the taste profile of many signature menu items, a fact that cannot be dismissed when considering sodium reduction strategies. We must move judiciously to reduce sodium and reformulate products in order to ensure consumer acceptance of those projects. If we move too quickly, the consumer will reject the product and/or increase salt use after the point of purchase, in which case the only thing we would have achieved is the twin failure....

Do you want me to go faster now?

● (1540)

The Chair: No, I want you to look at wrapping up, because I've given you extra time.

Mr. Ron Reaman: Okay. Again, let me underscore our commitment to the process, that we are actively engaged with the sodium working group that has already been established by Health Canada. We're prepared to do our part in achieving greater sodium reductions by Canadians.

Thanks for the opportunity to speak with you today.

The Chair: There will be lots of time as we get into questions.

Thank you, Mr. Reaman.

Now we go to Bill Jeffery, national coordinator for the Center for Science in the Public Interest.

Mr. Bill Jeffery (National Coordinator, Centre for Science in the Public Interest): Thank you, Madam Chair.

The Centre for Science in the Public Interest is a non-profit consumer health advocacy organization specializing in nutrition issues, with offices in Ottawa and Washington, D.C. Our Ottawa health advocacy is funded by 120,000 subscriptions to the Canadian edition of our monthly *Nutrition Action Healthletter*, which you all receive. CSPI does not accept funding from industry or government, and *Nutrition Action* does not carry advertisements.

Last month the Centre for Science in the Public Interest published a report called “Salty to a Fault: Varied Sodium Levels Show Lowering Salt in Processed Foods *is* Feasible”. Experts agree that excess sodium intake kills more Canadians every year than does any other chemical substance. But in countries like Canada, three-quarters of the sodium comes from salt added to foods by food manufacturers and restaurants.

In “Salty to a Fault”, we reported samples of products in 41 categories of groceries and nine categories of restaurant foods that Health Canada and others consider to be major sources of sodium. These categories include soups; sandwiches, especially bread, cheese, and meat; salad dressings; cereals; sauces; and restaurant foods generally.

“Salty to a Fault” reveals that brands of foods often vary widely in sodium levels within otherwise comparable categories. For example, we found sodium levels ranging from 40 milligrams of sodium in a 70-gram serving of french fries at a Swiss Chalet restaurant, which leaves salting to the customer, to 555 milligrams in fries at Harvey's. Likewise, there were 320 milligrams of sodium in a half-cup serving of Classico tomato and basil pasta sauce, compared with 710 milligrams in Antico organic tomato and basil sauce.

Twofold variations were common among products that we surveyed.

Despite industry claims that large amounts of salt are needed to make dough rise, act as an emulsifying agent or anti-caking agent, or preserve and improve the taste of foods, these variations in our report reveal that it is demonstrably possible to make countless foods with less sodium, and many foods with much less sodium.

The expectations for success in Canada's efforts to reduce sodium are justifiably higher than for the United Kingdom or Finland. Those countries were both pioneers, and Canada has been able to learn from their experiences. Also, the Government of Canada has legal authority to refine regulations governing nutrition labelling, high-sodium warning labels, compositional standards for standardized staple foods such as cheese and pickles, and food additives, including low-sodium substitutes for salt, while Finland and the United Kingdom must defer to the European Union authority over many aspects of those regulatory options.

Nutrition labelling also has been mandatory for most foods in Canada since December 2005. This helps officials and our organization monitor sodium levels in prepackaged foods, though not in restaurants, and identify the range of sodium levels within categories of comparable products.

Our report makes 12 recommendations. I will highlight a few.

First, setting and monitoring category-specific sodium reduction targets must be combined with mandatory front-of-pack warning labels for high-sodium products.

Second, the daily value for sodium specified in the food and drug regulations—used as the basis for nutrition facts label information—should be reduced from 2,400 milligrams to 1,500 milligrams.

Third, serving sizes upon which nutrition facts information is reported on food labels should be based on the standardized reference amounts specified in schedule M of the food and drug regulations, or other appropriate standardized sizes, and not left to the unfettered discretion of manufacturers.

Fourth, the food and drug regulations limiting the scope of the nutrition facts requirements to prepackaged foods should be expanded to ensure that at least the amounts of calories and warning labels for high-sodium foods be posted on the menus or menu boards of large chain restaurants with interprovincial operations.

And last, *Canada's Food Guide* should be revised to highlight the importance of, and strengthen advice about, reducing sodium intake.

In closing, setting and monitoring achievement of sodium reduction targets for at least several dozen food categories is the cornerstone of an effective sodium reduction strategy.

● (1545)

Companies' efforts to achieve those targets should begin now. They should not wait until the sodium working group report is published.

However, to ensure that Canadian sodium reduction targets are successful, regulatory amendments are needed to eliminate some impediments to reductions, and new regulations may be needed to mandate targets currently envisioned as voluntary if the call for sodium reductions is not taken seriously by affected companies.

Minister of Health Aglukkaq needn't wait to impress upon companies the importance of reducing sodium levels. Health Canada's message should be clear: salt should be used judiciously in foods, not gratuitously. Persistently gratuitous use of salt should be met with regulatory action.

Thank you, Madam Chair.

The Chair: Thank you.

We'll now go to Phyllis Tanaka, vice-president of scientific and regulatory affairs.

Ms. Phyllis Tanaka (Vice-President, Scientific and Regulatory Affairs (Food Policy), Food and Consumer Products of Canada): Good afternoon.

Food and Consumer Products of Canada welcomes this opportunity to speak to the Standing Committee on Health. FCPC is the largest industry association in Canada, representing the food and consumer products industry.

The points I will make in the next few minutes, while more succinct, capture the key elements of the full FCPC submission in support of briefing this committee on sodium, and I will focus on looking at the Blood Pressure Canada recommendations, the CSPI recommendations, and the work of the multi-stakeholder working group.

The recommendations out of Blood Pressure Canada's policy statement and the Centre for Science in the Public Interest report, as is evident in appendix 1 of these speaking notes, have common elements, and both direct their recommendations to Health Canada. From FCPC's perspective, Health Canada has listened.

Blood Pressure Canada's policy statement was made available to Health Canada in 2006. Their recommendation to establish a multi-sectoral task force to address this public health matter was taken very seriously. I received my invitation to become part of the Health Canada-led multi-stakeholder working group on sodium reduction in 2007.

Health Canada was very thoughtful in shaping the working group. The stakeholders invited to take part ensured that all perspectives and expertise required to develop an effective strategy were involved. Representatives from the scientific and health professional community, health-focused and consumer non-governmental agencies, the food products and food service industry, and government agencies sit on the working group. The actions of the working group are in line with recommendations common to both Blood Pressure Canada's policy statement and the more recent CSPI report.

The working group is establishing goals based on the dietary reference intakes reports of the Institute of Medicine at the National Academy of Sciences. The working group has listened to experts from Finland and the United Kingdom on their sodium reduction strategies. This has helped the working group develop consensus on the need for a strategy that's built on graduated targets.

The working group has established a three-pronged approach, one that involves education, voluntary reduction of sodium levels in processed food products and food sold in food service establishments, and research. From FCPC's perspective, a three-pronged approach is critical to success.

The food-manufacturing industry is engaged in product reformulation and product development research to reduce sodium levels in processed food products. In fact, at the public consultations held by the working group in February of this year, a number of food manufacturing companies spoke to the work they are undertaking. However, the food manufacturing industry knows that such endeavours will succeed only if accompanied by a concurrent consumer awareness education campaign. The successful reduction of sodium in the diets of Canadians will only happen if, in concert with changing the food supply, Canadians are informed on why this is happening. Also, this information must come from a respected third-party source, such as Health Canada, if it is to resonate.

Finally, the working group knows that a monitoring and assessment process is integral to success. The requirement is captured within the working group's terms of reference. There are four stages to the terms of reference: the preparatory or information gathering stage; the assessment or review of data gathered stage; the strategic framework development stage; and the implementation stage, which has built into it the mandate to oversee implementation and monitor progress.

As a point of reference, the working group is currently winding up its assessment stage and moving into the strategic framework development stage.

