House of Commons
CANADA

Standing Committee on Health

HESA • NUMBER 024 • 3rd SESSION • 40th PARLIAMENT

EVIDENCE

Thursday, June 10, 2010

Chair

Mrs. Joy Smith

Standing Committee on Health

Thursday, June 10, 2010

● (0900)

[*English*]

The Vice-Chair (Ms. Joyce Murray (Vancouver Quadra, Lib.)): Good morning, everyone.

This is meeting 24 of the Standing Committee on Health. We are studying the implementation of the recommendations of the Weatherill report on the 2008 listeriosis outbreak.

Thank you to all the witnesses who are here to work with us today. There will be five-minute presentations. I believe three of the witnesses will be presenting.

We'll be starting with Meena Ballantyne, the assistant deputy minister of the health products and food branch of the Department of Health.

Ms. Ballantyne, it's your turn.

Ms. Meena Ballantyne (Assistant Deputy Minister, Health Products and Food Branch, Department of Health): Madam Chair, if I may, I think it is Dr. Butler-Jones who is going to be leading off the presentation.

Is that okay? That's what we had planned on.

The Vice-Chair (Ms. Joyce Murray): Sure.

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

Thank you once again for the opportunity, particularly to update the committee on the government's progress on food safety.

Here with me today from the Public Health Agency of Canada is Dr. Mark Raizenne, the DG of our Centre for Food-borne, Environmental and Zoonotic Infectious Diseases.

This morning I'd like to provide a bit of context just to get started, along with a brief overview of what we've been seeing over the past year and where we are headed.

First, Canada has long had one of the safest food supplies in the world, but as with any area of public health, responsibilities for safe food and safe eating go beyond governments and industry to every one of us. The vast majority of food poisoning occurs at home from unsafe handling or preparation of food, even when the food supply is safe. From the farm to the kitchen, outbreaks can and will happen, as well as from the kitchen to the table.

[*Translation*]

On top of all this, we know that nature is constantly inventive and always has new surprises for us.

[*English*]

To ensure that we're prepared for all of these threats, we need strong links in every part of the chain, from regulation, inspection, and surveillance to education and safe individual practices. Every step on the farm-to-fork continuum is critical. For the government's part, when a national food safety threat poses a risk to Canadians, as it did in 2008, the health and agriculture departments and agencies at all levels of government must work together closely to respond to that risk.

Today I'll speak to the agency's role specifically. The Public Health Agency of Canada provides support to a province or territory conducting its own outbreak investigation, upon request, but when an outbreak of food-borne illness spreads beyond a province, territory, or country, the Public Health Agency assumes the lead to coordinate the outbreak investigation and the response with its partners. For example, when our national lab in Winnipeg linked listeriosis cases in provinces other than Ontario, where the outbreak started, the agency took the lead in coordinating the national investigation and response.

[*Translation*]

So, hopefully this provides some context. I'll move on now to a brief surveillance update.

[*English*]

Generally speaking, there are approximately 1,000 cases of E. coli reported each year in Canada. Based on our surveillance data, there has been a decline in the number of these cases. Most of these cases are also isolated and not part of an identified widespread outbreak. In 2009 the agency was involved in the investigation of 50 food-borne illness outbreak issues and it led nine of the investigations. These illness outbreaks implicated multiple provinces, or were international in scope.

So far in 2010, there have been a total of 12 investigations, and the agency has led three of these. All outbreaks are complex events involving a variety of players. Fortunately, they do not always result in the number of deaths that we saw in the listeriosis outbreak in the summer of 2008. But that experience showed us that no matter how much we apply from our past experience, more can be done.

[*Translation*]

Each event presents new lessons and new, emerging challenges.

[*English*]

While past lessons have led to Canada becoming among the safest food suppliers in the world, we all need to continue to be open to learning as we move forward. In this way, collaboratively, we can become even more efficient in managing new and emerging risks to human health due to food-borne illness.

Following the 2008 outbreak, the government immediately took a number of actions to prevent and reduce those risks, guided further by the Weatherill report in 2009. Working in collaboration with our partners in Health Canada and at the Canadian Food Inspection Agency, PHAC continues to work forward on the Weatherill recommendations and is making progress. The most senior levels of the responsible government partners are collaborating to address improvements to Canada's food safety system.

With regard to governance structure, the Clerk of the Privy Council gave Deputy Minister Knubley of Agriculture Canada the responsibility to chair a committee of deputy heads in 2009. Part of this work includes an oversight role in the coordination of actions by CFIA, Health Canada, and PHAC in relation to the Weatherill recommendations. I'm a member of this committee and am pleased to report that we've been meeting regularly for the last six months. The committee is supported by ADM- and DG-level committees as well as a full-time secretariat at Agriculture Canada.

The food-borne illness outbreak response protocol guides federal, provincial, and territorial collaboration in response to outbreaks. This key technical and operational protocol has been extensively revised in consultation with implicated government players, including the Public Health Agency, Health Canada, CFIA at the federal level,

[*Translation*]

and all provincial and territorial health and agriculture ministers.

[*English*]

The protocol has been endorsed by chief medical officers of health and by provincial and territorial deputies. The agency recently led a federal, provincial, and territorial review of the FIORP. This review has resulted in updated and clarified roles for responsibilities and collaborative processes and the articulation of clear guidelines for all involved during a food-related outbreak. FIORP 2010 will allow public health and food safety authorities across Canada to respond faster, more efficiently, and more effectively.

● (0905)

[*Translation*]

Along with the modernization of the protocol, the agency has been making progress on a number of other fronts.

[*English*]

Two major executive appointments have been made within the agency—namely, it now, as you know, has an associate deputy minister and an assistant deputy minister for emergency preparedness and response in corporate services. These appointments increase the agency capacity for flexible and timely response. We're working with provincial and territorial partners on a national public health surveillance tool called Panorama to improve our surveillance in early detection of outbreaks. We've expanded our participation in PulseNet, a national network of laboratories linking federal and provincial labs. PulseNet fingerprints bacterial samples from humans and food, facilitates coordination between food and clinical labs, and improves our ability to detect and respond to contaminated food products.

The agency is developing a comprehensive risk communication strategy to guide how it communicates to Canadians during a national outbreak, and we're also currently pilot-testing a model for rapid-response surge capacity. This will mobilize public health experts during food-borne outbreaks. All of this progress has been made possible by the allocation of approximately $18 million to the agency as its share of the government's three-year $75-million investment.

These initiatives address the recommendations of the Weatherill report as well as the concerns of the federal Standing Committee on Agriculture and Agri-Food. They highlight what the agency has been doing, although, as I say, we're only one part of a very large network of partners responding together when an outbreak occurs.

I'd be pleased to answer your questions. *Merci*.

The Vice-Chair (Ms. Joyce Murray): Thank you very much, Dr. Butler-Jones.

Ms. Ballantyne.

[*Translation*]

Ms. Meena Ballantyne: Thank you, Madam Chair.

Honourable members, I would like to thank you for giving me the opportunity to speak with you today about Health Canada's efforts.

[*English*]

Before getting into my remarks, I'd like to introduce Dr. Samuel Godefroy, who is our director general of the foods directorate, under whose responsibility this issue of listeriosis lies, as well as Dr. Jeff Farber, who is the director of our bureau of microbial hazards; he was directly involved at the time and continues to be very involved with these issues.

To continue from what Dr. Butler-Jones has said, let me begin by saying that protecting and promoting the health and safety of Canadians, their families, and communities are of paramount importance to Health Canada. At the federal level, Health Canada's primary responsibility in terms of food is prevention. We set standards and policies for the safety and nutritional quality of all foods sold in Canada and work as part of the wider global food safety network to increase our understanding of food safety risks as well as sharing early warnings of potential food safety incidents.

During food-borne illnesses and outbreaks we work as part of the team, part of the Public Health Agency, and with the Canadian Food Inspection Agency in a supportive role, and with our provincial, territorial, and local public health partners to confirm the source of the food-borne illness, to provide laboratory services, and to conduct health risk assessments in an efficient and expeditious manner.

[*Translation*]

It is within these parameters that I would like to illustrate the progress that Health Canada has made towards fulfilling the recommendations set out in Ms. Weatherill's report.

[*English*]

As mentioned by Dr. Butler-Jones, we have organized our work under three key themes: reducing food safety risks, enhancing surveillance and early detection, and improving emergency response.

Under the theme of reducing food safety risks, we must continually review and adjust our food safety standards, policies, operational procedures, and legislative framework so that oversight continues to be effective in these risks.

In terms of listeria, Health Canada has revised and strengthened its listeria policy, which includes all ready-to-eat foods. We have held targeted stakeholder consultations to guide the revision, and the revised policy was released for public consultation on our website from March 22 to May 3 of this year.

Stakeholder comments and feedback received through this consultation are currently being analyzed by Dr. Jeff Farber and his team in order to refine the policy. We expect it to be finalized by the fall of this year.

● (0910)

[*Translation*]

In the Weatherill report, it was recommended that Health Canada review its approval processes and fast track, where appropriate, new food additives and technologies that have the potential to contribute to food safety giving particular attention to those that have been scientifically validated in other countries.

[*English*]

Health Canada is doing exactly that. Guidelines to assist industry are being developed using established criteria that would allow us to prioritize and fast-track approvals of food safety interventions that have proven health benefits. We anticipate that these guidelines will be finalized by the fall of 2010. In the meantime, we are already implementing these processes internally.

[*Translation*]

As an example, Health Canada used this process to approve the use of sodium acetate and sodium diacetate as preservatives in the preparation of meat and poultry products, including cooked and cured meats.

[*English*]

This process will also help us to address other food safety and nutrition issues, which could include, for example, finding alternative fats and oils to help reduce trans fat in our food supply, and therefore Canadians' consumption of this harmful substance.

[*Translation*]

In her report, Ms. Weatherill also noted the differences in perspectives regarding the quality and strength of evidence on which to base recall decisions.

