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Chair

The Honourable Shawn Murphy

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● (1530)

[*English*]

The Chair (Hon. Shawn Murphy (Charlottetown, Lib.)): I'd like at this point in time to call the meeting to order. On behalf of the committee, I want to extend a warm welcome to everyone here. *Bienvenue à tous*.

Ladies and gentlemen, this meeting of the public accounts committee has been called pursuant to the Standing Orders to deal with chapter 5, "Surveillance of Infectious Diseases—Public Health Agency of Canada", of the May 2008 report of the Auditor General of Canada.

The committee's very pleased to have with us today, from the Office of the Auditor General, the assistant auditor, Mr. Neil Maxwell, and he's accompanied by Madame Louise Dubé, the principal.

From the Public Health Agency we have Dr. David Butler-Jones, who is the accounting officer and the Chief Public Health Officer of Canada. He's accompanied by Dr. Gregory Taylor, director general, Office of Public Health Practice; and Dr. Danielle Grondin, acting assistant deputy minister, Infectious Disease and Emergency Preparedness Branch.

Again, I want to extend to everyone a warm welcome and thank you for being here.

We are going to hear from Mr. Maxwell.

Mr. Maxwell, your opening remarks.

Mr. Neil Maxwell (Assistant Auditor General, Office of the Auditor General of Canada): Mr. Chairman, thank you for this opportunity to present the results of our audit on surveillance of infectious diseases at the Public Health Agency of Canada, published in our May 2008 report.

With me today, as you've noted, is Louise Dubé, principal responsible for audits of the Public Health Agency of Canada.

Important to note is that the work on this audit was completed in October 2007, and we have not audited actions taken by the agency since then.

Public health officials need to know when and where infectious disease outbreaks occur so that they can reduce the health impacts on Canadians. The Public Health Agency of Canada, created in 2004, is the federal organization responsible for the surveillance of infectious diseases. The agency works in concert with other federal departments and agencies and other levels of government, as well as health professionals, hospitals, and laboratories across the country.

One of the things we examined was whether the agency, in collaboration with its partners, had obtained, analyzed, and disseminated the information needed by public health officials in Canada and internationally to help anticipate, prevent, and respond to threats of infectious disease.

We also followed up on some serious concerns raised by our audits in 1999 and 2002, when surveillance of infectious diseases was the responsibility of Health Canada.

[*Translation*]

We found that the fundamental weaknesses noted in our 1999 and 2002 reports remained. Although some important steps had been taken, our concerns related to strategic direction, data quality, results measurement and information sharing had not been satisfactorily addressed.

We also found that to obtain routine surveillance information, the agency relied on the goodwill of the provinces and territories to send useful and complete data, but this was not always done and the flow of information was interrupted at times. After two years of negotiations, the agency signed in September 2007 a comprehensive information-sharing agreement with one province, Ontario.

We were concerned that a nationally standardized approach to disease reporting remained years away.

[*English*]

Good information-sharing is especially critical in the event of a public health emergency. Local or provincial public health officials will almost certainly be the first to detect a public health emergency. As a national focal point, the agency needs the information about such events because, according to the revised International Health Regulations of 2005, the agency has 48 hours to assess all reports of urgent events to determine whether a potential public health emergency of international concern exists. The agency then has 24 hours to notify the World Health Organization of the results of the assessment.

Although the agency has laid the groundwork for sharing essential information in emergency situations, we found that critical arrangements still needed to be sorted out. For example, public health officials at all levels need to know the procedures for notifying other parties and what personal health information they can and should share so they can respond appropriately to the outbreak and ultimately save lives.

[*Translation*]

Therefore, faced with a public health threat that could affect other countries, and without information-sharing agreements in place, the agency may be unable to notify the World Health Organization within the times specified in the revised International Health Regulations (2005) and to keep it informed of subsequent events.

We are pleased that the Public Health Agency of Canada has agreed with our recommendations and that it has published an action plan and a timetable for its implementation on its website. Many of the actions identified in the action plan are time-sensitive. For example, in order for the agency to meet its obligations under the International Health Regulations (2005), an assessment of the surveillance capacity at the local, provincial, and national levels needs to be carried out by 15 June 2009, and mechanisms to ensure a complete and timely flow of information between the agency and the provinces and territories on public health emergencies need to be in place by June 2012.

Mr. Chairman, because this area is so critically important to Canadians, your committee may wish to ask the agency's officials what concrete results they have achieved since the tabling of our report in May 2008. Because many of the recommendations in the report date back to 1999 and 2002, the committee may also wish to obtain a commitment from the Public Health Agency to implement our recommendations and to provide the committee with regular progress reports.

Mr. Chairman, that concludes my opening statement and we would be pleased to answer your committee's questions.

● (1535)

[*English*]

The Chair: Thank you very much, Mr. Maxwell.

We're now going to hear from Dr. David Butler-Jones, the Chief Public Health Officer of Canada and the accounting officer of this agency.

Dr. David Butler-Jones (Chief Public Health Officer, Public Health Agency of Canada): Mr. Chair, members of the committee, I'd like to thank the public accounts committee for this opportunity to appear before you today.

[*Translation*]

I listened with interest to the remarks of Neil Maxwell from the Office of the Auditor General.

[*English*]

In 2003, our country witnessed firsthand the impact of an unknown infectious disease: severe acute respiratory syndrome, better known as SARS. The outbreak impacted both our people, claiming 44 lives, and our economy, costing billions of dollars. The outbreak led to the tabling of Dr. David Naylor's report, "Learning from SARS: Renewal of Public Health in Canada". One of its key recommendations was to establish a public health agency at the federal level, to provide national leadership and coordination on public health issues, and the position I have the privilege to hold.

[*Translation*]

In 2004, the Government of Canada created the Public Health Agency of Canada with a mission to "promote and protect the health of Canadians through leadership, partnership, innovation and action in public health."

[*English*]

The 2008 Auditor General's report identified key areas for improvement and continued improvement in the agency's surveillance activities, particularly with respect to infectious diseases. It takes us further down the path we started along four years ago. I welcome their assistance with our ongoing strengthening of surveillance.

Surveillance is simply the systematic collection and use of health data to track and forecast health trends and health events. As a result of our surveillance activities, the agency is able to guide and promote health policies and actions across Canada. As such, we have developed a surveillance strategic plan, a five-year plan that outlines the agency's surveillance priorities, goals, and objectives, which was finalized in 2007.

[*Translation*]

We have appointed a senior surveillance advisor, Dr. Gregory Taylor, who is providing me with updates and advises me on the status of surveillance activities throughout the agency including progress on implementing the Auditor General's recommendations.

[*English*]

I'd specifically like to address the issue of information sharing, particularly with provinces and territories. In ensuring we have a robust surveillance system, we must take into consideration the very nature of our health care system. The provinces and territories deliver health services and they own the resulting data. Furthermore, as a federal government, we encounter both legal and privacy constraints when we try to gather the most effective data in the shortest time period.

All our partners are well aware of the need for accurate and timely data to help maintain an understanding of infectious diseases in Canada, including in the event of a public health emergency. To this end, the memorandum of understanding for information sharing during a public health emergency was approved by federal, provincial, and territorial ministers of health in September 2008. The Pan-Canadian Public Health Network created an FPT task group, in which the agency is a lead member. It has begun work with the provinces and territories on the development of information sharing agreements. We are confident this will create a new path forward in federal, provincial, and territorial relations in the arena of public health surveillance and information sharing.

Also, as we get into questions, to some extent the proof is in the pudding in terms of the events we've dealt with over the last four years and the stark contrast between what occurred during SARS and our abilities as a nation to respond quickly and effectively.

I'm committed to implementing the recommendations put forth by the Auditor General, and we have made progress in many areas. I also recognize that more work needs to be done and that protecting the health and well-being of Canadians requires effective and timely surveillance as one of the actions.

Merci beaucoup.

● (1540)

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

I'm going to go now to the first round, seven minutes each.

Ms. Ratansi, you have seven minutes.

Ms. Yasmin Ratansi (Don Valley East, Lib.): Thank you, everyone, for being here.

My question is going to go back and forth between the action plan you've given and the notes the Auditor General has. In May 2008, the Auditor General examined whether the Public Health Agency had obtained, analyzed, and disseminated the information needed to respond to the threats. The audit specifically observed that there were no clear roles and responsibilities defined. The Auditor General's office just now said these are weaknesses since 1999. I can appreciate that this was Health Canada and then the agency was created.

Why is this action plan not robust enough, in terms of how it is really not addressing some of the issues the Auditor General has raised? For example, you said you had a senior surveillance adviser. How does that manage the risk the Auditor General is talking about? For example, how does that surveillance officer obtain information, from where will he or she obtain information, how will they analyze it, how will they disseminate it, how will they work with the provincial, territorial, and municipal partners? Where are the roles and responsibilities?

I know I have a lot of questions in there, but the question is addressed to the Public Health Agency. If the Auditor General's office could, in the response they give, tell me that's robust enough, then I'll go with that.

Thanks.

Dr. David Butler-Jones: Thanks very much for the questions.

There are a number of interrelated activities. Having the senior surveillance adviser is simply to make sure there's a clear focal point for responsibility. It is not to actually do the surveillance, etc., but to make sure we have the systems in place. Across the agency, we've been reviewing all our surveillance systems, not just in infectious disease. Also, within the public health network, which is again the joint governance of the system between the provinces, territories, and us, we have expert committees and others that report to the conference of deputy ministers, where I sit, and on to the conference of ministers, to actually do the kind of joint planning we need to do.

In addition, in terms of roles, we've worked through memoranda and letters of agreement. For example, with CFIA we have the MOU with the provinces in terms of roles. We have plans in terms of who does what when, related to our relationships with the provinces, not just on surveillance but also in response to it and who deals with issues as they arise.

Secondly, every day we do scan. We operate GPHIN, the Global Public Health Intelligence Network, and at this moment WHO tells us that between 40% and 60% of all outbreaks in the whole world are first notified to them by us, not by the country affected. We run that system for the world. Each day that's reviewed. In the morning there's a meeting of officials in the agency with other relevant people, to look at the risks that are occurring around the world. That then comes to a meeting with me, usually at 9:00 or 9:30, and decisions are made as to how we go forward, what we need to do, and what else needs to happen. If it's something that requires engagement with the provinces, we will have a conference call with the chief medical officers across the country that very same day. And that's how we've been practising.

