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Chair

Mrs. Joy Smith

Standing Committee on Health

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● (1415)

[*English*]

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

I want to especially welcome Minister Aglukkaq, the Minister of Health. It is indeed an honour, Minister, to have you here today. Thank you so much for making yourself so available right in the middle of summer. We appreciate it very much.

We also welcome Ms. Woods and Dr. Butler-Jones to the table.

In the first hour we are going to be having the minister present and then have questions and answers. I'm not going to give you a time limit. If you would just make your presentation, Minister, then we'll go into the questions when you've completed your remarks.

Minister.

Hon. Leona Aglukkaq (Minister of Health): Thank you so much.

Good afternoon, Madam Chair and members of the committee. As always, it's a pleasure to be here with officials to provide an update on the activities taken to date by the Public Health Agency of Canada and Health Canada to address the challenges presented by the H1N1 flu virus outbreak.

Appearing before me today are the chief public health officer, Dr. Butler-Jones, and Shelagh Jane Woods, who is from Health Canada's first nations and Inuit health branch. I may turn to them to respond to technical matters during today's session.

Since the outset, I have stressed the importance of collaboration in every action taken to manage the outbreak on behalf of Canadians. Our response has been supported by systemic ongoing contacts with the World Health Organization and other international partners.

Within our borders, we have made a concerted and coordinated effort to share information and lessons learned with our provincial and territorial counterparts. In my view, this collaboration reflects an unprecedented spirit of cooperation. Experts and decision-makers from all jurisdictions and the entire spectrum of public health management have come together to ensure an appropriate and timely response to the outbreak. I know there are critics out there who don't think we've done enough fast enough for enough people, but I am confident that the actions taken so far and the efforts we continue to make have and will serve Canadians well. I take very seriously the commitment of my government to support all members of Parliament in their duties to their constituents.

At my first appearance before the committee in February, I indicated that it was my intention to be open and to listen in order to build effective relationships with stakeholders and colleagues, as well as with critics. Having provided more than 20 briefings for opposition members of Parliament since the outbreak, I think I've lived up to that commitment.

While the course of this pandemic may have been unexpected, we have demonstrated our ability to adapt quickly and effectively to rapidly changing environments. The federal government's influenza pandemic planning efforts have paid off. This is a plan built on years of collaboration with provinces, territories, and the medical community. As quickly as the H1N1 virus hit Canada, we implemented our plan.

One of the cornerstones of our pandemic planning is to make sure we're talking to Canadians. In early May, we launched the first of a multi-phased marketing campaign that saw print advertisements placed in daily and weekly newspapers across the country. These ads reminded Canadians about appropriate infection prevention behaviours. They were supplemented by information on the website of the Public Health Agency of Canada and by posters at Canadian airports and transit ads in major Canadian cities. It's why more and more Canadians are getting the message: cough into your sleeve, wash your hands regularly, clean common surfaces, and stay at home if you feel sick.

You will continue to hear these messages and more as we move into the fall and the next flu season. The marketing efforts will continue to ensure that Canadians have the information they need to make informed decisions to protect themselves and their families.

When the outbreak began, I held daily news conferences with the chief public health officer. As the days passed and we came to learn that the severity of the outbreak was milder than first anticipated, we continued with weekly briefings, including the one we just had today. We are committed to ensuring that Canadians have the information they need.

I seem to have used the words “collaboration”, “cooperation” and “coordination” to the extreme in my comments today, but I am convinced that these characteristics are critical to our continued success in managing a possible more severe wave of H1N1 flu virus in the fall.

As Prime Minister Harper and Presidents Obama and Calderón made clear this week in Mexico, we will remain vigilant and commit ourselves to continued and deepened cooperation. We will work together to learn from recent experiences and prepare North America for the upcoming influenza season. Certainly, this applies to our efforts at home with the provinces and territories, front-line medical professionals, and first nations and Inuit leaders.

● (1420)

No matter what comes our way this fall, we are well prepared. Already we have seen pockets of greater severity. This has included outbreaks in a small number of first nations and remote communities. From day one, we have been working with first nations leaders and provinces to ensure that communities have everything they need in a timely manner, based on the best public health advice.

It's important for me to make it clear for you all today that pandemic planning for first nations communities is a shared responsibility. For example, Health Canada provides basic nursing services on reserves. However, first nations needing treatment for severe H1N1 symptoms receive hospital services through the provincial health care system. This arrangement calls upon all governments to cooperate to protect the health of communities. That is why we are committed to maintaining and improving our strong working relationship with provinces and first nations to ensure that all Canadians receive the care they need when they need it. Of course, we're committed to making sure that first nations have the support they need to protect their communities. As a result, we're providing all nursing stations in first nations communities with additional protective medical supplies, such as gloves, gowns, and masks. We're pre-positioning antivirals so that if they're needed in a remote community, they can be accessed as quickly as possible.

As we did in response to the situation in northern Manitoba, we're prepared to reallocate nurses to where needs are greatest. In addition, we're training home-care nurses to be ready to administer the vaccine once it's available. We're continuing to assist communities to complete and test their pandemic plans. Thanks to the support from Indian and Northern Affairs Canada, we're working to deliver supplies of water to communities to help prevent and control infections in homes on reserves.

Moving into the fall, we are increasing efforts to get the H1N1 and seasonal flu vaccines to those Canadians who want and need them most. Last week I announced the federal government's intention to purchase 50.4 million doses of the H1N1 vaccine from GlaxoSmithKline. This will be enough to cover the needs of Canadians. GSK is on track to deliver the vaccine doses, as planned, by mid-November.

In closing, I want to emphasize yet again my ongoing commitment to collaboration, transparency, and communication. They are our tools that will enable us to work best with our partners internationally and domestically.

I understand Dr. Butler-Jones will now make some brief remarks, after which I'll be happy to take any questions.

Thank you, Madam Chair.

The Chair: Thank you, Minister. Again, thank you for being so available today in this very important meeting.

I'll now ask Dr. Butler-Jones to begin.

You have seven minutes, Dr. Butler-Jones. We look forward to hearing your comments.

Dr. David Butler-Jones (Chief Public Health Officer, Public Health Agency of Canada): Thank you, Minister. And thank you, Madam Chair, for the invitation to speak before the committee today.

As the minister mentioned, the H1N1 flu virus has presented some challenges that we had not faced before.

● (1425)

[*Translation*]

One of our key messages during the response has been acknowledged as truly our best defence.

[*English*]

To build on the minister's remarks, I'll divide my comments this afternoon in terms of how we're getting information in, through cooperation with our partners, and how we're getting information out to the public.

First, in terms of information in, sharing information and cooperation between jurisdictions enables us to learn a bit more every day about how the virus behaves and spreads. This morning, as you know, the minister announced that the Public Health Agency of Canada has mobilized public health officials, intensive care specialists, and medical experts from Canada and abroad to share and discuss best practices for clinical care of severe H1N1 cases. That meeting will take place in Winnipeg on September 2 and 3. The meeting offers an opportunity for public health officials and critical care specialists to gain insights into the epidemiology of severe H1 disease, to discuss strategies for prevention and early recognition of severe disease, and to share best practices for clinical care, disease management, and resource utilization. This will assist us all in managing the anticipated fall pandemic wave.

[*Translation*]

I cannot emphasize enough how critical the strong collaborative working relationships we have established with our public health partners—domestic and international—has been to our overall response.

