HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

Standing Committee on Health

HESA • NUMBER 055 • 1st SESSION • 41st PARLIAMENT

EVIDENCE

Tuesday, October 2, 2012

Chair

Mrs. Joy Smith

Standing Committee on Health

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● (1100)

[*English*]

The Chair (Mrs. Joy Smith (Kildonan—St. Paul, CPC)): Welcome to committee today. It's great to have you all back here, and great to start on our pandemic vaccine lists dialogue that we're going to have over the next couple of weeks.

Today we have video conferences.

From Yellowknife we have Dr. André Corriveau. Welcome, Dr. Corriveau. We're glad to have you with us.

Dr. Corriveau, can you hear me?

Dr. André Corriveau (Provincial/Territorial Co-Chair, Public Health Network Council): Yes, I can hear you fine. Thank you.

The Chair: Wonderful.

We also have from the Government of Nova Scotia, Dr. Robert Strang.

Dr. Strang, welcome.

Can you hear me, Dr. Strang?

Dr. Robert Strang (Chief Medical Officer of Health, Department of Health and Wellness, Government of Nova Scotia): I certainly can. Thank you very much.

The Chair: We have Dr. Plummer.

How are you? You're back in Winnipeg.

Dr. Frank Plummer (Chief Science Officer, Scientific Director General, National Microbiology Laboratory, Public Health Agency of Canada): I am. It's good to be here again.

The Chair: Great. Thank you for joining us, Dr. Plummer.

In person we have Dr. John Spika from the Public Health Agency of Canada.

We will begin with you, Dr. Spika, for a 10-minute presentation.

Welcome, and thank you for joining us.

Dr. John Spika (Director General, Centre For Immunization and Respiratory Infectious Diseases, Public Health Agency of Canada): Good morning, everyone.

I am the director general of the Centre for Immunization and Respiratory Infectious Diseases at the Public Health Agency of Canada.

I played many roles during the time of the pandemic, as did the person who is accompanying me, Dr. Frank Plummer, who is the chief science adviser at the agency and also the director general of the National Microbiology Laboratory in Winnipeg.

We're here today to talk to you about the epidemiology of pandemic influenza and the role the agency plays in planning and preparing for a pandemic.

We will speak also about the way decisions were made about who was to be prioritized for vaccination and the moment and time that actually occurred. We'll talk at the end about some of the lessons we learned following the last pandemic and the go-forward in terms of our planning activities.

The federal government plays a leadership role in providing guidance to decision-makers to help inform response efforts. We work very closely with provinces and territories through the Pan-Canadian Public Health Network and the Council of Chief Medical Officers of Health. As has already been identified, Dr. Corriveau and Dr. Strang will be providing some information from their perspective as well.

I'll begin by explaining the importance of epidemiology in a pandemic.

People are exposed to different strains of influenza virus throughout their lives. The influenza viruses usually change, if only a little bit every year, and our immune systems adapt to these small changes, either as a result of vaccination or because we have what are generally mild infections. However, three to four times a century, the influenza virus undergoes a major change, causing a new strain to emerge for which humans may have no immunity. This is what leads to a pandemic, which generally causes a more severe disease than seasonal flu.

There were three influenza pandemics in the 20th century, one in 1918, one in 1957, and one in 1968. We've already had the first one in this century, in 2009. Each of these pandemics has differed markedly in severity, duration, and the populations most affected.

In 1918, for example, the Spanish flu was one of the deadliest, if not the deadliest, natural disasters in human history, in that it caused upwards of 50 million deaths. Some people have estimated that it may have actually caused 100 million deaths. Most of the victims were healthy young adults, in contrast to influenza outbreaks, which predominantly affect the young, the elderly, and persons with underlying chronic health conditions that put them at greater risk of severe disease.

The Hong Kong pandemic in 1968 caused an estimated one million deaths worldwide. In this case, it mostly affected the elderly, those 65 and older.

The virus responsible for the 2009 H1N1 pandemic was again different. This time, approximately 300,000 people globally died from the disease. Interestingly, many were younger people who were otherwise healthy.

You may recall that Canada played a leadership role in understanding and responding to the virus. Our laboratory and scientific expertise allowed the agency to decode the genetic makeup of the Mexican strain of the H1N1 flu virus.

The agency also assisted Mexico with diagnostic testing of clusters of severe respiratory disease in April 2009. Over 400 specimens from the ministry of health in Mexico were tested. Shortly thereafter, our National Microbiology Laboratory developed a test that allowed researchers to determine whether the strain of influenza involved was a common regular strain of seasonal flu or actually the new H1N1 virus.

The agency then, in collaboration with the provinces and territories, rolled out a national surveillance activity to track confirmed cases of the H1N1 virus in Canada.

● (1105)

At the same time, the agency was working with international partners. It sent officials, including epidemiologists and lab researchers, to Mexico to assist in the early investigation of the H1N1 outbreak. The investigations that were done there actually helped us a great deal in Canada, as well as other countries, in that we were able to better understand the transmissibility of the virus.

Our successful response to the H1N1 outbreak was, in great part, attributable to our advance planning. Canadian governments and public health organizations had been working together for many years to prepare for a pandemic. Canada was one of the first countries in the world to have a pandemic plan. Our first plan was actually developed in 1988.

The goals of pandemic preparedness and response in Canada have been, and continue to be, twofold: first, to minimize serious illness and overall deaths, and second, to minimize disruption to our daily lives.

The Canadian pandemic influenza plan for the health sector, which I will call the CPIP, maps out how the health sector can prepare for and respond to a pandemic influenza. It is a federal-provincial-territorial framework and the Public Health Agency of Canada is considered its custodian.

While the latest version was published in 2006 and consists of a main body and 16 annexes, it is important to note that a number of these annexes were updated in as late as 2009. These annexes address key aspects of the pandemic preparedness planning and response in greater detail and cover vaccines, antivirals, communications, and surveillance, among many other issues.

The 2006 CPIP was developed under the governance of the Pan-Canadian Public Health Network Council. It is the result of extensive federal-provincial-territorial dialogue and collaboration with a very wide group of stakeholders.

The CPIP is available on the Public Health Agency website. We have provided the link in the information note to committee members, as well as a copy of annex D from the pandemic plan, “Preparing for the Pandemic Vaccine Response”. That is actually dated September 2008 and was amended after the initial plan was published in 2006. This annex includes a prioritization framework that outlines the factors to be considered when developing priority access strategies, but it does not prioritize any group.

Population subgroups are identified within the vaccine annex. Under the subgroups entitled "key societal decision makers" and "pandemic societal responders", reference is made to fire chiefs and firefighters as examples of who would make up these groups.

As a pandemic is evolving, experts have to consider many factors in determining recommendations for priority access to vaccines. Factors include consideration of the severity and epidemiology of the pandemic, that is, who is most likely to be affected in terms of illness, complications, and death. Factors also include ensuring business and societal continuity and consideration of vaccine availability. In other words, during a pandemic, a risk management approach must be used to inform decisions. Guidance must allow for flexibility and latitude to enable jurisdictions to take into consideration their particular circumstances.

During the H1N1 outbreak, the epidemiology of the virus showed that some Canadians, that is, pregnant women, children less than five years of age, and people with underlying health conditions, were at higher risk of developing serious illness and death. It was those people and their caregivers who went to the top of the list when developing the pan-Canadian recommendations.

The list identified primary, secondary, and tertiary targets. Those who were at greatest risk were primary targets, along with their caregivers and health care workers. Secondary targets included firefighters; they were right behind those at most risk. That list, dated September 10, 2009, has also been provided to the committee members.