Those are just some of the systems we have in place. We monitor that on a daily basis, 24 hours a day.

Ms. Yasmin Ratansi: On these systems that you've put in place, did they come into place after the audit or were they there as the audit was being conducted?

Dr. David Butler-Jones: They were in place as the audit was being conducted, but one of the questions from the Auditor General's office really was, okay, can you put more structure to these? So, for example, do you have minutes for those morning meetings that were occurring daily? Now we do. There's an ability to track that.

We make the decisions, we act on the decisions, and we write them down, but now we have more detailed minutes of the items so that someone who wants to go back in 10 years can do that. It is the same with the development of chronologies of events.

● (1545)

Ms. Yasmin Ratansi: To the Auditor General, is that what you meant? I'm an accountant, so I need tangible things. When somebody tells me that I've achieved by putting in a senior surveillance adviser to the Chief Public Health Officer, I do not consider that to be managing risk.

Perhaps you can tell me from your audit whether you felt that the information and the processes that are in place, the processes they have, which probably in the auditor's mind were not so streamlined so that the information was not being gathered the way it should be gathered, posed any risks to the public.

Mr. Neil Maxwell: Thank you. Chair.

There are several elements in that.

Perhaps first to your question of whether it is robust enough, I'd make several points. One is that we have not audited the action plan. Just to put the caveat right up front, we haven't had a chance to sort of look behind the kind of progress that the agency is claiming in order to see what's actually been done.

The second thing I would say is that it is a very complicated business. When I see the action plan, what I see is some action on many different fronts, some of which is behind the scenes. Advisers on surveillance probably play quite an important role in terms of the governance and making sure that information is provided. I wouldn't discount the importance of the individual elements, but I would return to something I said in my opening statement. I think much of the real test of an action plan is its ability and the agency's ability to show concrete results.

I see as I review the action plan that they've made a number of improvements on the systems. I think ultimately the question, then, is that perhaps it is only reasonable to be looking for concrete results through a number of years. You don't expect a great deal of results in the very short term, but I think those are really where the key questions lie.

Ms. Yasmin Ratansi: Fair enough.

My question, then, goes back to Mr. Butler-Jones. How long have you been in that position? Since 2006?

Dr. David Butler-Jones: The agency and my position started at the same time: in September 2004.

Ms. Yasmin Ratansi: So from 2004 on, could you tell me what concrete actions there are? For example, if there were an Ebola outbreak in Congo, and because of the international travel, etc., what are some of the checks and balances you would have in place that would prevent it from coming here? We did not know SARS. We couldn't prevent it. It came. It cost us $20 billion in economic losses. What checks and balances do you have in place?

Dr. David Butler-Jones: There are a number of things. I mentioned GEF and the global intelligence network we operate. In retrospect, an early version of that before it was really operational picked up SARS in November, months before it broke out of China. Now we notify WHO and the affected country, and they can then deal with an issue earlier on. Plus, the addition of the international health regulations that put the onus on countries in terms of containing issues within their borders would allow things to be dealt with in the tens and hundreds, rather than in the thousands and tens of thousands.

Secondly, we have capacity, for example, for Ebola in Congo. We have a portable laboratory capacity that nobody else in the world has, and we've sent it to Vietnam, to Congo; it was at the Olympics in Beijing and it will be at the Olympics in Canada, with the ability to diagnose in the field some of the worst and most difficult nasty diseases so you know what you're dealing with. We have teams we send to those parts of the world to support the WHO and others in that work.

Also, there is the development of the public health network. Before there were many advisory committees across multiple FPT4, etc. Now that all comes to one place, where work plans, planning, etc., is jointly done with the provinces and territories. We review where the gaps are. We can do the kind of planning that's needed. If there are policy issues that need to come up to the deputies or on to ministers, we have a means to do that. Everything then is connected, and there are roles and responsibilities in the response to outbreaks, the chief medical officer's role, the minister's role. We do scenario planning and we also do testing of these things, for example, around a pandemic.

Canada was the first country to have a national pandemic plan for the health sector. Other countries have copied that and built on it. We have other things, like vaccine contracts, anti-virals, etc., to mitigate that. But it's an all-hazards approach, because the work we do is not simply looking at any one disease, like a pandemic of influenza. What if there were another SARS? There are many examples, but I'll give you one from last May.

We got notice on a Friday morning that there was a train in northern Ontario with a number of Asian tourists on it who were sick. One had died and one was airlifted. Within minutes we had our operation centre operating, but within hours, with the province, the local public health office, fire, and others, with VIA Rail, other departments of the federal government, we were able to figure out exactly what was going on. Fortunately, it was a series of unhappy coincidences: they were Australian tourists, they had colds, and the woman died of a pulmonary embolism. It was not the next SARS. But if it had been the next SARS, everything happened exactly the way I would hope it would happen.

● (1550)

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

Madame Faille.

[*Translation*]

Ms. Meili Faille (Vaudreuil-Soulanges, BQ): Thank you, Mr. Chairman.

First I would like to thank you for coming to testify on this quite important public health matter. I'm going to ask a series of questions that are more about surveillance mechanisms. As you no doubt know, ongoing population monitoring is an essential public health function.

I have previously worked in the international immigration field. I believe that exchanges with various departments and agencies within the government are a problem when it comes to obtaining information on their activities, operations, objectives, methods of detecting diseases and so on. I'm going to give you an example. In the immigration process, a medical examination is always required and a disqualification process is provided for cases where individuals represent a burden to Quebec and Canadian society.

Among the challenges you must face, is information-sharing with the various departments one that causes a problem?

Dr David Butler-Jones: No. We have a very good relationship with the Immigration Canada people. We have signed a memorandum of agreement with them and with the departments whose mandates concern health and the effects of infectious and chronic diseases internationally. Now there is also a physician who represents us in Beijing, in the east. That helps us maintain good relations with China, in particular, where infectious diseases that are dangerous for us may come from.

Ms. Meili Faille: All right. If you don't have any problems within the machinery of government, do you have any with provincial officials?

Dr. David Butler-Jones: No. In fact, it's very interesting to see that our challenges transcend jurisdictions. The collaboration between my colleagues and provincial deputy ministers is good. From time to time, our opinions and approaches differ, but that affords us the opportunity to discuss matters and to improve the situation. In any case, there isn't just one response to the challenges. I think the collaboration is very good.

Ms. Meili Faille: I'm asking you these questions because I have here a surveillance report from the Public Health Agency. It states that the surveillance function is currently a problem. On that point, it states:

> No prospect of increased resources: The limited and unequal resources assigned to surveillance by region and the numerous duties often performed by those same resources [...] are a major challenge for legal agents in fully discharging their obligations.

This is a document that dates from 2008. From what you're telling me, you have enough resources, and information exchanges with the various orders of government are not a problem. However, this provincial report states the contrary. That may be due to a poor understanding of the situation.

● (1555)

Dr. David Butler-Jones: The relationship and collaboration are good. Resources improve from time to time. This month is better than last month or last year.

[*English*]

We've not arrived yet. There's still much work to do, and it is being done in collaboration and jointly. What I was speaking to was the good will. The efforts are being made. The progress is being made. We're not there yet. We are not able to survey everything we would like to survey. We do not have all the capacity we would like, but we're continuing to build that.

Merci.

[*Translation*]

Ms. Meili Faille: You tell me everything is going well, but I'd like you to tell us where the problems are and what recommendations we can make to help you meet your challenges.

[*English*]

Dr. David Butler-Jones: Okay.

[*Translation*]

I'm sorry. I hadn't understood the question. I thought it was about collaboration and so on. As regards challenges, we're talking about electronic information, about the ability to understand all the diseases. One very important thing for us is

[*English*]

syndromic surveillance. *C'est comme les maladies respiratoires, mais pas spécifiques pour* un specific disease. So that's part of it.

[*Translation*]

Here we're talking about the skills, the knowledge,

[*English*]

the training. There's a shortage of public health people in Canada, period. So having that capacity is a challenge for all jurisdictions.

[*Translation*]

Ms. Meili Faille: Do I have any time left? A minute?

In fact, you've somewhat hit on the problem. I'm told there's currently a lack of resources to train people in the field of surveillance. The various departments need help to implement public health surveillance plans. They are having trouble getting resources to clarify what has to be done. People also need training on the use of data bases and new sources of information. Could this need to be adequately trained be a challenge for the agency?

Dr. David Butler-Jones: Yes, it's a challenge for the system, but we have planned some measures to improve the situation. I'm going to continue in English.

[*English*]

We have the field epidemiology programs. We have people we train, who we put out, who the provinces call on. They can come in and work with them on investigations and also do training. We also have web-based training on basic surveillance and data gathering and other things that public health workers and others can access. We also have a mentor program.

We're developing a public health service. We're actually hiring people who are agency people. They're being placed, in particular, in areas that have less capacity, like the north and the east, but they are working with all provinces and territories alongside their colleagues. That will augment their capacity, and we can call on them if there's a national emergency.

The Chair: Merci, Madame Faille.

Thank you very much, Dr. Butler-Jones.

Mr. Christopherson, seven minutes.

Mr. David Christopherson (Hamilton Centre, NDP): Thank you very much, Chair.

Thank you for your presentation and for being here today.

I have some experience working with the medical officer of health back in a previous life as a regional councillor, as chair of the combined health and social services committee. Of course, the MOH reported back to me, so I've worked with this.

I've also seen you publicly commenting on some issues and I was very impressed. Knowing of your role, I thought the message you were conveying and what you were saying to the Canadian people was very good. I was very impressed. I wanted to start with that compliment, because it's the last one we're going to hear.

Some hon. members: Oh, oh!

Mr. David Christopherson: Yes. Enjoy it.

This is about the surveillance of infectious diseases. Given that we're a country that's gone through SARS, this is a pretty big issue for us. I have to say to you that given the nature of the report, this is pretty scathing. There's nothing here to be too damn proud about in terms of the surveillance and what's been done.

This is one of those cases, to members who are new, that I spoke about earlier. One of the things that incenses me, at least, and incensed many of the previous members, is an audit report that shows a problem, then another audit report that shows that problem wasn't dealt with, and yet a third report that says the first report wasn't dealt with and neither was the second one. That's what we have right here.