● (1550)

In summary, FCPC believes that the leadership being provided by Health Canada in leading this multi-stakeholder working group process is resulting in a strategy that will lead to the successful reduction of sodium levels in the diets of Canadians. FCPC believes the driving concern behind both Blood Pressure Canada's policy statement and the CSPI report is being addressed.

Thank you very much.

The Chair: Thank you very much, Ms. Tanaka.

We'll now go to Dr. Mary L'Abbé from the University of Toronto.

Welcome.

Dr. Mary L'Abbé (Earle W. McHenry Professor, Chair, Department of Nutritional Sciences, Faculty of Medicine, University of Toronto): Thank you very much, Madam Chair and members of the committee.

I am pleased to attend this session, and I appreciate the opportunity to speak to you today about the sources of sodium in our food supply. I'm a professor at the University of Toronto and the chair of the department of nutritional sciences there. I'm also the vice-chair of the sodium working group.

In preparation for my remarks today I've provided you with two figures that I thought might be useful to help you understand where sodium is in the foods we eat. This data is from the Canadian community health survey, and it's very valuable to help us understand where the sodium is in our food supply. It's also the first national survey of nutrition that has been done in Canada in the last 30 years.

I would like to draw your attention to the first data I've presented to you on the pie chart and explain what was done here. I believe it was handed out to members. This is data from the community health survey where the food sources of sodium have been divided into the various groups. You can see that sandwiches have been split into the components of bread, meat, and cheese. All of those have been divided into the various food components.

When we do that we see that the major source of sodium in the diets of Canadians is bread products. This is followed by processed meats, vegetable juice, vegetable products, soups, and then pasta dishes. Even foods such as cheese and milk products contain significant amounts of sodium. You can see that in the bottom of the circle. This is followed by a number of meat and poultry dishes. In the case of these mixed dishes, the sodium usually comes not from the meat itself but from many of the other ingredients, such as sauces and batters, that are added to these mixed dishes.

It is also worth noting some of the other food categories on the left-hand side. Things like breakfast cereals, potatoes, fish, rice dishes, and eggs are not normally products that Canadians would consider salty, but in actual fact they provide more sodium in our diets than things like potato chips and salty snacks, which the consumer might think of as being the salty sources of foods in the food supply.

In summary, there are two important features about this data that I have presented to you. One is it reflects the total amount of sodium that people consume. Things like bread may only be moderate in their level of sodium, but Canadians consume substantial amounts. On the whole, they eat relatively large quantities of a product like bread and they consume it virtually every day. Secondly, there's no one food group or few food groups that provide most of the sodium. Reducing sodium will mean changes have to occur in virtually every food group and food product in the marketplace if we are to achieve meaningful reductions in our sodium intake.

The second figure gives you a snapshot of some of the ranges of sodium that we see in these foods that I've spoken to you about. They're not meant to single out any one particular brand because these are fairly typical of the types and levels you'd see in a food category, although, as Mr. Jeffery has pointed out, there is still tremendous variability within each of these groups.

So you can find high-sodium cereals or low-sodium ones, or vice versa, in the salty snacks. If you look at this table you can see that the breads have only about 300 milligrams of sodium, which is a moderate amount. Some of the soups, pogos, and hot dogs will have about double that amount, about 500 or 600 milligrams. That's approaching one-third to one-half of the sodium that's recommended for a whole day.

Then you can get into some of these mixed dishes. The product in the corner provides almost the total recommended amount that you would consume in a day.

A consumer might think the mixed sandwich is a healthy product because it has whole wheat and less than six grams of fat. But that product contains almost the upper level for sodium for a whole day. You might have a couple slices of bread with that or a dessert, or some other food as part of your meal.

So the take-home message here is that sodium is found throughout our food supply and consumers do not necessarily see these as salty foods.

● (1555)

With these remarks, I would like to thank you for giving me the opportunity to speak to you today about the sources of sodium in our food supply.

Thank you very much.

The Chair: I want to thank our guests for their insightful comments today.

We'll now go to the first round of questions and answers. It will be seven minutes for the question and the answer, per person.

We'll start with Dr. Bennett.

Hon. Carolyn Bennett (St. Paul's, Lib.): Thank you very much, and thank you all for coming.

As you know, we are in level six of a pandemic and we sort of have some concern that we need to get back to that.

I understand you are all part of the sodium working group—is that right?—and that it was established by the minister in October 2007. Obviously, we want to know what the working group will come up with. I would like to know when it will report.

In looking at the terms of reference of your working group, it seems to say that you will develop, implement, and oversee a population health strategy based on the recommendations of the Institute of Medicine. It then says that there will be a three-pronged approach: education, a voluntary reduction of sodium levels in processed foods, and research.

I have some concerns. To me, a strategy is what, by when, and how? We already have the what, which is that you want to have Canadians at the Institute of Medicine level. I guess I want to know what's been happening over the last two and a half years. And how do we get going? Is this mandate broad enough for you to do what you need to do? How long did it take to figure out that Canadian All-Bran shouldn't be three times as much as the All-Brans around the world? Do you have enough money to do it? How come you're working in such an invisible way that if it weren't for the *Globe and Mail*, nobody would even know that there's salt in bread, I don't think.

Without a citizen engagement strategy, without a transparent process for your working group, without some targets, and without adequate resources, I'm a bit concerned that you're not going to get where you need to be, if indeed you're supposed to report in the spring.

I'm not really sure whether the members of this committee knew that this group was already working and is supposed to report. Talk about a silent killer—this is a silent working group that doesn't seem to have the profile it needs to do the job. Do you need more money? Do you need a better process? How are you going to engage Canadians in this job? How on earth would you sit on a committee where you're restricted to voluntary approaches only if that's all you're allowed to report?

● (1600)

The Chair: Who would like to take this myriad of questions?

Perhaps a couple of people would like to engage. Dr. Campbell, do you want to begin?

Dr. Norman Campbell: Sure, I can address some but not all of those issues.

I think one thing that's very clear is that the working group needs very substantive resources to mount an education campaign for Canadians so that they understand the health risks of high dietary sodium, they understand where the sodium is coming from, and they understand what they can do. I think that much is very clear.

From the point of view of our organization, we've been very active in trying to educate Canadians within the means and mechanisms we have at our disposal. We have an extensive network of health care professionals across Canada, including all primary care disciplines. We've been developing resources for those health care professionals to educate them, and we have provided resources that they can provide to their patients. I think this is insufficient to do the trick, but it is certainly one of the things that's available to our particular community.

Hon. Carolyn Bennett: Maybe Dr. L'Abbé could tell us what the budget is for the working group and what, so far, has been spent on public education.

Dr. Mary L'Abbé: I can't speak directly to the budget, but Health Canada has spent in excess of several hundred thousand dollars a year supporting the work of the sodium working group, and that was through our early stages. I appreciate the comments of Dr. Campbell. I think the working group spent, at the last meeting, a significant amount of their time looking at what a good education campaign to develop a strategy and awareness campaign about sodium and blood pressure in Canadians would be. And that would take significantly more resources than has been dedicated to this.

Hon. Carolyn Bennett: But are you not a bit disappointed that after two years...? This is an advertising agency's problem, not a problem with the science. The science is there. Why can't we just start?

Dr. Mary L'Abbé: In all fairness to the committee, they have worked very hard. There was an open, public consultation in February this year. We are disappointed that we had to delay it. There was an election in the interim. We had planned it for last September, so a year ago—

Hon. Carolyn Bennett: You can speak to the Prime Minister about that.

Dr. Mary L'Abbé: That's the life of advisory committees. They are shut down during an election call.

We did have public hearings in February of this year.

Hon. Carolyn Bennett: Members of Parliament didn't know that. How can you have public hearings without even the public representatives knowing?

Dr. Mary L'Abbé: There were more than several hundred, as well as an announcement on the website. Hundreds of replies came in from consumers and consumer organizations, as well as industry and the health NGOs. We don't have the resources to do that type of—

Hon. Carolyn Bennett: How many more resources would you need? Members of Parliament would be happy to put an announcement in our householders for free. Any time you want publicity, give us the camera-ready art and we'll put it in our householders.

Dr. Mary L'Abbé: That's a wonderful opportunity. The working group would love to take you up on that. They are busy working away on an education campaign, so that would be a useful vehicle.

