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Chair

Mrs. Joy Smith

Standing Committee on Health

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● (1540)

[*English*]

The Chair (Mrs. Joy Smith (Kildonan—St. Paul, CPC)): Good afternoon. I'm so pleased to have everyone here today. We're in a new room today and there's more room to spread out.

We're so pleased to have our witnesses come today from the Department of Health. We're having Samuel Godefroy, director general of the food directorate; Hasan Hutchinson, director general of the office of nutrition policy and promotion; and from the Public Health Agency of Canada, we have Kim Elmslie, director general for the Centre for Chronic Disease Prevention and Control. Welcome.

We'll start with Hasan Hutchinson, director general.

[*Translation*]

Dr. Hasan Hutchinson (Director General, Office of Nutrition Policy and Promotion, Department of Health): Thank you for the opportunity to address the committee today.

[*English*]

I'm sorry that there hasn't been quite enough time to translate fully all of our opening remarks for today's meeting. They are currently in translation and will be provided to the clerk by the end of this week.

[*Translation*]

In October 2007, the Minister of Health announced that the Government of Canada would establish an expert working group. The Sodium Working Group, the SWG, was established in early 2008 to develop and oversee the implementation of a strategy to reduce the overall consumption of sodium by Canadians. The SWG is working on a three-pronged strategy, which will include education, research and voluntary sodium reduction in processed foods and restaurants and food services products.

The SWG mandate, its terms of reference and membership list are available on the website. I believe you all have these documents. There is an error in the list of members: I am not on the list. As president of this group, my name should be added to the list.

The group has met in person or by teleconference 6 times in the last 18 months, initially focusing on establishing a common knowledge base for all members including supplying information on current activities across Canada.

[*English*]

The preparatory stage was completed by May 2008. Baseline data on sodium levels in the diets of Canadians and on the primary sources of dietary sodium were obtained from the Canadian Community Health Survey. The synopsis of the U.K. Food Standards Agency's program on salt reduction was prepared, and an *It's Your Health* fact sheet was also developed. I believe we distributed as well the *It's Your Health* document on sodium for all of you.

The assessment stage is also being completed. An important element of this data-gathering phase was an expert public consultation held in February 2009, where invited experts described the challenges and opportunities in sodium reduction, including those from the United Kingdom and from the European Union, who describe their experience with and plans for sodium reduction in their jurisdictions.

The sodium working group also heard from industry groups, social marketing experts, and health organizations.

[*Translation*]

Work on the strategic framework phase began in the spring of 2009 at the May 2009 meeting where the SWG identified the elements under each of the three prongs of the strategy and formed focused subcommittees for every prong. Substantive progress was made through the summer and the subcommittees reported on their progress at the September SWG meeting.

[*English*]

The first subcommittee, which deals with the voluntary reduction in foods, has embarked on developing a Canadian approach on reducing sodium in foods by using best practices from other countries such as the United Kingdom. Consultations are also under way with health authorities from New York City.

Information sessions were held in September to inform industry about the need for sodium reduction, sources of sodium in the diet, and the various approaches to reducing sodium in processed foods and foods sold in restaurants and food service establishments. As a follow-up, discussions with food industry stakeholders will be undertaken shortly to set sodium reduction targets and a schedule for the voluntary reduction of sodium levels in food products.

For the education prong, work is under way to develop a national public awareness and education campaign to educate and inform Canadians on sodium and the health consequences linked to high levels of sodium intake and to increase consumer demand for foods lower in sodium.

With respect to research, a research agenda is being developed to support the food industry in reformulating foods lower in sodium, to facilitate behaviour change in Canadians, and to monitor and evaluate the effects and impacts of the strategy on the health and well-being of Canadians. In conjunction with CIHR, a research summit is being planned for January 2010.

At our September 2009 meeting, the working group members also agreed to an interim sodium intake goal of 2,300 milligrams per day by 2016. We must say that right now the levels of consumption for Canadians are around 3,400 milligrams. In the long term, we are moving towards a goal of approximately 1,500 milligrams.

A detailed draft of the three-pronged strategy will be discussed by the working group members at a meeting in December 2009. The working group expects to complete its report by mid-2010.

● (1545)

The Chair: Thank you very much.

We'll now go to Samuel Godefroy, director general of the food directorate.

Mr. Samuel Godefroy (Director General, Food Directorate, Department of Health): Thank you, Madam Chair.

Good afternoon, honourable members.

At the outset, like Dr. Hutchinson, I would like to apologize to committee members for being unable to table my opening remarks with you today. Unfortunately, again time did not allow for translation to be completed on time and before the meeting. I'd like to also assure the committee members that translation is under way and that the opening remarks will be provided to the clerk by the end of the week.

The Chair: We'll make sure they're all distributed.

Thank you.

Mr. Samuel Godefroy: That's excellent. Thank you.

I would like to use this introduction to focus on some of the actions, including the regulatory actions, that will help address the serious public health concerns related to overconsumption of sodium in the Canadian food supply. These actions include both actions that the government has already undertaken and further actions that Health Canada is considering.

Health Canada is the federal health authority responsible for establishing policies, setting standards and regulations, conducting health risk assessments, and providing advice and information on the safety and nutritional value of foods available for sale in Canada. These tools, whether they are regulatory or non-regulatory in nature, are used to ensure the safety of the Canadian food supply and to ensure that this food supply, as safe as it is, continues to be a major contributor in protecting and promoting Canadians' health.

The serious adverse health outcomes related to overconsumption of sodium have been a concern for Health Canada for a number of years. During the development of the labelling regulations that came into effect in 2007, it was clearly recognized that providing clear information to consumers on the labels of prepackaged foods could be an important first step in reducing consumption and intake of sodium by Canadians.

Mandatory labelling regulations were therefore established. These regulations require the total sodium content in the product to be included in what we know as the “nutrition facts table”. It is also required that a second value be included on the nutrition facts table, and that's the percentage of the daily value of sodium that a single serving of food would provide. This allows consumers to identify products that are higher or potentially lower in sodium content, and of course enables consumers to make choices among these products.

[*Translation*]

A second labelling tool is also included in the new labelling regulations. Rules were established about the amounts of sodium in foods labelled as "low in sodium", "salt-free" and "reduced in sodium".

Further, a health claim was established that could be used on products that are low in sodium and high in potassium, linking a diet high in such foods with a reduced risk of high blood pressure. With these additional claims, consumers can easily identify and choose foods that are low in sodium. These claims allow food manufacturers to highlight the positive aspects of their products, and motivate competition and low-sodium product reformulation. Labelling and information to consumers was only a first step. It was felt that it could be a powerful tool to help reduce sodium intakes, but would probably only take us part of the way.

It was recognized that further action may be needed to use additional regulatory and non-regulatory tools to intervene at the food supply level.

● (1550)

[*English*]

In support of the work of the sodium working group, Health Canada scientists have also undertaken analysis to help improve our understanding of the sources and the levels of intake of sodium in Canada. It is clear from this analysis that over-consumption of sodium is a problem for both children and adults.

Canadians age one year and older on average consume about 3,400 milligrams of sodium per day. This is to be compared to the upper limit of intake that has been set for sodium, which is at 2,300 milligrams per day for adults and 1,500 to 1,900 milligrams per day for children. In fact, the amount of sodium that is considered to be adequate to support its role for normal healthy functioning actually ranges between 1,000 and 1,500 milligrams, and that's of course again depending on age.

Clearly, and to no one's surprise, the intakes of sodium in Canada were found to be higher than what is recommended and continue to represent a public health concern.

Additional analysis was undertaken to determine the sources of sodium intake and again to help us to identify where intervention in the food supply might be the most effective. In fact, it has been reported that in the North American diet the vast majority of the sodium is coming from processed food. It's approximately 77% that comes from processed foods. Only about 11% of the sodium intake comes from additions by the consumers at the table or during cooking. This confirmed that additional action was needed to intervene at the level of the food supply.