[*English*]

For example, early on in the outbreak, the Government of Canada established with its provincial and territorial partners the special advisory committee on the H1N1 flu virus, SAC. It is made up of chief medical officers of health, such as me and others, as well as other senior public health officials, and it has a network of committees under it. Its mandate is to provide policy and technical advice to the federal, provincial, and territorial deputy ministers of health, where I sit, on public health matters related to the H1N1 flu virus outbreak. This committee has been crucial to the management of the H1N1 outbreak response. I believe this collaborative effort, along with the many activities that are under way, has ensured Canada's place as a leader in public health management of the international H1N1 response.

I'd also like to discuss the many efforts under way in the agency to get information out—that is, about how we are getting information to the public. As the minister indicated, our communication efforts have been intense since the outset of the flu outbreak. On a weekly basis, the Public Health Agency receives an average of 50 to 70 H1N1-related media calls, resulting in hundreds of stories and media interviews. As of today, more than 20 national news conferences have been held and webcast.

To give you an example of the thirst for information, 1.8 million visits have been made to the H1N1 web pages on the FAQ website between April and August. We are also giving out information directly to thousands of Canadians through our 1-800 toll-free telephone line.

The Public Health Agency is committed to providing Canadians with the information they need to make appropriate decisions related to the H1N1 flu virus to protect themselves and their families. This includes communicating with at-risk populations, such as pregnant women.

In early May, the agency launched a comprehensive marketing strategy, which the minister referred to earlier. I can assure you that extensive planning is under way to continue this marketing effort into the fall and through the flu season. Our continuing goal is to raise awareness and knowledge so that individuals and families, regardless of whether they are living in a remote community or a major city, feel they have the best information readily available to them so they will know what to do in any given situation.

[*Translation*]

In closing, I would like to remind the Committee that, as Chief Public Health Officer, I have maintained a consistent public presence through all of these developments.

My top priority has been, and will continue to be, to ensure that the Public Health Agency is in a constant state of readiness for the fall.

[*English*]

I've been working diligently, as have many, many others, on everything from issues of vaccine supply to guidance documents, to maintaining close consultation with our domestic, international, and myriad other partners to make this happen. Canadians need to have all appropriate knowledge about self-care, family care, immunization, and pandemic preparedness should a severe second wave of the H1N1 pandemic occur during the 2009-10 flu season.

Information in and information out: these are critical to our readiness for the fall. I believe that together we are succeeding.

Thank you, Madam Chair. That concludes my remarks. *Merci*.

The Chair: Thank you, Dr. Butler, for your very insightful comments.

Now the committee will go into questions and answers, and the first round will be seven minutes for both questions and answers. I'm going to keep to the time very tightly so everyone gets a chance to ask all the questions they want, so they can get all the answers they want.

We will begin with Dr. Bennett.

● (1430)

Hon. Carolyn Bennett (St. Paul's, Lib.): Thanks very much, Madam Chair.

Thank you very much, Minister, Dr. Butler-Jones, and Shelagh Jane Woods.

First, I want to say it is very important to us that you have come today. As a committee, we take the responsibility given to us by Parliament very seriously. I hope you will understand the difference between parliamentary oversight and an informational session or a briefing; that all members of this committee have been given the responsibility to make sure that we're as prepared as we possibly can be by the fall; and that we hope this meeting and others like it will help Canadians understand that, as their representatives, we are doing everything we possibly can to make sure they feel confident that they will know exactly what to do when this pandemic hits again in the fall.

I believe Canadians want to know where the gaps still are. In your remarks, you have said this afternoon that we can rest assured that this government is well prepared for this pandemic and will continue to implement the plan. We have been criss-crossing this country and know there's a lot of people who still don't know quite what they will do or what the mom will do about sending their children to school in two weeks, or their university student going off to university. There are also day care supervisors, and particularly chiefs and councils. Last week we heard from the Federation of Canadian Municipalities, but also particularly from the premiers, who were calling for immediate and meaningful cooperation in tackling H1N1.

After SARS, the Naylor report said we needed to focus on four Cs: collaboration, communication, cooperation, and a clarity of who does what and when. We are very concerned that clarity does not exist, and we need you to help us understand who is expected to do what and where in the plan. How can Canadians understand what is in the plan and what is their responsibility?

Minister, I want to know when you will be meeting with your provincial and territorial colleagues. Have the roles and responsibilities been signed off? As to the money that is expected, is there enough money? And will you identify the gaps for us of the things you're still working on and the things that we, as parliamentarians, could help with?

The Chair: Madam Minister.

Hon. Leona Aglukkaq: Thank you. I'll start off with the response, and then Dr. Butler-Jones may want to add more to the response.

In terms of having conversations and working with them, it's been a daily contact with the provinces and territories. Last week I was teleconferencing with the ministers of health across the country pretty well daily in regard to planning for the fall. The FPT will be meeting on September 18 in Winnipeg, where we'll be finalizing some other plans on a going forward basis related to the pandemic.

In terms of what we are doing for the fall, Dr. Butler-Jones made reference earlier to the fact that we are working with guidelines based on best information that will be going out there, and this continues to be worked on to date. During the summer months it's a very busy time for many chief medical officers across the country who have formed committees to deal with guidelines for schools, guidelines for the private sector, guidelines for medical practitioners, and so on, and that work continues to date.

The guidelines will be implemented through the provinces and territories. There are a number of stakeholders involved. Provinces deliver health care; we know that. We need to work with the provinces as ultimately, at the end of the day, they will be the ones responsible for the delivery—

Hon. Carolyn Bennett: Do you have a memorandum of understanding with the provinces in terms of roles and responsibilities?

Hon. Leona Aglukkaq: The memorandum of understanding has been shared with the provincial and territorial ministers and is being finalized as we speak.

Hon. Carolyn Bennett: So it has not been signed.

Hon. Leona Aglukkaq: The memorandum of understanding that talks about.... I'll give you one example. Each province has credential recognition of health care professionals. They have a process in place that will say that this nurse will practise here, and each one of them is different. In the memorandum, as one example, that piece needs to be ironed out in the case of a pandemic, when you have an outbreak in one province that may require additional health care in some other—that support system. That needs to be an agreed term within that MOU. That memorandum of understanding is being finalized. It's with the provinces and the territories and should be completed very shortly.

Dr. Butler-Jones may want to elaborate on that.

● (1435)

Dr. David Butler-Jones: All these memoranda have been supported in principle by all the jurisdictions in terms of the roles and responsibilities on information sharing and on mutual aid, as well as working through some of the financial annexes on the information sharing. We're anticipating ministers dealing with that in the fall. However, it has not impeded the work in any way. The thinking that goes behind these memoranda is the essential matter we're dealing with in terms of cooperation, collaboration, and sharing of information. All those things are in place and are working.

In terms of the question with regard to not everybody knowing, I'm sure that's true. That's always true. Seven years ago, long before I started this job, I was working with the local health authorities, with municipalities, with representatives from multiple municipalities, from police, from fire, as well as undertakers, working on the pandemic plan for that region. That's a region that probably has a lot of things in place now, seven years later, that some others may not have.

We know, at the outset of H1, not every jurisdiction was at the same level of planning or had the same level of connection between medical officers, municipal officials, hospital officials, etc. We've been encouraging, because we don't do it. Public health is a local activity. The hospital is local, everything is local, but it can connect through provinces, territories, and the national and international governments.

So we've been working to encourage that, to develop the resources, to build collaborative mechanisms to foster that, but at the end of the day it really is a shared responsibility that each level, each jurisdiction, needs to address. So if there are questions to be answered, part of it is asking the question; and if it's the local police or fire, it's talking to the local medical officer, because that's actually where the action takes place. The issue of the broad guidelines is important, but those are broad guidelines at a national level that then need to be adapted and used locally.

