House of Commons
CANADA

Standing Committee on Health

HESA • NUMBER 010 • 3rd SESSION • 40th PARLIAMENT

EVIDENCE

Tuesday, April 20, 2010

Chair

Mrs. Joy Smith

Standing Committee on Health

Tuesday, April 20, 2010

● (0900)

[*English*]

The Chair (Mrs. Joy Smith (Kildonan—St. Paul, CPC)): Good morning, everybody.

I'd like to start on time. We are a little late.

Before I start, I need to make sure we get our budget....

No, we don't have a quorum for our budget. Okay. We'll do the budget in between witnesses and Q and A.

The orders of the day are pursuant to Standing Order 108(2), the study of elevated rates of tuberculosis infection in first nations and Inuit communities.

We're very pleased to see our witnesses this morning. We're very pleased to be able to hear what you have to say. It's a very important topic.

We have, from the Department of Health, Shelagh Jane Woods. Welcome back, Ms. Woods. We're happy to see you back. And Dr. RoseMarie Ramsingh is here as well. Welcome to you.

From the Assembly of First Nations, we have Chief Angus Toulouse, regional chief. Welcome, Chief. And we have Kimberley Barker, public health advisor. Welcome.

From the Inuit Tapiriit Kanatami, we have Elizabeth Ford, who is a director in the department of health and environment. Thank you for coming. And I think we have Gail Turner. I can't see your name tag, but I think that's who you are. Thank you, Gail. She's from the national Inuit committee on health and she is the director of health services.

From the Northlands Denesuline First Nation, we have Chief Joseph Dantouze. Welcome. We're glad you're here.

We're also going to have a teleconference, so from Edmonton, Alberta, via telephone, we will have Dr. Richard Long. He's director of the tuberculosis program evaluation and research unit, first nations and Inuit health, and the immediate past medical officer of health for tuberculosis with the Province of Alberta.

We are going to begin. Our time is very tight. We want to hear from everybody, so your presentations will be three to five minutes, and I will have to be very tight on the time.

Could we start with Ms. Woods, please?

[*Translation*]

Ms. Shelagh Jane Woods (Director General, Primary Health Care and Public Health Directorate, First Nations and Inuit Health Branch, Department of Health): Good morning, ladies and gentlemen. My name is Shelagh Jane Woods. I am director general of the Primary Health Care and Public Health Directorate in the First Nations and Inuit Health Branch.

[*English*]

On behalf of Health Canada, I would like to thank you for inviting me to speak here today. I am pleased to attend with my colleague, Dr. RoseMarie Ramsingh, the executive director of community medicine at the first nations and Inuit health branch.

Let me begin by emphasizing the fact that Health Canada is working diligently with all of its partners to help close the gap that remains in the overall health status of first nations on reserve and Inuit, including the burden of tuberculosis.

I think it is fair to say that we have helped bring about a significant reduction in TB rates among first nations on reserve and in Inuit communities over the past 30 years. The rates, however, as we all know, remain much higher than among the non-aboriginal population born in Canada and among the overall general population.

During the three-year period from 2005 to 2008, the overall aboriginal TB rate was relatively stable, with an average of 27.3 cases per 100,000 people. This, of course, is much higher than the rate among immigrants to Canada of 13.4 cases per 100,000 in 2008, and the overall rate in the general population, everyone included, of 4.8, which is much lower.

Canada adopted the global stop TB partnership rate reduction target—3.6 cases per 100,000 population by 2015—for the entire Canadian population, including first nations and Inuit. It will take a concerted effort among all partners to get there. We are engaged in a number of activities now toward that goal.

Our mandate at Health Canada is to provide or support the provision of health services in on-reserve first nations communities south of the 60th parallel. In addition, we currently provide funding for TB prevention and control in Nunatsiavut in Labrador. The three northern territories, as you all know, are responsible for all health program service delivery there, and this incorporates TB prevention and control activities for all territorial residents, including the first nations and Inuit. Health Canada and the Public Health Agency of Canada provide funding to support certain health promotion and disease prevention activities in the territories.

The regional offices of the first nations and Inuit health branch work very closely with key partners to ensure the delivery of TB prevention and control services to first nations on reserve, comparable to the services available to those living off reserve. These partnerships exist across each of the regions and include the provinces, local or regional health authorities, and of course, most importantly, the first nations communities themselves.

We support TB reduction through the application of the Canadian tuberculosis standards, which provide the Canadian standard for both public health and clinical management aspects of TB prevention and control.

While each regional office of the first nations and Inuit health branch has its own unique partnerships in place for the delivery of these services, the goal remains the same: to try to ensure equitable access to timely diagnostics, treatment, and follow-up care for those exposed to and diagnosed with TB. Additionally, the provision of TB prevention and education are important components of these programs in every region.

From fiscal year 2004-05 to fiscal year 2009-10, Health Canada invested a total of $42.4 million in our national TB program. The program is currently funded at a rate of $6.6 million a year. In 2009-10, that is, in this last fiscal year, Health Canada invested an additional $3 million to support the delivery of health promotion, TB prevention, and, most importantly, outbreak control services on reserve across Canada. This included support for on-reserve communities to build their own capacity and TB programming. We also supported some project-based work with Inuit Tapiriit Kanatami and the Assembly of First Nations.

In recent years, the first nations and Inuit health branch has reallocated additional funds, particularly to the Manitoba region each year, due to its relatively high incidence of TB, in support of the latter's TB program and to provide the additional funds needed to cover surge capacity and other activities during TB outbreaks. We do this wherever there are outbreaks.

The national TB program at the first nations and Inuit health branch at Health Canada is closely linked to the Public Health Agency's TB program. The agency is currently developing a Canadian tuberculosis prevention and control strategy, and in parallel we are renewing our own first nations national TB elimination strategy, which will be included as a component of the Public Health Agency's strategy.

Our strategy is being renewed through a working group of federal partners, external TB experts, stakeholders and—

● (0905)

The Chair: I'm sorry Ms. Woods, but you are over your time now. I did give you a little extra. Could you just wrap up quickly?

Ms. Shelagh Jane Woods: I was just going to say that we're very fortunate to have Dr. Paul Gully working with us on this important file. He wanted to be here today, but he's in Vietnam. He will maintain close links with us on this file.

I'll leave it there to leave lots of time for others.

The Chair: Thank you so much, Ms. Woods.

We'll now go to Chief Toulouse, who is a regional chief in the Assembly of First Nations.

Chief Angus Toulouse (Regional Chief, Assembly of First Nations): Thank you.

I'm presenting today on the root causes of the elevated rates of tuberculosis infection in first nations communities. According to information recently released by the Public Health Agency of Canada, in 2008 rates of tuberculosis among members of first nations were 31 times higher than among others born in Canada. It is worth noting that this figure represents a rise in the rate of TB among first nations from only a few years before. It's unconscionable that rates of tuberculosis continue to increase among first nations in a country that otherwise boasts one of the lowest TB rates in the world.

Behind these rising rates are significant disparities between health services available to first nations and those available to other Canadians, as well as disparities in the social determinants of health. If we are to arrest the high rates of TB among first nations, we need to pursue two courses of action.

First, we need to improve the quality of TB control programming within the first nations and Inuit health branch so that it matches standards and resources applied elsewhere in Canada.

Second, we need to address the social determinants of health that contribute to the spread of TB in first nations communities.

Let me expand on the first point, improving the quality of TB control programming within the first nations and Inuit health branch. There is an urgent need to develop consistent program standards that will be followed in all of the first nations and Inuit health regions. These programming standards should be comparable to those that serve other Canadians and may even need to include additional measures to address issues such as latent TB, which, evidence would suggest, continues to persist at higher rates among first nations citizens.

In terms of programming standards, first nations and Inuit health in Ottawa funds its regional branches for TB control. When we examine what is happening in each region, we find there is no consistency in how regions program or monitor for TB in first nations communities. For example, there is no consistency across the region in how to define a TB outbreak. In the absence of an outbreak being declared, there are insufficient resources to control the treatment and spread of the disease. For example, regional health authorities and services are not brought in to assist and chief and council are not notified that persons have TB within their community.

Another example of this inconsistency is in the researching of case contacts, or, in other words, determining who may have come into contact with the disease and who may be at risk. It is left to the first nations and Inuit health regions to determine how many case contacts they will search and when they have searched sufficiently. Again we would suggest there should be national standards.

I also stated earlier that programming within the first nations and Inuit health branch should match standards and resources applied elsewhere in Canada. We looked at the health systems in the provinces and territories. Each sets annual targets related to TB cases, and they report to the Public Health Agency of Canada on the progress they make against these targets. For example, they may look at trying to reduce the number of cases by a certain amount on an annual basis or set a target for expanding their search for contacts.

Within the first nations and Inuit health branch, there are no annual targets for reduction of TB that would enable regions or the federal government to monitor the progress made in addressing TB or reducing rates. In fact, in a recent evaluation of the first nations and Inuit health branch communicable disease cluster, there were tables containing multiple gaps and blanks where there should have been information on a number of cases. This is an important gap that calls for immediate action. Programming and monitoring standards for first nations should be comparable to those that serve other Canadians.

If there is any doubt that programming and monitoring for tuberculosis in first nations falls below the levels serving other Canadians, I would point to data collected by the World Health Organization, which shows that Canada invests on average $47,000 in each case of tuberculosis for non-native patients. However, a report commissioned by the Public Health Agency of Canada reported that the first nations and Inuit health branch invests less than half—only $16,700 per case—in treating first nations citizens, including those in remote communities.

● (0910)

This table is shown as part of the package. Clearly, new investments are critical to closing the gap on standards of care between first nations and other Canadians.

I've also said that additional measures are needed to address issues such as latent TB.

The Chair: Chief, I'm sorry. I've given you extra time. We need to get everybody in. Can you wrap up, please?

Chief Angus Toulouse: Sure. Let me just essentially say that overcrowded housing, poor nutrition, and a lack of access to health care contribute to the higher rates of this disease among first nations, and these are the same conditions that were stated in the H1N1 outlook.

The Chair: Thank you, Chief.

We'll now go to Gail Turner.