As Dr. Hutchinson mentioned, last month the food supply subcommittee of the sodium working group, along with Health Canada, held several meetings with several food industry stakeholders, including major food industry associations in the country. These meetings aimed to initiate discussions on sodium reduction targets for processed foods and foods that are sold through food service establishments. There was a clear willingness by industry to work together to set targets and develop steps to achieve these targets.

Also, at the end of September 2009, the sodium working group recommended an interim goal for reduction of average sodium intakes in Canada, and this interim reduction goal was set as 5% per year between now and 2016. Achieving this goal, as was mentioned earlier, would see the average intake in adults be reduced from the current value, estimated at 3,400 milligrams, to about 2,300 milligrams. This is again seen as a first step, and a longer-term goal will still aim to reduce the intakes to about 1,500 milligrams, which is the recommended intake.

It is recognized that government cannot do this alone, and to be truly successful we will need to work with industry and health professionals to take the concrete steps that are needed to reduce sodium in the food supply, steps that are achievable and that will not compromise the ability to reach our public health goals. A number of actions are planned in order to reach this goal.

[*Translation*]

We are learning how to achieve these goals by looking at some of the best practices internationally. In particular, we are looking at the U.K. In 2006, the U.K. published their first set of targets for sodium levels in foods. Working with industry since then, they have steadily moved toward reducing sodium in their food supply and recently published updated targets.

While the U.K. started from higher intakes than the levels in Canada, we are looking at the steps that they have taken in cooperation with industry to see how these practices might apply in Canada to help us achieve similar gains.

● (1555)

[*English*]

As recommended by the sodium working group, Health Canada will also be reviewing a number of potential regulatory barriers that could impede the food industry from using healthy alternatives to salt and sodium-containing additives. We will also be looking at options on how we can make label statements to highlight gradual sodium-level reductions—for example, to be able to highlight reductions of less than 25%.

Again, November 2009 will be a very active month for consultation with industry in Canada to develop the steps necessary to complete this particular prong of the sodium-reduction strategy. Health Canada will be working with technical experts from the food manufacturing and the food service sector to look at the proposed sodium targets.

Data collected by Health Canada on the current sodium levels in foods will be shared also with the food industry to support setting those reduction targets. These discussions will of course consider the challenges that industry may face to meet these targets and explore possible ways to overcome those challenges. From these and from ongoing discussions with industry, targets will be finalized and a set of feasible and realistic steps will be developed to achieve these targets.

It's clear that there are challenges before us to achieving changes to the food supply—for example, the ubiquitous nature of sodium in the food supply; finding affordable replacements; the use of salt as a tool in food safety applications; and also consumer acceptance. While we appreciate these challenges, the government is committed to reaching these targets using all the tools at our disposal, whether it be the regulatory tools or non-regulatory options.

Thank you.

The Chair: Thank you very much for all your insightful comments. It's quite shocking when one hears some of this information, and the processed foods piece has been very useful. Thank you to both of you.

We'll now go to the Public Health Agency of Canada, and Kim Elmslie, who is the director general for chronic disease prevention and control.

[*Translation*]

Ms. Kim Elmslie (Director General, Centre for Chronic Disease Prevention and Control, Public Health Agency of Canada): Thank you, Madam Chair.

[*English*]

I think you have received my comments in both English and French and they've been distributed to committee members.

As Madam Chair has indicated, I'm from the Public Health Agency of Canada. Working with my health portfolio colleagues, we share a common objective—that is, reducing sodium in Canada's food supply and supporting the health of Canadians.

I'd like to stress in my comments today the health impacts that we know result from excessive sodium consumption and highlight some of the statistics and research that has been done, as we have a very well-developed body of research in Canada and internationally to draw on to help us understand this complex problem. As my colleagues have already indicated, it truly is a complex problem that will require us to use multiple levers and multiple partnerships in order to reach our goals.

[*Translation*]

Cardiovascular diseases are the leading cause of death and disability in Canada. Elevated blood pressure is a major risk factor for cardiovascular diseases and the most powerful predictor of stroke and heart failure. Elevated blood pressure has been identified by the World Health Organization as the leading risk factor for premature death in the world.

[*English*]

Nine in ten Canadians will develop hypertension if they live an average lifespan. Preventing or delaying the development of elevated blood pressure by reducing the population's average blood pressure is an important way of reducing the health consequences and costs associated with cardiovascular diseases. We know that high dietary sodium increases blood pressure, which poses a health risk.

Sodium consumption over 2,300 milligrams a day has been shown to have an immediate as well as a long-term effect on blood pressure and cardiovascular outcomes. We know that societies that consume low levels of sodium have modest or no increase in blood pressure over time.

There is a direct and progressive relationship between the amount of sodium we take in and the increase in our blood pressure. The increase in blood pressure is most evident among those who have a cardiovascular disease or who have one or more cardiovascular disease risk factors, which include hypertension, obesity and diabetes.

Most deaths attributable to elevated blood pressure actually occur in those with blood pressure levels in the upper half of the normal range; that is, 130 over 85. There is also evidence that lower sodium intake in childhood results in lower blood pressure later in life. In children and adults alike, a modest reduction in salt intake has been shown to have a considerable effect on lowering blood pressure.

Research on high sodium intake in animals and in humans has demonstrated that, besides its indirect effect on the cardiovascular system through an increase in blood pressure, it has a direct effect on the heart and blood vessels. These studies have shown an immediate increase in the stiffness of blood vessels and their changed ability to react to stress. Further, we know that research on the cost-effectiveness of interventions tells us that sodium reduction is the most cost-effective way of reducing the burden of cardiovascular disease.

A recent study that we conducted at the Public Health Agency has shown that a gradual annual reduction of sodium intake by 10% could result in close to 30,000 fewer cardiovascular events and a cost savings of about $330 million over 10 years.

Another Canadian study from 2007 has shown that a reduction of 1,800 milligrams in sodium intake could potentially decrease the prevalence of hypertension by 30%, resulting in over a million people not needing hypertensive medication and an annual direct cost savings of about $430 million. High sodium intake is also associated with non-cardiovascular diseases such as the development or severity of asthma, stomach cancer, obesity, renal stones, and osteoporosis.

I'd like to stress that we have programs and initiatives in place in the country that, along with the efforts that are currently being directed at sodium reduction in the food supply, are necessary for us to fix and maintain Canadians' attention on this important health problem. The Canadian hypertension education program plays a significant role in increasing professional and public understanding of the impact of sodium on health.

Thank you.

● (1600)

The Chair: I thank you. It's quite astounding, some of the things we've heard this afternoon.

We're now going to go into our first round of questions and answers.

Dr. Martin.

[*Translation*]

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

[*English*]

Thank you all for being here today.

In looking at your assessment stages, it seems to me that you're still at the assessment stage, which means that we're about a year behind. If that is so, could you let us know what's holding back our progress?

Secondly, we know that cardiovascular and other health problems are associated with salt. It's like saying smoking is bad for you. We know this. And we know that excessive salt intake is a causative agent of this. What I find interesting is that if you take a casual walk through the grocery store, you see that the foodstuffs are just packed with salt, even things that are considered “healthy”. Can you let us know, specifically, how you anticipate trying to limit the salt in the foodstuffs that most people who eat in a healthy way are consuming? What solutions are you proffering? Even though consumers are very knowledgeable about the excessive consumption of salt, the practical matter of going through the grocery store and picking up something that is low in sodium is actually quite difficult. If you have some solutions, that would be very worthwhile.

I think Mr. Valeriotte's going to pose a question too. Thank you.

● (1605)

The Chair: Who would like to take that question?

Mr. Godefroy.

Mr. Samuel Godefroy: Yes, I could start maybe with some elements of answers—

The Chair: Yes, please. Thank you.

Mr. Samuel Godefroy: —and maybe my colleagues could complete it.

Definitely you're highlighting the complexity of the problem, because essentially we have an ingredient here that is ubiquitous in the food supply, that is present in a number of commodities. So given the health impacts that were identified, it's clear that one approach will not be enough. That's why, essentially, the sodium working group has identified this three-pronged approach, one of which is definitely education, gathering the information.