I think many of those guidelines were actually in place before H1, because we've been working on these issues, as I think the committee knows, for a long time. But then when we saw H1, they needed to be adapted, because it's not exactly what we expected. We had guidelines around for health care facilities, etc. Once we saw H1, in the first weeks, we adapted those guidelines for H1, and we've recently revised them based on, now, several months of experience.

That revision will continue to go on. They get posted; they get shared. Sometimes there are gaps in the information because not everybody knows at the same time, but again, it's key, and I want to stress that, from all areas, if people don't know, they need to ask. We'll communicate. Each level will communicate, but it's important also that they ask, and there is the planning that needs to take place locally.

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

I want to interrupt for a minute to tell Dr. Bennett that the time is up for her questions, but please finish your answer and we'll go to Monsieur Malo after that.

Dr. David Butler-Jones: Early on we established the special advisory committee, which I referred to, of public health officials and others. We bring together the expert committees, etc. We have weekly meetings of deputy ministers, as well as bilateral meetings. For example, last week I was on the phone to every jurisdiction in the country.

To allow for more questions, I'll leave it at that.

The Chair: Thank you.

Monsieur Malo.

[*Translation*]

Mr. Luc Malo (Verchères—Les Patriotes, BQ): Thank you, Madam Chair.

Thank you very much, Minister and Dr. Butler-Jones, for being with us today.

Last week, you announced that you would be purchasing vaccine. A little earlier, you announced that you would be buying antivirals, and this morning, there was another announcement about money that will be used to develop a strategy to support small business. We are seeing a series of public announcements that look very much like a communication strategy. However, these are isolated announcements. At this stage, we are not in a position to have a more comprehensive picture of the situation.

In the not too distant future, rather than proceeding on a case-by-case basis to make announcements which, of course, are important, would it be possible to be given an overview so that, as Ms. Bennett was asking earlier, we could see where more preparation is needed, so that everyone is on the same wavelength?

● (1440)

[*English*]

The Chair: Who would like to comment on that? Perhaps the minister.

Hon. Leona Aglukkaq: Thank you, Madam Chair.

In terms of the overall plan that was adopted, the pandemic plan was established back in 2006, defining the different roles and responsibilities of federal, provincial, and municipal governments, and so on. Within the pandemic plan, there are a number of areas identified: roles and responsibilities, vaccine development, and pandemic vaccine or antiviral stockpiling. Those are all within that plan. They are being implemented at different stages in how we're responding to H1N1, depending on the situation we're coming across. It's a plan that's being modified or updated as we deal with the situation. It is the overall plan that defines the roles of the federal government, provinces and territories, municipalities, and health care providers. There are a number of agencies involved in the implementation of the plan.

The announcement made last week relating to the H1N1 vaccine and how much we need to purchase is part of the plan; part of the plan is to purchase the vaccine. To do that, we needed to have conversations with the provinces and territories to make decisions on the number of vaccines we would purchase, and then to place our order. So that was announced when we made those decisions.

Today we're working with private industry to assist small businesses to respond to H1N1, how they can better prepare themselves and get the information they need to manage their businesses as we go into the fall season.

So the plan outlines all of those pieces, and we are implementing them at different stages as we deal with the H1N1—and we are at different stages. So as we learn more, we share more. As we learn more about it, there are certain things that are triggered. And come the fall, the guidelines will be developed for schools, health care providers, private industry, and so on, and who will get vaccine first and how. That, and the timing of it, will all unfold as we go along. Again, that requires research and working with the provinces and territories.

One other example is that the Public Health Agency's national microbiology laboratory has been in partnership with intensive care units across the country to learn more about the severe cases in order to ensure that when we do the guidelines for the fall, the people who require the vaccine most will receive it first. This will allow us to make an informed decision in terms of prioritizing implementation, and so on, come fall with the vaccine. That's an example of how the provinces and territories are collaborating in developing the guidelines for the fall.

Dr. Butler-Jones may want to add to that. But the pandemic plan is at different stages, depending on what we're dealing with related to H1N1.

[*Translation*]

Dr. David Butler-Jones: Thank you.

We have a national plan, which you have read. Every territory, province and municipality has a pandemic response plan, but the level of preparation and needs vary from one city to the next. Planning is extremely important at every level. We believe our plan to be transparent and would be prepared to discuss the measures laid out in the plan, which covers the period from early summer to fall.

Mr. Luc Malo: Minister, as I don't know when I will have another opportunity to speak with you, I would like to briefly address another matter, if you don't mind.

The medical isotope crisis is going to cost the provinces more money. Yesterday, the Quebec minister asked for financial compensation, like his counterpart from Ontario.

Will you bring the necessary pressure to bear on the President of the Treasury Board so that Quebec and the provinces receive fair compensation for the additional costs occasioned by the crisis?

● (1445)

[*English*]

The Chair: Monsieur Malo, I want to intercede here for a moment. I thought this committee meeting was called for H1N1, so can we stick with that and perhaps go on to the other issues another time? Do you have a question on H1N1?

[*Translation*]

Mr. Luc Malo: Dr. Butler-Jones, when we met this winter, there was already a risk that H1N1 would evolve and mutate. I don't know to what extent you have been following the evolution of the virus per say, but what would happen to the vaccine if we were to realize that H1N1 were mutating in the fall, for example?

Dr. David Butler-Jones: That's a good question.

At the present time, the virus is the same; it has not changed. It is beneficial to buy a vaccine that contains an adjuvant. Experiments on the H5 virus showed that vaccines with an adjuvant can protect against mutations or changes in the virus. If that were to continue to be the case, it would be a good thing for us.

[*English*]

The Chair: Thank you, Mr. Malo.

Ms. Wasylycia-Leis.

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

Thank you all for being here.

I first want to say that we do appreciate the regular briefings that we have received. We know it takes time to do them and we appreciate the fact that Dr. Butler-Jones, Ms. Woods, and also Dr. Grondin and others have been able to give us some time, but they are no substitute for a real dialogue with parliamentarians, no substitute for an exchange of ideas and an expression of concerns that we are hearing.

I know, Madam Minister, you have suggested that we are playing politics by holding this meeting and that there really is no need for this midsummer meeting. You and others have suggested that. But there are summer camps out there looking at closing their doors. There are schools planning for the fall. There are businesses worrying about what to do. There are pregnant women calling us. So my first question is, if you don't think midsummer is an appropriate time to deal with this, what is a good time?

Obviously I am not here to criticize everything you are doing, but we are all here to say we don't sense that there is a complete coordinated national plan that has evolved over the summer that you are prepared to share with us today. That's what we're here for.

Let me get some specific questions in.

Who is in charge of the incident command and control centre? Who is in charge? Who is on the committee? Which departments are involved? How are you coordinating matters within your own government? Why, if in fact we are so far advanced in terms of our planning, do we not have a list of priorities in terms of who shall get the vaccine whenever it is ready, unlike in the United States, where the CDC developed that list two weeks ago? People are asking us about this. If you have done so much work this summer, how many new staff have been hired to help meet the needs and get prepared for the fall? What new budgetary provisions are you prepared to consider, given the fact that if this hits and when it hits, the impact on all of the provincial and territorial health systems will be significant, not to mention the whole fabric of society—

The Chair: Ms. Wasylycia-Leis, to enable the minister to answer the questions, we are going to have to stop there. When she is finished answering those questions, if you have time, you can continue with your others.

Madam Minister.

Ms. Judy Wasylycia-Leis: Could you please answer those four questions.

Hon. Leona Aglukkaq: Thank you for those.

In terms of this summer meeting, I recognize the importance of a dialogue and discussions around this. We have made efforts to communicate as much information as we can to Canadians as well as committee members about the questions that are raised and so on.

