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Chair

Ms. Bonnie Brown

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● (1540)

[*English*]

The Chair (Ms. Bonnie Brown (Oakville, Lib.)): Ladies and gentlemen, it's my pleasure to bring this meeting to order and to welcome back into our midst the now Honourable Minister of Public Health, Dr. Carolyn Bennett, who has returned to the scene of the crime.

Before we begin, Minister, I'd like to thank you for the tour of the Public Health Agency you arranged for us and for introducing us to the Chief Public Health Officer of Canada, whom we enjoyed meeting this morning and whom we will meet a little bit later, when he will get to present to us.

So for now we'll begin with the minister. She will take us through the deck.

Before you begin, Minister, does Dr. Butler-Jones have a separate presentation for later?

Hon. Carolyn Bennett (Minister of State (Public Health)): Yes. I thought maybe we'd go through the deck, and then let Dr. Butler-Jones make his introductory remarks as the first Chief Public Health Officer. Then maybe we could do the questions together. There may be some there just for me, and that's fine, on the appointment process and things. In effect, he does function at the deputy level in the area for which I have responsibility.

The Chair: Great. I think we'll do it that way.

Many of us have met with the two doctors earlier today. I'm thinking we might leave some room in the question and answer period for those people who weren't there.

Go ahead, Minister.

[*Translation*]

Hon. Carolyn Bennett: Good morning and welcome to this briefing on the Public Health Agency of Canada.

[*English*]

It's pretty exciting, I think, for us. Though people sometimes think that in government everything happens at glacial speed, somehow SARS really did galvanize all of us. As you'll hear from us later, here in Canada we're pretty proud that we beat the European Union by three days by having our Public Health Agency up and running on September 24. The EU opened its agency in Stockholm on the following Monday. Dr. Butler-Jones and I were pleased to be there in this new approach to this tiny planet, where germs don't respect borders and we are all in this together. It's really important that there's a network of agencies.

I don't think anybody needs any reminder of where we were 18 months ago with SARS. It really was just one year ago that Dr. David Naylor's report on lessons learned from SARS was tabled. It was very quickly after that when I was appointed as the first Minister of State for Public Health, and then on May 17 we were able to announce the design of the agency. In September there was the order in council that established the agency and we made the announcement of Dr. Butler-Jones as the first ever Chief Public Health Officer for Canada.

As you can see, there was a need. As you go to the deck on page 2, I think we were very proud that we held consultations really everywhere in this country, 38 different round tables around the country, trying to make sure that what we were trying to design was relevant and responsive to what people needed. I think we feel that usually, almost always, public health emergencies are very local occurrences. We were very clear that what we needed to do was to know what was needed in order to enable those local communities to respond in a way that was coherent.

The issue of the Naylor report was really a lack of cooperation, collaboration, communication, and a real lack of clarity on who does what when in an emergency. I think that's what we now feel we've been able to deal with in the new Public Health Agency. As we get through the deck, I hope you'll recognize that we weren't waiting to cut the ribbon on the agency in order to get moving on some of the things that were really missing during SARS with respect to the ability of provinces and territories to talk to one another, the national immunization strategy, and the new Canadian pandemic plan, which the World Health Organization has now celebrated as the best in the world.

What you need to know is that realizing the existence of real accountability to Parliament, the Chief Public Health Officer has the autonomy to speak his or her mind. The Chief Public Health Officer of Canada reports directly to the Minister of Health or to Canadians, through the Minister of Health, through Parliament. My job is to oversee the daily operations of the agency and to work very closely with the Chief Public Health Officer, who is the new professional head of the agency. I think that's what a lot of people felt and why all other countries have moved in this way, to actually have a professional leading the agency who is able to speak directly to Canadians about what is the right thing to do, without people worrying that there's some sort of political interference or there's something being hidden or some trouble.

The other exciting piece of this is that just having a counterpart federally who can deal directly with the chief medical officers of health in each of the provinces and the territories has made a huge difference, this informal network. Dr. Butler-Jones will talk to you about how it will become formalized and the way we will move towards a public health strategy for Canada.

Dr. Butler-Jones also then becomes the point person in Canada to deal with his counterparts at the WHO, at CDC in Atlanta, at the Health Protection Agency in Britain, and in the new European CDC. I think in the questioning it would be interesting to learn that when we were in Stockholm meeting the counterparts from the European CDC, Dr. Butler-Jones had side meetings with the people in Hong Kong. It's just knowing that there are real relationships.

● (1545)

[*Translation*]

The Public Health Agency of Canada includes two pillars: Winnipeg and Ottawa. The National Microbiology Lab and the Centre of Expertise in Infectious Disease Management are located in Winnipeg. The Agency now assumes responsibility for the services and resources of the former Population and Public Health Branch of Health Canada. Six national collaborating and international coordination centres have been announced on May 17 last.

[*English*]

We can just briefly go over the six collaborating centres. To me, the collaborating centres had two functions. One was the glue that was missing in the regions so local public health, provincial public health, the federal agency staff, academia, stakeholders like the disease organizations and the people who really know about things could be in constant communication to deal with the collaborating centre for that region. We then decided that it would be really important to have a sixth collaborating centre to deal with our most pressing problem, which is the gap in health status of our aboriginal people. I'm pleased to see and welcome the chiefs here today as testimony to the fact that we really feel it will be our ultimate report card in closing that gap in health status.

In an interesting federal and provincial meeting with stakeholders in the spring there were five areas they decided to focus on. So we've decided that each of the collaborating centres will become what I lovingly refer to as a "theme park". They would become the Canadian clearing house for what is going on in that area across the country and help us develop best practices and share information on what's working and what's not working. The collaborating centre in Atlantic Canada will look at health determinants. The collaborating centre in Quebec

[*Translation*]

The National Public Health Institute of Quebec will deal with health risks and policies.

[*English*]

So it's being able to deal with really the whole issue of risk and assessing risk, but also healthy public policy. I think we feel it's very much part of the Quebec model to make sure that the health lens goes across all public policy, and they're going to help us with that.

In Ontario they will be working with us, with their universities, on what we call "new tools", which is the info-structure infrastructure. That will be around all the new technology they use. As those of you who were at the centre this morning know, they have GIS mapping systems and those kinds of things, but there's also the kind of technology we can use for citizen engagement. McMaster and other places have done an amazing job on multidisciplines, on how you develop health tasks, and who is the best person to do which job.

In Manitoba, Saskatchewan, and Alberta their collaborating centre will be on infectious disease. I'm particularly interested in what's happening in Saskatchewan because of their collocation of a medical school with a veterinary school. I think what you'll hear is my big realization as minister that I never understood how close these are. Eighty per cent of the new and emerging diseases come from the clients of veterinarians. To have the laboratory systems closer together and a real partnership between those two disciplines has become really important. Then, of course, there's the work done in Alberta around vaccines, and the other work that is going on there.

British Columbia will be doing the environmental collaborating centre, and it will take the lead on the aboriginal collaborating centre. We believe their new University of Northern British Columbia in Prince George will have some role in that, but it will also be working with First Nations University, with the new Northern Ontario School of Medicine, with Manitoba, and the places that have really demonstrated interest in aboriginal health.

I think you know what we were able to achieve in the budget last year. I thank you all for your help on that. We were able to achieve $665 million in new investments. As you know, $400 million was in the trust fund that went directly to the provinces around immunization and around building up the local public health capacity, and $100 million went to Infoway to help us bring work on the electronic health record, etc., closer to public health. Infoway was able to help us with the public health surveillance piece. It was impressive to hear at the health ministers meeting, in the presentation from Dick Alvarez, how much they are actually ready to go on that.

The $165 million was to help with emergency response, the new health emergency response teams; some bursary scholarships and community-based apprenticeships; enhancing the surveillance, as we saw today, out at the collaborating centres; helping with the enhanced laboratory capacity; and strengthening international coordination and collaboration.

As we were explaining this morning, we've built a communications centre at the Winnipeg lab that can help us track outbreaks and deal with scientists around the world. They will not only help deal with the science and the outbreak tracking there, with the infectious diseases, but they will also be in contact with the emergency operations centre here that will also have to coordinate with defence, and security, and the central agencies that will have to help manage whatever it is, including those health ones that aren't infectious diseases—nerve gas or other kinds of things that would require an agency and perhaps whole of government response.

I think we've talked about David's role, that of Chief Public Health Officer. We decided before the election that it was very important to move on this, and in a very transparent way. On May 17 we appointed a search committee of Dr. Naylor, Perry Kendall from British Columbia, Brian Postl from Manitoba, the Honourable Monique Bégin, and Ian Green.

● (1550)

With the help of the search committee, Janet Wright and Associates did a very extensive search across the country and internationally, with ads posted everywhere. They then decided to choose who would be interviewed, and gave an announcement to us and to the Prime Minister of their recommendation.

In the job description that was posted, it was very clear that the new Chief Public Health Officer's role would be to be the leader of the Public Health Agency.

