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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, everybody.

Welcome, Dr. Martin. It's nice to see you sitting on our committee. It's a pleasure to have you here.

Welcome to our witnesses today. We are so pleased you could come to committee to give us some insight into community preparedness for H1N1. We've been studying it extensively, so we're glad to have a new perspective today.

I'm going to ask each organization to have a person give a 10-minute presentation. If you want to share, that's just fine too. I tend to have a little leverage on that to make sure you get to say everything you want. Following that, we'll have two rounds. If you have two people presenting, each will have five minutes. So guard your time accordingly.

Right now we're going to start with your presentations, then we will have a seven-minute question and answer round.

We'll start with Dr. Anand Kumar. I would very much like you to present, Doctor, and welcome.

Dr. Anand Kumar (Doctor, As an Individual): Thank you for the invitation to be here today.

My name is Anand Kumar. By way of background, you should know that I have some unusual qualifications to speak to you on the subject of the threat of pandemic H1N1 today. I'm an academic intensive care specialist from the University of Manitoba. I'm one of about 12 physicians in Canada trained in both critical care medicine and infectious diseases.

As you all know, Canada is in the midst of a major H1N1 influenza epidemic that represents the leading edge of the first influenza pandemic in over 40 years. During the first wave during the spring outbreak in Manitoba, over 50 mostly young, relatively healthy patients with H1N1 influenza were admitted to the ICUs of Winnipeg with severe viral pneumonia complicated by an exceptional degree of lung injury, kidney failure, and occasionally shock. All were at immediate risk of death, and eight died—that's about 20%.

The strain on ICU and hospital resources during the epidemic was severe. I know this because I was there and, along with several of my colleagues, treated many of the patients stricken during the most severe portion of their illnesses. There is an appropriate concern that the Manitoba epidemic was simply a harbinger of a larger pandemic that we're beginning to see this fall.

The experience of the Manitoba spring outbreak and the subsequent smaller outbreaks across the country during the summer may provide important lessons for the Canadian response to the H1N1 threat going forward. Among the key observations is that relatively healthy adolescents and adults, particularly women, are the primary groups at risk for severe illness and death, which is a tremendously unusual pattern of illness.

In addition, first nations communities, the obese, and pregnant women are at especially high risk. Further experience to date suggests a remarkable degree of illness associated with severe H1N1 infection and an astonishing requirement for ICU resources to support such patients. These observations by me and my colleagues in the Canadian Critical Care Trials Group were published just last week in the *Journal of the American Medical Association*.

The price for the earliest of these lessons was paid by the citizens of Manitoba, from the severe illnesses and deaths in both Manitoba first nation and non-aboriginal populations to the exceptional strain on our health care workers during the epidemic. Their losses and sacrifices should be acknowledged. In addition, I want to make particular note of the leadership of Brian Postl and Dan Roberts of the Winnipeg Regional Health Authority; the tremendous effort and resilience of ICU and ER nursing and support staff at all of the WRHA hospitals, particularly the Health Sciences Centre and St. Boniface hospital; and the professionalism and dedication of our intensive care and emergency room physicians. I've been honoured to work alongside all of them.

The boundless efforts of my colleagues, particularly Rob Fowler in the Canadian Critical Care Trials Group, should also be noted. Dr. Fowler's foresight and the dedicated efforts of group members are responsible for the collection of tremendous amounts of critical data on the national spread of the spring/summer outbreak. The data the group collected, at their own expense and without any immediate external financial support, has been crucial in formulating our national H1N1 response strategy, from identifying groups at highest risk for early intervention to determining optimal medical therapy for the most severely ill subset of patients.

The efforts of the Public Health Agency of Canada and the scientists of the National Microbiology Laboratory of Canada, headed by Frank Plummer, should be lauded. As the magnitude of the local threat became apparent, they quickly offered their resources and support without precondition. This allowed us to collect important biological samples for analysis early in the epidemic to help determine ideal diagnostic and therapeutic management strategies. Their support has also been crucial in forging relationships between industry, academia, and government, which are leading to the improvement of standard therapies and the development of novel treatments rapidly enough to make a difference to the patients we will see in the weeks and months ahead. Further, the Public Health Agency and NML quickly arranged a national conference of ICU specialists, public health professionals, and other stakeholders to share information about the pandemic H1N1 risk.

Although much has been learned and substantial progress has been made, significant risks remain. Prime among those risks is the persistent skepticism among the public about the utility and safety of vaccination. The potential benefit of influenza vaccination will never be greater than it is this year. Normally the very old and debilitated are the major victims of influenza. This year its victims will look much like the people in this room and like our children. It is imperative that we find a way to transmit to the public the importance of vaccination, which is the single most effective way of limiting potential damage from pandemic influenza. In addition, although ICU resources have been supplemented, we need to remain vigilant in certain areas, particularly in nurse staffing, where systems stresses may be acute in the months ahead.

● (1535)

There is also an immediate need for increased applied research funding on this epidemic. Funds were recently allocated for influenza research. That's a good thing, but a casual perusal of funded projects suggests that most will yield dividends years in the future. The gun is at our collective heads right now, and we should consider additional funds to answer key questions that will inform our management of patients immediately.

l'd be happy to take any questions.

The Chair: Thank you, Dr. Kumar.

You and I are both from Winnipeg, and I'm very aware of the excellent work the doctors, the nurses, and the staff at St. Boniface hospital and the Health Sciences Centre did on that issue of the pandemic. We're following it very closely and are very happy you could make it here today.

We'll continue now with the Canadian Healthcare Association and Denise Desautels, their director of policy and communications; and Pamela Fralick, president and chief executive officer.

Please go ahead, Pamela. Thank you.

[*Translation*]

Ms. Pamela Fralick (President and Chief Executive Officer, Canadian Healthcare Association): Thank you, Madam Chair.

[*English*]

Thank you very much to all of the committee members for the opportunity to speak with you.

Frankly, I'm not sure I can say anything today you haven't already heard. That being said, given the opportunity, I'll certainly underline some of the key issues. My presentation will be moving very much from the front lines to the systems issues, so it will likely be a different perspective for you.

I am going to assume that most around this table do know that the Canadian Healthcare Association is a federation of provincial and territorial hospital and health organizations. We really do represent a very broad continuum of health in this country.

I have to tell you that the members of CHA are, in general, very satisfied with the treatment of the issue thus far and are certainly in agreement with the Public Health Agency of Canada's management of this file. We know there have been glitches along the way and that there are still issues to be dealt with, but I did want to pass on that message from our members.

That being said, there are seven points that I think you should hear about today, which I'll make fairly quickly to leave lots of time for questions.

One goes without saying, and that is the importance of an evidence-based approach in everything we do. It does speak to an issue just raised about getting the public's confidence. We recognize that we cannot truly predict the full severity and impact of a potential outbreak, but it's very important that all of us, including our media stakeholders, are sensitive to the negative effect of fear on both the general public and the professional health system community. Therefore, it's critical that we make sure the decisions reached and strategies implemented are evidence-based as much as we can and that we accept scientific guidelines as credible and legitimate.

Perhaps one of our most important points has been addressed by Dr. Kumar, and that is the role of prevention. We know that current data suggest that only about 35% of Canadians at large will take advantage of immunization. We also know that many health care workers haven't been taking advantage of the seasonal flu vaccination; there's only about a 40% to 60% compliance rate among them. So programs and approaches must be put in place to promote or encourage all Canadians, including health care staff, to be vaccinated against H1N1. We have to convey with great confidence that evidence supports mass inoculation and collectively encourage Canadians to subscribe to this approach.

While Dr. Kumar was speaking, I found myself wondering whether having this entire committee receive their vaccinations on national TV might be a good way of instilling confidence, showing all-party support for an initiative. But I'll leave that with you for in camera discussion.