Ms. Gail Turner (Chair, National Committee on Health, Inuit Tapiriit Kanatami, and Director of Health Services, Department of Health and Social Development, Government of Nunatsiavut): Good morning.

Current data reveal that the rate of TB for Inuit Nunaat is 185 times that of Canadian-born non-aboriginals. The significance of this cannot be ignored or dismissed. Social research has provided ample evidence that TB is a disease of poverty and social inequality. The same poverty marginalizes communities and threatens health through inadequate housing, food insecurity, and poor access to health care.

Inuit homes are the most crowded in Canada. It is estimated that 53% are overcrowded, a legacy of poverty and the government promise of housing to those who resettled, resulting in a high dependence on social housing, creating true hardship among all four regions, with impacts on psychosocial and physical health. It is estimated that Nunavut alone needs 3,300 housing units to address immediate need.

Inuit have the highest birth rate in Canada, a demographic reality that creates even greater housing need and results in multi-generational overcrowding that can present the perfect milieu for the transmission of reactivated TB from the elderly to the vulnerable young.

Inuit families are seven times more food insecure than other Canadian families. Food security is a complex issue in the north. Rising fuel costs impact immediately on the cost of produce brought in from the south and on the ability to hunt and fish for the country food so essential to optimal health. Weather variations due to climate change have a profound impact on food security, as witnessed this past year with mild temperatures and a lack of sea ice. Ice is essential to transportation and hunting.

The impacts of colonization and resettlement have led to communities in crisis, where coping mechanisms are challenged and addictions and underlying mental health issues are prevalent. These have an impact on wellness and healthy immunity that can make people more vulnerable to TB and can create challenges during treatment with adherence and drug toxicities.

The counselling supports needed for a holistic approach to TB are seriously lacking in many Inuit communities.

In regions with high rates of both latent and active TB, late diagnosis can further increase risk of spread. In many Inuit communities, there is no access to chest X-ray, and people have to fly out for service.

Why are the technologies for TB diagnosis not available where they are needed most? Tuberculosis is a simple medical diagnosis in a complex social situation. It cannot be mentioned without reference to the biological, historical, cultural, political, social, and economic conditions that have contributed, and continue to contribute, to this public health concern.

For Inuit, there appears to be a disconnect between what we know at the community level and what is known at the varying levels of governance and policy about what needs to be put in place to change health outcomes. Is the problem jurisdictional? Is it the lack of clarity around fiscal responsibility for Inuit? Is it the lack of capacity that forces a reliance on southern expertise, who may not have the cultural awareness for the appropriate fit?

Dr. Ellis, manager of TB prevention and control for the Public Health Agency of Canada, describes what is happening with TB among the Inuit as the perfect storm, where the combination of elements, each of which can cause concern, come together to create a serious situation.

Without the right type of intervention, the situation will continue to worsen. To treat TB without addressing the root causes is like using painkillers without looking for the source of pain: it will not go away. There must be a whole-of-government approach to Inuit health, with concrete goals set for immediate and long-term actions to address the social determinants that most impact TB among Inuit: housing, food security, income, and access to health care.

There is a call to consciousness that requires a strong commitment, both human and fiscal, and Inuit must be engaged at every step.

Nakurmiik. Thank you.

● (0915)

The Chair: Thank you very much.

We'll go to Chief Joseph Dantouze, please.

Chief Joseph Dantouze (Northlands Denesuline First Nation): Good morning to all.

I wish to thank the committee for inviting me to participate at this meeting. My name is Joe Dantouze. I'm the chief of the Dene people of the Northlands First Nation in Lac Brochet, Manitoba. This is an isolated, fly-in community south of the Nunavut border and 1,009 kilometres north of Winnipeg.

Our community is very familiar with tuberculosis. It has been making our people sick for over 100 years. Our people remember being taken from the community to sanatoria. For many people, we do not know where they are buried. We have rates of TB that are higher than most of the developing countries. From 1994 to 2004, our yearly rate of TB was 636 cases per 1,000 people. TB was an epidemic in our land before this time and it's still with us today.

For my people, tuberculosis is a social issue, a health issue, and a justice issue. All three issues must be addressed at the same time. This is the only way TB can be controlled.

There are social conditions that allow TB to spread in the first nations communities, and there must be immediate action to address these conditions, especially poor housing and a lack of food security. Our community lacks some of the basic things that we need to keep us healthy. In my community, 763 people live in 130 houses. The average homes in my community have 5.2 people in them. The average Canadian house has 2.5. Ventilation systems are absent or non-functional. In more than 80% of our homes, two-thirds of the people report mould in their houses. There are concerns that the mould affects our breathing and immune systems. Windows are damaged, air cannot circulate, and these conditions lead to the spread of TB and more illnesses. Low income and high food prices also mean that it is difficult or even impossible to maintain adequate nutrition, which is so important to prevent not just TB but also diabetes and other diseases.

Addressing TB as a health issue requires serious and proactive programs in partnership with first nations people and communities. People with TB need to be found early and not turned away for months because they are misdiagnosed. People who have been in contact with TB must be found early and treated with prevention therapy. They must not be missed due to poor follow-ups. The workers need to be from our communities, with the knowledge of our culture and the respect of our people. In my community, our nurse is one of our people and she is effective. TB workers need to be true partners in the program and part of the planning, implementation, and evaluation. First nations TB program goals, statistics, and evaluation must be up to national and international standards and they must be openly available. It is a matter of accountability and responsibility. We have met with health officials and Indian and Northern Affairs officials, and both point fingers at each other when we ask for both the social and medical aspects of TB to be addressed together in a coordinated, serious manner.

TB is a justice issue. Health care is a treaty right. Social conditions cause illnesses and steps must be taken. For health care, housing, and human rights, article 25 of the Universal Declaration of Human Rights states:

> Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care....

In the Speech from the Throne of March 2010, Prime Minister Harper committed to sign the United Nations Declaration on the Rights of Indigenous Peoples, which confirms the rights of the indigenous people to housing, health, and social security in articles 21, 23, and 24.

● (0920)

We ask for a true partnership fighting this disease. We ask for community-based programs that are accountable.

● (0925)

The Chair: Thank you, Chief. You'll have more time. I've let you go over time, and I need to hear from Dr. Long. So could you just wrap up quickly?

Chief Joseph Dantouze: I ask that we be in it together and address it together. We have been waiting too long, and something has to be done for my community of Northlands First Nation.

Thank you very much.

The Chair: Thank you, Chief.

We'll now go to Dr. Long, who will be joining us via phone.

Dr. Long, are you there?

Dr. Richard Long (Professor, University of Alberta, and Director of the Tuberculosis Program, Evaluation and Research Unit, First Nations and Inuit Health, and Immediate Past Medical Officer of Health for Tuberculosis, Province of Alberta): Yes. Can you hear me okay?

The Chair: We can hear you very well, Dr. Long. I'm sorry, but I'm going to have to keep you to three minutes. Can you please begin your presentation?

Dr. Richard Long: I would first like to thank the committee for the opportunity to speak.

Tuberculosis control programming in Canada is a provincial-territorial responsibility, with the exception of tuberculosis control in first nations communities and selected Inuit communities, largely those in Atlantic Canada and south of the 60th parallel, where tuberculosis control is a shared federal and provincial-territorial responsibility.

One must be careful with respect to tuberculosis incidence rates in aboriginal peoples, as the only two aboriginal groups in which there is reasonably reliable denominator data are status Indians and the Inuit. However, if we put aside denominator data for the moment and include all aboriginal groups, the gravity of the tuberculosis situation in aboriginal peoples is evident in a single observation. The absolute number of tuberculosis cases in aboriginal peoples in Canada has not changed for 15 years or more, while it has been steadily falling in non-aboriginal peoples.

From 2003, the absolute number of cases of tuberculosis in the aboriginal peoples of Canada, who comprise only 4.7% of the Canadian-born population of Canada, has exceeded the number of cases in the remainder of the Canadian-born population. The ignominy of persistent, seemingly intractable tuberculosis in the aboriginal peoples of Canada while rates of tuberculosis in the Canadian-born, non-aboriginal peoples continue to fall and ratios between the two groups continue to rise is not to be borne by people of conscience in a developed country.

I would encourage the federal government to adopt a broader perspective. First, more than ever, aboriginal peoples need to be at the table federally, provincially, and territorially. Historically they have not had a seat at the table. If they are not given a seat, we, the dominant society, will only continue to promote our legacy to aboriginal peoples, a legacy of learned helplessness, which if we are to move forward we must recognize as untenable. Education of both societies with a view to a deeper understanding of our history and commonality are in order.

Second, the bacterium that causes tuberculosis is uniquely well adapted to exploit weakness in the social development of its host. The disease thrives wherever conditions of poverty exist. The unrelenting success of this pathogen inculpates each new generation of its host in its failure to address the basic social needs of all. Attention to the upstream determinants of health, which impact the proximate risk factors for tuberculosis, is urgent. Aboriginal peoples have on average more frequent contact with people with active TB, a higher likelihood of crowded and poorly ventilated living conditions, limited access to safe cooking facilities, more food insecurity, lower levels of awareness and/or less power to act on existing knowledge concerning health behaviour, and limited access to high-quality health care.

Addressing the social determinants of health is a tuberculosis prevention paradigm that is complimentary to the traditional biomedical prevention paradigm of providing preventive therapy to someone who has latent infection. There is a historical and moral imperative for all Canadians to address this socio-economic disparity. This imperative goes far beyond tuberculosis, but tuberculosis as a social disease is like a barometer in measuring the success of our efforts.

With respect to all of the above, government must recognize that public health achievements may well depend on actions outside the health care sector. They must be prepared to work across ministries and in a non-partisan spirit that goes beyond election cycles and pursues social policies aimed to promote equity in health.

I'll stop there.

● (0930)

The Chair: Thank you, Dr. Long.

Dr. Long, we'll keep you very much in mind. I'll refer to you, because visually you can't see the committee and we can't see you. I'll make sure I touch base with you to ask if you want to make comments when the question period comes.

Right before our first round of questions—I could not do this at the beginning of committee—I need to get the budget passed.