[*Translation*]

It plays a leading role in the area of national public health and in obtaining the citizens' engagement in this issue.

[*English*]

He will help us coordinate the federal government's policies, provide advice to the ministers, and work with the other government departments, the provinces and territories, the public health community, and Canadians on public health issues. He will be the spokesperson for the Public Health Agency on public health issues.

The interactions are clear, I think, in the deck. As we heard today, there is this powerful army of groups and communities that know a lot about the areas in which we need to work in terms of non-communicable disease, communicable disease, and community action.

David Butler-Jones will deal with his counterparts at the Council of Chief Medical Officers of Health; the regional health units; the laboratory and emergency preparedness networks; the departments of health, wellness, and social services; and such federal departments as Minister McLellan's, and Immigration Canada and Transport Canada.

In terms of internationally, we talked about all of the work that's being done and the new agencies that are happening.

What we're excited about, as we spent the summer hoping that the first ministers meeting would, as all of us on this committee know, move away from the repair shop....what lovingly, in one Calgary round table, was called the “tyranny of the acute”. David Butler-Jones calls it the “sickness system”, or the “health insurance system”. We'd like to actually be able to equate the sustainability of our health care system with the whole work on prevention and promotion.

We were very thrilled to see that recognition in the communiqué of the first ministers meeting in September, as well as in the Speech from the Throne, and then again in the FPT health ministers meeting ten days ago.

The next steps are to create the public health strategy, to strengthen the pan-Canadian public health network, to launch the collaborating centres, and then my new favourite thing, to try to do as the first ministers asked us to do—that is, to build some real goals for health for Canada. We haven't had them. Other countries have, and have had them differently. We need to really move forward on being able to achieve, with the provinces and experts, a set of really inspirational health goals for the country.

This is a big country, and one of the things that can really galvanize us all is to pick some goals to give us strong common purpose, and then allow for and respect the local wisdom, local knowledge, to get it done. Most of the work in public health is done in communities. We need to reinforce that and to actually then show the leadership that helps everybody get aligned, where the grants and contributions end up aligned, and we then can move forward to this shared mission of keeping as many Canadians healthy for as long as possible.

Thank you very much, Madam Chair.

● (1555)

The Chair: Thank you, Minister.

We'll now hear from Dr. David Butler-Jones.

Dr. David Butler-Jones (Chief Public Health Officer, Public Health Agency of Canada): Thank you, Madam Chair.

[*Translation*]

I am pleased to be here today.

[*English*]

I suspect that this will be the first of perhaps many appearances before the committee over the years. I do thank you for this opportunity.

I did want to open with some prepared remarks and then hopefully leave lots of time for conversation and questions. As I had mentioned at the open house today, certainly we're interested in trying to find and share the best information possible so that people have what they need in order to make the kinds of decisions we have to make, either personally or as a government, in policy.

Last month I had the honour to accept an offer to become Canada's first Chief Public Health Officer and to take a leadership role in the new Public Health Agency of Canada.

[*Translation*]

Last month, I had the honour to accept the offer to become Canada's first Chief Public Health Officer and take a leadership role in the new Public Health Agency of Canada.

[*English*]

As you know, the agency was formed in large part in response to the report of Dr. Naylor, “Learning from SARS”, and in particular it discussed the need for fulfilling the four Cs: collaboration, communication, cooperation, and clarity, which I think are actually a pretty good description of what this new agency and my role, particularly, should strive for.

SARS was a wake-up call for Canada, that we need to better anticipate, better prepare, and be more coordinated, cooperative, and effective in our response to public health.

● (1600)

[*Translation*]

SRAS was a wake-up call for Canada that we need to better anticipate, be better prepared, and be more coordinated and cooperative in our responses in public health.

[*English*]

The next SARS, with potential catastrophic impacts—if it were even more infectious than SARS—in terms not only of its impacts on the health care of Canadians but also potentially on our economy and business, is only a plane-ride away. So we must do better in recognizing the danger, protecting ourselves from it, restricting the spread of disease, and, finally, to eradicate it if possible.

That's only part of the agency's mandate. Aside from ensuring our preparedness for possible health crises, the Public Health Agency will take a lead role in the prevention of disease and injury, as well as in the promotion of healthy living for Canadians and in things like tackling the problem of obesity or physical inactivity. We will also serve as a centre for expertise and research in public health to develop a strong relationship with the rest of the health portfolio in the federal government, including Health Canada, the Canadian Institutes of Health Research, and regulatory agencies and others to internationally serve to strengthen Canada's place as a leader in global health efforts while providing a central point for sharing Canadian expertise with the world and in applying international expertise at home.

I think these foundations for health are essential to improving our health outcomes, because if we don't have a strong foundation, we can have the best hospitals, doctors, and medicines, but all the patching in the world will not solve the cracking problem in our walls. And we have now a new agency with a new outlook, a renewed emphasis on developing an effective cooperative relationship with the provinces and territories. It isn't enough to focus on quick solutions; we have to look upstream to see how people live, how their circumstances affect their health, and how we can impact on the broader determinants of health.

We as an agency are working on a plan specific to our agency on where we want to go and how we will get there, which is only a piece of the puzzle.

[*Translation*]

We are working on a plan specific to the Agency on where we want to go and how we will get there.

[*English*]

The agency's objective and my objective in all things we do must be to help Canadians to be the healthiest people in the world.

The agency has been in place now for only a few weeks. It was officially launched, as the minister described, on September 24. So by necessity, much of our efforts so far have been devoted to just getting it established and on the ground. We have two locations or centres in Winnipeg and Ottawa, as well as regional offices, and we are developing collaborating centres.

We've made a good start, spreading the word that we're here and in fact in operation, and we are putting in place strategies and infrastructure for the future and responding to challenges as they arise. It's amazing how quickly they can come.

Personally, since accepting this appointment my life has been a bit of a whirlwind. As the minister described, we were in Sweden for the opening of the European public health agency; we have been across the country with community groups, stakeholders, chief medical officers, federal, provincial, and territorial ministers and deputy ministers; and we have participated more recently in the introduction of the reforms to the Quarantine Act. All of these were necessary and I think informative in giving our partners and stakeholders a clear perspective on the issues, challenges, and priorities of the agency and to start the process of addressing the four Cs.

As well, the agency has successfully managed issues arising from an outbreak of tularemia, originating in hamsters in Manitoba—which even made *Air Farce*—the flu vaccine shortage in the U.S., and renewed concerns over *Clostridium difficile*in Canadian hospitals.

[*Translation*]

As well, the Agency has successfully managed issues arising from an outbreak of tularaemia, originating in hamsters in Manitoba, the flue vaccine shortage in the U.S. and renewed concerns over C. Difficile in Canadian hospitals.

[*English*]

Certainly, we've hit the ground running. I also believe it shows the potential for national collaborative leadership for public health. In the next few months you will be hearing a lot more about the Public Health Agency as we move into the more proactive aspect of our mandate.

[*Translation*]

In the next few months, you will be hearing a lot more about the Public Health Agency of Canada as we move into the more proactive aspect of the Agency's mandate.

● (1605)

[*English*]

We will work with the provinces and territories towards developing a pan-Canadian public health network comprised of public health expert programs and policy across jurisdictions and sectors to coordinate responses to public health emergencies, to develop collaborative public health strategies, and to develop national standards and agreement on key issues.

Second, we're working with our partners on a pan-Canadian public health strategy and to develop a set of national goals for public health.

Third, we're developing six national collaborating centres, each focusing on a particular area of the field to act as catalysts in bringing together relevant information, to analyze it, and to develop knowledge that can then be applied to improving public health throughout the country.

Fourth, we're playing a leading role to ensure passage of the Quarantine Act to ensure we have the legal tools for preventing the import, export, and spread of serious infectious diseases, while affording individuals full protection under the Charter of Rights.

Fifth, we will enhance our international collaboration with the WHO, the Centres for Disease Control, and others to strengthen partnerships on chronic disease initiatives, to improve outbreak responses, and to build public health capacity around the world and in Canada.

[*Translation*]

We will enhance our international collaboration, with the WHO, CDC and others, to strengthen partnerships on chronic disease initiatives, improve outbreak responses and build public health capacity around the world.

[*English*]

We will be an agency that supports and promotes excellence in scientific public health research, translating that knowledge into policy and practice. This not only concentrates on our current challenges, but also seeks to anticipate the public health challenges that will confront Canada next year and the years after that.

[*Translation*]

This is an ambitious agenda. And we have much to do. We have made an excellent start. Now we must move forward to make progress on all fronts. I believe we have the skills, we have the expertise and I believe we have the determination to make Canadians the healthiest people in the world.

[*English*]

This is an ambitious agenda and we have much to do, but we have made an excellent start, I think. Now we must move forward to make progress on all fronts. I believe we have the skills and the expertise, and I believe we have the determination to make Canadians the healthiest people in the world.

If I might draw on one of my favourite philosophers, Mark Twain, we must always remember that even when we're on the right track, if we're not moving, we'll be run over.