● (1540)

The Chair: Well, I would have to consult with Monsieur Dufour to see if he likes needles, before we could agree.

Ms. Pamela Fralick: I will leave that to your in camera discussions.

A third point I wanted to mention—again, I'm sure this is not new to you—is the communication issue and the need for consistency of messages. We feel strongly that there does need to be a sole source of communications. Messaging has been coming from federal, provincial, and local levels. They need to come more quickly and they do need to be consistent.

We do respect the right of every jurisdiction to shape their own communications in every health delivery issue, but right now we feel that the right of Canadians to receive clear, consistent messaging should override any other needs. We do feel that there's a situation where many players feel the need to say something about this, and say it in their own language. For the average Canadian, that's simply not acceptable at this point in time.

There also are communication gaps at the community level. I'll combine two points: a great deal of the focus has been on the acute care setting, and for obvious reasons, but we know from all of the information provided from the specialists that this is a community-based issue. The information is not being conveyed appropriately to health professionals in that particular setting.

Another area of consideration, because we do try to bring forward information on solutions and not just problems, is that the health professional associations are a tremendous source of information sharing. They have not been utilized. We've been trying for years to have greater utilization of the health professions.

For example, many of you know about the Health Action Lobby, HEAL, which has been around for many years, a coalition of 38 national health associations. It's a naturally built community, if you will, to get information directly in the hands of every health provider, which can only consolidate and strengthen the information being received from other sources. So I would put that forward.

Clearly the need for sufficient staff to care for the anticipated ill patients is a great concern. We're concerned about the coordinating piece of it. I would put a few words on the table, such as labour mobility, AIT, and licensing issues, which I know we've tried to address since SARS hit, but I'm not quite sure how well they have been addressed, even with all provinces signing on to AIT. Are there implementation processes in place so that if the crisis situations are not in the entire country at one time, but are at different times in different parts of the country, we can share human resources to help and address the staff shortage that we absolutely anticipate?

The education of health professionals is perhaps the final point that I'll bring forward. These are folks who will be administering the vaccine. They do require specific information on the safety and the risk of the vaccine.

I might also highlight what might seem a minor issue: expiry dates on the various drugs and the vaccinations. We know that the dates provided are the best possible dates, but we also know that many medications are valid beyond that day. So if supplies are in short supply and great demand, how do we find out which ones can in fact be used safely and effectively beyond the expiry date that is given? It's perhaps a minor problem, but it could be a big part of a solution if we find ourselves in a great shortage.

There are a number of other issues that we won't go into detail on at the moment. Perhaps they will come out in conversation. These include the psychological and ethical sides that arise in situations of resource allocation, and the tough decisions that need to be made. We feel that these have not yet been addressed in the face of just the basic logistics of getting vaccination out.

We do recognize that dealing with this unfolding situation is no easy task for all of us. We do welcome this opportunity to further the dialogue and work on solutions with everyone who's part of this committee, and we look forward to taking part in the discussion after the presentations.

Thank you.

● (1545)

The Chair: Thank you very much.

Ms. Debra Lynkowski.

Ms. Debra Lynkowski (Chief Executive Officer, Canadian Public Health Association): Thank you so much for this opportunity to appear before you. We had hoped to have Dr. Cordell Neudorf, who is our chair, and he's also a medical officer of health from Saskatoon region, but he wasn't able to be here today. I solicited some feedback from people who are on the ground who are dealing with this, as Dr. Kumar is as well.

In general from CPHA's perspective, we feel that much has been learned from previous public health emergencies. Thanks to the leadership of the Public Health Agency of Canada and our chief public health officer, we feel there have been dramatic improvements this time around. The level of coordination and communication and cooperation between the federal agencies and the provinces and territories has been quite exemplary when you compare it to something like SARS. We're seeing similar leadership at the provincial-territorial levels and at the local levels as well.

All that said, we do know we are dealing with a unique situation, and we're trying to respond to the spread of the virus in real time. I think that is what makes this so challenging. It's a bit like the canary in the mine shaft with SARS, and now with H1N1. It points to the vulnerabilities in our public health system and in our acute care system as well. I wanted to talk to you a little bit today about the observations from the ground from a public health perspective in terms of what we feel is working and where we anticipate challenges.

In general, I think the sense is that there is an overall plan, and people feel that plan is working well and is evolving. I think everyone understands it has to evolve because of the fact that this is complex and that, really, within a six-month period we have gone from identification of a virus to a vaccine, to full immunization campaigns, so it's quite remarkable.

The public health surveillance systems are working well and they're tracking the disease. Public health laboratories, as mentioned by Dr. Kumar, are doing exceptionally well. The development of provincial networks, and in particular new public health agencies.... B.C. isn't so new, but B.C., Quebec, and Ontario have made a real difference in terms of how we're able to respond this time around. The new pan-Canadian public health network has really given us an opportunity to have that ongoing dialogue and coordination, and it has allowed for more standardized responses, which has been very important.

Finally, most of you have probably seen the recent release of the preparedness guide. We're very pleased that the information to the public that is available now is very accurate and accessible.

We anticipate there will be challenges, and one of them probably isn't new to this committee. Public health in Canada continues to be chronically underfunded and under-resourced. There are many different figures, but what I do know for a fact is that it's between 4% to 6% of all health spending. When you look at that in terms of being able to mount a response, there are limitations. Most public health units today don't even have the resources to implement best practices in general, so it's very difficult to then add a pandemic into the mix. We're less than two weeks away from beginning the largest immunization campaign in decades, and what we're looking at is two to three times more doses than we would in a normal campaign. All of this is happening in a system that is, quite frankly, stretched to capacity, and all of it without any additional resources.

There's an implication and a cost to this. At a local level, public health is having to defer, cancel, or scale back on most other services for a one- to two-month period to mount this campaign. What does that mean to Canadians? Past experience shows us there may be a cohort of children who never catch up on their regular immunizations, mothers who don't get visited, and quite frankly, inspections that won't get done. Surge capacity simply doesn't exist in public health. As I've been told by my colleagues on the ground, we can't have two public health crises at a time; we couldn't deal with them.

We anticipate there will be information challenges for general practitioners, primarily physicians and acute care practitioners, because while there are public health networks that are well connected, acute care networks that are well connected, they aren't necessarily well connected to one another.

Another challenge would be to make sure we have the best information on the vaccine, because what you're dealing with are practitioners who then have to translate that science into clear accessible advice for their patients.

Most importantly, I think, given what Ms. Fralick just said as well, public health can't be reduced to sound bites, and that's what we've been trying to do lately, catch these sound bites and put them in the media, and it just doesn't work. It's far too complex. As someone told me, public health is just as much of an art as it is a science.

● (1550)

So while we do know that there will be differences in approach among provinces and territories, it is becoming increasingly confusing for the public, and we all have a responsibility to ensure that the best evidence-based recommendations are out there and are consistently promoted.

In closing, I just want to say I realize that this committee wants to know what's happening today and wants to know what we can do today, but we also need to look to the future. We need to have a long-term vision for public health. I urge you, in the context of your deliberations about the present, to look to the future.

Both CPHA and the Canadian Coalition for Public Health in the 21st Century—and Pamela Fralick and I co-chair that group—have made a series of recommendations, most recently in a backgrounder that was sent to all members of Parliament, but also in pre-budget consultation briefs. I won't go into that now. We have those documents available, and Christine, we can get them to you as soon as possible.

I think what's important to remember is that public health always operates under the radar. My famous line is that I want my family to understand what I do, because no one understands what public health is. It tends to operate under the radar, and we take all of our public health successes for granted. We have clean, safe drinking water and we don't wonder how that is. We prevent injuries by seat belt and workplace legislation, and we don't think about that. We think about it only when there's a crisis, and Walkerton, SARS, and H1N1 are perfect examples. So we need to use this current experience to inform the future. If we deal only with this issue at hand, we will invite another crisis in the future.