[*English*]

To address this issue, Health Canada, in collaboration with its national and international food safety partners, has developed a draft guidance document on the weight of evidence needed to support appropriate and timely actions to protect consumers during food-borne illness outbreak investigations.

The weight of evidence takes into consideration all the information gathered through food sample testing and human illness reports, as well as the investigation of farms and/or food premises. Federal, provincial, and territorial counterparts have reviewed the draft guidance document, and it will be shared with a number of Health Canada's international counterparts later this month.

Health Canada is also enhancing our standard operating procedures in support of CFIA's food safety investigations. This includes clarification of timelines in the health risk assessment processes as well as improving the quality of our risk assessments with improved methodologies. The department will continue to add specialized expertise and is in the process of training more staff to conduct health risk assessments in order to continue to provide 24/7 coverage and enhance surge capacity preparedness.

Under the theme of enhancing surveillance and early detection, Health Canada is working in collaboration with CFIA to improve and validate detection methods for listeria and other hazards in food to reduce testing time and enable more rapid response during food safety investigations.

For example, we have an enhanced method for detection of listeria, which will lead to results being available in five to seven days, rather than the ten days that it took us previously. This has been developed by Health Canada, and we're currently validating it for different food commodities and categories. We've also begun working with the National Research Council on a multi-year project to develop even faster lab results, which will allow for the detection of listeria within 48 hours. A first-generation prototype is anticipated for mid-2011.

Under the final theme, improving emergency response, Ms. Weatherill called for targeted communication efforts for particular vulnerable segments of the population. The government recognizes the importance of providing information to Canadians on how to handle food safely to help avoid food-borne illness. Efforts to provide this information are ongoing, and target those populations that are at greater risk of complications from food-borne illnesses—for example, older adults, pregnant women, and those with weakened immune systems.

In March of this year we launched the first stage of a social marketing campaign targeting at-risk populations. This included the publication and distribution of booklets. We brought copies of these, which we'd be happy to share with all of you.

● (0915)

The Vice-Chair (Ms. Joyce Murray): Excuse me, but could you wrap up with your conclusion? Thank you very much.

Ms. Meena Ballantyne: I would just like to say that Ms. Weatherill also called for coordination among the federal members. As Dr. Butler-Jones has stated, there is a deputy minister committee, and we have an ADM committee that meets regularly to support Dr. Butler-Jones.

The bottom line is that Health Canada is making measurable progress in the recommendations that pertain to us.

We'd be happy to answer any questions and provide further details.

Thank you.

The Vice-Chair (Ms. Joyce Murray): Great. Thank you very much.

We'll have our first round of questioning, with seven-minute sections.

Dr. Duncan, you're first....

Yes, Ms. Leslie.

Ms. Megan Leslie (Halifax, NDP): Madam Chair, there's a second handout. Is this from Health Canada?

The Vice-Chair (Ms. Joyce Murray): "Progress on Food Safety" is from the department.

Ms. Megan Leslie: Okay.

The Vice-Chair (Ms. Joyce Murray): It's from Health Canada....

Ms. Meena Ballantyne: It's a Government of Canada progress report.

Dr. David Butler-Jones: The secretariat is at Agriculture. It has CFIA at the top, but it is from the four departments.

Ms. Megan Leslie: Perfect.

Thank you.

The Vice-Chair (Ms. Joyce Murray): Thank you for clarifying that.

Dr. Duncan.

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

Thank you to all the witnesses. Thank you for the update.

I'm wondering if you have seen the 2010 food safety performance world ranking study, and I'm wondering if you could tell us how Canada performed on the ability to trace the source of tainted food.

Ms. Meena Ballantyne: I'll invite Dr. Godefroy to answer that question.

Dr. Samuel Godefroy (Director General, Food Directorate, Health Products and Food Branch, Department of Health): Thank you, Madam Chair, and thank you for the question.

We have indeed seen the report that was published, I believe a week ago or so, from the University of Saskatchewan rating the food safety systems internationally. We were very much interested in the methodology according to which this type of evaluation was conducted. We noted that the report showed some progress in Canada's position in terms of the food safety system we have internationally. In fact, I believe the report noted that we were ranked fourth in the rating.

Ms. Kirsty Duncan: We moved from fifth to fourth, and I think the researchers commented—maybe you'll talk to it—on why we moved up.

Dr. Samuel Godefroy: That is correct. I guess the report highlighted strength in the area of our food safety systems, in particular our ability to address food recalls and our ability to investigate food safety incidents and address those. The report noted, however, as you mentioned, issues associated with traceability. The issues identified in the report are related mostly to industry practices in traceability, so it's not necessarily identifying issues with traceability in the context of food safety investigations but rather in the food production systems where improvements are required.

Essentially, we're looking still with our colleagues in the federal-provincial-territorial partners—because this is a shared responsibility—at the outcomes of that report and in what way we could address those.

Ms. Kirsty Duncan: Thank you, Dr. Godefroy.

Yes, I believe Canada ranked at the bottom of the list of 17 countries along with the U.S. I think the reason for the poor showing was that neither country has established farm-to-fork traceability systems, so we don't have the ability to trace tainted foods. And they also pointed out—I'm wondering how you'd respond—that Canada's ability to trace tainted foods has actually declined between 2008 and 2010.

Dr. Samuel Godefroy: Thank you. Yes, we noted the way the report showed the traceability issues. Again, those traceability issues really are related to the production systems themselves, and that is being currently discussed, actually, as part of our federal-provincial-territorial discussions on food safety both between the health portfolios but also the agriculture portfolios.

● (0920)

Dr. David Butler-Jones: If I may supplement just briefly, it's a traceability in terms of within the industry, in terms of cow X ending up Y, as opposed to the issue of is there human disease or not and are we able to trace that back to the source of the human disease.

In the case of listeria, at the time of the maximum of the outbreak, when there were seven cases a week in Canada and we had only seen a couple of confirmed cases, we were able to identify the source of that and trace it back to the original plant and stop it from infecting anybody else—against the background of 20,000 to 30,000 of us who have those symptoms every single day in Canada.

So our systems in terms of identifying the human risk and the human health issues actually are quite superior.

Ms. Kirsty Duncan: I guess my concern is that after the death of 22 Canadians, I think the ability to trace tainted foods really should be a number one priority.

I'm wondering what specific actions have been taken to trace food from the farm to the fork—you mentioned production—and include all the agencies and industry participants along the way.

Dr. David Butler-Jones: Can I suggest that is in fact within the agriculture portfolio? We'd be happy to take that question back to CFIA and Agriculture, but our part is the actual dealing with the human impacts, the identification of risky foods, etc.

The purpose of what they're talking about in that study is that if you have a cow with mad cow disease or whatever, you're able to trace that through the system. We deal with the issue of what people are eating, not other parts of the system. That's where the human health direct implications occur and that's what we're able to identify.

We'd be happy to take that question back to CFIA, because they're the ones actually doing that part of the system.

Ms. Kirsty Duncan: Are we able to provide answers? Maybe we should have had CFIA here.

I think one of the concerns from the Weatherill report was actually the lack of communication, the lack of—

Mr. Colin Carrie (Oshawa, CPC): A point of order, Madam Chair.

The Vice-Chair (Ms. Joyce Murray): Dr. Carrie.

Mr. Colin Carrie: We did agree to have the committee look at this issue, but we want to focus on the health issues. CFIA—that's a whole other committee looking at this whole thing. We don't want to duplicate.

The Vice-Chair (Ms. Joyce Murray): Okay. Thank you for your comment. It is Dr. Duncan's turn.

I think it's fair enough—

Mr. Colin Carrie: It was a point of order.

The Vice-Chair (Ms. Joyce Murray): —for her to make that observation.

Continue.

Ms. Kirsty Duncan: Thank you, Madam Chair.

I'm wondering what countries are at the top of the 2010 food safety performance world ranking and why they outperform Canada.

Dr. David Butler-Jones: Again, that's a focus for the agriculture part of the system, not the human health part of the system. It's something that would be better addressed to CFIA.

Quite honestly, I don't have that answer.

Ms. Kirsty Duncan: Could Canada's food safety system be the best in the world? If so, what specific changes would need to be made?

Dr. David Butler-Jones: If we're not the best, then I think we're one of the best in terms of outcomes. I mean, that is the issue; there are certain things that could improve it, but in terms of the outcomes, which is human health risk and disease, Canada is among the best, if not the best, in the world. That's our focus.

There are always ways we can improve. From an agriculture standpoint, probably they would like to have some better points of traceability, etc., and that's what they're working on. But it's not a simple process and it's a very expensive process to track every single cow, etc.

I'm not an expert in that area. I do know that with respect to what we see in terms of food-borne outbreaks in Canada, sourced in Canada, we have an exceptionally good record. At the end of the day, it's interesting that with everything we did with H1, we actually saw reduced transmission of a range of infections, including food-borne infections—at least those that relate to home—where, if we don't wash our hands or we cross-contaminate, etc., most of the food poisonings actually come from.

The Vice-Chair (Ms. Joyce Murray): Thank you.

It is Mr. Dufour's turn.

[*Translation*]

Mr. Nicolas Dufour (Repentigny, BQ): Thank you very much, Madam Chair. Thanks to the witnesses for being here today.

Ms. Ballantyne, in your brief, you told us that guidelines to assist the industry are being developed and that you expect to have the final version of those guidelines in the fall of 2010. You also told us that the department will continue to increase its capacity by adding specialized expertise and by training more staff to conduct health risk assessments in order to continue to provide around the clock coverage and to enhance preparedness in crisis situations. I feel that we have to underline the words “crisis situation”.

If I understand correctly, your problem is the way in which responsibilities are shared between Agriculture Canada and Health Canada. You are actually only responsible in crisis situations. Prevention is a problem. In the mid-90s, Agriculture Canada put in place a large number of food inspectors, and it created a kind of imbalance.