This has been dealt with before. Some of these issues are ongoing. It just doesn't seem to be getting dealt with.

I look at things like this from the auditor's report, which states, “Comprehensive surveillance standards still need to be finalized”. As well, it says, “They are essential for detecting outbreaks quickly and accurately...”. So we're not talking about some little piece of a remote department. This is essential to the ability of this department to protect the health of Canadians.

What does it go on to say? It says, “Without approved standards, cases may be reported by using differing sets of symptoms or diagnostic tests”. As well, it states, “Since 2002, the Agency has worked with the provinces to prepare the updated list...”. “The list appeared in 2006”, says the audit, but it still has not been finalized.

In 2002 the auditor recommended “that Health Canada work with the provinces and territories to establish common standards, and it agreed to do so”. Further, stated the auditor, “Work is under way on these standards, but in our view, the progress on this recommendation has been unsatisfactory”.

The report states, “In 2002, Health Canada undertook to implement a data quality framework for its public health data in response to one of our recommendations”. Further, it states, “We conclude that progress on our 2002 recommendation has been unsatisfactory”.

Says the report, “In 1999, we noted that Health Canada had completed few evaluations and had no formal plan to evaluate its surveillance systems”.

As well, states the report, “In 2002 we found that Health Canada was still developing its performance measures and that reports to Parliament remained inadequate”. The report says that “in our opinion, progress has been unsatisfactory on these recommendations”.

Then, on the next page, when you get to the four infectious diseases, it concludes, “In our view, progress on this recommendation has not been satisfactory”.

And yet here's what we get from the department—and I've mentioned this to colleagues before—and the departmental performance report. This is the kind of problem we get. That's what's coming from the Auditor General in three different audit reports, and her issues don't get raised in a 31-page report until page 24, in one little paragraph. And today, Doctor, you say to us, “I...recognize that more work needs to be done, and that protecting the health and well-being of Canadians requires effective and timely surveillance”.

I want to know, given the lack of urgency that I sense in your statement, what makes your promises of today any more credible and reliable than the promises we've already had, Doctor. We need some answers. We need some action. Start telling me things that would alleviate my concerns over this report, because what we're hearing is that this has been identified for ten years now.

You're just not taking this seriously enough, Doctor, and I need to hear more. I need to hear better.

● (1600)

Dr. David Butler-Jones: Thank you for the question and for the kind words to start.

I cannot speak for prior to my tenure and the previous two audit reports, other than to say that we have, from the founding of the agency, taken it very seriously, restructured ourselves, and restructured the system with our partners in the provinces and territories, ticking off the boxes as we move.

We take it very seriously. The fact that we developed a strategic plan to outline how we're going to get there over the next few years is pretty key, I think.

In terms of definitions, case definitions, etc., again, because we are working with our partners, it is something that we need to do jointly. The federal agency cannot say, “This is your definition”. We have to negotiate that with the provinces and territories. That's ongoing, and by—

Mr. David Christopherson: That's an acceptable answer for the first go-round, Doctor, but not for the third.

Dr. David Butler-Jones: We are now focusing on what we need to do in order to get there. We expect that the next round will be done this year for case definitions.

As well, by 2011 we will have funded through Canada Health Infoway the development of Panorama, which will allow all jurisdictions that participate to electronically input, so that we can have effectively immediate data on cases anywhere in the country.

I've outlined before a number of things that we've done, and we continue to go through the long list of things that need to be done, as we've been doing over the last four years, to continue to tick those off. As I said at the outset, each month we're better off than we were the month before. We're not there yet, but we anticipate that in the next couple of years.... So if you come back to me in two years and don't see continued major progress, then I'd be more than open to your criticism.

Surveillance is fundamental to public health. Good information is fundamental to what we do. We're starting with what we had. Part of the issue with SARS was a recognition that public health capacity in Canada had been for two decades neglected, as we focused on a very important thing, which is funding of the health care system. But public health as a priority for governments was not there, and SARS brought that out in spades, as did Walkerton, as did North Battleford. Now we have entities in place: we have the agency federally, we have agencies in provinces, we have “healthy living” ministers. Five years ago, when federal-provincial ministers met, public health was almost never on the agenda. When deputy ministers met, it was almost never on the agenda. Now it's on every agenda and is often half the agenda. There is a sea change, but as Neil was saying earlier, it's not something that happens overnight, but every year, every month, we are making progress.

● (1605)

The Chair: Thank you, Mr. Christopherson.

Mr. David Christopherson: Well, you can give that line bureaucratically, but that's not going to help families if we have another SARS, and that department hasn't been where it should have been for years.

Dr. David Butler-Jones: I gave the example of the train.

Mr. David Christopherson: And I don't appreciate your being entirely defensive on everything. Listening to your remarks, you'd swear that you're arguing this is not true.

The Chair: Order. We'll move on.

Mr. David Christopherson: We'll have another chance to chat.

The Chair: Mr. Saxton, you have the floor.

Mr. Andrew Saxton (North Vancouver, CPC): I'd like to thank Mr. Maxwell for his presentation earlier.

And I'd like to thank you, Dr. Butler-Jones, for providing the committee with so much information on your action plan and the progress you've made to date. I haven't been on this committee that long, but I have to say that this is the first time I've seen information in this detail, and I commend you for taking the quick action to implement the recommendations from this report. Specifically, I want to thank you for the summary action plan that you sent to us.

It's my understanding that this new agency was created in 2004. As I was doing some research for the committee today, I was pleased to see that your agency released an action plan immediately after this report. I think this is a good example for other agencies to follow.

My first question is for Mr. Maxwell. To me as a parliamentarian, this action plan and the information provided is very helpful. Is the Office of the Auditor General pleased overall with the information provided to date?

Mr. Neil Maxwell: Thank you.

The information they've provided—the update on what they've done—is certainly quite comprehensive.

Perhaps I could use this opportunity to comment a bit on some of the earlier questions as well. These are really important issues for Canadians, absolutely. We all understand that; we all get it. I think, too, it is a complex business. When we noted in our report the extent of progress, we came to the judgment that it wasn't satisfactory. We never come to that judgment lightly, and it is reflective of the seriousness of these kinds of issues.

I wouldn't discount the action plan, as somehow showing that they're not being serious about acting. I believe that what we see in the action plan represents a very serious effort to try to improve surveillance. Much of what I hear both in your question and in previous questions has focused around whether that rate of progress is enough, given the seriousness of these issues.

Thank you.

Mr. Andrew Saxton: Thank you, Mr. Maxwell.

I have a couple of questions now for Dr. Butler-Jones. Overall, I can see that a lot of hard work has gone into this action plan, and I commend you and your agency for the work.

I see that this surveillance strategic plan was developed last year. Can you describe overall what the goals are for this framework?

Dr. David Butler-Jones: To be a little more specific I'll turn to Greg, but fundamentally it's a question of what we need to do. We inherited a number of surveillance systems, which may or may not have been connected, in a range of areas, as well as different approaches. What we've been doing is reconciling them and focusing on where the gaps are that we need to fill, what the areas are that we need to build upon, and how we need to move the whole thing forward so that we have a more comprehensive approach to surveillance, one that's more effective and better connected.

Greg.

Dr. Gregory Taylor (Director General, Office of Public Health Practice, Public Health Agency of Canada): Thank you.

As Dr. Butler-Jones indicated, the agency inherited a number of individually managed surveillance systems, systems that were managed at a programmatic level.

What the surveillance strategy is doing is putting them together so that the agency manages all of our surveillance approaches in the organization as an agency. Currently, we're monitoring well over 50 diseases, which for the most part have been individually based. Putting it together and giving it a strategic direction, with goals to be the best data source and the best surveillance system in the world, allows us to think of it from an organizational perspective.

The role of the senior surveillance adviser is unique in the agency, in that all the surveillance has direct access to the CPHO on a daily basis to ensure that it's moving in the right direction. It allows us to apply evaluation to all the systems simultaneously. It allows us to look at standards, simultaneously for all our systems rather than as a series of one-offs. It allows us to interact with all the provincial and territorial partners as an organization, rather than in one-offs. It allows us to do our information sharing agreements jointly for all of the surveillance systems at the same time. It really is giving a common organizational perspective to what in the past, when we had individual programs, were functioning relatively independently, and which the agency inherited.

● (1610)

Mr. Andrew Saxton: Thank you.

Can you tell me how the appointment of the senior surveillance adviser changed the focus of the agency and how it has affected the implementation of this action plan?

Dr. Gregory Taylor: Sure. I speak for myself. I have the role of overseeing this and ensuring that the action plan we've made is moving forward.

We have a small group of individuals, a surveillance coordination unit, who are dedicated to ensuring that things are working and moving forward and to monitoring the progress of all the individual program levels. Along with that unit, I report to Dr. Butler-Jones on an ongoing basis, letting him know whether things are moving or not moving. If the agency is slow in one area, that's how he finds out about it, rather than its coming from the programs and through the typical bureaucratic channels.

It's an oversight mechanism to ensure that the agency is moving forward.

Mr. Andrew Saxton: Thank you.

I have no further questions.

The Chair: Thank you very much.

That concludes round one.

I have a couple of issues I want to pursue, Dr. Butler-Jones.

The first issue I want to talk about is your departmental performance reports. You operate a challenging agency, and as you indicated, it's a new agency. Probably, if we were to go back to six years ago, it wasn't a priority with either the federal government or the ten provincial governments. It is now, and you have a broad mandate.

As Mr. Christopherson said, the audit is fairly damaging; it's not a positive audit. Canadians should be concerned. Members of Parliament should be concerned.

I took the opportunity to read your departmental performance report. It was issued a long time after the audit was out. It was signed by the new minister. To be quite honest, it is what disturbed me more than the audit. I read this departmental performance report, and in everything here there's no indication that you have any challenges, risks. Everything is very positive. Every priority goal is being met and it's checked off—whether you have the right communications; "strengthen public health within Canada and internationally" is successfully met; "strengthen public health capacity in Canada through enhancements to public health work force"; "public health information knowledge systems" is satisfactorily met. It was so positive I would think that you and your whole staff could take nine months off. You have no challenges, no risk, and no problems.

Yours is not the only agency in the department that does this. It really grates on me that departments and agencies in Ottawa write this stuff for members of Parliament, because this, sir, is fiction. You have a lot of challenges. You run a tough department. I sympathize with you; it's not an easy job you have.