It is moved that the proposed operational budget in the amount of $20,600 for the committee's study on elevated rates of tuberculosis infection in first nations and Inuit communities be adopted.

(Motion agreed to)

The Chair: Thank you.

We'll now go to our questions and answers and to our seven-minute round. I'll be tight on the time to ensure that everybody can get their questions in.

We'll begin with Ms. Murray and Dr. Bennett. Who wants to start?

Hon. Carolyn Bennett (St. Paul's, Lib.): I'll start. I have a couple of quick questions.

Ms. Woods, the winter 2009 draft of the Canadian tuberculosis prevention and control strategy, appendix 9, says, “The Inuit TB strategy is under construction and in preparation”. We've heard already today that somehow there isn't a strategy. I think what we are hearing even today is that we don't even have the data to actually do a strategy on what, by when, and how. If you don't have the numbers, then I think TB is a barometer, or almost a measurable sign, of inequity. That is what we're hearing. What I'm hearing is that because it's shared, there are different standards, according to the performance indicators, in every region. Without a strategy, how can we actually do the job? What are the standards? How are we meeting them? Why is it different in different aboriginal communities or across the country?

As we said during estimates, when somehow the medical services branch at CIC gets almost twice the money the first nations and Inuit health branch gets for TB.... Is it resources? Is it a lack of a plan? How can this steadily get worse over these last years as the non-aboriginal population gets better and better and we leave our aboriginal populations behind? I guess at some point the lack of X-ray machines obviously is huge in all these fly-in communities.

I'll leave these other questions. Maybe we'll just let Joyce ask her questions, and then you can all answer them.

What are we doing, obviously, on the social determinants of health, because we're not going to win anywhere without the help of INAC and the other government departments that can help with those things?

Ms. Joyce Murray (Vancouver Quadra, Lib.): Thank you for your testimony and for helping us understand the gravity of this inequity and the evidence.

The tuberculosis sub-working group had a resolution, which was to reduce TB incidence to 3.6 per 100,000 among on-reserve first nations and Inuit peoples. I noted in some of the testimony that the rates were stable at 27.3% until 2008. But I also heard that they're rising. What's the current rate? What is the trend? Where are we heading with that? Really, I just want to understand the rates and where they're headed.

Second, is a holistic approach needed, with goals and measures? That seems to be something we've heard, and I presume this is a common view. To what degree is tuberculosis being addressed as part of the whole health of the aboriginal status and Inuit and Métis people as opposed to being treated as a separate disease?

Finally, if it is tied in with the social determinants, which we've heard from everyone it is, what's the role of the federal government in terms of providing leadership and pulling other levels of government together? What's needed to have that actually happen?

● (0935)

The Chair: I'm sorry. You have less than two minutes, and I don't know where you're going to start.

Ms. Shelagh Jane Woods: Neither do I, but I'll figure it out as I talk.

The Chair: Ms. Woods, are you starting?

Ms. Shelagh Jane Woods: Yes.

The Chair: Okay, thanks.

Ms. Shelagh Jane Woods: Thank you for the questions. Those are very complex questions. I'll try to give a very quick answer.

The first nations and Inuit health branch strategy is under renewal. We've had a strategy for a long time, but we haven't renewed it in a very long time.

I wouldn't say there are different standards; as you know from other testimony from many other people here, our regional offices tend to follow the clinical care guidelines, the practices, and the standards of the provinces in which they find themselves, and those standards do not differ markedly. There may be different approaches, but the standards are all pretty well the same. I don't think there is a lack of a plan. As I say, we are updating the plan. That's important work that we have to do with our partners.

I'm not sure it's lack of money, but that's one of the things that renewal of the strategy will tell us. We are always able to find the money to cover the outbreaks when they occur, which is not necessarily a sign of good planning, but at least it's a good response.

I'll try to do justice to the social determinants of health. Yes, we understand how important it is. We've spent a number of years working with our partners at the Department of Indian and Northern Affairs, for example. There is a much greater recognition of the importance of the social determinants of health to their work, not just to ours. I think we can make some breakthroughs with them, but it's going to take a concerted effort.

On housing, I agree with the things people have said. Of course, overcrowding is a very big issue. We obviously have to do a lot of work with the Assembly of First Nations and then at the regional level with first nations organizations and with the communities themselves. That's exactly how we're doing the renewal of this strategy and all the other activities that take place.

I'm sorry about the shortness of time. We definitely are trying to treat tuberculosis not as just a separate disease but more as a bellwether of the social determinants of health. That's definitely the approach we're trying to take.

The Chair: Thank you so much, Ms. Woods.

We'll now go to Monsieur Malo. You have seven minutes.

[*Translation*]

Mr. Luc Malo (Verchères—Les Patriotes, BQ): Thank you for being here.

I am going to continue along the lines you were discussing, Ms. Woods. In this present situation, we see that the same elements lacking in all the problems that affect aboriginal populations are factors here too: housing, nutrition, all the social determinants of health are involved.

I saw you taking notes as the witnesses were testifying. So I suppose that you were writing down the answers you wanted to give to all the questions that people asked: are there intermediate targets; why are we spending less on the treatment of tuberculosis in aboriginal society than in non-aboriginal society; why are there problems in diagnosis; why are aboriginal communities not more involved in the entire process of treating disease? I would like to add one more question: how will you reach the target of 3.6% by 2015? According to the infection numbers we have been given, that seems to me to be a very bold target, to say the least.

● (0940)

Ms. Shelagh Jane Woods: Are those your questions? Yes, I agree that the elements are the same in all the determinants of health. I am not sure that we are spending less. That was a—

Mr. Luc Malo: —a question from Chief Toulouse.

Ms. Shelagh Jane Woods: Yes, and it was exactly why I was taking notes. It interests me a good deal and I am probably going to work on it with my colleague Dr. Barker.

[*English*]

There are a lot of things that have to go into the renewal of our strategy. With every one of the elements you touched on, we have to know what the factors are underlying the differences in expenditures. I don't know about those, so I can't really comment on them at this point.

It's audacious and bold to set a target of 3.6 by 2015. I cannot see how we could say 3.6 is good for the overall Canadian population, but we are not even going to try for the aboriginal population. I honestly believe that between 2010 and 2015, if we get it right, if we have the active and willing partnership of the first nations, and if we support them well in this, it is something we can achieve.

I cannot imagine that we could settle on a less ambitious target for first nations and Inuit. That's not fair or right.

[*Translation*]

Mr. Luc Malo: Chief Toulouse is asking you for intermediate targets. Is that something he is going to get?

Ms. Shelagh Jane Woods: That is exactly why I was so interested. I am of the same opinion: it would be very useful to have them, but we have to develop them together. Because, for sure

[*English*]

it's not up to the first nations and Inuit health branch to try to do this by ourselves. We must work with our partners on this.

Dr. Kimberley Barker (Public Health Advisor, Assembly of First Nations): Thank you.

I think one of the limitations the federal government has in all of this is that the accountability of the FNI regions is nil. Money is given to each of the FNI regions to support their TB programs, but there is no accountability and no expectation that these regions are accountable for the dollars they are reporting on an annual basis. In fact, we rely on the provinces and territories to determine who the first nations and Inuit cases are, and we only get this data through the Public Health Agency; we don't get this through FNIHB.

The report we referred to on the evaluation of the cluster demonstrates that even FNIHB doesn't know the number of cases and the amount of money that's being spent, because of their lack of control over the region. That's how the structure is in place. It's certainly not their fault, but it does mean that the vulnerability of the communities is not what Ottawa decides but what each of the FNI regions decide. Somehow there will have to be some changes within the strategy that demands a level of accountability by the FNI regions on these programs.

Dr. RoseMarie Ramsingh (Executive Director, Community Medicine, First Nations and Inuit Health Branch, Department of Health): I just want to say that the FNI regions don't operate in isolation. They are very closely tied to the provincial TB directors. So the TB services that are supplied to everybody in the province are the same services that coordinate that in most of the provinces as well.

There is a tripartite type of relationship in most of those places.

Dr. Kimberley Barker: I look forward to hearing from our provincial experts in the next round at 10 o'clock, where they will deem that actually is not happening.

The Chair: You have another minute.

[*Translation*]

Mr. Luc Malo: Do other people want to say anything?

[*English*]

The Chair: Ms. Turner.

Ms. Gail Turner: As someone who lives in an Inuit region in a province within an Atlantic FNIHB region, there is a serious disconnect. The people most disconnected are we, the Inuit, who are engaged with FNIHB but not engaged with the province, which has responsibility for our public health. That's a real challenge.

In fact, if you read the document on TB control for Canada, there's no clarity around who is responsible for Inuit. It contradicts itself, and again today I've heard another contradiction, particularly for Nunavik and Nunatsiavut in Quebec and in the Province of Newfoundland and Labrador.

I suggest that's part of the problem. The *Canadian Tuberculosis Standards* has only one paragraph that addresses special concerns for remote and isolated communities. For those of us looking for guidance on practice, it doesn't fit. In that paragraph on page 266 it suggests there are particular challenges, and perhaps extra mobile test units need to be brought to a community. If they are not, who do you then hold responsible?

● (0945)

The Chair: Thank you, Ms. Turner.

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

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

Thank you very much for being here today, on what I think is clearly a national emergency. I'm not sure we're hearing today from the Government of Canada a response that is commensurate with the urgency of the situation.

I'm not here to criticize Shelagh Jane Woods. I am here to say that I don't think a strategy developed in 1992, which is only now under review and sitting as a blank page on the Health Canada web page, is appropriate. We're almost at the same rates we were at in 1992. I think the real question here today is, what the heck has the government been doing? What has FNIHB been doing? What has Health Canada been doing? What has the Public Health Agency of Canada been doing?

In fact, we are at earth-shattering numbers. As many have said, rates of tuberculosis are higher than in third world countries like Bangladesh. We're here today because of the groundbreaking research of someone like Jen Skerritt and the *Winnipeg Free Press*, who went up to Lac Brochet, talked to Chief Dantouze and others, found the grave of Catherine Moise, and helped to focus our attention on the human issues involved. We're hoping today to get some answers. I don't hear much from the government except that the strategy is under review.