Now, as for the stage where we are right now in the strategy, I would say that we are past the assessment stage in that we are right now in the process of developing the strategy. That being said, it doesn't mean that the knowledge base that we have and that we rely on is complete. We have identified that actually from the outset and through the expertise that was brought to the sodium working group and that was gathered by scientists from Health Canada and other groups.

It was clearly identified that we have made some analysis. We have already some of the data that support the development of the strategy, but we have also identified a number of data gaps. For example, we have made an estimation right now on where sodium is coming. We have identified its ubiquitous nature. We have clearly identified that we cannot target one specific food commodity, and there are a number of food categories that we'll have to look at, because essentially this would come from all sorts of processed foods, whether they be soups, juices, for example—which is the healthy option you've mentioned—potentially vegetable mixes, and so on, or whether they be highly processed—

Hon. Keith Martin: It is one year behind, and at a charitable level, you're still one year behind. Is there something you can share with us that's preventing this from being on track?

Mr. Samuel Godefroy: There are definitely some delays in accomplishing the goals, and perhaps I would say there are several reasons for that. Some of it is related probably to the way the goals were set. There may have been over-ambitious goals originally when the sodium working group developed the different prongs of the approach that it would go through and realized while implementing that the data and the analysis that is required would be more thorough than originally anticipated. There were some elements related to that.

The Chair: Mr. Godefroy, I'm just going to say Mr. Valeriote is sharing his time with Dr. Martin, so you might like to incorporate in some of the question Mr. Valeriote had.

Go ahead.

Mr. Francis Valeriote (Guelph, Lib.): Thank you for appearing before the committee today.

I have a very brief question. It's probably a little more comprehensive and not directly related to sodium as such. I'm one who believes that we need a national food policy that incorporates not just the issue of food sustainability and sovereignty and security but also wellness. This fits in nicely with a national food strategy, and I'm wondering to what degree Health Canada is able to facilitate a comprehensive review of not just sodium but all additives and chemicals and elements and whether or not you would see that as a strategic part of a national food policy.

The Chair: There's just a minute left, so if you want an answer you're going to have to stop.

Mr. Francis Valeriote: That's fine. Go ahead.

Mr. Samuel Godefroy: I could start.

Dr. Hasan Hutchinson: Okay. He's the starter here.

Mr. Samuel Godefroy: I guess there are two segments in your question, honourable member. You mentioned chemicals and additives, but you mentioned as well any types of issues related to food that have an impact on health. The answer to the second part of the question—whether there is an interest in developing a comprehensive approach to tackle various issues related to the food supply that are linked to chronic diseases and health and wellness—is yes. This is being incorporated with the approach that is developed throughout the health portfolio, both with the involvement of the Public Health Agency of Canada, which is actually monitoring the state of our health and also identifying the reasons related to that and the linkages—for example, to food-borne issues—and our work within the Department of Health and also with the agriculture portfolio, in order to come up with potential solutions that would address that.

Sodium reduction strategy would be one of those. Transfat reduction would be one of those. Reduction of exposure to chemicals in food would be one of those. Reduction of food-borne illness related to microbial hazards would be one of those. So the intent is definitely to incorporate that into a comprehensive strategy that would enable us to achieve these goals.

● (1610)

The Chair: Thank you.

I would ask the witnesses to keep an eye on the light that goes on to signal you that you've reached your time. There are so many questions that people would like to ask right now.

Now we'll go to Monsieur Malo.

[*Translation*]

Mr. Luc Malo (Verchères—Les Patriotes, BQ): Thank you, Madam Chair. Thank you to all our witnesses.

Ms. Elmslie, thank you for your statistics even though they are not very encouraging. I'm thanking you for them because it is important that the public be given a clear picture and be aware of the effect of salt and high blood pressure on their health.

Could you tell me how long we have known about the effect of salt on blood pressure, and the effect of hypertension on cardiovascular health and on the mortality rate?

[*English*]

The Chair: Who would like to...?

Ms. Elmslie.

Ms. Kim Elmslie: I'll answer that. Thanks.

We've known from research evidence and from the surveillance we do in the Public Health Agency of Canada that sodium reduction is an essential component of public health efforts to help keep the Canadian population healthy.

I have brought for you an in-depth report that we've completed in the agency, which I hope will serve as a reference for the committee. It's called *Tracking Heart Disease and Stroke in Canada*. It will point out to you very specifically what we've seen in growth in cardiovascular disease and how trends in hypertension have changed over time. That sodium is a problem and a health problem for us is well known. There's no doubt about that.

The Chair: Do you have extra copies of that? Did you bring them with you?

Ms. Kim Elmslie: I do; I have them here with me.

The Chair: And are they in French and English?

Ms. Kim Elmslie: They are.

The Chair: We'll distribute them, if that's okay.

Ms. Kim Elmslie: Yes, that would be fine.

The Chair: Would you like a copy, committee members?

Okay.

[*Translation*]

Mr. Luc Malo: For how long has Health Canada been working on sodium? For how long has it been studied?

Mr. Samuel Godefroy: This is not a recent problem, as was stated, but the issue has been raised to a much greater extent since 2007, and since the announcement from the health minister that a Sodium Working Group was going to be established. There has been extra impetus since 2007. That doesn't mean that no work was done on this previously. Furthermore, international organizations have highlighted this problem, but since 2007 work has sped up with the announcement of the working group and with the number of activities taking place related to data collection and greater stakeholder involvement.

Mr. Luc Malo: Compared to other countries Canada was late in considering this issue. Even today the working group hasn't actually done anything concrete. You did give yourselves until 2012 to table a first progress report on sodium reduction.

If today, at the end of 2009, as nothing concrete has come out of this working group, how will you manage to prove in 2012 that there has been progress in the reduction of sodium consumption on the part of citizens?

Mr. Samuel Godefroy: There has been some progress but it is not a simple issue. We started more intensive efforts later than other countries, such as the United Kingdom which began in 2006. It should be pointed out however that sodium intake in Canada, currently, without our having yet implemented all the necessary reduction steps, is below the sodium intake currently recorded in the United Kingdom, after two years of reduction efforts there.

By studying previous experiences, for examples in countries such as the United Kingdom, we were able to observe that even the strategies originally developed were questioned because of the problems implementing them. Thus, the initial United Kingdom targets were continuously reviewed and corrected with an eye to their practicality.

The work that we are doing is essential work because an in-depth analysis has to be undertaken in order to define concrete reduction targets and, especially, to invest taxpayers' money in measures that will work.

● (1615)

Mr. Luc Malo: Do you think that a reduction by approximately half in average sodium consumption by 2020 is a realistic and achievable target?

Mr. Samuel Godefroy: Based on the data that is currently available, it is possible, since we have seen efforts to reduce consumption elsewhere. I do not want to speculate on the future. We will have to wait and see how these efforts to reduce consumption can be implemented. If other committee members are interested, I will explain some of the complex aspects of the issue. The problem is not a simple one, but for now, we feel our objective is attainable.

Mr. Luc Malo: The labelling you referred to does not seem to be very effective at present, as there are a host of ways to indicate reduced quantities of salt. For example, we have the Health Check program, which is perhaps not well known enough and which may not be the standard the government wants to put forth.

How do you see labelling in the future so that consumers will be able to know exactly what has been done to reduce the amounts of salt in foods?

Mr. Samuel Godefroy: Labelling is not an end in and of itself; it is a tool but not a miracle solution. The main objective of labelling is to provide information, and setting up a panel on nutrition is already an important step. Furthermore, indicating amounts of sodium should be mandatory. In this case, recording the amount of sodium in a pre-packaged food is mandatory. That is an important aspect of enabling consumers to make a choice.

I fully agree with you: labelling, in and of itself, is not a miracle solution. Labelling must be combined with other tools. Health claims will make it possible to identify products where efforts have been made to reduce sodium content. That is another useful aspect of labelling.

[*English*]

The Chair: I'm sorry to interrupt you, but we're going to have to go on to the next questioner.

Ms. Wasylycia-Leis.

Ms. Judy Wasylycia-Leis (Winnipeg North, NDP): Thank you, Madam Chairperson.

Thanks to all of you for being here.