I would also like to say that over the spring and through the summer there were—as Ms. Tanaka mentioned—three subcommittees of the group. They focused on three components, working hand-in-hand with the staff at Health Canada. We have now come up with draft targets for the food supply, and last spring we were understanding where the food supply was.

Those are the targets that are necessary to reduce the sodium levels in Canadian foods so that Canadians can get to those levels of the IOM. Those targets have been based on where Canadians are consuming their sodium. So that is a big step forward, as well as the education campaign. We're pleased to say that the Canadian Institutes of Health Research have come on board to help us with the research necessary to support the work of the working group.

● (1605)

The Chair: Thank you, Dr. L'Abbé.

We'll now go to Dr. Malo.

[*Translation*]

Mr. Luc Malo (Verchères—Les Patriotes, BQ): Thank you very much, Madam Chair.

I want to thank our witnesses for being here this afternoon.

We have heard a lot of very important things regarding a collective effort to reduce Canadians' daily intake of salt. We know that studies have been done indicating that way too many people consume more salt than is acceptable. We heard that, of all chemical substances, salt is the leading cause of death and that there is a misconception among consumers about the amount of salt they consume. We also learned that salt has a major impact on the number of cases of disease and, as a result, on healthcare costs, as shown by a survey done by World Action on Salt and Health. The survey revealed that, in Canada, the salt content in a number of products was among the highest in the world, while the salt content in the United Kingdom was among the lowest. In addition, a very targeted campaign was organized to reduce salt consumption. Like Ms. Bennett, I would like to know what the group did. I also want to know when the findings will be made public and when action will be taken.

Ms. Tanaka, you said that the sodium working group studied the British model. What lessons have you learned from that model?

Ms. Reynolds, you also encouraged the committee to study this issue. What can the committee do to help your group and to ensure that consumer products contain less salt in the coming months? As some studies have shown, between 75% and 80% of the salt consumed daily comes from processed foods, not the salt shaker.

[*English*]

The Chair: Who would like to take that?

Ms. Reynolds.

Ms. Joyce Reynolds: We are educating our members about the sodium issue. We've developed a booklet similar to those we developed on trans fat and nutrition labelling in our nutrition information program. These are available on our website to all restaurant operators right across the country.

But the key point we want to make is that this has to be a coordinated, industry-wide, nationwide approach. There is no point in one sector of the economy reducing sodium levels if the consuming public doesn't understand why. They have to understand that they have to adjust their palates, and that takes time. We're all working in our individual sectors, and the working group is trying to coordinate all of that work.

[*Translation*]

Mr. Luc Malo: What can the committee do?

[*English*]

Mr. Ron Reaman: The working group looked at the U.K. and found that their government dedicated something on the order of $36 million to a public education and awareness campaign. This is going to be a critical piece of the success story around sodium reduction in Canada. We would implore this committee to lend support to this effort, and that is going to have to translate into dollars coming from the public purse.

My industry is working to educate our members, and our members will work at their level. But there has to be a concerted effort. The funding has to come from more than one sector. The Government of Canada needs to show leadership in this effort, needs to demonstrate its commitment to the process.

● (1610)

The Chair: Mr. Jeffery.

Mr. Bill Jeffery: I can't speak for the committee—I defer to Dr. L'Abbé for that—but this committee could emphasize to government the need for regulatory amendments to facilitate the transition. We've looked at models from Finland and the United Kingdom. They produced some benefits, but their sodium levels are still on a par with ours.

We'd like to see some more ambitious outcomes. It may well be that the calls for voluntary efforts will be insufficient. If that proves to be the case, I hope we'll find out immediately and move to etch some of those targets in regulations.

More resources for the committee or Health Canada to mount a public education campaign are important. We read the householders at our house. We're probably not alone in that, but we're at least lonely. We had envisioned a more sophisticated media strategy that involved television messaging.

The Chair: Dr. Campbell.

Dr. Norman Campbell: It's important to recognize some of the barriers that are faced. Overcoming them will require interactions between Health Canada, individual food companies, and groups of food companies. This is going to require the hiring of trained personnel. There are going to have to be negotiations about the targets and timelines, and this will require technical expertise in the relevant foods. That will mean hiring people and obtaining monetary resources.

The actual surveillance is complex and has to be representative of the Canadian population. There is a mechanism for that: the Canadian health measures survey. It's ongoing but it will need additional resources for the sodium monitoring—and that's on top of the education. This will probably come to $10 million to $20 million a year.

The cost savings from reduced need for antihypertensive agents will be around $300 million a year. So there is a monetary investment, but there is a direct, accelerated return on investment.

The Chair: Ms. Wasylycia-Leis.

Ms. Judy Wasylycia-Leis (Winnipeg North, NDP): Thank you, Madam Chairperson. And my thanks to all of you for being here to discuss an issue critical to the health and well-being of this country.

I just spoke to Dr. Eldon Smith, who is involved in the heart health strategy. As I understand it, there are more deaths from heart disease and stroke than from all other chronic diseases put together. An important factor in this situation is high sodium. In fact, the news reports indicate that reduced sodium intake could reduce the number of people who have heart attacks and strokes by 11,500. That's a lot of people who would be affected by action on this front.

Your committee was set up almost two years ago, and it was to come up with a plan of action. Do you have a plan of action you can present to us today?

The Chair: Who would like to take that question?

Dr. L'Abbé.

Dr. Mary L'Abbé: I would say the sodium working group has the nexus of a plan. We have discussed and decided upon certain elements, and I can elaborate a couple of them for you.

For example, the sodium working group has decided the strategy should be phased so that we have set some targets that should be brought in, in a number of years, and in more aggressive timelines later. We recognize we need to get some immediate timelines and immediate targets so we can get the benefits that would be achieved with those. We have reviewed a very significant sodium education and awareness strategy, but obviously we would be looking to government to have the funds to support that, although I must say I was heartened by the support around the table of a number of the health NGOs and other sectors as well as industry indicating their willingness to participate in a large national campaign directed toward sodium awareness. So the components are there, but the specifics are not, and I think those would likely come in the form of our report later on this year or early next year.

Ms. Judy Wasylycia-Leis: I guess I'd echo some of the concerns that Carolyn raised. If it hadn't been for Carly Weeks in the *Globe and Mail* , and some other work done by CBC, I don't think any of us would have necessarily been confronted with the significance of this problem. Maybe that's partly the work you're doing behind the scenes, but I think most of us really didn't know what you were doing. Now we hear it's going to be another year, so there is a concern about this. This is such an urgent issue. What is taking so long? I guess we're here to see if we can help move this along as quickly as possible.

My follow-up question is this. If the key to all of this is setting targets to reduce sodium intake—and we know that Canadians now have on average 3,500 milligrams of sodium a day and it should be more like, I think you're saying, between 1,200 and 2,300—have you agreed on a target?

● (1615)

Dr. Mary L'Abbé: I will say yes.

Ms. Judy Wasylycia-Leis: What's your agreement?

Dr. Mary L'Abbé: We've agreed our first target is to get the Canadian population down to the UL. We think that is the first achievable milestone that we can—

Ms. Judy Wasylycia-Leis: What's UL?

Dr. Mary L'Abbé: That's the upper level, the 2,300.

That would mean a significant reduction in sodium intake by the Canadian population. And we feel that although that might—

Ms. Judy Wasylycia-Leis: Significant enough to achieve some instant reduction in some of these numbers that are killing people?

Dr. Mary L'Abbé: The experience in a number of countries is that even.... We discussed things like 5% per year; those would translate into significant lives lost. I think Dr. Campbell is a better expert at doing the calculations, but the feeling is that that gradual, sustained, continuous change in the food supply over time is the approach to take. And that is the approach that has been used, for example, in the U.K. system. The working group has borrowed very heavily on its experience to develop the targets for Canada, or draft targets at this point.

Ms. Judy Wasylycia-Leis: I'd love to hear from Dr. Campbell.

While you answer that, maybe you could also answer the question of a voluntary versus a regulatory approach, because I think we've learned from the trans fat experience that voluntary only takes you so far. At some point, industry starts to feel the pain of a system that has some complying and others not, and that causes serious concerns in terms of the food and restaurant association, I'm sure. So wouldn't it be better to get right to it and set some definitive targets?