Taking into consideration the list and the rationale provided for priority access, provinces and territories then made their own decisions based on what was occurring in their particular jurisdictions.

● (1110)

Manitoba and Yukon chose to allow firefighters to be immunized within the first week of vaccination clinics. Others gave higher priority to vaccinating schoolchildren.

The 2009 pandemic was the first major public health event to test the CPIP and Canada's pandemic response generally. Reviews played an important role in paving the way to ensure that we are even better prepared the next time around. One of the reviews was undertaken by the Senate Standing Committee on Social Affairs, Science and Technology, at the request of the Minister of Health.

Overall, the Senate committee concluded that pandemic planning was successful. It did recommend that the agency collaborate with the provinces and territories on revisions to the CPIP that would allow for a more scalable response to address particular pandemic epidemiology. That way, the CPIP would more easily be adaptable to mild, moderate, and severe pandemics.

In this regard, the agency has been working with provinces and territories to review the CPIP and to revise it as required. This work is being conducted over a three-year period and will include consultations with all key stakeholders, including firefighters.

The revised CPIP will be tested on an ongoing basis to ensure that Canada maintains its ability to prepare for and respond to any emergencies that might threaten the health and safety of Canadians.

We continue to dialogue with the provinces, territories, and principal stakeholders, notably, the organizations that represent first responders, to enable us to prepare for a pandemic and to develop our activities in general that allow for a pandemic response.

I thank you for the opportunity to speak on the issue.

● (1115)

The Chair: Thank you.

We'll now go to Dr. André Corriveau of the Public Health Network Council.

[*Translation*]

Dr. André Corriveau: Thank you very much for inviting me to take part in this meeting. I will speak mainly in English.

Still, I want to emphasis that I am currently the co-chair of the Public Health Network Council of Canada. It is a mechanism we have to work together with the federal government, the provinces and territories on public health issues.

[*English*]

I should also mention that at the time of the pandemic, I was not the co-president; I was basically the chief medical officer for Alberta. I played a role in some of the working groups as part of the PHN Council and as one of the members.

I was involved in all aspects of the process. For example, I co-chaired one of the working groups, or expert groups, dealing with isolated and remote communities and how to modulate the response in those kinds of settings. That was one of the working groups that fed information to the pandemic coordination committee, which then advised the Public Health Network members, and ultimately, the Conference of Deputy Ministers of Health on the decisions that had to be made.

I don't really have a lot to add to what Dr. Spika said. Basically, even though the pandemic plan is designed to deal with pandemics in a generic way, we really rely on the epidemiology of each pandemic to ascertain what the response will have to look like in its fine details, including prioritization for immunization.

It was in the lessons learned during the first wave of the pandemic that the evidence started to emerge, as was mentioned by Dr. Spika, with regard to some particular groups that were at higher risk of severe illness. These included pregnant women, people with chronic medical conditions, some people living in aboriginal communities, and very young children. That provided the evidence for the expert group, which had been put in place to advise us on prioritization, to do its work over the summer and come up with the recommendations that Dr. Spika outlined.

I'm not going to add anything else at this point. I'll wait for questions that come up. I know that you have two other speakers who will provide additional details.

The Chair: We'll go to Dr. Robert Strang, chief medical officer at Nova Scotia's Department of Health and Wellness.

Dr. Robert Strang: Good morning, everybody. Thank you for this opportunity. I'll be brief.

As I think you've heard from others, if our primary goal of pandemic response is to minimize severe illness, then clearly determining the priority groups for who gets immunization needs to be based on the available epidemiologic evidence in that regard: who is at greatest risk of becoming severely ill.

It's also based on the understanding that an influenza pandemic and how we respond to it is an evolving event. At any given time during a response, our information will be incomplete, but we have to make decisions based on the best information available at the time and be able to review and adjust our decisions as more information on the pandemic unfolds.

This was the process that was used in developing priority groups during our response to H1N1, to facilitate a coordinated response when H1N1 first appeared in the spring of 2009. There were two existing FPT groups, which you've heard about: the Public Health Network Council and the Council of Chief Medical Officers of Health. They were combined to form the special advisory committee, or SAC. The two groups were brought together to allow us to be a bit more nimble in our response. We established some technical working groups reporting to us, and then we in turn reported to the Conference of Deputy Ministers of Health.

We did identify, as Dr. Spika has already noted, that as part of our pandemic response plan which we had in place, developing a prioritization list was one of the issues. That was referred to a working group. They did their work during the summer of 2009. They brought forward recommendations, based on existing epidemiological evidence, that were approved at the special advisory committee and then went up to the deputy ministers for further approval.

We had that prioritization list. When a vaccine shortage did occur at the end of October 2009, all the provincial and territorial jurisdictions and the federal government used that established prioritization list to phase in our immunization programs. The extent of the vaccine shortage required that we subdivide the first priority group. While we strove to have consistency through discussions at the SAC table, there were, as Dr. Corriveau has noted, some interjurisdictional differences in how we did that first subdivision.

We had a very evidence-based, epidemiologically driven process. That's the process we'll need to have in place for future pandemics. In Nova Scotia we did have firefighters on our list, and we went through three steps of phasing in different groups. We always considered firefighters, along with police, as to when we could offer them vaccine, knowing that there were other groups who were at greater risk from their work and at greater risk for severe disease. We were about to implement firefighters in our last phase-in when the shortage was relieved in late October and we were able to offer vaccine to all Nova Scotians.

● (1120)

The Chair: Thank you very much.

Members of the committee, we will be having Dr. Brendan Hanley join us via video at around noon. He was unable to make it until then.

We'll be going into questions and answers shortly. I want to remind you that at 12:45 today, we will suspend to go in camera for a 15-minute business meeting at the end of the committee. Having said that, let's go into questions and answers, being mindful of the fact that at noon we'll interrupt that session to listen to Dr. Hanley.

We'll begin our seven-minute round with the NDP, starting with Ms. Davies.

Ms. Libby Davies (Vancouver East, NDP): It's good to be back at committee and getting back to our business.

Thank you to all of the witnesses for being here today, either by video conference or in person.

I know that previous standing committees on health had a lot of information on pandemics and what the government's response was. My former colleague, Judy Wasylycia-Leis, was the NDP health critic. There was very intense information given.

However, I think you should be aware that most of us are new to this committee, so we're a bit green on this issue. If some of my questions seem a bit naive or not very substantive, it's because I just don't have the background that some of our colleagues gained as a result of the events in 2009.

It sounds as though there's a good process in place. We have the Pan-Canadian Public Health Network Council and the Public Health Agency of Canada. It sounds as though things are very well established.

Who actually decides that there is a pandemic? At what point does it move from an epidemic—and I don't know if that's the right term—to a pandemic? What is the qualitative difference? Is it something that we ascribe to under the World Health Organization? Is there a definite line when it moves from one to the other? I'm curious to know what kickstarts that. When we reach that point, how quickly can decisions be made? You have a plan, but I assume you're getting information from local health authorities about cases. Again, what's that line that kicks it into something else?

Also, this committee is going to be looking at electronic health records during the coming months. I would imagine that a lot of what you are dealing with relies on recorded information and a database. I'm curious to know how well developed that is. Are you able to quickly assess that we've moved from one scenario to another scenario?

Those are the questions I have, and I'd invite all of the witnesses to respond.

● (1125)

The Chair: We will begin with Dr. Plummer. You were with us during the pandemic, Dr. Plummer. We worked very closely together during that time. Perhaps you could start off with how you know it's a pandemic.

Dr. Frank Plummer: Sure, I'd be glad to do that. Thanks for the question.