Thank you. Merci.

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

We'll move to the question and answer period now, and we'll begin with Mr. Merrifield.

Mr. Rob Merrifield (Yellowhead, CPC): I want to thank you for the tour this morning. It was enlightening and interesting to see what you're doing here in Ottawa in the centre. It would be very interesting to see what's going on in Winnipeg at the same time. I look forward to that sometime in the future.

Before I ask the question, I wish you well in where you're attempting to go. You talk about collaboration, communication, cooperation, and clarity. Those are all valid in their own right. So we wish you well in doing that nationally, for the betterment of the health of Canadians. Looking upstream, I think everyone around this committee has talked about this sort of endeavour in the past. We wish the agency well and we wish the minister well in her endeavour.

I'd like to go back 18 months with SARS. I'd like to ask some of the questions...when we saw actually what happened. I was really intrigued this morning when we saw what we called the GPHIN program and realized that was in place back in 1998-99. So we have been doing this for a number of years. We actually picked up SARS and fed that information to the World Health Organization, and yet we were so terribly unprepared for it when it reached our borders and landed in Canada. Your organization or agency will be responsible directly to the minister, as I understand what you're saying, which is not much different from what was the case at that time in that situation.

I guess I look back at that time and say, what have we learned, and did we have a legislative vacuum at that time that prohibited us from acting the way we needed to act, or was there just a leadership vacuum at that time, where nobody picked up the ball and really put it together to make the defence of Canadians priority one, whether it's provincial jurisdiction or federal jurisdiction? Was it a leadership problem from your perspective, Mr. Jones, or was it a legislative deficiency?

● (1610)

Dr. David Butler-Jones: I think the issues we faced in SARS have been fairly well laid out in the reports that have been done. SARS was, I think, a wake-up call for the world, not just for Canada. We see the extent to which international health regulations are now being revised in the light of SARS, which would allow, for example, the WHO, when we have an idea that something is going on in southern China or central Africa or wherever, to actually go and investigate and not simply wait for a country to provide evidence or advice or reporting on the disease that's going on there. That's one thing.

Second, for many years now we've come to take public health for granted. We've been very successful historically in the development of clean water, safe food, adequate housing, municipal and provincial services, etc., to ensure that we had a pretty good public health system. Unfortunately, we took that for granted. Some of the things that we now have in place and are putting in place are things that.... We just expected life to go on, and of course, we'd deal with it, whether it was.... With the tragedy of Walkerton or North Battleford, all these things, public health did respond in an effective way to address the problem once it was recognized, but then life went on. What SARS pointed out is that everything is connected, and if we don't actually focus on the fundamental underpinnings of our collective function in addressing public health, we will never catch up, we will always be playing catch-up, and we will never really be able to assure Canadians that we have a system that is able to respond as effectively as anyone could possibly hope it to do.

So that's where the agency has an opportunity to focus on these issues without distraction. The mandate of the agency is to address these issues and to work with our various partners to try to ensure that. That is what I think is the chief advantage we have this year.

Mr. Rob Merrifield: What I understand you to be saying is that it wasn't really a legislative change, it's just that we woke up, we realized that SARS.... Whatever SARS was at the time it hit, we didn't even have any idea of what it actually was. What you're saying now is that it was a catalyst to create more attention to this as an—

Dr. David Butler-Jones: Generally for the system's response.

Hon. Carolyn Bennett: Rob, I think what David is saying and what has happened even since then, an example being avian flu, where scientists from Health Canada went out to help them with the epidemiology and the risk of communication, is that there's this new understanding globally about how we have to help one another. With this mystery disease that was in Guangdong Province, as David said, it really was only when it came to North America that the science began to figure out the incubation period of this, the mode of transmission. Literally, the responders were operating in the dark here, because we didn't even know what it was.

Mr. Rob Merrifield: Yes, but we did all of that outside the agency, within Health Canada. Now we've just moved it outside and put a priority on it. We could have done it within Health Canada. We were at that time, right? Whoever was in charge of it in Health Canada was responsible to the minister. That is not much different than you are at the agency.

Dr. David Butler-Jones: Except that I report to the minister, but it is focused on public health. It is not focused on public health as one of many other things.

There are several things that have happened since SARS. One is when you look across the country at the level of developing collaboration, conversations between the institutional sector and public health, the development of plans and response plans locally, provincially, and nationally, whether it's pandemic flu or as it applies to other outbreaks or emergencies

In addition, nationally, we've been working on the development of building up the national stockpiles. We have quarantine officers in place at major airports, the alert system for respiratory diseases, the surveillance systems, the respiratory outbreak protocol that we've negotiated with the chief medical officers in the provinces, the development of a more systematic approach, rather than waiting to see what happens and then trying to cobble it together, which was the challenge we faced in SARS. While there were a number of those elements in place, they weren't in place in the same kind of focused way that allows us to work and respond quickly.

● (1615)

Hon. Carolyn Bennett: Rob, I want to say that at my first briefing I was pretty upset to learn that even in the transmission of information from the provinces to the feds or from hospitals to hospitals...coming from Toronto...to realize that no one would tell whether it was one patient who went to two hospitals or two different patients who went to two different hospitals. It's very difficult to track an outbreak if you don't have that basic information.

The idea of getting health professionals across provincial borders was a big problem. So from then to this.... I asked if I could see one. So a pandemic influenza plan where literally everybody in every province can say which stage of an outbreak we're in and what we all do together is just hugely different. I think that's really important.

Mr. Rob Merrifield: I don't have much time. I just want a quick—

The Chair: Thank you, Rob.

It's six minutes now for Ms. Skelton.

Mrs. Carol Skelton (Saskatoon—Rosetown—Biggar, CPC): Thank you very much.

I'd like to thank you both for coming this afternoon.

You were talking about the six national collaborating centres. How long is it going to take to have these up and running, and how much have you budgeted for that?

Dr. David Butler-Jones: In regard to the centres themselves, we're in the planning and development process. I would expect that by the new fiscal year we will have elements of that in place, agreements in place, and they will have the ability, basically, to hit the ground running. Their focus is in excellence in training, education, and research and the linking, the knowledge transfer, between what happens in research and policies and programs.

We're currently working on that, so I would expect we will have it in place at least for five of the six, and we could come back to you later in the new year so that they'll actually be working by April.

Mrs. Carol Skelton: How much have you budgeted for them?

Dr. David Butler-Jones: I'm sorry, I don't have the number in my head.

Hon. Carolyn Bennett: It's not a lot of money, about $2.5 million per year per centre, which is really just enough to get them going. We think each of them might be able to do two projects out of that.

It's also, Carol, probably going to be a little different in British Columbia because of the BCCDC, in Quebec with the Institut nationale de santé publique du Québec, and with the new agency in Ontario. It might actually be easier for them to get up and running just because one province is the region, as opposed to Atlantic Canada or the Prairies where there has to be a more cooperative, collaborative model, like the aboriginal one.

Mrs. Carol Skelton: Will your agency report to Parliament?

Dr. David Butler-Jones: The chance is that there would be an annual report. Obviously, it's up to the process.

Mrs. Carol Skelton: Will the agency be subject to access to information and report to the Auditor General?

Dr. David Butler-Jones: Yes.

Mrs. Carol Skelton: How many doses of smallpox vaccine do we have available in Canada at this present time?

Dr. David Butler-Jones: At the present time, if we needed it tomorrow, we'd have about 6.5 million doses, which from a public health perspective is more than enough to contain an outbreak, using the same strategies that eliminated smallpox.

We're currently doing research because the evidence suggests the vaccine could potentially be diluted 5:1, which would give us even more doses. But we're doing the research on that right now.

Mrs. Carol Skelton: Recently, in the Winnipeg lab, the national laboratory, there was a group of U.S. researchers who reconstructed a version of the 1918 pandemic flu virus. Now, this has caused some controversy.

I would like to have your comments on this and what you have gone ahead and done about it, because there has been concern brought in from the scientific community on this whole issue. I would like to hear what both of you have to say about that.

Dr. David Butler-Jones: First of all, it's a level 4 lab that's involved in the research to help us understand the different potential threats. One of those things is getting a better understanding of why it was that the 1918-19 flu killed young people with direct viral pneumonia in a very short period of time. Typically with the influenzas we see, it's the secondary infections, etc., that kill people.

They're not the only lab doing this work. There are labs around the world that are involved in similar work, different aspects of it, and the sharing of information. It was published in a popular journal, and that's why people then raised questions. But there is research like this going on in other labs.

It's a level 4 containment lab, and it's appropriate work, I think, for us to understand these viruses in a way that we can develop more effective strategies to address them.

● (1620)

Mrs. Carol Skelton: On the tour this morning I noted that you have four beds in the centre here so people can stay if there's a pandemic or something. Is that correct?

Dr. David Butler-Jones: No, there would be more. It's just that if somebody needs to lie down for a rest after working long hours, there are beds.