There are a lot of inspectors in my constituency. I recall them telling me that, previously, there were preventive inspections. Inspectors went into supermarkets almost every day to conduct checks and surprise inspections. Some were done at industry level. Today, there are precious few anymore.

As a result, there is precious little prevention anymore. You are dealing with this problem because you only get involved in crisis situations. As I understand it, you ride to the rescue at the last minute. It is all very well to adopt guidelines and develop plans. But if there is no prevention on site, if there are no inspectors, if you cannot hire any to do the checking before a crisis begins, you will always have to be managing the situation from crisis to crisis rather than doing basic prevention so that the crises never arise. Am I mistaken?

● (0925)

Ms. Meena Ballantyne: Thank you for the questions. I would like to ask Dr. Godefroy to answer.

Dr. Samuel Godefroy: Thank you, Madam Chair.

In the food safety system, Health Canada's role is above all in prevention. That is the core of our mission. The department's responsibility is to define the standards that set production conditions that ensure that food products are safe and cause no harm.

The department's role is also to facilitate risk assessments in investigations—food-related investigations, that is—when there has been no incident. If you look at all the incidents that I will call "food related"—involving potential contamination—the large majority of them have no effect on human health. Hence the importance of that prevention role. This is the context in which we intervene.

To answer the first part of your question about what will become available in the fall of 2010, I think you are referring to food additives and to the process of intervention in food production in order to limit contamination. Health Canada has, in fact, worked on this specific recommendation from the investigator. We have already reviewed all the submissions made by the industry, on food additives, for example, or on technological agents that can have an immediate effect on public health—a positive, preventative effect—such as antimicrobial agents. We have prioritized our assessment of these agents. I could tell committee members about this assessment. There are no more agents undergoing scientific and technical assessment in terms of their safety and their positive effect on the system.

● (0930)

Mr. Nicolas Dufour: I am sorry to interrupt you, Dr. Godefroy.

First and foremost, the processing site needs to be hygienic. This is not just about what is put into the food. I think that it is a little sad. It may not be the role of the Standing Committee on Health to assess this aspect. We actually thought that it was to be excluded, but your prevention role is limited to some aspects only. Your work has limits. As long as Agriculture Canada is not able to extend its inspection role, you are going to be stuck. The food is one thing, but then there is the packaging.

Dr. Samuel Godefroy: To address that aspect specifically, I will say the policy on listeria monocytogenes, which was amended by Health Canada and which was made available in an initial version this spring, specifically sets safe production conditions and gives the industry the framework necessary to avoid any possibility of contamination at all stages of processing from the raw materials to the final product. That is part of Health Canada's prevention role. We have to set the guidelines that the industry must follow and under which the Canadian Food Inspection Agency is going to monitor compliance. We have actually made steady progress in that area.

[*English*]

The Vice-Chair (Ms. Joyce Murray): Thank you, Dr. Godefroy.

Dr. Butler-Jones had something to add.

[*Translation*]

Dr. David Butler-Jones: Thank you.

The gist of your question is about local and provincial public health inspectors. In the last decade, we have recognized the need for a risk balanced approach, as we call it.

[*English*]

"risk-balanced approach".

[*Translation*]

Convenience stores do not present the same risks as other producers. Most inspections focus on high and medium levels of risk. If there is a problem, a lot of inspections are done. In other cases, it may be once per year.

[*English*]

It's the same thing, I think, in CFI and others. There is the recognition that you go where the problems are, and on those that are low-problem you don't spend as much time. You make sure that people understand what things they can do to reduce the risk and focus on that rather than just look at things going by. That's a principle in public health that we've applied for the last 20 years, and it resulted in a change in the way we do inspections.

The Vice-Chair (Ms. Joyce Murray): I'm sorry; there's no more time in this section.

Dr. Farber, you can contribute your ideas perhaps through one of the other discussions.

It's now Ms. Leslie's turn.

Ms. Megan Leslie: Thank you Madam Chair.

Thanks go to all the witnesses for appearing before this committee.

My first question is for Ms. Ballantyne.

You said that there is a strengthened listeria policy. Can you tell us what that is? How is it strengthened? What does it look like?

Ms. Meena Ballantyne: This is Dr. Jeff Farber's area, so I think he would be best placed to give you a precise answer.

Dr. Jeff Farber (Director, Bureau of Microbial Hazards, Health Products and Food Branch, Department of Health): Thank you very much for the question.

Just to start off, the main focus of the listeria policy is on prevention and early detection. The proposed changes that we've made to the policy will encourage early identification of contamination in the plant environment.

This would help take corrective actions earlier and help avoid contamination of the finished product. It's based on looking at the environment and trying to find the sources of listeria, because listeria is a very complex organism, and it likes to hide out in little niches. The whole idea is to try to find those niches in the plant where listeria is hiding.

Ms. Megan Leslie: This is pre-consumption?

Dr. Jeff Farber: Yes. It's root cause analysis: you do sampling, let's say, of the environment, to find out where it is, and once you find that it is there, you take steps to eliminate it.

We've made a number of changes to the overall policy from the previous 2004 policy. I can give you just a few examples.

We've strengthened the end-product compliance criteria in terms of the numbers of organisms we allow in a food; we've actually strengthened that.

We've also stated, as I mentioned, that an environmental monitoring program should be used in all plants. We've also brought up the whole issue of trend analysis, so that a plant is not just doing tests and then putting the results in the drawer but is looking at the whole continuum of results over a period of time, as with trend analysis data. That's what companies have already started to do.

It also very importantly lists and encourages the use of post-processing inhibitors. For example, if you put a chemical in that can inhibit the growth of the organism, basically you're reducing your risk to near zero. We're encouraging companies to use technology, such as adding chemicals, maybe using processes such as ultra-high pressure, which a number of companies have already started to use. This high pressure can burst a cell and inactivate cells with listeria monocytogenes.

We also have an increased focus on outreach with the federal-provincial community to increase awareness of the risks of food-borne listeriosis. We've worked very closely with the CFIA on the policy as well. We've had excellent feedback from them. We have had excellent feedback also from the provinces.

So we feel we've come up with an improved policy and we have already had excellent comments back from industry as well on our efforts.

● (0935)

Ms. Megan Leslie: Thank you.

Along the lines of public understanding and awareness of the issue, I find that brochures are very useful in theory: in practice, they sit in boxes and such places.

What's the rollout program for this information? How are you targeting audiences, and how are you tracking who is actually picking these up?

Ms. Meena Ballantyne: What we're doing is a multifaceted social marketing campaign; the brochures are just one part of our strategy. We have brochures, we have posters, we have web-based information. We're working with the provinces and territories, with NGOs, with associations to make sure that this information gets out to populations. We're going to be sending it out directly to nursing homes. We're working with the medical officers of health through the public health channels as well to produce a guidance document that could guide people in nursing homes concerning what foods to eat and how to eat them and what the risks are.

It's a three-year campaign. We just launched it in March of this year. We had radio ads as well. We're trying to use a variety of means to get to all the at-risk populations. We have it up on our website. It's just been launched, and—

Ms. Megan Leslie: It sounds great that you're targeting. Are you also, then, somehow collecting information about what groups are accessing it?

Ms. Meena Ballantyne: We'll be using all our networks in place to monitor how this is being used and any problems that are being encountered, getting feedback from them. We have a variety of channels. We work through the public health network and the chief medical officers of health. We have a federal-provincial-territorial group as well on nutrition.

So we have a whole bunch of networks that we use to make sure people are getting the information. If any concerns are being raised, they should be raised in these fora. Then, we invite people to send us comments as well.

Ms. Megan Leslie: Thank you.

This could be a very simple no or yes. Are any of you able to answer questions about the meat hygiene manual procedures, or is that totally CFIA?

Ms. Meena Ballantyne: It's mostly CFIA, but it is directed by our listeria policy.

Perhaps Dr. Farber can at least provide the link from our policy to the meat hygiene manual.

Ms. Megan Leslie: And any updates to it that you can speak to.

Dr. Jeff Farber: I have not been directly involved in the meat hygiene manual. But definitely, as Ms. Ballantyne mentioned, there are directions in our listeria policy that are being thought of for use in the meat hygiene manual.

There are also a number of other policies that will be coming up. For example, we have one out now on E. coli, and that's a very important part in terms of E. coli contamination of raw meat. Some of the thoughts that we have in those two policies will be moving ahead and be implemented in the meat hygiene manual.

We will be working with CFIA, but I have not been directly involved.

Ms. Megan Leslie: Thanks.

I still have some time?

The Vice-Chair (Ms. Joyce Murray): A very quick question and answer.

Ms. Megan Leslie: Great.

Dr. Butler-Jones, you spoke about the modernization of FIORP. So what does that look like? What is the modernization of FIORP?

Dr. David Butler-Jones: Basically it takes the lessons of the last few years, since the previous agreement was in place, and brings more specificity. It outlines the roles of the different players and how we will act.

That protocol will then be tested again because it crosses over agriculture and health perspectives. That will be tested, and then we'll be looking at it again to see if there are any new modifications that are needed, basically to make the response as seamless and clear as possible. So if there was any confusion, hopefully there's much less now.

● (0940)

Ms. Megan Leslie: So it's primarily policies and processes versus staffing and....

Dr. David Butler-Jones: Protocols and...yes, it's really about how we do our business and who does what.

Ms. Megan Leslie: Thanks very much.

Thank you, Madam Chair.

The Vice-Chair (Ms. Joyce Murray): Okay. Thank you.

Dr. David Butler-Jones: And it is posted on the web.

The Vice-Chair (Ms. Joyce Murray): Mr. Uppal.

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

When do you expect the full implementation of the recommendations, and is the government on track for that?

Dr. David Butler-Jones: The commitment in response to the Weatherill report is that it's...2012?

Ms. Meena Ballantyne: September 2011.

Dr. David Butler-Jones: September 2011—right.

And yes, we're on track; short form.