I would like to know from all of you what we can do to get this government working for all of us with standards of care and a focus on the determinants of health. As Chief Toulouse said, look at the money being spent on a per individual basis for an Inuit or a first nation person. It's $17,000, compared to $47,000 for a non-first nation or a non-Inuit person. There's a huge gap. Somebody is not doing their job. I think it's time we get a strategy in place to address it.

First of all, Kimberly Barker, you have told me in the past, and so has Chief Toulouse, that when first nations have requested assistance from Health Canada or FNIHB in terms of something as simple as a mobile X-ray unit to test people, in fact, you can't even get that. I want you to use that as a jumping-off point, and then I would also ask you, as well as Gail Turner, Chief Toulouse, and Chief Dantouze, for other recommendations.

Dr. Kimberley Barker: Thank you.

There are a number of communities—probably only five or six, actually—that seem to be the epicentre of the outbreak. These communities in the past have asked FNIHB to do entire community screenings. That's not an unreasonable request by international standards. If there are high rates of TB and frequent outbreaks within a community, one is encouraged to screen the entire community, looking for latent TB cases.

In Garden Hill, for example, when Chief Harper came to Ottawa in 2006 and asked FNIHB to support the entire community screening, he was told there was insufficient evidence to suggest this would be required. Not only that, it would require nursing staff around the clock for at least a year. With the nursing shortages, nobody had nurses, and there would not be sufficient funds to be able to support one community having 3,000 people screened. If you ask the TB experts who are in the room today, asking for community screening at that level is not an unreasonable request.

Ms. Judy Wasylycia-Leis: Do you think there's any possibility that the federal government refuses to do that kind of screening and help with that screening, bring in the mobile X-ray units, because they don't want to know the actual numbers, because it would be too embarrassing nationally and internationally?

Dr. Kimberley Barker: Perhaps, but I think it's an issue of resources. I think it's largely that you're going to end up robbing Peter to pay Paul. They will end up saying, which nurse do you want to take out of which community to do all that screening for you?

Ms. Judy Wasylycia-Leis: Let me ask Gail Turner a question. When we had the minister before us and asked her about the fact that the rate among Inuit is 185 times the rest of the population, she basically said you've got to go to the provinces and territories to get solutions.

Can you tell me what you think the federal government should be doing? What should Health Canada and the Public Health Agency of Canada be doing to help at least coordinate services and bring some measure of high-priority strategy to this whole critical issue?

● (0950)

Ms. Gail Turner: I think first and foremost there really needs to be a clarification about who is responsible for Inuit. We don't have a piece of legislation in the same way that our brothers in first nations do. That creates some challenges.

I think there also has to be recognition that given the geography and culture of the Inuit, we will require a separate strategy. Our rates are extremely high; in fact, we have communities with rates as high as 500 for 100,000. The Inuit must be engaged. We know what the solutions can be, but people don't talk to us, and the solutions will still be made for us and they won't work.

I also think we really have to look at access to health care. I have a very short story to bring this home. In one of my communities last October, we had a case of TB. One of the contacts who tested positive—and for people in the room, they'll know we're probably looking at latent TB—is terrified of flying. She refuses to leave that community to go for a chest X-ray, which is critical to finalizing her diagnosis, until the ice goes out and the ships start sailing in June.

Dr. Kimberley Barker: What I really want to emphasize to a group that may not feel they have the medical expertise to fully understand this is that this is not a complicated disease. This is curable, treatable, easy, cheap. It's not rocket science. It doesn't require a wizard to be at the steering wheel. It simply requires dedicated resources, ongoing monitoring, and a decent program with acceptable standards.

Ms. Judy Wasylycia-Leis: Is there any point in setting targets if there is no strategy behind those targets? It seems that we talk big about following the World Health Organization's strategy to stop TB, but there's nothing on paper and there's nothing that has a plan of action to say we are going to conquer this.

Can you tell me what we put in our report to Parliament to call on the health minister to do after the end of this session, because we only have one little session on this national emergency?

The Chair: Who would like to answer that question? We only have a very short time.

Ms. Judy Wasylycia-Leis: Perhaps to be fair we should ask Dr. Long.

The Chair: Dr. Long, would you like to answer that?

Dr. Richard Long: I'll make a few comments to try to answer that.

I did raise a couple of points that I really think the federal government should think seriously about. They're big picture points. There is a set of standards for tuberculosis control, but they are applied differently across regions. There's no question about that.

Just as there needs to be a recognition of the interdependence of social determinants and risk factors, there needs to be a recognition that tuberculosis control in aboriginal peoples is a fragmented exercise with jurisdictional issues that confound control unless they are properly addressed. As an example, precipitating this hearing are events in Manitoba and Saskatchewan. With respect to those two provinces, which along with the territories are the last major strongholds of tuberculosis in aboriginal peoples, the endemic tuberculosis is largely restricted to maybe 10% to 15% of 192 reserve communities.

The Chair: Dr. Long, I'm going to have to go on to the next person. Thank you.

Ms. Davidson.

Mrs. Patricia Davidson (Sarnia—Lambton, CPC): Thanks very much, Madam Chair.

And thanks very much to our presenters here this morning.

Certainly we've heard a great deal about this issue. I would like to address some of my comments to begin with, to Ms. Woods, please. I'm going to refer to some of the things you said in your opening remarks.

You said that Health Canada is working diligently to help close the gap between the first nations on reserve and the Inuit. You said there had been a significant reduction in TB rates over the past 30 years but they still remain much higher than in the non-aboriginal population. My first question would be, how and what you are doing to close the gap specifically?

Then you talked about adopting the global stop TB rate reduction target. I'm wondering if you could talk a little more about that, because I don't think you were able to explain too much of it in your opening remarks. Could you tell us how that's going to work and how you are going to try to attain that target?

One of the other things you talked about was the $3 million of additional funding in 2009-10. I'm wondering what that was specifically put towards and if we have seen any results or any feedback from that additional funding.

● (0955)

Ms. Shelagh Jane Woods: Okay. Thank you for those questions. That's a lot to cover.

Let me start with the last one. The additional $3 million last year was money that we scraped together. A lot of it went to outbreak control in Manitoba, but it was spread more broadly than that. I think that accounted for maybe half of it. It went to enhance a whole lot of activities in various regions, but largely it was in Manitoba and Saskatchewan last year.

You're asking how we intend to get to the global reduction target. I won't have a good answer to that question until we finish re-examining the national strategy, because within the national strategy there will be a number of targeted approaches to the key areas. As Dr. Barker said, there is an epicentre; what we now have to do is make sure our focus is squarely on the epicentre and on finding out the things that are going to work. That will require working very closely with the communities, with Dr. Barker, and with other people at the table to ensure that we have approaches that will work, community by community.

There are jurisdictional complications, without doubt, as I believe a number of people have said, most notably Dr. Long. There are confounding jurisdictional issues. It's evident we have to rise above them. We have to get beyond them. We have to sit down with our partners.

I am hearing a lot about disconnects; we're going to have to work with our regional offices on this issue to make sure we have a better understanding of what's going on. I will take exception to Dr. Barker's statement that they are not at all accountable; of course they're accountable, but perhaps just not in the way she would like to see. Again, we can sit down and work on this aspect to see where we can set realistic evidence-based interim targets so that we can achieve something, instead of sitting here every year explaining why we haven't made any progress.

Mrs. Patricia Davidson: Are there others who need to be at the table but aren't?

Ms. Shelagh Jane Woods: Yes, I think eventually you're going to want to talk to people from the Department of Indian Affairs. You'll remember that in the budget there was a lot more money for housing. We're really hopeful that there will be.... As I said at the beginning, there is a greater understanding of the importance of the social determinants of health across all federal departments. It's not our domain; it's a federal domain, and there is a much greater understanding, certainly at the Department of Indian Affairs, about the importance of it, so there is much more of a shift towards taking not just an economic view of housing but a very social view.

There are a number of initiatives broader than what we have here. You may want to talk to my colleague, Kathy Langlois, about efforts on food security, since that has come up in what everybody has said. Those are important initiatives to understand.

As I said earlier, this issue is broader than just tuberculosis, and perhaps we have erred in focusing a little too closely just on the disease of TB itself. We are now certainly aware that it's much broader than just TB.

Mrs. Patricia Davidson: Is there more time?

The Chair: You have about one minute.

Mrs. Patricia Davidson: Okay. I'll pass it to Ms. McLeod, please.

Mrs. Cathy McLeod (Kamloops—Thompson—Cariboo, CPC): I will focus on the health service component as opposed to the very important social determinants.

I'm having a bit of déjà vu here. I might be dating myself, but back in the 1980s we had mobile chest X-rays that went into every community. We had BCGs, we had a very systematic process around sputum samples, we had people observing therapy, and it didn't seem to get us anywhere. Is that accurate, or did we move away from that type of process in a way? Do you have some general comments there? That used to be how things were in the 1980s, as I recall.

● (1000)

The Chair: Who would like to answer that?

Dr. RoseMarie Ramsingh: Could you just clarify? Are you asking if the process that was there in the 1980s is still in place at this time?

Mrs. Cathy McLeod: We were hearing about mobile X-ray units. That used to be the way it was, and BCGs for infants used to be the way it was, but after all these years they're asking for those things again. Didn't they seem to make a difference? Maybe you could describe the trends in what we've done.

The Chair: We have just 30 seconds.

Dr. RoseMarie Ramsingh: Okay.

Well, I'll just say really quickly—then maybe I'll pass it to you—that we do follow the Canadian tuberculosis standards. They have evolved over time in terms of what's included and what's recommended based on the evidence. Richard Long is actually one of the editors of the last version of them. Some things that were done in the eighties are probably dropped off. We've taken up some new technologies and different ways of doing things.

So we try to keep up with the latest guidelines.

The Chair: Thank you so much.

I'm going to suspend the committee for only two minutes.

I'm going to ask that you not come over to the committee members and talk with them. If you want to speak with them, just go outside the door and they'll speak with you.

I am going to ask our next panel to quickly come and take their seats.

Two minutes: thank you.

● _____ (Pause) _____ ●

The Chair: We will begin.

I want to welcome our witnesses. Thank you very much.

I would ask everybody to welcome our witnesses to committee.