Dr. Norman Campbell: We've been a while setting the targets. The ultimate target is to get us down to between the adequate intake level, which is 1,500 milligrams for an adult of average age, but is considerably lower for a younger or an older individual, and the upper limit target is likely going to be around 2,020.

It was felt that it was important to get an interim target that was feasible and could be achieved. That's 2,300 milligrams in 2016, and that requires about 5% per year. In Finland, that achieved 40% reductions. It took them about 20 years to achieve that. In the U.K., they're achieving somewhat over 2% per year. So it's a fairly substantive effort that Canada is trying to achieve.

It's important. Each year, as you know, we're estimating that 11,500 people have a cardiovascular event while we're waiting to achieve these targets. So from my own perspective, it's quite urgent that we do so, but we must do so in a way that we're actually able to achieve. I think that's going to require very strong government oversight, with voluntarism.

There will be good corporate citizens that toe the line. There will be companies that try to avoid the issue, potentially to gain a commercial leg up on some of their competitors. If that's a substantive problem, I'm guessing that our good corporations will be advocating for regulations.

I'm told that's actually starting to be the case in the U.K., where a number of companies really have made substantive reductions and are looking at some of their confreres who haven't. Some companies are requesting regulation.

In Finland, there were a number of regulations introduced, including high-sodium warnings on food. In Portugal, the amount of sodium in bread products was regulated, and that was the highest source of sodium there.

The advantage to regulations is that there is a very rapid change, but sometimes regulations can take considerable time. The model we're looking at, which currently is probably the most defensible one in the world, is the U.K. model, where it is voluntarism, but voluntarism with strong government oversight and with the threat of regulations should there be failure to comply.

The Chair: Thank you, Dr. Campbell.

We'll now go to Dr. Carrie.

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

First of all, I want to thank the witnesses for being here.

I want you to know that we as a committee are committed to studying healthy food. It's one of the things that was brought up as one of our priorities, but personally, I'd like to admit first that I am a recovering saltaholic. I love the stuff, but I'm okay now. When the salt shaker's passed, I do get some shakes, but overall I think I'm doing much better.

I was shocked, Dr. L'Abbé, by one of your handouts. I look at some of the food on there and see that the numbers are really high. I am aware that the industry is taking this seriously. I have been visited by one of the major potato chip manufacturers, another product that I love, and they've taken a lot of action already to lower the amount of sodium.

But I am concerned. My colleague brought up World Action on Salt and Health, and sodium levels in selected products internationally, and bran flakes were mentioned. In Canada, the stated number was 861 milligrams for a serving, but in the U.S. it's only 258. Onion rings, another favourite of mine, in Canada are at 681, while in the U.K. it's down to 159. Popcorn chicken in Canada is at 908 and even Malaysia has it at 560 milligrams.

When I look at these differences internationally, I think there's an obvious question. How does Canada compare to other countries with respect to sodium intake? I was wondering if you have a hypothesis for why. Is it cultural reasons? Is it historic reasons? When I see numbers like that for the amount of sodium we have in products, that looks to me like the average MP's diet.

Voices: Oh, oh!

Mr. Colin Carrie: Why the big difference? How does Canada compare? Could you comment, please?

● (1620)

The Chair: Who would like to answer that?

Ms. Phyllis Tanaka: As we're a trade association, I obviously can't speak on behalf of individual companies, but yes, it is known that there are differences between products in different parts of the world, and it can be on both sides of the fence. There will be some products in Canada that are lower in sodium than they are in the U. K., for instance.

But you did point out that you wondered how we compared to other countries with respect to our population's sodium intake. In fact, in Canada, while we are high at 3,100 milligrams per day, if we compare that to the U.K., their population's sodium intake when they started out was much higher. Looking at individual products doesn't give a full picture of all the elements that shape the population health status of different countries.

Mr. Colin Carrie: Dr. Campbell.

Dr. Norman Campbell: Both the Stroke Network and Blood Pressure Canada collaborated on the World Action on Salt and Health survey, but we went into that enthusiastically, thinking Canada would look very good because we had had two to three years of widespread publicity around the issue, and we thought Canadian companies would respond. I think most of us were totally shocked when the results of the survey came out, and it was very disheartening. I think it indicates that a lot of companies have the exact same product in a different country that's very low in sodium, and it speaks favourably for impacts that we could have.

Notably, high sodium is not an issue for just Canada, it's a world issue. Sodium is added to food around the world. It's one of the priorities of the World Health Organization. Very recently the Pan American Health Organization struck a sodium committee to try to develop policy recommendations for reducing sodium in the countries of the Americas, some of which have very high rates. Notably, stroke rates around the world correlate very closely to sodium intake, and that's because they are associated with high blood pressure, but also some other health issues such as gastric cancer. High dietary sodium is also a procarcinogen and has other potential adverse health effects.

Mr. Colin Carrie: We are trying to send a message to the average Canadian that eating well and staying active is really important for a “healthier you”. I was wondering if you could give the committee an opinion on why sodium is such a high-priority issue when we have other things like fat—we talked about trans fat—and sugar. Why is sodium such a big priority relative to other things?

● (1625)

Dr. Norman Campbell: Just recently I was invited down to the Centers for Disease Control and Prevention in the United States, where they're restructuring how they deal with their health system and they're looking at the major risks to health in their population and how feasible it is to deal with them.

Number one, increased blood pressure is the leading risk for death in the world. That's from complex analyses done by the World Health Organization, and it relates to the fact that blood vessels are everywhere in your body and that increased blood pressure damages them.

The leading causes of death in our country are stroke and heart disease, and high blood pressure accounts for about 66% of strokes and about half of heart disease. The increase in blood pressure that we experience in our society is not experienced in primitive societies where they eat unprocessed foods, are lean, and are physically active. When we look at the different reasons for increased blood pressure, we see they relate to a number of dietary factors—high caloric intake, saturated fats, low calcium, low magnesium, low fibre—but in a large proportion, high dietary sodium is one of those big contributors.

As I indicated earlier, about 30% of hypertension in Canada, the clinical diagnosis, would be associated with high dietary sodium. When it's examined how much you're going to pay for how much you're going to get out of it, again, international analyses have suggested the most cost-effective way to improve the health of the population is to reduce dietary sodium. This includes reduction in tobacco smoking, which is viewed as highly cost effective. But reducing dietary sodium will get you more bang for your buck. That's why there's a focus on it.

That's not to suggest that other health issues are not critically important and shouldn't be dealt with. We do have Canada's guide to healthy eating, which indicates what we should be eating. Perhaps we need an overarching strategy on how we can get the Canadian population to eat that way, as opposed to just putting it out as a nice handout.

Mr. Colin Carrie: Madam Chair, just briefly, can we ask if anybody else has an opinion on that, or does everybody agree with Dr. Campbell?

The Chair: We'll have to wrap up with Mr. Jeffery. I'm sorry, Monsieur Malo, we've run out of time.

Briefly, Mr. Jeffery.

Mr. Bill Jeffery: With regard to the nutrients you identified, trans fat and sodium, excess sodium intake is responsible for about four times as many deaths as trans fat by some estimates. However, we're still talking about thousands of premature deaths per year. The World Health Organization, in May of this year, issued a scientific update on trans fat, indicating that the scientific case is even stronger for getting it out of the food supply. But we still have this voluntary program, and we're waiting to find out if the Minister of Health is going to make good on Health Canada's call for regulations in the absence of strong action from industry.

There are other factors to consider too. Canadians get inadequate intakes of fruits and vegetables and whole grains and legumes, and those are all important risk factors. They're just not as well studied in terms of the actual population level implications in terms of premature deaths, but they are important too.

The Chair: Thank you, Mr. Jeffery.

We're going to have to bring this to a close. Perhaps we can have this topic on another day. It's very interesting and I think more questions are pending.

I want to thank you very much for being here.

I would like to ask now that we suspend for two minutes to allow our next guests to come to the table.

●

(Pause)

●

● (1635)

The Chair: I will ask all members to come to the table, please.

I would also like to ask all witnesses to come and take their places. We're quite looking forward to your presentations today.

We're now going into the second hour, which will be the H1N1 preparedness and response.