I think Dr. Spika is probably in a better position to speak to some of these questions.

An epidemic is an increase in the number of cases of a given illness in a particular location. We call it a pandemic when it's pretty much global in nature, when the epidemic is occurring everywhere. That's the basic difference in terms of epidemiologic definitions.

The connotation of the word “pandemic” has come to mean a very severe influenza outbreak, as in 1918, but that is not really the definition of what a pandemic is. It doesn't necessarily have to be severe. To my mind, that's the origin of some of the criticisms of the WHO and others as to making the call about a pandemic, because it wasn't as severe as it might have been and it certainly wasn't as severe as the one in 1918.

I would refer the rest of the question to Dr. Spika or the other witnesses.

The Chair: Perhaps, Dr. Spika, you could continue with that.

Dr. John Spika: It's a good question. It's a point about which questions have been raised in a number of settings.

There are two aspects. A pandemic influenza is caused by a novel virus. It's not the seasonal viruses, but there's been a dramatic change in the virus itself, so that the regular susceptibility we have on a seasonal basis is greater, because many of us haven't seen the strain before. It's also an international event from the standpoint that not only has this virus emerged, but it's demonstrated that it can be transmitted very efficiently from person to person, just like seasonal flu, and it's spreading globally.

The WHO definition from the past is that, before they would declare a pandemic, it actually had to affect a number of the WHO regions. There are six of them. I think in terms of our pandemic planning, the situation we found ourselves in is that we thought it was going to be emerging from Southeast Asia, where a lot of the new viruses emerge, and that we didn't need to have a plan in place, or that it would be declared a pandemic before we actually saw it here in Canada.

Actually, the reverse was true. Here we were actually having illness before it was even recognized as a new novel strain, because of Canadian tourists going to Mexico. Nova Scotia was a good example, where they had some school kids who, I believe, were down in Mexico on vacation. British Columbia had tourists who were down there. All of a sudden, when we recognized that this new strain had emerged, it was already spreading around Canada, but it was still not called a pandemic from a WHO perspective, because it was just in North America. It wasn't until after it spread into Europe and some of the other WHO regions that the WHO officially declared it a pandemic.

In a way, that underscores the fact that our plan needs to be flexible, and not just totally dependent on the WHO declaring it to be a pandemic before we activate our plan and get going.

● (1130)

Ms. Libby Davies: Do I have a little more time?

The Chair: You're right on the button. Sorry.

We'll now go to Dr. Carrie.

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

I just noticed, Dr. Corriveau, that you're only going to be here until noon, and I do want to ask you a question.

I understand you were the chief public health officer of Alberta at the time. I was wondering if you could comment on why you think it's important that provinces and territories have the flexibility to determine their own priority list for vaccines during a pandemic.

Dr. André Corriveau: First of all, I just want to expand on what Dr. Spika said. Even though it's called a pandemic plan, we also react to what's happening on the ground.

As was mentioned with Nova Scotia and B.C., we also had a lot of tourists coming back from Mexico. We had already activated, to some extent, the alert among ourselves. As soon as we heard there was an unusual illness going on in Mexico, we had weekly and then daily phone conferences to keep track of what was going on.

Through our provincial labs, Alberta in my case, we had reports of people being diagnosed with a novel strain of influenza. Way before it was declared a pandemic, we had already started to take action. Of course, we didn't have vaccine available in the first wave, but we knew something unusual was evolving and we needed to act. I think we did that as a nation. We developed our guidance documents together.

Your question is around the flexibility we need at the provincial level. First of all, I think we are hit differently. For example, Alberta was the first place that had first nations people who were affected. We had the first death. We had the first disease emerge in pig farmers, for example. In our case, we had a lot of firsts going on. We had to adapt the plan to fit the circumstances we were dealing with.

Those circumstances were localized, but they were also related to the way our health care system is structured. For example, in Alberta at the time, we had just abolished all the regional heath authorities and had created a single one. Therefore, the structure of response had to be different from that in Ontario, which has a very different type of health care system.

Even though we all endorsed a similar plan and signed on to the prioritization list, it played out a little differently in terms of implementation. For example, in Alberta, where they had chosen to use mass clinics for the immunization program, although in our communications to the public we highlighted who should come first based on the national plan that had been developed jointly, initially they didn't have the structure to screen people at the door. Basically whoever came to the clinic was accepted and was immunized.

That was a difference in what might have been done in another jurisdiction. Although we were still providing the same guidelines to our front line people, in our public communications we were using the same list as everybody else.

Mr. Colin Carrie: Thank you very much, Dr. Corriveau.

Dr. Spika, we're talking about the framework. How is the pandemic vaccine prioritization framework set up, and how are the groups prioritized?

Dr. John Spika: The framework is interesting in that it doesn't prioritize per se. It actually identifies factors, both ethical and epidemiological, that one would want to consider at the time of a pandemic as to whether or not certain groups would be included in the priority list. From that standpoint we've talked about the epidemiology, those who are most affected by the disease, but also those who are taking care of people. Clearly, health care workers, people with direct contact with patients who are providing patient care, would be high on the list. You want to maintain at least that care component. You don't want to be turning people away at the emergency rooms.

The interesting thing from the firefighter perspective is whether you consider them first responders or part of the basic societal infrastructure. Depending on the jurisdiction and their responsibilities, they could be considered both.

Again, it's a matter of balancing, in this case what the Public Health Network was doing. Where was most of the burden of disease occurring as compared to who was perhaps most likely to get ill? That was an important distinction, and it's why all jurisdictions then identified pregnant women, people in remote and isolated communities, young children, who we were seeing had a lot of serious diseases. Then there was that flexibility to adapt to some of the other groups as they saw them on the ground in the jurisdiction.

● (1135)

Mr. Colin Carrie: Are these frameworks used every time a pandemic comes up? Can you comment on that? I know that these things are rare.

Dr. John Spika: We've had a pandemic plan of sorts in place since 1988, but that was after the third pandemic of the 20th century. In effect, this was the first time we actually were able to test the plan and the framework. I think we learned a lot. I definitely see that in the future, unless we have an unlimited supply of a vaccine that's good against all influenza strains, or we can vaccinate everyone and have the health care resources to do that, we're going to have to have a framework to at least identify, based on the epidemiology, who should be targeted first.

The Chair: Thank you so much.

Dr. Strang also has to leave at 12 o'clock, so if you have any questions as we continue, be mindful of that.

We'll now go to Dr. Fry.

Hon. Hedy Fry (Vancouver Centre, Lib.): I want to thank the witnesses for coming to discuss an issue that is of great importance to all of us.

I am very well aware that when you look at a pandemic or an epidemic, you're looking at the causative agent. You have to be mindful of the mode of spread, etc., as you apply public health principles to diminish the spread, or to find the best ways to protect vulnerable populations.

I'm going to ask a series of questions.

Did you learn anything from the way in which the last H1N1 epidemic was handled? Do you feel that you learned some important lessons? Would you do things differently the next time around?

If another pandemic were to occur, and it could be H1N1, a flu, or something else, would you always set a priority list of the people who must be vaccinated or must be protected? I would think that first responders would always fall into that category. It is not only because of the mode of spread. Some first responders may not contact the disease if it's a different mode of spread than one in which they are going to be in touch with the people. However, they must always be ready and on the ball as first responders to go into the community and do what they need to do. Their getting sick is not going to help that.

I would like to know how you feel about putting first responders always on some priority list, if you're facing any kind of epidemic, because of their importance to the community in terms of their need to be in the community to do their work.