To bring us back to today, I actually want to reiterate what Ms. Fralick said. The two most important things that you can do as committee members today to support this national response to H1N1 is get your H1N1 immunization, do it publicly, and encourage your friends, families, and colleagues to do the same.

Thank you very much.

The Chair: Thank you very much for your presentation.

I just want to say, before we go into the rounds, that we will be going into committee business at five o'clock. So we will have questions and answers for the next hour and ten minutes, and then we'll do our committee business.

We will start with Dr. Duncan.

Ms. Kirsty Duncan (Etobicoke North, Lib.): Thank you, Madam Chair.

You've all raised such important issues. I think I'm going to start with surge capacity, though.

Dr. Kumar, I know you treated many people from the aboriginal community in the spring and summer. What was the average time for treatment in Winnipeg, and what was done prior to treatment?

Dr. Anand Kumar: Do you mean time presenting to the hospital or getting medical care?

Ms. Kirsty Duncan: Yes.

Dr. Anand Kumar: I was going to say I have data only on ICU patients, but I actually have data on everybody who presented to either the emergency room, the hospital, or the ICU. One of the things we found was that the speed with which you go from symptom onset to therapy—which is the time that you present to the physician or the emergency room—actually has a direct bearing on how severe your disease gets.

So what we found was that among those who died, the median time delay was approximately eight or nine days. Among those who were admitted to the ICU but didn't die, it was approximately seven days. Among those who were hospitalized, it was about five days, and among those who came to the emergency room but were never hospitalized, it was just three days. So there's a fairly strong correlation between the severity of the disease you have and how quickly you present for medical care.

● (1555)

Ms. Kirsty Duncan: If people travelled from aboriginal communities, did they get antivirals in their community? What was the time from presentation of symptoms to getting the antiviral drug, and did that impact outcome?

Dr. Anand Kumar: I have no doubt that impacted outcome. You know, you never expect a pandemic to occur in your backyard, so there was a lot of uncertainty and a lot of confusion, let's say, early on in terms of exactly what was happening. Quite frankly, the advice we were getting from various sources was predicated on ambulatory patients, patients who were not that critically ill. Initially, the advice we got was that for people who were presenting like this, first, we should wait for confirmation of the H1N1 test, or influenza at least, and that took three days because we were testing only twice a week. There are all sorts of reasons that there were delays. Because our aboriginal communities were first hit, they bore the brunt of the lack of knowledge, basically, so the delays in their community were quite long, in the order of, I think, seven or eight days.

Ms. Kirsty Duncan: Does the chance of recovery really drop after 48 hours in terms of the antivirals?

Dr. Anand Kumar: No. I think there has been some misinterpretation of what the 48-hour rule should be. We always talk about evidence-based medicine, but what we don't recognize is that if the group you studied isn't the group you're treating, there is no evidence, basically.

What we found, and what we know, is that if you have mild disease and you get antiviral therapy within 48 hours of the onset of symptoms, you have about one day less of symptoms before you get better.

Ms. Kirsty Duncan: What about severe disease?

Dr. Anand Kumar: Exactly. Initially they said to us, quite frankly, that if they've had symptoms for more 48 hours, don't bother treating. Unfortunately, some of our physicians took that to apply even to ICU cases. The fact of the matter is that if you are severely ill, getting treated at any point is better than not being treated at all.

There have been many other fallacies we were told in terms of the accepted wisdom. We've had to kind of reinvent things and re-examine them as time has gone on. I think part of the reason we're doing better nationally is that we have re-examined all the accepted wisdom, basically.

Ms. Kirsty Duncan: One of the things going forward, even with severe disease, is to get the antiviral.

Dr. Anand Kumar: Oh, without question, if you have severe disease that requires ICU care, even if you're four, five, or six days out, you want to have antivirals administered.

Ms. Kirsty Duncan: That's what I wanted to hear. Thank you.

I'd like to know at what capacity you were operating during the spring and summer and what the impact of flu was on your staff, supplies, ICUs, and ventilators. Are we still looking at 25% to 35% of the population impacted, with about 1% of people suffering severe disease? And if 1% suffers severe disease, what does that mean in numbers in Manitoba? Can you meet the ICU and ventilator demand? If there's difficulty, how do you make those tough decisions?

Dr. Anand Kumar: Well, there are a lot of questions there.

Ms. Kirsty Duncan: Yes, there are.

Dr. Anand Kumar: The current projections for potential attack rate, quite frankly, have varied quite a bit. We've done some mathematical modelling. We think that the ultimate attack rate in this wave of the epidemic, population-wise, would be somewhere between 25% and 30%; that is, 25% to 30% of the population will get hit, basically, this fall, assuming that the vaccine isn't out there. That's on the low end of pandemic attack rates, basically. Pandemic attack rates historically have been between 25% and 40%. So you can figure that a good portion of the population is going to be hit.

Now, I think the key question is this: what percentage of those people will become critically ill or ill enough to be in hospital? The numbers and the projections on that, quite frankly, are all over the place. I don't think anybody is really certain. Initially we were talking about one in 250, which is a number that has been used in seasonal influenza. My estimate is that the number has gone down fairly substantially. I suspect that it's on the order of one in 1,000, or less.

Again, we have some data we've recently submitted to the CMAJ. By the way, the data I gave you just a moment ago on the time to antivirals was developed by Ryan Zarychanski, one of my colleagues.

We've developed some data that looked at a dynamic model of the number of cases we might see, assuming that the vaccine was not aggressively deployed. We thought we might see as many as somewhere in the ballpark of 1,500 to 2,500 cases simultaneously across the country. That's more or less a worst-case scenario, because we only have about 3,000 ICU beds—that's a ballpark figure—across the country.

● (1600)

The Chair: Thank you, Dr. Kumar. You'll have more questions coming to you.

Dr. Anand Kumar: Sure.

The Chair: I'm going to ask you to watch the light, because when I turn that on, it means we're over time. I'd like all members of the committee to have an opportunity to ask you questions.

Thank you.

We'll now go to Monsieur Malo.

[*Translation*]

Mr. Luc Malo (Verchères—Les Patriotes, BQ): Thank you, Madam Chair and thank you to our witnesses for joining us this afternoon.

Can everyone understand what I am saying?

[*English*]

Dr. Anand Kumar: I'm sorry, I've never used this before. Nobody gives you instructions when you get here.

All right.

The Chair: Are you okay now, Dr. Kumar?

Dr. Anand Kumar: I can hear the English. I can hear somebody.

The Chair: All right, Monsieur Malo. Are you on channel 2? That's where you should be.

[*Translation*]

Mr. Luc Malo: Thank you for joining us this afternoon.

For the past several meetings, I have always started off by putting the same question to all of the witnesses, because there seems to be some confusion about the importance of getting vaccinated. I know that all of you mentioned this point during your presentations. However, I would like you to list clearly all of the reasons why you feel it is important for members of the public to get vaccinated.

[*English*]

The Chair: Who would like to take that question?

Ms. Debra Lynkowski: I apologize; my French is very poor, so I won't burden you with that. I'll speak in English.

I think it's a matter not only of individual responsibility to take care of yourself but also a duty to take care of others as well. So it's not just a matter of vaccinating to protect yourself and your family; it's a matter of protecting the entire population. Immunization has been one of the greatest achievements in public health, and when you look at the number of diseases that have been completely eradicated, it's been because of immunization. What we know is that there have been pockets where immunization hasn't been successful, for instance in some countries in Africa where polio is resurrecting—we thought this disease was long gone. So it's both an individual duty and a public duty, from my perspective. And it's one of the safest and most effective public health initiatives we've ever had.