In terms of what's happening and the statement that during midsummer no work is being done, there are a lot of people in the provinces and territories working very hard to plan for the fall, whether it be assessing how we are doing, whether it be understanding the more severe cases and why did this person pass on. This is all the work that is being done to prepare for the fall, whether it be the microbiology lab with intensive care units, vaccine development, or what guidelines are we going to develop. These are in the works right now. The summer months are a critical time for us to get that information completed. That involves a number of provinces that deliver health care, chief public health officers, the health boards, and so on. So there is a lot of coordination involved in that through the Public Health Agency of Canada as well as through my office.

Last week there was a discussion every day with all the provincial health ministers to plan for the fall. Who is in charge—

● (1450)

Ms. Judy Wasylycia-Leis: But I asked you four specific questions.

Hon. Leona Aglukkaq: As to who's in charge of the implementation in provinces and territories, the provinces' and territories' health ministries are.

Ms. Judy Wasylycia-Leis: Who's in charge of the federal incident control and command centre? Do you have a name for that committee, and which departments are involved?

Dr. David Butler-Jones: Maybe I can answer that, Minister. Thank you.

Public Safety has overall responsibility for coordination of government—

Ms. Judy Wasylycia-Leis: Could I interrupt you, please?

The Chair: No, Ms. Wasylycia-Leis. Please let—

Ms. Judy Wasylycia-Leis: It's a very specific question, and in the interest of time—

The Chair: May I ask you to let Dr. Butler-Jones finish, and then you can go on?

Ms. Judy Wasylycia-Leis: Yes, sure, as long as I can get some specific answers.

The Chair: Dr. Butler-Jones, go ahead.

Dr. David Butler-Jones: The Minister of Health is the lead minister on the H1N1 response.

Ms. Judy Wasylycia-Leis: Who's the bureaucrat?

Dr. David Butler-Jones: Me.

Ms. Judy Wasylycia-Leis: So you're the head of the incident control and command centre?

Dr. David Butler-Jones: In terms of the emergency operation centre, we have it within the Public Health Agency, with Morris Rosenberg, who you know is the Deputy Minister of Health, with the Privy Council Office. In terms of linking to other departments, we do that directly; but in terms of bringing them together, he has regular meetings of deputy ministers, including me, from across the departments to coordinate the government's effort. I myself, as chief public health officer, am the senior official responsible for public health.

Ms. Judy Wasylycia-Leis: Thank you.

Let me go back, then, to costs and the federal funding commitment to help in the event of this pandemic.

We know you've been negotiating with the provinces. My colleagues have already mentioned the fact that you're paying for, I believe, 60% of the vaccine. Why aren't you paying for all of the vaccine?

You're doing the contract with GSK. You're making those arrangements. In other instances, whether it's HPV or a meningococcal children's virus, you've paid for it fully. You have money, through this stimulus package, to bring in Bill Clinton; why don't you have money to pay for a vaccine in the event of a flu pandemic? Why aren't you at least following some of the work that has been done in the United States in terms of the federal government paying for the vaccine and in terms of a list of priorities for who shall receive vaccine?

The Chair: Minister, would you like to answer?

Hon. Leona Aglukkaq: Yes. In terms of the vaccine cost, normally provinces and territories purchase their vaccines for the regular fall immunization—

Ms. Judy Wasylycia-Leis: But this isn't a seasonal flu we're talking about.

Hon. Leona Aglukkaq: I didn't say it was.

That falls within the jurisdiction. In this particular situation, discussions have been going on since about 2006 on the 60-40 arrangement. When we purchased the antivirals, that was what our cover was, the 60-40 with provinces and territories. On behalf of the provinces, we also retained a contract with GSK. We have invested approximately $17 million to retain a contract with GSK on behalf of the provinces and territories to purchase vaccines within Canada.

As to what's happening in the United States in terms of their timeline and stuff, the timelines of Canada and the United States are quite close. What I've said before is that we have a window of opportunity here within Canada to examine the situations and cases we have seen in Canada, the severity of some of those cases, and so on, to have a good understanding of prioritizing who will receive the vaccine.

That's an important point. We don't need to rush into it.

● (1455)

Ms. Judy Wasylycia-Leis: Okay. I appreciate that.

Hon. Leona Aglukkaq: We have two months' time to develop the guidelines for that, and the vaccine will be ready in the fall.

Ms. Judy Wasylycia-Leis: I have one last question on prioritization—

The Chair: Thank you.

We'll now go to Dr. Carrie.

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

I want to start by personally thanking the minister for being here today and really explaining. I think Canadians are pleased to know that our government took a proactive approach to this back in 2006, to put that $1 billion aside, and that we're far advanced compared to other countries in the world.

I know you came from a system of consensus and collaboration, so I think you're well positioned to deal with this situation, and I want to thank you for your approach. I too have been watching the media and I'm a little disappointed with the trend to play politics here on such an important issue, because I think Canadians expect all public officials to work together.

I want to thank you for taking a leadership role in that regard, because when I was on the health committee before in opposition, I was never offered departmental briefings. I never had access to a minister in the way you've made yourself accessible. I really appreciate the fact that you've had those 20 briefings with opposition members. I think that's totally unprecedented. As well, with over 20 press conferences, again I think that's totally unprecedented.

So thank you very much for your approach in this very serious matter and for working together with all levels of government so that we can implement this plan and adapt the plan as it moves forward. That's what I want to ask you about.

We've learned a lot since the spring. I wonder if you could let Canadians know what lessons we have learned from the spring and how this is going to shape our planning for the fall.

Hon. Leona Aglukkaq: Thank you for that.

Overall, I think Canada's experience of the first wave of H1N1 highlighted that while we may have had strong pandemic plans in place, we can always continue to improve our ability to apply those plans in real time and look at gaps that may exist. The challenge has been in implementing the plan as we learn about H1N1. We didn't know anything about H1N1 until April, so as we learned about the virus, we needed to respond accordingly with the provinces and territories, and to communicate that in real time with provinces and territories to respond, and we will continue to do that. I think we've learned over the first few months that, come fall, that will be essential to how we respond. We don't know the kind of severity of cases we will be seeing, and so on, so that will require us to be vigilant and continue along that path.

With the other jurisdictions, other countries, involved, we recognize that it's an issue that sees no boundaries and we need to respond accordingly as provinces and territories. Cooperation is key, communication is essential. We've also learned that we need to work very closely with Mexico, with the United States, and the WHO, in how we plan. It's not only a plan within Canada. Public health officials have been working very hard, and I've had meetings with the United States as well as the Mexican health ministries, simply in terms of how we will plan for the fall and how we can better position ourselves.

This is ongoing work that we need to do, the assessments and evaluations in terms of how we're responding. We're learning from other countries in terms of their vaccine development, and that will help us make the best decision in real time about who requires the H1N1 vaccine, when, and so on. The information and the time we have over this summer are essential in getting the necessary and the best information, based on real cases and situations that we face in our country, to prepare for the fall.

We have to enhance our surveillance systems come fall. That communication strategy will become essential, and again, that involves provinces and territories. There are many stakeholders involved, such as the municipalities, and it takes a lot of coordination; there are many agencies involved to prepare. It's not one agency's responsibility. We as individuals have a role as well, to communicate with our families and friends and so on, but in order to allow Canadians to make the best decisions with the best information we have at the time, it is going to be essential for them to make informed decisions on how they can prevent the spread of H1N1 and so on.

I don't know if that answers the question. You may want to elaborate a bit more.

● (1500)

Dr. David Butler-Jones: I'll simply give you a couple of quick, simple examples. When we ran the operations centre, traditionally we would use directors general, senior officials, experts in their field, and what we found is that we really needed them managing their part of the department as opposed to managing the outbreak. So we're in the process of training other people to do that.