We have four organizations represented today. Starting with the Canadian Nurses Association, Rachel Bard is the chief executive officer. Welcome, Rachel. And we have Della Faulkner, nurse consultant, public policy.

We have five-minute presentations today, Ms. Bard. We have a lot of presentations and we want to make sure there's an opportunity to ask questions as well. When you see this light on red, I need you to wrap up before very long.

Welcome, and we look forward to listening to your presentation.

Ms. Rachel Bard (Chief Executive Officer, Canadian Nurses Association): *Bonjour.*

I am certainly pleased, as the chief executive officer of the Canadian Nurses Association representing registered nurses from across the country, to have the opportunity to present. Thank you very much for the opportunity to present nurses' solutions to successfully managing the H1N1 influenza pandemic.

Our analysis of the implementation of the pandemic plan to date reveals several improvements since the last public health crisis—namely, SARS—but also several areas that require action. Let me begin with the strengths.

First, we commend Minister Aglukkaq and our Chief Public Health Officer for their regular communication with the public and health professionals. CNA appreciates the regular opportunities for communication with officials at the Public Health Agency and the minister's outreach to Canada's nurses.

Second, consultation with the health professionals has been fairly extensive. CNA and other national health professional groups have been consulted on a number of policy documents, including PHAC's guidance on the sequencing of vaccine delivery and the development of an online course for health professionals.

Third, we support PHAC's efforts to provide an evidence-based approach to the pandemic, using data and information from around the world to inform our implementation.

This is not to say that there isn't room for improvement. Coordination is a challenge, especially as it relates to communication. Canada's registered nurses tell us that they are receiving communications from multiple sources, and not all of the messages are consistent. They receive information from PHAC, their provincial or territorial government, their local public health unit, their employer, and the media, and I could go on.

While we recognize the responsibilities of various governments and stakeholders, we need to find a way to coordinate and streamline our communications. We urge the federal government to lead this effort by ensuring consistent and timely messages, policies, and implementation. Without this, we will confuse health professionals and the public and erode trust in our public health system and governments.

Health professionals are inundated with information that is critical to their practice. From the very onset of this pandemic, CNA has called on the federal government to produce for health professionals factual and consistent guidelines that are user-friendly and easy to access. Given that health professionals may be operating under difficult conditions, it is imperative that they be able to quickly refer to a definitive source of information that focuses on essential facts. This information must be available in both paper-based and electronic formats in order to reach nurses and other health professionals in all corners of the country.

Our second concern is for protecting the health and availability of nurses during this pandemic. Nurses tell us that some employers have not offered fit testing for N95 masks, or that N95 masks are not available. Imagine how the health system will fare if the largest group of health professionals, that being nurses, fall ill and can't report to work. We need your help to ensure that Canada's nurses are protected.

Third, the electronic health record is an essential component in the real-time tracking and reporting of patient information during public health emergencies. Continued investment in e-health is critical. We therefore urge the federal government to release the $500 million announced in the federal budget for Infoway to continue implementation of the electronic health record.

Finally, we believe this pandemic points to the need for better research to observe and evaluate the allocation of nursing research. Lessons learned will inform our action this time around, help us improve our level of emergency preparedness, and benefit all Canadians in the future.

Canada's registered nurses and CNA are ready and willing to work with governments to minimize the effects of this pandemic. RNs have the skills and knowledge to play a number of key roles.

● (1640)

In fact, CNA's provincial and territorial members have been working with their governments to expedite registration for recently retired nurses so that they can take an active role in dealing with the crisis.

Canada's registered nurses are partners with government in this pandemic.

Merci beaucoup.

The Chair: Thank you very much, Ms. Bard.

We'll now go to the Canadian Federation of Nurses Unions.

Welcome to Linda Silas, the president.

Ms. Linda Silas (President, Canadian Federation of Nurses Unions): Thank you.

My remarks will focus specifically on infection prevention and safety in the health care system.

It appears that, with the exception of Ontario, the provinces and territories are set to follow the Canadian pandemic guidelines, which are based on occupational health and hygiene, not safety. If the federal government releases and accepts these as they are currently drafted, and the provinces and territories accept them verbatim, a nurse in Ontario will be better protected than the other nurses across our country. This is not the message our members or the public want to hear. They want to know that all levels of government are taking all possible precautions to eliminate, and where that is not possible, to minimize, the risk to health care workers.

Let me remind the committee, and I'll quote from its website, that the Public Health Agency of Canada was created for “clear federal leadership on issues concerning public health”. As a nurses' union, we think the Public Health Agency of Canada is setting a gold standard for public health concerns generally. We need the same clear leadership in annex F, which is on employee personal protection. If PHAC cannot provide this leadership because of so-called jurisdictional issues around workplace occupational health and safety, we believe that silence from the federal government would be better than the lowest common denominator.

We feel strongly that the use of occupational health and hygiene as opposed to occupational health and safety downplays the legitimate work and concern in the field of occupational health and safety, that is, workplace and employee-focused safety. If safety standards are used for firefighters, miners, and police officers, they must also be the standards used for nurses and other health care workers. As reported by the SARS Commission, the precautionary principle generally impacts worker safety.

We can have a battle of words, and let me tell you, we've been having it—researcher X said this and researcher Y said that—but what we all agree on is that the evidence is not clear. What we have learned from SARS is that it's too dangerous to wait for conclusive science before deciding on protective measures. Therefore, while scientific debates persist, we have to exercise the precautionary principle: be safe, not sorry.

Another example of our disbelief in the direction PHAC is taking in annex F are the tools suggested to determine that a health care worker is at risk. An employee is required to navigate through four separate tables, which is very confusing and inefficient. If we simply applied the precautionary principle, we would have health care workers equipped with N95 respirators when in a room or in an area with a patient who has an influenza-like illness during the pandemic. There's no need to navigate through a maze of confusing guidelines. There's no need to place that on a nurse who will be working at 4 a.m., when most everyone in Ottawa will be sleeping. She will be there to defend her own safety and the safety of her patient. We will not accept this.

This doesn't mean that everyone in a hospital needs to wear an N95. Let's be clear. We can determine who actually needs respirators by conducting risk assessments.

Let me remind you that of the 251 probable cases of SARS in Canada in 2003, 247 were from Ontario. Of these probable cases, 77% were exposed in the health care sector. Two of our members died there. Health care workers made up half of these cases.

Ontario has incorporated the precautionary principle in occupational health and safety in its pandemic influenza plan. We urge you to protect health care workers and to make SARS the lesson for national lessons. If PHAC won't do it, nurses will.

Merci beaucoup.

● (1645)

The Chair: Thank you.

We'll now go to Dr. Doig from the Canadian Medical Association.

Dr. Anne Doig (President, Canadian Medical Association): Thank you.

Good afternoon, Madam Chair.

The Canadian Medical Association is pleased to address the committee as part of its ongoing study of H1N1 planning and response.

In the broad context of pandemic planning, the CMA has focused on developing information and education tools on its website to ensure that Canada's doctors are equipped to provide the best possible care to patients. We have also engaged in discussion with the Assembly of First Nations to address workforce shortages in first nations and Inuit communities during a pandemic. Despite the work of governments and others, there remains much to do.

To provide optimal patient care, individual physicians—primary care providers and specialists alike—require regular updates on the status of H1N1 in their communities; timely and easy access to diagnostic treatment recommendations, with clear messages tailored to their service levels; rapid responses to questions; and adequate supplies of key resources such as masks, medications, diagnostic kits, and vaccines.

The CMA commends federal, provincial, and territorial governments for creating the Canadian pandemic influenza plan for the health care sector. The CMA was pleased to provide feedback on elements of the plan, and we are participating on the antiviral and clinical care task groups.

There are three issues that still must be addressed: the communications gap between public health officials and front-line providers; the lack of adequate resources on the front lines; and variability that exists across the country.

Physicians must be involved in the planning stages and must receive consistent, timely, and practical plain-language information. They should not have to seek out information from various websites or other sources, or through the media. This communication gap also includes a gap between information and action. For example, we are told to keep at least a six-foot distance between an infected patient and other patients and staff. This will not be possible in a doctor's waiting room, nor will disinfecting examining and waiting rooms in between each patient.