Ms. Pamela Fralick: I can only repeat what Ms. Lynkowski has said. But if one moves away from the duty issue, which is paramount, and looks at the practicalities, we think they're very much intertwined: your own health, the health of your family, the health of your co-workers, the cost to the health system of dealing with actual cases as opposed to prevention, and the cost to the productivity of this country—one could go on and on with the practical side on top of the duty.

As far as we know, this is a very safe process. I think there will always be a question. People still say they won't have the seasonal flu shot because it gives them the flu. We have a lot of difficulty in dealing with myths out there. That's why at this time we need leadership, and we need leadership from those in the country who are best positioned to show it. I'd go on TV, but no one knows me from a hole in the wall. You folks do represent.... I'm not pushing the idea that you do this, by the way, but frankly I propose it, for all those reasons.

Dr. Anand Kumar: I have a very visceral and straightforward approach to vaccination. I mean, I had 50 people struggling for their lives in the intensive care unit. And this wasn't a case of, you know, you go on the ventilator for two days and you get better. This was, by and large, three weeks of daily battle to keep people alive. These were the sickest people I've ever seen in my life as a group, and it's a small miracle that we only lost 20% of them. Had they been older, had they been in their fifties or sixties, we probably would have had a 60% mortality rate.

The fact that you can have a vaccination and just avoid the problem—I don't know if I'm allowed to say it's a no-brainer, but it's not a difficult decision, as far as I'm concerned, if you accept that the vaccine is very safe and very effective. Most of these people would have told you that their risk is very low and that they're young and healthy—"How could I get that sick?" But they were that sick. So I think it's a very clear-cut kind of case.

● (1605)

[*Translation*]

Mr. Luc Malo: Thank you very much.

[*English*]

Ms. Pamela Fralick: Just to add one comment, I would ask everyone on the committee how they feel about seat belts. There was a time when no one wore seat belts. Frankly, even today you can wear seat belts and may not survive a car crash, but we all wear seat belts. We're looking at limiting the use of hand-held cell phones and have done so across the country.

So to quote my colleague, it's a no-brainer; it's about prevention and promotion. And for some reason, we don't attend to that concept in the health discussions in this country and elsewhere. It's about doing upstream activities that prevent so much heartache, death, and cost, all in one fell swoop.

[*Translation*]

Mr. Luc Malo: Ms. Fralick, in your presentation, you alluded to the possible future psychological effects of the pandemic. Would you care to elaborate on your statement?

Ms. Pamela Fralick: I'm sorry, but while I would like to answer your question in French, my French is a little rusty. If you don't mind, I will continue in English.

[*English*]

I don't know that they are all documented. We're just starting to hear those words, that language, from our members.

But there are a number of levels that one could approach. First of all, in terms of ethics and decisions around resource allocation, Doctor Kumar has just mentioned to us.... Your statistic, I think, was an anticipation of 1,500 to 2,000 serious cases requiring intensive care. And we only have 3,000 ICU beds in this country. What happens if the number is 3,500? How do we decide who receives the care if we run out of vaccine, if we run out of N-95 masks, whatever the supplies are? There's that level of decision-making. There are no guidelines out there. There are ethical review boards. They don't have the capacity to respond so quickly. So that's a huge difficulty.

There are psychological issues around, I would call it.... What did we call it today? PTSD, during post-traumatic stress disorder. But even as it's unfolding, seeing this level of illness and having to deal with that is going to have huge repercussions on health providers and family members. But it's a starting point. I see the light on.

The Chair: Thank you, Ms. Fralick. It's very insightful information.

Ms. Wasylycia-Leis.

Ms. Judy Wasylycia-Leis (Winnipeg North, NDP): Thank you, Madam Chairperson, and thanks to all of you.

First of all, I agree with all of you when you say we have a responsibility to carry out when it comes to acknowledging the importance of vaccinations. I think some of us were a bit miffed when the Prime Minister hesitated a bit when asked. And hopefully, that's been clarified.

But there is confusion out there, and some of it has come from the medical profession. There have been studies suggesting that we haven't really researched the vaccination enough, and therefore people aren't sure if it's safe. There have been people suggesting that there's a problem in terms of interaction between the flu vaccine and the H1N1 vaccine, and that has caused confusion.

What's the best thing we can do right now to undo that problem of confusion so that people get one message and get it fast, aside from each one of us standing up publicly and saying, “I'm going to get vaccinated”? What else can we do to increase the numbers of Canadians who say they're prepared to get vaccinated?

● (1610)

Ms. Debra Lynkowski: I'll start with this. It's a very good question. It's very important.

Again, I want to reiterate a point that I'm sure you all know, but it is the challenge that we're dealing with something in real time, and the scientific debate is happening as we're trying to develop a vaccine and actually respond to the pandemic in the midst of the pandemic. So that is the challenge.

However, I would agree that there's an opportunity now to ensure that all messaging that comes forward through the media, through various public forums such as this, relies on the best science and evidence we have to date, recognizing that it will evolve with time and that we don't necessarily use the issue as an opportunity to put forward a number of platforms, as Ms. Fralick mentioned. There has been lots of debate in the media, and debate doesn't really help at this point.

The chief public health officer is out there with some good recommendations. Our local and provincial authorities are out there with good recommendations. And we should be urging the general public to listen to those recommendations because they are based on science.

Dr. Anand Kumar: One of the difficulties is that in the initial phase of the epidemic the general public message was that this was a mild pandemic, and what people took from the term “mild pandemic” was that it's a mild disease, so why should I worry about it?

We need to be a little bit careful and on message that, yes, this is a mild pandemic from the point of view that most people who get it will have mild disease. But we need to be very clear in the message that there is a small subset of patients who will become seriously ill, and a good number of those may become life-threatening ill. And the reason to get vaccinated is to avoid being in that small minority. I think we need to be consistent about that.

Ms. Judy Wasylycia-Leis: Thanks.

The issue that concerns me the most is not vaccinations, it's not prevention; it is the state of our acute care health care system in terms of responding if in fact there is a significant development with respect to the spread of H1N1. One of the articles I was reading was by Mark Humphries, who is with Mount Royal College in Calgary. He said that the lesson of the 1918 pandemic is to focus on treatment, not prevention. He suggests that our health care infrastructure is not prepared to meet the challenges if there are any serious developments in this area. Dr. Kumar, you have spoken a bit on this.

One of the studies that were released at the symposium at the beginning of September suggested that we are at full capacity now in terms of our acute care system. So what do we do if there is any kind of need? Second, they said there are currently only 8.7 medical ventilator beds per 100,000, and if we were talking about a full-bore H1N1, we'd need something like 3,000 ventilator beds per 100,000. And if we are talking about 30% to 35% of the population off sick, many of them needing intensive care for six to eight weeks, our acute care facilities are just not able to deal with this.

It's one of the areas where the federal government has been fairly silent and said it is all up to the provinces. I am concerned that we're leaving it out there as an unknown, and we are all hoping this isn't going to become serious, and if it does become serious we're going to be up a creek without a paddle, so to speak.

I need to hear your thoughts on the state of our acute care system. We have to talk about public health in the long term, and I agree with that, but I am asking whether right now, if something serious happens, we are ready to go.

The Chair: Who would like to answer that?

Ms. Fralick.

Ms. Pamela Fralick: I can start.

I'm not sure I have the answer for you, but given that I speak on behalf of the system that does include the acute care centres as well, the messaging I get from my members is prevention. That's why we focus on it. We don't want to get to the point where we can't in fact respond to the need, because you're absolutely right, the issues of staffing and surge capacity are frightening. We talked about those, as you know, in the health committee. Several of you have been around this committee for some time and you were, prior to H1N1, doing a series of consultations on HHR, health human resources. We're already in a crisis situation, and increasingly so with the U.S. potentially moving to a different system that will require more health providers for more of their people. Where are those health providers going to come from? For many of them, they will come to Canada. So already in crisis, we are going to be very challenged to deal with that. That is why, from my perspective, we focus so much on the preventive side and why it is so important.

