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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, everyone.

I'm so glad you're here, committee members. We're going to very quickly go over some business. First of all, we're going to go over a motion.

Dr. Carrie, could you read it into the record, please?

Mr. Colin Carrie (Oshawa, CPC): Thank you very much, Madam Chair. I think it's very timely.

We heard the questions in the House a few minutes ago, and I've been told we're supposed to be doing clause-by-clause on this bill in the Senate tomorrow, so I'm very glad that I've put it forward. I'll read it into the record:

> That the Standing Committee on Health report to the House its opinion that C-6 is necessary to fill regulatory gaps and allow government the power to issue recalls and that the current framework for product recalls does not allow for timely and consistent action to protect Canadians; and that due to the committee extending its hours in order to ensure the timely passage of C-6 as well as the House of Commons unanimously passing this important piece of long overdue legislation, this House should strongly encourage members of the Senate Standing Committee on Social Affairs, Science and Technology to act responsibly and, in the interest of the safety and welfare of all Canadians, pass this crucial piece of legislation without delay.

The Chair: We'll open it for discussion now.

Ms. Murray.

Ms. Joyce Murray (Vancouver Quadra, Lib.): Thank you, Madam Chair.

First, I'd like to put on record that no Liberal Senator is delaying Bill C-6. The Senators are dealing with Bill C-6 in a responsible manner. They, like the Liberals on this committee, support the safety of consumer products for Canadians.

I consider this motion not only extraneous, but insulting. This bill was in the House for 70 sitting days and it has been in the Senate for only 28 sitting days. I think the member opposite will agree that there were some complex issues that needed to be addressed and witnesses to be heard from in order to understand this bill. This has been expedited.

The government first spoke to Bill C-6 in the Senate on June 23, which was the day before the House adjourned. Liberal Senator Day spoke to the bill two sitting days later, on September 16. This bill was referred to committee on October 7, but it didn't even get heard in committee until October 21. So this is a bill that will end up spending half the number of sitting days in the Senate that it did in the House, and on clause-by-clause, so a vote will be taking place next week. The senators have all been responsibly passing this in an expeditious fashion, so the Liberals will be abstaining on this extraneous vote.

Thank you, Madam Chair.

The Chair: Thank you.

Is there any other discussion?

Monsieur Malo.

[*Translation*]

Mr. Luc Malo (Verchères—Les Patriotes, BQ): Madam Chair, after having studied the matter, the way in which this committee has gone about expressing its desire that Bill C-6 be passed with all due speed is through the work that has been done in the House itself. If my colleague considers the Senate to be an obstacle to the way in which Parliament should work, he should actually be talking about abolishing it.

At the moment, the Senate is there, and senators are studying the bill. They already know that we want the bill passed for the benefit of our fellow citizens because of all the discussions that we have had in the House of Commons.

So, for those reasons, Madam Chair, I will vote against my colleague's motion.

[*English*]

The Chair: Is there any further discussion?

Can we go to the vote now?

Some hon. members: Yes.

(Motion agreed to)

The Chair: Thank you very much.

I want to let the committee know that the minister will appear before the committee on Wednesday, December 2, to discuss supplementary estimates (B).

I want to also let the committee know that we will consider the HHR draft report—yay—on Monday, December 7. Having said that, I will note that committee business is now closed and I would ask our witnesses to please take their seats.

Good afternoon to our witnesses.

I want to welcome you to the health committee. We are so pleased to have you here today. We are very concerned about the HHR study that we're doing right now and we are so pleased that you can be here to give us further insight.

Pursuant to Standing Order 108(2), we'll begin with our study on health human resources.

We have in front of us, first, from the Association of Faculties of Medicine of Canada, Dr. Nick Busing, president and chief executive officer.

Welcome, Dr. Busing.

From the Canadian Association of Naturopathic Doctors, we have with us Dr. Paul Saunders, vice-chair of the government relations committee, and Dr. David Lescheid, scientific adviser to the government relations committee.

Welcome to you both.

From the Canadian Pharmacists Association, we have with us Dr. Jeff Poston, executive director.

Welcome, Dr. Poston.

From the Canadian Physiotherapy Association, we have with us Michael Brennan, chief executive officer.

I should mention that we also have Steve Slade with us, who is from the Association of Faculties of Medicine of Canada.

Is that "Dr." Steve Slade?

● (1535)

Mr. Steve Slade (Vice-President, Research and Analysis, Association of Faculties of Medicine of Canada): No, it's "Mr.".

The Chair: Okay. Mr. Steve Slade is the vice-president of research and analysis.

We're very pleased to have all of you here. We will have a five-minute presentation from each association. Following that, we will go into our first round of questions and answers.

We'll begin with Dr. Nick Busing, president and chief executive officer of the Association of Faculties of Medicine of Canada.

Dr. Nick Busing (President and Chief Executive Officer, Association of Faculties of Medicine of Canada): Thank you very much, Madam Chair.

We did circulate a document that is my version of a PowerPoint presentation. I would ask you to perhaps follow along with me, because I'm going to refer to some data on it, and some of my comments may be a bit out of context unless you have it. If I may, I'll tell you as I move through the pages.

Once again, thank you very much for giving us this opportunity.

For those of you who don't know about the Association of Faculties of Medicine of Canada, we represent the 17 Canadian faculties of medicine. We have a tripartite mission: educating the future physicians and scientists of this country; doing health research; and providing clinical care, particularly in our tertiary and quaternity care centres.

We are currently graduating over 2,300 physicians a year. We have more than 10,000 students studying to be physicians. We have 12,000 post-graduate trainees and, now, with our distributed campuses, we have 21,000 faculty across the country in full- and part-time positions. Canadian faculties of medicine receive $2.6 billion in health research.

As it states in my introduction slide, there is a significant alignment between the priorities of AFMC—and I've mentioned three strategic goals—and the standing committee's invitation and request to us to address issues of national HHR planning, innovative solutions, research and data collection, labour mobility, collaborative practice, and recruitment and retention. Within our five minutes, I'd like to touch on most of those.

The next slide says to you that we are on the same page. At our recent Deans on the Hill event, in which we met at least four or five of you around the table in one-on-one meetings, from all of your caucuses it became clear that the issue of HHR crosses all political boundaries, of all stripes. Regardless of the party or the person we interacted with, we heard clearly the message that this is a critical issue for the country, so we think we have the right group of people here to hear our observations.

We'll address four proposals very briefly.

I would ask you to go to the next slide, entitled "New Training Opportunities for Canadian International Medical Graduates". This slide tells you that we have in our system 830 residents in training who are here on a visa. A visa resident is somebody who is not a Canadian; is not expected to stay in Canada; is supported by a sponsor, usually a sponsoring government; and is expected to return home. So that is a large number of trainees in a system which we're already currently expanding.

The next slide talks about international medical graduates. It gets a bit complicated, because an international medical graduate is somebody who is either a landed immigrant in Canada or a Canadian who studied medicine abroad and has returned here. So this is another cohort, of which, as you see, there are 1,387 who applied for training in Canada. We had capacity for 392.

So we have a relatively simple proposal, which we have spoken to some of you about in the past and which we want to reiterate. That is, we think it is time to modestly reduce the number of visa residents we have in our system and increase our capacity to take more international medical graduates. I know that all of you have constituents whose children are studying medicine abroad and want to return to Canada. They will be labelled an international medical graduate when they come back. This is a modest proposal to increase the capacity to take these sorts of students into our system.

However, visa residents come with a price tag. Faculties of medicine receive funding for visa residents. This is a proposal to replace 50 visa positions with international medical graduate positions funded by the federal government. We could fine-tune this proposal for you and suggest that that you may want to identify particular areas of need for those 50 positions. I think this could be a win-win opportunity on a small level.

The next slide is complicated and it is complicated for a purpose: to remind you that getting international medical graduates into practice in Canada is not a simple effort whatsoever. In fact, we have six major assessment centres across Canada assessing international medical graduates.

● (1540)

And yes, I know that many of you wonder why can't we take that physician when he or she arrives in the country and move them from a job outside of medicine into our operating rooms immediately. But there is a transition required, and this slide just reinforces for you the complexity of getting international medical graduates into practice.

The third one—

The Chair: I'm sorry, but we're just over five minutes. If you could quickly go over....

Dr. Nick Busing: On pathways to medical practice, we're talking about the need for a summit on pathways to practice. We think we should bring all the players together, the stakeholders, to exchange perspectives and try to rationalize the complex system of six assessment centres in a national strategy.

I will move right to the other issues. I'm sorry, but we have too much data for five minutes.

The Chair: Yes, I'm sure, but we are going to have questions and answers, so I think we'll have to go on to our next one now, Dr. Busing.

Dr. Nick Busing: That's great.

Thank you.

The Chair: We'll now go to Dr. Paul Saunders.

Dr. Paul Saunders (Vice-Chair, Government Relations Committee, Canadian Association of Naturopathic Doctors): Good afternoon, committee members.

My name is Dr. Paul Saunders. I'm a naturopathic doctor in private practice in Ancaster, Ontario. I'm on the faculty of the Canadian College of Naturopathic Medicine and engaged in teaching, research, and clinical education. I am vice-chair of the CAND government relations committee.

I'm joined today by my colleague Dr. David Lescheid, who is a naturopathic doctor in private practice here in Ottawa, a clinical researcher, and scientific adviser to the CAND government relations committee. We want to thank you for the invitation to present to you today.

Naturopathic medicine is a distinct primary health care system that blends modern scientific knowledge with traditional and natural forms of medicine. Naturopathic doctors are primary care professionals with a minimum of seven years of post-secondary education, including an undergraduate degree and four years of full-time study at an accredited naturopathic college.

We have a detailed infrastructure of educational requirements, licensing examinations, jurisdictional examinations, and legislation in six provinces across Canada. We are fully compliant with chapter 7 of the Agreement on Internal Trade.

We are one of only three health care professions in Canada that offer primary care for patients, along with medical doctors and nurse practitioners. Our scope includes the ability to communicate a diagnosis.