But I question why, when you prepare these reports and file them in Parliament through your minister, the Minister of Health, you do not identify the challenges, risks, and problems your department faces and the things you're doing to correct them. That, to me, is an honest dialogue that I would like to have with all 88 agencies and 22 departments. But we don't see it. If I took your departmental performance report and took the document prepared by the Office of the Auditor General, the first question I would ask is whether there are two Canadian public health agencies. And I know there's only one.

My question to you is, what dialogue goes into preparing this report? And please don't say it's accurate. What dialogue goes into preparing this report? Is it prepared under your supervision, and is there any reason you don't try to identify the risks, the problems, and the challenges you face, which are real risks?

I'm not being overly critical. When you start an agency as big as yours and with the challenges you face, the problems you have are real. It's not a criticism. But why don't you mention them here, instead of saying that everything is perfect?

● (1615)

Dr. David Butler-Jones: It may be a relative measure, in terms of where we started from, the efforts and the work that have been put into place, and the processes that have been put into place to address them.

In terms of the function of public health—and as Neil was saying, there are very complex, multi-sectoral kinds of things—for us, and for me, having done this a long time, the proof is in the pudding. While we work to get formal agreements and we work to get some of these things in place, which we continue to do, they don't come easily. The secret and the challenge is can you respond effectively at the time?

Back to your question, Mr. Christopherson, I look over the life of the agency now and the events we've dealt with, and how different they are today from what they were during SARS or before SARS: the identification in the case of polio; the identification of bird flu on farms and the engagement of CFI and others; the finding of the H2N2, which could have been the next pandemic, which we figured out and found and were able to work on with the Americans and others because they had sent it all around the world to track it down. And there was the listeria outbreak. There were many challenges around that, but fundamentally, from a surveillance standpoint, during the outbreak there were five extra cases of that in Canada a week—five cases a week—against a background of 20,000-plus of us with those symptoms every single day, and we were able to figure out not only that there was an outbreak but where it came from. That's very different. Five years ago that would never have happened.

And back to the DPR—

The Chair: Doctor, I'm going to have to interrupt you, sir. The DPR is what I'm talking about.

Dr. David Butler-Jones: It's the context for that.

The Chair: Please identify the DPRs.

Dr. David Butler-Jones: Yes.

The development of the DPRs—and again, maybe it's a broader discussion across government, as you say, sort of something that you hear across government, and maybe it's an issue of how they're formatted, what goes into them, how they're articulated, and the kinds of conversations that follow. We've been following what we understood to be what we do. It's fair comment, and I'll take that back.

Thank you.

The Chair: Thanks.

I don't want to belabour the point, but there's no mention of your lack of legislative framework, there's no mention of the lack of memoranda of understanding with the provinces, no mention of the privacy issue, no mention that you're not in compliance with the 2009 and 2002 recommendations. There's the whole issue of the World Health Organization, that you have to be assessed this year and you have to be compliant by 2012, which is a major issue. These aren't easy challenges that you face, and I would have thought there'd be something. But you went on for how many pages here?

Dr. David Butler-Jones: If I may, Chair—

The Chair: You went on for something like 40 pages, and it just couldn't be better, according to this document.

Dr. David Butler-Jones: Well, if I may, again, I'm speaking from a public health perspective, in terms of having managed outbreaks for 25-plus years, of having worked across jurisdictions for that amount of time. These are important issues that we are addressing, but they are process issues. I can have legislation that compels provinces to give me information. If they don't give me information, I still don't have it.

Because the legal wording, etc., is really important and the provinces care a lot about that, we've focused on making sure that they're comfortable with any agreements. Those take time. But in the meantime, we've built the relationships so that chief medical officers phone me up and say, "I'm worried about this". We have systems in place; we monitor things all the time. So from a public health standpoint, they're important to do, but they're not the most essential things to do. It is not make or break for the ability of the people—

The Chair: Okay.

Before we go to Ms. Crombie, I urge everyone who hasn't read it to read the departmental performance report, and you'll be surprised what you read.

Ms. Crombie, you have five minutes.

Mrs. Bonnie Crombie (Mississauga—Streetsville, Lib.): Welcome to the public accounts committee.

Mr. Butler-Jones, I would challenge you that these issues aren't process issues. They're accountability issues, accountability to the Canadian people. In your last comment you said this is a process issue, and I feel it's an accountability issue.

Dr. David Butler-Jones: Fair enough, fair comment. That's why we're doing them, because they're important to do. We do them, but they do take time.

But from a public health standpoint—the public can agree with me or not—the point is to find the disease, figure out what's going on, and stop it, and whatever the paperwork is, that follows behind.

● (1620)

Mrs. Bonnie Crombie: Okay, let's continue.

Mr. Saxton was very glowing in his comments. I just want to ask you about this action plan, which I received about 30 minutes before this meeting. It is helpful, but it's not useful if it's not implemented, and it's not helpful to us if we don't receive it with some advance warning.

Is there any reason that we didn't have this document with due course?

Dr. David Butler-Jones: I'm sorry, I'm not sure about the timing, but we will be implementing.

Mrs. Bonnie Crombie: Okay.

Let's go to our commitment to the WHO. In 2006, which I think is your era, we committed to implementing parts of the regulation. The audit has found we have not taken the steps to meet our commitments and we may not be able to obtain the information needed to do the assessments within 48 hours or notify the WHO within 24 hours or keep the WHO informed. The results are inadequate with respect to information-sharing agreements with provinces and territories.

How many provinces have entered into the MOUs to date, and when do you anticipate securing agreements with other provinces? And what are the reasons for the delays?

Dr. David Butler-Jones: In terms of the information sharing for that purpose, all.

Mr. John Weston (West Vancouver—Sunshine Coast—Sea to Sky Country, CPC): Point of order, Mr. Chair.

Mrs. Crombie, can you say where you're reading from, because I'm interested in that area as well.

Mrs. Bonnie Crombie: These are my notes, Mr. Weston. Yes, it's all there.

Mr. John Weston: Which part of the report? No?

The Chair: What's the problem?

Mrs. Bonnie Crombie: I have to go back and look at this. The witness doesn't have it.

The Chair: Okay, one speaker at a time. What's the problem here?

Mrs. Bonnie Crombie: We're not sure.

Dr. Butler-Jones?

Dr. David Butler-Jones: There are two things. One is the international health regulations and our ability as a country to respond to them. All jurisdictions have committed to that in Canada and we're working on implementation of that. We have a memorandum with all jurisdictions in Canada, all the provinces and territories, around information sharing and public health emergencies. That is in place. We are supplementing that with routine information sharing with the provinces, as we now have with Ontario, and that will be implemented as soon as we can get those agreements in place. But in emergencies, the kinds of things that are critical, that's in place.

Mrs. Bonnie Crombie: Okay. On a slightly different tack, if I have time, what role does the Public Health Agency have in response and alerting the public of possible epidemics and public health emergencies? For instance, what role do you have in preparing or preventing outbreaks such as SARS and avian flu and hoof and mouth, for that matter? Do you have a role in making the scientific and pharmaceutical biotech industries aware of potential outbreaks and allowing them to prepare? I have the pharmaceutical company Hoffman-La Roche in my riding, and they are the creators of Cipro, as you know. Do you play a role in emergencies in letting them know what minimum target levels of antibiotics they need to keep on hand and who is responsible for setting those?

Dr. David Butler-Jones: It's a shared responsibility, because health care is largely provincial and territorial, and public health is local. It may happen in a thousand localities at the same time, but it's still a local event. And that's why you have local structures for public health medical officers, inspectors, nurses, and others, linked in to the hospital sector, etc.

Most of the legislation is provincial. It supports the local public health officers, and then we support the provinces and local public health officers, sometimes based on a request but obviously it's multiple jurisdictions. We also are the keeper of the pen, for lack of a better term, on the national pandemic plan and other plans, best practices, guidelines, etc. We work through the various expert committees and with the provinces and territories in terms of what that is. We also maintain stockpiles. We have the national emergency stockpile. We also have a joint stockpile of antivirals with the provinces for dealing with the pandemic of influenza and in our national emergency stockpile we have a range of equipment, drugs, etc., to support that. The planning in terms of what is needed happens at two levels. One is locally, what is needed; and then provincially, they make their decisions, and then we're part of the overall coordination of those activities.

In terms of the sharing of information, again it depends on its level. If it's a local outbreak in a nursing home, generally it's the local medical officer, etc., who will deal with it. If it's multi-jurisdictional or they need help, that's where we send in field epidemiologists and others to assist them with the investigation. We also have the reference lab, and we do the more sophisticated testing for strange bugs.

The Chair: Mr. Kramp.

Mr. Daryl Kramp (Prince Edward—Hastings, CPC): Thank you, Chair.

I want to deal with the zymotic issue just for a second. I have a company called Bioniche in my riding. They are the people who created and manufacture the E. coli vaccine. As such, knowing the immunization for E. coli is done at the animal level and it stops the reproductive cycle, obviously it has no effect on humans at that point so it is not necessary to inoculate humans. Would it be desirable to have something like that on a national scale? Would it be helpful or effective?

● (1625)

Dr. David Butler-Jones: There are a number of different strategies. This is one that is quite innovative and very interesting. There are others in terms of using phages...the way you feed animals, in other words. If you change the percentage of feed, you can change the risk for those animals for E. coli and other infections. So there is a lot of very interesting research going on now. I'm not the expert to comment on which is best, but our scientists work with CFIA scientists and others in terms of what makes the most sense. As the consensus develops, then obviously those guidelines are shared.

Mr. Daryl Kramp: On the E. coli situation, how involved are you actually with assessment of E. coli now? It could be on spinach. It has all kinds of degrees of severity. By all standards and by most people's knowledge, it's a lot more prevalent than it actually is reported to be on the deadly stage, such as the Walkerton deal. I'm wondering just how current you are and how effective and involved you are with the assessment of E. coli.

Dr. David Butler-Jones: E. coli is a normal bug in the gut. We all have E. coli in our gut. It's the O517:H7 or other strains that are more toxigenic and create the problems. We're very much involved from the human health standpoint.