Those are the questions I wanted to ask you. Did you learn anything? Do you believe that every time there's an epidemic you should set up a priority list, which would include first responders because of the nature of their work, regardless of the mode of spread, so they will be able to do their jobs in the community?

● (1140)

The Chair: Dr. Corriveau, I think I saw you raise your hand. Did you want to respond to that?

Dr. André Corriveau: Yes, please.

We have learned a lot. Most jurisdictions, including at the national level, have done a review of what happened during the pandemic of 2009 and 2010, and they have received recommendations from advisory groups. When I was in Alberta, the Health Quality Council of Alberta did the review and provided a list of recommendations that were accepted by the government. There's work being done to improve. I think we all learned how to do things better.

It was the first pandemic, I should point out, where we had a vaccine. For all the previous pandemics in the 20th century, there was no vaccine available at the time. We also had to develop priority lists for the use of antivirals, because in the first wave, the antivirals were all we had available, besides the social-distancing techniques that can be applied in any situation of that sort. We learned from that as well.

The final thing I want to add is that first responders were on a list. They just weren't at the top of the list, because we had identified some groups that were at the highest risk of dying and having severe morbidity. You have to recall that some of the people would end up in an ICU. Instead of spending two or three days each, they would spend weeks, sometimes two or three weeks, in an ICU, and would be mobilizing beds that would not be available for other types of emergencies. That was viewed as our very top priority in terms of immunization.

The Chair: Thank you, Dr. Spika.

Did you want Dr. Spika to comment?

Hon. Hedy Fry: Yes, if Dr. Spika has something to say, but I have a couple more questions to ask.

The Chair: Go ahead, Dr. Fry.

Hon. Hedy Fry: You had first responders on your list the last time, but the question is, how long did it take between giving it to your top-of-list people and to the first responders? Was it a delay of a day? Was it a delay of two days? How long did it take to get to first responders?

We know that because of global travel and ease of movement, pandemics are not going to be rare any more. Unfortunately, they're going to be the norm. Would you want to identify the causative factor once you have a vaccine, and if you have one? Will you now always build in a first responder piece? Will you order enough vaccine so first responders can be moved up the list, in terms of the people who should get the vaccines? Is that something you feel is more important?

Again, I'm harping on the fact that first responders are essential in the community. They are the people we need to put out fires, for example. They need to be well and healthy to do their work.

What do you think? What was the difference in time between first responders getting the vaccine and the people at the top of the list?

Dr. John Spika: It did vary by jurisdiction. Perhaps either Dr. Strang or Dr. Corriveau could comment from their perspective in terms of how long it took. In general, it would appear that it was anywhere from the first responders being identified during the first week that the vaccine was rolled out to maybe the third or fourth week in one jurisdiction.

Hon. Hedy Fry: Did Dr. Strang want to say something?

Dr. Robert Strang: I can add to that with some specifics.

In Nova Scotia, we first rolled out vaccine on October 30 and then by November 20, we had made vaccine available to all Nova Scotians. I clearly recall that we were making decisions with our emergency responders well in mind, but we did not include police or firefighters in our previous allotments as we added people to the prioritization list. It was not because they weren't important but, as Dr. Corriveau referred to, our overall priorities were to protect those who were at the greatest risk of getting ill. We needed to preserve the health care system, but we also acknowledged that we were looking to include police and firefighters to protect the community infrastructure as soon as we had sufficient vaccine available.

I do know that if we hadn't obtained enough vaccine to open up immunization to all Nova Scotians by November 20, our next move would have been to add further subgroups, which would have included police and firefighters.

● (1145)

The Chair: Thank you very much. If you could just wind up. We're quite a bit over the time.

Hon. Hedy Fry: Okay, thank you.

The Chair: We'll now go to Ms. Block.

Mrs. Kelly Block (Saskatoon—Rosetown—Biggar, CPC): I would like to join my colleagues in welcoming all our guests who have been able to join us today.

Dr. Corriveau, I thought I heard you say in your introductory remarks, given that pandemic planning is an evidence-based epidemiologically driven process, that is something that drives your decision-making. Would jurisdictions have several plans in place to address that fact?

Dr. André Corriveau: The plan is developed more generically. I think Dr. Spika highlighted that it provides the framework to make the decision on prioritization, but it doesn't spell out which groups will be first, second, and third. You have to wait until you see it unfold and gather the evidence. Most of us who have access to a public health lab had the results in the morning from the testing that was being done the day before. We were able to keep a rolling tally. We were sharing that information across the country. People in Nova Scotia knew what was going on in Alberta, and vice versa, on an almost real-time basis. That was quite a feat and can only get better as we improve our information systems. Then the decisions are made.

If we had found out, for example, that as in 1918-19 the greatest mortality was in young adults, people 20 to 35 years old, the prioritization would have been quite different from what we ended up doing. We saw that pregnant women were getting very seriously ill, very young children were ending up in the ICU, and first nations people were being affected disproportionately, as we saw in the news. The final list was prepared using the framework, but with an outcome that might have been different had it been a different virus or a different pattern of illness.

The Chair: Dr. Plummer, I think you raised your hand.

Dr. Frank Plummer: No, I didn't.

The Chair: Okay, thank you. You can't scratch your ear around here.

Dr. Spika.

Dr. John Spika: To me, that's one of the key lessons learned from the last pandemic. That came out loud and clear in the Senate report. Our plan was inflexible and not scalable.

We're working to adapt to that. Instead of having one scenario, we're looking at four scenarios, based on the overall impact they may have, from low to high, so that jurisdictions are in a position to better plan for these differences.

Mrs. Kelly Block: Thank you very much. That's a great segue into the other question I want to ask this morning.

In your opening remarks you gave us some of the history on the different pandemics we have faced. In 1968, it was the Hong Kong flu. It was 20 years later that CPIP was created. I would like to know what transpired in that 20 years to cause the federal government to decide to create CPIP.

Then in 2009, H1N1 hit. It was the first major public health event to test CPIP. Given that you've identified one lesson learned, are there others you can share with us today, before the report is released, from the H1N1 pandemic?

● (1150)

Dr. John Spika: It's an interesting question.

Canada was one of the leaders in pandemic planning. It wasn't as though everyone else was out in front of us in 1988. We, and maybe the folks in the U.K., were working on it. We were the leaders. It's just that people hadn't really thought about how to approach it.

In terms of the overall lessons learned, one of the key things is that following the Senate committee review, both Health Canada and we have developed a management response and action plan. On the basis of that, we've identified a number of areas where we need to work.

To highlight some of them, it's to strengthen federal-provincial-territorial capacity. We are working in those areas, both in the way we engage the stakeholders and the way we're working with jurisdictions in the development of the new pandemic plan.

Another one is in the area of information exchange. We are working with other jurisdictions, the provinces and territories, to develop agreements on how information can be shared, particularly at the time of an emergency, but in general as well, because that's when it's probably needed the most. We are continuing to communicate and test our federal emergency management roles and responsibilities.

Another one of the issues that came out of that review was our ability to communicate complicated information to the public in an understandable way. That's another area of focus that we've been working on.

The Chair: Thank you very much. You have about 30 more seconds.

Mrs. Kelly Block: That's fine.

The Chair: Okay. Thank you very much.

As I told you before, Dr. Hanley will be joining us. We'll suspend right at 12 because two of the doctors have to leave the committee and another doctor will be coming in.

We'll go into our five-minute rounds because we have time. We'll begin with Dr. Sellah.

[*Translation*]

Mrs. Djaouida Sellah (Saint-Bruno—Saint-Hubert, NDP): Thank you, Madam Chair.