An increasing number of Canadians are using naturopathic doctors as their primary care providers despite the fact that naturopathic services are not covered by public health care systems. For example, in P.E.I., 8,000 individuals do not have primary health care, and it's estimated that over 5,000 of them are treated by the qualified naturopathic doctors in P.E.I.

While conventional medicine is experiencing an increase in the number of MDs retiring and a reduction in the number of medical students choosing family practice, we are experiencing significant growth. In the two accredited colleges in Canada, there are over 715 students currently enrolled, with 160 students entering the program each year. We have a viable career choice for these individuals and, as a result of the growth of our profession, over 65% of them are between the ages of 25 and 35. I don't qualify for that, but it is an indication that when our naturopathic doctors graduate, they will be in practice for a long time.

Treating and preventing many different illnesses is a big scope of our practice and one of our unique capabilities, and we feel that we are in an effective position to offer this to the overburdened Canadian health care system.

I want to turn the rest of the presentation over to Dr. David Lescheid.

● (1545)

Dr. David Lescheid (Scientific Advisor, Goverment Relations Committee, Canadian Association of Naturopathic Doctors): It's great to be here today. Thanks for the opportunity.

Naturopathic doctors' services are covered under extended health care plans, but not under any publicly funded plans. Patients taking a proactive approach to health by seeing an ND are therefore eliminating any financial burden on Canada's already overtaxed health care system.

Recent government and independent international reports have made it clear that Canada has an opportunity to improve its delivery of health care. In our view, an integrative, collaborative, team-based approach is necessary to support and revitalize Canada's health care system to enable it to meet current and future challenges. The challenge is to effectively integrate and utilize both publicly and privately funded health care professionals.

There are some examples of NDs who are working collaboratively with conventional health care professionals in multidisciplinary clinics, community health care centres, hospitals, and remote and rural communities. That's an important point. Canadians in remote and rural communities must often travel many hours to find a health care provider, if one is available at all. Those living in these areas tend to take a more traditional view of health and find they're in tune with the approach taken by naturopathic doctors.

Removing barriers to collaborative, innovative, multidisciplinary practices would assist Canadians by providing access to the health care professional of their choice who can provide the right services at the right time in one location. Barriers include a lack of funding, direct access to diagnostic services, access to substances, and professional bias. These things result in an inability to treat appropriately or refer or receive referrals, putting patients in an awkward position that results in fragmented patient care and, ultimately, increased costs.

Clearly there is a need to develop a more proactive, efficient, effective, and ultimately more sustainable health care system in Canada. We need to lower our health care footprint and minimize the impact we have on the cost of maintaining a health care system that remains socialized and accessible to all. We need to improve our health promotion strategies and support health care professionals with expertise in health promotion and disease prevention.

In the context of the terms of reference for the health committee's study of human health resources, we recommend that, first, the funeral government...I mean the federal government. That's a bit of a slip there.

The Chair: That was a Freudian slip, I assume.

Voices: Oh, oh!

Dr. David Lescheid: We recommend that the federal government: provide leadership and support for the development of fully integrated collaborative health care teams; provide leadership to ensure that all health care professionals are able to practice to their full scope, therefore addressing the shortage of primary care providers and allowing greater access for patients; provide leadership by funding initiatives to remove these barriers to truly collaborative, multidisciplinary, integrated care; and ensure health care professionals, such as NDs, have access to all the substances they require to treat patients safely and effectively—

The Chair: Thank you, Dr. Lescheid.

Keep in mind that we do have your written presentation and the committee is very careful.

I've let everybody go over a minute and that cuts into our question-and-answer time. I'm not trying to be rude. It's very difficult. Just watch when I turn the light on, because I hate interrupting you guys.

Dr. David Lescheid: Oh, that's fine.

The Chair: Thank you.

We'll now go to the Canadian Physiotherapy Association, with Michael Brennan, chief executive officer.

[*Translation*]

Mr. Michael Brennan (Chief Executive Officer, Canadian Physiotherapy Association): Thank you very much, Madam Chair.

[*English*]

Good afternoon to all the members.

The Canadian Physiotherapy Association's 11,000 members work and study in all provinces and territories, and we are very pleased to participate in these deliberations.

As noted in the brief we circulated last week, we feel that the answer to the question of sufficient health human resources can be found in the rigorous implementation of inter-professional collaborative care. The efficient use of professional skills in collaborative teams, free from outdated hierarchy, has proven beyond any doubt to improve health outcomes, reduce wait times, and lower costs.

It's not too presumptuous to say that we know already what must be done to meet our health human resource needs. The solution is not to be found in simply increasing the numbers of physicians, or nurses, or physiotherapists, for that matter.

As the Health Council of Canada indicates, in applying what we've learned about team-based, patient-centred care, we can resolve a significant portion of our health human resource needs today. The truth is that bigger is not better: better is better. There's an opportunity today for the Government of Canada to put into practice health human resource management techniques that are proven to yield better patient outcomes at lower costs.

The public service health care plan is by far the largest health services plan in Canada and one of the largest health contracts in Canada. Nearly 1.2 million employees, pensioners, and their families are covered by this plan. Over $700 million in claims were paid last year. On top of that, the government recently awarded Sun Life the contract to administer the plan at a cost of $30.5 million annually. Given the size of this contract, the government's influence as Canada's largest employer and purchaser of benefits is tremendous.

We respectfully submit that members of Parliament have a duty to ensure that this multi-billion-dollar plan incorporates the most efficient use of human resources possible. Within the current plan, physicians serve as gatekeepers. You cannot access physiotherapy, for example, or other health services, without a prescription from a physician. Patient self-referral to a physiotherapist is legal in all provinces and territories; however, under the plan, you will not be reimbursed for a physiotherapist's treatment without proof of a physician's prescription.

This policy is wasteful. Every year, millions of health care dollars are spent on physician referrals that do nothing more than add red tape. This policy is harmful. Bureaucratic delays in accessing physiotherapy services for acute musculoskeletal injuries can result in chronic impairment, costing employers millions in additional staff absence. The sooner a patient receives proper treatment, the better the outcome.

Patient self-referral to physiotherapy services has proven to be less costly, improves outcomes, and decreases employee absence from work. Extensive studies in the United States, the U.K., the Netherlands, and Australia demonstrate beyond any doubt that direct access to physiotherapy results in better outcomes, earlier return to work, and lower costs.

[*Translation*]

The Government of Canada has the opportunity to put these proven techniques into place. We are asking the members of this committee to share this information with their colleagues in the hope that members of Parliament of all political parties will be able to express the collective will that health human resources be effectively used.

● (1550)

[*English*]

You do not need to wait for a popular uprising to implement this change. As Henry Ford said, “If I'd asked my customers what they wanted, they would have said faster horses.” This is an opportunity for leadership. The 1.2 million Canadians covered under the public service health care plan may not yet appreciate the benefits of this proposal, but once it is implemented, overall health of the public service will improve, employees will return to work faster, physicians will have more time for other priorities, and program costs will go down.

The members of the Canadian Physiotherapy Association are committed to their patients. A thorough examination of our proposal will show that we are not asking for more compensation or any competitive advantage in the market. We are asking simply for the removal of red tape based on outdated thinking. We are simply trying to make it easier for our patients, including the public service, to receive the care they need with fewer administrative hurdles.

If Canada is to enjoy stable and sufficient health human resources, we must apply what we've learned. It is no longer time to study the issue; we are very well informed of the problem and of a number of practical solutions. We urge the members of this committee to help implement a simple yet significant change. In so doing, you will demonstrate both a clear understanding of what needs to be done and the will to do it.

Merci beaucoup.

The Chair: Thank you so much. I have to commend you. You have a presentation of 5:01 minutes, so you're a chair's dream, actually.

We'll now go to the Canadian Pharmacists Association, with Dr. Jeff Poston.

Dr. Jeff Poston (Executive Director, Canadian Pharmacists Association): Thank you very much.

Thank you for the opportunity to present to you today.

I'm the executive director of the Canadian Pharmacists Association. We are the national voluntary professional association representing Canadian pharmacists. Our members practise in the community, in hospital, in academia, and in industry.

Earlier presentations to this committee have advocated the need for a pan-Canadian health human resource strategy and have introduced the concept of the need for a national HHR institute or observatory. We, as the Canadian Pharmacists Association, would certainly support those proposals. However, in this presentation, I want to highlight three things from our submission that are innovations required to promote recruitment and retention of pharmacists in health care.

First, pharmacists want satisfying, meaningful jobs, and this means an expanded role for pharmacists in the health care system. Second, to develop these, we need investment in training places in the practice setting. Third, we have to move to become more self-sufficient and reduce our dependence on pharmacists who have been trained outside of Canada.

Pharmacists are experts in ensuring medications are used safely and rationally. It's clear that patients need help getting the best from their medications and that the health care system would gain through improvements in the safety and quality of drug use. There's also increasing evidence that pharmacists, particularly in collaborative practice models, can improve outcomes from drug therapy.

Supporting collaborative inter-professional models of health care delivery is critical to system sustainability and this will increase the need for pharmacists with the specific skills and expertise for expanded practice. The development of these skills requires experiential inter-professional training and practice, and universities require additional funding to increase the number of such training opportunities.

Best practices in recruitment and retention must also consider the proportion of internationally trained pharmacists in the workforce. International recruiting, while a potential solution to workforce shortages, must be done in an ethical manner. In the longer term, Canada should work towards becoming more self-sufficient in meeting its health care workforce needs.

The Association of Faculties of Pharmacy of Canada reports a pharmacy school applicant acceptance rate of one in six, yet in Canada last year the national examining board for pharmacy registered more than 1,200 pharmacists who were eligible for licensure, and 40% of these pharmacists were trained outside the country. More than 50% of pharmacists licensed in Ontario last year were trained outside Canada.

Despite these numbers, pharmacist shortages in both community and hospital settings continue to be a challenge, although somewhat less so than in the past. This leads to significant dissatisfaction as pharmacists continue to report heavy or increased workloads as their biggest challenge, while owners and managers report finding and keeping qualified staff as their challenge. Overwork and burnout are common complaints, resulting in lack of time to meaningfully interact with patients.