Mr. Tim Uppal: I'm just trying to get to the basic question of whether Canadians will be better protected once the Weatherill recommendations are fully implemented. As you said, the government has a commitment to report back to Canadians in September of 2011 on the full impact of implementing the recommendations.

What assurances can you give that these recommendations, once implemented, will actually improve the food safety system?

Dr. David Butler-Jones: Well, many of the things have already been implemented. For example, the revised FIORP is in place as a response to one of her recommendations. There are a number of other recommendations that have already been in place, as well as the thinking around it. While it's sometimes getting the protocols right, etc., it's if the thinking and the approaches have changed sufficiently that we know it's a better system.

One of the things we have to recognize, though, is even with the best food safety system in terms of what we do federally, what the provinces do, etc., the vast majority of food poisonings in Canada still occur in the home through cross-contamination. You make a salad when you've got a sore finger; it sits out; and then you have staphylococcal food poisoning, or whatever.

So good food practices at home are an equally important part of that whole chain. The more we can do that people understand.... Keep cold foods cold, hot foods hot, don't cross-contaminate between the chicken and your salad or potato salad. All of those things can make a tremendous difference. Even the washing of hands can, and we've seen that since H1N1. The washing of hands and avoiding people when they're sick has really improved our food safety as well.

Ms. Meena Ballantyne: Thank you.

I'd just like to say that the implementation of the Weatherill recommendations will certainly strengthen the food safety system. As you've heard from the listeria policy, industry is working with government, and we're putting measures into place that will most definitely strengthen the food safety system. But as Dr. Butler-Jones says, we can never reduce a risk to zero. You can never know which pathogen or which chemical contaminant may come at us next time.

There is no doubt that we've learned a lot from the tragedy in 2008, and we've put systems in place to ensure that we can mitigate the risk to the extent available.

But we know that science and information change all the time. We've just got to keep up to date with it, which is what we're trying to do. The Weatherill report has certainly added to strengthening the food safety system in Canada.

Mr. Tim Uppal: Dr. Farber.

Dr. Jeff Farber: Thank you very much.

Just to add to what Ms. Ballantyne said, as I mentioned before, we've already seen changes in the meat industry. For example, there are companies that are using ultra-high pressure to inactivate listeria. There are other companies that are using inhibitors to actually inhibit the growth so it never gets to a level that can cause disease. These changes already have made a significant impact, and we will continue to work.

As was mentioned before, you really have to look at the whole farm, what we call the farm-to-fork system. We've been working, for example, with CFIA and Agriculture on on-farm food safety programs. We work at the processing level to work, for example, systems such as hazard analysis critical control point systems to improve those. Then, on the consumer end, we're also working to improve that. All in all, I think we've definitely made excellent progress on this.

Thank you.

Mr. Tim Uppal: It's interesting you were mentioning that there's a lot being done through this implementation and that work's already been completed. You mentioned that you can't eliminate the risks altogether. A lot of this has to do with what people do at home, their cooking practices, and their understanding of what to do and what not to do.

As Canada is obviously a very multicultural place, a multilingual place, this information is good. As you said, it needs to be distributed in many different formats, and that's good. Is it being produced in different languages? Or who's responsible for that?

● (0945)

Ms. Meena Ballantyne: We haven't yet given any thought to producing it in different languages, but we can certainly take that into consideration, because you're absolutely right. We had *Canada's Food Guide* translated into 10 different languages that are prominent here. We can certainly take that into consideration.

Dr. David Butler-Jones: In addition to that, when you think of it as a system, local public health often does that and then we facilitate the sharing of translation so that others can make use of that. Toronto has made very extensive efforts at translating key documents for the public, etc. I think one of our things is to try to make sure that we don't have to do that over and over again. So people who do have access...because, again, linguistic access is key.

Mr. Tim Uppal: You're right; I think it's not a matter of just the government doing it. As long as it's getting down to the people, whoever at the local level is doing it, as long as it is being done—that's what's important.

Several of Weatherill's recommendations dealt with the need to modernize and exercise the food-borne illness outbreak response protocol, or FIORP. What is FIORP used for, and what are the government's priorities related to it?

Dr. David Butler-Jones: The FIORP, clearly, is to make clear the relationships and the actions that are taking place, and who does what and how we do it, and to make sure there's a clear and easy flow of communications, etc. It's now been approved at the deputy minister level, both on the agriculture and on the health side. It is now in place, in effect. It's posted on the website, etc., and that will guide our work.

We will then be testing it in terms of different scenarios as well as in real-life situations. We have a commitment to make it "ever-green"—that is the jargon—to make sure that any learnings from future events or from the tabletops, etc., that we do can then be incorporated into it.

Basically, it formalizes the learning from every event, and that learning gets applied, hopefully consistently. This will assist us in ensuring that there is consistent application, across the country, of the underlying principles.

Mr. Tim Uppal: Do I have more time?

The Vice-Chair (Ms. Joyce Murray): No, you're done.

Dr. Bennett.

Hon. Carolyn Bennett (St. Paul's, Lib.): Thanks.

This is a follow-up on Mr. Uppal's question on translation. Certainly during H1N1 a lot of the smaller public health units were very concerned that even handwashing documents would have to be translated and then retranslated back, because translators are not public health officials, and therefore sometimes the message could be like bad karaoke: when you bring it back, it isn't what you meant.

It's expensive to have it translated and retranslated. Is there a reason that the Public Health Agency of Canada or Health Canada doesn't produce this in a number of languages that then could be shared with public health?

Coming from Toronto, it seems a bit not fair that this is all done on the backs of Toronto Public Health. Outside Toronto, say, where there's a small Portuguese community, why don't we just do it for them? Wouldn't that be leadership?

Dr. David Butler-Jones: I'll tell you why. Having been a local medical officer who does those translations, or has those translations done, we were constantly having to retranslate the stuff that came from the federal government or from the province because—

Hon. Carolyn Bennett: But now you're in charge, David.

Dr. David Butler-Jones: No, but we would.... It's not from a scientific standpoint. It's because the local community would say, "But that's not how we speak the language." We'd use the local community to translate it in a form that is the way they speak.

Again, French communities in Kapuskasing use the language a little bit differently, perhaps, from French communities in Penetang. At least that's what they told us. So it is important to be able to adapt it locally.

Hon. Carolyn Bennett: Okay.

Recently Dr. King's report on H1N1 was sort of saying that Panorama is necessary and that we have to get on with it. What is the status of Panorama; when can we expect it; and what are the obstacles to having it now?

● (0950)

Dr. David Butler-Jones: Again, Panorama is something used primarily by provinces and territories. It's a case management tool, but it also has surveillance components so we can access the data.

Hon. Carolyn Bennett: Do you have information-sharing agreements with each of the provinces and territories now?

Dr. David Butler-Jones: We have an information-sharing agreement with all provinces and territories, related to information sharing and public health emergencies. We have one specifically with Ontario. We were using that as a model for other jurisdictions. Other jurisdictions have different considerations, so we're doing bilateral relation stuff, but we're getting the information we need, which is the bottom line. We are working on having formal agreements, as the AG requested, to ensure that we have formal agreements. It has not stopped us in any way from getting the information we need.

In terms of Panorama, some of the resources are actually going to pilot and implement Panorama around food-borne outbreaks, so we'll see how that works. We're doing that with the provinces and territories.

Hon. Carolyn Bennett: Regarding concerns around communication, as you know, people think that once something hits the food system—BSE is an agricultural problem if it's not in the food chain yet—it's a public health issue. In your FIORP, or in whatever, in a future listeriosis outbreak, would it be very clear that the Chief Public Health Officer of Canada had the lead and we wouldn't be having press conferences run by the agriculture minister for something that's clearly a public health issue?

Dr. David Butler-Jones: It's clear in the FIORP that once it's a human health issue, it's public health. If it's confined to a local jurisdiction, then they'll be responsible for that, and we will provide support if they need it. If it crosses jurisdictions or is international in scope, then the agency will be the lead.

In terms of press conferences, unfortunately when listeria started, I was in my other headquarters, in Manitoba, where I was based, and so I was on the phone all day long every day but not at the press conferences held in Ottawa. That's why I wasn't there in the first days. I was there a couple of days later, once I got to Ottawa, but unfortunately they were no longer being broadcast live. While I was at all the press conferences subsequently, they just weren't broadcast live so there was an illusion that I was not involved, but I was behind the scenes constantly, and I was speaking out publicly.

Hon. Carolyn Bennett: I think the issue—

The Vice-Chair (Ms. Joyce Murray): Your time is up.

Hon. Carolyn Bennett: — is that it should be the press conference of the Chief Public Health Officer and not the Minister of Agriculture.

Dr. David Butler-Jones: Well, I think there are political—

The Vice-Chair (Ms. Joyce Murray): Excuse me.

Thank you. It's now Ms. Davidson's turn.

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

Thanks very much to our presenters for being here. You're becoming very familiar faces around this table.

I see in the document that was handed out, “Progress on Food Safety As of March 31, 2010”, that the government is going through the response. They certainly are moving forward on the recommendations. From what we've heard this morning, there has been a great deal of progress made. It also says that the recommendations and the way forward are being put into three different categories: reducing food safety risks, enhancing surveillance, and improving emergency response.

As I glance through this and I see the different categories, I wonder if you could outline for us this morning how you're moving forward on those three categories and how you may be cooperating with Agriculture, which I think has been expressed as a bit of a red herring but a bit of a problem, too, because the issue does fall under two different departments. I think there is cooperation and collaboration, but maybe you could just point out the different ways you're doing that.

Dr. David Butler-Jones: It happens at multiple levels. Part of it is the clarity around the pieces. In general terms, as it relates to the human health impacts of food, it's Health Canada, in terms of the guidelines, standards, etc., working very closely. CFIA manages the farm to the store, or the distributor kind of thing. For us it's the overall engagement around prevention, but also, when there are outbreaks or human health concerns, making sure there's a public health perspective to that.