I would like to thank Dr. Spika, who is here with us, and the other witnesses, who have joined us by videoconference, for their contribution to this very important discussion.

I listened attentively to what Dr. Spika was saying. He said that two leadership groups would be involved in the case of a pandemic. There is the network of public health physicians. He also mentioned the medical officers of health.

Dr. Robert Strang, from Nova Scotia, also joined us. I know what a hygienist does, but for the average citizen, I was wondering if Dr. Strang could explain what a medical officer of health does. Everyone knows what a dental hygienist does, but not the role of a medical officer of health, who would intervene in the case of a pandemic in the vaccine process?

Dr. Strang, could you please provide some clarification in this respect?

[*English*]

Dr. Robert Strang: Sure. The two groups were the Pan-Canadian Public Health Network Council and the Council of Chief Medical Officers of Health. As I indicated, those groups were pre-existing leaders in public health, and they were brought together as part of our response.

Each province and territory has a chief medical officer of health. We have the lead accountability for public health in our provinces. We all have legal authority under some type of health protection act or health act that allows us to take certain actions and to provide advice to our elected officials. When there are threats to the public's health, we have some level of independence to take action, if required. We're able to delegate those functions to our medical officers and their regional health authorities, and to delegate it down through front line staff, both public health nurses and public health inspectors.

● (1155)

[*Translation*]

Mrs. Djaouida Sellah: My next question is for everyone.

According to the appendix of annex D, the pandemic vaccine prioritization framework of the Canadian Pandemic Influenza Plan in the health sector states that "the degree to which prioritization will be necessary will be linked primarily to the rate of vaccine production, which will not be known until production is under way."

During an influenza outbreak, does the Public Health Agency of Canada usually publish an official list of priorities? If so, at what stage in a pandemic is the list communicated? Which jurisdictions receive the list? Provincial, territorial or municipal governments? I was wondering if someone could answer my question, please.

[*English*]

The Chair: Who would like to take on that question?

Go ahead, Dr. Spika.

Dr. John Spika: In general, it's really the jurisdictions that prioritize how vaccines are given in their particular communities and to whom they give the vaccines. Some jurisdictions, even with seasonal flu, give the vaccine to selected groups as opposed to the whole population, as is the case in Ontario and certain other selected jurisdictions where they have universal flu programs.

We would only develop a priority list for influenza vaccine in the case that there was a flu vaccine shortage. From the standpoint of a jurisdiction, it would probably be at the jurisdictional level, based on their issue. It does raise an interesting question about when we've had other vaccine shortages, not flu vaccines but other vaccine shortages. The jurisdictions have to work together, which they do, to identify how we're going to adjust to that shortage. Sometimes it can mean that we're looking for vaccine from another supplier. I have to admit, from that standpoint, there's always work to be done. That's another issue that has been identified as we think about our national immunization program: How do we plan and mitigate against vaccine shortages and adjust and work together to address them when they occur?

From a pandemic standpoint, we have a framework. We're not going to address a prioritization framework for the next pandemic until it occurs.

The Chair: Thank you so much. Our time is up, Dr. Sellah. I gave you a little extra.

Dr. Corriveau and Dr. Strang have to leave at 12 o'clock, and we're at one minute to 12 now.

Thank you so much for joining us today on this very important topic. I appreciate your time.

We are going to suspend the committee for a couple of minutes, because Dr. Hanley will be joining us shortly. We'll listen to Dr. Hanley and then we will go into our five-minute questions and answers.

With your indulgence, Dr. Plummer, we'll be back online very shortly.

● _____ (Pause) _____ ●

● (1200)

The Chair: I would ask the committee to resume.

We have Dr. Hanley online.

Can you hear me, Dr. Hanley?

Dr. Brendan Hanley (Chief Medical Officer of Health, Department of Health and Social Services, Government of Yukon): Yes, I can hear you well.

The Chair: Dr. Plummer, are you online as well?

Dr. Frank Plummer: Yes, I am.

The Chair: Thank you so much.

Our committee has reconvened.

Dr. Hanley and Dr. Plummer, I want to thank you so much for discussing this very important topic.

Dr. Hanley, as you know, the committee listened to some other presentations prior to your arrival. We went into the seven-minute Qs and As and started the five-minute Qs and As. We are now going to break the five-minute Qs and As to listen to your presentation.

We're so grateful that you're here. You have 10 minutes. Would you begin, please, Doctor?

Dr. Brendan Hanley: Thank you for this opportunity to speak. I won't take long and I won't belabour points that you likely already are familiar with from perusing the national pandemic plan and other sources.

Yukon itself has a fairly high-level pandemic plan that was revised in 2009 during the H1N1 pandemic, incorporating early lessons learned.

It's important to remind committee members that we are a small territory. We have only 35,000 people in the entire territory. One quarter of our people are first nations. As a small territory, we do not have a great capacity for research or analysis, nor for in-territory scientific expertise which the provinces may enjoy. However, we do have excellent collaborative relationships with our colleagues in the south. As a small territory, we also have the advantage of close connectivity between the public clinicians, political leaders, and public health personnel. In short, when we need to, we think we can get things done.

We were part of the national vaccine prioritization discussions held during pandemic 2009. Prioritization became a question of how best to protect a population with limited vaccine supplies and how we define protection for a population. Is it protecting societal function? Is it protecting the most vulnerable? Is it protecting children? Is it preserving the most life years possible for a population?

In the motion brought to the standing committee, there's reference to “the epidemiology” of the pandemic. What were the important aspects of the 2009 pandemic that related to prioritization? I would submit they were the following. The influenza was relatively mild but occasionally severe, especially for those with underlying medical conditions. There was some evidence of greater susceptibility among aboriginal peoples. There had already been a first wave of the pandemic, so an unknown number of people were already likely immune. The senior population had residual immunity from prior exposure to similar influenza viruses.

You can see how these features would influence prioritization. This would mean that if we were to prioritize, we would be very interested in our first nations people and those with underlying medical conditions, and perhaps we would be putting less priority on societal disruption and the senior population.

Apart from epidemiology, however, there was a key issue. The availability of the vaccine itself was in a tight race with the coming of the second wave. Therefore, for 2009, timing was everything.

In Yukon, though, as in other northern territories, at a certain point we realized we had a huge advantage that left us more or less peripheral to the detailed and angst-ridden prioritization discussions. For pandemic H1N1 2009, because of our small population, we were able to have all of our vaccine supply delivered in one shipment. In addition, we had the logistics to be able to deliver vaccine quite quickly.

Rather than having to triage people by susceptibility, age, gender, and occupation, we felt it was more efficient to offer the vaccine generally to the population. We believe our strategy worked well. Within two weeks we had covered 50% of our population, and after that, there was very little uptake in the weeks that followed.

Since firefighters are specifically mentioned in the motion, I'll offer the following.

Generally speaking and for future planning, protecting first responders and essential services people such as EMS, police, and firefighters has to be balanced with protecting the most susceptible members of the population.

Decisions about how to organize such priorities will of course depend on the epidemiology of the next pandemic and on features such as: whether certain age groups are more susceptible; the rate of transmissibility; the rate of severe disease; the expected demand on clinics and rural health centres, EMS, emergency wards, and in-patient services; and when the vaccine is actually going to be available vis-à-vis the course of the pandemic itself.

Regarding the importance of preserving societal function, we should agree to continually revise our definitions of what essential services are.

You may have heard that Yukon had a total communications blackout only two weeks ago. What use is a 911 system without working phone lines or a cellular network or Internet? That is just one example of the complexities of assigning values to societal importance. In this case, we just might want the cable guys who are out there fixing the lines to be the most healthy.