Achieving optimal drug therapy outcomes needs an approach that requires time. To meet some of these challenges, we've seen employers introduce innovative HR practices, such as flexible work hours and compensation packages with incentives. such as signing bonuses and subsidizing continuing education.

On a more pragmatic side, pharmacists currently spend too much time on drug plan administration. Simpler drug plans would be a good first step to better manage the use of Canada's available pharmacy workforce.

We also need innovation in the use of trained pharmacy technicians to support the optimal use of Canada's pharmacy human resources. We now have accreditation standards for pharmacy technician education programs and approved entry-to-practice competencies, and many provinces have put in the legislative and practice requirements to allow for the registration and eventual regulation of pharmacy technicians.

In conclusion, to make better use of pharmacists in the health care system, we need innovation to develop expanded roles for pharmacists that will lead to increased satisfaction; we need investment in inter-professional education and training in practice settings; we need to develop the role of pharmacy technicians in relation to drug distribution; and last, we need new practice models with new methods of compensation.

With support from the federal government, and indeed many provinces, we are beginning to develop innovative practice models. At the national level, we're supporting a major “Blueprint for Pharmacy” initiative to lead and direct change in the profession.

Thank you very much.

● (1555)

The Chair: Thank you, Dr. Poston.

We'll now go to our seven-minute question-and-answer round, starting with Ms. Murray.

Ms. Joyce Murray: Thank you.

Thanks for being here to help us understand the shortage of health human resources and what we need to do about it.

We've heard from a number of witnesses before today about the benefits of inter-professional collaborative care. We're hearing more support for that. We've also heard about barriers to implementing the model in pilot projects that's been shown to work.

I'd like to hear from the representatives of the naturopathic physicians. This is about barriers to this kind of practice. We've heard about such barriers from other members of the medical profession. I'm hearing that there's more bias and there are additional barriers to those generally in place through...well, the other kinds of changes to the system that would be needed to foster inter-collaborative care.

I have two questions.

First, can you tell me what kind of research supports the cost-effectiveness of naturopathic treatment?

Second, perhaps you could tell us a bit more about your problems with or barriers to access to substances that you use in treating patients, and how restrictions on the full scope of practice for which you're trained also create a barrier to your contributing to the health human resource solutions.

I'll be sharing my time with Dr. Martin as well.

● (1600)

Dr. Paul Saunders: I'm going to answer the first part of your question and let Dr. Lescheid answer the second part.

On the first part of your question, I'll use an example. We worked with Canada Post in doing a research study in which patients received standard naturopathic care, including all of the things we do, or physiotherapy care, or just the usual sort of care. What we showed in that particular study was that for the postal workers who received naturopathic care, there were savings of more than $1,000 per person in health care costs, and individuals returned to work sooner, were much healthier, and were able to do their work much better. There have been similar studies in the United States.

That's an example of research that actually shows naturopathic care is effective and cost-effective.

Dr. David Lescheid: Just to give you some examples of barriers for us, we have a lot of training in different kinds of natural health products, and one of the barriers is access to the substances that we have training in.

I'll give you three examples. The first two examples are about access to the doses that we know are safe and effective. One of them is for vitamin D, which is really the Michael Phelps of the vitamin world. We've learned a lot about vitamin D in the last little while. Currently, the upper limits are 2,000 international units. The science is suggesting that you need to go higher in order to have a therapeutic effect, but you need to go higher with a person who's well trained and knows the dosing. Yes, we could have our patients take handfuls of 2,000 international units or less, but really, it's best to be able to have access to a larger dose.

Something that goes along with this is that we're now starting to learn that vitamin D is related to vitamins A and K, and we're also restricted as to the amount of vitamin K we can use. So even though we do understand the interaction and vitamin K has really been shown to be a very, very important vitamin, we just can't get access to it with Health Canada.

So that's the dosing. Something such as L-carnitine is an example of one that is safe, but we don't have access to it because it's on schedule F. I'll just give you an example of the barriers and how frustrating they are, I work in a medical building that's owned by a medical doctor. We share patients. A patient went to him to ask about L-carnitine. The medical doctor said that he really didn't know much about L-carnitine, but he told the patient to see the naturopathic doctor downstairs. The patient came to see me and I was able to tell him about L-carnitine, the doses, the side effects, and what he needed to look for. Then, at the end of the conversation, I had to tell him that it was on schedule F and I couldn't do anything about it, that he'd have to go back upstairs to see the medical doctor to get a prescription for it. So here's a way that—

The Chair: I'm sorry, but Dr. Martin is going to run out of time completely unless he asks his questions now.

Or do you want to continue with this, Dr. Martin?

Hon. Keith Martin (Esquimalt—Juan de Fuca, Lib.): Will there be another chance? Is there time?

The Chair: No, probably not.

Hon. Keith Martin: Then I'll quickly submit my questions, if I may.

The Chair: Go ahead.

Hon. Keith Martin: Thanks to all of you for being here.

Briefly, Dr. Busing, could the AFMC submit a couple of things to this committee?

Number one, you've done some excellent work in showing the demographic changes within the physician and the nursing populations. If that could be submitted, it would be appreciated, because it shows the graphic change taking place within the profession.

Secondly, if it isn't in your submission, could you also submit the plan for the 3,000 spots at the undergrad level, and also the plan for the 250 spots at a cost of $86 million in order to dramatically increase the post-graduate training positions the AFMC has?

Thank you.

Dr. Nick Busing: Thank you.

A couple of the asks are embedded in the slides, but I will be happy to formalize them in the way that Dr. Martin has suggested.

● (1605)

The Chair: That would be wonderful. If you submit it to the clerk, we'll ensure that each member gets a copy, including Dr. Martin.

Dr. Nick Busing: That's fine.

The Chair: By the way, welcome, Dr. Martin.

He's not a regular member of our committee but is a very valued member when he comes to our meetings.

Hon. Keith Martin: Thank you, Chair.

Ms. Joyce Murray: Do we have additional time left, Chair?

The Chair: Of course you do.

Ms. Joyce Murray: Thank you.

It seemed as though you weren't complete with your response, and we still have a bit of additional time in this section.

Dr. David Lescheid: I was almost wrapping up. It just seems like a very inefficient use of health care dollars to have essentially three different visits in order to be able to answer the question for this person about how to safely and effectively use L-carnitine.

Ms. Joyce Murray: Are you suggesting that the federal government ought in some way to work with the provinces to update the scope of practice for naturopathic physicians?

Dr. David Lescheid: Absolutely: to include the substances that we're trained to use safely and effectively.

Ms. Joyce Murray: Lastly, have you studied the B.C. scope of practice that's just been formalized in regulation? Does that fit what you're requesting?

Dr. Paul Saunders: Yes. We have looked at the B.C. scope of practice. It's just being put into place so we don't have all the details, but that would definitely be very helpful, because it will allow them to have access to the botanicals, the nutritional substances, the amino acids, and the vitamins and minerals that we are trained to use and are able to use in practice. That would definitely help.

The Chair: Thank you so very much.

Now we'll go to Monsieur Malo.

[*Translation*]

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

In the documents that our witnesses have provided us with, I find one aspect to be virtually the same: the use of human resources. With your permission, I would like to highlight it for the committee.

Here is what the Canadian Physiotherapy Association writes in a paragraph entitled: “The importance of efficiency in health care and health human resources”: “The only way to afford current health care standards in the face of this increased demand is by increasing efficiency”. This, then, is about the efficiency of health care and health human resources, as the title indicates.

Here is what the Canadian Pharmacists Association writes: “The health system is not optimizing the use of its pharmacy human resources”.

In the brief from the Canadian Association of Naturopathic Doctors, the first point in the conclusion says that it is necessary to: “ensure the utilization of all health care professionals to their full capacity”.

So all three seem to be telling us that health human resources are not well used or are not used to their full potential.

I just wonder—and this is my question for the witnesses—since health care is in the jurisdiction of Quebec and the provinces, have the witnesses also, first and foremost, made these observations to stakeholders in Quebec and the provinces?

I have a follow-up question. Since our witnesses feel that their observations are clear, that the present level of human resources is adequate but they are perhaps poorly used, why do we still have problems?

[*English*]

The Chair: Who would like to begin with that?

Mr. Brennan.

[*Translation*]

Mr. Michael Brennan: Thank you for the question.

Yes, indeed, we feel that improved efficiency can resolve, if not all the problems, at least a majority of them. Given the age of the population, we will certainly need more doctors, nurses and physiotherapists. On the other hand, we know that studies done in Canada and around the world show that health care efficiency is suffering, here in Canada, and around the world. The teams that are often mentioned have been tested, and pilot projects have been conducted. We are known as a country of pilot projects.

The time has passed for asking questions or studying examples. We know that all members of those teams work to their potential, meaning that they use their knowledge, skills and experience to the best of their ability and that it is not a question of supervision, but of cooperation. The potential exists.

The first question is to find out whether present legislation allows that knowledge to be used. The second question is whether, given our culture, Canadians are ready to go to see a physiotherapist before going to see a doctor.

The answer to the first question is that, in some provinces, the problem has not been solved and we are requesting that this be done in each one of them.

The answer to the second question, about the culture of Canadians, is why I gave my speech. Employers must demand change. It is up to us to tell Canadians that they can benefit from more a efficient health care workforce. But it is up to Canadians to understand their rights by asking for specific services in a given area.

● (1610)

[*English*]

The Chair: Would anybody else like to comment on that?

Dr. Saunders.

Dr. Paul Saunders: Yes. To answer your first question, it is. We have brought this up to the provinces numerous times across Canada. Secondly, Canada's primary health care transition fund funded a study from 2004 to 2006 to establish interdisciplinary cooperative care. They established models. They put together a tool kit. They put together ways in which to do this and were ready to set up demonstration projects.

Unfortunately, there was no funding for the EICP findings, so they have sat on the shelf since 2006, until now, and there really has not been an opportunity to demonstrate that these cooperative things will work, and that when you remove these barriers, various practitioners, primary care providers, and secondary providers can work together as well.

The Chair: You have a little bit more time.

Go ahead.