Dr. Earl Hershfield, professor of medicine, University of Manitoba, welcome. I'm glad to see you here.

Dr. Pamela Orr, professor, department of medicine as well, is here from the University of Manitoba. Welcome to you. I always like to see people from my home province.

We also have, from the Canadian Lung Association, Dr. Brian Graham, chair of the chronic disease policy. Welcome, Dr. Graham. I'm very happy to see you here.

From the Canadian Public Health Association, we have Elaine Randell, communicable disease consultant from Nunavut. Thank you so much for joining us, Elaine.

We have James Chauvin, policy director with the Canadian Public Health Association. Thank you for joining us as well, James.

From the Canadian Society for International Health, we have Janet Hatcher Roberts, executive director. Welcome.

And from the University of Alberta, we welcome Dr. Anne Fanning, professor emeritus, faculty of medicine.

We feel very honoured and very privileged to have you here. We're going to keep our presentations to three to five minutes. I'm sorry, but I will have to watch the time; I can't have one person or one committee member monopolizing it. We need to be able to get in all the questions and all the presentations.

Thank you for being patient.

Dr. Hershfield.

● (1005)

Dr. Earl Hershfield (Professor of Medicine, University of Manitoba, Former Director of Tuberculosis, Province of Manitoba, As an Individual): Thank you, Madam Chair.

For me, this is a reminder of what Yogi Berra said, “It's déjà vu all over again.” I've been to a number of these meetings over the years.

What I want to talk briefly about is what I consider a proper tuberculosis control program. We can discuss later whether it is being applied across the country.

Tuberculosis, as previous speakers have said, is easy to control, and it has four or five elements to it. You have to find the cases, especially infectious cases. You have to register those cases. You have to get all the details that are necessary to get a picture of that case. You have to put the patient on treatment, and it doesn't matter what regimen you put them on—it could be an old regimen or a new regimen—it's a matter of whether the patients take their pills for the proper length of time. So regimens are not an important aspect of the treatment control program. And you have to find the contacts.

Each infectious case is said to infect four to 20 people over a year. If you say there are 100 cases in a particular jurisdiction and you're looking at 10 contacts, it's a lot of work for the public health system to look after the cases, to diagnose those cases, to trace the contacts, to put the contacts on a treatment program or watch them, and it's cumulative over the years. So tuberculosis control, though easy, can be administratively cumbersome.

Some of the ancillary issues are that all positive cultures must have TB sensitivities done. All the provinces have labs that do anti-TB sensitivities. All TB cases must be HIV tested, since HIV is the strongest ancillary problem with tuberculosis patients, especially in Africa.

All cases of TB should have a diagnosis investigation of diabetes. Diabetes is the second most common worldwide associated condition with tuberculosis, and in Canada, amongst the first nations people, it is probably *the* most important ancillary condition. Somewhere along the line, these two diseases have to be melded in order to deal with the problem, because we'll not deal with it unless diabetes is looked at.

All anti-TB drugs must be free to the patient. You may think that's a given, but in many countries of the world, the patients have to pay for their drugs. We must keep a situation in Canada where all drugs to the patients are free.

All AIDS patients, HIV-positive patients, should be TB tested in order to determine which of the patients who are HIV-positive have been affected by the TB germ. There are priorities in prevention. A jurisdiction has to decide whether they want to treat their positive patients with drugs. The most important priorities are contacts, converts, HIV-positive patients, and immunosuppression.

Unfortunately, tuberculosis is not a single disease in the sense that it can be looked at in isolation. There are multi-factoral, socio-economic determinants: substance abuse, overcrowding, poor housing, malnutrition, lack of fresh water, sewage problems, and difficulty interfacing with the established health care system, which in Manitoba, in my experience, has been a great problem amongst first nations persons interfacing with white man's medicine. They just won't come forward many times, and there are many other problems as well.

The Chair: Dr. Hershfield—

Dr. Earl Hershfield: I have one more statement, if I might.

The Chair: Very, very quickly.

Dr. Earl Hershfield: Too rapid a diminution or discontinuation of a public health program often leads to resurgence of the problem that appeared to be under control. It's a public health maxim and it has been shown in the literature over and over again. If you dismantle a program—

The Chair: Thank you, Dr. Hershfield.

Dr. Orr.

Dr. Pamela Orr (Professor, Department of Medicine, Medical Microbiology and Community Health Science, University of Manitoba, As an Individual): I want to thank the committee for inviting me. I speak as an individual rather than on behalf of any organization.

I have four recommendations.

One, there must be one single unified TB program in each province for both aboriginal and non-aboriginal people. The program must be accountable to and the responsibility of the chief provincial officer of health. The current system of two TB programs, one administered by FNIHB, the other by the provincial department of health, is not only inefficient but counter-productive. TB does not respect boundaries and cannot be controlled by fragmented methods. The responsibility and accountability are opaque in the current system. Cooperation and communication should not depend on personality but should be mandated. People may argue about whether two public health systems, federal and provincial, work for other diseases such as hepatitis, but it clearly does not work for tuberculosis.

Two, there must be clearly articulated objectives, performance targets, and yearly evaluations. These must meet national and international standards. The data must be openly available and shared. This is required in order to expose what is being done and what is not being done in aboriginal TB programs in Canada. Meaningful data are not currently uniformly available. Patients are often blamed, but programs need to take a hard look in the mirror. Confidentiality is often used as an excuse for secrecy; however, it is possible to share information while ensuring patient and community confidentiality. If we had information we would see that some programs succeed and some fail. We see late diagnoses, misdiagnoses, inadequate treatment, failure to contact trace, and failure to employ prevention therapy. The causes of failure include lack of fiscal human resources, insufficient knowledge, insufficient skilled or consistent staff, failure to endorse or follow accepted guidelines, and failure to engage communities. Aboriginal people need to be part of this process. Programs must be accountable to the health authorities but also to aboriginal people.

Three, TB programs must support, nurture, and form a true partnership with those in each community who have capacity. This promotes community ownership of problems and the solutions. TB programs are often so focused on the disease, they fail to use local people. The Navaho have a successful program run by local Navaho people. They are responsible to the Indian Health Service, but their community feels ownership because they see their own faces working the program.

Four, the social determinants of TB, including poor housing and poor nutrition, must be addressed seriously and credibly. There is an unfortunate tendency of TB programs to blame these social determinants for the failure to control TB. However, we have to remember that the fastest decline ever recorded for TB occurred in and among the Inuit from 1960 to 1980, and it was achieved primarily through the medical program.

● (1010)

The Chair: Thank you, Dr. Orr.

We'll now go on to Dr. Graham.

Dr. Brian Graham (Chair of the Chronic Disease Policy, Chief Executive Officer of the Lung Association of Saskatchewan, Canadian Lung Association): Thank you, Madam Chair and members of the committee. I'm pleased to be here on behalf of the Canadian Lung Association, and I wish to thank the committee for recognizing that this is a serious issue that deserves the attention of Parliament.

Rather than repeat a lot of the information that you've already heard this morning, I want to reinforce two points from the lung association's point of view. These are that we do need improved treatment of tuberculosis, and secondly, that we also need to be addressing the social determinants of health.

But there are a couple of other points I'd like to raise. The third point has to do with the nature of the support that's required for tuberculosis. It has to be long-term and sustainable support, and one of the reasons for that is due to the disease itself. Some diseases are dangerous because they grow very quickly and rapidly, but tuberculosis is dangerous because tuberculosis germs grow very slowly. In a society where we appreciate speed, that might be hard to comprehend, but it takes six months or more of taking combinations of drugs to cure a case of tuberculosis. Without intervention, a tuberculosis epidemic can take 200 to 300 years to run its course.

The lung association has been fighting tuberculosis for 110 years; we are here for the long term. Solutions to TB problems in first nations, Métis, and Inuit communities will require long-term programs, with long-term indicators for success, and long-term, sustainable funding. One of the things to consider in looking at these indicators is that if you start improving TB control programs, initially you're probably going to find more tuberculosis. Rates of tuberculosis might even experience an initial increase, and that shouldn't be a reason that one would yank the funding. You have to look at this in the long term.

If we look at where rates are among the aboriginal population right now, it's been about 30 years since rates were that high in the non-aboriginal component of the population. It took 30 years to bring that rate down below one per 100,000. We have better tools now. As Dr. Long has said, a lot of the high risk and high rates of tuberculosis are located in geographically confined communities. We can achieve a faster decline of rates of TB in the aboriginal population, but we still need to build capacity and work with first nations and Métis and Inuit community leaders and champions to make effective TB control a reality.

A couple of programs have worked. The SCRAP-TB program, which was developed in B.C., and the World Health Organization's PAL program appear to have some promise. Both of these programs are based on the notion that there's not one size that fits all.

● (1015)

The Chair: Thank you, Dr. Graham.

Dr. Brian Graham: May I make just one more point on this?

In closing, I think we have tools and expertise, but we need to collaborate with the first nations and Métis communities. As I said before, we all have to be working together on this.

The Chair: Thank you, Dr. Graham.

We're now going to the Canadian Public Health Association.

I understand, Mr. Chauvin, that you want to say a couple of things before Ms. Randell. If you start within the context of three minutes, as long as you're aware of it....

Mr. James Chauvin (Policy Director, Canadian Public Health Association): Thank you, Madam Chairman.

I'm going to forgo making an introductory statement, but I would like to thank you on behalf of the Canadian Public Health Association for the opportunity to appear before the committee.

I'd like now to hand over to my colleague, Elaine Randell, registered nurse and communicable disease consultant with the Department of Health and Social Services of Nunavut. She's here as a CPHA member to share with you her first-hand experience of what's happening in the field.

Ms. Elaine Randell (Communicable Disease Consultant, Department of Health and Social Services, Government of Nunavut, Canadian Public Health Association): Thanks.

To fully understand the pattern of TB in most aboriginal populations in Canada, it's important for us to understand the history of TB among this group, where the epidemic came from, as well as the social determinants of health that significantly contribute to the continuing high rates of infection and disease.