At the provincial level, people recognize that.... We assume that hospitals, because there have been guidelines for years on how to manage respiratory cases...and suddenly because it's H1N1, they look to Public Health and say, “Tell us how to do this.” Well, you're the respiratory specialist, so apply what you already know. It's no different from that. Again, we've been able to take some of those lessons and apply them as we move forward. Some of them are very basic and simple like those; some are bigger in terms of making sure we've got the right connections, because even when we assume people know where to look or what they have, it requires constant reminding.

Mr. Colin Carrie: Dr. Butler-Jones, as we're learning here, it sounds as if you're getting, as you said, the information in and information out. It looks like you're able to get that information in, make a decision, and get that information out.

Because we did mention different comments in the media and I heard that somebody in the media mentioned that you may be muzzled by the government, I was wondering if you could comment. Speak freely. We're in committee here, and could you let us know, number one, if you feel that you're being muzzled in any way in your decision-making process? And would you let Canadians know how you have found the process so far?

Dr. David Butler-Jones: I guess the thing I want to say particularly about that is that I've always felt the only thing that's truly mine is my integrity. It's something I will guard forever. Those who have worked with me at all levels of government in other things know that on things that really matter, I'm not easily muzzled. I'm open to suggestion, open to conversation. We've always had those kinds of discussions about what's important and what isn't. It's important for me to have every perspective possible in doing that, but then at the end of the day, for what I'm responsible, I have to make that decision.

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

I understand, Minister, that you had an hour to give to us and that you have other meetings lined up and you now have to depart the meeting. I want to thank you once again so much. I know Dr. Butler-Jones will be remaining for additional questions, but I want to thank you so much for joining us today. We all appreciate it, as a committee.

We'll give you some time to depart, and then we'll go on with the questions.

We'll be going into a second round of five-minute questions, starting with Dr. Duncan. Perhaps we'll get right into it so we don't lose any time.

Dr. Duncan.

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

We were not made aware that the minister was only going to be here for one hour. Some of the most serious concerns we have are about our aboriginal people, which is not the responsibility of Dr. David Butler-Jones or, with due respect, Shelagh Jane Woods. The responsibility for aboriginal people is a direct responsibility of the Government of Canada, and I am very disappointed that the minister is leaving now.

First, I don't think an hour is enough to deal with this, period, and I don't know what the minister's going to that's more important than this. But secondly, if indeed there was some pressing thing she had to go to, we needed to be advised of that. We would have reorganized our questions. This is unacceptable, and I hope that we will right now commit to a full meeting on the state of our aboriginal peoples, with the minister present, as early as next week.

And it is unsatisfactory for us to be treated like this, as parliamentarians, for one of the most important reasons we called this meeting. With the experience that my colleagues have had on reserves across the country, meeting with aboriginal leaders, being at the Assembly of First Nations meeting—we were all there—we have huge concerns, and that was to be the second and third line of questioning for us.

I am extraordinarily disappointed that you, Madam Chair, did not make us aware of that at the beginning of this meeting. Parliamentary committees decide this themselves. This is unacceptable, and I hope that—

● (1505)

The Chair: Dr. Bennett, just one moment. This is not a point of order. I think clearly this—

Hon. Carolyn Bennett: It is point of order. Why is the minister going to leave?

The Chair: Dr. Bennett, you're out of order, and I'll suspend the meeting if you don't allow it to go on.

I'm just saying, quite categorically, that everyone here was very interested, showed up today, made sure we were here, when the members called for this very important meeting. The minister herself cut short what she was doing to make sure she was present at this committee meeting today. This is a very important issue, and Dr. Butler-Jones, who works in very close collaboration with the minister, is remaining for another half hour.

I think we all agree that this is an extremely important issue that needs to be discussed at this committee, and I don't think it's appropriate to continue in this manner when we have this very important issue to discuss today.

Minister, thank you for coming today. I know you do have to go.

We're going to go into the second round—

Ms. Judy Wasylycia-Leis: I have a point of order.

The Chair: This wasn't a point of order, and I'm not going to entertain something that isn't, Ms. Wasylycia-Leis.

Ms. Judy Wasylycia-Leis: I have a point of order.

Yes, I would like, since the minister has to go—

The Chair: Yes, she does.

Ms. Judy Wasylycia-Leis: —just to ask for her to come back to us with some information pertaining to the scientific and serious evidence that suggests first nations people are actually being affected more seriously than others, and in an acute way, by H1N1. We would like to know very clearly what the government's plan is for dealing with the fact that first nations people and Inuit people are more seriously affected by this flu than others.

The Chair: Thank you for that suggestion. I will ask for a written response and get back to the committee on it.

We're going to be going into our second round now of five-minute questions and answers.

Thank you once again, Minister, for being for so kind for being here.

Let's begin with Dr. Bennett.

Did you have a comment, Minister? Go ahead.

Hon. Leona Aglukkaq: Thank you for that.

Just quickly, I am prepared to have a discussion in regards to first nations and Inuit health at any time. I come from an Inuit community, if you want to call it that, one of the 25 isolated communities in Nunavut territory. We also have officials here who work very closely with the provinces and the territories in regards to the delivery of health care.

As I said in my earlier comments, first nations health in every jurisdiction is a shared responsibility, because once you leave the community and work in a hospital, it is a provincial responsibility, so it is a matter of cooperation. I'm prepared to have a discussion on that, and the staff here have worked very closely with first nations communities. I will also be meeting with the new chief in regards to planning for the fall, communication and so on.

But in terms of my territory of Nunavut and the plans there, where 85% of the Inuit live, Dr. Butler-Jones was also just up in the territory and he can speak to that as well. If there are questions at a later date, I'm prepared to have a conversation in regards to that. I'm open to that.

At the same time, in regards to the science and information we're studying this summer, it will help us understand the question Ms. Wasylycia-Leis raised. These are things that can be responded to by Dr. Butler-Jones.

I want to thank the committee members for your time today, and I'll leave it at that.

Dr. David Butler-Jones: Madam Chair, if I may, just to add to that in terms of the request and the science, it's still very early to tell whether or not that is true, and if so, for what reasons, because we're not seeing that in other aboriginal communities.

To what extent what was experienced in northern Manitoba was a function of this being early in the outbreak and therefore being a little slower to come to the fore as opposed to other communities; whether it is a matter of underlying risk factors that we know put people at greater risk of severe disease, such as diabetes, chronic lung disease, smoking, obesity, pregnancy, etc.; or whether in fact it was in any way a genetic basis, we don't know, and it will take some time to figure that out. There won't be a quick answer to that.

Certainly in the Inuit communities we have seen less severe disease. In fact, there've been very few medivacs, very few hospitalizations, relative to the number of people affected. We don't know all of the answers to that, but what I can say is that we are focusing on it very carefully—the Public Health Agency, FNIHB, and the provinces and territories—and have a committee looking specifically at the issues of remote communities and how we need to adapt and address issues there.

So it doesn't matter what your ethnic background is; if you are at risk, we need to be able to address these issues. People need to be assured that for vaccinations and treatment with antivirals, we have plans in place to actually address those and then to respond when people are severely ill—if that happens to them.

● (1510)

The Chair: Thank you so much.

I wish all of us could work together very collaboratively on this particular issue, because I know your concern, Minister, and everybody's concern that it's of paramount importance. So the committee just wants to make sure they have all bases covered.

Thank you for your gracious reply.

Dr. Butler-Jones, I know you'll remain for some more questions. I know Dr. Duncan is up next. Perhaps she would like to ask some of those questions.

Thank you very much, Minister. I'm sorry you were a little delayed.