Dr. Jeff Poston: The issue of health care reform, and particularly reform relating to primary care, is high on the agenda for many provinces, and particularly the development of inter-professional practice as well. We appended to our submission the results of a large national study we had done in terms of the changes that needed to be made with respect to pharmacy human resource policy, and we're beginning to see some of those changes.

Our large "Blueprint for Pharmacy" project is really going to be aimed at bringing the profession together in one place and communicating to provincial governments some of the changes, but change management in health care is a complicated process. One of the things we've identified is that you actually need integrated changes in five areas: education and training; information technology; pharmacy human resources; legal, regulatory and liability; and financial viability and sustainability.

I think the work is going on. I think it needs some further funding for research. Funding for the EICP project is a good example. But the professions are engaged in communicating this and taking our own initiatives to begin to move this sort of thing forward.

The Chair: Dr. Busing, I think you wanted to make a couple of comments.

[*Translation*]

Dr. Nick Busing: Yes, please, I would just like to add a few words.

First, I have listened to the other presentations and I would like to refer you to the fourth recommendation of ours. We are trying to deal with that situation, in fact. That is, the federal government must play a leadership role by creating an environment that allows all the information to be gathered in our country. I do not want a situation in which we would make ad hoc decisions; I want an environment in which we will be able to gather all the resources so that we can develop a strategy for health human resources. I feel that that is the best way to move forward.

Second, in regard to interprofessional care, Mr. Brennan said that we are a country of pilot projects and I really agree with that. There are a number of examples: here in Ontario, we have the Family Health Teams, and in Quebec, they have the CMSs. Interprofessional models are starting to be developed.

Third, we have done a study on doctors' education. We are going to present the recommendations, one of which is clearly

● (1615)

[*English*]

to have more inter-professional education and practice.

[*Translation*]

Everyone has their own perspective, but there must be an environment in which everything can come together.

[*English*]

The Chair: Thank you, Dr. Busing.

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

Ms. Judy Wasylycia-Leis (Winnipeg North, NDP): Thank you all very much.

We've been talking for years and years about changing the scope of practice, about moving towards multi-disciplinary teams, about opening up the gates so that some of the other professions, such as naturopathic doctors, could be included. We've been talking about being less territorial. We've been talking about holistic approaches to health care.

You're all saying that today. How do we move this ship? What do we do?

The Chair: Mr. Brennan.

Mr. Michael Brennan: If I may be so bold—and I've had an opportunity to talk to some of you about this before—I think this is an opportunity for the federal government to take a dramatic leadership position and say that it will only pay for health systems that truly incorporate inter-professional collaboration.

I keep coming back to the public service health care plan, but it's a very big and very expensive example. All it takes is the stroke of a pen from the Treasury Board Secretariat to say that we are going to allow these teams to work collaboratively so that you don't all filter through a bottleneck to access these services. That's one example, and it may be the best example in terms of what you could do this week.

Beyond that, in our proposal, we talk about how it may be time to talk about funding for implementation when it comes around to the 2014 health care transfer discussions and so on. It's not too early to start talking about that. There are some dramatic successes that came out of the 2004 funding model, whereby innovation was rewarded. I think we can do the same thing, but we would surely encourage that bold first step to lead by example.

Ms. Judy Wasylycia-Leis: While you are answering that, Steve, if this came forward, phased in with collaboration from the provinces, do you think there would be any objection from provincial governments, which have been struggling with the same thing for an equally long period of time?

Mr. Steve Slade: I think it can be frustrating to see HHR conferences held across the country and disconnected from one another. We have agencies such as CIHI, Statistics Canada, and Health Canada's pan-Canadian HHR strategies division all doing excellent work, but if you ask where home is, where you would direct your question to, and where there is an agency that brings together these myriad stakeholders of government, health care providers, managers, researchers, and then across clinical scopes, the nurse practitioners, nurses, physicians, pharmacists, and physiotherapists, there is no such place right now.

There is, I think, among those organizations, a willingness that has not been there in the past. The turf wars that are part of our history have really become a thing of the past. The HHR observatory, our proposal 4, really is the spirit of this. We have a body with many appendages and now we need a brain, but that brain doesn't exist right now. Through that human analogy, that's what we are proposing.

Ms. Judy Wasylycia-Leis: That's a good analogy.

Paul—and then I'll get to Jeff—never mind 2006: we've been doing this since, what was it, 1990?

Dr. Paul Saunders: I know. I was only giving the example.

Ms. Judy Wasylycia-Leis: Ten years ago, this committee came up with a report on natural health products and alternative medicines.

Dr. Paul Saunders: It was 10 years ago, back in 1999.

Ms. Judy Wasylycia-Leis: Has anything happened since that report?

Dr. Paul Saunders: No, not really. In fact, natural health products are still not fully regulated. That's the problem, and yet some of the things are disappearing. But as my colleagues have said here at the table, I think we need a push from the federal government to tell the provinces that we all want cooperation so let's do it. Let's get together, get the best minds from each of these groups together, and figure out a way to make this happen cooperatively. We would be very happy to come to the table to do that.

Ms. Judy Wasylycia-Leis: Jeff.

Dr. Jeff Poston: I actually think that provinces are beginning to take some action. We've seen dramatic change around scopes of practice for pharmacists, with legislation to give pharmacists prescribing authority in a number of province. There have been quite dramatic things, but the issue is that we really need an integrated approach.

A good example is that in some of the provinces we've seen legislation that has given pharmacists prescriptive authority, but there haven't necessarily been any systems developed to support education and training. The processes haven't been in place to support collaborative practice in terms of communication with family physicians.

What we're learning from our experience and the international experience in pharmacy is that changing one thing on its own doesn't work. In terms of changing legislation, changing payment models, and changing education and training, you need an integrated approach. That's where I think the idea of an HHR observatory or an institute is going to be very valuable to tie the pieces of string together and to begin to develop an integrated approach.

● (1620)

Mr. Michael Brennan: If I may just add one more thing, it's critical.... I hope I'm not conveying the message that the federal government is responsible in some way for this, because the federal government is a participant in this, but the professions themselves must inform health consumers about what works and they must do it collaboratively. We have a very good relationship with physicians, nurses, and other health care professionals, and if we fail to make a cultural change where patients expect this collaborative care, then the fault is ours.

We are undertaking a national advertising campaign starting in February, at our expense, with our communications—by the way, as a primary health care profession—to tell patients about what collaborative care and access to physiotherapy means for them. We're not looking for any government handouts. We're simply asking the government to seize the opportunity.

Ms. Judy Wasylycia-Leis: Would there be agreement among all of you for how we would describe that conditional transfer of money? Would it be collaborative practice or multidisciplinary group practice? I mean, is there enough in all of your papers that we could put this in as a recommendation in a report that we're supposed to do very soon?

Dr. Jeff Poston: I think there probably is. I would suggest.... I think the word that's emerging is inter-professional; it's either collaborative practice or inter-professional practice. I think that's where the literature and the serious thinking around this are heading.

Ms. Judy Wasylycia-Leis: Didn't Roy Romanow's royal commission put the emphasis on group practice?

Dr. Jeff Poston: I think the important thing is the inter-professional piece, which is the bit that that we want to try to get at.

Dr. Paul Saunders: It might be in groups, but it's a group of professionals working together cooperatively.

Ms. Judy Wasylycia-Leis: That's very helpful. Thank you.

The Chair: Thank you so very much.

Now we'll go to Dr. Carrie.

Mr. Colin Carrie: Thank you very much, Madam Chair.

I'm really interested in what you have to say because of my background. I'm a chiropractor. I.I've worked in multidisciplinary clinics with physicians, physiotherapists, psychologists, nutritionists, and naturopathic doctors, so I've seen first-hand how it works, but I was wondering if you could help us out.

My colleague asked what the federal government can do. We've heard that the federal government doesn't have a brain, but with jurisdictional issues, I believe that—

Voices: Oh, oh!

Mr. Colin Carrie: I think health care is a provincial jurisdiction anyway.

But what can your professions do to help decrease wait time? We've heard of this collaborative model, and I know that in my own practice, about 30% to 50% of the practice of the average physician that we worked with was musculoskeletal. They didn't like doing it. They referred it to the physiotherapist or the chiropractor and that freed them up to do a lot of other things.

We're talking about better use of professions on the ground. We've heard that naturopathic physicians have said that sometimes there's bias in the system. What do you mean by that? Is it the government? Is it the insurance companies?

I've heard stories about notes for work. People go to the physiotherapist or chiropractor or somebody, but they have to go to the physician for notes for work.

You mentioned therapy requirements. Can you give us solid things as recommendations? Should we work with insurance companies and tell them that they will start taking notes for work for these things from naturopathic doctors, chiropractors, and pharmacists as well. That won't cause this bottleneck to occur. Could you comment on that?

I may be sharing my time with Mrs. McLeod if we can get that answer.

The Chair: Maybe you will.

Who would like to tackle that first?

We'll start with Dr. Busing, and then we'll hear from Mr. Brennan.

Dr. Nick Busing: I speak from a physician's perspective, but we see a number of examples in the country that we need to build off. I think there are a few things in common, so I'll just mention two very quickly.

You all know about the hip-and-knee study out of Alberta. How did they move from many weeks to a matter of a number of weeks to move people through the system?

I think you all know about the breast cancer study out of Mount Sinai in Toronto. Again, it's the same thing.

We should look at a couple of those studies and at what made the difference. We see a number of themes. I don't have them in front of me, but one theme is that both of those models had, for want of a better word, a "facilitator" to make the whole system work. There is some literature around the use of facilitators, triage officers, or managers, whatever you want to call them, who are the people who just take the individual patient through the system.

I'm giving you just one example because we have very limited time. I think this is the kind of strategy we should look at because the evidence is pretty powerful.

On the primary care side, which is an area I practice in when I have a moment to practice, we are developing advanced access systems. We are trying to encourage family physicians to change their whole model of booking so that the bookings are not based on coming back in four months for high blood pressure. The bookings are based on same day and 24- and 48-hour calls to the physician.