The consistent messages are getting out there. We were slow with it, but they have improved dramatically, I would say, in the last few weeks to a month or so.

One of the points I raised in my presentation was looking at the labour mobility and licensing issues, which we have looked at since SARS. AIT is in place. We understand that all the provinces have signed on, but is it truly implementable? I don't know the science of this—perhaps Dr. Kumar does—but if the disease presents in different places at different times, can we move health providers around? Is that one of the solutions?

● (1615)

The Chair: Thank you, Ms. Fralick.

Ms. Judy Wasylycia-Leis: Could I ask Dr. Kumar to respond?

The Chair: Dr. Kumar, would you like to make a comment on that?

Dr. Anand Kumar: Do you mean on the narrow question of moving people around?

Ms. Judy Wasylycia-Leis: No, on the question of whether we are ready from the acute care perspective.

Dr. Anand Kumar: I think we are close to ready. There are some areas where we can still improve. I think the hit that we're going to take is actually potentially manageable if we prepare. It's not going to be an overwhelming hit, but even if we prepare, we can't be ready for it. If we prepare for it, we can be ready and we can handle it. I think we are getting close to that.

Ms. Judy Wasylycia-Leis: Thank you.

Ms. McLeod.

Mrs. Cathy McLeod (Kamloops—Thompson—Cariboo, CPC): Thank you, Madam Chair.

I'd like to thank the panel members. Also, I'll be the first to say in this committee that I am happy to roll up my sleeve in front of any media to get my vaccination and I certainly will encourage everyone I can to also have their vaccination. Certainly, as you clearly identified, it is a hugely important strategy in our movement forward.

I have actually a number of questions for a number of different people on the panel, but to start, Dr. Kumar, you were part of that technical expert group that looked at treatment in acute care. Is there some best practice? Has some best practice been developed for our more acute care patients?

Dr. Anand Kumar: It has, from the context of the ICU. I've been involved in that portion of it, and in fact the Public Health Agency of Canada will shortly come out with guidelines on management of ICU patients. Several of the comments that Dr. Duncan made will be addressed. They will recommend that even after 48 hours you get treated, and they will recommend that 10 days of antiviral therapy be used instead of the standard five that people had been doing.

In addition, it will make clear that the diagnostic test, which has been said to be 100% sensitive, in real life is in fact not 100% sensitive, so if you have a case that looks like it's the real deal, then you will treat it like the real deal until you're certain. There are a bunch of guidelines that will come out along those lines.

Mrs. Cathy McLeod: That's quite imminent, then.

Dr. Anand Kumar: It should be in the next few weeks.

Mrs. Cathy McLeod: Great.

I was also quite interested when you talked about applied research. We obviously all heard of some great research work and about funding for research work on a more long-term basis. When you were talking about applied research, what were you seeing as some of the interests, the gaps, and things like that? What were you thinking of in terms of needs?

Dr. Anand Kumar: There are two or three areas I can think of right now. One example is that most intensivists think we really need to have a system whereby we can have a real-time understanding of what the bed situation is and where the bed stresses are across the country, particularly in a pandemic. Right now we don't even know how many ventilator-capable ICU beds there are across the country. We're trying to collect that information. The Canadian Critical Care Trials Group is doing that, but real-time intelligence to allow you to redeploy resources to hot spots if you need to doesn't exist. We have no hope of doing that right now. The development of a system like that is important.

There are other important issues along the same lines. You may not know it, but the funding that exists does not actually fund therapies that are close. For example, in the case of hyperimmune globulin therapy, which I think is by far the most likely unapproved therapy to be useful in critically ill patients, we're struggling to find development funding because there's no mechanism for it. You go to pharmaceutical companies and try to find some money and try to figure out a way to get it done, but federal funding and that kind of thing....

For example, the WHO has said that one of the key questions is to find out whether standard-dose antivirals or high-dose antivirals are more effective. There are all these very practical things. Another example is just looking at the testing to see how effective it is. These are very practical, immediate things, but to a great extent the mechanisms for funding them don't exist.

● (1620)

Mrs. Cathy McLeod: I was wanting to move on, but I think you've tweaked some interest there. Certainly this is a global pandemic, and it would be very interesting to have different countries take on the different pieces of this challenge, as opposed to everyone doing the same thing. I think that who is tackling which piece is certainly part of the conversation that I'm sure is happening. Again, there might be some opportunity there.

Dr. Anand Kumar: Let me just mention that Dr. John Marshall of the Canadian Critical Care Trials Group, who is at St. Michael's, has actually been instrumental in setting up a worldwide network to do exactly what you're suggesting, so that different people work on different areas.

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

Certainly the federal government has its role and the provinces have their roles. We have regional health authorities and a number of different organizational structures in our provinces. From your member organizations, how are you getting a sense of their planning processes across the country in terms of the provincial and the regional health authorities? Are you getting the sense that in the last couple of years people have really tackled this? Are they feeling more confident?

Ms. Pamela Fralick: We certainly stay in touch with them regularly. We meet via teleconference with the CEOs of the provincial and territorial health bodies or whoever is representing on our group. To a great extent, they feel they're getting sufficient information at the provincial and territorial levels. We believe that's because there's a good system of information flow in place, so they haven't needed quite as much from us.

That having been said, we did hold a teleconference with them just last week. The number one issue is H1N1, and consistency of messages, surge capacity, and staffing issues. All the things I mentioned in my presentation are still of great concern, as much as things have improved.

Mrs. Cathy McLeod: But they're sort of in the planning process—

Ms. Pamela Fralick: Very much so. They're very much involved. In fact, in most calls we have, one or two can't come because of dealing with H1N1 in their particular region. So they're very involved with it.

I may be missing part of your question.

Mrs. Cathy McLeod: Okay.

Certainly our health care system and our provinces have had to deal with ethical issues throughout time. Dealing with ethical issues is not unique. Usually structures are in place to deal with ethical issues within, again, the different structures that are there, if anyone wants to expand on the discussion around ethical issues. As I say, we deal with these all the time in many ways, and we have bodies that I think are in good position, because they have structures in place.

The Chair: Well, our time is about up, but perhaps someone would quickly like to make a comment on that. Ms. Fralick.

Ms. Pamela Fralick: Since I raised it, the brief comment is that I believe why this has come forward from our members at this point in time is because of the immediacy and the unpredictability of what we're dealing with. I mentioned there are ethical review boards, academically and in every hospital, whether or not they have the capacity to deal with immediate issues.

Frankly, one might look at the situation in Manitoba and the body bags and how that decision was arrived at. Is there an ethical component to that that might have been deployed to prevent that situation from having arisen?

You look confused.

Mrs. Cathy McLeod: No, that's—

The Chair: Thank you very much.

We'll now go to Ms. Murray.

Ms. Joyce Murray (Vancouver Quadra, Lib.): Thanks for being here and educating us.

I want to ask you about the prevention side, because I hear from you the importance of preventing people from getting the virus through a mass vaccination program. I am not aware that there has been clear direction to that effect from the Public Health Agency leadership, other than, yes, there'll be enough vaccine for everybody. Are you aware of there having been a strong directive to all the provinces and territories saying, do mass immunizations in your area?

● (1625)

The Chair: Go ahead.

Ms. Debra Lynkowski: I think the direction has been fairly clear from the Public Health Agency of Canada, and then it spreads out through the provincial authorities to the regions, and they're certainly encouraging mass immunization.

I know that at the public health level, our public health colleagues are preparing for mass immunization campaigns, which is why some other public health initiatives have been either suspended for now or scaled back.

Ms. Joyce Murray: Thank you.