Mrs. Carol Skelton: For example, if something hits tomorrow, like SARS, we've got the command centre we need. We found in Toronto that there were medical people who had to go home and ended up getting sick and taking it to their families. Do you have a facility here in the centre in Ottawa and in Winnipeg where staff can stay contained in the centre?

Dr. David Butler-Jones: First, the Ottawa centre is not a research centre in the sense of working with these organisms. It's for rest, okay. The lab itself in Winnipeg is contained. Where the work is taking place in the lab, if you have a chance to go and see it, there are multiple layers of security to prevent breach of organisms. Generally, you're talking about a person who might be exposed at any given time, not dozens of people, should that ever happen. So it's not really like what the hospitals were facing in Toronto, where they had hundreds of workers potentially exposed in the facility, and so not going home was an issue. That's part of a discussion for another day on the Quarantine Act and being able to have a facility that can be made secure, so we can provide services if that were to take place in a hospital or some other facility.

Mrs. Carol Skelton: But if somebody who's been trained in emergency services, as I have, I think if you have a command centre where the people are working virtually 24 hours a day or on call 24 hours a day, you want those people contained in some place where they are safe and are not going to get sick. Because if you lose a key person out of that command team, you're in serious trouble. That's my concern.

Dr. David Butler-Jones: That kind of thing is part of contingency plans, where you would go if there were such a disease and you needed to protect a cohort. You would take over an area and provide an area that was secure.That is part of contingency planning for those events.

Mrs. Carol Skelton: Okay. Thank you.

The Chair: Mr. Ménard, followed by Mr. Savage, followed by Mr. Blaikie.

[*Translation*]

Mr. Réal Ménard (Hochelaga, BQ): I have five questions for you and I will put all five of them quickly all at once. I would appreciate having short answers. I apologize for having missed this morning's visit, but I was making a speech on the *Quarantine Act* and my whip did not allow me to leave.

Are you coming to us this afternoon with the support of the Government of Quebec for the establishment of the Agency, given that there is some risk of duplication and overlap with Quebec's Institut national de santé publique, to which you already alluded?

Second, in the documentation about the Agency, there is some talk of support for public health systems of provinces and territories. What form will this support take and what will it mean in concrete terms?

Third, I have read in your budget documents that there were $200 million set aside for 1,700 community program projects receiving grants and contributions. I would like you to elaborate somewhat on that and table a list of these projects by province.

Lastly, I am very much concerned about the determinants of health: mental health, smoking, obesity. What are the links between the health determinants and the Agency?

Finally, could you table some documents on the utilization of the $400 million for the national immunization strategy?

Let us take them one by one. The support of Quebec, do you have it?

[*English*]

Hon. Carolyn Bennett: There's not only the support of Quebec, but the assistance of Quebec, in that they really have a splendid approach to this. Dr. Poirier, Dr. Lessard, and Dr. Masse really are some of the best experts in the country, and they've been very helpful to us.

● (1625)

[*Translation*]

Mr. Réal Ménard: Second, in practical terms, how will you help the provinces and territories? Will there be financial resources? How will the help be provided to provinces and territories?

Dr. David Butler-Jones: The Agency's special expertise will allow us to work together with the provinces and territories. There will be $400 million for national activities, which will benefit provinces and territories. In my view, there will be in the future opportunities in the budget for...

Hon. Carolyn Bennett: Just like in the United States, the approach is really an invitation. It is an invitation from the provinces to the federal government. It would be impossible for the federal government to operate within a province...

Mr. Réal Ménard: Concerning the $400 million for the national immunization strategy and for the activities of the Agency, which is said to be at the service of provinces, could you send the clerk of the committee a breakdown of that money by province? Do you have any information to give us at this stage?

Hon. Carolyn Bennett: Yes, absolutely. It is a trust fund for the provinces.

[*English*]

There's a committee on national immunization, which picked the four immunizations they thought were necessary. We then gave a certain amount to each province in trust. They could then provide additional immunizations, which hadn't been possible before. Ontario has now covered other immunizations. British Columbia did that last week with exactly the money the federal government gave.

We can easily give you the breakdown of what they got in their trust. That was $300 million. We were hearing that people felt local public health capacity was somewhat frayed, so we gave an extra $100 million, again in a trust, to each of the provinces and territories to improve their local public health capacity.

[*Translation*]

Mr. Réal Ménard: The health determinants are quite important, namely smoking, obesity, mental health, and so on. How do you see the role of the Agency in dealing with each of these issues?

I understand that the Agency will have a much wider scope than merely the issues of infectious diseases and virology. With regard to the determinants of health, how do you envisage this contribution? What are your strategies in this regard?

[*English*]

Hon. Carolyn Bennett: David can fill this in.

The population of the Public Health Branch, as it was, had all of the functions of public health, the infectious disease and the emergency preparedness. It also had, as you say, the really important work of trying to reverse the other epidemics, diabetes, cancer, heart disease, the whole gamut of chronic disease prevention and injury prevention. All of that is very much part and parcel of the work of the agency. Whether it's obesity or diabetes, all of these things have an actual focus in the agency.

We should have brought the organizational charge of the agency, so that you could see the various programs that exist within the agency and that work is there.

Separately from that, as was part of your other question, the grants and contributions process very much helps local communities to do the work on HIV/AIDS, diabetes, and heart disease in those local communities. It's a two-pronged approach, the work actually in the agency and the cooperation with provinces and territories.

● (1630)

[*Translation*]

Mr. Réal Ménard: Do I have the time for one last question?

[*English*]

The Chair: Actually, you have three minutes and six seconds.

[*Translation*]

Mr. Réal Ménard: I have been told by organizations fighting against tobacco use—I would have to ask Ms. Copps; I don't know if you have any idea about this—that when Mr. Martin tabled the $250 million budget over five years to fight tobacco smoking, only half of the funds had been used. The fight against smoking is one determinant of health. Do you in your Agency have any information on the manner in which Health Canada has used the $250 million over five years that were intended for the fight against tobacco smoking?

[*English*]

Hon. Carolyn Bennett: I will speak first. One of our biggest dilemmas right now, and it's like the conversation we had a couple of times in this committee, is that the work between regulation and the collaborative cooperation a lot of people feel is quite a different approach.

So at the moment the only things that automatically come into the agency are the things that don't have regulation in them. At the moment, the tobacco program and the nutrition program still rest in Health Canada because they both have regulation and the program delivery piece in them. What Dr. Butler-Jones now will do is figure out what we do about that, and I feel a bit guilty because I was very much part of putting all the tobacco stuff together a number of years ago when we were worried about this, and now we have to make this decision.

[*Translation*]

Mr. Réal Ménard: Could you give us some real assurance that there will be a very distinct sharing of the work between Quebec's Institut national de santé publique and the Agency which will be established through legislation? What elements differentiate the mandate of each organization? When reading the annual report of the institute, one really has the feeling that there will be some overlap and duplication.

[*English*]

Hon. Carolyn Bennett: To me, it's two and two makes five.

[*Translation*]

Dr. David Butler-Jones: We are a partner of Health Canada, volunteer agencies, as well as the provinces and territories, regarding the national strategy and the Canada-wide objectives. The Agency's expertise will contribute to enhance the efforts made by others.

Mr. Réal Ménard: With regard to notifiable diseases...

[*English*]

The Chair: Mr. Savage, for ten minutes, unless you wish to split your time with somebody.

Mr. Michael Savage (Dartmouth—Cole Harbour, Lib.): I will split my time with Ms. Dhalla if there is any time left, if that's okay.

Thank you for the tour this morning. I found it extremely enlightening and somewhat comforting as a Canadian. So thank you for that.

I want to follow up on some comments actually that Mr. Ménard was talking about, and Dr. Bennett will not be surprised that I want to talk a little bit about the population health aspect of your mandate. The first question is, should we be concerned that population health was actually part of the previous title,and now is not part of the Public Health Agency? I know you'll say we shouldn't, and I know there are many people who say the distinction between public health and population health is purely semantic, because I think you told me that this morning, but I know there are also many certainly non-profit health agencies that believe there is a very big difference between population health and public health. The public health aspect of this is very important, but the population health aspect is to me as well, and whether you want to call it promotion or population health, or a national wellness agenda, whatever you'd like to call it, I think it's important.

I come from Atlantic Canada where the incidences of chronic disease are totally out of hand—the highest in the country. I'm glad the health determinants institute will be in Atlantic Canada. I'm wondering if you could talk to me a little bit about that. I'm not even sure where it's going to be, whether it's in Dalhousie or.... Maybe you can tell me where it's going to be. Give me a broad outline, if you would, of what it might do and of whether you have any models internationally that you have looked at in putting this institute together.

● (1635)

Dr. David Butler-Jones: I would argue that public health is the original population health, because the roots of public health are understanding the health and function of communities and what it is we do collectively to address those. In some popular consciousness, because of the nature of infectious diseases, a lot of the focus on public health is about the control of infectious diseases, or perhaps it's about the prevention of certain diseases, injury, etc.