Patient volumes may increase dramatically, and there are serious concerns about how to manage supplies if an office is overwhelmed. There is also considerable concern over whether we can keep enough health care professionals healthy to care for patients and whether we have enough respirators and specialty equipment to treat patients.

Intensive care units of hospitals can also expect to be severely strained as a second-wave pandemic hits. This speaks to a general lack of surge capacity within the system. Also, pandemic planning for ICUs and other hospital units must include protocols to determine which patients can benefit most when there are not enough respirators and personnel to provide the required care for all who need it.

Beyond the need for more supplies, however, there is also the concern that there are only so many hours in a day. Doctors will always strive to provide care for those who need it, but if treating H1N1 cases takes all of our time, who will be available to care for patients with other conditions?

The CMA has consulted with provincial and territorial medical associations. Their levels of involvement in government planning and general state of preparedness vary greatly. There is also marked inconsistency from province to province around immunization schedules. We need a clear statement of recommendation to clear up this variability.

In summary, there remains a great deal of uncertainty among physicians about the vaccine, the supply of antivirals, the role of assessment centres and mass immunization clinics, delegated acts, and physicians' medical-legal obligations and protections. The bottom line is that there is still more work to do at all levels before front-line clinicians feel well prepared with the information, tools, and strategies they need.

• (1650)

The CMA was pleased to meet with Dr. Butler-Jones to discuss our concerns last week, and we will continue to work closely with the Public Health Agency of Canada to identify gaps and to prepare user-friendly information for clinicians.

Thank you, and I welcome any questions.

The Chair: Thank you very much, Doctor.

We'll now go to Dr. John Maxted, from the College of Family Physicians of Canada.

Dr. John Maxted (Associate Executive Director, Health and Public Policy, College of Family Physicians of Canada): Thank you, Madam Chair.

The College of Family Physicians of Canada is pleased to be invited to present again to the Standing Committee on Health about H1N1 pandemic preparations. Having spoken to you on August 12, we'll provide an update on the progress made to address the issues identified at that time.

Specifically to your question about whether the situation has improved and whether family physicians feel more confident now than they did eight weeks ago, our short answer is that much work has been done, but much more remains.

There have been improvements. The Public Health Agency of Canada has invited the College of Family Physicians of Canada to several tables, including those where vaccine sequencing and antiviral therapies have been discussed. During our recent visit to the agency, Dr. Butler-Jones and agency staff demonstrated their continued openness and transparency in listening to our concerns. As a result, we are currently working with the agency and other key stakeholders to develop information resources that will hopefully be more accessible, easier to read, and focused on information of practical value to family physicians and other providers in busy office settings.

Nevertheless, what keeps us awake at night is that all of these good intentions, hard work, and multiple resources will be of minimal benefit to front-line providers unless they are translated for their realities and pushed to them through the channels of communication with which they are most familiar. This must happen at the local level, not solely at national or even provincial or territorial levels of our health care system, for while some regions have been blessed with too much information through a variety of channels, thereby raising the risk of mixed messages, others have not had enough, producing a patchwork of resources for family physicians and other providers across the country.

If you overlay this mix with the clinical controversies—about the interaction between seasonal and H1N1 flu vaccines, post-influenza viral spread, who should be prescribed antivirals pre- or post-exposure, and what defines populations in Canada with the greatest potential to be most affected by this pandemic—then we may have the right components for a health system storm.

We respect that protocols and advice will necessarily change as new information comes to light. However, related to vaccine sequencing, we must also not be afraid to answer broader questions such as these. When will the vaccine be available? Why sequenced groups if everyone can get the vaccine? And if there are priority groups, where do people over 65 years of age fit in?

Infection control is a high priority in family practice. SARS and H1N1 have brought greater attention to the way family physicians manage patients with infectious diseases in their offices. Most family practices have not been designed to handle a deluge of pandemic patients, and practical advice is needed to consider patient flow and spacing issues. Family physicians and other members of the health care team also need expedited access to resources for infection control—for example, fitted N95 masks and other personal protection equipment. They need to know where and what the right resources are.

As stated on August 12, it's the unknown potential of an advancing pandemic outbreak that should cause governments and public health authorities to strive for optimal conditions that will provide family physicians and other health care providers with the information resources they require to manage patients who will present first with H1N1 flu symptoms to their family doctor and primary care providers.

To summarize, the CFPC recommends the following. Timely, consistent, easy-to-access, and user-friendly pandemic information must be provided to all family physicians and health care providers included in front-line services. Information must come to family physicians and other providers from public health at the local level. It is imperative that we work together to translate pandemic information into the practical realities that front-line providers experience. And finally, public health resources must be clearly defined and readily available for patients, family physicians, and other health care providers involved in first-contact services.

In closing, the CFPC and family doctors believe that we can respond collaboratively to the H1N1 pandemic outbreak. We are grateful for the significant efforts that have been made and welcome opportunities to address the ongoing challenges.

Once again, thank you very much, Madam Chair.

• (1655)

The Chair: Thank you, Dr. Maxted.

We'll now go into our first round of questions—seven minutes for the questions and answers—and we'll begin with Dr. Duncan.

Ms. Joyce Murray (Vancouver Quadra, Lib.): We'll be sharing the time, Madam Chair.

The Chair: Okay, Ms. Murray, go ahead.

Ms. Joyce Murray: Thank you.

There are two areas I want to ask about, and one has to do with resources and one has to do with the communication and coordination gap. I've heard from the provincial health agency level that there are concerns about not having federal cost sharing of expenses. That might be things other than vaccines, such as sanitizers, health care worker availability, supplies, respirators, costs of planning, and continuity of care. In asking the Public Health Agency of Canada, we were assured that resources and cost sharing are not and would not be constraints. I want to know from the front-line level whether you see an absence of resources to those non-vaccination expenses as a constraint, or do you predict that it might be? That's the first question.

Second, with respect to the concerns around the Public Health Agency's ability to provide clear leadership concerning public health with this situation, my question is whether you see the concerns being a matter of resources not being adequate to have that clear coordination and leadership at all the levels, or do you see it as a matter of organization, that we don't have the clear lines of responsibility and accountability, starting with the minister probably, so those inter-jurisdictional gaps are still apparent? Is it a matter of resources or organization, in your view?

The Chair: Who would like to take that?

Ms. Silas.

Ms. Linda Silas: I'll take the first, the cost, and then let my colleague speak on the organizational structure. The number one reason we hear on the debate between the respirator and the surgical mask is the cost attached to the compliance because of a lack of education. They all have to be fit-tested, and an education program on how to use them needs to apply, so it's attached to a cost. When we meet health ministers, we encourage them to look at the vaccination program and to lobby the federal government for a 60:40 split in the cost share, similar to what they did with the vaccination.

Ms. Rachel Bard: If I may add to this in terms of the cost issue, we certainly see it as a shared responsibility. The health and availability of the health professional must be a top priority with the federal government. We really see the federal government as showing leadership and clarifying this issue. It will cost even more if we don't look after making sure the professionals are well protected.

In terms of the communication, there again we see the importance of the federal government leading this initiative. We all know it is important that the proper information is received by the health professionals in a timely, concise, and easily accessible fashion.

I think we're getting a combination of communications, and I think it's important for the federal government to show leadership in trying to get it well organized and making sure it is reaching the professionals.

● (1700)

The Chair: Thank you.

Dr. Duncan, you should take your time as well.

Ms. Kirsty Duncan (Etobicoke North, Lib.): Thank you, Madam Chair, and thank you all for outlining your concerns.

I'm going to put a number of questions out there, and we won't have time for all.

First, what are the key remaining challenges in terms of medical surge and vaccine distribution? Have we looked at the modelling for surge capacity at 15%, 35% of the population affected? In the United States, they've used a higher number to model. What percentage of our provinces could exceed 80% of their capacity or more? I think this is another real issue we have to look at.

Ms. Silas, you talked about this. What are the discrepancies we're hearing at the different levels, whether it's the federal, local, or professional organizations?

We want medical professionals to feel safe to come to work. Are we meeting our legal and ethical responsibilities, duty to care?

The Chair: Who would like to lead on that?

Dr. Doig.

Dr. Anne Doig: If I may, I think I articulated for you what the CMA believes are the three gaps.