In terms of vaccines, we're not the regulator of these things. We engage with our partners both in the health portfolio as well as CFIA and others around the public health perspective on these issues, but ultimately the regulatory decisions, etc., are theirs.

Mr. Daryl Kramp: There's a bit of an interesting sidebar here. Anecdotally, the flu shot we all get, or many of us do get or should get or whatever.... It's been told to many of us that it wasn't a good choice this year and that it hasn't been as effective because it was obviously not directed to the virus it should have been directed to. Is that correct? If that is correct, what precautions could be taken to alleviate that situation?

Dr. David Butler-Jones: Influenza is an amazing bug. It is constantly variable. It's full of surprises. That's why we have pandemics two or three times a century. It's constantly changing its genetic makeup and is very adaptive. Every year, you have to have guessed the year before what the most likely strains are. Usually in the vaccine there will be two of the A influenza type and one of the B. This year, for one of those three, there was not as good a match as sometimes. You still have protection against the other ones. You still have partial protection against this one. But it's not 100%.

Even where there is an absolutely good match, there are still surprises. Even mid-year—a few years ago, for example—the virus can change. You get a slightly different virus, so some of us get sick. But having the immunization, if you do get sick, you tend to be less sick, less likely to be in the hospital, and less likely to die, because there's some protection.

Mr. Daryl Kramp: Okay. Thank you.

On the departmental report and the progress to date, you've made progress on a number of significant issues, but I'm also concerned with the ones where either no progress or limited progress has been made. I'd like to know what issues you're either not willing or unable to address.

Dr. David Butler-Jones: Sorry, in which—

Mr. Daryl Kramp: With regard to the concerns of the Auditor General.

Dr. David Butler-Jones: We're planning to address them all. I don't think there are any that we—

Mr. Daryl Kramp: I just want to ensure that there's nothing outstanding that you either disagree with or you don't feel you can comfortably handle, given a reasonable amount of time.

Dr. David Butler-Jones: No, I think we're really focusing our energies on this one. As I said before, it is fundamental to us. There are other things that aren't in the Auditor General's report, like the building of relationships, the strengthening of the network, etc., that we will continue to do because they are fundamental to good public health.

Mr. Daryl Kramp: I do understand that. I think as far as Ms. Crombie's situation.... Yes, we just received this here today too, but I think it's been on the Internet since 2008. But, yes, I haven't accessed it.

Mrs. Bonnie Crombie: That's the old version. This is the new version.

The Chair: Thank you very much, Mr. Kramp.

Monsieur Desnoyers.

[*Translation*]

Mr. Luc Desnoyers (Rivière-des-Mille-Îles, BQ): Thank you, Mr. Chairman.

I have the same concerns as a number of my colleagues, both the Chair and my NDP colleague, concerning the Auditor General's report in which she raises a number of major problems. Those problems haven't been addressed quickly, or as they should have been addressed. Moreover, Mr. Neil states in his report:

> "We are concerned that a nationally standardized approach to disease reporting remains years away."

So we're talking about agreements here. This is troubling. There may be another way to activate this approach. It is important to know what is going on across the country when it comes to infectious diseases.

You said there are no problems with communication and cooperation. I entirely agree with my colleagues, who believe that's the case, particularly when you look at the MOUs, the question of the WHO raised by Ms. Crombie, and the entire legislative framework that provides you with no support. My first question concerns measures for activating the process of signing MOUs so that you have access to that information as soon as possible.

You've also submitted an action plan which is supposed to be important and which, I think, requires very quick implementation. That may result in additional expenditures. I don't know whether you've provided for that eventuality or whether you have made requests for that purpose. If not, perhaps you should think about it and do so quickly in order to protect Canadians adequately. This involves training, equipment and laboratories.

Can you tell me where the laboratories are located in Canada where a situation can be analyzed quickly so as to respond immediately to the various needs respecting infectious diseases? You mentioned a few of them earlier: West Nile virus, bird flu and SARS, which was devastating. I'd like to have some answers to these questions that I've asked.

● (1630)

Dr. David Butler-Jones: Thank you for the questions.

We don't need MOUs to find information. All the provinces provide us with the information we need. There's no problem, but there may be a risk. Formalizing the relationship is a good thing. For more than four years now, we've had no problems with the provinces or territories in obtaining the information we need. The same is true of the WHO and the international situation. Our cooperation, the information we give the WHO and the information we receive from the WHO are not a problem. There's no deficiency.

Mr. Luc Desnoyers: I don't know whether we've misunderstood each other, but, in paragraph 5 of his report, Mr. Neil clearly states that there are major problems. Talking about information-sharing with the various provinces, he says he is concerned, and I quote:

> "[...] that a nationally standardized approach to disease reporting remains years away."

I don't know whether you have access to recent information, but the Auditor General says there is a problem and you're saying the contrary. I'm just trying to understand.

Dr. David Butler-Jones: I'll answer in English, please.

Mr. Luc Desnoyers: Say it in English.

[*English*]

Dr. David Butler-Jones: In a way, it's a matter of degree. We do not have any problem. We have the full cooperation of the provinces. Any information we ask for, we get. That's not an issue. It's the same with our relationship with the OMS.

What I think the Auditor General is asking is how we can be sure unless we have memoranda signed and agreed to. The challenge for memoranda is that with legal and other things, they take time. And if there's something new, again, if we have a call that day, the chief medical officers will start reporting. That has not been an issue in the four and half years of the agency.

The operative word is "may" be a problem. They're pointing out a potential risk, which I think is a legitimate thing to point out. It's part of the reason we're pursuing as quickly as we can all these agreements. Again, they're to give more clarity, formality, and common understanding to as much as possible. In the meantime, we've not had a problem. We've had many problems we've had to deal with, and we've dealt with them successfully with our partners.

● (1635)

[*Translation*]

Mr. Luc Desnoyers: Among other things, the implementation of your action plan may require much larger amounts of money. If so, have you filed a request for that purpose with the Treasury Board?

[*English*]

Dr. David Butler-Jones: The agency has actually received, in previous budgets, money related to pandemic preparation and planning, etc. That has been a very beneficial resource to help us to move forward on surveillance and a whole range of things in preparing ourselves and the country for dealing with it.

The national lab, which is in Winnipeg, is the reference lab. Again, there has been good collaboration with laboratories across the country, provincial laboratories and others. We do the reference so they can take tests to a certain point, and then we can follow up from there.

There's still more to be done. I don't want to be naive about this, because we're always finding new things. Every year there are new diseases that we're discovering and new capacities that we can bring to bear, but we're continuing to make progress.

[*Translation*]

Mr. Luc Desnoyers: Mr. Chairman, he didn't answer my question.

[*English*]

Dr. David Butler-Jones: I'm sorry. I missed what you said.

[*Translation*]

Mr. Luc Desnoyers: What I asked concerns the action plan, which is important. Does the agency need additional money to implement that action plan? If that's the case, has it made a request to the Treasury Board?

[*English*]

The Chair: Please give a quick response, Dr. Butler-Jones, and then we're going to go to Mr. Weston.

Dr. David Butler-Jones: Very quickly, as I was saying, we've had new resources, and we're applying them. If it looks, as we move forward, as though we need additional, then obviously we would be making that request. At the moment, we're able to continue to develop with the capacity that we have.

The Chair: Merci, Monsieur Desnoyers.

Mr. Weston, you have five minutes.

Mr. John Weston: Thank you, Mr. Chair.

In recent weeks we've reviewed interprovincial and federal-provincial transfers and federal-provincial jurisdiction also.

I want to thank you, Dr. Butler-Jones and Mr. Maxwell, for sharing with us infectious diseases.

I would like to take up where Ms. Crombie left off on the international level. I think probably the most terrifying book I can ever remember is the *The Andromeda Strain*. Bugs have no boundaries. It seems to me that SARS came from China; West Nile came from Africa; AIDS came from Africa; and Ebola came from Congo, I gather. There are twin problems, in that you have no jurisdiction to deal with how things are dealt with in other countries, and secondly, if someone decided to spread a disease as a weapon of war, then you have no control over that.

With that sinister background, I have three questions.

Much of what I read in chapter 5 of the Auditor General's report dealt with the World Health Organization. The first question is wouldn't it be good to expand the membership of the WHO? For various reasons that I don't understand, Taiwan has been excluded. Wouldn't it be good to have Taiwan as a member, and other countries as well?

My second question is how you deal with this. I think I heard you say that other countries are coming to you for reports, which would be a very positive compliment on how we're doing in this area, but how do you deal with the fact that there are all of those other jurisdictions?

My third question is whether there have been lessons learned during your international involvement.

Dr. David Butler-Jones: Thanks for the questions.

Post-SARS, one of the developments is the international health regulations, which put some responsibilities on governments.

Under the surveillance system that we operate internationally, as I was saying, the WHO indicates that between 40% and 60% of the notifications to them and then from the country come from us. That's down from 80%. So it is actually changing. Countries are looking harder for these things, partly because they'd rather find something themselves than hear of it from us.

In terms of the World Health Organization, the membership in the organization is a political issue. I will avoid that, but we work with Taiwan, other countries work with Taiwan, and the WHO works with Taiwan. They are resident on committees, etc., and they are part of the world. As you say, from a public health standpoint, we include information sharing, technology exchange, all of those kinds of things, with a range of countries, some of whom are more strategic than others. As I was saying earlier, we have someone based in Beijing because of the risk in that part of the world for emerging new diseases.

The lessons learned generally are that SARS was a wake-up call for all of us. We can never completely eliminate risk. Nature is fundamentally inventive; there will always be surprises. Even during and before SARS, SARS was an atypical pneumonia. At that time, for 60% of the people with atypical pneumonias, we never figured out what the bug was—never—but SARS was one that we figured out because of a concerted effort by our lab and others. But there are many more diseases out there. There will always be surprises, but that's why there's the general preparation that we do, the planning, etc., so we can respond to whatever might come.

The basic lesson beyond the fact that there are always surprises is the connectivity of issues. So those who died of SARS, by and large, were those with underlying chronic disease. So if we don't address the basic health of populations, we'll never even get at infectious diseases effectively.

And there is, post-SARS, a level of.... Again, we're not there, and I don't want to diminish the challenges of intergovernmental work, etc., but the level of willingness to collaborate and work together across countries and within countries—in our case, within our federation—I've never seen in 25 years. That doesn't mean we're there, but it does give me hope about the willingness, and even the relative transparency, of other countries now compared with five years ago. Their willingness to share their failures, not just their successes, is also a hopeful sign.