But public health is a way of thinking about problems; it's not just a series of programs. So when we started to coin other terms.... Population health promotion is an approach to addressing things, but that's one of the public health approaches, and actually we're starting to rediscover that in fact public health is encompassing all of these things.

In my work, what attracted me to this specialty is that I can do more as a medical officer in that kind of a role than I could ever do clinically. It depends on not just addressing the lifestyle and one on one, but in fact the fundamental determinants that underlie a healthy community or not. Really, the roots of that are public health. That's what, 100 years ago, helped move societies towards universal education and housing, sanitation, school programs, and support for low-income families. It's a way of thinking about problems that understands that it's connected, so in that sense it is part of it.

I think the use of the language is less of an issue. I hope you and others—certainly the voluntary sector and others—will continue to look at us and say, you're getting the balance right. We have to.

There are two things. One is the things that are killing us on a regular basis are the non-infectious diseases—heart disease, cancer, diabetes, injuries, etc. On the other hand, when we have an outbreak like SARS, if we do not do it well, we do not have much credibility for anything else. We need to be prepared to deal with the outbreaks, etc., but not let that divert us from the reality that what it is that kills us prematurely on a regular basis is not infectious. It's always waiting there, preparing to pounce. If we're not doing the chronic disease prevention, we're going to miss the boat.

One of the points I made very strongly on the committee is twofold. One is that it's a public health capacity issue in addressing that, not just an infectious disease one, and that's really for two reasons. The first one is that most of the people who die, unfortunately, from some of the new diseases have underlying chronic disease. If you are fundamentally healthy, your risk of dying from these new infections is much less. So if we're healthier, then our risk of dying from the infectious diseases is less.

Secondly, you don't just have a whole lot of people sitting around waiting for the next outbreak. You need to have joint capacity, so that in the interregnum, while the plans are in place, they're in a position to actually help us address these underlying chronic diseases, injury, etc. You have to look at it as a whole. That's how I think the agency will view it.

Hon. Carolyn Bennett: Mike, I just want to say that I was surprised by how important the language actually is. I didn't realize that the HIV/AIDS community really hated the words “public health”, in that it took them back to the old days of the sex police and people shaking fingers at people. So the language is important. Also, people would say to me, is public health the opposite of private health? There's this civic literacy, health literacy, that we have to do that understands that public health really is the big umbrella of keeping people well, and population health is an approach to that.

Now, on the Atlantic collaborating centre—

The Vice-Chair (Mr. Rob Merrifield): Just finish quickly.

Hon. Carolyn Bennett: —it's going to be up to the region to decide. But I'd love you to chase this for me. There was a separate proposal for an Atlantic institute of population and public health, which is the way they themselves want to get organized in the region, and we haven't really seen any more on that.

● (1640)

The Vice-Chair (Mr. Rob Merrifield): Thank you.

Actually, we were supposed to go down to the NDP ahead of the Liberals, so we'll just let Bill take it for 10 minutes and then we'll come back to you.

Hon. Bill Blaikie (Elmwood—Transcona, NDP): Thank you, Mr. Chairman,

I was in an unusually non-obstreperous mood and allowed that to occur, but I'm glad the chair noticed that this was the case and corrected the situation.

A few comments first, before questions. I just want to say that I think to the extent that the creation of this new public health agency represents an advance in the overall paradigm with which we deal with health care in this country, it's long overdue. Just this week in the House a statement was made by the NDP leader concerning the 100th anniversary of the birth of Tommy Douglas, and certainly one of the things that I know Tommy looked forward to was the day—because he never thought medicare was "it". He never thought medicare was "the answer". He always felt it was the first stage and that we needed to get beyond medicare to address the determinants of health, to move to health promotion, disease prevention, wellness promotion, etc. To the extent that only the future will judge, this may represent, finally, the institutionalization of that insight.

We've had many reports in the past, going back to the Lalonde report, and many other things. We've been debating this for the 25 years that I've been around here, and finally now it seems to me we're having the institutionalization of this insight.

I can remember 20 years ago, when I was sitting around the health committee finalizing the Canada Health Act in the spring of 1984, moving an amendment to the preamble of the Canada Health Act—which I was trying to lay my hands on earlier but couldn't—saying that ultimately the health of Canadians would depend on the social, economic, and ecological dimension, not just on acute care, etc., or language to that effect. And here we are 20 years later finally institutionalizing that insight. I hope this will be the kind of progress so many people have been looking at.

I ask you this question. "Germs don't respect borders," I think is what the minister said. Of course, I would hope that some day we would have the kind of collaboration between countries that respected the fact that pollution doesn't respect borders, because we don't have that kind of collaboration now, and we may be able to collaborate with people to make sure that SARS doesn't come from somewhere else or to identify it before it does get here, but are we doing the same thing with toxins and pollutants? I don't think we are.

But there's an issue that has to do with toxins and pollutants and public health and everything else, and that of course is tobacco. I wonder if the minister has an opinion, or perhaps Dr. Butler-Jones, on the fact that right now the Government of Canada, in the name of the Canadian people, is intervening on the side of the tobacco companies in a lawsuit that is currently going on. I understand there's a class action against the tobacco companies. It goes after them for the labelling of their light and mild cigarettes, etc., and the very same person, who is now the Minister of Health, sued the tobacco companies when he was the attorney general in British Columbia. Now, as the Minister of Health for the federal government, he's intervening in this particular court case, not as one might have expected against the tobacco companies, but on the side of the tobacco companies.

How do you reconcile that with the prevention of disease? How does the federal government on the one hand create this agency and all this appropriate talk about prevention of disease and health promotion—that's what it's doing with its left hand—and yet with its right hand—I don't mean this ideologically, of course, Mr. Chairman, out of all due respect to you—is taking the wrong side, it seems to me. Even neutrality would be preferable to actually intervening on behalf of the tobacco companies.

● (1645)

Before we proceed to the answer, I'd just like to say that that was a five-minute question. I think you've met your match, Madam Minister. Now you have five quick ones to answer.

Hon. Carolyn Bennett: Let's take the easier ones first.

Hon. Bill Blaikie: I only had one question.

Hon. Carolyn Bennett: On the toxins piece, the whole circumpolar thing is going to begin the work on the toxins and the POPs, which don't respect borders either. We have this huge responsibility as a northern country to get our act together. I'm really looking forward to the work we're going to do in preparing for the 2007 international polar year as we really get going on this stuff.

On tobacco, I'm not a lawyer. The health minister is.

Hon. Bill Blaikie: Don't apologize for not being a lawyer.

Hon. Carolyn Bennett: I understand it is an absolute technicality because the Government of Canada was named in the suit. I understand it is a way of limiting the liability of the Government of Canada in this suit in terms of limiting the class. It's not actually about being on the tobacco side in the case. It's about getting the class certified. I think we will be on the right side of that file once we get to fight the case.

Dr. David Butler-Jones: Can I just add a little bit to the point on the respect of borders? It's not just pollution either; it's issues around how we deal with advertising and foods and the influence across cultures and societies and the impact ultimately on that. That's why working with WHO and with our partners in other countries is really essential. The WHO, for example, has conventions around tobacco and other things. More and more we need to be working together so we have a common understanding and the evidence that allows people to make the decisions, and hopefully have a better way of dealing with things not just confined to our borders.

Hon. Bill Blaikie: Following up on the WHO, Mr. Chairman, I wonder what kind of relationship would your agency then have with public health authorities in Taiwan, given that there's a lot of traffic back and forth between Canada and Taiwan, yet Taiwan is not permitted to be part of the WHO. In fact, in spite of the will of the Canadian Parliament, there is no support for it even having observer status at the WHO.

Is the committee concerned that so far the Canadian government hasn't acted on this? Given that they haven't acted on it, how do we deal with those gaps in that international collaborative context where people aren't permitted to be at the table?

Dr. David Butler-Jones: One of the advantages of being an agency is that we relate profession to profession. For example, if there's an issue, I can call up my counterpart in Taiwan or Hong Kong or wherever and ask what is happening there, and if they have some challenges, we share expertise and we share experts too with the WHO in other countries. We have epidemiologists who sometimes go and assist with investigations in other countries. We have relationships with other agencies that mean we can draw on their expertise and experience. It really allows us some flexibility that sometimes is more difficult for ministries.

Hon. Bill Blaikie: Just very quickly, one of the other things you referenced was the issue of reconciling everything you do with the Charter of Rights and Freedoms. Can you give me an example of where that kind of tension is in play between the Charter of Rights and Freedoms and public health?

Dr. David Butler-Jones: Again, this is a conversation perhaps for Thursday, but certainly one of the issues in the old Quarantine Act was that it was from a time when the ability of government to take people and lock them up because of an infection was relatively unfettered. What the new act is intended to do is balance the need to protect the public with individual rights to appeal or to a hearing or whatever. That's one example.

● (1650)

Hon. Bill Blaikie: It's probably used on election day, Mr. Chairman.