We will now go into the five-minute round; that's five minutes for questions and answers. We'll start with Dr. Duncan.

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

Thank you to the officials for coming.

I really want to stress at the beginning that it was not partisan politics to bring this committee back. We have a window of unprecedented opportunity to prepare for a pandemic, to reduce the economic and social impacts, the cases, hospitalizations, and deaths. We don't know what the fall will bring. We have to be prepared, and preparedness is our insurance policy.

I have many concerns. Back in June, I put close to 35 questions on the order paper, one question with 35 parts. Dr. Bennett and I submitted a letter with 17 questions to the first nations and Inuit health branch on June 16. We are still waiting for the answers to those questions. Dr. Bennett did an open letter to the minister, and she is still waiting for that information. There needs to be a real dialogue with Canadians, providing real information, without being alarmist.

For example, when do you seek urgent care and when do you not need to worry? People need to remain vigilant, but that's just a word. What does “vigilant” mean? Have we looked at the communication among stakeholders? What was the public awareness, degree of concern, complacency? We need to encourage our communities and vulnerable populations to be prepared.

We have been in first nations communities. We were in a community five minutes away from a community that was beautifully prepared, and they really hadn't started their planning. They didn't even know that they could order supplies. We know now that there is going to be help with business planning.

My real concern, though, is a possible gap, a gap between when vaccines might be ready, mid-November, and if this was to start earlier in the fall. So my question will be around vaccines. First of all, why do we have to wait until mid-November? And the second part of that is, what are we going to do in the meantime should this hit earlier?

Thank you.

The Chair: Dr. Butler-Jones.

Dr. David Butler-Jones: I assume that question was meant to come to me, and certainly on the questions, we had thought—and apologies there—that through the regular briefings and the opportunity to answer questions they were being answered. A formal response obviously is something you want, so that will come. I'm not sure about the 35 questions on the order paper, but we'll make sure that you get the answers to all of your questions shortly.

On the issue of the vaccine, mid-November is when we anticipate everything having been done—the regulator being happy, the trials having been done, etc.—so that we can actually commence immunization. By that time, if all goes as we expect it will, we will actually have in hand between 15 million and 20 million doses already in vials, ready to immunize people, unlike anybody else in the world.

Ms. Kirsty Duncan: Dr. Butler-Jones, there will be a gap.

Dr. David Butler-Jones: I'll get there. I'm working through your questions. Thank you.

So we will have vaccines, so that we should be able immunize everybody with at least one dose before Christmas. After Christmas is when we would normally see it. Interestingly enough, the trials in the U.S., trials in Australia, etc., aren't really going to generate much of anything earlier than what we will have in order to move forward. The reason for that being in November in the northern hemisphere is because WHO asked all of the companies to make sure they've finished off their seasonal flu production first. So they weren't actually able to start with the H1N1 until that time.

● (1515)

Ms. Kirsty Duncan: I appreciate that. But there's a gap period in between.

Dr. David Butler-Jones: But that was part of the answer.

So now in terms of in between, that's partly because the planning is comprehensive. It's not just about planning for a vaccine, it's also for what else you do. So there are the distancing measures, the stay-at-home measures, which will slow its spread, the guidelines for schools. And we have antivirals sufficient to treat anybody who needs treatment.

Ms. Kirsty Duncan: Can I address the antivirals, then? We know about the plan and what needs to be done. On antivirals, I have real questions here. Why are we not providing the same level of protection for emergency service providers, like firefighters, police, paramedics, and organizations like the Red Cross? They're going to be critical.

Dr. David Butler-Jones: They're all the same. In the spring, because we were coming to the end of flu season, because of the uncertainties about the development of resistance, universally it was felt that we wanted to use Tamiflu or Relenza for those with underlying risk conditions that put them at greater risk of severe disease. That was the recommendation: everybody had access to that. We did not release the joint stockpile for general use, because again we didn't want it to be used in ways that would promote resistance. Come the fall, it doesn't matter who you are, the necessity for treatment is the same. It doesn't matter whether you are a firefighter or a Wal-Mart greeter; access to the antivirals is the same and will be the same. So there should be no issues there, and if there are issues, then they'll be dealt with directly.

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

We'll now go to Mr. Clarke.

Mr. Robert Clarke (Desnethé—Missinippi—Churchill River, CPC): Thank you, Madam Chair.

I'd like to thank the witnesses for attending the meeting today.

First of all, I'm first nations and 62% of my riding is first nations. Earlier this summer I took a tour through my riding and went to the most northern part, to the community of Fond Du Lac. That community is a fly-in and is remote. They are part of the Athabasca health region. One of the questions that came forward was preparedness. Are they prepared? The answer, I was told, is yes. This is a first nations reserve, and they showed me their stockhouse of supplies for a second-wave pandemic, if it should occur.

One of the things I hear about here today is first nations and aboriginals, but I think we also have to look at the big picture. We are all Canadians. There are no ethnic lines here. We are here as the health committee for Canadians and to address these issues. It gets me a little bit upset, because my wife is non-aboriginal and we have a blended family. We look at ourselves as Canadians.

The question I have is this. For the 62% of my riding who are aboriginal, is there an adequate supply of antiviral drugs available for first nations? Can you give this committee your assurance that there is or will soon be an adequate supply?

Second, will first nations be part of a national pandemic plan that includes a strategy for reaching remote communities and will include an extensive public education program?

Thank you.

Dr. David Butler-Jones: Thank you. I'll start, and Shelagh Jane can continue.

On the issue of antivirals, collectively the provinces and territories have built a stockpile of 55 million doses. In addition, the federal government, in our national emergency stockpile, has another 20 million doses. That should be more than sufficient to treat anybody who needs treatment in this country come the fall. It doesn't matter what your ethnic background is or whether you are a firefighter or a policeman or a Wal-Mart greeter; there are sufficient antivirals to treat all those who need it and want it.

On the issue of vaccine supply, again, it is the same. We are indiscriminate and are purchasing enough vaccine for everybody who would possibly need it and want it.

In terms of the planning and all the other work we are doing, we have a specific committee that is looking at rural and remote isolated communities and the special needs of those communities and how we're going to address them. Shelagh Jane actually co-chairs that committee with André Corriveau, who was previously of the NWT and is now of Alberta.

I'll stop there and turn it over to Shelagh Jane.

● (1520)

Ms. Shelagh Jane Woods (Director General, Primary Health and Public Health Directorate, First Nations and Inuit Health Branch, Department of Health): Thank you.

I guess I'd say I'm not actually surprised at the experience you had, because we know that over 90% of the first nations reserve communities do have completed pandemic plans.

As you are probably aware, we've spent a lot of time, a number of years, working with the communities to make sure they do complete plans and also, importantly, that they make the necessary links to the rest of the provincial health system, because that's critically important.

The other thing we did as H1N1 began to emerge, before we knew exactly what it was, but as it looked potentially serious, we started to pre-position things like antivirals in our nursing stations because we knew that the response time—the time in which you start to use them—has to be quite short. We are particularly aware of those communities that are remote and isolated and have access issues. So we pre-positioned some antivirals. We also provided some additional personal protective equipment for all of the front-line health care workers in the reserve nursing stations and health centres.

The Chair: You have only half a minute left. You will have to talk very quickly.

Mr. Robert Clarke: Right.

I do recall in my experience as a police officer having to sit down in the early 2000s and work out a pandemic plan for first nations and non-first nations and Métis communities throughout northern Saskatchewan with the health care agencies, the hospitals, the ambulance attendants, and I do recall being supplied protective outfits for such a pandemic outbreak. I'm very pleased that this is still taking place today.