● (1640)

Mr. John Weston: Your report refers to an action plan to be completed by December 2009. Paragraph 5.89 of the Auditor General's report says that “as required by the World Health Organization, the Agency will work with partners to develop a comprehensive action plan by December 2009...”. So it gives me some comfort, in response to Mr. Christopherson's line of questioning, that there is an action plan and that you've specified a date.

One question I have is that I don't see the Centers for Disease Control and Prevention in Atlanta mentioned anywhere in the Auditor General's report or in the other material I reviewed, but I would think it would be a leading agency that you would work with on these things.

Dr. David Butler-Jones: Yes, we work with quite a range of countries, some closer than others. We're a key part of the global health security initiative, and the Global Health Security Action Group, as one of the G-7-plus one countries, in terms of planning for a whole range of not just outbreaks and epidemics, but also bioterrorism and other things.

We work very closely with CDC. There are some things they're better at than we are, which we learn from; and there are some things we're better at than they are, which they learn from.

And we share capacity. For example, PulseNet, which looks at characterizing the genetic makeup of bacterial diseases that cause food poisoning, for instance, is a shared system. We and the Americans and the Mexicans now use that. It makes it easier for us to figure out: oh, these five cases in Toronto, these three cases in New York, and these 12 cases in Atlanta are all the same strain, coming from the same place. What are the common factors? Then we can trace those back to figure out where it came from. The listeria outbreak is a good example of that.

The Chair: Thank you, Mr. Weston.

Thank you, Dr. Butler-Jones.

Mr. Christopherson, for five minutes.

Mr. David Christopherson: Thank you, Chair.

On my second round, what I want to come back to is your comment earlier. I thought it was quite interesting that when we were talking about the memorandum of agreement and other standards and things that are not in place, you left the impression with me that we don't need a Dr. David Butler-Jones out there or a senior bureaucrat to manage these issues. What we need is a U.S. General Patton just to go out there and cut through all the nonsense and get to the heart of it. Nobody's ever missed a deadline, we get the job done, and all of that.

There are two ways to look at that. One is that it's absolutely true that there's a lot of useless red tape that's been made up by bureaucrats who are looking for make-work projects. Then there's the other side of it, which is that perhaps the details of reporting mechanisms and agreements and standards and commonalities actually matter in terms of protecting the health of Canadians.

The Auditor General, in her report, and she's very careful about words she uses—she's quite the wordsmith—says:

> Surveillance standards ensure that infectious disease occurrences are defined, reported, and recorded uniformly across the country. They are essential for detecting outbreaks quickly and accurately, describing national trends reliably, and planning and evaluating control measures consistently.

She deliberately uses the word “essential”. You deliberately used the words “not essential”—I don't have the exact wording, but I'll stand by the Hansard—when you were talking about the difference between the ultimate goal of information that needs to be gotten and whether the actual details were done.

This stark reality between the Auditor General saying that these are essential and you saying that they are not essential—you used those words—troubles me in terms of whether you're getting where we're coming from or whether this is just a process for you to go through: just write it off as a bad day and go about your regular business.

The Auditor General, in defence of her position, said, in paragraph 5.86: “In its current form, the memorandum is largely a statement of principle and is not sufficient to ensure a complete and timely flow of information between the Agency and the provinces and territories on public health risks and emergencies.”

She goes on to say, in paragraph 5.99:

> In the event of a public health emergency, the Agency runs the risk of not obtaining the information needed to do an assessment of the situation within 48 hours, to notify the WHO within 24 hours, and to keep it informed of subsequent events, as required, because information-sharing agreements with the provinces and territories are missing.

The Auditor General says to us, the public accounts committee, that this stuff is essential. You, as the national medical officer of health, have come in and said that it's not essential. Which is it, Doctor?

● (1645)

Dr. David Butler-Jones: It's actually somewhere in between. If I wasn't clear when I said it, the most essential thing is to get the information, not the agreement.

The first effort of the agency has been to make sure that we have the relationship with the provinces and territories and others—all our colleagues—so that a phone call will solve it. Rather than that, you can have the regulations in place, you can have a memorandum of understanding, and you can have timelines, and then they wait for 48 hours to send it to you, as opposed to picking up the phone.

We have standard case definitions. You're mixing up a number of things and putting them all under the statement. We do have standard case definitions. We all report on the same things. The issue is that getting the agreements in place takes time. If you think of any FPT agreement, they do take time. We are taking that very seriously. We want them in place. We agree with the Auditor General. We've said so. I'm just talking about the reality.

In the U.S. you have a Surgeon General—I'm the equivalent of the Surgeon General and the head of CDC—and the Surgeon General has no power over the states to order them to do anything.

What you want to ensure is that you have the system working, and we will get the agreements in place to reinforce that. Greater specificity is absolutely essential. I totally agree with that. I'm just speaking to the reality that I want to make sure that I have the information, period. We'll work on the agreements, but I'm not going to spend time working on agreements before I get the information.

Mr. David Christopherson: You know what worries me? I remember this distinctly. If my colleagues from city council were here, they would recall this vividly. We had a developer sitting at the table at a committee meeting, and we were advising the developer of certain requirements that he needed to put in place. He got all upset and lost his cool and said, “You know, I've just about had it with the city and all these mamby-pamby rules.” Well, the mamby-pamby rules were the Ontario fire code regulations. And I see your response very similarly, sir.

You're not taking this seriously enough. I understand that you're getting the job done. I'm pleased about that. I hope you have a horse waiting outside your office so you can jump on it and rush to the middle of the scene of the panic so you personally can solve everything. But I have an Auditor General, who knows a hell of a lot more about these things than you or I, telling me that these things are essential. They need to be in place, and you're going on, sir, telling me how unimportant they are, or that they're not as important. I just want to hear you tell me that you agree that these things are essential. You're saying that they're in the middle. That's not good enough.

The Chair: Okay.

Mr. David Christopherson: I want to hear you say they're essential and assure us you're going to do something about it.

The Chair: David, your time is up.

We'll have a brief response from Dr. Butler-Jones, and then we'll move on to Mr. Shipley.

Dr. David Butler-Jones: You're misconstruing. When I was talking about the middle, you had a specific question. Now you're taking that middle to something else.

Let's be very clear. We have responded to the Auditor General. We have agreed we are going to do this.

Mr. David Christopherson: You agreed in 1999 and 2002 also, sir.

The Chair: Go ahead.

Dr. David Butler-Jones: Okay. There are practicalities of getting it done. The key elements are whether we get the information we need, whether we have the collaboration we need. That is in place. We will get these agreements done and that will reinforce that.

The Chair: Thank you very much, Mr. Christopherson.

Thank you, Dr. Butler-Jones.

Mr. Shipley, five minutes.

Mr. Bev Shipley (Lambton—Kent—Middlesex, CPC): Thank you.

I just want to appreciate the opportunity to be here with you folks today and to listen. Obviously, it's a concern of a number of folks. We talk about public health; it's always a concern for all of us. You said there will always be surprises. Because of travel, because of global trade that is happening, I suspect surprises will be coming more often. I suspect, because of the poverty and some of the things around the world that are not reflected as much in Canada, that those surprises will not always be as easy to detect, and I appreciate that.

One of the things the Auditor General talks about on page 8, 5.17, is that there are nationally notifiable diseases. The top 60 diseases formed the updated list published in October of 2006, and the provinces and territories have agreed to report cases of these diseases to the agency voluntarily. How is this list monitored? Is it continually updated? Is there a concern in terms of some? We're always concerned when we miss the mark and a disease hasn't been detected. Is there concern that you overreact on something that really isn't an issue but could actually become a national concern?

I'll leave it at that for now.

● (1650)

Dr. David Butler-Jones: They are regularly reviewed, because it's a joint project with the provinces and territories and the experts in the area. So they do get periodically reviewed, and that will continue. There are always surprises, but that's also why, for example, in the middle of an outbreak, something we've never seen before, we develop a case definition that day as a working definition, so all jurisdictions can do it, so we know what we're looking for. This is not an infectious disease issue, but with melamine and the children, through our surveillance system that we operate with the Canadian Paediatric Society, they were able to contact all the pediatricians in the country looking for these symptoms and to see if in fact there was any impact in Canada of that from a syndromic surveillance standpoint, before we even knew there was melamine in baby formula in Canada.

That's the kind of stuff we have to do. In all these things there is no disagreement between us and the Auditor General in terms of importance of these things. We will do that. It does take time. I can't speak for the previous two audits. This is the first one I've dealt with. We've made significant progress since the beginning of the agency. We will continue to do it, so when you come back to this again I'm sure you will be happy, for lack of a better term.

Mr. Bev Shipley: I can appreciate that.

You talked about the provinces and you got an agreement. I'm talking now about the implementation. I appreciate the fact that you say it is voluntary and that the cooperation has been good. Is that the same for the responsiveness from the provinces, also in terms of that cooperation?

Dr. David Butler-Jones: Absolutely. It works both ways.

Mr. Bev Shipley: If there were SARS that were to come out now, what has changed? I read in the report that there have been significant changes that have happened since 2003. If that were the case, what are the main changes that have happened that would give Canadians the security that it has improved a lot since 2003 on a major outbreak like SARS?

Dr. David Butler-Jones: I've given you a few examples. There are lots of other examples of where we've actually done this.

Basically, there are a number of things in place—the Public Health Network, for example. We now have a coordinated connection of public health across the country in all jurisdictions and a mechanism by which decisions can be made rapidly, people can be consulted. Our communication systems are much better. The surveillance systems at the provincial level, territorial level, and our own are improving. The cooperation is different. We've sorted through a lot of the legal issues around information sharing, etc., and that takes time. We should not be in a situation again where information was not being shared as during SARS. We have a greater capacity, too, to actually respond to things.

Mr. Bev Shipley: I'm sorry...?

Dr. David Butler-Jones: We have greater capacity to actually respond. We have more people in the agency. We have more people working in public health. We have better connections. It really is about getting the most appropriate expertise to the right place at the right time.

● (1655)

The Chair: One more question.

Mr. Bev Shipley: I have one follow-up question, for my understanding and maybe some others.