We have a number of things going on and we need to pull them together. We've done a lot of pilots and we're doing a lot of things, but we're not putting it together. I must say that we're probably duplicating it across the country, and we wouldn't need to if we could roll it out.

● (1625)

The Chair: Mr. Brennan.

Mr. Michael Brennan: Thank you.

Dr. Busing stole my Calgary example, which is perhaps the most famous one where physiotherapy is concerned. The reduction of wait times for musculoskeletal surgery—hip and knee especially—is very dramatic and the example is so clearly understood by a layperson such as myself that it begs the question of why we can't do this across the country.

The answer is that we can and in fact we are. The question is, are we doing it fast enough to meet the needs of this ever-increasing health care cost? Bill 179 in Ontario is a good example of a provincial government getting ahead of the pilot project type of approach and opening up or removing, if you will, barriers to the implementation of exactly those kinds of projects and systems. I think there's a lot of potential there.

Again I would come back to what the federal government can do, which is simply to make sure, if you are funding any kind of health care expenditure, that the folks you're giving the money to are using those types of inter-collaborative models. The health care expenditures in first nations, in the military, and, again, with the public health care plan: those are billions of dollars. Obviously we're talking hundreds of billions when you do health care systems provincially, but it's still a significant amount of money, and you can take action on that today.

The Chair: Mr. Poston.

Dr. Jeff Poston: Yes, if I could just add to that, I think we've seen some good examples recently, one, for example, from the United Kingdom, where the government is actually funding—and Scotland has been the key piece—minor ailment schemes for community pharmacies. Patients register with a pharmacy and the pharmacy is reimbursed on a capitation-based system.

The idea there is that the pharmacy actually takes care of a lot of the routine stuff in terms of minor ailments and common symptoms and helps to reduce some of the pressure on family medicine and on emergency teams. I'm hoping that's something that we may see come out of Bill 179 in Ontario.

The Chair: Are there any other comments?

Dr. Lescheid.

Dr. David Lescheid: I just had one point that I think we could be helpful with. I think one of the messages that I'd like to see strengthened is the importance of health promotion and disease prevention. We could actually keep people from the hospitals, from the wait times, by really promoting a stronger stance on health promotion. I was fortunate enough to speak at an international swine flu conference yesterday, and one of the messages, loud and clear, was that we have a reactive rather than a proactive health care system.

I think there's been a lot of evidence in regard to looking at the chronic diseases, the complex chronic diseases, and at how we can prevent a lot of that through diet, lifestyle, nutrition, and natural health products. I'd like to see that emphasized more and I'd like to see people who really have an expertise in that area having a stronger place at the table. I think that would be really helpful.

The Chair: Very quickly, Mrs. McLeod. We only have one minute left. Go ahead.

Mrs. Cathy McLeod (Kamloops—Thompson—Cariboo, CPC): It's okay. That's not enough time for anything.

The Chair: I'm so sorry. We watch the time very carefully and that's why we're so strict with it. My apologies.

We certainly have appreciated the input and the expertise you've brought to the panel today. We're about to go into another topic now so we will suspend for one minute, but I thank you for joining us today.

● _____ (Pause) _____ ●

● (1630)

The Chair: I ask our guests to please take their seats.

Welcome back. We're so happy to see you once again. Pursuant to Standing Order 108(2) and a motion adopted by the committee on Wednesday, August 12, 2009, we're going through a study of H1N1 preparedness and response.

Truthfully, Dr. Butler-Jones, Dr. Gully, and Sue Ronald, we are so happy that you take the time to come here to update us and allow the committee to ask questions on this very important topic.

Can we start, please? You know the regular course of events.

We'll begin with the Public Health Agency of Canada and Dr. Butler-Jones.

Dr. David Butler-Jones (Chief Public Health Officer, Public Health Agency of Canada): *Merci.*

I'd like to begin by introducing Sue Ronald, director of marketing, creative services and e-communications at the agency. She will be pleased to answer questions on communications activities and explain Twitter if you like.

As usual, I'm here to provide an update on the H1 flu virus. FluWatch, the national surveillance system, tells us that current activities are still well above the expected range, so it's really not time for complacency. The number of hospitalizations of severe cases and deaths is still increasing, although the rate of increase in hospitalizations is smaller than in recent weeks.

However, there is some promising news. There is now evidence that the rate of influenza illness in many Canadian communities has begun to level off. The number of positive flu tests has fallen and there have been fewer results of flu outbreaks in schools.

● (1635)

[*Translation*]

Even though we have not yet had any spikes nationally, the level of flu activity in the community shows that we could be starting to reach the height of the season.

[*English*]

Influenza remains unpredictable, though, and reaching the peak of the second wave does not mean the pandemic is over. There remain millions of infections to be prevented. Current flu activity levels are still well above the expected range for this time of year. The numbers of hospitalizations, severe cases, and deaths are still increasing.

Oh. I have that twice.

An hon. member: It must be important.

Dr. David Butler-Jones: It must be. The rates were four to seven times....

Thank you, Sue. Monday marked the fifth week...I'm not sure how.... Anyway, don't mind me. I'm not sure what planet I'm on at the moment.

The Chair: Dr. Butler-Jones, we really don't want to hear that.

Voices: Oh, oh!

Dr. David Butler-Jones: It's all a blur.

Monday marked the fifth week since Canada's largest immunization campaign began. This week, almost 4.8 million doses will be distributed. That brings the total to over 15 million doses, enough to vaccinate close to half the population. We anticipate more than 5 million more doses next week.

In many provinces and territories, vaccine clinics have been opened to the general public. Our message to Canadians is that it is as important as ever to be immunized as soon as possible. By encouraging all Canadians to take the vaccine, we're aiming to lessen the impact of the current wave and then any further waves of activity. Even after a large second wave, many people at risk will not yet have been infected. They will remain susceptible to the virus, making subsequent waves possible, and our best protection then is to immunize. There will be enough vaccine for every Canadian who wants to receive it.

As I noted last week, since clinics have opened, the Public Health Agency, Health Canada, the collaboration of provinces and territories, the Canadian Paediatric Society, and a network of researchers have been actively monitoring serious events. All reports associated with the vaccine are received weekly from the provinces and territories and are investigated. The most frequent reported events are minor, including nausea, dizziness, headache, fever, vomiting, and injection site reactions. For anybody who has had this, many of us, certainly, end up with a sore arm for a few days.

We're seeing an increased interest in reporting and that is a very good sign that our surveillance system is working. The one recognized potentially serious adverse event is anaphylaxis, a serious severe allergic reaction. The reported rate of anaphylaxis is 0.32 per every 100,000 doses.

Immunization remains, then, our strongest line of defence. We have a safe and effective vaccine. Programs are rolling out across the country and they have the potential to make a strong impact on the way the virus behaves.

In communities where flu activity is still high, mass immunization can result in a more rapid levelling off of flu activity and an earlier and smaller peak. In communities where flu activity is levelling off or possibly decreasing, immunization is still effective in reducing the risk of severe disease and death.

Merci.

The Chair: Dr. Gully, go ahead.

Dr. Paul Gully (Senior Medical Advisor, Department of Health): Thank you, Madam Chair. Of course, I'm always on the same planet as Dr. Butler-Jones.

Over the last two weeks we've seen that the rate of increase of influenza-like illness in first nations communities is levelling off, as per Canada as a whole. According to FluWatch, since the beginning of the second wave of the pandemic after August 30, aboriginal people represent 4.5% of hospitalizations, 6% of ICU admissions, and 7.8% of all deaths. This is a marked reduction in the level of severity from wave one, when aboriginal people represented 18% of hospitalized cases, compared with 4.5% now; 15% of ICU cases, compared with 6% now; and 12% of all deaths, compared with 7.8% now.

As aboriginal peoples in Canada account for approximately 3.6% of the Canadian population, the data to date certainly suggest an overrepresentation of the population in severe cases in wave two, but this is expected given the high proportion of aboriginal people with risk factors such as underlying chronic conditions, youth, pregnancy, and adverse socio-economic conditions.

First nations make up the bulk of hospitalizations of aboriginal people, 129 out of 152, with Métis and Inuit accounting for smaller numbers. A similar trend was observed for aboriginal cases admitted to ICU. The majority of cases, 29 out of 33, were first nations. Most of the deaths, 7 out of 10, were also first nations. It is important to note that this number includes not only first nations on-reserve, but first nations off-reserve.

Health Canada will continue to track H1N1 activity on-reserve, keeping in close contact with community nursing stations to watch for patterns of patient visits, the number of antiviral prescriptions, vaccine adverse events, and any required medical evacuations. This will allow us to work with first nations community leadership and provincial governments to respond as required to any community-level outbreaks.

In terms of immunization, uptake of H1N1 vaccine in first nations communities remains good, and clinics in first nations communities have been operating smoothly and effectively overall. We're nearly one month into the vaccination rollout; to date, approximately 99% of first nations communities have initiated immunization clinics, and we believe that those that have not have in fact ensured immunization in other communities. Over 193,000 doses of H1N1 vaccine have been administered on-reserve.

As a result of collaborative efforts, we've confirmed that at least 47% of on-reserve first nations populations have been vaccinated to date. The actual number will be higher once we receive complete up-to-date information.

As I mentioned last week, the virtual summit on H1N1 in first nations communities was held on November 10, and the webcast recording of it is still available for you if you wish to see it, on www.fnh1n1summit.ca, until the end of December. We continue to promote that website.

In addition, we've been taking other steps to implement the joint communications protocol on H1N1 signed with the Assembly of First Nations and Indian and Northern Affairs Canada. For example, the AFN is now participating in monthly ADM-level meetings with INAC and Health Canada to ensure timely updates on our joint plans and activities.

We also have been sharing our experiences and approaches more broadly. Yesterday evening, I participated in a call with government officials from Canada, Australia, and the U.S. to discuss international approaches to the management of H1N1 in indigenous populations. Further calls will be held that will be valuable in examining the influence of risk factors on indigenous populations as well as immunization programs. These communications activities build on our already strong collaborative working relationships to ensure that first nations communities receive the health services they need.