I want to start by saying, with all due respect, that we as members of Parliament don't need, I think, detailed information about the harms of high sodium levels. We've been informed of them for some time and we had a fairly good discussion about it with the working group.

That meeting came about because in fact through the media we learned that this working group was hidden away somewhere in some basement, plodding along and not accomplishing anything. We're all here today with one purpose in mind, and that is to figure out when you're going to start with a plan of action that actually means something.

Why has this been kept in the dark for so long? Why now...? At the end of the last meeting we thought, good; at least they have a target: it's going to be 2,300. Now you're telling us 2,300 by the year 2016. My goodness! It is appalling that there isn't more of a strategy coming forward at this point.

I think the *Globe and Mail* said it all in the editorial on September 15:

> With health care costs ever-climbing, governments have an extra incentive to do everything possible to prevent disease. Ottawa's leisurely approach to salt overuse is baffling.

That's a mild way of putting, I think, the concerns today.

Kim, you're a part of the Public Health Agency. I thought your job would be to push and prod Health Canada to come up with something. Since 2007 we've had a working group, and now, in 2009, two years after it got started, you're telling us that in 2010 we might kickstart a strategy that might get us to the upper levels by 2016. Canadians are far more advanced than you are, than this government is. They expect some leadership.

I guess my question, at least today, is: why can't you at least begin a major public education campaign? Canadians know the dangers of salt. We know that heart attack, high blood pressure, heart disease are directly related to excessive levels of sodium in salt. We know that it's costing our system $2 billion a year. And Canadians are prepared to do something. In fact, as you both noted, it's not at the home that the problem exists; it's in manufactured foods and in restaurant foods.

So why isn't there a public campaign to alert Canadians, not with more information about what happens, but how to do it, what to do, what you should be eating? Why isn't there some kind of voluntary program such as Britain has? Why didn't you, in 2007—

● (1620)

The Chair: Ms. Wasylycia-Leis, I hate to interrupt you—

Ms. Judy Wasylycia-Leis: I know. I'm going to maybe use my seven minutes for ranting, because I'm really frustrated.

The Chair: Do you just want to have a rant?

Ms. Judy Wasylycia-Leis: Yes.

The Chair: Okay, go right ahead.

Ms. Judy Wasylycia-Leis: I think all the other questions have been “Where's the action?”, and we're not getting very far, so I'm trying to present this in a way that will force some action.

The Chair: So you don't want an answer?

Ms. Judy Wasylycia-Leis: I do. Let me finish, Madam Chair. I have seven minutes.

The Chair: Okay, I'm just clarifying it.

Ms. Judy Wasylycia-Leis: Where is the voluntary plan for industry and for restaurants? Why not reduce salt voluntarily in 80 foods available on grocery shelves by 20% to 30%? Why not a big public relations campaign? Why not a labelling system that people actually understand and know what to do with?

What did you do between 2007 and 2008, when a whole year went by and there's not one record of the committee doing anything? Why, in the spring of 2009, was your objective to identify measures and mechanisms to continue to advance the strategy's development work during the summer months? What kind of an action plan is that?

I want to know where the plan is. When are we going to see it? Why can't you kick-start something now?

The Chair: We have three minutes, and I'm going to be strict with the time.

Dr. Hasan Hutchinson: Very good.

Let me first of all address where we are with the plan.

We do have these three subcommittees, as I've mentioned, that are working very hard to develop the three components of what will be the strategic plan, one of which, as you pointed out, has to do with the need to have a very strong education and public awareness campaign.

Ms. Judy Wasylycia-Leis: In two years, that's where we're at? You're talking about a three-pronged approach that might do some public education? Why isn't it up and ready now? What did you do between 2007 and 2008? What did the working group do? Anything? Were there any meetings?

Mr. Samuel Godefroy: Absolutely, yes.

Ms. Judy Wasylycia-Leis: Why is there no public record of them? Where are the minutes? Do you want to table them? How many groups were involved—

The Chair: Ms. Wasylycia-Leis, you have to be polite enough to let them answer at least one of your questions; otherwise I will not recognize you next time.

Ms. Judy Wasylycia-Leis: I thought I had seven minutes to use as I saw fit, Madam Chair.

Mr. Francis Valeriote: You're using them.

The Chair: Who would like to answer that question?

Dr. Hasan Hutchinson: First of all, let me just say with respect to the posting of the meetings, they are all on our website as well. All of the meetings have been posted here, and we're just working on finalizing the minutes from the last meeting, which just happened two weeks ago.

With respect to the working group, I think you mentioned, between 2007 and 2008, there's no record because what happened in 2007 was the announcement by the minister. The actual working group did not come together until early 2008, and what was done in that very first period was, as I mentioned in my introductory remarks, the initial assessment stage. Again, as I mentioned as well, we did put together the information with respect to sodium. We did do a review of what was happening in other countries and we had organized our public consultation and our expert consultation as well.

Unfortunately, the consultation did get delayed. It was originally planned to happen in the fall, a year ago, and it got delayed by about five months into the beginning of this year, at which time we brought in experts from the U.K. and from the EU and got their best experiences, and it built upon that.

What we have come up with is I think a very clear strategy in the three different areas, and we are developing those three areas right now.

As Dr. Godefroy has pointed out, the actual working out of the targets and how we get to the targets with a Canadian approach has proved to take a lot more analysis than we had originally planned. I think that what we have in terms of timelines in the mandate of the sodium working group were far too aggressive for the production of a strategic plan.

These groups are working quite hard right now and—

● (1625)

The Chair: Thank you. I'm sorry, we're just about out of time—

Dr. Hasan Hutchinson: Could I just—

The Chair: —and I gave you over your time. I know you want to say something, so quickly just go ahead.

Dr. Hasan Hutchinson: Yes, what I was going to say is that we certainly are taking very much a rigid project management approach now and we do hope we will have a draft of the plan by December for discussion at our next meeting on December 3 and 4.

The Chair: Wonderful. Thank you.

Dr. Carrie and Ms. McLeod, I believe you're sharing your time. Okay, Dr. Carrie.

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

I want to thank the witnesses for being here on such short notice and also for the good work you're doing.

I was a little startled on some of your statistics. I remember 16 years ago, when my son was born, looking at baby food and the high content of sodium and sugar. I remember that my wife and I chose to make our own baby food. What impresses me, though, since then is that the industry has seemed to take an approach to remedy the situation.

I was quite happy to hear that you've talked to industry and talked about voluntary reductions, because I think that's probably one of the fastest ways we can react. I have spoken to industries that have already taken steps to decrease the sodium in their foods. But I was wondering if you could give the committee some background information. Why is sodium added there in the first place? What can replace it? That is the first question. Second, what are the challenges that industry will face by decreasing the sodium levels? Could you be fairly brief?

Thank you.

Mr. Samuel Godefroy: There are several purposes for the addition of sodium. Sodium content has a technical effect in the food. In fact, the amount of sodium or salt that can be present in dough to make bread, for example, is fundamental in order to give a particular characteristic to the bread. In fact, if you reduce sodium too much, you may end up with bread that is essentially not what consumers can expect to be bread. It affects the viscosity, if you will. There are also additions that are mandated by food safety. Sodium and salt actually contribute to the preservation of the food.

There are a number of additives, particularly for preservation purposes, where the salts used for the additive have to be sodium salts. There are several reasons why sodium is added. Of course, there is the flavour, which is essentially the palatability of the food and the acceptance of the food by consumers.

All of these elements are contributors to the challenges when somebody starts undertaking reduction efforts.

Mr. Colin Carrie: Are there safe alternatives to salt?

Mr. Samuel Godefroy: There are some alternatives. That is essentially the challenge, to assess the safety and also the accessibility. It's also a fact that in a lot of instances—and that's based on best practices elsewhere, known internationally—some of the alternatives are not cheap and will of course have an effect on the affordability of the food.

This being said, it doesn't mean that there aren't options for reduction. There is research that has been done in order to contribute to the reduction of the sodium content while at the same time maintaining the acceptability of the food and also ensuring that the technical effect exerted on the food is still preserved.

The Chair: Mrs. McLeod, would you like to go ahead now?