What supports that are a number of committees at different levels, as well as day-to-day ongoing collaboration and consultation, discussion, to make sure we are taking into concern—so CFIA and agriculture—human health issues and are considering how the system works, so that we have an understanding of it and so that it moves as seamlessly as possible. So clarity in roles has been very helpful and is very important.

As I mentioned, there is a deputy ministers committee that meets regularly that I'm part of. It looks at the overall work plan to ensure we're making progress on each of the items. There are also ADM and DG committees that support that work, and then those who are actually doing the work themselves. So we meet regularly to go over where we are, what we have accomplished, what we still need to do, what other issues we're facing, etc.

It's a huge collaboration, but I must say it's very effective and useful. Generally, having been in public health now for too many decades, it really is gratifying to see the level of collaboration across departments federally, but also with other jurisdictions in terms of the desire, the willingness, the interest, and the capacity to work together to solve these problems. None of us owns them alone, and all of us are necessary to create the solutions.

I've never seen anything as good as this. There's still a lot we can learn, but I'm quite gratified.

● (0955)

Mrs. Patricia Davidson: Is there anything you want to add on the different categories—for example, improving emergency response and how that is being coordinated?

Ms. Meena Ballantyne: On improving emergency response, we have the FIORP in place, which we've discussed at the various levels, so we're all made aware as soon as there is an emergency. The communication protocols are in place and people know who's responsible for what, so you're not wasting time in an emergency trying to figure that out.

As Dr. Butler-Jones said, we have committees at various levels. We go through all of these recommendations to make sure we are able to respond. To me, the governance part is the most important part of improving the emergency response—just knowing who's responsible for what, who you are going to call, and what information we're seeking.

For example, in the listeria tragedy that happened, now we know what information the lab needs and what the timelines are, so we can make sure the request is clear and the information we need to make the health-risk assessment is clearly identified, clearly provided to us. The protocols are in place as to where you send it, what information you send, and what is the expected timeline for a response from the Health Canada labs. All those protocols are now in place to make sure we can respond very quickly to an emergency.

Mrs. Patricia Davidson: Does the general—

The Vice-Chair (Ms. Joyce Murray): Thank you. That's the end of the time.

Mr. Malo.

[*Translation*]

Mr. Luc Malo (Verchères—Les Patriotes, BQ): Thank you, Mr. Chair. Good morning and thanks to the witnesses for being here.

Ms. Ballantyne, after your presentation, three questions occur to me. I am going to ask you those three questions and anyone who wants to can reply.

You mentioned a policy on listeria monocytogenes. We are well aware that there are a number of bacteria and we really do not know which one will cause the next outbreak. Does this policy just apply to listeria monocytogenes? Can we move away from listeria monocytogenes and apply it to various kinds of bacteria that might cause a similar problem to the one that occurred in 2008?

You also said that, using the process that you are putting in place, we will be able to find replacement oils that can reduce the amount of trans fat, which we know to be harmful. That is what you are saying. My question is simply this: with the work you are doing and the process that you are currently putting into place, will we really find a definitive solution to the problem of trans fat in food?

Now for my third question. You say that Health Canada is also working to improve its operational methods to support Canadian Food Inspection Agency investigations. We know that, in report after report, the Auditor General has pointed to ongoing problems with information management and internal communications in that agency. Given those problems raised by the Auditor General, I just wonder how you have been able to establish links to ensure that communication between Health Canada and the Canadian Food Inspection Agency is really effective.

● (1000)

Ms. Meena Ballantyne: Thank you for the questions.

I would like to start by answering the last question, if I may. Then, I will ask Dr. Farber and Dr. Godefroy to answer the first two.

[*English*]

For the third question, concerning processes with CFIA, we work very closely, as I said, with CFIA—extremely closely, at a variety of levels. Dr. Farber and his team are in virtually daily contact with CFIA; I'm in weekly contact with CFIA, at the very least; and we have these meetings every two weeks at which the ADMs and DGs get together to go through whatever the issues are and walk through each of the recommendations and the progress and discuss how we're advancing these issues at the health tables and at the CFIA tables.

[*Translation*]

Mr. Luc Malo: One way you do it is through senior management, but my concern is with the operations. I am sure that the senior managers talk to each other.

Ms. Meena Ballantyne: Of course.

I would like to ask Dr. Godefroy to reply.

Dr. Samuel Godefroy: Thank you for the question. Since the Canadian Food Inspection Agency was established, in fact, protocols have been put in place to clarify the roles and responsibilities of each and to make sure that we work together under very precise conditions. Of course, we saw the tragedy as an opportunity to review all the protocols and to strengthen the communication protocols.

We have 24-hour coverage, seven days a week. Our technical experts follow up on the investigations of potential food incidents. Each of those experts knows who to call and where to call every day, including weekends, for example.

The goal of the protocols we have established is to increase our response capability in peacetime, if I may use that expression. Maybe there are no incidents, but we are managing potential incidents every day. We also want to strengthen our ability to respond to a food emergency, or the beginning of one. The FIORP in particular is a very precise document that clarifies the roles and responsibilities not only between Health Canada and the Canadian Food Inspection Agency, but also with the Public Health Agency of Canada.

So we definitely follow very strict protocols and operational procedures that go beyond individuals. The objective is for operations and procedures to be transferable from person to person.

[*English*]

The Vice-Chair (Ms. Joyce Murray): Thank you, Mr. Godefroy.

It's now Ms. McLeod's turn.

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

I'm going to take a slightly different tack to this. I know the absolutely critical importance of having a safe and secure food system. And we've certainly seen the tragedy of the listeriosis crisis. I also know that sometimes in our efforts to secure safe food systems, consequences come down the pipe that perhaps are unintended. I'll take a local example: community outrage, not related to what we're doing federally, but in terms of not being able to have bake sales at flea markets or not being able to take a birthday dinner of a culturally appropriate food into a seniors' home. These certainly hit the newspapers in terms of issues that are outcomes from our desire to protect the health and safety of our citizens.

As we implement these recommendations, do you see anything that is going to filter down to people at the table, and should we be anticipating any kinds of impacts?

● (1005)

Dr. David Butler-Jones: What you're describing is what will always be a certain amount of local variability in terms of the application of principles.

Having been a local medical officer, taking over a health unit where steelworkers who had no sick-leave plan would be put off work until they were clear of giardia, even though it was no threat to anybody in a steel workplace...but again, interpreting the rules very strictly. As another example, people were not allowed to have cream in a mug; it had to be in the little packets, even in a four-star diner. So that is local application and interpretation.

The way we need to address this is through education as much as possible, whether through the Public Health Association and its work or through the inspectors and sharing information so there is more consistent application of the principles, so it can be respectful of some of these things. There are just so many examples. I remember schools wanting to have muffin programs, and you had to have three sinks and you had to have this and you had to have that. Well, that's silly. So we worked out, with the inspectors, the school boards, and the communities, some simple ways to make that food safe, without getting stuck in the same rules that apply to major restaurants and vendors.

One of the challenges is making sure that people have an understanding not only of the rules and what we're trying to do but also the principles and approaches, and how you can accommodate that. That's like when you see laws being interpreted by one policeman a little bit differently from another. And that's why there are rights of appeal, and all these kinds of things.

We hope to see more and more education, more and more engagement in these issues, and more and more understanding. The decisions that are made locally will be more consistent because they will have a more consistent understanding of the principles, the objectives, the processes, and what really is a big risk versus a small risk. The whole HACCP approach, which is really looking at risk-based things, has facilitated that much more than let's say 20 years ago when people were often focusing on the wrong things. There was a regulation for the height of a railing. It was a quarter of an inch short. And they weren't focusing on the fact that they were leaving food sitting out too long. So it really is something that requires both education and engagement.

Just to pick up on Monsieur Malo's point very quickly, we are looking at all forms of food poisoning.

[*Translation*]

We are looking at all viruses, bacteria and parasites.

[*English*]

Mrs. Cathy McLeod: We have 17 recommendations from Weatherill, which you've put into three categories, and you've indicated you're making good progress. Which one is your biggest challenge to move forward on? Of course, you still have some time to get there, but....

Dr. David Butler-Jones: The biggest challenge—it always will be, as Dr. Bennett was referring to—is that in every jurisdiction their laws, their privacy issues, are a bit different. It takes a lot of work to get the formal agreements. It doesn't stop us from doing the necessary work, but getting formal agreements in place is difficult.

That being said, the FIORP revisions were remarkably well done quickly across multiple departments and multiple jurisdictions. One of the things I thought was going to be much more difficult turned out to be a great success because of all those involved.

Some of the more formal agreements will continue to take some time to get in place, but they're not related only to this issue.

Ms. Meena Ballantyne: I would say that—

The Vice-Chair (Ms. Joyce Murray): Thank you. That's it for the time.

Dr. Bennett.

Hon. Carolyn Bennett: Go ahead, Meena.

Ms. Meena Ballantyne: Thank you.

I would say that all of these recommendations—there are 57 of them—present their own challenges in terms of how you move it forward, because you are coordinating across jurisdictions and across the industry sector, governments, and consumers. As we've learned, protecting health and safety is a shared responsibility and all of us have to do our part. We were talking about the local communities, and consumers have to do their part in terms of making informed choices. Industry has to do its part in terms of making sure that the products are safe to begin with, and utilize all the processes that are necessary. Government also has to do its part, through the regulations, but through the standards-setting and policies and procedures that we have.

My view would be that we're making great progress on these recommendations. We're aiming to implement them all by September 2011. But as we continue, some of them are going to take longer to implement and to make sure that we get these principles entrenched in ourselves: it's only now that we're learning that we shouldn't leave cut fruit or cut tomatoes out for longer than two hours, for example.

Food safety has become an increasing part of our psyche and we are, as a population, absorbing the things that we can do as Canadians. All those things take time to permeate.