Since coming to Health Canada at the end of August, I've been very impressed by the level of collaboration shown between first nations, federal departments, and provincial governments. It has made a significant difference, I believe, in terms of outcomes, whether in terms of the completion and testing of pandemic plans or in the good progress to date in terms of uptake of H1N1 vaccine.

● (1640)

We're actively engaging with provincial colleagues and aboriginal partners at both the national and regional levels, including work under the pandemic coordination committee and the utilization of our formal tripartite planning tables in British Columbia and in Manitoba.

It should be noted that annex B of the Canadian pandemic influenza plan does go back to 2004 but was updated in 2008, a process involving the Public Health Agency, Health Canada, the provinces, and the Assembly of First Nations. I fully expect that this level of collaboration will continue as we move forward and begin to more closely examine the lessons learned from the current pandemic.

Thank you.

The Chair: Thank you, Dr. Gully.

We'll start now with our seven minutes of Qs and As.

Dr. Martin and Ms. Murray, you're sharing your time. Would you please watch very carefully that you don't go over? Because unfortunately sometimes the other partner doesn't get a chance to ask a question.

Thank you for doing that.

Dr. Martin.

Hon. Keith Martin: Thank you, Madam Chair. I'll share my time with Ms. Murray.

Thank you all for being here. This probably seems like old times for you once again.

I have three quick questions for Dr. Butler-Jones.

First, given what you've gone through in this entire process, what jurisdictional changes would you recommend to improve the rollout of a vaccine nationally when addressing a pandemic?

Second, are there any deleterious health effects from squalene in the adjuvanted vaccine?

Lastly, do we have enough stockpiled meds to keep patients intubated in the ICU in the case of a larger peak that may be forthcoming?

Thank you.

● (1645)

Dr. David Butler-Jones: I'll address each question in turn.

In terms of jurisdiction, in a federated state I think each level of government has a role to play, and certainly for the federal government's role in terms of coordination, access to vaccine, antivirals, etc., I think that's very important. The delivery of public health is fundamentally a local activity. It needs to be coordinated at each level and the local jurisdictions are in the best position to actually do that.

We can facilitate and have certainly facilitated the sharing of information and of lessons learned, so that we've seen a major improvement in the clinics as we've moved forward. I'm not sure there's a jurisdictional issue there, since we're working well together.

In terms of vaccine and squalene, squalene itself is basically a fish oil with water and vitamin E. Other than increasing the risk of local side effects, we're not really seeing anything major related to the adjuvant other than the improvement of immunity, greater cross-protection, and a lower dose of the actual antigen being required.

In terms of antivirals as well as the medications in ICUs and in hospitals, hospitals in health regions across the country have been adding to their stockpiles, given the recognition in the spring of the kinds of medications that we need for these patients given the complexity of their disease, which they don't typically see with influenza. Some of the medications they would not normally use as much of, they went through very quickly, particularly in Manitoba, which was very hard hit. Each jurisdiction has added to its stockpiles of those.

As well, we have added them to the national emergency stockpile, with backup to the provinces and territories. We should be in a good position going forward. As we're now seeing 25% to 30% of the general population having been immunized, as well as much higher rates in the north and remote communities, rates of 50% to 60% or more, we should be getting well ahead of this over the next month.

Hon. Keith Martin: Thank you.

Ms. Joyce Murray: Thank you, Madam Chair.

Welcome back.

In the past I've raised the issue of Vancouver Coastal Health's plan to address the 2010 Vancouver Olympics in terms of preparedness for H1N1. We have, plus or minus, half a million people coming to Vancouver. They'll be descending on our city through airports, largely, and crowds and gatherings will be the norm.

When I last spoke with the health authorities, there were no additional resources from the federal government to help them carry out their plan. I'm advised that it's a good plan, a comprehensive one, but there has been no help with resourcing. That's unprecedented in a mass vaccination program coordinated from the federal government.

Given that we have 79 days left until the 2010 winter games begin, has that changed? Are resources now being provided to help implement the plan? As well, what specifically has the federal government done to address the public health challenges posed by the 2010 winter games?

Really what I want to know is this: what assurance can the chief public health officer give to Canadians that Vancouver is on track to host the world in a safe, secure environment that's not at risk of being a ground zero for a resurgent H1N1 pandemic?

Thank you.

Dr. David Butler-Jones: From a public health standpoint, I think we're in good shape. We've just gone through "Exercise Gold", and have a series of other exercises that involve both federal-level as well as provincial- and regional-level people. We will be placing a number of resources there in terms of support locally around enhanced diagnostics, etc.

We've been involved very closely, obviously, with BCCDC and B. C. around how things will be managed. Whether it's a half-million people in Vancouver for that or for other major events across the country, it is something that the local authorities address, the province supports, and generally we federally support the provinces in addressing those issues. We bring specific expertise in addition to the support we provide.

As you know, BCCDC is an extremely competent organization, with good capacity, and the local health authority can address that. On the issue of specific staff, etc., depending on the issue, every jurisdiction really plans for that and addresses the needs accordingly. First their approach would be to the province, and then, if the province needs support, we can provide support to the province. That's normally how it works, whether it's an event like this, the Pan-American Games in Winnipeg, or some other major event—even the increasing tourism in the summertime.

That's all part of the planning, and the way in which we deal with outbreaks is being reviewed with VANOC and other levels of government, including other departments of government that have an interest in everything from the outbreak of infectious diseases to the potential for other events that need to be addressed. It's quite a comprehensive plan.

● (1650)

Ms. Joyce Murray: I guess what I'm struggling to identify is whether there are actually funds in place to help ensure that this plan is able to be rolled out appropriately. These are Canada's games. Vancouver will have an influx of people from around the world and the rest of Canada, and I do see a strong logic for the federal government to assist in financing the H1N1 plan.

The reassurances that—

The Chair: I'm so sorry, Ms. Murray, but your time is over.

Dr. Butler-Jones, can you just make a comment on that?

Dr. David Butler-Jones: Yes, I'll speak to that.

There is a whole range of levels. If you're talking about public health nursing services, or surge capacity in services, we are part of that. In terms of money, I mean, I've not seen a request, and it's not appropriate to come to me from the local health authority. The local health authority is there to deal with it in conjunction with the province. We are providing support to the province. How that gets addressed and allocated, based on....

It's the same thing for any other event, any other games, whether it's in Quebec or Nova Scotia or anywhere else. If it is a local activity, they identify what they need. Ideally what we expect is that the vast majority of Canadians will be immunized. That's our best protection no matter where we are in the country, whether we're visiting the games or staying at home and watching them on TV.

The Chair: Thank you.

Monsieur Dufour.

[*Translation*]

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

I would like to thank our intrepid witnesses who have been coming to meet with us week after week.

Mr. Butler-Jones, in a press conference recently, you mentioned that the provinces are presently tallying up the costs of the H1N1 pandemic. The government has a pandemic plan and has set aside about $400 million for situations like this.

Does the federal government intend to provide provincial governments with the money set aside for pandemics, since it is the provinces that pay the hospitalization costs for this disease?

Dr. David Butler-Jones: Health is a provincial responsibility. The federal government has paid for anti-viral vaccines and for the preparation of plans at both federal and provincial levels. We have cost-shared. It was very important for the federal government to participate in that way because the whole country is facing this challenge.

I do not know how much this epidemic will end up costing the provinces, or whether the costs will be different from any other epidemic of seasonal flu. It may be that, after the vaccinations, we will find that the cost of this pandemic was less than the cost of a seasonal flu. We are committed to discussing various aspects of the pandemic afterwards, including the costs.

● (1655)

Mr. Nicolas Dufour: If the cost is lower, the provinces will be paying the bills without any federal help. If this epidemic costs less than normal flu, there will be no assistance. That is how I understand it.

Dr. David Butler-Jones: To date, we have invested a considerable amount of money, more than $1 billion for the vaccine, the preparations, and so on. All provinces and territories decided to deal with the pandemic first and to gather all the facts, costs and other details afterwards. The decision will be made when the pandemic is over.

Mr. Nicolas Dufour: Last week, there was an announcement that, after examining people who had died from H1N1 flu in Norway, it was found that the virus has mutated. I am going to ask you three quick questions.

Have we seen that mutation in Canada? Can you confirm whether the virus has mutated or whether the virus that is presently going around is a new strain? Is Canada ready for a mutated form of the virus that is resistant to anti-virals and the GSK vaccines?

Dr. David Butler-Jones: Those are good questions. The change seen in the virus in Norway is similar to what has happened in six other countries. This is not a form of the virus that is normally found in the population. The virus is always changing; there is always a risk of it mutating. We are seeing it, but it is not causing us great concern at the moment, unlike in previous weeks.

In Canada, there is some protection because most vaccines contain an adjuvant and an adjuvanted vaccine helps to prevent the spread of the virus. This is a good thing for us. We are on the lookout, and we have seen a similar virus in Canada, but it has not infected other people. There is perhaps a risk of it spreading in a group of people, in a family, for example, but there are no more serious risks of infecting others.

Mr. Nicolas Dufour: No tests have been done on people who have had the virus in Canada in order to determine if a mutation has taken place?

Dr. David Butler-Jones: A mutation has taken place, but not into a form of the virus that can spread to the population. Sometimes, we have seen the virus passed on. It is important for us to watch for occurrences of that kind, but they only become significant if the virus changes and starts to spread into the population.

Mr. Nicolas Dufour: Okay.

Do I still have a little time left, Madam Chair?

[*English*]

The Chair: You have one minute.

[*Translation*]

Mr. Nicolas Dufour: Mr. Butler-Jones, at our November 18 meeting, you said that, across the country, some translations were not always useful. In some cases, that even involved translations into French. Complaints were received and the PHAC had to accommodate dialects and local variants.

I would like to know if that situation has been rectified and if you know the nature of the complaints that were made about it.

Dr. David Butler-Jones: It is up to each region to do any necessary translations. When I was chief medical officer for a region, it was the same; we had to adapt brochures and other documents. It is impossible to translate everything.

[*English*]

En anglais, if we did it, I wouldn't want it if I were a local medical officer because the chances of our getting the local dialect are not very great. We have to be generic for the country and that then allows *l'adaptation locale*.