Mrs. Cathy McLeod (Kamloops—Thompson—Cariboo, CPC): Thank you. I guess our time is quite short, so I will throw about two questions and hopefully there is enough time to answer them.

First, to build on my colleague's comments around baby food—and of course it's back in my history also—with the reductions that have now been made, with an infant at six months, nine months, or a year, if they have a diet that consists completely of prepared food, will they be within an acceptable range of sodium intake? So I guess my first question is, have we met the need to protect our youngest citizens?

Second, many of us have said right now that we believe that Canadians are very well aware, but I'm not sure that's quite the case. I'll use my assistant as an example. It took him one meeting at the sodium working group to be shocked and checking labels. I think we have a lot of work to do. It's actually not difficult work. Is the labelling and public messaging, which is quite simple, actually, happening right now?

● (1630)

Mr. Samuel Godefroy: I can start maybe by speaking to baby foods.

In fact the addition of salt and sodium to baby food, and particularly to infant food, is regulated. We do have stringent requirements for the addition of salt to infant food. They are mandated by regulation. These levels are so low that industry does not resort to the addition of salt in infant food, so it doesn't seem to be a category right now that would be posing a challenge specifically for infants. Again, industry has resorted to no addition.

And the other part of the question...? I'm sorry, maybe....

Mrs. Cathy McLeod: We've embarked on a labelling process. Has that changed any of our consumer habits? Even though you haven't finished your group, is there any sort of...? You talked about hypertension. That is hitting people who are sort of well past the post. What about our young citizens? Where are they getting the information that they need?

Dr. Hasan Hutchinson: Let me speak briefly about the labelling side of things. We certainly know that Canadians have taken to this new tool, are at least using it, but as I think has been pointed out, perhaps we're not always very clear about exactly how to use it and how to understand it. Certainly our group carried out quite a large education campaign a year and a half ago. We have collected information about that. Right now, we are embarking on the planning of a new campaign for next year as well, which will get to one element at least of what is needed, and that's really education, about how to use the panel itself. Certainly we are moving well ahead already on the planning of that part of the campaign.

With respect specifically to sodium, what we are trying to put together is a very comprehensive social marketing awareness education campaign that involves all of the different stakeholders and different sectors. It's a very coordinated approach as we move forward.

The Chair: Thank you very much.

We have a very special event today, so could I have the attention of all committee members? I am so glad that you are here to join us, because we are very cognizant of good healthy practices on this committee. If you'll notice, when we have to bring some food in, there is always fruit and things like that. But we have a little secret thing going on behind the scenes. We have to give an award to one of our committee members today, because he discovered the secret.

Will Monsieur Dufour please approach the bench?

I am serious. You are getting an award.

I have to tell you, what we did is to decide that we would not have caffeinated coffee, we would have decaffeinated coffee. We appropriately labelled it and did everything. We thought that somebody somewhere at sometime would cotton on to the fact that this wasn't the real thing, that it was decaffeinated coffee, but no one did. So I went merrily along my way until today, when Monsieur Dufour tippy-toed up and spoke to the clerk and said, “Do we only have decaffeinated coffee?”

So today I will present to Monsieur Dufour a Starbucks card and congratulate him.

Voices: Hear, hear.

Mr. Nicolas Dufour (Repentigny, BQ): Thank you.

The Chair: Having said that, we will suspend the meeting for two minutes, so we can prepare for our next guests.

I thank you for your presentations.

● _____ (Pause) _____

●

● (1635)

The Chair: We will resume our meeting. I thank the witnesses today.

I would ask the people in the room who are having conversations to be so kind as to take the conversations outside.

Today we're very pleased to have Dr. Danielle Grondin, acting assistant deputy minister for infectious disease and emergency preparedness. You're not new to this committee, and we thank you for coming today.

We also have another person who is not new to this committee, Elaine Chatigny, general communications. We also have, from the Department of Health, of course, Dr. Paul Gully, senior medical advisor.

You know the routine. We have a five-minute presentation and then seven minutes of questions and answers.

Dr. Grondin.

● (1640)

Dr. Danielle Grondin (Acting Assistant Deputy Minister, Infectious Disease and Emergency Preparedness Branch, Public Health Agency of Canada): Yes, thank you very much.

I'm very pleased to be back to talk to you today and to give you an update on H1N1. I want also to express regrets for Dr. Butler-Jones, as you know. But you have heard today the very important announcement that the adjuvant vaccine has been authorized for release to be used by the public.

Basically, what that means is that we are now confident that the safety and the effectiveness of the vaccine has been demonstrated, and in the next few days all the health professionals in the provinces and territories will be in a position to implement their plan for the rollout of the vaccine.

What also was important in today's announcement is that we have made recommendations for its use.

[*Translation*]

We have made dosing recommendations for the vaccine. We recommend two half-doses of adjuvanted vaccine for children aged six months to nine years, and the interval between doses should be a minimum of 21 days. We also recommend that anyone 10 years of age or older should receive one dose of adjuvanted vaccine. As for pregnant women, we recommend that they receive the unadjuvanted vaccine.

[*English*]

However, should a pregnant woman live in an area where the non-adjuvant vaccine is not available, she should be offered the adjuvant vaccine.

Again, as of today, there have been in Canada over 1,500 hospitalizations, 300 of them in intensive care units, and 83 deaths. As you have said, it's not that we want to be alarmist about that, but just to stress that it is really a serious illness and the best way to stop the transmission of this virus is to immunize as rapidly as possible as many people as possible.

You have also heard, perhaps, Dr. Perry Kendall today speaking on behalf of the provinces and territories. The Province of British Columbia has announced that it is in the second wave. We have also experienced increased activity, as expected with the season, of this virus across Canada. The prairies and other provinces have seen an increase.

Really, it's very important to stress that now that the vaccine is out, the onus—if I may use the word "onus"—is on the provinces and territories to distribute and establish their clinics, but very importantly, on every Canadian, every single one of us, to now go and take the vaccine, which, again, has been determined safe and efficient.

Another piece of information I would inform you about as well is in regard to the second wave and this increase. We are working with provinces and territories to get timely surveillance data, as you are aware. We have established some made-in-Canada types of key indicators. They are for our country, with our specialists, to establish a sort of threshold that will signal the arrival of the second wave. These criteria are the ones that British Columbia has been using.

Basically those criteria are the percentage of persons who are testing positive for the H1N1 influenza, the absolute number of persons testing positive, the number of influenza-like consultations, the sales of anti-viral medications across the country, and information about hospital admissions and deaths. So the surveillance is really critical, and with the provinces and territories we continue to do so, strengthening even our flu watch that you are aware of.

Also, we at the Public Health Agency of Canada are currently exploring, with the front-line physicians and all the national partners, other surveillance programs to help us to keep on track with it, basically to try to receive as much information as possible, on time.

My time is almost up, so I will stop here, because this has been to encapsulate the important events, particularly in the last week and with the announcement today.

Thank you for your attention, and I will certainly be willing to take your questions.

● (1645)

The Chair: Thank you very much.

Now we will go to Ms. Elaine Chatigny.

[*Translation*]

Ms. Elaine Chatigny (Director General, Communications, Public Health Agency of Canada): Thank you very much.

As Dr. Grondin said earlier, we held a press conference today to announce that the vaccine had been approved. We also updated our website, FightFlu.ca. The last time we appeared before the committee, we talked about fact sheets that we were preparing to put on the website. We put them on this morning. I invite you to go and look at the website. We have added fact sheets that provide information for pregnant women, young mothers or caregivers looking after babies under six months of age. There is also another one dealing with the benefits and risks of the vaccine and with what people should know before getting vaccinated. We have really increased the quantity and, we hope, the quality of information available so that Canadians can be well informed when they have access to the vaccine in their province or territory.

[*English*]

The last time we were here we mentioned we would be launching a personal preparedness guide, and you have a copy of this guide. It is available by calling 1-800-O-Canada, by downloading it on our website, and as of the end of this week it will also be available at Canada Post outlets across the country.