● (1010)

Hon. Carolyn Bennett: I guess what we had hoped and thought is that, of the 57 recommendations, there would be ability to give an update—i.e., completed, almost there, or nowhere there. Between yourselves and CFIA, could you send us a proper briefing as to where you think you are on each of the recommendations? As parliamentarians, if it's a resource issue, if there's something we then can advocate for you, to get it done more quickly or to make sure that you'll complete it by the time that was there, that would be very helpful.

Also, on FIORP, you said it would be tested. Is that a formal tabletop exercise with all the players?

Dr. David Butler-Jones: Yes.

Hon. Carolyn Bennett: This is about the confidence the public has that there have been some lessons learned, so would that tabletop exercise be made public? Could you let people know that it's being tested?

I think practising these things and letting the public in might be very interesting and might raise the confidence of Canadians that these kinds of things are worked through.

Dr. David Butler-Jones: Certainly most people find it kind of boring if they're not involved. But if, for example, someone from the committee would like to be an observer to see how it works, I would have no issue with that.

Dr. Raizenne.

Dr. Mark Raizenne (Director General, Centre for Food-borne, Environmental and Zoonotic Infectious Diseases (CFEZID), Public Health Agency of Canada): Thank you very much.

In doing the consultation on the revisions of the FIORP, it was very clear that, as was mentioned, every province deals with food-borne outbreaks in various ways. In some cases, it's the chief medical officer of health who actually manages everything; and in other places, it's managed very much on the agriculture side and on the health side in separate ways.

It was clearly identified that what we wanted to do with the FIORP was bilaterals. We'd actually do it province by province.

We've already done Ontario. We've had a very good first pass with Ontario.

We actually also did a tabletop exercise with all of the epidemiologists and laboratory leaders in Winnipeg, in May, to see how it would resonate as a collective. The plan is, in the fall, to systematically go to each province, where the province would like us to look at their provincial FIORP process, and then bring everybody together at one point.

Hon. Carolyn Bennett: Okay. I think it's to bring everybody together, because this clearly was a pan-Canadian outbreak. It was such a large plant that went across the country very quickly, which I think is the concern.

Can you let us know when the pan-Canadian tabletop will take place?

Dr. Mark Raizenne: Yes, we will.

Hon. Carolyn Bennett: Okay.

Again, I just want to go back to Panorama. When will it be there; how quickly?

Dr. David Butler-Jones: It's close. Infoway had a process; IBM is the contractor. B.C. was the lead province, working with the other provinces. We're very much involved. We're looking at what is the best way to move it forward at this point, as B.C. moves away from that, and we're doing some work now with the provinces and territories to do it with this, with food-borne.

● (1015)

The Vice-Chair (Ms. Joyce Murray): Thank you very much.

Just as a point of clarification, Dr. Bennett asked for a report of the progress on each of the 57 recommendations, which had been completed and the timeframes for the others. I saw a lot of nods, but I just would like to clarify who's taking responsibility for that request and when it will be available to the committee.

Hon. Carolyn Bennett: There's also a question on the order paper.

Dr. David Butler-Jones: We can certainly take responsibility for our part, and we can relay the request to others.

The Vice-Chair (Ms. Joyce Murray): When can the committee expect that update?

Dr. David Butler-Jones: In practical terms, what, a week to 10 days...?

Dr. Mark Raizenne: Certainly by the end of the month.

Dr. David Butler-Jones: By the end of the month.

The Vice-Chair (Ms. Joyce Murray): Thank you very much.

Dr. Carrie.

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

Again, I want to thank you all for being here.

I must say, today, after listening to you, I'm very impressed with the action you're taking with the investments the government has made to implement these recommendations. I'm also impressed with how you've improved the communications and working collaboratively. I think all of us here understand from the lessons we've learned how difficult it is with the communications locally, provincially, federally, with industry and with the public, and how difficult it can be sometimes to respect all these different jurisdictional challenges in Canada.

I was wondering if you could take us through the process now with what you've learned.

Dr. Butler-Jones, you made an interesting comment at the beginning. I think you said that over 20,000 Canadians per day can have symptoms of something such as listeriosis, or whatever will come around in the future. If you look at listeria in general, it's very common. Much of this is handled at the local level.

I was wondering if you could walk us through just a little bit of the process of what you've learned and what we've seen in improvements in terms of how to take something that's locally at a doctor's office to, here we go, now we have to take a look at this as a bigger-picture type of spectrum.

Dr. David Butler-Jones: Surveillance is going on all the time in the sense that if someone is ill, they go to the hospital or the doctor's office. They may or may not be tested. If they are tested, then that will eventually end up in the lab. If it's one of the organisms we're interested in, then local public health will get a report. If they identify that it's more than just a one-off, all of them will be inspected in the sense of is this a family issue, is it a bigger issue? If you have 30 cases of the same bug, then you get concerned.

Sometimes it's even far less than that. For example, we had half a dozen cases of cryptosporidium, which prompted the boil-water advisory in North Battleford, because where else could it have come from? Then rumours of other people.... Part of it, at the end of the day, is that whether you need a food recall or not, there are also public health interventions in terms of advice, etc., in the beginning.

So we get these samples. In the case of listeria, listeria is ubiquitous in the environment. Most of us don't ever get sick from it, even if we're eating it on our lettuce or whatever. But for vulnerable people, it can be a very nasty disease, as we saw a couple of summers ago. In that case, what happened is that we got lab samples. Ontario recognized that they had a couple more cases than they would expect. We were able through the PulseNet system to identify that we had one strain of this particular bacteria, which meant that it had a common source. We didn't know at the time what the common source was, but it forced us to go looking, and with CFIA to go looking. At the same time, there was a nursing home outbreak with a couple of cases—not dozens, but a couple of cases—that had the same pattern. By tracing what they'd been eating, etc., we were able in fairly short order to identify that it had come from that particular Maple Leaf plant, and to make the connection.

While at the end of the day we had lots of people being ill, and deaths, at the time that we recognized it we'd actually had only a handful of cases, but the recognition was that they were common and they had a common source, so we needed to pursue that. Again, because listeria has such a long incubation period, it meant that even though we had identified it, at that point these were people who actually had eaten it many weeks before so there would be more people. But once you recognize it, you can reduce the risk of anybody else eating it, and as a result reduce ultimately the number of people affected and reduce the number of deaths.

● (1020)

Mr. Colin Carrie: Excellent.

So what are we seeing now with the improvements in communication and collaboration amongst the different levels, local, provincial, and federal? What are you seeing being put into place, and what do you foresee in the not-too-distant future?

Dr. David Butler-Jones: In practical terms, I think it will allow us to get the communications more quickly, the recognition of the problem more quickly, and the engagement of other parts of the system more quickly, so that the decisions come more quickly about what else needs to be done.

As well, the improvements in testing, etc., will mean a shorter time between having a potential issue and recognizing it as a real issue. That's really important, because with a lot of these things it's not like on *CSI*; you don't have half an hour and it all comes together. It is over days and sometimes weeks.

The point is that the shorter we can make that period...but at the same time, we don't always wait, and it's important to not just wait. So there is the regulatory process and the recall issues, etc., but there's also the public health process, so that if we have a suspicion, we actually speak to that and remind people of the importance of good food practice—because with many of these things, if you cook it properly, you've eliminated the problem.

The Vice-Chair (Ms. Joyce Murray): Thank you.

Ms. Leslie.

Ms. Megan Leslie: Thank you, Madam Chair.

Mr. Farber, when you were telling me about the listeriosis policy, I'm not sure if I heard you talk about adding chemicals to food, or to the food production line. Is it specifically to food?

Dr. Jeff Farber: Yes, it's actually specifically to the food.

Ms. Megan Leslie: Okay.

Is there food that you can't add chemicals to? Obviously, prepared meats are....

Dr. Jeff Farber: There are foods you wouldn't necessarily want to add to. As Dr. Butler-Jones was mentioning about a risk-based system, you want to focus on those foods that have previously been involved in listeria outbreaks. For example, deli meats are obviously high-risk. You would want to add something like sodium diacetate to them to inhibit...but there are other foods that you cannot add to, because of their flavour characteristics. There are other foods, for example, that we know have never caused listeria outbreaks before.

Ms. Megan Leslie: Is there a correlation there? For example, the foods that you can add chemicals to tend to be the foods that have had the outbreaks and therefore are high-risk, versus foods you can't add chemicals to.

Dr. Jeff Farber: No, there is no correlation. The main thing with listeria, just so you understand, from all the risk assessments that have been done is that you really need to have fairly good growth of the organism to reach levels that actually cause disease. For example, let's say a listeria cell fell on a raspberry. Because the conditions within the raspberry are very acidic, you would not actually get any growth of the organism and you would probably get inactivation of the organism. It would be destroyed on that raspberry. So it really depends on the food and it's ability to support good growth.

So for the most part, we are talking about refrigerated foods, because listeria is an organism that we refer to as a psychrotrophic organism, meaning that it can actually grow at temperatures as low as four degrees Celsius in your fridge. Just to give you some context, if you take something like salmonella, which everyone knows about, it can't grow at four degrees Celsius. So the strategies you have to put in place are very different from one organism to another.

Ms. Megan Leslie: I'm clearly belying my ignorance about these issues.

So what do you do with food that can't be chemically treated and that is also high-risk?

Dr. Jeff Farber: There are a number of other options, and we always like to say that we provide an outcome-based approach. Obviously, industry has the main responsibility for producing safe food. We set the standards. We say, for example, that we want them to produce food that has listeria absent in a certain amount of product. It is up to them to use processes within their plant to do that. For example, they could use a heat process and they could use pressure to inactivate the organism. There is a variety of means at their disposal to inactivate the organism and/or prevent its growth.

Ms. Megan Leslie: To go back to what you were saying about seeing the patterns of outbreaks and understanding them and reacting to them with a bird's-eye view of the macro situation, can you help me understand what that looks like? Is it pre-sale of the product or pre-consumption of product? What are you tracking? It's probably all.

● (1025)

Dr. Jeff Farber: Yes, it's all, but the one I was specifically referring to was trend analysis. So, for example, you have to know what the baseline in your plant is.