Contact with European merchants and traders in Canada occurred in sequence, beginning with the Atlantic provinces in the 16th century, Ontario and Quebec in the 17th century, the Pacific provinces in the 18th century, the prairies in the 19th century, and the territories in the 20th century. Contact in the territories began in the west in Yukon, and to the east, which is now Nunavut. The subsequent wave of settlement that followed this changed the way that aboriginal populations lived, from small, isolated, mobile groups to large groups living in settlements and stationary.

This social colonization was what provided the vector for the spread of tuberculosis. The earlier the epidemic began, the sooner it reached its peak and began to fall, until the last 15 years or so, as we've heard, which is why we see the pattern of TB rates we have amongst aboriginal populations, the rates being lowest amongst the population where the social colonization occurred earliest and highest in areas such as Nunavut, where it occurred most recently.

Inadequacies in the social determinants of health are key in continuing the cycle of outbreaks and high rates of TB among aboriginal populations. Crowded and inadequately ventilated housing increases transmission. I'm aware of situations in which infectious cases have been recorded in houses with 13 people or more, including young children, who are especially vulnerable. The rate of transmission in these situations is very high. Those without housing move from home to home as guests, thus increasing the number of people who are exposed and infected. Long periods of cold weather and darkness in the north lead to longer periods of time spent indoors in crowded and inadequately ventilated housing. This leads to increased exposure and shared air space and subsequent increase in transmission. Poor nutritional status increases risk of progression from infection to disease. In many remote communities, selection of nutritious foods such as fresh vegetables and fruits is extremely limited and prohibitively expensive. Programs such as food mail that provide access to more nutritious foods are easily accessed by people who have credit cards, but many Inuit don't have credit cards and don't even have bank accounts.

Delayed diagnosis of infectious cases results in prolonged exposure time for contacts. Diagnosis is delayed when regions don't have local diagnostic capabilities and expertise.

Some remote communities lack continuity of health care providers. A successful TB program is dependent on a relationship of trust between the residents in the community and their health care providers. This requires continuity of staff and health care workers who are experienced and trained in early detection of tuberculosis.

Social colonization is the primary root cause of TB among aboriginal populations. Issues related to the social determinants of health, which include crowded and inadequate housing, poor nutritional status, and lack of continuity of health care providers, are the root causes of continued high rates amongst Inuit. TB rates in Europe began to fall even before the introduction of the first medications, with improvements to standards of living. By addressing issues such as poverty, housing, and access to health care and nutritious food, we can expect the same to happen here.

● (1020)

The Chair: Thank you so much for your presentation.

We will now go to our second-last presentation, which will be from the Canadian Society for International Health.

Ms. Roberts.

Ms. Janet Hatcher Roberts (Executive Director, Canadian Society for International Health): Thank you.

As Rosemary Brown has said, “Until all of us have made it, none of us have made it,” and clearly we haven't made it here in Canada yet.

What is stunning, as Dr. Hershfield said, is that the root causes haven't changed. If Dr. Hershfield had déjà vu, I'm sure that Dr. Osler, who in 1900 said that TB is a social disease with a medical aspect and we need to look at housing and nutrition, would clearly be appalled.

The global picture of TB reflects the same inequities we see in first nations in Canada in low-income countries, where poverty and the distribution of poverty is massively inequitable, especially in Africa and South Asia. As well, the expenditure on health care is reflective and inequitable. It has an impact as one of the determinants of health, and thus is one of the determinants of tuberculosis.

There are 370 million indigenous people worldwide. No one knows the prevalence of tuberculosis, because most national tuberculosis programs don't count indigenous people, and there are very significant barriers in access to care.

Canada has made commitments to the world in reducing tuberculosis through a number of initiatives. The millennium development goals include tuberculosis as one of the goals, and there is a call for global partnership to address these issues. We are committed to those millennium development goals, yet here in Canada we have seen an increase in tuberculosis amongst our first nations communities. So while we should be concerned about reaching millennium development goals globally, we should be concerned about our inability to address progress amongst first nations communities. We have committed over $124 million worldwide to tuberculosis, and we will be called upon to reinvest in the global fund next year.

What is needed is a health systems approach, not a health care approach. We've heard this today. We put a little diagram together for you to pull those ideas together. It integrates social determinants and health in all policies; establishes processes for measuring the quality, reach, outcomes, health information systems, surveillance systems, human resources, and evidence-based approaches that are culturally sensitive. It engages communities to allow them to be empowered and accountable, with an ability to interact with governments, researchers, private sector, and other civil society players.

At a global indigenous TB meeting last year, a framework on opportunities for leadership for Canada, in Canada and abroad, brought forward a number of recommendations that we put in our report. They can be considered by this committee.

In closing, it's clear that we need policy coherence. We need to bring together the different policy demands. I suggest an interdepartmental committee be struck to address this issue.

Thank you.

The Chair: Thank you, Ms. Roberts.

During the questions everyone will be listening very attentively. They will ask you questions, so you will be able to add extra points that you want to put across.

Now we'll go to the University of Alberta and Ms. Fanning, please.

Dr. Anne Fanning (Professor Emeritus, Faculty of Medicine, University of Alberta): Thanks very much. I'm going to deviate from my prepared remarks to try to summarize their essence.

It's fantastic that this issue is being addressed by this committee. Congratulations. It is a blot on the conscience of Canadians that the disparity is as profound as it is.

TB control requires a very standard, globalized approach that you've heard about. You find the cases, you cure the cases. You find the contacts, you prevent them, and you do so on an urgent basis for the reasons already described. There's no question about it.

Canada has those standards, but we do not have performance indicators at the regional level to determine whether the standards are being met. These should be measured on an annual basis, and we either pass or fail. We deliver that program in order to save lives, prevent transmission, and to reach elimination strategies.

There is no question that we can do it, because we did it in the fifties when rates were 2,000 to 3,000 per 100,000 people. Now the rate is four per 100,000. But in the north, where a determined Canadian program or policy was put in place—I'm sure at great expense—the rates fell faster than they did anywhere else in the world. They hit their nadir, the bottom, about the mid-eighties.

Since then, they've been rising, because our attention has shifted. We failed to sustain what we were required to do to ensure that we reached the elimination point, and the rates have gone up and up and up in every region of this country, but especially in Nunavut among the Inuit. The rates have gone down in one province, which happens to be Alberta.

I hesitate to brag, but I want to tell you how that program is described. It's described as “pigheaded”, because we are determined to do it. The program works because there is collaboration between the federal and provincial authorities and there are performance indicators measured annually. People talk to each other, and when a case occurs, it is considered an emergency and urgent action emanates as a result. I suggest this happen everywhere.

● (1025)

The Chair: Thank you, Ms. Fanning, and thank you for encapsulating your presentation. That was very helpful.

We'll now go into our seven-minute question and answer session. We're going to have shared time between Ms. Neville and Ms. Murray.

Who would like to begin?

Hon. Anita Neville (Winnipeg South Centre, Lib.): I'm going to start. Thank you.

Ms. Fanning, would you mind tabling your prepared remarks that you deviated from? Would you table them with the chair so we can see the full scope of your comments?

Dr. Anne Fanning: I'll try to remember what I said. Thank you.

Hon. Anita Neville: No, we would like the prepared ones, not the deviated ones.

I have all kinds of disjointed questions to ask. I was struck when listening to you and the group that was here before by the insanity, I guess, for lack of a better word, of the preponderance, and increasing preponderance, of TB in a country as abundant as ours.

My first question is for Dr. Hershfield. Am I correct that there is a vacancy in the position of director of tuberculosis control in the Province of Manitoba? I wonder if you could speak to that briefly and the impact it's having.

Dr. Earl Hershfield: There isn't a vacancy, but the director of tuberculosis control happens to be the chief medical officer, who has 117 other jobs to do. So there isn't a tuberculosis control program as such with a head. That's what the problem is, as I see it, in Manitoba.

The other problem in Manitoba with respect to FNIHB is that they have abdicated their responsibility by contracting out the services on reserve to the Winnipeg Regional Health Authority. The Winnipeg Regional Health Authority, in my view, looks after health in Winnipeg. I have no idea what it's doing on reserve.

So there isn't a regular TB program directed from the top down. That is one of the problems in Manitoba and it is why, as I see it, Manitoba has the highest TB rates in Canada outside of Nunavut.

Hon. Anita Neville: You're touching on the other area I wanted to talk about. What we heard from the group today and from the previous group is that there is a lack of coherence, a lack of congruency, in the programming.

Dr. Orr, you mentioned that there should be one organization or one jurisdiction taking the lead. We have a whole array of organizations here. Do the governments, the private sector, and not-for-profit groups speak to each other? What can be done?

Dr. Orr, you had four points. You were cut off at three. If you would like, you can complete your fourth one. Then talk about what's necessary in terms of providing some coherence. We heard Dr. Hershfield speak about Manitoba.

● (1030)

Dr. Pamela Orr: On the first point, I would just say that my observation is that in some regions—Alberta is one of them—FNIHB and the province get along very well and work together cooperatively. But in other parts of Canada, that doesn't happen. It's dependent on personality, and it shouldn't be. That's the reason I believe only one unified program can work. Communication shouldn't be dependent on personality.

The second issue is that, basically, improving the social determinants of health must happen at the same time as the medical intervention. That's a question of justice, which Chief Dantouze and Chief Toulouse talked about so eloquently. However, this mustn't be an excuse. The medical program mustn't point a finger at the social determinants. The medical programs have to take a long look in the mirror and fix themselves before they point the finger at the social determinants.

Hon. Anita Neville: Does anybody else want to comment? Ms. Roberts? There is no other comment?

Go ahead, Joyce.

Ms. Joyce Murray: Dr. Fanning, I was interested in your comment that Alberta seems to be more successful in reducing TB rates in rural and first nations communities. How would the federal government extend that approach to other provinces without stepping on jurisdiction, in your view? Have you thought about that?

Dr. Anne Fanning: That's a difficult question. But I think we have an obligation to deliver the best possible program in every single region. There is no excuse not to. I think the money should follow the authority or the authority follow the money. It should be an obligation to meet the performance indicators we've identified. They're out there, but they're not measured on an annual basis. I think the program could be emulated, but I think that would not sit well with lots of regions. But if every region is measured on an annual basis on their delivery—cases found, cases cured, prevention, action taken....