With respect to vaccines and pharmaceuticals, in the global perspective, if there were an outbreak, how would that work when you may have something you're not familiar with from another country and having the vaccines that would be needed to treat that disease?

Dr. David Butler-Jones: It really depends on the disease. The most worrisome is a pandemic of influenza, because of its large scale. The interesting thing, though, is that more people die from influenza between pandemics than during pandemics—from regular every-year flu. We lose about 4,000 people a year from influenza, which is much greater than the worst predictions we can think of, for even one as bad as 1918-19. So prevention immunization on an annual basis is important.

As I mentioned earlier, we operate the national emergency stockpile. Provinces have their stockpiles. When it comes to influenza, which is the one we're most concerned about, we have a joint stockpile, plus what we've supplemented federally. We think we would have enough, assuming it is effective, for whatever the pandemic strain would be.

We could treat in the meantime, while we get vaccines into people's arms. We have a domestic-based manufacturer that can produce enough vaccine for the whole country. We're the only country in the world that has developed that capacity.

The Chair: Thank you, Mr. Shipley.

Ms. Ratansi, five minutes.

Ms. Yasmin Ratansi: Thank you.

I have some brief questions.

The audit found that the national surveillance remained weak, that you lacked timely, accurate, and complete information on infectious disease, and that in 2004, since the Public Health Agency has been established, the agency has only signed one agreement—in 2007, with Ontario—to a nationally standardized approach to disease reporting.

You gave an example of what happened in northern Ontario and how you were able to capture the problem, a person. Could you tell me if this was goodwill, luck, or were there systems in place? Basically the audit did mention that you relied on the provincial information you were gathering, which was based on good will.

How much of a national strategy do we have? What systems are actually in place? I guess everybody is playing with that notion, but we do not seem to see something tangible. You've been able to address issues, but after SARS we still do not have a national strategy or standardized approach to collecting and disseminating information, trying to get immediate information to every player of what the problem might be.

Dr. David Butler-Jones: We actually do. We have several protocols in place. That's how we operate. The question is, do we have—

Ms. Yasmin Ratansi: You have protocols in place?

Dr. David Butler-Jones: We have protocols with the provinces on a range of issues. What is the overarching memorandum that says, as government to government, we will do this? We do that. I mean, it's the nature of what we do. And we have the relationships, the protocols. We have things about what goes to whom, who makes decisions, all of those kinds of things. That's all in place.

Ms. Yasmin Ratansi: How solid are those protocols, Mr. Maxwell?

Mr. Neil Maxwell: Thank you. I was starting to feel a little unloved here.

Some hon. members: Oh, oh!

Mr. Neil Maxwell: Thank you for that question.

There have been several questions, I think, that really get to this question: how important are all these agreements? We said in the report they're essential, and they are essential. I think what's really important on this subject is all of the direct contacts and all the relationships and the networks that have been built. There really are important networks in place, and that was a major accomplishment for the agency, but it's not an either/or. That's important. Equally, those agreements are important as well.

What we were concerned about in the audit—and thank you for referencing that particular case—is that on the side of the routine collection of surveillance information, outside the situation of an emergency like SARS, the only agreement in place is the one with Ontario. That came after a very difficult period of about two years, in which the Province of Ontario was quite concerned about the ability of the agency to protect privacy, to protect personal information. Because of those concerns, the Province of Ontario no longer provided the same level of detail in information that they had previously, so there have been interruptions.

On the side of emergency, again, as Dr. Butler-Jones has said, I think the achievement of getting an MOU with all the levels of government in support of the international health regulations is a major achievement. Our concern in the audit was very much that that it's good as a first step, you know, but the devil's always in the details. Getting the protocols in place that would actually dictate how that would work in an emergency situation is important.

Lastly, I might just note again in regard to the importance of agreements that I recall David Naylor's report in the aftermath of SARS. One of the things that Naylor concluded was that those agreements were very important and that many of the problems of SARS were in fact due to the absence of protocols and agreements and too much reliance on goodwill.

● (1700)

Ms. Yasmin Ratansi: If I'm reading your report or your analysis correctly, there are procedures in place so if there is a SARS outbreak in China and a traveller is coming from China to Canada, we have all the protocols in place to catch the disease and notify public health and safety officials of the problem, isolate it, and ensure it doesn't spread.

Dr. David Butler-Jones: To the extent that it's recognized, yes. No surveillance system will deal with that issue. As a for instance, the difference between Vancouver and Toronto with SARS was that a woman arrived from Asia, came to Toronto, and died at home, and nobody knew what was going on. Her children then took it to hospital. They had no travel history, whereas in Vancouver there was a clear travel history.

We absolutely agree—and again, I wanted to make this very clear—with the importance of these. That's why we're working very hard to make sure we get them in place, but in the meantime, in terms of the question of whether it's the paper that reassures Canadians or the experience, the commitment, and the collaboration, I think it is both. We need both and we've been addressing both, but in terms of many of those issues, we're much better off. We will still get surprises. The sooner we find them, the better.

Mr. David Christopherson: Why can't you—

Ms. Yasmin Ratansi: Wait, David, it's my turn.

The AG was looking for some key indicators. Do you have those key indicators in place?

Also, I will just throw something in. I went to an APEC conference with the health minister. What do you do when countries do not share information with you? For example, Indonesia or Vietnam might have a pandemic outbreak. If they don't share what they have found, what do you do?

If you could, address my first issue on key indicators that are available so that the AG can be satisfied with that, and also the second one on an international scale.

Dr. David Butler-Jones: On the indicators of performance, I'll come back to that.

First is the interconnection. It's the WHO. When we get information on a country, we give it to the WHO, and they work with the country.

In addition, one other advantage since SARS is the development of the International Association of National Public Health Institutes, the CDCs of the world, the agencies of the world, and developing and developed countries. Most of these countries are now part of that.

The Gates Foundation provides funding to ensure that developing countries have access. It's about building capacity for public health and building expertise in public health, but it's also about sharing. I have counterparts around the world who I now know and can phone up, rather than going government to government, and ask, “What's really going on?” That helps. It doesn't guarantee, I know, but it's certainly one more piece of information.

In terms of the performance indicators, they will be done this year.

Ms. Yasmin Ratansi: Thank you.

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

Mr. Young, five minutes.

Mr. Terence Young (Oakville, CPC): Thank you, Chair.

Dr. Butler-Jones, I've been listening very carefully to what you say, and I've read your reports, and I think the concern of some of my colleagues on this committee is that the reports are all about process, and the remarks are all about process, and in fact most of what you do is communications. And of course what we have to be concerned about, what the public's concerned about, is where processes produce results, where the rubber hits the road.

I'm going to go over some territory my colleagues covered in part, and if you could give me a detailed answer, it would be very helpful.

There was one thing you said that was really impressive to me. You said, “The proof is in the pudding—can you respond effectively at the time?” And then, and I wish this was in the report—I think that if it was in the report we all would have felt better about the report—you said, "Chief medical officers phone me up and say they have a problem”.

I've done a lot of research into prescription drug safety, and I know that when somebody is injured or dies after taking a prescription drug, no one calls anyone. So I know it's really important when the chief medical officer calls you, but I wonder if you could tell me what happens next. I understand your role is primarily communication, but what would happen next? Like the previous SARS epidemic, what would you do and what would happen step by step after a chief medical officer calls you? And then I'd like to know what the result would be this time. Forty-four people died last time. Forty-four families lost a loved one. Can you say there would be far fewer deaths? What would be the result with a similar situation this time? That would give us an idea of how far you've come along.

● (1705)

Dr. David Butler-Jones: Again, given the vagaries of nature and how infectious—fortunately SARS was not more infectious than it was. It was obviously a great tragedy in and of itself and a big wake-up call for the system. I'll walk you through a little more details in terms of.... We get a call. We have people on 24 hours. They're monitoring the system. They're looking around the world and in Canada for potential outbreaks for other things. So we get a call.

Mr. Terence Young: You have a 24-hour hotline?

Dr. David Butler-Jones: Yes.

Mr. Terence Young: I didn't know that. That's excellent.

Dr. David Butler-Jones: And we have people monitoring the world, like the Internet and other things, 24 hours a day, looking for potential risks.

Mr. Terence Young: Please go ahead. It's very interesting.

Dr. David Butler-Jones: I'll go back to the train incident last May, where we get a call, we have concern, we have this train, we have people who are sick on the train, they're apparently Asian tourists. We don't know what's going on. The local police and the health department have gotten involved. We get a call from Ontario. We activate our operations centre. We get transport, VIA Rail, other departments of government involved. We have planned out a series of calls of engagement in terms of what do we need to find out, what do we need to know, how are we going to get the test results out to figure out what's going on. We're communicating with the local medical officer, with the provincial medical officer, and with the local on-the-ground emergency workers, trying to figure out what is actually going on, what's the true story, who's actually on site, who was the person who was taken and flown out, what did they actually have. We talk to the doctors at the hospital in terms of what's going on there.

Mr. Terence Young: Are you in charge at the time when this is going on?

Dr. David Butler-Jones: I wasn't in the operation centre the whole time, but we have a whole team who are there monitoring the situation, communicating, etc.

Mr. Terence Young: Twenty-four hours a day.

Dr. David Butler-Jones: The whole team isn't there 24 hours a day, but if we need to we can bring them in.

Mr. Terence Young: Please go ahead. It's making a picture for me.

Dr. David Butler-Jones: Okay. So I'm in the operation centre. We try to figure out who needs to do what, so you do the planning in terms of what information do we need, what do we need to know, how are we going to find it out, what other things need to be done, what are the kinds of things that you need to do: contain it; make sure that the province and us and the local health authority are onside in terms of how we're going to make sure this doesn't get anywhere in the meantime; what provisions are at the hospital where the woman was taken, to make sure they're isolated so that nobody else in the hospital is affected; and then to work through step by step. The diagnostics—

Mr. Terence Young: What about warnings? When do you decide to issue a warning to the public?

Dr. David Butler-Jones: It really is at the point where there appears to be a risk. You have to know a little bit about what you're talking about, but if there is something that you don't know about, again there is some judgment call to it. In that case the press already knew. It was international news for a short while, but within the space of three or four hours we were able to figure it out and deal with it in a way that recognized that, no, it's not a public health emergency. It's a tragic event, but it's not a public health emergency and people can get on with their lives. If it had been a public health emergency, then that day we'd be out to the public.