Ms. Megan Leslie: Right.

Dr. Jeff Farber: You track an organism; then you may see a blip one day, whereby it's going up. You know at that point that you have to really focus. What is actually going on? You get your whole HACCP team in the plant to take a very aggressive look. Is this an issue? There are plants we've spoken to recently that have meetings every day to discuss lab results. They go in and do a root cause analysis and make a great effort to get rid of what I was referring to before as those niches in which listeria can be found, to get rid of those biofilms or niches.

Ms. Megan Leslie: Thank you.

Ms. Ballantyne, you spoke about fast-tracking approvals of food additives that have food safety benefits. My understanding is that there was a backlog of these approvals, so it's great to hear that the fast-tracking could be happening.

Has the backlog at Health Canada been ameliorated?

Ms. Meena Ballantyne: Yes, it has been.

The Vice-Chair (Ms. Joyce Murray): Excuse me, it will have to be a very quick answer. Time's just about out.

Ms. Meena Ballantyne: The backlog has been reduced, and we prioritize based on public health benefits. What we have to do first is a safety assessment, and then we have to put it through the regulatory process, because each food additive has to have an amendment to the food and drugs regulations. That process takes quite a long time. But the backlog has been reduced.

The Vice-Chair (Ms. Joyce Murray): Thank you.

Mr. Brown.

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

Looking at some of the positives, I understand that Canada is one of the best-performing countries in the 2010 food safety performance world ranking study. Its overall grade was superior, earning it a place among the top-tier countries according to the OECD food safety performance world rankings. That's certainly encouraging to hear.

I understand that 538 new inspectors have been hired since 2006, which I think highlights that things are heading in the right direction.

I understand there's a new initiative with regard to traceability. I'm not sure whether anyone can comment on this, but I understand that next year there's an investment of $20 million as part of the livestock auction traceability initiative. Do you have any information you can share with us on that?

Ms. Meena Ballantyne: That was the issue we were talking about earlier, which is really within the agriculture portfolio. It would be better for us to get the answers from CFIA and Agriculture, to give you accurate and more precise information.

Dr. David Butler-Jones: The point is that it is an area of emphasis and work, and something that they're working towards. The investment, I think, will certainly assist that.

Mr. Patrick Brown: That's certainly one of the reasons the agriculture committee took an interest in this. It intertwines a lot more with that committee, but it's great to have the Public Health Agency's opinions on this.

To see the OECD speak so glowingly about Canada on food safety is something I'm certainly proud of from a health perspective.

I know that my colleague Cathy McLeod has a comment to make as well.

Mrs. Cathy McLeod: It's a question.

I quickly went through the brochure, and as I went through it I was noticing, for example, that you talked about safe meats as being pepperonis or whatever rather than deli turkey. I think we all believe that deli turkey is a much healthier choice than pepperoni, so how are we putting a lens to the thinking around what we're recommending?

Dr. David Butler-Jones: I'll get started from a public health standpoint and then leave it.

One thing that OECD and others.... Some 90% of Canadians have confidence in the food safety system in Canada. But it's interesting that a little less than half of them think you can tell food is bad by looking at it. Unless it's really rotten, you just can't. It's growing things in the fridge. So we still have a lot of work to do locally as well in education, understanding, and application.

In terms of how we're doing, everything is about relative risk. If you drink too much water, you die; if you don't drink enough water, you die. It is about the balance. Clearly turkey, leaner cuts, etc., from a general health standpoint are safer. But if you happen to be someone who's immunocompromised, then you want to make sure it's cooked, because of the risk. It is always about balancing risk. Not everybody is going to have a problem with listeria; in fact, the vast majority of us won't. All of us are potentially susceptible to salmonella, so cook your chicken. If you have hamburger meat, most of us are susceptible to E. coli 0157 or other toxigenic E. coli, so cook your hamburger all the way through. Those are very practical things.

But for a lot of us, our tolerance, our immune systems, are quite adequate to deal with deli meats. I wouldn't want everybody switching from turkey to pepperoni, just from the obesogenic aspects of it, if nothing else.

I'll turn it back over.

● (1030)

Dr. Jeff Farber: It's a very good question and point that you brought up. We have already had a number of these discussions, for example, with the Council of Chief Medical Officers of Health group that I'm working on concerning listeria education.

Just to give you the one example of old age homes, for these elderly individuals, a lot of these meats are a very good source of protein and are very easy to chew. We had a lot of discussions on this. Do we really want to tell them to avoid these?

It comes back to Dr. Butler-Jones' benefit risk. For example, if you really know, there are things you can do by way of the sourcing and also the storing of the meat. If you're sourcing it from a very good supplier, are eating it right away, and know how it's been stored, you could look at the benefit risk and say, yes, this makes sense for this person: they really need their protein and they love this. These are discussions we're going to have once the base document is finished, and we'll be rolling it out to the provinces.

It's a very good question.

The Vice-Chair (Ms. Joyce Murray): Thank you.

That concludes our second round of five-minute questions and answers. We have time to go into another round.

I would like to begin with Dr. Bennett.

Hon. Carolyn Bennett: We've learned today that really, in terms of the continuum, it's pretty hard to look at just the health side without having the CFIA officials here. Just as an example, I understand there's a vaccine that has been found to be effective against E. coli 0157 for cows, but no one seems to want to do that. That's obviously a public health issue, but where does it get approved, or how does it become stopped? Who makes the decision whether we go forward or don't go forward, when there's a vaccine that could prevent something ending up in the food chain, which is actually a public health advantage, but that would delay the commercial availability of that cow for a while?

Our concern has always been that CFIA seems to have this mixed job: promoting the industry and regulating it. This seems to get us into trouble. I thought Health Canada gets to set the rules, and then CFIA gets to enforce them. Could you explain how a decision on an E. coli 0157 vaccine for cows would be taken by the government and why it's not happening?

Dr. Jeff Farber: Thank you very much for the question.

The two departments, CFIA and Health Canada, actually get involved. The vaccine you're talking about was produced by a Canadian company. What it does is reduce the shedding of E. coli in the feces. It is one tool that can be used in the overall arsenal to try to reduce the load of E. coli 0157 in the food supply.

From what I remember, some of the difficulty is in showing the public health benefit of this. For example, with the use of this vaccine, can you actually show that you've had a reduction in the number of cases of E. coli 0157 in the human population? That is quite difficult to do because of the complexities of the system.

I agree with you that it is a good tool, but it is just one of the tools. There are other things that have been used—for example, bacteria flushes—to inactivate cells of E. coli.

So it's a good tool and one that can be used, but its efficacy in reducing the burden on public health due to E. coli 0157 is very difficult to ascertain.

● (1035)

Hon. Carolyn Bennett: Maybe David will just explain that for human vaccines we have a pan-Canadian process whereby all the provinces and territories and the federal government decide on cost-effectiveness, or whether or not it's recommended. This isn't exactly being put into the arms or the whatever of humans. What would be the process for determining whether this is cost-effective or not? It doesn't seem to be an inclusive process; it seems to be almost a process that is behind closed doors.

Dr. David Butler-Jones: I'll just speak to it quickly, and then I'll turn it over to Sammy.

The research is still preliminary on it. It doesn't eliminate shedding; it just reduces it. So that shed is still there, and once it's on meat it can still grow. So it doesn't eliminate the problem, it just shifts it and maybe gives a false sense of security, which is a concern.

We have that same issue with human vaccines. If you actually give a vaccine and all it does is you have more asymptomatic cases that are still spreading the virus, that's not helpful. As Jeff was saying—

Hon. Carolyn Bennett: But I think, David, this was about getting into the water system, in terms of these industrial farms, more than actually being present on the food.

Dr. David Butler-Jones: But there are other means to...I mean, they're engineering them. Whether it's pig farms or cattle farms or whatever, sewage containment and control in terms of environmental protection is another issue. It may be useful, but again, the studies to this point are, for instance, is it sufficient to actually make a difference? Are there other things that are more efficient? Are bacteriophages more efficient?

Hon. Carolyn Bennett: But I think the question was, who decides? How is the decision made?

Dr. David Butler-Jones: Well, I think it's a multiple. We're involved, from the public health aspects.

I'll leave it to you now.

Dr. Samuel Godefroy: Yes.

The approval—

The Vice-Chair (Ms. Joyce Murray): Excuse me, Dr. Godefroy, but time is up. You can perhaps work that into another conversation.

Dr. Carrie, your turn.

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

I want to get back to one of the issues my colleague brought up about the food additives.

Dr. Farber, I think you brought up something a little bit earlier. I want to ask you this question, because I didn't quite understand what you were saying.

We have these different food additives, but you talked a little bit about different technologies that were out there as well. I hear a lot from different Canadians. Some people like food additives and some people don't like food additives, so I recognize the challenge that you're in sometimes. For something like listeria, Dr. Butler-Jones was saying that the average Canadian wouldn't get sick from that, so does that mean we put these food additives in everything across the scope? And when some Canadians do have that worry, it's something that's a bit of a balancing act.

You mentioned these pressure techniques in lysing bacteria and through different techniques like that. Could you expand on that? I didn't quite understand. You mentioned it earlier.

Dr. Jeff Farber: What some companies are doing at the end of the process—for example, with meats that are sliced and in bags—is actually put the meats into an ultra-high-pressure machine that generates very high pressures, at some 87,000 pounds per square inch, for three minutes. That high pressure will actually inactivate the cells of listeria monocytogenes and other bacteria as well that may be present on the meat. For example, when you plate out bacteria from the meat, you don't see any cells actually on the agar plate.

There are companies out there that are actually using it and you've probably seen or heard some of the commercials where they're actually promoting this technology on their products.

Mr. Colin Carrie: Well, that's where I'm leading with the question of different technologies. As Madam Ballantyne was saying, there was a backlog and we're getting through that.

How is that process going as far as expediting some of these new technologies? That was one of the recommendations.