We launched this a week ago, and I can say that so far Service Canada has received more than 84,000 requests for this guide, which in seven days is huge. From a social marketing perspective it's highly unusual to get that much awareness and interest.

We have 7,800 downloads from our website for the product. Again, that's extremely high for a seven-day period, and that's only based on earned media—in other words, just the talk from media, not purchased media. That's coming. It also means that based on our analytics, we also know that through 1-800-O-Canada and the website some national organizations are also requesting quantities, so we know it meets the need of national organizations that require this kind of information for their own constituents and members of their organizations. We're really pleased with that.

Because we know that dosage is important to parents in particular and to individuals who want to know the facts on dosage, we created this downloadable document. It's an easy reference.

As well, later this week we are going to be mailing a pamphlet to all households that talks about symptoms: how to recognize symptoms, how to treat, what to do; it's very straightforward. It also contains the 1-800-O-Canada number and FightFlu.ca web URL, encouraging Canadians to obtain the preparedness guide.

Although there are clearly pockets of activity in some parts of the country as we move into flu season, we do know there's a level of complacency and a relatively low level of concern. We still think the opportunity is ripe to raise awareness about the H1N1 pandemic, to encourage Canadians to become informed about ways to recognize symptoms, and what to do if they become ill or need to care for family members.

I don't think we're there yet in terms of the level of awareness, in terms of some concrete actions that people need to take, so I think we've taken an important step in implementing our national social marketing strategy.

In a few days you're going to start hearing more radio ads encouraging people to become aware and informed of the symptoms of H1N1 and to take action, and in November we're also going to be providing more specific information nationally around the vaccine itself.

Although we announced the authorization today, we know the vaccine is just starting to roll out across the country. The intense activity around mass vaccination clinics will really start ramping up, so we're going to coincide our vaccination marketing activities and messages for that period of time, understanding that it will take between now and the end of December, probably around Christmas, before we have completed these vaccination campaigns. We need a certain window of time to ensure there are messages in the public domain so Canadians can make the informed choice they need to make.

That's the update I wanted to provide today.

● (1650)

The Chair: Thank you.

Now can we go to Dr. Gully?

Dr. Paul Gully (Senior Medical Advisor, Department of Health): Thank you, Madam Chair. Thank you for inviting me back again.

We continue to monitor cases of influenza-like illness in first nations communities in collaboration with the provinces and territories. As Dr. Grondin mentioned, there has been an increase in influenza activity nationally, in particular in British Columbia and now in Alberta and the Northwest Territories, and cases in first nations communities have reflected the activity in the provinces and territories. That's certainly been the case now in Alberta.

As we've said before, first nations communities continue to be able to access the appropriate medical equipment, supplies, antivirals, and so on in response to the pandemic. We continue to work with the first nations communities in terms of pandemic preparedness, and now our assessment in terms of our relationship and discussions with the communities is that in most regions almost all communities have a plan and almost 90% have in fact tested those plans.

In terms of the vaccine, we work with the provincial governments because the vaccine is distributed from the provincial governments. Health Canada's first nations and Inuit health branch then enables that vaccine to be distributed to communities. It will be distributed according to the provincial guidelines and will then be available, in most cases, as per seasonal vaccine. However, for H1N1 there will probably be more mass immunization clinics than there are normally. Remote and isolated communities have been included, as you are aware, in national vaccine-sequencing guidelines. In two provinces, I think Manitoba and Saskatchewan, first nations have been named in particular for prioritization.

As with seasonal influenza vaccine, regional differences in timing are to be expected. This will also apply to first nations communities. The precise timing will vary depending on the province and time of distribution, although the methods of distribution are there, as is the plan for occasional challenges in terms of weather. Sometimes the first nations communities will express a preference in terms of timing. I am aware, for example, that some communities across Manitoba have said that they would like it one week as opposed to another week.

Because the distribution is similar to other vaccine distribution in the province, there are therefore well-established processes for handling vaccine and implementing the programs. Community members will be notified of clinics through a variety of means, such as local radio, community bulletins, and posters, but we will be relying on chiefs and community leaders to promote the vaccine. I was in northern Manitoba yesterday and I would describe it as what I think is a partnership between the provincial government, the Government of Canada, and first nations in order to be able to promote the vaccine. It is a community-level activity.

As I've described before, we're now mobilizing health care professionals to support immunization campaigns in the provinces. I know that as of Sunday, certain individuals from Health Canada will be going to provinces to assist in mass immunization.

We continue to work with the Assembly of First Nations and Indian and Northern Affairs Canada to implement the various activities in the joint communications protocol. As you'll be aware, last week the Minister of Health visited the Cowessess First Nation in Saskatchewan and highlighted that community's success, which I certainly don't think was unique. We had a very positive discussion with members of the community, the chief, council elders, and the pandemic planning committee there.

● (1655)

In terms of citizen readiness, as Ms. Chatigny has outlined, that is ongoing and there are certain products that are tailored for first nations communities. And we're taking steps to ensure that the guide is available in communities, because not all communities have post offices and we want to ensure that first nations communities have this available as well.

Finally, we're making very good progress in planning for the virtual summit together with the AFN, the Assembly of First Nations, and we're having daily meetings with the AFN to plan for that. It should happen in early November and will have various webcast components and web-based content, which will then enable us, at the time that immunization is being rolled out, to answer questions and to continue to promote immunization in first nations communities.

Thank you.

The Chair: Thank you so very much.

We'll now go into our round of seven minutes of questions and answers, starting with Dr. Duncan.

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

Thank you to all the officials for coming in, and your time, your effort.

If I could address two issues, one is surge capacity. We've been hearing that there is little or no surge capacity in the system, and I'm wondering what your modelling shows. We've heard 1% severe illness, we've heard one to 50, we've heard one in 1,000.

Even if it's one in 1,000, that's going to translate to 1,500 to 2,500 cases of severe illness needing ICU across the country potentially simultaneously, and perhaps 3,000 beds. I'm wondering what happens if the number is greater. Is there a national surge capacity plan? Is there a mechanism to move resources from places?

It's so encouraging to hear of the work that has been done in first nations and aboriginal communities. Last day we learned that Manitobans bore the brunt of the lessons learned in the spring, and that was both in the aboriginal community and the non-aboriginal community.

We know patient outcomes depend on how quickly you're treated. We heard that there was a real lag of perhaps seven to eight days. I am concerned going forward. How do we assure that there is not that lag?

One way is the prevention side of this, to make sure people get vaccinated. What is the rate of vaccination and what tends to be the pickup in aboriginal communities? I'm really concerned about social distancing measures when you have several families living in a dwelling. Do we need more money or resources?

Can I ask one more? I can just put it on the table.

● (1700)

The Chair: It depends on whether or not you want an answer.

Go ahead.

Ms. Kirsty Duncan: In terms of the vaccine for pregnant women, if the unadjuvanted is not available, how have we come to the figure of 20 weeks? What is the evidence for that, and how does that compare with elsewhere?

The Chair: Who would like to tackle these questions? Dr. Gully, would you like to start?

[*Translation*]

Dr. Danielle Grondin: Of course.

[*English*]

There are several. I hope I've captured most of them I can answer, Madam Duncan.

On this capacity issue at the health care delivery itself, last time you heard Dr. Kumar and so on explaining. They are working.

In terms of a national plan, we have had our conference where we brought together all the intensivists and the persons, and there is also the network of the emergencies and the health care, and they are working on that.

There is one point I would like to make, though. It's important because this modelling and all those numbers that you brought forward—and we agree on them—-are numbers that could happen if we don't have immunization, if people do not get immunized. That's the reason it's so important.

[*Translation*]

We have to work upstream.

[*English*]

How do I say that in English? We have to start at the beginning. Death is the ultimate result. Intensive care is the second.

The thing is that we have to work now to prevent it. Prevention is where we come in as the national Public Health Agency. The message is that if, for example, in the best scenario we succeed in immunizing 100% of the population, then the H1N1 will disappear.

It is important to know, and perhaps you heard this at the conference, that the efficiency of this vaccine is greater than all the vaccines that we have. It is well over 90%. So it has the capacity to stop H1N1, and that's the reason it is important.