● (1205)

In summary, I can offer a few lessons from what I have learned.

One, rather than being a purely value-based system, it's crucial that prioritization be based on an ethical framework that is accountable and is free of bias, as should be the best of democratic processes.

Two, technology can change everything. Canada needs to be a leader in investing in immunization technologies for the next pandemic, whenever that may occur. I hope we're not still waiting for chickens to lay enough eggs in which to produce viral strains for vaccine.

Three, even when supplies may be limited, consideration should be given to the inefficiencies and societal distress inherent in assigning values and priorities. There may be lessons to be learned from what happened in the north: wide open access and rapid immunization of the population as a whole, an efficient, democratic, and equitable practice that we were lucky to have.

That's all I have to say. Thank you very much.

The Chair: Dr. Hanley, I think you've said quite a bit and said it most colourfully and adequately. Thank you very much.

We'll go back to our five-minute questions and answers. Mr. Strahl.

Mr. Mark Strahl (Chilliwack—Fraser Canyon, CPC): Thank you, Dr. Hanley, and the others who are still with us from the first panel.

I remember the 2009 event mainly because I was the father of a five year old, who turned eight today, actually. I remember at the time the worry that was in the population for those groups that were identified as being vulnerable. I certainly was thankful that young children were in the top priority, or certainly in the second tier in British Columbia.

My question, as we are considering this motion in the context of firefighters, is that if we mandate that vaccinations must be given to those who may not necessarily be vulnerable based on the epidemiology, does that not necessarily put those who are vulnerable at additional risk?

Again, based on the epidemiology and the availability of a vaccine, if there is a limited supply, would you not agree that we must maintain as much flexibility as possible to ensure that we are treating those who need it the most and that we don't politically tie the hands of our public health officials by mandating that they vaccinate those who may not need it in the future?

The Chair: That's to Dr. Hanley, I would presume.

Mr. Mark Strahl: Dr. Hanley or Dr. Spika.

The Chair: Dr. Hanley, would you like to take a shot at that, please?

Dr. Brendan Hanley: Yes, sure.

I think the key word is “politically”. I'll go back to what I said, that there is going to be a balance between preserving societal function and protecting the most vulnerable. I don't think there is one answer. Both are critical functions, and which becomes more important depends on what we're watching from the course of that pandemic.

Again, this is where we need an ethical framework. We need to keep politics at arm's length and let the public health officials.... There will be debate, but let that debate occur based on public health values and a public health ethical framework.

● (1210)

The Chair: Thank you, Dr. Hanley.

Dr. Spika, with your vast knowledge, did you have something that you would like to contribute as well?

Dr. John Spika: The only other thing I would add to that is that maybe 10 years from now we'll have the first vaccine available in 12 weeks instead of 22 weeks, as we had during 2009, just because technology is changing.

In effect, our whole approach needs to be flexible to address it based on what we have at that time.

I agree with you, given the changes in technology, given that we don't know what the virus is going to do, the comment about flu pandemics is to expect the unexpected, not that it is unique to flu pandemics, but what occurred in 2009 wasn't what we expected.

Anyway, I support your comments.

The Chair: You have a minute more.

Mr. Mark Strahl: In that same vein, if we're talking about prescribing who must be included in the first batch if there is a limited vaccine, at the federal level I think we need to be careful that we don't impose that requirement on the jurisdictions of the provinces and territories.

Were there any provinces after the 2009 review that came forward and said that they would have preferred if the federal government had mandated the priority for the vaccines, or did they say they needed that flexibility in their own jurisdiction?

Dr. John Spika: We heard no comments to the effect that they wanted more direction. I think the process during the time of H1N1 was really remarkable in that we got all jurisdictions working together, and we at least agreed on the framework and allowed them some flexibility to adapt to their local situation. In reality, even if we have enough vaccine, we may not have enough vaccine givers.

The Chair: Thank you very much.

Now we'll have to go to Dr. Morin, please.

[*Translation*]

Mr. Dany Morin (Chicoutimi—Le Fjord, NDP): I thank the witnesses very much for being here.

In the Senate committee report entitled "Canada's Response to the 2009 H1N1 Influenza Pandemic", the committee made recommendation 15, which reads as follows:

> The committee therefore recommends that Health Canada's First Nations and Inuit Health Branch work collaboratively with Indian and Northern Affairs Canada as well as the Public Health Agency of Canada to identify and address the conditions particular to on-reserve First Nations and Inuit communities such as overcrowding and poor access to clean water that make them vulnerable to communicable diseases, including pandemic influenza, and that this collaboration include measures to improve the public health infrastructure.

I have a question relating to this recommendation that I would like to ask one of the representatives of the Public Health Agency of Canada.

The report was tabled in December 2010. So the recommendation was made close to two years ago. What progress have you made in this regard with the Department of Indian and Northern Affairs? Have you been able to implement this? Has much progress been made on this recommendation?

[*English*]

Dr. John Spika: We have certainly some ongoing work with the first nations and Inuit health branch of Health Canada, but in terms of a response, I would probably want to defer that to Health Canada to respond because we're not directly involved in that interaction.

● (1215)

[*Translation*]

Mr. Dany Morin: Okay. I asked the question because your agency's name was in there. But, I will put my question to a Health Canada representative.

I am very much interested in the aboriginal populations, particularly when it comes to health. Therefore, I have other questions that the most qualified person could answer.

It was mentioned earlier that…

[*English*]

The Chair: Dr. Morin, if I could intercede; that's a very good question. We had invited the Department of Health and they said that it's not within their jurisdiction. Perhaps when we have them in again, you could ask that question.

It's a very legitimate response, Dr. Spika. I know that you're not avoiding the question. It's just not your jurisdiction. That might help you a little bit.

[*Translation*]

Mr. Dany Morin: Thank you for the suggestion.

I will continue with my next questions. Are there aboriginal professionals in on discussions about determining priority sub-groups? Since the aboriginal populations are different and have particular needs, because their health is more vulnerable than the rest of the population, I suppose that you have a different approach when it comes to them. Could you speak some more about that? How do you modify the sub-groups when aboriginal groups are involved, especially when it comes to intervention methods? Obviously, individuals living on native reserves do not necessarily have the financial or qualified human resources to implement the recommendations and the implementation plan related to a pandemic.

[*English*]

Dr. John Spika: Those are good questions.

At this point in time, in terms of developing a new pandemic plan that responds to the concerns of the Senate report, we've worked primarily with the provinces and territories, as well as some stakeholder groups, to address the main body. We're hoping that main body of the pandemic plan will go out at least to our provincial and territorial stakeholders this fall. The idea is that we would more generally engage all stakeholder groups in the spring on the main body of the umbrella document, in terms of the approach we're using.

Having said that, we're also prioritizing certain annexes for development, one related to vaccines, the use of antivirals—currently issues related to first nations and aboriginal groups—as well as the communications component, the laboratory network component. Those I anticipate will be coming along over the course of the next year.

Certainly from our standpoint, the first nations and Inuit health branch of Health Canada has been involved in that planning process. We have not actually gone out, at this point in time, to engage the first nations groups as part of that consultation, but it is coming.

The Chair: Thank you, Dr. Morin.

Now we'll go to Mr. Lobb.

Mr. Ben Lobb (Huron—Bruce, CPC): When a municipality is planning for development around a lake or a river, it is looking at 100-year events for floods and whatever. When you're doing your planning, I'm sure you do the same for 100-year events for pandemics.

Could you tell us a bit about that?