The Vice-Chair (Mr. Rob Merrifield): I'm sure we'll have more questions about that on Thursday.

Ms. Ruby Dhalla (Brampton—Springdale, Lib.): I'm a new MP. I haven't gotten the bug to ask a long question, so it's going to be short.

The Vice-Chair (Mr. Rob Merrifield): That's no problem; it'll come soon.

Ms. Ruby Dhalla: First of all, I want to congratulate you for the initiative that's been undertaken with regard to some of the mandate you've outlined, in particular trying to shift our society from a very reactive approach that's existed in the past to one of proaction, especially with regard to your mandate where you've outlined the prevention of disease and the promotion of healthy living.

My question comes with regard to what the minister has spoken about and the development of a long-term strategy and a long-term vision for where the department is going to be going in the future. As we look at certain diseases, certain demographics of society are predilected to certain conditions. We look at the aboriginal community, the first nations, as having a huge predilection for diabetes. We look at the South Asian community and there's a huge predilection for heart disease and high cholesterol. We look at the youth of our society and they have a predilection to certain other diseases.

With the collaboration centres, and as you move forward, I would like to ask you where you are right now in terms of targeting some of those initiatives. Traditionally, as government, I think we've always advertised in places like the *Toronto Star* or *The Globe and Mail*, whether it be for grants or contributions,as the minister outlined. Well, those communities don't read those types of things.

What initiatives are going to be undertaken by yourself to ensure that the outreach is done and that it really reaches the people it needs to?

Dr. David Butler-Jones: I think it happens at many levels. Part of the response is in ensuring that we improve our connections at different levels of the delivery of public health services. At the local level, medical officers, nurses, health promoters, etc., work in communities and have a better understanding of communities. Our partnership in working with the First Nations and Inuit Health Branch in Health Canada, with the different cultural communities, etc.—some of that we would do directly at the national level, and a lot happens through making sure we've got the right partnerships through the system, so local public health can.... Then issues that are in common can feed up, and potentially we have an ability to address them collectively better than individually. So the understanding around whether it's our own guidelines, the value or understanding of how integrated strategies are more effective than isolated strategies....

The work coming up in November is the global forum for integrated chronic disease prevention, and following that will be a national forum. We're integral to that with partners across the disease entities and the Chronic Disease Prevention Alliance of Canada, which has come together to recognize that many of these issues we do better collectively than individually with separate strategies. Obviously there are particular populations that are affected by one more than another, and the strategies, or whatever is developed, have to reflect that.

Hon. Carolyn Bennett: As we were trying to make sure this agency felt different, there were two things that obsessed me about it. One was evidence and the other was citizen engagement, and that we actually have to build those into the DNA of this new organization.

On the evidence side, what we're trying to do is make sure that the other pieces of government, like CIHI, like CIHR, like Stats Canada, as well as the Public Health Agency.... How do we make sure that each of those is informing the kinds of questions we need answered, and that we can influence getting better answers? But then how do we make sure the agency ends up with the new tools—and that's what Ontario is going to help us with, with their collaborative centre —using the most modern technology? We know that teens go to the web for their information on sex. How do we make sure that what's there speaks to them in a way that they understand and be motivated...? I was pretty impressed when we were down at the CDC in Atlanta; they have a TV station.

But your point in terms of the culturally sensitive things.... I also have to say—though the chiefs aren't here—that some of the research we have not done in a population way.... I am pushing that Canada's food guide may not apply properly to the various populations we have. Aboriginal people never had carbohydrates in their diet. Dr. Jay Wortman is obsessed that the first wave of diabetes in aboriginal people came when they started to grow corn in southwestern United States. We need better research to show that without carbs in the aboriginal diet, diabetes among aboriginals comes down—and we've certainly got the anecdotal piece on that.

The same is the case with milk in the adult diet. There are some Southeast Asian nutritionists who would say maybe that shouldn't have been there. How do we get the research to show that one size doesn't fit all?

● (1655)

The Vice-Chair (Mr. Rob Merrifield): Mr. Fletcher, you have five minutes.

Mr. Steven Fletcher (Charleswood—St. James—Assiniboia, CPC): Thank you, Mr. Chairman.

I am looking at page 4 in your handout, with the heading "Public Health Agency of Canada". Point 4 on page 4 says that the agency is an important first step towards building a seamless, comprehensive national public health system in Canada. I think that's probably correct.

Point 1 says that the Chief Public Health Officer reports to the federal Minister of Health. The second point says the minister of state oversees the operation of the agency. Point 3 says the agency is managed by the Chief Public Health Officer. I don't see what the practical difference between "oversees the operation of the agency" and "managed by the Chief Public Health Officer" would be.

My question is to Dr. Butler-Jones. In the spirit of a seamless operation, would it not be better to just have your position and perhaps remove the minister of state from the loop?

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

Mr. Steven Fletcher: Surprise, surprise.

Dr. David Butler-Jones: Well, no actually—and I've said this and I believe it—one of the things I think was a very positive move for public health, which is the health of the country, is to have political oversight to the process, which is dedicated to the public health realm as opposed to health in its breadth.

I report to Minister Dosanjh as the minister accountable for the health portfolio. I work closely with Minister Bennett. My role is the function and the professional activities of the agency. The minister of state's is how that interacts with the political process. I think it's a tremendous benefit to have a minister who is dedicated to these functions, as opposed to being one of the 20 activities Minister Dosanjh has to pay attention to.

Mr. Steven Fletcher: If we accept that logic, then why don't you report to the minister of state and not the health minister?

Dr. David Butler-Jones: The simple thing is that the direct line is to the minister and then to Parliament, or whatever. The budget comes under the minister, not the minister of state, and I should go where the money is.

Mr. Steven Fletcher: That sounds like a typical Liberal.

Some hon. members: Oh, oh!

Dr. David Butler-Jones: I'm non-partisan.

Hon. Carolyn Bennett: The other thing is how we are able to deal with the determinants piece in a whole-of-government way. What we're trying to make sure is that the Chief Public Health Officer doesn't get to sit at the cabinet table.

When last week Minister Dryden, Minister Owen, Minister Ianno, and I had breakfast to deal with the determinants of health piece about keeping people well, that is the sort of coordinating function I get to do across all of government. While David worries about running the agency, I get to do the healthy public policy piece, as well as deal with my counterparts, such as the fabulous new minister responsible for healthy living in Manitoba, Theresa Oswald.

It's that whole-of-government piece that I'm responsible for. But as David said, there's also the fact that Minister Dosanjh's responsibility is to see how the Public Health Agency fits into the whole portfolio of health, in terms of all of the pieces he looks after.

This is my work in progress, my little "healthy Canadians" tree. I think if you look at the healthy Canadians tree, you can see in the root system that I actually need to be dealing with all of the other ministers who can help me on the determinants side as we work together on the risks and the outcomes cited within the agency.

● (1700)

The Vice-Chair (Mr. Rob Merrifield): You may have just one quick question.

Mr. Steven Fletcher: Minister, then where is your legislative authority? If the Minister of Health has all the power, what more—I don't know what else to say; I'm just a rookie and I'll be blunt: what is your role more than a figurehead role?

Hon. Carolyn Bennett: I think there's no question that's what ministers of state do, but my main job is to bring people together and to make things happen. My job was to get the agency up and running. My job was to get the search committee and the Chief Public Health Officer appointed. My job was to convene 38 round tables across this country to make sure what we were doing was relevant and responsive.

I do love my job.

The Vice-Chair (Mr. Rob Merrifield): Ms. Chamberlain, you can pick up five minutes.

Hon. Brenda Chamberlain (Guelph, Lib.): Dr. Butler-Jones, I wanted to ask you something very specifically. You must play a fairly important role, I would think, if one of our nuclear plants were to have some problems, whether that were an attack or whether it were a leak.

Can you tell me what type of thing you have prepared for and how you would go about helping people?

Dr. David Butler-Jones: There are a couple of aspects to that. One is that around each of the nuclear plants there are response plans that are provincially based and regionally based. We would fit into that. The other is that there is some expertise within the federal government, of which we have a part, around the health effects of radiation, etc.

So we're in a position to provide some additional support, advice —technical advice, etc.—to build on the regional and provincial capacity in dealing with it. It really is a partnership.

Ultimately, one of the things involved in my role as CPHO concerns the public's understanding of issues and trying to make sure they have the right information, etc.

As an agency, our interest is that wherever planning needs to take place there are appropriate plans in place. I know, having worked in Ontario and with my colleagues who are around the nuclear plants there, they all have contingency plans for dealing with these things for which, while the odds are very small—everybody hopes it would never ever happen; that's why there's so much redundancy in the system—at the same time you have to prepare for it, just in case.

Hon. Brenda Chamberlain: Absolutely.

So it is the province that's mostly responsible, is it? Am I hearing you correctly on that?

Dr. David Butler-Jones: Yes, in terms of the health response, because it involves health services, public health locally, etc. There is a federal role concerning atomic energy involving safety, etc., which is a federal responsibility that we relate to.