● (1040)

Dr. Samuel Godefroy: Clearly those types of applications, particularly when they require Health Canada's oversight in terms of pre-approval before they get used, have been identified and are identified very early on in the process. Actually, at the pre-submission level, in discussions with industry in applying those recommendations, we would identify the potential public health benefit from the application, and it gets triaged into a high priority for the safety and efficacy assessment.

Now, depending on the type of the application, we may or may not require a regulatory amendment. In those modern technologies that Dr. Farber was mentioning—the ultra-high-pressure processes—they actually fit the definition of "novel processes". Actually in that case, we have a modern regulation: it's the novel foods regulations, encompassing novel processes. Those processes are immediately identified as a priority. They do not need a regulatory amendment but we need to ascertain the safety and efficacy assessment, and then they get treated as a priority. A number of those were approved previously and also most recently. We encourage submissions from industry to have those technologies first approved, and then potentially taken up by industry.

Mr. Colin Carrie: How would you say Canada is doing in the world with the uptake of these new technologies? Are we leading in that? Is Canada one of the few countries using these new technologies?

Dr. Jeff Farber: In the area you mentioned of the ultra-high pressure, we're definitely in the lead. One of the companies I mentioned just spent over $2 million to install a state-of-the-art plant using ultra-high pressure.

Mr. Colin Carrie: Just out of curiosity, does it affect the taste or anything like that?

Dr. Jeff Farber: No, it doesn't.

Mr. Colin Carrie: It's still pretty good.

Dr. Godefroy, you were cut off on your answer last time. I'd like to give you the opportunity to finish your thought.

Dr. Samuel Godefroy: It also goes back to the example that oversight for approval of those interventions is at the federal level, so in this case it's an animal health intervention. CFIA is responsible for the approval, in collaboration with Health Canada and particularly, in this case, with our veterinary drugs directorate. But then it's the uptake of that intervention by industry, and really looking at the cost benefit. What will the cost be to have this vaccine? Will it actually be a good measure to have this vaccine as a mandatory type of intervention? Those are not federal responsibilities. They are mostly business and industry decisions in the first place.

Mr. Colin Carrie: I am impressed. It seems that these new technologies are coming out, and what Dr. Farber was saying—

The Vice-Chair (Ms. Joyce Murray): Excuse me, Dr. Carrie, your time is up.

Mr. Malo.

[*Translation*]

Mr. Luc Malo: From Dr. Butler-Jones' answer earlier, I gather that the current policy can be applied to all bacteria that can occur in the food chain or the process. Perhaps Dr. Farber can give us more details about that.

Let me come back to the question I asked earlier. How can the current process lead to trans fat being eliminated from food?

You also mentioned allowing sodium acetate and sodium diacetate, especially in cooked and cured meats. Those items are already very high in sodium. I just wonder whether that addition is also going to raise the sodium content.

[*English*]

Dr. Jeff Farber: Thank you very much.

I'll address your question related to listeria policy. It's a very good question.

As I was mentioning before, listeria is a very unique organism. With respect to the policy we have in place, there are some things that would encompass the reduction of all bacteria—for example, the use of good manufacturing practices, especially the sanitation. Increased emphasis on sanitation would definitely reduce all bacteria, not specifically listeria. As well, the use of the hazard analysis critical control point approach would also be generalized for all bacteria in a plant.

One thing you need to realize in terms of this organism is that because it is so very widespread we can use environmental testing to track different species of listeria in a plant. If we had something like salmonella, where it's not as widespread, we'd have to use totally different techniques.

Another thing that's very specific is the type of foods. As we mentioned, it's those foods that have a long shelf life, that are refrigerated and can support the growth, that are an issue. That would be very specific for listeria. Spices, for example, would not even be an issue for listeria, so that's not included in the policy. But it would be an issue for an organism like salmonella, which we know has caused problems in spices.

What this really relates to is the infectious dose for humans. For listeria, we know you need quite a high number of cells in order to cause infection; whereas for an organism like salmonella or E. coli 0157, sometimes as little as one cell that's present in the food can cause disease.

Some of the other specific things we have in the policy are criteria for looking at the absence and presence of listeria. This would be very specific for listeria because it relates to the infectious dose I mentioned. To give you one example, for standards for salmonella in a ready-to-eat product like meat, we would never have different tolerance levels like we have for listeria, where we allow 100 cells per gram of food in certain foods. We would never do that with salmonella or E. coli 0157 because in contrast to listeria we know that very low levels of those organisms can actually cause disease.

The other specific things we mentioned—for example, the addition of inhibitors like sodium diacetate—would be very specific for the inhibition of listeria and they would not necessarily inhibit a lot of the other pathogens we talked about. To get even more specific on the distinction between viruses and parasites, they cannot even grow in a food—they just don't grow.

There are very specific things in the policy specific to listeria, but some of the general concepts in it could actually reduce the total counts you would find in a food.

● (1045)

[*Translation*]

Dr. David Butler-Jones: That policy applies to listeria. There are other policies for other organisms.

[*English*]

Dr. Jeff Farber: Yes. For example, we have a policy coming out soon on E. coli 0157 in ground beef because we know it's an issue, and listeria would never be an issue in ground beef.

Thank you.

The Vice-Chair (Ms. Joyce Murray): Thank you.

It's Ms. McLeod's turn.

[*Translation*]

Mr. Luc Malo: Anyway, Dr. Godefroy is going to come and see us again to discuss food safety. That is for sure. So I will get the answers to my questions.

[*English*]

Mrs. Cathy McLeod: Thank you, Madam Chair.

There were 57 recommendations, but the Public Health Agency of Canada is focused on 17? Is that right?

Dr. David Butler-Jones: That sounds like a good number.

Mrs. Cathy McLeod: Okay.

We know we have 538 new inspectors. We know there was $75 million provided. That is transitional support to change things, to create the new structures and processes.

Can you talk about how the $75 million is being utilized and how much went to the Public Health Agency? How is that all fitting together?

Dr. David Butler-Jones: I can talk to that. I will start, and then I'll pass it over.

The $17 million that came to the agency is a mix around improving our lab diagnostic and networking tools in terms of the work with provincial labs, etc. That actually covers a number of the recommendations and the modernization of the FIORP, which we now have in place and will be continuing to test. To actually create a food-borne illness emergency plan and command structure, again, that's something that is well along the way and we are pilot testing.

We're actually looking at a surge capacity model so that we can draw on retired public health people and others who have expertise that we can quickly call on to assist in any sort of public health event. There is also a risk communications plan much as we have for H1. Again, having one specifically for food-borne outbreaks, we can tailor it to both the risk groups but also the general messaging. Plus, as you saw in H1, in spite of André's article we did use Twitter. We did use all the media and all the mechanisms possible to engage with the public in both dialogue and to provide information, as well as Panorama, which Dr. Bennett had raised before as part of that work.

● (1050)

Ms. Meena Ballantyne: From Health Canada's perspective, we have seven recommendations where we're the lead, and we have $10.5 million over three years.

There are three areas that we put it towards. The first is the listeria policy that Dr. Farber is working on, as well as the additives and fast-tracking additives and reducing the backlog on additives and increasing the health risk assessment capacity. We have people trained to be able to work 24/7, and we're cross-training them as well, so it's not just listeria that they can provide a health-risk assessment on but E. coli, salmonella, and other pathogens as well. That's one area of responsibility.

The next one is improving our lab detection methods, as I talked about, doing the testing so that we can identify listeria in five to seven days versus ten days and working with the NRC to come up with a 48-hour testing for listeria. We are improving and validating some of these methods in order to detect listeria early on.

The third area is the risk communications, the pamphlets and the brochures that you saw, which is a three-year targeted communication strategy and social marketing campaign.

Mrs. Cathy McLeod: So when we look at their check mark with where we're going with the 57 recommendations, the money truly is transitional money. It's to get the organization structure from A to B, and once we're at B, we should have good structures in place to be in a better place. So we're not looking at needing significant ongoing support in terms of the recommendations. Has there been any costing at all in terms of what might be ongoing?

Dr. David Butler-Jones: We will deal with that. Again, it's part of the overall budgeting, allocation, planning, etc., in terms of once we get to that point, what if anything else is needed, or is it shifting?A lot of this is actually setting the stage for the right kind of work to be done. That's really key, and the resources have been very helpful in assisting us to do that.

Mrs. Cathy McLeod: Thank you.

The Vice-Chair (Ms. Joyce Murray): Dr. Bennett, this will be shorter than a five-minute section, because we need to wrap up.

Hon. Carolyn Bennett: For the vulnerable populations, there was a suggestion that if turkey breast was microwaved and heated up, you would reduce the risk or eliminate the risk. Is that advice you would give, in terms of nursing homes or the places that like the stuff but have been frightened off by this?

Dr. Jeff Farber: Thank you very much.

In general, the directions that we'd like to give is actually to cook the meat to steaming hot, because as we've seen in a number of situations microwave heating is very uneven, so you may have several cold spots in the food that would not reach the temperatures that you need to actually inactivate cells of listeria.

Dr. David Butler-Jones: Yes, you need to make sure that the food is truly heated through. In terms of even the prepared dinners and things, you look at them now and they're talking about ensuring that it's heated through if you're using a microwave or an oven. That is important.

For fans of fried bologna, that should work.

Voices: Oh, oh!

The Vice-Chair (Ms. Joyce Murray): Thank you very much for that advice for the next time I fry my bologna.

I would like to request, Dr. Butler-Jones, that you table a report with this committee, a progress update on this Panorama surveillance system. By when could we expect that?

Dr. David Butler-Jones: The FPT process, which is looking at that, setting down governance issues and all of that, is ongoing. We can certainly give you an update before the House rises, but it will be an update. There's still a great deal of discussion to go on.

● (1055)

The Vice-Chair (Ms. Joyce Murray): Thank you.

Thank you very much to all the witnesses for coming and enlightening us today.

The committee 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