To address your specific question about surge capacity, I'm sorry but I don't have absolute numbers for you. I'm sure we can get them for you if you want them.

Ms. Kirsty Duncan: I would like that.

Dr. Anne Doig: What I would encourage you to think about is that over the last 10 to 15 years we have been driving towards using our facilities at greater than 95% capacity, particularly our in-patient facilities. There is no capacity. So if we're talking about surge capacity in the context of an overburden of illness and a background in which all of us—physicians, nurses, and HHR all together, all of the infrastructure, all of the support services, everything—are running at 95% or 98% capacity, there is no surge capacity. So whether we're talking 10%, 15%, or 20%, it is irrelevant because it isn't there.

With respect to the vaccine issue, I think the most important thing for us to understand is that there needs to be absolute clarity. This is a disease that is sweeping across the country; it is no respecter of provincial boundaries, no respecter of provincial and territorial authorities or the divisions of programmatic responsibility. What needs to happen is that we need to agree on very clear direction that is uniform across Canada and roll it out without the need for people to tweak it a little bit to fit this circumstance or that circumstance. It needs to be said: this, this, this, and please go and do it.

The Chair: Thank you, Dr. Doig.

We'll now go to Monsieur Malo.

[*Translation*]

Mr. Luc Malo: Thank you very much, Madam Chair.

I want to welcome our witnesses and thank them for being here this afternoon to help us with our study.

First of all, I want to come back to a discussion this committee had last week and ask the Canadian Medical Association a question.

You put out a postcard for health professionals entitled *H1N1 flu virus. Prepare yourself. Prepare your practice. Prepare your patients.* Under the "Prepare yourself" column, the first recommendation is "Get a flu shot." That is a guideline or recommendation for health professionals and doctors. Under the "Prepare your patients" column, the first recommendation is "Ensure your patients get a flu shot."

Many Canadians are wondering why they need a flu shot, and there is a lot of information on this topic out there, especially on the Internet. Can you tell us why the Canadian Medical Association recommends that Canadians and health professionals get a flu shot?

● (1705)

[*English*]

Dr. Anne Doig: The short answer is that is the only method of primary prevention for influenza.

This is a brand new strain of influenza. It is something that people under the age of 65 and their immune systems have not seen; they have not seen anything that closely enough resembles it to have immunity against it. It is going to hit broadly; it is going to hit hard. The only way we have of trying to prevent this is to provide people with immunization.

Fortunately, there is immunization. We've been assured that the supplies will be there and that they will be adequate for every Canadian to receive immunization. So there's no argument about shortages of the vaccine itself; just get out and get one.

There is confusion around some of the timing. There is confusion about the relationship between the pandemic flu immunization and the seasonal flu immunization. That's exactly what my colleagues and I were talking about when we were saying there needs to be clarity of messaging; there needs to be a very clear understanding of the population groups who should get the vaccine; and that if there is prioritization for the purposes of expediency of delivery, it needs to be clearly articulated.

Health professionals should get vaccinated. They are going to be the ones who are most highly exposed to the virus and they have the highest duty to society to protect themselves, both so they can remain at work and so they don't become a reservoir of disease.

[*Translation*]

Ms. Rachel Bard: The Canadian Nurses Association agrees with that recommendation. It is very important to ensure that the public is protected, and therefore, we have to be clear about safety precautions. As for the flu shot, it is equally important to make sure that our health professionals have the facts they need to make their decisions. Basically, we must ensure that our professionals can do their jobs with a view to protecting the public.

Mr. Luc Malo: Dr. Doig, earlier you said that you had met with Canada's chief public health officer. Are more meetings planned?

You also mentioned areas where there may be some inconsistencies. Are there other meetings planned? Have nurses had similar meetings? Will there be others?

[*English*]

Dr. Anne Doig: Yes, there are meetings planned. There is a commitment to ongoing work, which I understand is proceeding quite quickly, to produce a very simple algorithmic pathway for people to look at to help them with clinical decision-making. And other tools will be made available.

Our association has regular weekly conversations with the Public Health Agency, and I'm sure that is true of others as well.

[*Translation*]

Ms. Rachel Bard: The same goes for our association. We met with Dr. Butler-Jones and Dr. Grondin to discuss certain details. There will be other meetings. We also stressed the importance of getting clear and accurate information. That is what we need now so we can work together and ensure that our professionals—nurses—receive that information. So other meetings are planned.

Ms. Linda Silas: I want to point out that we have been meeting routinely for three years now. There will be more, but there is little to show for it.

Mr. Luc Malo: Dr. Maxted, you are the only one who has not given their opinion on this. Is it the same on your end?

[*English*]

Dr. John Maxted: I certainly agree, and meetings have been occurring. But an overall answer to a lot of the questions you've been asking here is to recognize the patchwork in our health care system and the fact that within our health care system we deal with the same FPT issues that you deal with here in government. That's why I stressed in my presentation that we have to get to the local level.

We can meet all we want and do all we want at the national level, but if it doesn't get translated into what the realities are of health care providers at the local level interacting with providers and the public health authorities within that local level, I'm afraid we're not going to be very good in our delivery of health care and public health.

● (1710)

[*Translation*]

Mr. Luc Malo: Is that a problem that your members have raised?

[*English*]

Dr. John Maxted: Absolutely, and what we see is a patchwork. Earlier somebody was asking about discrepancies, resources, and the availability of resources. As we go across the country and ask our members—the college has 10 different chapters—there's a variety of responses as to whether resources like N95 masks are available, whether they have to pay for them, and whether they're readily available.

In my own area, where I happen to practise part-time, I've been told that they've been fitted for their masks but no masks are available at this time. So if the pandemic were to hit next week or within the next few weeks, as we're supposed to expect to some extent, there could be some severe implications from that.

[*Translation*]

Mr. Luc Malo: Have you gotten any answers about the lack of masks? That is the issue you raised.

[*English*]

Dr. John Maxted: We continue to work at the national level to try to push some messaging into the local and regional areas and to deal with our regional counterparts in trying to achieve the best outcomes for them. But it's also important for us to support the kind of interaction that has to happen at the local level.

[*Translation*]

Mr. Luc Malo: Thank you very much.

Thank you, Madam Chair.

[*English*]

The Chair: Thank you, Monsieur Malo.

We'll now go to Ms. Wasylycia-Leis.

Ms. Judy Wasylycia-Leis: Thank you, Madam Chair.

Thanks to all of you for being here, and especially Dr. Maxted for being here again. You were here on August 12, and I don't hear much of a change in your presentation. You warned us then of a multi-vehicle pileup. You talked about problems in communications—you said that was key and there needed to be a coordinated communications strategy. You talked about having directives foisted on you without consultation, and you talked about confusion in the system.

Has anything changed since August 12?

Dr. John Maxted: The messages you've just outlined have been heard, and some activity is taking place right now.

Would we have liked to see that activity occurring three to six months ago? Absolutely. But there is some activity that shows a light at the end of the tunnel in the kind of availability of resources, the communication we think needs to be reinforced, and the fact that we need a better communication network than we have right now. We're seeing some action. We hope it's not too little, too late. We hope this will become reality, because as much as we can talk about it, it has to become a practical reality for those on the front line.

Ms. Judy Wasylycia-Leis: Well, I guess the question is that if this really hits next week or the week after, it's not likely that we're going to be ready with that nationally coordinated, communicated plan that's so necessary to protect people in the event of a pandemic.

Linda, in your presentation you mentioned some of the same problems. And in previous correspondence that you sent to committee members you talked again about guidelines being developed in terms of occupational health and safety—or in the case of the federal government, it uses the words “safety” and “hygiene”. You talked about your concerns about the different standards in this country, a hodgepodge, a patchwork of systems. And you talked about the need for the precautionary principle and for nurses to have access to the N95 respirator.

I raised those concerns with Dr. Butler-Jones, the head of the Public Health Agency. He basically said that we don't need the masks, that there's no evidence to suggest you're better served by them. And he did not suggest that there were any problems with the national guidelines.

Can you comment?

Ms. Linda Silas: With all due respect to David Butler-Jones, I'm sure if he were to go on a unit where 100% of the patients were affected with H1N1, he would be wearing an N95—well-fitted. That I guarantee.