Mr. Terence Young: You're saying that like it happened before with SARS, you would have been able to catch it early?

Dr. David Butler-Jones: It would be much, much more likely, but never say always.

Mr. Terence Young: You were involved because the nurses started to get it, the staff in the hospital. That's when it became frightening, right?

Dr. David Butler-Jones: No, there was a problem on the train. The train notified authorities that they had a death and that someone with respiratory symptoms was being flown out. That would automatically go to the local hospital, public health, and the province, which called us.

Mr. Terence Young: So you think you'd get a far better result now, if the same thing happened now as it did before with SARS?

Dr. David Butler-Jones: All the work that we're doing is targeted to do that.

Mr. Terence Young: Do you think you would get a far better result?

Dr. David Butler-Jones: Oh, yes, I think so. When I look at all the cases we've had, whether it's tularemia, the H5 outbreaks, H2N2, listeria, or this one, the ability of the system to respond effectively in a coordinated way never existed five years ago.

● (1710)

The Chair: Okay, thank you very much.

I just have a couple of questions, Dr. Butler-Jones, on the recommendations.

Recommendation 5.50 on page 16 reads:

> The Public Health Agency of Canada should periodically evaluate its surveillance systems to ensure that they are working as intended, and it should report the results publicly.

In the Auditor General's report, your agency indicated this would be done by March 31 of this year. Do you think it's going to be accomplished?

Dr. Gregory Taylor: Perhaps I could speak to that.

As I mentioned earlier, when we put this together, the evaluations of the systems were being done *en totale*. In the past, the evaluations have been done independently. So what's happened at the agency is that we've created an entire framework for evaluation of all the systems, a framework that is in place now, and we're going to be doing a number of the individual evaluations over the next few months of the evaluation. So it's coming into place now. It's been a little bit delayed on the planning, because it was done for all of them at the same time and not independently.

The Chair: But your response was made in May, when you indicated this would be done and the public would be informed. So is there going to be a delay on that, is that it?

Dr. Gregory Taylor: Yes, there is.

The Chair: On the next page, the recommendation in paragraph 5.54 reads:

> To ensure that its surveillance systems for HIV, the West Nile virus, and the influenza virus are best meeting the needs of the users, the Public Health Agency of Canada should systematically assess and document the user needs.

That was to be done by December of 2008. Do you have any update?

Dr. Gregory Taylor: There has been a user-needs assessment done for one of our HIV reports. Routinely, the user needs assessments in the past have been informal, and these are now formalized, and the plans are to continue going forward using user-needs assessments on an ongoing basis.

So one has been done formally, and the rest informally, but that's changing.

The Chair: I just have one last area on which I want to get a comment from you. It wasn't part of the audit, but I notice in your departmental performance report that you do work on the whole area of public preventive health, whether it be obesity or diabetes. It's certainly a major issue right across Canada.

At the same time, obviously, there is a jurisdictional issue here. But in the work that you do, are there any specific targets that you undertake with the provinces? Or do you have these targets in your own agency? I ask this because, in my own view, it's wanting, it's needed. I know you're doing some of this, but with your budget, you're not really able to crack the nut, so to speak—but it is something.

Where's this going, Doctor? I guess that's my question, the long and the short of it.

Dr. David Butler-Jones: Thanks for the question on something other than infectious disease, because the agency's mandate is across the realm of public health.

We have agreements with the provinces and territories. We provide cooperative funding for healthy living. We have an FPT agreement on a healthy living strategy, as well as targets. Ministers have agreed to targets on physical activity plans for children and adults. And with our counterparts, we're currently developing plans as to how we are going to get there.

You may have heard me say this before, but one of the huge challenges, given the trends in the last 20 years and what's happened with obesity, particularly in children, is that this really could be the first generation of children not to live as long or as healthily as their parents. It's a huge challenge. At one level, it's very simple: the difference between a 10-ounce and a 20-ounce can of pop a day is 10 or 15 pounds a year. At one level, that is very simple, but the issues underlying it are much more complex. Really, it is a whole-of-society issue; it's not even just a public health issue.

The Chair: Okay. We have a little extra time, if people want to jump in for a two-minute session.

Madame Faille...?

[*Translation*]

Ms. Meili Faille: I believe we have no more time, but I thank you. In fact, I would like to know, given that this is a new agency, whether you necessarily need a source of inspiration somewhere, a model on which you can develop your organization.

Could you tell us what governance model you support? Are there any countries where there are good systems in place, such as the United States or Australia, that you are drawing on?

● (1715)

Dr. David Butler-Jones: Every country is different, and my opinion also differs with each country, based on my title, my position, my own role and that of the deputy minister. In the United States, there is a division between the Public Health Service, with the Surgeon General, and the CDC and the Health and Human Services.

[*English*]

What we have done is to align. For example, in the infectious disease world, our units parallel the American units, so it makes interaction between us very simple. So the head of that division can talk to their American counterpart, as opposed to two or three different people.

We did look around the world a bit. We continue to evolve, but every country is different.

[*Translation*]

Ms. Meili Faille: The purpose of my next request is to help us understand the role of the provinces and that of the federal government. You said a little earlier that you had entered into agreements.

Could you provide a list of the agreements reached with the provinces and those that are being reached, or tell us whether there are areas in which there are specific agreements?

One of your challenges will be precisely your ability to adjust, because the disease context is constantly evolving. Consequently, the information you need today may not necessarily be the same in future.

Could you send us a sample MOU that states the rule of the provinces and the agreement on information management, to determine your flexibility in that matter?

[*English*]

Dr. David Butler-Jones: A couple of things.

For the Public Health Network, which is joint federal-provincial, that's all laid out in documents, actually, in terms of the role of the network, the kinds of committees, the way we process things, how we make decisions, who's in charge.

In addition, we have various memoranda around healthy living and others with provinces, because we co-share. For example, in Quebec, we jointly agree on projects that we'll fund. It's the same with other jurisdictions. So they're quite varied and across the system in different areas.

Basically, one of the things we did when we set up the agency was recognize the core role of provinces and territories. What is our federal value added to the system? And it's in expertise, it's in coordination, it's in best practices, so not everybody has to figure everything out on their own. We bring specialized capacities to that, and we work to ensure that the system, as a whole, is as effective as it can be and that we're in a position to identify where there are gaps, for example.

[*Translation*]

Ms. Meili Faille: It's that—

[*English*]

The Chair: Madame Faille, I want to move on.

[*Translation*]

Ms. Meili Faille: All right.

[*English*]

The Chair: Mr. Weston, you have a question. Then we're going to....

Mr. John Weston: Thank you.

Dr. Butler-Jones, you've spent an afternoon being challenged by us. I'm going to give you a chance to challenge us in return.

You referred to obesity as being a big challenge to our kids. I've heard Senator Nancy Greene Raine say it's the biggest challenge in a generation. What could we, as parliamentarians, as role models, do to deal with that?

Dr. David Butler-Jones: We could have a very long answer, but I think the short answer is that we do take it seriously. We've lost a couple of decades. It isn't that it necessarily needs whacks of money, but it does need thinking through: how we invest, how we make decisions, what we do, and things that support kids to be active, things that support healthier choices as being the easier choices in schools, etc. So it's all levels of the system actually thinking about what's connected to what.

And if you ask kids—there's a recent survey that came out—what they do after school and what they want to do after school, they actually want to be a lot more active, but they don't have an easy, safe place to do it, as a for-instance. And if you're in a neighbourhood that has green space, you're healthier than those who don't have green space—period, end of story.

So it's how we design our communities, how we make our investments. Do we have easy, safe places for people to walk or ride their bike? When you go into the school, is chips and gravy cheaper than an apple?

I'll leave it at that, because there are all kinds of little things. We need to see the connections.

The Chair: We could go on for another two hours, if we wanted. It is a very important issue.

Anyway, colleagues, on behalf of everyone in the committee, I want to thank you all for being here today.

Dr. Butler-Jones, you have a very challenging and important job. It's a job that is of tremendous interest to all Canadians. Again, I want to thank you very much.

We do have a few minutes, and before we adjourn I want to ask either Mr. Maxwell or Dr. Butler-Jones if they have any closing comments.

Mr. Maxwell, you first.

● (1720)

Mr. Neil Maxwell: Thank you, Chair. Knowing you have a few minutes, I'll use them.

We were very pleased with the questioning and the interest of the committee on this topic. There are a few things I might highlight.

I think that a lot of the discussion, quite appropriately, was around the action plan and what kinds of actions were being done. This audit was completed almost a year ago now, so I think those were the right kinds of questions.

One of the members I think mentioned two years for following this up. I would think that given the importance, it might be quite important to get periodic updates from the agency. Inevitably, action in the early years is often about systems and process. Some of those improvements being made should generate the kind of information that would actually start showing results when these program evaluations get done.

I think your committee would soon be able to get from the agency some very concrete ideas of the results that are being achieved.

The Chair: Thank you, Mr. Maxwell.

Dr. Butler-Jones, are there any final comments you want to make?

Dr. David Butler-Jones: Thank you very much to the committee, and thank you for your pointed questions. I do take them seriously. As I said at the outset, these are things that are important to us and that we're working on.

I try to speak to the practicalities, but that does not diminish our commitment and effort. I'd be very happy to come back, if you wish, in a year, or to do something in writing to support the committee.

As Neil said, I really appreciate the interest of the committee on this issue. This is important to us.

I must say, having been in public health for 25-plus years, the fact that people even care and take this seriously, even if we don't agree on every aspect, bodes really well for the health and well-being of the public. I really appreciate that.

Mr. David Christopherson: Can I have 15 seconds?

The Chair: Fifteen seconds, Mr. Christopherson. It's yours.

Mr. David Christopherson: You commented that you appreciated the interest. I want to comment on how much we appreciate young doctors who decide to go into public health. It is not necessarily where the money and the glory are, as you can well see, but it's so important. It sets a good example for other medical students about this being an area to look at. It's important, too.

So thank you for that.

Dr. David Butler-Jones: Thank you.

The Chair: I am going to remind members to meet on Thursday. We are dealing with chapter 7 of the December 2008 Auditor General's report, “Economy and Efficiency of Services—Correctional Service Canada”.

The meeting is adjourned.

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