In the month I've been on the job, I haven't actually sat down with them, but it is my intent to do so.

Hon. Brenda Chamberlain: That's great.

Just as an aside, I saw you in getting your flu shot. I have to assume you must think it's fairly important for the general population to get, if you and Carolyn were in there getting yours.

Dr. David Butler-Jones: I think we both meet the criteria, in terms of high risk. Actually, I had my flu shot in Winnipeg the other day, but I gave the minister hers today. Certainly, in terms of those who are at risk.... I have asthma. If I were to get influenza, I would be in big trouble. So even when I wasn't doing clinical medicine, I've always gotten it.

I think it's important that parliamentarians also be immunized, because if suddenly half of the Parliament were down, it would create challenges for the operation of government, which is key. You fit into the essential community services group, I think.

Hon. Brenda Chamberlain: Is there any way to track that flu shot to know if it's actually doing what it's supposed to? Do we know that? Do we have figures on it?

Dr. David Butler-Jones: Yes. There's always ongoing research in terms of the development of the vaccines. Then we look at what's happening each flu season. No vaccine is 100% effective. No medication is 100% effective. What you're trying to do is reduce the severity.

In terms of influenza in those who are at greatest risk of the complications, while not all of them will be 100% protected, if they do get the illness their risk of severe outcomes is much less.

As well, we recommend those who are in close contact—health care workers, etc.—create, in effect, a ring around those who are at greatest risk. The sad irony is that those of us at greatest risk are also least likely to develop the best immunity, so those around us are part of the protection, along with washing of hands, etc.

So we do follow it. Each year the match is different. The virus changes. For example, last year we were all a bit surprised when the Fijian strain came along, which was enough of a variant that the vaccine did not have as great a protection as typically. We're expecting that this year will be better. You cannot predict from year to year how bad the year will be for flu. We're hoping, especially given the challenge the Americans are facing, that it's a mild year, but only time will tell.

● (1705)

Hon. Brenda Chamberlain: Carolyn, I saw you nodding that yes, we do have figures. If you have them, could you send them to me, please? I'd like to see what they are and how good we think we're doing on this.

I think this is very important, and to the general population, it's a really important thing.

Dr. David Butler-Jones: We know that putting a ring around people, like in old-age homes and places like that.... In many of them, only half the staff are immunized. That's a huge risk to their patients.

It's really important that health care workers and others are.... In most of the epidemics in nursing homes and other places it's either brought in by staff or spread by staff, because we're actually infectious before we have symptoms. The only way to prevent that at the front is to make sure we're immunized.

Hon. Brenda Chamberlain: Thanks very much.

The Vice-Chair (Mr. Rob Merrifield): Mr. Lunney, five minutes.

Mr. James Lunney (Nanaimo—Alberni, CPC): Thank you very much, Mr. Chair.

I want to also express my appreciation for the tour through the facility today. Thank you for welcoming us.

I for one want to go on record as saying that I am glad we have such an agency for public health. We're certainly glad to see such an excellent facility here coordinating with Winnipeg. We want to see it be very successful in assuring Canadians and helping to respond when we need to.

I wanted to make a couple of comments.

First, I heard a quote earlier that if we don't do the surveillance and if we don't process data and collaborate and communicate, we'll always be playing catch-up. I saw some of those screens about events around the world that you're monitoring with the GPHIN program, where they monitor issues and risk factors and so on around the world.

You mentioned that you want to focus on prevention and promotion. Walkerton, West Nile, and SARS have sort of jarred the public as to the importance of public health.

I want to talk about a concern that's current today, and that's *C. difficile*. It's certainly current in Quebec. The papers were full of it last week. We saw reports going by about this particular bacteria that is related to hand washing and *Clostridium* spores. We saw overcrowding in the hospital rooms and overuse of antibiotics all mentioned as issues.

I met briefly with the minister of state and with one of your officials on the phone, Dr. Butler-Jones, about a risk factor that was mentioned at least a year ago. It was also reported in July in our own *Canadian Medical Association Journal*, and it's been in the popular press. That is the relationship, the risk, associated with a commonly prescribed group of drugs that a large segment of the population are going on.

The CMA journal says that the use of proton pump inhibitors, commonly known as gastric acid inhibitors, has doubled in the last two years. For heartburn, people are on these medications to reduce their gastric acidity. If that's a factor with *C. difficile*, if in fact the *C. difficile* is controlled by gastric acidity, the medication reduces that gastric acidity. Then they get on the antibiotics, which wipe out the flora that also help to contain *C. difficile*, and it creates an open playing field for *C. difficile* to multiply, with risk of death to these people.

If the agency is aware of this risk, what is being done in a proactive way to warn people?

Dr. David Butler-Jones: There are a couple of things with that. Ultimately, it is a clinical decision and trade-off. While it's one of the risk factors that increases the risk, if you get *C. difficile*, of it being severe, it's only one factor.

The problem is that if you warn people that they shouldn't go to hospital if they're on these, or that they should stop them, the risk is that they end up with either bleeding ulcers, reflux, or other issues, and the net benefit is negative. It's one of those things that is a clinical decision.

On the website when we talk about *C. difficile*, it also has information about this association. We don't know that there's a causal link, but there is an association. It's something people should talk about with their physician; they should not act on it. The last thing you want to do is put out a warning that, by people acting on it, would end up actually increasing their ultimate risk of dying or having severe disease.

In the medical journals there has been, as you say, information to doctors, etc. We've added it to our website. It really is—I'll put my physician hat on now—a clinical decision. I would have that conversation with my patient. If I were a surgeon or if I had a patient in hospital, it would be one of the factors I would look at, but only one of the factors.

● (1710)

Mr. James Lunney: But, Doctor, the *Canadian Medical Association Journal* suggests that it's two and a half times the risk if they're on those medications. Two and a half times is a 150% increase in the risk. That doesn't sound to me like a peripheral thing; it sounds like a very significant thing. If that is the case, this is a combination of meds that some have been suggesting...and I'm referring to the *Journal of Infectious Diseases*...a hospital infection. That was a year ago. There have been editorials in the Montreal *Gazette* and the *Toronto Star* making that link. Surely you are not equating a medication that just reduces gastric acidity for heartburn.... It's hardly fatal. I'm not aware of a lot of people who are dying from gastroesophageal reflux.

Dr. David Butler-Jones: It's not just for heartburn. With severe reflux disease, people can get aspiration. They can get secondary pneumonias. People can get bleeding ulcers and die from them. It is not a trivial issue. Part of the challenge is always the clinical decision between the balance of risks. Each time we go into the hospital, no matter what we do, everything that happens has a risk, and it is a balance of risks. If I have surgery, I could die from the surgery. We need to balance the risk of the surgery versus the alternative. Any medications I take can kill me, even in the correct dose. One aspirin could kill me if I'm allergic or have an anaphylactic response.

It really is the balance of risks.

Mr. James Lunney: Doctor, with all due respect—

Dr. David Butler-Jones: If I might just finish, I'll be very quick.

That's why it's my decision to say I'm not going to issue a general warning to the public. I think it's important that physicians, as part of their responsibility to their patients, understand this risk in the context of the other risks their patients are facing and make a clinical decision in conjunction with their patient in the best interests of the patient. But to send out a general advisory, other than the information that is available generally on the website, etc., would not be responsible at this time.

Mr. James Lunney: With all due respect, Rob, just a moment.

The Vice-Chair (Mr. Rob Merrifield): James, I'm sorry, your time is gone.

Hon. Carolyn Bennett: I would like to say that these are prescribed by physicians, and we are—

The Vice-Chair (Mr. Rob Merrifield): I'm sorry, we have to respect the time. Perhaps at the end we'll have another opportunity to ask more questions on this.

Madame Demers.

[*Translation*]

Ms. Nicole Demers (Laval, BQ): Thank you, Mr. Chair.

Thank you for this morning's visit which was quite interesting. I was very much impressed that technological advances would allow us to follow accurately on the map everything that is going on all over the world in the area of infectious diseases.

This is not what concerns me. In my view, it is quite relevant that it should be the responsibility of a Canada-wide agency. However, I have concerns about the responsibilities that Health Canada has delegated to you and that are encroaching on the provinces' jurisdiction.

You were telling us earlier that the provinces, Quebec specifically, were in agreement with your approach, but I am wondering whether these people know about the Agency's powers and the extent of these powers in the area of mandatory notification of communicable diseases and of the power that is being exercised beyond the scope of the existing authorities. For example, we have in Quebec a health agency that is doing some very good work.

In the course of your presentation or during your meeting with the Quebec people involved, were they made aware of all the issues that you will be supervising or overseeing? Do they agree with the responsibilities that this involves?

● (1715)

[*English*]

Hon. Carolyn Bennett: Is Richard Marceau on the committee with you? Wasn't he on the other committee?

Dr. David Butler-Jones: There were others. I think the partnership....