Dr. John Spika: Pandemics in general occur three to four times a century. You can look back 400 years, and what appear to have been pandemics have been occurring with that frequency. Of the ones that we're aware of, every one is different, from the most severe one in 1918 to perhaps one of the milder ones in 2009.

In the previous pandemic plan, I guess we tried to pick a most likely scenario.

Mr. Ben Lobb: The way I look at it is, if you looked at a 100-year event with a pandemic, the worst case—even if you used 1968 as the example—and thought, in all practicality, who would be on the priority list: firefighters, yes; police officers, yes; EMS, yes; and all those who are currently on the priority list, and I know EMS is on the priority list, is it possible in a 100-year plan that isn't going to cut it, either?

On this list I don't see any of the military. It's possible in a 100-year event the military could be called upon to provide some help as well. I'm curious as to why members of the military aren't on any of the lists.

● (1220)

Dr. John Spika: The military are not the responsibility of public health. The military have their own supply of vaccine that they purchase. They made their own decisions about the vaccine they were getting. They're not on there because it's public health, but they're definitely getting the vaccine. They have their own priority groups.

Mr. Ben Lobb: Within their structure they will prioritize that as well.

Dr. John Spika: That's right. Certain groups that are—

Mr. Ben Lobb: Hypothetically then, just so I'm clear, would they receive it before any of the people who are on the primary list, or would they receive it at the same time?

Dr. John Spika: As part of the purchase of vaccine, they had their own supply going to them. They had their portion of vaccine, out of the overall pot, that was going to the military.

Mr. Ben Lobb: Mr. Hanley, let's say we included firefighters. Let's say we included police officers. Let's say we included absolutely every single person we could think of—the coast guard, you name it. We include everybody on the primary list. For your government, under what obligation are you to receive all these people on the priority list? You're independent to decide for yourself which ones you're going to put on the priority list and which ones you're not, right?

Dr. Brendan Hanley: Yes, that's right. I'm not quite understanding your question.

Mr. Ben Lobb: We've talked a little about the political aspects of this motion. I guess what I was going to say is if I amended the member's motion to include everybody who was on the secondary list on the primary list, you, as the Government of Yukon, would not be beholden to accept that list, that everybody is on the primary list. You decide yourself as an independent jurisdiction, correct?

Dr. Brendan Hanley: That would be my understanding.

Of course, my particular position is also at arm's length to the Yukon government. My understanding of how the Yukon government would make its decisions in conjunction with my advice to the Yukon government and my direction to the Yukon government under a medical emergency would be that we would likely make our own decision.

However, there would be a great need to be doing something that is in harmony with what the rest of the country is doing, and that's the reason for the importance of the national discussions that Dr. Spika referred to, which we believe happened successfully in 2009. If one jurisdiction is doing something completely different from another jurisdiction, it becomes really distressing for everyone and difficult to carry out. Therefore, although we may not be obligated to, there may be more of a peer-based onus to do something that is harmonious with what the rest of the country is doing.

The Chair: Thank you very much.

You have no time for more questions, Mr. Lobb.

We now go to Mr. Kellway.

Mr. Matthew Kellway (Beaches—East York, NDP): Thank you, Madam Chair, and thank you to all the panellists for joining us today.

One of the essential issues for the need for a priority list seems to be the supply of vaccine. I'm wondering about two things. Could one of you explain to me how that supply process works?

I think, Dr. Spika, you called these novel viruses, so I presume vaccines need to be made up in response to a particular virus. I'm wondering what that process looks like, in very brief terms, and whether the pandemic plan has something in place to hurry that supply chain.

Also, there's the issue of jurisdiction and whether the federal government or provinces and territories are in control of that supply chain and getting hold of the vaccine.

Lastly, is there anything such as a geographic prioritization of where the vaccine goes? Do we prioritize places where the virus or flu may be arriving in the country?

● (1225)

Dr. John Spika: I'll give a short version of vaccine 101 here.

When the flu virus emerges, a new vaccine has to be made. It is a little more complicated, in that it is a different virus from the standard annual virus. There's an approval process that has to be gone through by the regulator.

In general, using egg-based technology, it takes about 20 to 22 weeks from the time they get the virus to the time they can start releasing the vaccine. That's just egg-based technology. You can shorten that by maybe four weeks using a cell culture-based technology. If we were to use some of the newer DNA technologies, we might be able to cut it in half. Canada was actually the first country in the world to develop a domestic capacity to produce a vaccine for its pandemic needs.

That isn't all the vaccine we need in one week; we have to wait until the vaccine is available. The capacity we had in the initial contract at the time was about eight million doses a month. That was put in place around 2000-01. The production capacity was upped so we might have the capacity to take on about 12 million doses a month, but it wasn't 30 million doses a month. We didn't have enough vaccine for all Canadians within a month after the pandemic. We also had that lag period.

Recognizing that even in a situation where we had earlier production of vaccines, the first wave had already passed before vaccine was available. We didn't start vaccinating until the second wave was approaching its peak. There were delays. There was demand. There was also the need for the infrastructure to be able to give the vaccine.

With regard to the provinces and territories, the agreement is that it's divided up based on population. The only exceptions to that were the three territories. Because the volume was so small, Yukon, the Northwest Territories, and Nunavut got all their vaccine at once. They didn't have the same prioritization concerns that the rest of the jurisdictions had based on the number of doses they were getting. They had it all. They just had to prioritize based on their ability to give vaccine using whatever mechanisms they used.

In terms of a geographic prioritization, by the time the vaccine was available, the virus was everywhere. If we'd had vaccine available earlier, perhaps one could have shifted...particularly if one could have intervened in the first wave, which was very spotty across the country. By the time the second wave happened in the fall, it literally was everywhere.

The Chair: Thank you so much.

We'll now go to Mr. Lizon.

Mr. Wladyslaw Lizon (Mississauga East—Cooksville, CPC): I thank the witnesses for coming today.

My colleague, Mr. Strahl, spoke about the priority list and maybe it shouldn't be politicized. I understand that the priority list that was made during the H1N1 outbreak was based on scientific evidence and epidemiology, but I don't think we should forget about the psychological portion.

For people who work as first responders, the quality of their work would also depend on their state of mind. If the person is afraid to be in contact with people and the person's primary task is to be in contact with people who may be sick, how do we balance this? Let's say we're not going to put firefighters or police or anybody else on the list. We have scientific evidence for pregnant women, etc., but others can wait. It should be balanced, in my view. I think they should be on the list.

When you identify a strain, how do you know who is going to be affected the most? I would assume that you base it on the evidence that is perhaps after the fact.

Can you identify the risk groups based on the virus strain that you've identified?

● (1230)

Dr. John Spika: First of all, I think Canada was in a very privileged situation because the agency and the National Microbiology Laboratory were all engaged in the outbreak going on in Mexico well before we even recognized there was a pandemic going on. There was an increase in respiratory illness. Very early in the emergence of this virus, we actually had people on the ground who were learning about what was going on in Mexico, which was the first country to be heavily affected.

Also, in terms of the vaccine itself, it was not available until after the first wave had already gone through Canada. We also had a couple of months to gain information about the epidemiology of the disease here in Canada to be able to base our decisions on—

The Chair: If I might, I just want to say that Dr. Plummer also wants to make a comment. I just want to make you aware that we've only got about a minute and a half.

Dr. John Spika: It wasn't a quick decision based on limited data. We had quite a bit at the time. I'll turn it over to Frank.