Ms. Kirsty Duncan: I agree, but right now we are seeing that the percentage of people who are wanting to take the vaccine is down at 33%.

Dr. Danielle Grondin: I agree, but that's the reason it has become a collective effort here, as Madam Chatigny has explained.

The effort, if I may, in a respectful way, is your effort as well. You are powerful people in your constituencies, so you can pass on the message and try to change what we are hearing a little bit. I'm talking with a lot of respect here, but the thing is we go to the media, we explain the vaccine, and then we hear that people don't know what it is. Something is wrong somewhere. The message has to get out.

We have high regulatory standards in Canada. The vaccine, as we now know, is safe. It corresponds with what we are hearing. It is highly efficient. If people take it, it has the power to stop the H1N1.

That is the first thing, that the message has to get out loud and clear. I hope all of you will be taking it.

The other issue is

● (1705)

[*Translation*]

working upstream.

[*English*]

There is the vaccine, but there is also the message of the antiviral. Nationally, out in the provinces, there are enough antivirals in stock to treat every Canadian who needs them. That is the reason we have passed a strong message to Canadians and to health professionals to get early treatment with the antiviral. This is another step to try to avoid being hospitalized or admitted to the ICU.

We also have identified high-risk persons who are to get the vaccine and who should go quickly to see their physician.

So it's a package of everything.

The numbers you are quoting—yes, but the thing is that if people are not taking the means to protect themselves.... And it's not only to protect oneself. If I take the vaccine, I will prevent transmission. I will not transmit or be a vector of the transmission of the virus to any of you, if you don't take it.

These are important messages that have to come across. Certainly we are looking at you and the power, the influence of your position to pass this message very strongly to your constituencies.

That is about the numbers.

Regarding a pregnant woman and the 20 weeks, we don't have the evidence for the H1N1; it's a new virus. This will come. We have worked that out with the Society of Obstetricians and Gynaecologists of Canada to try to balance the risk of the mother, the fetus, and so on. Right now, 1% of the population in a given year is pregnant in Canada. Right now, 5% of pregnant women are among those who are hospitalized, and 5% die. It's very important.

We really need to bring the highest level of safety to these women, so they feel that within the first trimester, for example, [*Inaudible—Editor*] is not a risk, but then they can be protected.

There are also studies that the influenza might be a risk in those trimesters. We are working on that with the college.

The Chair: Thank you.

Monsieur Dufour.

[*Translation*]

Mr. Nicolas Dufour: Thank you very much, Madam Chair.

Thank you for being here today and for providing additional information on the H1N1 flu.

The vaccine has been approved and it was authorized today. If I understand correctly, clinical trials in Canada were not finished, but the vaccine was nevertheless authorized.

What led the agency to use European studies, rather than finish the ones it was conducting?

Dr. Danielle Grondin: I know that next Monday, you will be hearing from experts on regulations. I am not an expert in that area, but I can, however, provide some clarification.

For this vaccine, as for all other vaccines or medications, the Canadian government, Health Canada, our colleagues, examine all of the clinical studies conducted in Canada and elsewhere throughout the world. All of the data is compiled. Canadian studies were conducted, but they are perhaps not as comprehensive, because there are still more to come. The clinical data we received is sufficient to reassure us: the vaccine is safe and more than 90% effective for protecting Canadians who receive it.

Mr. Nicolas Dufour: Could it not have been approved much earlier?

Dr Danielle Grondin: No.

Mr. Nicolas Dufour: In the end, the result is the same.

Dr. Danielle Grondin: No, because we had to analyze all of the data that was coming in. They will explain to you what all of the steps entail, if necessary. As we have said on several occasions, a vaccine must be provided quickly, but not too quickly so that safety problems can be prevented. That is the balance that must be struck. The timing was perfect to date.

Mr. Nicolas Dufour: GSK, GlaxoSmithKline, appears to be managing studies on the vaccines and awarding contracts to research companies to verify the long-term effectiveness of the vaccine, in other words to determine if it will be effective against the virus for several months.

Are those routine studies, or is there a real risk that the vaccine will not be effective over a long period of time?

Dr. Danielle Grondin: This is an influenza virus. It is different from viruses like polio or yellow fever, where the vaccine lasts 10 years. Influenza viruses mutate several times each year. That is why for the seasonal flu, we adjust according to the virus that is out there. Why is it so important for so many Canadians as possible to be immunized against H1N1? Because we expect it to be around for many years to come. By giving immunization today, we are probably investing for the years to come. Bear in mind that that is a hypothesis.

The fact remains that for any vaccine, for this virus, we know that less than 10 days after the first dose, immunity is over 90%. We do not achieve that percentage for seasonal flu. Now, they want to ensure that at some point, for more than 21 days, it can be maintained in future years. That is part of the normal aspects considered by pharmaceutical companies. They always assess how long a vaccine will protect us.

Mr. Nicolas Dufour: Those are routine examinations.

Dr. Danielle Grondin: They are routine examinations, absolutely.

Mr. Nicolas Dufour: How is it that we are preparing for a massive vaccination campaign, but that the unadjuvanted vaccine, which must be administered to pregnant women, is not even ready? Will that not lead to some confusion or problems?

Dr. Danielle Grondin: No, not at all. The campaign must be coordinated with the provinces and territories, which must prepare the logistics, once the vaccine has been authorized for distribution.

The deadline was set for the start of November. That is when both vaccines will be available. Today, much earlier, we have received approval for the adjuvanted vaccine. However, we are still on target for both vaccines to be offered on the scheduled date, at the start of November. We have some leeway.

Mr. Nicolas Dufour: Mr. Gully, you stated—and the remarks were made at a press conference last Friday—that the minister had announced that more than 90% of communities were already prepared to deal with the pandemic. So that means approximately 10% of communities are not ready.

Has the department identified those communities? Could the committee receive the list of those communities?

● (1710)

Dr. Paul Gully: I will answer in English, if I may.

[*English*]

The way we have approached this is that the regions know very well the communities that do not have a plan, and they are working with those communities. We think that's where the responsibility should lie, because they do know those communities, and in fact we do recognize that there will always be some communities who either do not wish to have a plan or, because they're so small, in fact may not have the capacity to have a plan. What is important is that the regions know those communities, and then if there is a problem in those communities—if H1N1 is a problem—we would add support to those communities in order to be able to respond.

I think we're asking some very small communities to be prepared, whereas if we compared them with non-first-nation communities of the same size, I would contend that probably the vast majority of first nations communities may well be better prepared because of the work and also because of the time and energy that those communities and community leaders have in fact put in and applied to pandemic preparedness.

The Chair: Thank you.

Ms. Wasylycia-Leis.

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

Thanks to all of you, again.

I think we'll be in a stronger position to recommend to people in our constituencies to take the H1N1 vaccine if you can give us more information about the testing that was done for efficacy and safety.

What pre-trial testing was done for this particular vaccine, our Panvax?

[*Translation*]

Dr. Danielle Grondin: If I may, I would really prefer suggesting you put that question to the experts, our colleagues from Health Canada who are familiar with all of the details and who can explain the exact meaning of all of that, in terms of regulations. I know that they studied all of GSK's scientific data, compared the studies, and verified the safety of the product.

[*English*]

Sorry, you asked in English, and I'm answering in French. I apologize.

[*Translation*]

Ms. Judy Wasylycia-Leis: No problem.

[*English*]

Dr. Danielle Grondin: They will be the best ones to answer and they will be here Monday to speak with you. I apologize, but I think you will have a more satisfactory, more precise answer.

The Chair: Thank you.

Ms. Judy Wasylycia-Leis: Perhaps I should save my next question for Monday as well, but I need to ask it now, because people will be asking us questions over the weekend, now that the vaccine has been released.

What mechanism is in place for surveillance of the vaccine to record and ensure national compilation of data with respect to adverse reactions?

Dr. Danielle Grondin: There are already some surveillance systems in place. There is the IMPACT system. It's the immunization monitoring program across Canada, where we have health professionals report any severe secondary effect to the vaccine.