[*Translation*]

There is expertise in Quebec as well as in other provinces and territories. Our objective is to facilitate and improve measures being taken to enhance what is being done under the provinces' and territories' jurisdiction. We are partners.

Hon. Carolyn Bennett: We are talking here about collaboration and communication. It is a parternship approach. The risk of SARS, for example, was an extremely important issue for Canada.

[*English*]

It's not central command and control any more, really; it's a distributive model. We can go and help in a jurisdiction if they invite us to come and help. In terms of diseases, all of those things, it very much is that everybody now gets it. That's why the EU could come together so quickly toward their European CDC. They understand that they need to collaborate across borders, need to be talking to one another about what's going on.

The Vice-Chair (Mr. Rob Merrifield): Mr. Carrie.

Mr. Colin Carrie (Oshawa, CPC): I want to be the devil's advocate for a moment, just looking at SARS and the public health reaction to situations like this.

I know the mandate is to protect Canadians and to err on the side of caution. There was a huge economic consequence from SARS on the tourism and hospitality industries. I was just wondering, what do you have in place now to talk about realistic cautions, actual concerns, versus the media and the paranoia generated by this? If you remember, it was a worldwide thing. How do you decide on what action to take and what criteria to use?

Dr. David Butler-Jones: In a way, it relates also to Mr. Lunney's question. I know there are people in Quebec who are saying, because of this disease, I shouldn't go to hospital at all. That's a huge risk for them if they really need to attend a hospital.

Part of the challenge, and I hope part of the reason I'm doing this job, is to work with the media. The media has tremendous power to either inform or misinform. We need to ensure that we have the relationships or the understandings that mean they have good information when messages get conveyed.

When we went through SARS, the first part of SARS, I remember a media debate that I was part of. It almost sounded like a Gothic novel—you know, virus oozing from every pore, with each organ, one by one, shutting down, etc. And then later on in the outbreak, the media became more interested in helping people understand the issue, what really was happening, and what kinds of things they could do to reduce their risk, etc. So we want to try to move very quickly into that form of communication.

Secondly, it's having the partnerships and the relationships that transcend health so that decisions are made in light of evidence and consequence. At the end of the day, however, if it's a threat to Canadians, I have to speak to that issue.

● (1720)

Mr. Colin Carrie: Do you have something in place to deal with a situation like that?

Dr. David Butler-Jones: There are a couple of things I could mention very quickly. One is that we have regular meetings of the chief medical officers across the country. In a couple of hours, we can have a phone call, have that conversation in terms of what's happening, what their experience is. Or we can get whoever we need around the table to have that conversation. So it's not a week's debate, it's more like hours. A decision is made and then we move forward.

As well, there are people within the agency who then make sure that others know about what it is and bring in other information that we don't anticipate, etc. We can then move very quickly on these issues.

Hon. Carolyn Bennett: I think the doctor is being modest. There was no question that the job description of this position included being an excellent risk communicator. I think that very much was what the search committee was looking for in their selection of Dr. Butler-Jones. From his handling of North Battleford and other kinds of things, people know that he can speak to the camera and do that kind of risk communication, about what's a zero risk or what's a minimal risk.

Health Canada certainly learned a great deal in terms of SARS. Unfortunately, even on the website it looked like the number of cases was going up, when actually the number of new cases was going down. I think we learned a great deal around how we explain risk.

I think this committee needs to really struggle somehow with how we can maybe do a better job on what's zero risk, on what's minimal risk, on drawing the line for Canadians in terms of what is acceptable risk or not, whether it's BSE or any of these things. How do we inform Canadians, as you asked in your question, without alarming them unduly and taking some sort of real hit economically?

Mr. Colin Carrie: I am glad you have looked at that issue.

I have another quick question. This spring the health committee learned that the Canadian diabetes strategy has been renewed for a year for $30 million, and we're wondering if the strategy will receive a further funding commitment.

There's a whole review of all the branch contributions. We're expecting it shortly, right?

Hon. Carolyn Bennett: The Auditor General is in the agency now reviewing the grants and contributions. We are very interested in looking at how we do this and how we do it in a coordinated fashion. There's no question that we need a diabetes strategy for Canada and we need to be able to help pay for that.

My obsession, if you look at my tree, is that in funding for the common risks—smoking, exercise, diet—those common risks are also for cancer, heart disease, and diabetes. The question is, how could we do that in a more integrated fashion? So you'll see in the first ministers' communiqué the interest in integrated disease strategies is very much how we do this for teens, for seniors, for kids, how we get integrated strategies where some of the prevention promotion is done in a coordinated way. That is why David, with the coalition for public health, and also the new coalition around chronic disease that these diseases are trying to come together to do this in a more coherent way....

We really feel the tsunami of diabetes, particularly in adolescents, and particularly in our aboriginal people, obesity. I think we're going to have to take real steps towards that. But how we do that is yet to be determined. As for the groups on the ground who are working on diabetes now, I think we will know that we need to help them do that.

The Chair: Thank you, Mr. Carrie.

Mr. Thibault.

Hon. Robert Thibault (West Nova, Lib.): Welcome to your new position and to the service of Canadians. I don't know very much about you, except for having met you a couple of times and having had a chance to have that encounter with you today—the tour of your facilities. Everybody seems to have great confidence in your ability to do the job to which you have been appointed. All media reports have been positive. It is very seldom that we see public officials get unanimous approval, and it seems to be that I haven't seen anything negative.

For the benefit of the committee, Dr. Butler-Jones, could you tell us a little bit about what you have done previous to coming to this position that so impressed the media as well as the committee that was doing the search?

● (1725)

Dr. David Butler-Jones: That's awkward.

Quite honestly, I don't often talk about myself, and even with the committee one of the questions was “Why you?” It's not the easiest thing. The way I sum it up is I've had the good fortune to work in clinical medicine and academic and research and public health at the regional and provincial levels in different parts of the country, as well as having worked consulting, providing advice to other countries in the world on different issues. I have been dragged into things, whether North Battleford outbreaks or smaller ones or the response to SARS or chairing the round table on climate change and health, and trying to bring together industry and advocates and health and other perspectives into something that makes sense collectively.

I've just been tremendously fortunate. It's been an incredible gift for me. To be able to do this job now is a tremendous challenge and also a great privilege. I must say the level of support has been very gratifying, but at the same time embarrassing, and also a little bit foreboding in terms of the magnitude of it.

Someone in the media asked me about it the other day, because they keep referring to me as Canada's doctor, which again.... There are an awful lot of good doctors in Canada. But I guess the simile for that is in clinical practice my patients, or my patient, I dealt with individually, and in this case my patient is the country. My purpose is to try to bring together the best strategies, knowledge for the patient, prevention promotion, appropriate treatment, appropriate understandings that help the patient move forward to be the healthiest he can be, and to narrow the gaps between the least and the most healthy.

That's an incredibly exciting challenge, and quite honestly, I've never been more optimistic about our ability as a nation to do that.

Hon. Robert Thibault: I can understand that. Seeing the pretty well unanimous support that there was for you in that position, you must have worried whether or not you had taken the right decision to accept the position.

There are two very quick points I'd like you to touch on. One is the relationship between your organization and organizations like the Canadian Institutes of Health Research and others as to priority setting in light of the new organization.

Second, I'd like to finish my time with this. Perhaps you could tell us what you'd consider to be the greatest challenge, or the goal by which you'll mark your success or lack thereof—but I'm never negative; I'll be positive.

Dr. David Butler-Jones: For us to be effective, it's having the appropriate linkages, cooperation, joint planning, etc., with other agencies and levels of government, voluntary sector, etc. That's essential. We've already been involved in a number of conversations around the development of potentially pan-Canadian goals or around their research funding and what we and others do in research—how that can contribute to the whole. All of that is certainly essential. That's where we're going at this point.

Sorry, quickly, what was the second part of the question? I didn't write it down.

Hon. Robert Thibault: What would you consider your greatest challenge?

Dr. David Butler-Jones: What I would measure as success would be that at the end of my five-year term people would look at the agency with some confidence that in fact the agency has done what we said it would do—that it has contributed to the health of Canadians—and we have confidence that as things arise...and I would not be surprised to see them; nature is completely inventive. In fact, as a country, we've responded as effectively as anybody could hope we would.

Hon. Robert Thibault: Thank you, Madam Chair.

● (1730)

The Chair: On behalf of the committee, I'd like to thank the minister and the Chief Public Health Officer. I find that quite a mouthful. I always want to say the chief medical officer of health.

Dr. David Butler-Jones: People often confuse the terms.

The Chair: Thank you for your time both this morning and this afternoon. I hope this has created a level of understand among all of us that will equip us to tackle your first piece of legislation, which is coming to us on Thursday, and at which time we will welcome you or whosoever you wish to send in order to help introduce that legislation to us.

Thank you very much.

I would just say to my colleagues on the committee that you will recall you have received a notice of motion. That will also be on the agenda on Thursday. I believe we will deal with it first. In fact, there are two motions.

Thank you very much, ladies and gentlemen.

This meeting is adjourned.

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