Dr. Frank Plummer: I would add to what John said. The picture emerges over time. The H1N1 virus is a good example. When it first emerged in Mexico, it appeared to be a pretty severe problem because the most severely ill people are the ones who come for medical attention first. But as things evolved we learned that it could be severe, but most cases were pretty mild and got better fairly quickly. It's a constantly changing picture, and you don't know when you're starting. You can make some guesses based on past experience, but you don't know until you've actually seen what's happening.

The Chair: Thank you very much.

Dr. Spika, you've got 30 seconds or so left if you have anything else that you'd like to add to that.

Dr. John Spika: Clearly, we are also learning from our neighbour to the south. The U.S. was experiencing it as well. There was a fair amount of epidemiological data that was floating around and being exchanged under existing international agreements we have between our countries, as well as the global health security initiative countries in Europe.

The decisions we came to were very reasoned and based on the best data that were available, and there were enough data available to make good decisions.

The Chair: Thank you.

Now we'll go to Dr. Carrie. Mr. Brown, I think you're splitting your time. We'll begin with Dr. Carrie.

Mr. Colin Carrie: My question is for Dr. Plummer and Dr. Spika.

Dr. Spika, you mentioned that one of the suggestions for improvement was that we should be more flexible and more scalable, when we're looking at these lists, who's on the list, who's off the list. All kinds of very important work gets done during a pandemic, but I do understand there are challenges. I know for example that in Nunavut first responders are typically nurse practitioners because firefighters are not traditionally the first to arrive on the scene up north.

If the federal government actually starts dictating who should be on the list and who should be off the list, would that make our pandemic plan more flexible, more scalable, or would we be doing the exact opposite of what has been asked of us?

Would you be able to comment? Maybe Dr. Plummer has a comment, too.

● (1235)

Dr. John Spika: Personally, I think it would make it less flexible, less scalable. Clearly, given that pandemics are unpredictable, it makes it very difficult to try to force ourselves into a corner. A classic example is what happened in 2009. We developed a plan based on a 1968 scenario, and that wasn't the case at all.

The Chair: Dr. Plummer, do you want to comment on that?

Dr. Frank Plummer: I would add that I completely agree with Dr. Spika. I think it would box us in.

The Chair: Mr. Brown.

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

I come from Barrie, Ontario, and I've talked about this issue with local firefighters. I have a lot of sympathy for their concern on this issue.

I have an interesting story about how they're all working in the same area in terms of being first responders. I talked to a nurse, Kim Sweeney, and a police officer, Mark Hyatt. They told me about the percentage of nurses, police officers, and firefighters who are married. It is incredible. They mentioned about 10 different cases of firefighters, police officers, and nurses in Barrie who actually are married, because they work so closely together. There are EMS nights. The reason they have this close relationship is that in many cases, in a lot of their work in their day jobs or night jobs, they are there first. They get called to the same calls. That's why I think there was a concern from police and firefighters about their not being on that list.

I realize there's an effort to have provincial discretion on this. How far have some of the provinces gone on pandemic preparation? In the case of my home province, Ontario, was there a rationale as to why firefighters weren't included on the Ontario list? I understand that in some parts of the country, there might have been inclusion.

I apologize if this was raised in the first hour. I was at a different meeting during the first hour.

Could you maybe enlighten us on that?

The Chair: Doctor, go ahead.

Dr. John Spika: I don't know if I'm the best one to respond to that, as opposed to Dr. Hanley, given that it's sort of a provincial issue.

How and why certain jurisdictions make their decisions is really up to them. We can provide the higher-level plan.

The Chair: Do you have an answer to that, Dr. Hanley?

Dr. Brendan Hanley: I can only say that it is not written into our plan. As I mentioned, our pandemic plan is high level and does not have that amount of detail. It is also subject to continually being revised. I think that really depends on what's going on with the actual epidemiology of the pandemic and the timing of the vaccine.

It's a valid question. If different parties of people are at the same scene, why should one be included and not the other? It's really a matter of the range of functions individuals have in their work.

It also speaks to the need, and this reflects some of the questions from the previous speaker, to have a very robust communications plan so that what we're doing has input from all parties.

It sounds as though there's a tremendous amount of anxiety associated with some of these questions. I think a lot of it—

● (1240)

The Chair: Thank you, Dr. Hanley. In the interest of time, we need to carry on to the next question.

Mr. Goodale, I understand that Dr. Fry has given you her slot to ask a question.

Hon. Ralph Goodale (Wascana, Lib.): Yes, she has, Madam Chair, if that is acceptable to you, and thank you for the opportunity. I'll try to be very brief. I have just two or three specific questions.

Dr. Spika, at the beginning of the meeting, right at the very end of your remarks, and I'm not quite sure this is on the record, the last paragraph was, "we will continue to engage with provinces and territories and key stakeholders, including organizations representing first responders, to prepare for pandemics and our broader emergency preparedness activities". That's the way your statement ended.

In that effort, have you yet had an opportunity to meet with the representatives of the International Association of Firefighters? If not, I presume that they will be on your guest list, and you will consult with them.

The Chair: Dr. Spika.

Dr. John Spika: There are two firefighter groups: the international association and the Canadian association. We have had most of our contact with the Canadian association. We had face-to-face contact with them maybe a year ago or so, and before that, we had a number of interactions with them.

We have not had contact with them recently, but they are clearly one of the key groups on our stakeholder consultation list. As I mentioned, I anticipate that stakeholder consultation with the broader stakeholder group is going to start in late winter or early spring.

Hon. Ralph Goodale: Good. I think that's an important consultation to undertake.

Madam Chair, I want to ask Dr. Spika, and perhaps the other witnesses, about two documents. One is "Guidance on H1N1 Vaccine Sequencing", dated September 16, 2009, a document that was referred to earlier, and appendix to annex D, "Preparing for the Pandemic Vaccine Response". I am looking at page 10, which includes a table that I think outlines in graphic form the framework you referred to earlier today listing the various potential prioritization categories.

I have two questions.

One is on the legal status of both these documents, the one back in 2009, which I presume is being replaced by the new one that's in the appendix to annex D for the period going forward. The legal status of these documents, I take it, is that they are not mandatory, in the sense that they're not legally binding, that they're advisory. They're intended to try to bring the most helpful coordination in the context of a national public health emergency. What is their legal status? Are they mandatory or advisory, always leaving flexibility for local variations?

In comparing the two documents, it appears to me that first responders have moved up in the appendix to the annex compared to where they were in 2009. My practical question is, given the nature of the job that first responders do, in that when they're at the scene of an accident they deal with what's in front of them, no matter what, why would first responders not be included in the same broad category as health care workers or health care responders, as opposed to the lower categorization of a social workers or responders? Why would these first responders not be among the health care responders, as opposed to the societal responders? On the scene of an accident they're going to be dealing with a person in some physical health distress, and if they don't do their job right, that person won't get to the hospital to be treated by a doctor.

The Chair: He's not going to be able to answer the question, Mr. Goodale. You have less than a minute, Dr. Spika.

Dr. John Spika: I'll have to talk fast.

The annex you're referring to is linked to the 2008 pandemic revision to that annex, annex D. In terms of status, those annexes would have been approved by the Public Health Network Council, and sometimes by the Conference of Deputy Ministers of Health.

The other document you referred to, I'm not familiar with. You said it was dated the 16th of September. This would have come off the web. I'll have to—

● (1245)

The Chair: I'm sorry, Dr. Spika, our time is up now, but perhaps you could answer that question. We could distribute it to the committee. You will have time to look at it and put it together.

Thank you, Mr. Goodale.

I will now suspend the committee. We're going in camera for business, so I'd ask all people who are not members to please remove themselves from the room. In 30 seconds we're going in camera to get all our business done.

[*Proceedings continue in camera*]

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