Ms. Joyce Murray: Just to understand Alberta's situation, was that methodology and the pigheadedness driven by your provincial medical officer or by the provincial government or by the university and academics? Who has put that forward and is driving it and pushing it?

Dr. Anne Fanning: I think it has been a philosophy for 30-plus years. And I think that in spite of some attempts within the province to water it down, the personalities have remained pigheaded and have kept it going. I think it's a mixture of factors, but it clearly works and could be emulated.

Ms. Joyce Murray: Ms. Roberts, what can we take from other countries? Are there other countries that have dealt with the specific kinds of challenges we have with the Inuit and with the historical changes, which Ms. Randell explained, that you would advise this committee to study? Are there particular regions?

Ms. Janet Hatcher Roberts: First of all, the idea of imposing versus emulating I think is an important distinction. The idea would be that those are best practices. If everybody is tasked with a report card, then they're going to have to come up with those best practices. It isn't imposing; it's adoption and emulating. So I don't think we have to be so concerned about jurisdiction. Certainly internationally we have some wonderful examples of tuberculosis control, exactly as Dr. Hershfield has said.

The Chair: Thank you, Ms. Roberts.

Ms. Janet Hatcher Roberts: If you follow along with those steps, it will happen.

The Chair: Monsieur Dufour.

[*Translation*]

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

First of all, I would like to ask Ms. Hatcher Roberts a question.

Before exploring some matters in depth, I too would like to know what is being done internationally. How is Canada viewed internationally when it comes to tuberculosis in aboriginal populations? I know that, a little earlier, you told us that, in some developed countries, national programs do not necessarily include the aboriginal population. Do we have comparative figures to see how well Canada is doing internationally? And are there good practices that we could import?

● (1035)

[*English*]

Ms. Janet Hatcher Roberts: When we implement programs, we bring people like Dr. Fanning and Dr. Hershfield in to actually deliver those national TB programs. So we use the best practices that have been used here in Canada, that have been tested out, that have been proven to work. Exactly what Dr. Hershfield said—and I'm sure Dr. Fanning can elaborate—those are the steps.

We work with national TB programs to not only adopt those steps but to build the capacity and involve communities. I think somebody else was talking about this. If you involve communities and train them, they don't all have to be doctors, but we do have to involve an interdisciplinary team to approach that: laboratories, nurses, doctors, and community health workers. And it works, but it has to be a comprehensive investment.

Perhaps Dr. Fanning or Dr. Hershfield could comment, but one of the examples is Guyana, where I worked with Dr. Hershfield. I know the Canadian Lung Association has done considerable work in Ecuador, and Dr. Fanning has worked elsewhere.

If you go in with that approach, it does work, but it requires continued investment. You can see in Canada what the result was when that didn't happen.

Dr. Anne Fanning: I've just recently looked at Australia, New Zealand, the U.S., and Greenland, because they have disaggregated data on aboriginals. In aboriginal communities in each of these countries, the rates are higher by factors ranging from 1.5 in the U. S., to ours, which is the highest.

In all of the countries but the U.S., the rates are going up in indigenous peoples, not as dramatically as in Canada, except in Greenland.

Greenland had the same Inuit experience in the 1950s. Their rates went way down because of an excellent program. It bottomed out in 1987 and their rates are now higher than the Inuit of Canada.

It is related to program delivery in a sustained, committed, well-funded, participatory fashion, engaging communities and making sure the capacity exists in those communities with the kind of health professionals who know the circumstances of those communities.

I might add why it works in the U.S., just to say that they have program indicators, and every state reports every year on their performance.

The Chair: Dr. Hershfield, did you want to make a comment on that?

Dr. Earl Hershfield: Yes.

One of the problems in Canada is that we do not have a national TB program. We have provincial programs that can do as they like at any time, but we do not have a national program. That's the trouble in trying to compare Canada with other countries.

One of the things that I would hope would come out of a committee like this is that there should be a national program. It can be administered by the provinces for those individuals who have federal responsibility.

The problem is that each province must have a distinctive TB program. It can vary from province to province, but how you carry it out is simple, easy, straightforward, and it has been done for 50 years.

The Chair: You have two more minutes.

[*Translation*]

Mr. Nicolas Dufour: You were talking about a national program. Of course, the provinces will not just have to be consulted, they will have to take the operational lead.

We also have the problem of a lack of communication that we heard about earlier. There seems to be some vagueness; we do not know exactly who should be dealing with the problem and how it should be handled. Ms. Turner told us that, not only was there just one paragraph, but also that it was very vague. There are no specifics about who should be dealing with the problem. How do you see it? The question is for all the witnesses.

● (1040)

[*English*]

Dr. Earl Hershfield: I go back to what I said previously: each province has to have a vertical tuberculosis control program. This is frowned on by some people in public health. It isn't to say that the director of tuberculosis control is a world unto him or herself, and in fact they should be responsible to the chief medical officer, but the tuberculosis control program in each province must be single, vertical. It can be horizontal at the community level, and should be horizontal at the community level, but the control and the decision-making and the program itself must be a vertical program. That's anathema to some public health individuals, I understand that, but it's the only way TB is going to come under control in Canada.

The Chair: Is that the end of your questioning, Mr. Dufour? You've only got about 30 seconds.

[*Translation*]

Mr. Nicolas Dufour: A little earlier, Mr. Graham told us that it has taken 30 years for the rate of tuberculosis in non-aboriginal populations to fall to 30 cases per 100,000. The government has set a goal of bringing the rate down to 3.6 cases per 100,000 by 2015. Do you really think that is realistic?

[*English*]

Dr. Brian Graham: Yes, I do. I think some of the reasons for this are that in the Canadian population as a whole we were dealing with a whole country, and it's one of the things Dr. Long has pointed out, and especially from our experience in Saskatchewan, where we've seen, as he's pointed out, that there are may be six or seven communities that have the highest burden of tuberculosis. So it's not a whole stretch in that regard. We also have better tools than we had before. We have better ways of diagnosing tuberculosis and recognizing and treating latent tuberculosis.

The Chair: Thank you, Dr. Graham.

We'll go to Ms. Wasylycia-Leis.

Ms. Judy Wasylycia-Leis: Thank you, Madam Chairperson, and thanks very much to all of you for coming to talk about a national emergency.

I want to just begin by noting that Dr. Fanning's comments were much appreciated. She is not here just as an expert and a doctor and a professor, but she is also a winner of the Order of Canada for her work on tuberculosis. I think we need to take very seriously her very straightforward recommendation, and I hope we can put that directly into a report that goes to Parliament and that will then be acted on by the government.

I want to say, sitting here and listening to all of this, I feel so embarrassed to be a Canadian when I hear what you're saying, which is so basic and so possible and not being done, either because of lack of political will or just sheer inability—or maybe incompetence—to coordinate folks across this country according to one national standard that is monitored annually, and if the targets aren't met and if the performance isn't met, then action is taken. What can be more straightforward than that?

I want to know a couple of things. According to the department, she said today, we spent $42 million in the last five years on TB and all the while the numbers are going up. What's clear is that the money is being spent, allocated to regions, with no targets, no performance criteria, so we don't even know where that money goes. Maybe it's all going into pollsters. Who knows? And maybe what we should be doing, Madam Chairperson, is having the Auditor General in to look at this fund and find out where the heck that money is being spent and why it's not going to where it should.

I want to ask Dr. Orr something, and I don't know if this is okay with you, Dr. Orr. As I understand it, you were the director of TB control in Manitoba, and you got frustrated and quit your job, partly I think because of the absolute inability to coordinate anything with FNIHB. I don't want to put words in your mouth—I'd love for you to tell your story—but what I'd like to know from you is, how do we get FNIHB and the Public Health Agency of Canada to do what you recommended today, to take this seriously, to kick-start this issue and start putting the resources and standards in place to deal with an absolutely ballooning number of TB cases in a supposedly civil society that is not a third world country?

● (1045)

Dr. Pamela Orr: I want to say that I've seen a great deal of leadership on this issue from Dr. Ed Ellis from the Public Health Agency of Canada, and he's a hero of this process. I would just say that when you have a TB program, let alone an HIV or hepatitis or cancer program, in which there are different leaderships, jurisdictions, you are going to get fragmentation, and that may be okay for hepatitis or cancer—I don't think it is—but not for tuberculosis. One has to have a single program in each province, and the medical officer of health will then have to answer for what goes on in his or her region according to the performance targets. To do otherwise is to allow for the variance between some areas of Canada, where personalities are pigheaded and effective and they get along, they cooperate, and other areas where there's a disconnect and non-communication.

Ms. Judy Wasylycia-Leis: You're right about Dr. Ellis. And we should mention that he put out a report on January 20 of this year, which said, "The TB situation in Canada, Forgotten by most, but not gone: a new TB case in Canada every 6 hours", and a death every two weeks. He actually identifies a number of the problems, from the rise among aboriginal peoples, including delayed suspicion of disease by health care providers, delayed diagnosis due to time required to obtain sputum and X-ray data results...all of which are under the jurisdiction of the federal government and are not being done. That's why I'm so embarrassed.

I was in Dhaka, Bangladesh, and I saw the sputum tests being done in a little tent in little rural villages of enormous poverty. They were sent off, and if X-rays were needed they were followed up and medicines were provided. Volunteer nurses were making sure that the medicines were taken. They're conquering it by that. We're not even doing that in Canada.

My question is this. Would it not make sense to at least have Health Canada and the FNIHB, with public health agencies, send in special teams to those hot spots in this country, like Lac Brochet, where they can't even get a team in to do the X-rays, where there are only 750 people but where they expect there is widespread tuberculosis in that community? Why couldn't they at least say, "We will do that today, we will send in a special team to those 10 to 15 hot spots in this country and get to the bottom of it"? At least get the accurate numbers, get the prevention, get the drugs in place, and start to work on it.

The Chair: Dr. Hershfield.

Dr. Earl Hershfield: It's a jurisdictional problem. The federal government—I don't think—comes to the Province of Manitoba and says, "I'm going to do this in Lac Brochet", without consultation, at least, with the provincial program.