I'll have to check where that clear directive has come out, because I've heard on the ground that it hasn't, and that it would be helpful if it were to do so. I'm not sure if all your colleagues agree that it is a clear coordinated instruction from the Public Health Agency.

The Chair: Ms. Fralick, do you have any comment on that?

Ms. Pamela Fralick: I was going to add that I have myself heard that clear directive, but I think there are areas in the health system, and the public obviously, where it is not that clear. Within the health professions there has been a great deal of debate on whether or not health care providers can be mandated, frankly, to be vaccinated, and the professions have decided that, no, there's no way that can happen, it must be voluntary.

So there is still a lot of discussion on that angle of the issue.

Ms. Joyce Murray: The big concern I have is the no funding from the federal government. I imagine cartons of vaccines sitting on delivery docks. But the step from there to a mass immunization being completed involves a lot of cost, and I believe the estimate in B.C. is somewhere between $8 and $10 per person, depending on isolated or not isolated. This means some $25 million in additional costs for B.C. alone if 70% of the people are vaccinated. The health authorities in British Columbia are already running deficits and they have to pull back to manage their budgets. The provincial government's in the same boat.

So are you aware of mass immunization programs like this in which the federal government did not contribute to the costs of delivering the mass immunization, aside from the product itself?

A witness: No, I'm not.

The Chair: Who would like to answer that question?

Ms. Joyce Murray: I saw a bunch of heads shaking, so I thought I'd just go on from there.

The Chair: Okay. You don't want any verbal comment.

Ms. Joyce Murray: My concern is that it just won't roll out without some funds because of the deficits that the provinces and the health authorities are dealing with. Do you think having federal funding for potential cost sharing for that $25 million would make a difference in getting the result that people are actually vaccinated in this mass vaccination, sort of theoretical exercise?

Ms. Debra Lynkowski: I think additional funding and support always makes a difference. As I mentioned before, we have confidence from the public health perspective in how they will rearrange and redirect their current activities to make this happen. But additional resources are always welcome to make that happen more efficiently and more ably.

Ms. Joyce Murray: Ms. Lynkowski, you believe that the health authorities in B.C. will be able to somehow conjure up the resources of nurse time, travel, supplies, communications, flyers, and everything else in a timely way without any additional federal resources, to the tune of about $25 million?

Ms. Debra Lynkowski: No, I can't really comment on every jurisdiction. I think every jurisdiction will be different. Every region's capacity at this point is very different. Every province and territory, in fact, in terms of their capacity right now is very different, so you really have to look at it within that context. Given the fact that, as we have mentioned, there isn't much surge capacity, any additional support, however that's provided, would likely help this go much more smoothly.

Ms. Pamela Fralick: I don't want to speak on behalf of other groups, but I know in several sectors—for instance with the nurses' unions and the Canadian Medical Association—the cost has been identified as a serious issue. If we want to equip everyone with appropriate masks, for instance, no one knows where the money is coming from at this point.

● (1630)

The Chair: Thank you very much.

Dr. Carrie.

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

I want to thank the witnesses for being here today. I did want to comment, though, that the federal government has taken the responsibility very seriously. I think we've already invested over $300 million in the vaccine, over $1 billion in the pandemic plan. If you compare that to the situation under SARS, I do think there's a vast improvement. There's always room for more improvement, and I do appreciate your comments stating that on the record.

I did want to tailor my comments to the front-line workers. My background is as a chiropractor. I worked in a multidisciplinary clinic, and during SARS we had all kinds of people walking in and walking out. I met with the family physicians, and they had significant concerns about, as you said, communication and different messaging.

You mentioned in your seven points that we really have to rely on the evidence-based information. I think everybody's in agreement with that. However, even sitting on this committee, which I think keeps everybody here really up to date, we see some conflicting evidence and conflicting opinions.

My colleague from the NDP pointed to the seasonal vaccine. We've heard from an unpublished paper that if you get that, you're more likely to get H1N1. We've heard of different provinces taking different protocols. Do you have any suggestions on how to get a sole source of communications? How would we go about doing that? You mentioned a guideline that is published online with accurate information. The minister stood up in the House and said we have that accurate information available, and it's evidence-based. There appear to be problems still getting it out there. I was wondering if you have some suggestions.

The Chair: I know. I think there are several questions here.

Dr. Kumar, I was noticing that you were shaking your head vigorously. Perhaps you'd like to start, and then we'll go to Ms. Fralick and Then Ms. Lynkowski.

Dr. Anand Kumar: I was just shaking my head on the issue of this unpublished study that suggests that getting seasonal influenza vaccine puts you at greater risk for H1N1. I just think that's.... You know, it's unpublished. It's virtually a rumour. I don't put too much stock into it, in great part because this question has been studied by many other groups who have looked at the same thing, including us, who have found no such effect. In fact, the majority of papers that are published—I would say nine out of ten papers—say that if anything, getting the seasonal vaccine is neutral. There have been one or two papers that have said it's actually protective. So I don't think I'd put too much stock in an unpublished paper at this stage.

Mr. Colin Carrie: I agree with you, but you brought up some important points. You're saying that these papers say this and these papers say that, but I look at you as an authority in this country on the issue. The public gets these mixed messages too, so I was wondering about bringing up the point of a sole source of communication.

Here we have front-line physicians who in a normal day may see 50 patients. Let's say that when this hits, you have the entire population with a fear factor. You've mentioned the psychological issues. I'm glad that my colleague brought this up as well. Somebody who has a cold, somebody who has the sniffles, suddenly is going to be presenting at a physician's office. So where they're used to seeing 50 people, they may need to see 100. I'm talking about communication issues getting down to the front lines.

I hear that there's really good communication between the federal government and the provincial and territorial governments. I was wondering what you're doing, or if there are things that could be done, between your group and the different regions and municipalities, so that with their distinctive desires and requirements there is some good communication material for them on the front lines too.

The Chair: Ms. Fralick, do you want to try that one?

Ms. Pamela Fralick: Thank you.

First, I want to pick up on your point about evidence. I did make that comment. I also said "when it's available", because we don't always have evidence. The key piece of this issue we're dealing with is that it's unfolding in real time. We're learning as we go. It's a combination. Evidence isn't necessarily scientifically rigorous evidence; it's best practice. It's making sure that everyone is sharing what they're discovering on a day-to-day basis, frankly.

You mentioned working in a multidisciplinary clinic and using that as your jumping-off point. One issue that I didn't highlight, but it is in our letter to you of a week or so ago, is the concern of part-time workers or multi-facility workers, whether they are nurses, physiotherapists, or physicians who are moving from one setting to the other, where there are, let's say, different policies in place.

I could go on and on, but in terms of communications, I wish I had a good answer for you. The best I can come up with right now is that we have the Public Health Agency of Canada. We have the chief public health officer. Increasingly, I've seen the support go to that office and that officer as the sole source of information. I think we could do better on ensuring that this is the best authority. Maybe it's not final, as it changes on a daily basis sometimes with some pieces of information, but that's where we go.

Yes, I think the provinces and territories are working well together, but as I mentioned earlier, I do believe there's a need to say the same thing differently: that's not right for Canadians. So it's about encouraging that buy-in to the office and officer we have in place as the sole source of information.

● (1635)

The Chair: Thank you.

Monsieur Dufour.

[*Translation*]

Mr. Nicolas Dufour (Repentigny, BQ): Thank you very much, Madam Chair. I would like to thank all of the witnesses for enlightening us.

We have been studying the H1N1 flu issue for several weeks now. We have met with many witnesses and I think we have a good grasp of the issue.

One thing has always concerned me and we spoke about this today. I would like to tie it in with the comments of my colleague Mr. Carrie. It would seem that many experts and front-line workers are reluctant to get vaccinated. Yet, they have access to a great deal of information about the benefits of the vaccine.