There is also the acronym CFIS, a system that is in place, which stands for the Canadian adverse reactions. We're following an immunization surveillance system. This is front line, sentinel, all broad health care professionals who report any secondary effect to the provinces and territories and then to us. Plus there are others.

Again, we can very easily forward to the committee—because time is short, I realize—all the systems and what they do, how they target.

Ms. Judy Wasylycia-Leis: That would be very helpful. In the past I don't think Health Canada has actually put in place a fail-proof national network system that shares information and can do the cross-checks to have some accurate data.

● (1715)

The Chair: Ms. Wasylycia-Leis, I think Dr. Gully wanted to answer, if that's okay.

Dr. Paul Gully: If I could add to Dr. Grondin's answer, in terms of first nations communities we will be implementing a system to collect similar but very specific information so that the nurses will be collecting information in all the communities where Health Canada will be immunizing. In some ways it will be a more complete collection of information because of the way those communities are isolated. Their ability to collect on a population basis will be there. I think it will be a valuable adjunct to those other systems.

Ms. Judy Wasylycia-Leis: Is that being done now with respect to the administration of Tamiflu?

Dr. Paul Gully: If there's a prescription for Tamiflu, it is a requirement if there is a severe reaction. Therefore, that would be reported. The requirements vary slightly from province to province, but certainly that would be in place.

Ms. Judy Wasylycia-Leis: Can only doctors prescribe Tamiflu?

Dr. Paul Gully: That varies from place to place. In first nations communities and some provinces nurses can say they would like it to be prescribed and they will call the physician. In situations where there are provinces that enable nurse practitioners to practise, they can make that decision.

Other provinces, such as British Columbia, are working toward a system so that registered nurses in isolated communities can make that decision. The nurses are licensed by the province and therefore under provincial jurisdiction.

We're comfortable that if an individual needs Tamiflu in a remote and isolated community they will get it if required.

Ms. Judy Wasylycia-Leis: Thank you.

With respect to non-adjuvanted vaccine for pregnant women, I know there's a limited supply at present. How will that get distributed? Carol was telling me about her own community in northwestern Ontario, small towns all over the place. What will pregnant women do, and how will they access the non-adjuvanted vaccine?

Dr. Danielle Grondin: Well, the non-adjuvanted vaccine, when it is authorized, will be distributed by similar mechanisms through GSK to the already established plans of distribution with provinces and territories, who will then distribute them to their various localities based on their geographical set-up.

Ms. Judy Wasylycia-Leis: Is there a national standard across the country, in terms of distribution of the actual vaccine?

Dr. Danielle Grondin: Yes. In fact, the distribution was mentioned in our Canadian pandemic plan, when it was returned in 2006. Right now, in the logistics of it, the details of how to do this nationally, each province and territory was invited to identify distribution spots and where the trucks of GSK will go and so on. Once that has been established, each province will undertake the rollout in their respective province, absolutely.

The Chair: Thank you, Dr. Grondin.

Mr. Brown.

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

Reading the booklet that was given to us today, *Your H1N1 Preparedness Guide*, one thing that I found curious and wanted to get some feedback on was when I was looking at the symptoms there could be greater complications for, one of the things listed in the three categories was neurological disorders. Our health committee has recently struck a subcommittee on neurological disorders. I was curious if you could expand upon that a little bit and why that would involve greater complications.

Dr. Danielle Grondin: In looking for the H1N1 more specifically, neurologically it is when somebody may have perhaps some lethargy, tiredness, that type of thing.

Sorry, I want to see what I'm reading here.

Mr. Patrick Brown: It's on page eight of the book.

Dr. Danielle Grondin: What type of neurological trouble they are suffering from to get the vaccine, do you mean?

Mr. Patrick Brown: Yes. It mentions there would be additional complications.

● (1720)

Dr. Danielle Grondin: I have the French, sorry. I apologize.

Okay. The people who have chronic conditions, basically neurological disorders, people with seizure disorders, for example. That would be an example of this that could be considered.

Mr. Patrick Brown: It could potentially provoke seizures, is that what you're saying?

Dr. Danielle Grondin: I'm not saying that it will provoke seizures. That has been a question, in all honesty, that has been asked. That's the reason we are talking with the Canadian Paediatric Society. For example, when you have young children who have what we call febrile seizures, if the vaccine can provoke a bit of fever, should that be a consideration? This is a question of concern to parents, for example, because the question was asked of us. So this is certainly one question we are looking at for the Canadian Paediatric Society.

I see Dr. Gully has one, and Madam Chatigny.

Ms. Elaine Chatigny: I simply want to clarify. What Dr. Grondin is talking about are potential side effects. These are not side effects. What this is about are people who are at risk of complications.

We're specifically saying that people with chronic conditions, such as those who may have diabetes or asthma or neurological disorders, may be at risk of greater complication of H1N1. That's what we're saying here. This is not a side effect.

Dr. Danielle Grondin: That's what I'm saying.

Ms. Elaine Chatigny: Yes, I needed to clarify that.

Dr. Paul Gully: Perhaps I could enlarge as well.

You are absolutely correct. Because certain individuals with neurologic disease may be more prone to pneumonia, for example, by virtue of their basic neurological problem, it may affect their ability to breathe properly. In addition, sometimes for people who have advanced neurologic disease it would be actually difficult to tell, perhaps, if they did have symptoms of H1N1. So it's logical that those individuals would be at increased risk, for a whole variety of reasons, to complication of H1N1, which may partly be related to a difficulty of diagnosis.

Mr. Patrick Brown: I think my colleague Mr. Uppal had a question.

The Chair: Mr. Uppal.

Mr. Tim Uppal (Edmonton—Sherwood Park, CPC): Thank you, Madam Chair.

One of the things we've found is that information is probably the most powerful weapon we have against this. Good information is important for prevention and preparedness. Even now, with the rollout of the vaccine today, people need to have confidence in the vaccine. Good information is what's going to get them there.

Further to some of the information you've discussed already—the rollout of the radio ads, other purchased media, and the earned media we've been getting—is there a plan for new Canadians, different cultural communities, and different language groups? Is there information for them through different cultural media outlets?

Ms. Elaine Chatigny: It is definitely a component that's been considered. We have primarily focused on making our information bilingual in English and French. In some cases we're working with the First Nations and Inuit Health Branch to make it available in certain dialects for first nations communities and in Inuktitut for communities in the north.

Our colleagues in Ontario, with whom we work very closely on developing much of our approach, and in British Columbia in particular, translate virtually all their social marketing products into multiple languages. For the city of Toronto, for example, the Ontario Ministry of Health regularly translates into more than 20 languages.

What we do is ensure the coherency of messages by working collaboratively with provinces and territories. They then drill that down by working with specific communities and with local medical officers of health. They know where their communities are at and how they would like to receive information. It's much more tailored and much more pertinent.

The challenge with us doing that is that we are not on the ground in these communities. This is the cascading approach we take.

Mr. Tim Uppal: Is this the provinces' responsibility, or is it the individual municipalities' responsibility?

Ms. Elaine Chatigny: It's not a matter of responsibility. This is not about responsibility or jurisdiction. It's about what makes the most sense. How do we work collaboratively? Where do we put our efforts? Where do they put their efforts? Where is their value added? Where is our value added?

It has nothing to do with jurisdiction.

● (1725)

Mr. Tim Uppal: But you're seeing it at the municipal level.

Ms. Elaine Chatigny: We're definitely seeing it in Toronto and in Vancouver. There is a big effort on the part of our provincial colleagues to reach out to their communities and to work with the municipalities and local medical officers of health to get information out in a more pertinent and grassroots way than we could federally.

Dr. Paul Gully: If I could just add to that, Madam Chair, I think that in first nations communities, for example, often one would want community leaders and others in the community to maybe translate, promote, explain, and be available to explain in another language. Often there are very different ways of explaining and understanding and enabling people to ask questions in another language. It is clearly something that cannot be done federally. It has to be done locally.

The Chair: I want to thank you very much for coming. We really appreciate these updates. I know that we will see you again very soon.

I want to thank you, and I want to thank the committee.

The bells are about to ring, so the committee is dismissed.

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