Dr. David Butler-Jones: That's nice to hear. At the time, I was chief medical officer for the province. That's what we're trying to do.

The Chair: Thank you very much.

We'll now go on to Monsieur Dufour.

[*Translation*]

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

I would like to thank our witnesses and the Minister—who was with us earlier—for attending this afternoon's Committee meeting.

Dr. Butler-Jones, I listened to the press conference you gave with the Minister where you made a number of announcements. You have awarded a $926,000 contract to the International Centre for Infectious Diseases, which will be working in partnership with the Canadian Chamber of Commerce to develop a communications strategy aimed at the 300,000 small businesses in Canada, in order to ensure they do not encounter too many problems. That is extremely important, because the H1N1 virus is a health issue that will have economic consequences.

If you do the arithmetic, that means about $3 per business. Have we been generous enough? Would it be possible to provide more money and develop a more specific plan aimed at the business sector? Also, have you discussed the potential impacts of this with the Department of Industry?

Dr. David Butler-Jones: We work cooperatively with all the other government departments. We have also prepared tools in French, English and another language. This resource is being made available to all businesses in order to facilitate their own planning. We are trying to help them improve their emergency response plans. It is easier for us to help them now, because significant resources are available for the activities that businesses and public organizations will need to develop. We are focusing on improving their readiness.

Mr. Nicolas Dufour: Basically, the $926,000 will be used to develop a communications strategy; but will that communication be aimed solely at the business sector? Will there be more than just guidelines or something of the sort? Will there be visits to business facilities to see what practical assistance they can be given?

● (1525)

Dr. David Butler-Jones: This is in addition to local activities, to what is being done by local public health authorities, and so on. There is also a telephone and web-based advisory service. That is not necessarily a perfect solution for everyone, but it is an important contribution.

Mr. Nicolas Dufour: Earlier, we were talking about the choice of antivirals. According to Danielle Grondin, of Health Canada, we still do not know how many injections will be needed to protect people against H1N1. In 80% of cases, Tamiflu will be used. Yet some studies done abroad suggest that Tamiflu could lead to complications —in children, for instance.

Some are expressing concerns about the choice of antivirals. Could you tell us overall why that is the case?

Dr. David Butler-Jones: There is always a need to assess the benefits and risks of any drug. In the case of Tamiflu, the benefits are very considerable.

I would like to continue in English, in order to give you a more detailed answer.

[*English*]

I think the challenge is that we know that Tamiflu and Relenza are effective. They're not always as effective as we'd love them to be, but there isn't anything else in terms of treatment. We know they are also safe and effective in children. And the risk profile is good; in other words, the risks are low and tend to be minor. Given the choice between influenza and the potential risk of severe illness and death versus a theoretical small risk from taking an antiviral, that again would tip the balance. But again, it's still a choice; it's a clinical choice in the setting.

These studies were done on seasonal flu, not the new H1. Talking to pediatricians and others who are actually assessing and seeing these children, the reflection to me was, well, we don't have the studies yet, but they have consistently said to me that the kids who come in and get on Tamiflu earlier have done better than the kids who did not.

So in the face of that kind of experience and evidence, given the choice, particularly with moderate or severe illness, I think I would have no hesitancy about using Tamiflu in that situation.

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

Now, Mr. Uppal.

Mr. Colin Carrie: Can I take his place?

The Chair: Absolutely, Dr. Carrie.

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

I was really impressed, Dr. Butler-Jones, when you were talking about information in and information out, and how we seem to be connected all over the world as far as the learning curve is concerned. We take examples such as Australia, which has gone through its flu season already.

I was wondering if you could give us some examples on how you are working on this “information in” with our world partners and how you're able to disseminate this information out to, let's say, the local communities through the provinces. What can the feds do to work with their provincial partners to make communication better with the smaller communities and first nations?

Dr. David Butler-Jones: Thanks very much.

There are many parts to that. I think it's really interesting when you look around the world. Influenza is such a variable disease. You'll have two communities side by side, and if you look at 1918 and others, the impact in neighbouring communities can be very different, or even within communities. And while the general risk factors, etc., may hold true, they may not hold true in all instances, because of this virus' variability.

For example, different parts of Australia were hit much harder than others. Now, that's not particularly useful, other than for the questions for the general public, but it's very useful as we start to plan and think towards the future. Or, for example, Argentina, unlike Chile, instituted all kinds of measures, such as closing schools, cancelling concerts, etc. Comparing Chile and Argentina would suggest that, in our view, cancelling schools and everything else is probably not helpful. It turned out actually to be true in their experience. So all of this is very helpful as we start to develop our guidance.

When it comes to communications, in a way you can never communicate too much. I'm struck by the differences in different communities, and part of that is the activities of local public health—and sometimes it's a local business that's interested.

I came back early to Ottawa from Nunavut to be here, and I was struck that in Nunavut, which again has a sparse population, there's a collaboration between the Nunavut government, the Canadian government, and local people. So you can't go into a bar or restaurant or hotel, or wherever, without signs graphically displaying how to cough, what to do if you're sick, how to wash your hands, etc. Even the small shops have signs and information, etc., and people are aware and are engaging in the conversation about how you can prevent this. We have done stuff in Inuktitut and a range of languages, and this can be adapted in other languages, as need be.

We can't communicate enough. We're continuing to do that. Will we ever do enough? I'm not sure, but again, these meetings, these forums, and the kinds of questions you're asking are all important in helping the public to understand the kinds of very practical things they can do, and what we as governments or organizations are doing to try to address this. People understand it better now than they did three months ago, or six months ago, and I'm sure as we move into the fall it will do well.

It's amazing. I was asked earlier today about culture change, and it's really interesting when I go out now. I remember that when H5 was ongoing, we were talking about hand washing and everything, and it was rare that I'd see someone leave a washroom without washing their hands. And then suddenly we started drifting back. Well, now it's coming back again. When people are out there coughing in public, people are looking at them funny or asking them to leave. So I think this will bode well not just for our ability to reduce the impact of a pandemic, but also for a range of other infections.

Thank you.

● (1530)

Mr. Colin Carrie: Thank you very much for that answer.

I wonder if you could give us a little bit, too, of a global understanding. The government took a proactive approach in 2006 to put a pandemic plan in place here in Canada. How has that helped Canada as we compare to other countries that didn't have that plan in place, that weren't so proactive?

I know it's a little subjective for you to state this, but how do we rate compared to other countries in terms of how we're handling this? I'm hearing some wonderful things coming out of Canada, how, when the virus was first discovered, we were able to map it genetically. How did that $1 billion investment in 2006 allow us to be leaders in the world?

Dr. David Butler-Jones: A number of things have been in place. The lessons from SARS put Canada in a position of needing to do something, and people around this table were part of that debate and discussion that created the formation of the agency. The investments, the focus, and the planning in 2006 have really brought that focus in a way that few other countries really have, to the point where having the public health network, having the ongoing collaboration at the federal, provincial, and territorial levels, having plans in place, being the first country to actually have a pandemic plan nationally and then working on it regionally and locally, having a contract for vaccine supply, having a stockpile of antivirals, when you put that all together, has made us quite unique—if not totally unique, then very rare in the world. We're fortunate, but it's for a lot of wiser people than me, I think.

Mr. Colin Carrie: Thank you very much for your answers. I know everyone around the table appreciates your attending at such short notice, and we thank all the witnesses.

The Chair: Thank you, Dr. Carrie.

We will now go to Ms. Wasylycia-Leis.

Ms. Judy Wasylycia-Leis: Thank you very much, Madam Chairperson.

I want to start where I left off in my discussion with the minister.