The evidence is not clear. We've been working on this with the agency for three years. No one can say 80% or 90% that the evidence is clear on what to wear. We do not believe safety should be put into jeopardy here.

We urgently went to the Standing Committee on Health on the safety issue because it was urgent. The Minister of Health urged us in May not to go public with this, not to create a public outcry. It is early October, we still don't have any results, and the pandemic could hit anytime. What governments, provincially, are telling us is that any health care worker who asks for an N95, regardless of where he or she works, can get one. That means every health care worker will have to defend himself—look for the mask, get a fit test. That is not appropriate in this country, and we will not stand for it.

● (1715)

Ms. Judy Wasylycia-Leis: What you're saying is that in some provinces there's a commitment to provide the—

Ms. Linda Silas: Just one, the province of Ontario, which lived the SARS experience. They have the Justice Campbell report. Let's also be clear, the fact document did not even quote Justice Campbell. That in itself should be a red flag for everybody around this table.

Ms. Judy Wasylycia-Leis: Well, maybe the question to both you and Dr. Maxted of the College of Family Physicians is whether the mushroom syndrome is still at work. That was the report coming out of SARS, based on the lack of consideration to some of the obvious recommendations. That's a rhetorical question, but if you want to answer it, let me just finish. My time is probably coming to an end.

When I raised this concern about respirators with Dr. Butler-Jones, he basically suggested that I didn't know what I was talking about and, by implication, that you didn't know what you were talking about. He said we're not talking about tuberculosis or smallpox, and if we were, then we'd talk about N95s. He said we're talking about a virus that is transferred when we cough. We handle it. We rub our noses and our eyes, hands in our mouth. He says that's the problem and that N95 respirators won't help at all.

What do you say to that? How do we get a better national standard to protect nurses on the front line?

Ms. Linda Silas: My question to him would be, how come when his own report of December of last year from the council of executives recommended the N95, they didn't support that recommendation? It was supported with their own report.

Ms. Judy Wasylycia-Leis: Dr. Maxted, is the mushroom syndrome still at work, or are we getting out of the dark and into the light?

Dr. John Maxted: I don't think we have time to cover that entire area, but what that reflected was the difficult relationship between public health and primary care, and the fact that the interface wasn't as strong as it should be. I think it is stronger than it was at that time. Is it strong enough to address the current pandemic and what we might anticipate? That's our concern, and I think that's why we're sitting at this table.

Ms. Judy Wasylycia-Leis: Do I have time for one more question of Dr. Doig?

The Chair: Very briefly, Ms. Wasylycia-Leis.

Ms. Judy Wasylycia-Leis: Dr. Doig, you seem to be saying as well that there's a lack of communication on what's happening. You're not even sure if there is a prioritization list for when the vaccine is available. I'm just wondering what this committee could say to Health Canada that would help in that regard.

Dr. Anne Doig: The answer is to tell Health Canada that you will give it the authority to roll something out without waiting for the multiple layers underneath. If there was a clear directive, and if the Public Health Agency had the authority to make a decision that would be acted on by everybody, then we would get rid of some of the confusion around the supply and the guidelines for immunization.

The Chair: Ms. McLeod.

Mrs. Cathy McLeod (Kamloops—Thompson—Cariboo, CPC): Thank you, Madam Chair, and my thanks to all the witnesses for coming here today and talking about this very important issue.

To summarize some of the comments I've heard, we now have some pretty good systems and processes in place between the Public Health Agency of Canada and your organizations, both in communication and consultation. That would be my first important take-home message. I don't think this has always been there. I am also hearing, however, that as it translates down through provincial and territorial systems, down to where it matters most, at the front-line caregiver level, there are still some gaps.

My first question is to Dr. Maxted. Confidence and knowledge on the part of clinicians and primary care physicians is critical. We also know that family physicians are busy and inundated with information from all sources. Are there plans for a multi-pronged strategy with the local health authorities, with the provincial health agencies, to support our physicians, whether it be through medical advisory committees or through various techniques?

● (1720)

Dr. John Maxted: We get the kind of information we've brought to you from our members, who are at the local level and who are experiencing the patchwork of communication. And communication is essentially the problem. The Public Health Agency of Canada has produced some excellent guidelines, but they are roughly two to three pages apiece. I don't know how many of them there are right now, and they're coming out at a rate of two or three a week. They're not necessarily of practical value to front-line providers; they're not the one-page, easy-access, and readily available information that they need.

Dr. Doig and I referred to the meeting we recently had with Dr. Butler-Jones and the agency. We tried to develop some of the one-pagers we need, and we are working on that. I'm hoping it wasn't too little, too late. We need something that's easier to read and much more accessible to a family physician who is seeing 30 patients a day.

I recently received a document from one of the regions for infection control—it was 111 pages long. You're going to find very few front-line providers reading 111 pages to figure out how to control infection, which has become a highly important issue in primary care.

Dr. Anne Doig: To give you an example, I will quote my colleague Dr. Shortt, who told me this afternoon that he was trying to find the clinical adult dosage for TAMIFLU and could not find that information anywhere in the published material now available. Actually, it was buried somewhere in the document on prescribing for pregnant women, and he eventually found the information he was looking for. But if my normal patient volume is roughly six patients an hour, and I'm now asked to see perhaps ten patients an hour, plus triage people on the phone, I can't be taking my time to run around and look for information. I need to have something at my fingertips.

I have non-registered nurses staffing my telephone. I need something that is quick and easy for a layperson to understand, because it will be a layperson on the phone talking to another layperson, trying to decide if that person needs to come into the office or not. Those are the kinds of practical tools that we need nationally. Something as simple as that doesn't require a lot of inter-jurisdictional consultation.

Mrs. Cathy McLeod: You have had those conversations and hopefully those practical tools are in process. I was quite intrigued by your idea of the rapid response line. Is that happening as we speak?

Dr. Anne Doig: Based on the conversation last week with Dr. Butler-Jones, my understanding is that there will be the development of a tool such as the one I just described to you—we hope quickly.

Mrs. Cathy McLeod: My next question is for Ms. Bard.

I appreciate and understand the value of our commitment to the electronic health record and Infoway Canada. As we all know, it's quite a lengthy process to roll out electronic health systems and records. I'm not quite sure, in terms of the timeliness of what's happening in the next few months, that it is actually going to be of any value.

Ms. Rachel Bard: I appreciate the question.

But the message we want to give is that in moments of a crisis like that, it is important that we allow proper tracking and reporting of essential information. It's important to have the information in real time.

I can appreciate that we're in it now, but the importance here is for government to maintain its leadership and commitment. There will be other crises, and if we don't start having the information at the fingertip for people who are in the community or serving the patients so that they have the information in real time, I think we will be putting the professionals and the public in jeopardy. I think it's using every opportunity to try to improve that real-time information.

● (1725)

Dr. Anne Doig: Madam Chair, if I may, I'd like to jump in on that as well.

There is absolutely no question that the Canadian Medical Association has been saying very loudly that this promised money must be released to be used at the front line. A year from now—after it's been studied again and again—is not soon enough.

My colleague has very clearly articulated to you that it's not just a question of our response now to H1N1; it is a question of a very necessary and important clinical tool that we do not have access to that we should have access to. That money needs to flow.

Mrs. Cathy McLeod: We've had some conversations about the federal response, that it seems fairly coordinated and certainly much improved. Are your organizations working with chapter levels or provincial levels? Do you feel you have good communication at a provincial organizational level to our provincial organizations?

I'd ask anyone to step into that one.

Dr. Anne Doig: The cma.ca website has a page that is dedicated to H1N1. It not only has the information that the CMA itself has made available, but it has links to all of the provincial and territorial medical associations and through them to the agencies that they are linked to. There's local public health and so on to make sure that we are doing the best we can to support our members in having access to information. We've already talked about the fact that it's not just access where they have to go and look for it. It's pushing things out to them that are going to be clinically useful in real time.

The Chair: Thank you, Dr. Doig.

I want to thank the rest of the committee members.

We now have to go into three minutes of committee business.

I want to thank you so much for your presentations today. I would ask that anybody who needs to have a conversation with you to go outside the door so we can complete our committee business today.

I'll suspend for one minute to allow you to leave the room. Thank you.

[*Proceedings continue in camera*]

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