Perhaps Mr. Kumar can help us debunk some of the myths surrounding the vaccine. While there is no miracle solution, do you know of a way to substantially increase the number of workers who get vaccinated? We understand that they cannot be forced into getting vaccinated, but is there a strategy that could be employed to increase the percentage of workers who do get vaccinated?

[*English*]

The Chair: Who would like to take that one?

Thank you, Ms. Lynkowski.

Ms. Debra Lynkowski: I'll just speak quickly on that.

I would agree that this is a very real challenge. Certainly, as we spoke about earlier, although the Public Health Agency can strongly encourage it, no one can be mandated to have the vaccine.

It's a big challenge, because health care workers are also individual Canadians who also read the news and who are affected just as much. Even if they have perhaps more information than those of us who are lay people, they're also affected by what's in the news. I think we have to go back to that broad communication strategy, which also has an effect on health care workers, and urge them to get vaccinated as well. My hope is that this year our rates will improve, because certainly there has been heightened awareness around H1N1 that we didn't have previously.

The Chair: Dr. Kumar.

Dr. Anand Kumar: I think you're right. I've heard from some of my colleagues indirectly that many of them are skeptical that it's worth getting the vaccine. I find that, quite frankly, absolutely astonishing.

There are many reasons, I think, that people are somewhat unwilling. What's going on right now is that there's a lot of bad information out there, and the best way to fight bad information is to generate good information. The way to do that is to do the research and come up with the numbers.

To give you an example, it has been estimated that during the swine flu pandemic of 1976 one in 100,000 people got Guillain-Barré syndrome—which is a problem, in great part because the pandemic never took off. Had the pandemic taken off, as it is clearly doing here, what you'd find is a mortality rate, a death rate, probably on the order of one in two and a half thousand. And by the way, influenza, in and of itself, causes Guillain-Barré probably on the order of one in 100,000.

So you have equal risk of Guillain-Barré, but you don't have the risk of death, which is one in two and a half thousand.

The Chair: Dr. Kumar, would you explain what that is?

Pardon my ignorance.

Dr. Anand Kumar: Guillain-Barré is an autoimmune disease. It's an illness where your body's own immune system is tricked into attacking itself, and in this case it attacks your peripheral nerves so you become paralyzed, basically. That paralysis can be for weeks, or on occasion it can be permanent. So it is something that you definitely want to avoid, but quite frankly, if you go through regular influenza, you're going to see on the order of one in 100,000 cases of it.

I think you counter bad information with good information, and you publicize it.

● (1640)

The Chair: Go ahead, Monsieur Dufour.

[*Translation*]

Mr. Nicolas Dufour: We were just talking about getting accurate information out to the public and about discounting some of the inaccurate facts that may be circulating. I question the media's actions.

Do you think the media have done their job and sufficiently emphasized the benefits of the vaccine, or the problems that could arise if a pandemic is declared? Do you think the traditional media have been an ally on the H1N1 issue?

[*English*]

Dr. Anand Kumar: I think the media have their own interests, as everybody does.

Do I wish they had emphasized more the importance of vaccination? Yes.

How can you bring it out further? I don't know. Maybe with some TV spots. But without question, the issue of vaccination is going to be a major issue going forward, because if you don't get sufficient penetration we are going to see a good number of very serious cases over the next six months.

The Chair: Thank you very much.

[*Translation*]

Mr. Nicolas Dufour: Ms. Fralick...

[*English*]

The Chair: Go ahead.

Ms. Pamela Fralick: Thank you.

I think the media are in a very difficult position, because they need to tell stories, tell news, keep people informed, and that doesn't always match well with our needs as health providers.

I will say one thing, though. In Toronto approximately 60 very desperately mentally ill people jump in front of the subway every year, and you do not read about it in the media. There is an agreement, unwritten, amongst the media. They do not report, because the research has shown there are copycat acts.

I believe the media can and want to be very responsible in how they deal with issues. Perhaps we need to connect in different and improved ways with the media to make them stakeholders in this as well.

The Chair: Thank you. Those are very wise words.

Ms. Davidson.

Mrs. Patricia Davidson (Sarnia—Lambton, CPC): Thank you, Madam Chair, and my thanks to our presenters here this afternoon.

This is an issue that we have been studying for quite some time, and rightly so. When we meet with different people, we get different perspectives. We're learning, and that's good. What we're hearing is encouraging. I think that we're going in the right direction.

It's also encouraging to hear people such as Dr. Kumar say that we're making progress. But I don't think anybody is going to say we're ready, and that's a wise thing. That is a good position to be in. I don't think we ever will know if we're ready. We need to have a fluid plan that will keep evolving as situations arise and we react to them. The readiness plan is to put as many different things in place as we can so we can react in many different ways. That's what we've been trying to do, and according to the people we've spoken with, we are heading in the right direction. We're not there, as everyone would agree, but we are going in the right direction.

We've been very strong on collaborating with the provinces and the territories. All the pandemic planning lays out a hierarchy, if you want to call it that, for different levels of government to be doing different things. That's extremely important for everybody to realize. No level of government is capable of supplying everyone and being everything to everybody.

We've been working to make sure these strategies are put in place in the other jurisdictions. We've released some interim guidance on infection prevention and control measures for health care workers and emergency workers. Could you elaborate on that, Ms. Lynkowski? Do you have an involvement in it?

● (1645)

Ms. Debra Lynkowski: We haven't had a direct involvement through CPHA, other than through our medical officers. I would agree that the mechanisms and the forums we now have in place, which we didn't have during SARS, have allowed for a coordinated and standardized response. This is particularly true of the level of coordination between the federal government and the provinces and territories. It has been a real success story with H1N1, one that we simply didn't have before. Through better coordination and communications we've been able to integrate with some of the health care associations and other providers of primary care.

Mrs. Patricia Davidson: Does anyone else have any insight into working with the emergency providers and first responders? No?

One thing that we've heard about here today is the importance of communication in convincing people that it is the right thing to do. When I talk to people on the ground, I very often hear the “why”—why get it? I think we are missing the mark on the communication end of it. How we get it out there, I don't know. It has to be multi-faceted. I don't think there's one specific way to do it.

We've talked publicly about the vaccination of this committee. It's more important to vaccinate health care workers than it is to vaccinate the eight people on this committee. Health care workers are seen as people with special knowledge in these matters. If they're not going to get it, why should anyone else? The health care workers are the ones who should know. We need a better communication and education strategy for health care workers.

The Chair: Ms. Fralick.

Ms. Pamela Fralick: It was part of my message that communication is an issue. I don't think the people who have put these processes in place have gotten enough credit. The folks at Health Canada and PHAC have done everything they could to get the right communication strategies in place, and some of them are very effective. But we keep hearing that it's not all getting through. We can't become complacent. We have to keep doing the messaging and then look for other routes, such as the health provider associations.

Mrs. Patricia Davidson: And I certainly commend those who have done all the great work they have done on the communication. I wasn't trying to belittle that at all, but I think we do need to look at other more innovative ways, if we can, and continue that process.

The Chair: Thank you.

Dr. Martin.

Hon. Keith Martin (Esquimalt—Juan de Fuca, Lib.): Thank you very much, Chair.

And thank you very much, everyone, for being here today.

In the interest of full disclosure, I have to say that Dr. Kumar and I went to medical school together, so if I'm really nice to him you'll know why. It's because I know all the secrets from medical school; that's why.

The Chair: And just remember you have the floor very shortly, Dr. Kumar.

Hon. Keith Martin: Thank you, Chair.

My first question for Dr. Kumar is this. When you're assessing our reserves of ventilators, both type and number, along with meds to keep somebody intubated and sedated and ventilated in an ICU, do we have enough stockpiled in those two areas?