● (1700)

[*Translation*]

Mr. Nicolas Dufour: Thank you very much, Mr. Butler-Jones.

[*English*]

The Chair: Thank you very much.

Now we'll go to Ms. Wasylycia-Leis.

Ms. Judy Wasylycia-Leis: Thank you.

My thanks again to all of you for being here.

I want to go back to a topic we discussed at a previous session. It has to do with health and safety concerns of nurses and other health care workers on the front lines, particularly with respect to their feeling that to be consistent with the precautionary principle, the N95 masks should have been considered as a national standard across this country.

Dr. Butler-Jones, whenever we've raised this in the past, you've said it's not necessary because we're talking about something spread through droplets. Some of us were recently at a session here put on by the Canadian Federation of Nurses Unions. There was a fairly prominent speaker by the name of Mario Possamai, who was a senior adviser with the SARS Commission. He gave us an in-depth presentation on the importance of lessons from SARS, the need to rely on the precautionary principle, and the need for us not to get caught up in splitting hairs.

He thought that, rather than arguing about droplets, we ought to ensure that the strongest precautionary mechanism was being used. Have you had any change of thought on this issue?

Dr. David Butler-Jones: That would be true only if it were effective. We have studies showing that the N95 masks do not reduce the risk of infection to health care workers working with influenza. Whether they use a surgical mask or an N95 mask, the risk is exactly the same. The precautionary principle would apply only if it actually made a difference, but in this case, it doesn't.

You can always find disagreement among experts. But the vast majority of experts, those dealing with infectious diseases on a regular basis, would say that (a) it makes no sense, (b) it's difficult, and (c) it may actually increase the risk if it gives a false sense of security.

Ms. Judy Wasylycia-Leis: I'm wondering if your study of the issue took into account the SARS example that was given to us. They contrasted Vancouver General Hospital's response, which employed the precautionary principle, with that of another city in another region. Vancouver demonstrated a minimal spread of the disease while Ontario showed a more significant spread because the precautionary principle wasn't adopted.

Dr. David Butler-Jones: There are many other variations when you look at a situation like that. I'll let Dr. Gully, who was actually around at the time AND working on those issues, speak to it.

What is very clear is that when you look at the protection of health care workers, you start with a whole range of things: everything from sanitation to access to handwashing to gels that supplement handwashing. Personal protective equipment is only one piece of that. Much of the spread of SARS had nothing to do with the use of masks. It had to do with how we recognized or dealt with basic infection control procedures. They should be in place in all hospitals at all times, particularly for people who have potentially infectious diseases but even for those who don't, because you can't predict or tell who has the infectious disease.

We have abundant evidence now that when you focus on just those who you think are sick, as opposed to exercising good infection control procedures all the time, you may actually increase the risk to health care workers. That does not necessarily mean N95 masks. There are certain conditions for which they are recommended. At the same time, there is an appropriate responsibility in the local situation to assess that situation and take the precautions necessary. However, the evidence suggests that in the vast majority of those cases N95 masks do not offer any more protection than surgical masks.

Go ahead, Paul.

Dr. Paul Gully: If I could just add to that, in our understanding, what happened in Vancouver as opposed to Toronto was what happened right at the beginning. In fact, it was a mask that was put on a suspected case of SARS, on an individual, a patient, as opposed to the utilization of masks by health care workers, that in fact then I think, perhaps to a great extent, led to the difference. At least, that was our assessment at the time. In fact, if I—

Ms. Judy Wasylycia-Leis: A thorough presentation by Mario Possamai, who I think was heavily involved in the entire SARS assessment afterwards, clearly presented the fact that in the case of Vancouver General Hospital, a patient who presented at the hospital was isolated within five minutes. Within 15 minutes, the staff had N95s, the respirator on, and so on. He contrasted that with Ontario.

I don't want to split hairs on this. I don't want to get into a debate. I think the issue here is that you have a strong message from a national association of nurses representing people right across this country who are very concerned about the way they are being treated. There is a feeling that the precautionary principle is not being respected and that their health and safety are at risk. I think somebody needs to take this into account and deal with it.

I don't think it should be left for us to hear presentations like this and then have their concerns dismissed. I think there has to be a way for this government to take the evidence and say that you'll study it, you'll talk to the nurses again, and you'll figure out what's going on. I think that would be a healthy response to the situation. It's not a trifling issue.

● (1705)

Dr. David Butler-Jones: This is the perspective of one scientist. We have consulted with the best scientists in the country, with experts in infectious disease and infection control.

These are not government guidelines. These are guidelines that have come up from committees of experts from across this country who have reviewed all the evidence from around the world. These are the recommendations based on that.

Let's look at the Vancouver General situation versus Toronto's. They knew what was coming. They knew there was a problem. They isolated it when it came. It had nothing to do with the N95 mask and everything to do with recognizing something and treating it seriously as opposed to not recognizing it and carrying on as if everything was just fine. That's when people are put at risk.

It's not about N95 masks versus surgical masks. It is about the whole comprehensive approach to infection control we need to follow all the time, whether we're talking about C. difficile, MRSA, H1N1, or anything else. It's about treating infectious diseases seriously in hospitals and following good infection control procedures. It is not about N95 masks versus surgical masks. Ninety-nine percent of it is about everything else.

The Chair: Thank you, Dr. Butler-Jones.

We'll now go to Ms. Davidson.

Mrs. Patricia Davidson (Sarnia—Lambton, CPC): No, it will be Ms. McLeod.

The Chair: Oh, I'm sorry.

Ms. McLeod.

Mrs. Cathy McLeod: Thank you.

I'll also be sharing my time with Mr. Brown.

I have to make a comment for the record. In British Columbia, the vaccine clinics opened to the regular population on Saturday. I decided to go up there on the first day. Parking was superb, the clinic area was superb, 30 nurses were working, and it was 15 minutes from when I arrived at that door until I received my vaccine.

Maybe there were some logistical issues at the very start, but I think they have done a superb job. I think we need to give credit to our health authorities and our workers on the ground. This was a Saturday and there they were. I don't know how many hundred injections each nurse does in a day, but they're significantly stepping up to the plate.

The thing that's interesting to me right now is my sense that within the general population we seem to have a quite quickly diminishing level of anxiety. With that, I have some worries about our getting that target level of population immunized.

I have two questions. First, do we have a communications strategy that's going to really start to work on that piece right now? Second, we're talking about massive volumes of vaccine being delivered, next week, finally, so does that keep going until we have all the doses, even though perhaps we're...? How is that staggering of vaccine going to happen as we look at diminishing as opposed to ramping up?

Those are my two questions. Thank you.

Dr. David Butler-Jones: Maybe I'll start.

Then you can follow up, please, Sue.

There is quite a communications plan moving forward. You've seen the earlier phases.

We'll be working closely with the manufacturer in terms of delivery in the provinces and territories. They say they're looking forward to the continued vaccine. At some point we will have enough vaccine to immunize all who need it and want it, and then it's an issue of what we do with that and how we manage that. We're in consultation both with the manufacturer and the provinces and territories about that. We're not there yet, but as we get there, we'll need to have that in hand.

On the other question, I guess people are getting more comfortable with it, but the reality is that we have 20 million people still potentially at risk, who have not either been ill or been immunized so far. Of those, if we have a 25% attack rate, eventually—not in the next few days or weeks—we'll get over the hump and then we'll see smaller numbers. But then you're looking at 4,000 to 20,000 hospitalizations just in that group, 500 to 4,000 in ICU, and 250 to 1,000 deaths somewhere. This is still to come, at some point, if we don't get more people immunized.

Nobody should be complacent about it. I know of young twentysomethings who unfortunately have died or are in ICU on ventilators. It's impossible to predict which ones will be affected in that way. This is not like seasonal flu. It's a different group, by and large, that is more severely affected and it is something that is cheap, simple, and easy to prevent through immunization.

Sue.

● (1710)

Ms. Sue Ronald (Director, Marketing, Creative Services and E-Comms, Communications Directorate, Public Health Agency of Canada): Thank you.

Yes, as you know, we do have a comprehensive citizen readiness marketing campaign that's been under way since April/May. Right now we're moving into the month of December so we'll be doing some messaging to the general population.

On what you pointed out, we have research rolling polls that are showing certain pockets of the population that don't have the pickup as much as some others. So in the first of the year, we're looking to start what we call drilling down into those target audiences to find out who the people are who aren't getting the vaccine.

Dr. Butler-Jones is right that the research is showing us right now that the 18- to 35-year-olds are the population that's a bit loosey-goosey, for lack of the technical term, about getting the vaccine.

The majority of our communications at this point has been targeted at the general population. Moving into the new year, we will be looking at which people we need to really go to now, the people who seem to have the information but don't seem to be taking the necessary action we want them to take. Of course, our goal always is to give people the information they need so they can take the right decision for themselves.

The Chair: Mr. Brown, perhaps you'd like to ask your question.

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

I, too, got my H1N1 shot last week, as Cathy mentioned, and I was surprised that there were no lineups. It took from five to ten minutes, so clearly the process is going along very smoothly.

I want to get a sense of whether we have any idea of how much has been spent on advertising. I remember that at one point there were some concerns from the opposition that there wasn't enough spent on advertising compared to other things.

I play hockey every Sunday with the person who does advertising for a local paper and he says your advertising is helping keep them in business. I notice when I read any paper that there are ads. If I turn the TV on, it's very difficult not to see your face.

I think there's been a very effective advertising campaign, so maybe if we have a sense of the numbers it might allay some of the fears of a month ago that there wasn't enough emphasis put on getting the word out.

Ms. Sue Ronald: Thank you.

Right now we've spent about $20 million on advertising. We've tried to put our money where it's best used. You have seen Dr. Butler-Jones out there a lot and that's thanks to the media, which are covering him wherever he goes.

As we're coming into December, we're getting ready to launch a print ad that will be in daily newspapers on Saturday, November 28, and then for two weeks nationally you will hear some radio ads, starting on November 30. Right before Christmas, you will see a couple of full-page print ads. You will also hear more radio ads prior to Christmas, but the message is going to change slightly. It's going to be about Christmas as a time when people have social gatherings and are around a lot of people, so we don't want people to forget to cough into their arm, wash their hands, and do all of those kinds of things.