Ms. Judy Wasylycia-Leis: Okay, but what I understood, first of all, is that it is federal jurisdiction that we're talking about—reserves.

Secondly, it seems to me, based on what I've heard from others and from you, there is in fact a lack of any kind of performance standards and will by the—

The Chair: Ms. Wasylycia-Leis, with all due respect, do you want to keep talking, or do you want him to answer?

Ms. Judy Wasylycia-Leis: I just want him to address it from the point of view of—

The Chair: Well, we're running out of time.

Would you like to answer, Dr. Hershfield?

Dr. Earl Hershfield: Yes, I would.

I agree with you, but the fact of the matter is that when I was director of Manitoba, we had regular meetings with FNIHB, the province, and everybody. And that's the way the program ran. Right now in Manitoba it's fragmented to a bunch of different agencies and/or regions. And that's the problem. To come in and say the federal government wants to do an X-ray survey of Lac Brochet would take a year to negotiate. That's a problem.

Ms. Judy Wasylycia-Leis: Well, yes, there are no performance standards nationally to direct the process. We end up with this fragmented approach. And surely that has to be one of our recommendations.

Do I have any more time?

The Chair: I'm sorry, Ms. Wasylycia-Leis. Thank you.

We'll now go to Ms. McLeod.

Mrs. Cathy McLeod: Thank you, Madam Chair. Again, thank you to all the witnesses.

I'd first like to focus in and ask a question.

Dr. Graham, you talked about the SCRAP-TB program in British Columbia. Could you elaborate a little bit in terms of what's happening there?

Dr. Brian Graham: Yes. SCRAP-TB stands for strategic community risk assessment and program for TB. It began in B.C. It was a way to involve the community, engage the community, and develop champions for TB within the first nations communities, to assist with the TB control program.

One of the other important aspects of it is that it wasn't a program that said you have to do it this way—a template. It was more of a way to say that we know that one size doesn't fit all. We've been talking about this problem all morning, saying words like "aboriginal", as though it's a homogeneous group, which it isn't. And even among first nations we know there are many first nations at different stages with different players, different people, and different cultures. We need to recognize that. That's the kind of program that is being developed, to have people within the community become more aware of TB and become involved in the TB process, raise awareness, improve, participate in some of the directly observed therapy programs for tuberculosis.

● (1050)

Mrs. Cathy McLeod: Can you tell me a little bit of the dynamics in terms of how the federal government interacted with the provincial government, interacted with the aboriginal communities? How does it all piece together?

Dr. Brian Graham: There was some federal funding provided that went into this, but there were other agencies that were involved in it as well that helped to develop the idea. I believe it was tested in about six or seven first nations in B.C. and Alberta and one in Saskatchewan.

In terms of the direct involvement, it wasn't that there was somebody who prescribed it. It was more of a grassroots kind of thing that built up with this type of funding. I believe it's under evaluation right now, looking at the potential for expansion.

Mrs. Cathy McLeod: We've heard comments about health services and how the medical community cannot absolve itself of responsibility because of certain social determinants. So recognizing in these comments the absolute imperative that we move toward more equity, and that might take a little time, if we had a really good system without jurisdictional barriers, could appropriate treatment reduce this to very small numbers? I recognize that we have to move toward a much more equitable system, but I'm talking strictly about the medical services.

Dr. Earl Hershfield: I'll say something Pam would say. Theoretically, yes, the treatment is known. TB is curable, and 98% of people who take their medication will be cured, everything else aside. If you give treatment to people who were contacts, positive tuberculin reactors, and they take their medication, they will not get tuberculosis in the future. So the answer is theoretically yes. The problem is the administration and setting it up in the field.

Dr. Pamela Orr: Yes. To reiterate, from 1960 to 1980, the great physician, Stefan Grzybowski, oversaw a very aggressive medical program for TB under very difficult social circumstances in what is now Nunavut—poorer housing and nutrition, etc., than we have today—and they achieved the most remarkable decrease in the incidence of TB recorded in the world. So yes, it can be done. Of course, working on the social determinants is a justice issue and a credibility issue with aboriginal people. You won't get cooperation on one field if you don't address the other field. So it's the right thing to do, but the medical intervention works.

Ms. Janet Hatcher Roberts: As everybody has been saying, nothing is as disarming as the truth. If there was a report card and if there were indicators, then a whole lot of other things would fall out, because people would be called upon to answer why not. Why didn't we get there? What's going on?

There are the federal-provincial-territorial mechanisms and there are interdepartmental mechanisms at the federal level and at the provincial level that allow for the true public health approach in terms of addressing TB in a vertical program, but they also allow for those other social determinants to weigh in. The report card and deciding on core indicators could work, because we've done it federally for other things and we can do it for this, and the interdepartmental approach allows that horizontal piece to play in as well.

● (1055)

Mrs. Cathy McLeod: I'm not sure if anyone here can answer this, but in terms of on reserve, off reserve, does anyone know the statistics with regard to the rates of tuberculosis?

Dr. Earl Hershfield: Manitoba has those statistics. I thought I brought them, but I don't think I did.

Dr. Pamela Orr: The federal government has statistics, which I have in my briefcase and which are on the web. It's aboriginal/non-aboriginal, under Inuit, first nations, Métis. Many of the provinces do not publish on-reserve and off-reserve statistics, and that's part of what one might call a culture of secrecy. There are concerns about confidentiality. Nevertheless, one can release information while preserving both patient and community confidentiality.

Dr. Earl Hershfield: The federal government produces statistics that talk about status Indians, non-status Indians, Métis, Inuit, and that's the way it's divided. That's because in provinces, those aboriginals not on reserve are counted as part of the provincial total as opposed to aboriginal totals, unless they have two addresses, which many people do. Then you have to choose which address you want to use for them.

The Chair: Thank you, Dr. Hershfield.

We only have a couple of minutes left, but there is something we need to address. In a motion the committee had talked about submitting a report to the House of Commons. So we need to discuss that, but before we do that, I want to thank the witnesses for being here.

This will end your witness time on our committee and you are free to go at any time.

Hon. Carolyn Bennett: I have a point of order, Madam Chair.

Seeing that we will be reporting back to the House, based on today's testimony, if anybody has specific recommendations you would like to see in the report....

Because of the federal-provincial jurisdictional problems and the fact that quite often we don't have even national numbers, as Dr. Hershfield just said, it's very important for it to be accurate. I was wondering if you would entertain the suggestion, Madam Chair, that we may need expertise, even for the draft report, to make sure we've got it right. In certain situations we've been able to circulate a draft report to make sure the experts are comfortable with it before we send it in. We just have this one opportunity. We don't have an opportunity to bring it back and test some ideas—

The Chair: What we can do is ask that the recommendations be brought in. We don't generally ask the public to write our reports for us—the committee will do that—but I suggest very strongly that you submit all your recommendations and everything you would like to see in that report. That would be very acceptable.

Go ahead, Ms. Wasylycia-Leis.

Hon. Carolyn Bennett: Madam Chair, with the disability committee report—

The Chair: It's Ms. Wasylycia-Leis. I addressed her first.

Go ahead, Ms. Wasylycia-Leis.

Ms. Judy Wasylycia-Leis: I suggest we ask our analysts if they could come up with a draft report as quickly as possible—within a week, even—that is short on background but focused on the recommendations.

It seems to me that four or five key points have already been brought to our attention. One is not to delay in this federal strategy, but to get it kick-started immediately, as opposed to waiting for October. Other recommendations would be that there be national standards developed, with a built-in accountability and assessment process; that the Auditor General be called in to look at the books; that there be an emergency federal-provincial-territorial meeting on this issue; and that there be an emergency strategy to immediately send in teams to the hot spots for assessment, so that at least we begin to deal with the problem.

The Chair: Our time is up, so could I ask you to please put all your suggestions in and send them in to the analysts? We will have time next meeting to take a look and see how much more time we need.

Witnesses, could you bring all your recommendations in? Suggestions from anybody around this committee could be put in as well.

Thank you for coming. We are dismissed.

● (1100)

Hon. Carolyn Bennett: No, I had a point of order on Thursday's meeting. I had explained to the clerk that I wanted to ask for an update on what we have heard in the RSVPs for Thursday's meeting.

A voice: Yes, that's a good question.

The Chair: Oh, okay, sure. We have RSVPs.

The Clerk of the Committee (Ms. Christine Holke David): Basically, for Thursday's meeting on CHVI, I received responses from Dr. Butler-Jones and Dr. Plummer saying they will be in attendance. I also received responses from the offices of Minister Toews, Minister Aglukkaq, and Minister Clement, and they have declined the invitation. I have not received any response from Dr. Jo Kennelly.

Hon. Carolyn Bennett: Madam Chair, I think we should put the ministers on notice that if they do not come on Thursday and do not comply with the motion of this committee, we will have to report back to the House that they've refused to appear before a parliamentary committee. I would like to ask the consent of this committee to subpoena Jo Kennelly.

The Chair: Okay, I am now going to dismiss, because time is up and other people are coming in.

The meeting is adjourned.

Published under the authority of the Speaker of the House of Commons

SPEAKER'S PERMISSION

Additional copies may be obtained from: Publishing and Depository Services
Public Works and Government Services Canada
Ottawa, Ontario K1A 0S5
Telephone: 613-941-5995 or 1-800-635-7943
Fax: 613-954-5779 or 1-800-565-7757
publications@tpsgc-pwgsc.gc.ca
http://publications.gc.ca

Also available on the Parliament of Canada Web Site at the following address: http://www.parl.gc.ca

Publié en conformité de l'autorité du Président de la Chambre des communes

PERMISSION DU PRÉSIDENT

On peut obtenir des copies supplémentaires en écrivant à : Les Éditions et Services de dépôt
Travaux publics et Services gouvernementaux Canada
Ottawa (Ontario) K1A 0S5
Téléphone : 613-941-5995 ou 1-800-635-7943
Télécopieur : 613-954-5779 ou 1-800-565-7757
publications@tpsgc-pwgsc.gc.ca
http://publications.gc.ca

Aussi disponible sur le site Web du Parlement du Canada à l'adresse suivante : http://www.parl.gc.ca