Dr. Anand Kumar: A few months ago I would have said I was very concerned about the ventilator issue. Our model suggests we've probably got enough ventilators, or close to it, now. If you take into account the extra stores individual places have—the federal stockpile, etc.—I think we're there. We still could be tight.

And I have to tell you that one of the things I am disappointed about in terms of where we are right now is that we really haven't come up with a good strategy to redeploy resources from one place to another. Because the way this pandemic will play out in Canada, as it has played out in every other pandemic, is that it's going to be like raindrops falling on the country. You don't know who is going to get hit and when and how severely. One can say that overall our models would suggest we are close to being ready, but some places may be overwhelmed because they will be hit particularly hard. And the question of how one redeploys resources from one place to another is not really clear, in my mind. Yes, we have these kinds of arrangements for nurses and doctors to be able to be licensed, but on an operational level, how do you do that? So that's one concern.

The other concern, as you mentioned, is that there are some subtle supply chain issues that I don't think have been adequately addressed. For example, when we got hit in Manitoba, we found that our patients required absolutely massive doses of sedation to keep them in a state in which they could be effectively ventilated. Being on a ventilator is very unnatural, so one requires a certain level of sedation. But these people required a massive amount. We ran out of sedatives on several occasions. Because we were the only place in the country being hit, we could import sedatives. If there are a lot of places being hit at the same time, that could be a problem.

Just to give you an idea of how much sedation we used, Keith, we went through 18 months' worth of sedation in two months.

● (1650)

Hon. Keith Martin: That's a shocking statistic, isn't it?

I have two quick questions. Could you let us know about the concept of herd immunity and how it's really important to hit that 70% immunization level in order to be able to really retard the spread of the virus?

And secondly, in your professional opinion, if one is vaccinated against H1N1, when the virus mutates, do you anticipate there'll be a cross-reactivity between this virus and its mutated version downstream?

Dr. Anand Kumar: As for the question on the mutation, I don't think anybody knows whether a mutation is likely at all. We don't even know what happened in 1918—that's what you're alluding to—where the second wave was much worse than the first. So to be honest with you, my expectation is that there won't be a major mutation. It's possible, and whether the vaccine then covers or not, I don't know.

I'm sorry, Keith, your first question...?

Hon. Keith Martin: It was on herd immunity and trying to hit that 70% target.

Dr. Anand Kumar: Essentially, herd immunity is this: you don't have to vaccinate everybody in a population to create an effective immunity within that entire population. You need to inoculate or have immunity in a certain percentage. That certain percentage depends on a lot of different factors, including the attack rate and such. Generally, the higher you get in terms of the population.... It could be entirely correct that if we get up to 50% or 60% of the population inoculated, that's enough, but right now we're not even close in terms of what people are saying they're going to accept.

Hon. Keith Martin: It seems to me that would be a very good selling point, that our individual action to receive the vaccine is also an act of public service to our neighbour, and in effect, by receiving the vaccine we're helping to protect and retard the spread of this virus to our fellow citizens.

Dr. Anand Kumar: Absolutely. I think that's absolutely true.

I'll tell you something, just as an aside. A lot of people are thinking, well, you know, I'm not likely to be hit, but I can tell you I think the saddest thing you'll ever see is a parent—because a lot of the people who are hit on this are young people—a mother, who's wondering why she didn't vaccinate her young child who has gone through an incredible illness. I can't emphasize enough how important vaccination is.

The Chair: Thank you.

Mr. Uppal.

Mr. Tim Uppal (Edmonton—Sherwood Park, CPC): Thank you, Madam Chair, and thank you to the witnesses for coming.

We've been doing this study for a while, and it's good that we've been doing this. I actually went over to one of my larger communities, Fort Saskatchewan, and sat down with our deputy fire chief and our senior health and safety adviser for the city just to talk about what they're seeing on the ground, what they're seeing at their level. Frankly, I was very reassured. They've got a plan in place and it has been in place for a while. Some of the plan, according to the deputy fire chief, is part of what they use as their disaster plan for other issues. In our riding, in our communities, we've got oil upgraders and other chemical plants, so they've got a disaster plan in place and they've been able to work with that plan that's already there and modify it for a possible H1N1 outbreak.

The business continuity plan is there. They've figured out within their bureaucracy and their positions what priority positions they need to work on. They've figured out how they can move staff possibly from one department to another department and also what they can do from home. It's very reassuring that they've already figured all this out.

When I asked them about what they would like to see, they said they're getting a lot of good information. Their concern is that it's too much information, and they're having trouble keeping up with all the information that's coming through. We've heard this from one of the doctors here and witnesses before that it's difficult for some of these people, who are very busy with their own jobs and other priorities they have throughout the day, to also be doing a lot of this reading. Their idea was to try to keep it simple.

Can I get some idea from you whether you're hearing the same thing?

● (1655)

Ms. Debra Lynkowski: I can speak to that from CPHA's perspective. Again, it's a legitimate concern. We ourselves have noted that, and we're working with the Public Health Agency now, as well as the Canadian Medical Association, the College of Family Physicians, and the National Specialty Society for Community Medicine, to ensure there are shorter versions, let's say, of the best evidence we have—guidelines for primary physicians on the front lines. It has been recognized as a concern. I believe the Public Health Agency is responding to that concern by trying to provide more user-friendly tools, and many of our agencies are working with them to make that happen and to work it through our respective networks.

Mr. Tim Uppal: Dr. Kumar.

Dr. Anand Kumar: I don't know how you simplify the messaging. I think you're right, there is an overwhelming amount of information out there. A lot of it is bad information, to be perfectly honest with you. I think the anti-vaccine forces have really jumped on this opportunity.

I don't know how you'd do that, except that I think you stay on message. You get all your involved parties giving the same message, maybe do some television spots. We did that with smoking, so why not with vaccinations? Beyond that, I don't know.

I will say, by the way, on the issue of preparation, that I think preparation is actually very good, by and large, on a local level. My concerns about preparation probably have more to do with inter-site cooperation. That is to say, public health is actually in pretty good shape with that, but as you may not know, ICUs have been kind of historically outside the domain of public health. Public health goes about as far as the hospital—maybe into bed utilization—but the ICU is a black box, so as for how we could cooperate if we were really pressed to do that, I think that's an unknown. It's one of the big deficits, in my mind: the cooperation of ICUs across the country, if it became necessary.

Ms. Pamela Fralick: I have just a quick comment.

Again, I lived in Toronto during SARS and was the chair of a hospital at that time as well. The business continuity was not a big issue at that point in time, but the document that came out that everyone wanted, that was considered the definitive business continuity plan, came from Sherry Cooper, who's an economist with TD Bank or CIBC.... Sorry, I'm getting a little message here. Anyway, I'm not supposed to say—

The Chair: Yes, a little message is right.

I thank you very much. Could you just take a minute to quickly wrap up? We are going to go into business after that. There will be no more questioning since we're going into business.

Ms. Judy Wasylycia-Leis: Can I ask one question?

The Chair: No, Ms. Wasylycia-Leis, we're going into business. I'm sorry about that.

Ms. Judy Wasylycia-Leis: I thought you said five o'clock.

The Chair: I want to tell you that we have appreciated your coming out today, and we have appreciated all the comments you have made. It has been very, very insightful.

I will suspend the meeting. We do have some very important business things to discuss, and I know Ms. Wasylycia-Leis has something to ask you, so what I am going to do is give three minutes. Ms. Wasylycia-Leis, will this help you? We're taking a three-minute suspension so the cameras can be removed. We will then do business until 5:30 p.m. before we have another meeting on neurological disorders.

I'm going to suspend for three minutes and ask that the committee resume in three minutes. Would everybody who is not on the committee please leave the room, because we are going into camera?

Thank you.

[*Proceedings continue in camera*]

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