Yes, a significant amount of money has been spent.

The Chair: Thank you, Ms. Ronald.

We'll now go to Ms. Murray.

Ms. Joyce Murray: I think that on all sides of this table everyone appreciates the job that the front line people have been doing. In fact, great people sometimes can overcome poor processes. That's a truism in quality improvement.

I want to go further into the question that my colleague asked on jurisdictional changes. I spoke with someone who was a former chief medical officer of a large population. This person's view was that Dr. Butler-Jones' role should really be one of reporting to Parliament. We know that coordination has been a challenge and that there has been some concern about coordination. When we had the public service briefing, it turned out that nobody was in charge of preparedness in the ministries, really, except for the ministries themselves. There was no one in charge overall.

We did have poor early communication and we saw that the budget spent on H1N1 communication was one-tenth of what was spent on advertising to persuade Canadians that the economy was doing well. We've had confusion and province-to-province differences over whether you should get the seasonal shot or the H1N1 shot. We heard from a lot of front line people that the clarity never got to their level, especially in the early weeks.

My very direct question is this: if we had a system in which the Public Health Agency of Canada and the Chief Public Health Officer reported directly to Parliament, would we have had fewer incidents of confusion, mixed messages, and early ineffectiveness?

● (1715)

Dr. David Butler-Jones: The short answer is no.

When the agency was established, I was part of the grand debate on what the role of the Chief Public Health Officer should be, who that person should report to, whether the agency should be inside government or outside of government, and so on, but I was not expecting that I would have to live with those recommendations. As I look at it, I don't really think there would be much advantage in that idea. I've been able to speak to the issues that I need to speak to.

Public health ultimately is a local jurisdiction. It is a local activity. It's important that local medical officers have it. If you look at what I said six months ago and what I'm saying now, other than where things themselves have changed, what I'm saying hasn't really fundamentally changed.

However, there has been a seeking out of different views, predictions, and recommendations, and that has confused the picture, because it gets play in the media as one scientist versus another, as opposed to 99 to 1, or all the chief medical officers in the country versus somebody who happens to work somewhere and has the title of doctor. That's part of the system. Whether you have a unitized system or a federation, as we do, I think that would still occur.

It is important to adapt things locally. It will vary a little bit. You don't see this level of scrutiny, interest, and comparing and searching for differences anywhere else in the world, even though those differences exist and even in unitary states. How it's carried out in one county in the U.K. is not exactly the same as the way it's carried out in another county, but here it's an issue, a media issue and a controversy, as opposed to being seen as just the way public health does business.

The short answer was the first one; I'm not sure it would ultimately make much difference to this situation.

What has made the biggest difference in terms of the positive things and the speed with which we've been able to come to ground on these issues is our public health network system. There's collaboration around the country. There is joint decision-making and planning with the provinces and territories, which then work with their local health authorities and bring together the expertise to address the issues. Very quickly you see people learn from the experience, and they apply it and share it across the country. That, in a federation, is a huge challenge.

Getting to those answers quickly is to the credit of the people at the local level and in the provinces and territories. I'm not sure it's so much a credit to us.

Ms. Joyce Murray: I have another quick question. We have heard that the level of activity of infection is well above what was the expected level for this time period and that hospitalizations and deaths are still increasing. Do you see any connection between that and the fact that we began our vaccination programs weeks later than other countries because of certain decisions that were made in the planning?

Dr. David Butler-Jones: Look at the United States, for example. They started into their second wave several weeks before us. While they had a small amount of vaccine a few weeks earlier than we did, it was really a very small amount. We've now immunized at least twice as many people as a percentage of our population as they have, within the first two or three weeks of the campaign. It's the same in other countries. They have much smaller amounts of vaccine actually in people's arms.

When we assess all of this in terms of the pattern and the evolution, how much is due to the fact that we were delayed in the second wave because of all the other things we've been doing, everything from treatment to prevention, and other things? We may never know for sure, but clearly we did not experience the same level of activity that a number of other countries did. We did the vaccine in Canada.... While there were other countries that had some small amount of vaccine earlier than we did—not very many, but a couple—we very quickly have overtaken that lead in terms of our ability to immunize the whole population.

● (1720)

The Chair: Thank you, Dr. Butler-Jones.

Now we'll go to Ms. Davidson.

Or is it Mr. Uppal?

Mrs. Patricia Davidson: Yes.

The Chair: Well, you're just a basket of surprises today, aren't you?

Mr. Uppal, go ahead, please.

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

This past week, I had the opportunity to go to India. As we were landing at the airport in New Delhi, we were given a questionnaire. The questions were specifically about H1N1. What countries have you visited? Have you been infected? Have you been in contact with somebody who has been infected?

When we landed, there was a place where you walk by scanners. Somebody was watching these scanners. I assume they were checking temperatures. They had people in masks taking these questionnaires and asking further questions if they needed to. To me, they looked like nurses, but they were some kind of medical personnel. On our return, upon landing in Toronto there were no questionnaires and there was nothing of the sort in our airports.

What's the difference? Do we not feel we need this? Why is it that other countries are doing this?

Dr. David Butler-Jones: There are a couple of things about that. One is that early on in the spring we did have notices that were given to everybody. When you did come back, you would have noticed general information about the flu and how to prevent its spread, etc., in Canada early on, but now it's widespread, in all communities. Really, the border issues are meaningless.

The key issue, as it always is in terms of the quarantine service and the work with airlines and others, is that if they see severely ill people they will call the quarantine officer and there will be an assessment. For the general population, it's not like you're going to bring influenza to Canada, because we already have it.

The other point is that temperature scanners were used in SARS. They were proven to be pretty much useless. It gives a sense of doing something, but it doesn't actually accomplish anything.

It's the same with having people screened directly by individuals or questionnaires: (a) it's easy to avoid and (b) you may not be sick this instant but in three hours you're coming down with it and already have spread it.

It really is much more about the general information that we have out there for the public about what to do and what to look for. It's the information that's being shared with households and is available generally and on websites. It's about what to look for, when to worry, and when to get attention, etc. That's been clearly shown to be much more effective.

A few countries do intensive screening. That is generally not very effective. It has the potential to be effective very early on if you're not actually seeing cases in the country, but with something like influenza...and not the temperature scanning, but the other questionnaires, etc. But something like influenza very quickly spreads. Also, those in the southern hemisphere are not in their flu season now, so they will need to be getting geared up for their winter season when it comes.

Paul?

The Chair: Dr. Gully.

Dr. Paul Gully: If I could add to that, another thing we learned during SARS was that the amount of time and energy that has to be put into producing pamphlets and getting pamphlets onto airplanes, handing them out, especially in an airport such as Toronto's, where you might have 80 or 90 airlines, is huge. It's tremendous. Therefore, I think we felt, going on with what Dr. Butler-Jones said, that if that was not effective, then we should be using those resources elsewhere.

Dr. David Butler-Jones: As you'll remember, early on in that outbreak we did have information that was handed out to all passengers for them to know what symptoms.... But again, there were few cases in the world, and we were actually the origin of most of them.

Mr. Tim Uppal: Thank you.

The Chair: Mr. Brown.

Mr. Patrick Brown: To follow up on the public awareness advertising, how does this compare to how the country faced the SARS crisis? Compared to that episode, how much more has gone into public awareness?

● (1725)

Dr. David Butler-Jones: I don't think there really was a lot in SARS. There was, as Dr. Gully has mentioned, the production of handouts for airports, etc., but most public communications was responsive to media questions; there wasn't actually a concerted effort to do it.

At the same time, there wasn't as much that you could actually do about SARS, It was a much more localized challenge. It had an effect on the whole country, but it really was the Toronto region that was most heavily affected.

Mr. Patrick Brown: Cathy spoke about the quick service in her local health unit. I noticed that in Barrie. Is this something you're noticing across the country, or are there some health units or some regions of the country where there still is concern about long lineups?

Dr. David Butler-Jones: Of course I don't know about all sites, because there are probably thousands of sites across the country, but generally the reports are coming back that people are very positive. They may have a wait, but it's very efficient.

Here in Ottawa, people talk about getting their vaccine as being very orderly. Even if there are 1,000 people there, at most they wait an hour to an hour and a half while going through the process. In general, they don't even have to wait very long at all. It's very positive. It's actually rather nice that some of my old health units have turned out to do a really good job. I'm not there anymore, so I can't take the credit.

The Chair: Thank you very much.

I know that at 5:30 sharp we're going to have the bells ring, so I want to take an opportunity to thank you once again for coming and informing us—

Ms. Joyce Murray: We still have four minutes. It's the Bloc's turn.

The Chair: Well—

Ms. Joyce Murray: It's not 5:30.

The Chair: We only have 15-minute bells. If you....

Make it very short, because I'm going to cut you off.

[*Translation*]

Mr. Luc Malo: That is fine, Madam Chair. All you have to do is interrupt me.

Dr. Butler-Jones, you stated that we have now reached a plateau in this crisis. Do you not feel that some could say that the worst is over, that the number of cases has peaked, and that they might wonder whether the H1N1 crisis was really such a big deal? Could they wonder whether they had been urged to get ready and to get vaccinated for nothing? As you told my colleague, it could turn out to be more or less like a normal flu. Under those circumstances, people could wonder, if the H1N1 crisis has hit its peak, why they should get vaccinated now.

Dr. David Butler-Jones: It is very important to get vaccinated because we still have more hill to climb before we reach the peak. It is very important to reduce the effects of this infection, because of the thousands of hospital stays, the intensive care, and, of course, because of the deaths. Prevention is possible in this case. For many infections, prevention is not easy. Without the vaccination, millions of people could be infected and have to spend three or four days in bed. Thousands of others might have to go into intensive care and hundreds might die. This is our opportunity for prevention. It is very important. The crisis is not over. Before it is over, approximately four to six million Canadians could be infected.

[*English*]

The Chair: Thank you very much, Dr. Butler-Jones.

Thank you to the committee.

The committee is adjourned.

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