We're hearing a lot from the minister and from you, Dr. Butler-Jones, about plans in the works for the fall. I think it's really hard for us to accept that when, as early as last June, you knew and you talked about this possibility of a mutation and a serious outbreak in the fall. So we expected that more planning would have been done this summer and we would by now be at the point where we'd hear specific plans and more concrete proposals for dealing with such things as the higher incidence in first nations communities and dealing with the questions we're all getting about adverse reactions to vaccines.

First of all, as Gary Doer, the Premier of Manitoba, said, we have a truck coming at us. It doesn't look like we're actually ready for this, so what happens if there is a significant outbreak in the fall? We don't have vaccines, we don't have a prioritization list, we don't have a contingency plan in terms of massive numbers in first nations or remote communities, so what are we going to do? How are we going to address these serious issues?

● (1535)

The Chair: Dr. Butler-Jones, I will give you a chance to answer this. We have another panel coming in and it has just been drawn to my attention that we've gone a little bit over time, but I know you had that one question, so go ahead.

Dr. David Butler-Jones: I don't know whether it's because it's like a duck and the legs are going a lot faster under the water than you see with it moving smoothly along the surface, but there's an incredible amount of work going on. There are plans in place. We don't need to prioritize antivirals, because we have enough antivirals to treat everybody. You don't have to line up.

Ms. Judy Wasylycia-Leis: Is it all going to be ready at the same time, or are there going to be some choices?

Dr. David Butler-Jones: No, the antivirals—the drug for treatment—are already in provincial warehouses and are already pre-positioned in remote communities.

Ms. Judy Wasylycia-Leis: But talk about the vaccine now.

Dr. David Butler-Jones: For the vaccine, we will have the priorities in September. We will have the vaccine in November. The planning is already taking place.

There are some things that are obvious. Those in remote communities, those with underlying risk factors, health care workers, and essential workers are going to be at a higher risk level. But if you go into a community of 300 people, you're not going to do only half the community. You're going to immunize everybody in that community.

So again, the working out of logistics is going on now, the refinement of guidelines, the publication of additional guidelines, getting the surveillance in place, getting the negotiations in place. Things have been going like crazy. We are in such a different place today in terms of response. It doesn't mean that everybody is there. There are lots of people who still have their head in the sand, but that doesn't mean there isn't a phenomenal amount of work going on. In fact, as Shelagh Jane was saying, 90% of reserves have a plan and they have tested that plan, or whatever.

So it's not like there isn't a lot going on. There's a huge amount going on. Are we there yet? No. The fact that there are communities still waiting for someone to solve their problem for them, or whatever, is a different issue.

The advice is there, the guidance is there, the capacity is there; it's really about applying it and finding ways and asking the questions. If people aren't sure, ask the questions, because we have local systems to address them.

The Chair: Thank you.

Ms. Judy Wasylycia-Leis: Could I ask a question?

The Chair: No, Ms. Wasylycia-Leis. I've had three people ask if they could ask a set of three other questions, so I'm going to stop it now.

Ms. Judy Wasylycia-Leis: Could we get further information about studies around vaccines that we've heard from Arthur Schafer—

The Chair: What we're going to do now is we're going to go to—

Ms. Judy Wasylycia-Leis: —his comments and concerns about the vaccine?

The Chair: You know what, we're simply going to have to suspend until we can get order here, because this committee is not going to go this way today. This is a very important issue.

Now, Dr. Butler-Jones, if you have a couple of closing remarks, we'll then go to the next panel.

Dr. David Butler-Jones: Only to say that, as everybody says, this is an important issue. There will always be one-offs; there will always be the one in a hundred who thinks everybody else is wrong. They may be right. Not very often, but they may be right. So in terms of the questions, it's one thing; the questions are very important. The so-called experts need to listen also to the answers.

What I understand is that we're going to be coming back to this. I'd be very pleased to come back at any time or, as we did in the spring, actually have an information meeting as opposed to a committee meeting, where MPs from the committee and others might wish to come and have discussion, talk about it as long as they want on these issues. I'd be very pleased to find a time to do that, to supplement whatever else you might do with the committee.

The Chair: I think you've heard today, Dr. Butler-Jones, the concern and the care and the involvement that all the committee members have. I want to commend you, the minister, and Shelagh Jane Woods for coming today and for being so accommodating in helping us with these questions. As the chair of this committee, I do like to be able to get all our witnesses in. Actually, these witnesses are from the opposition, so I'm trying to be very fair about making sure we have all these people come in. I thank you, and I thank you for your generous offer to be so available.

What we will now do is suspend for 30 seconds and we'll have the other panel come to the table.

Thank you.

● (1540)

(Pause)

● (1545)

The Chair: We will resume with our second panel.

We now have the College of Family Physicians of Canada, and Dr. John Maxted; and the Ontario College of Family Physicians, Dr. Jan Kasperski. They are going to share their time. Each group has a 10-minute presentation.

Following that we have the Federation of Canadian Municipalities, who will present for the next 10 minutes. That includes Berry Vrbanovic, second vice-president; and Alain Normand, manager of emergency measures for the City of Brampton. They will be sharing their time as well, I understand, for 10 minutes.

Let's start with the College of Family Physicians of Canada.

Dr. John Maxted, thank you.

● (1550)

Dr. John Maxted (Associate Executive Director, Health and Public Policy, College of Family Physicians of Canada): Thanks very much, Madam Chair.

First of all, I want to say that if we have 20 minutes to do this, thank you very much. We understood that we would actually have, between Ms. Kasperski and me, five minutes apiece rather than ten. Is that right?

The Chair: Five plus five equals ten. I had to get that in. It helps out. Thanks.

Dr. John Maxted: Thanks very much for inviting us here this afternoon.

I'm a family physician as well as the associate executive director of health and public policy at the College of Family Physicians of Canada, and I certainly welcome this opportunity to meet with you and to discuss what the college has learned over the last several months in dealing with the H1N1 pandemic.

CFPC is the voice of family medicine in Canada. It represents over 22,000 family doctors and it's the professional organization responsible for the standards of training, certification, and lifelong learning for physicians, and for advocating on behalf of the speciality of family medicine. The CFPC champions the rights of every Canadian to high-quality health care.

After the outbreak of sudden acute respiratory syndrome, commonly called SARS, back in 2003, followed by H5N1, sometimes called avian flu, the CFPC released a paper titled *The Role of the Family Doctor in Public Health and Emergency Preparedness*. Many of the recommendations in that paper emphasized the critical need to communicate effectively during a public health emergency.

If there is one clear message we are delivering today it is this: the need for consistent and timely communication to and with front-line health care providers, including family doctors. Communications must be two-way. Family physicians should not only be advised about how to respond most appropriately to a public health emergency, but also be given the opportunity to ask questions of the Public Health Agency of Canada, provincial or territorial health ministries, and local public health officials.

To government's credit, communications related to H1N1 pandemic improved when compared to SARS, but it could have been better. It's the unknown potential of an infectious disease outbreak on its way to becoming a pandemic that should cause government and public health authorities to strive for optimal communications strategies.

At the recent Council of the Federation meeting in Regina, the Premier of Manitoba referred to H1N1 as a truck coming around the corner. In reflecting on his comment, *The Globe and Mail* extended the metaphor to the potential for a multi-vehicle pileup in the making. As the editorial concluded, this is no time for Canada to fall asleep at the wheel.

In July of this year, the Royal College of General Practitioners in the United Kingdom presented its members' views of government preparedness for pandemic influenza. Of the 11 categories of concerns identified, the majority focused on the need for more and better communications. For example, the very first concern was the lack of information and conflicting advice.

In our experience, H1N1 communication was variable. Some jurisdictions transferred a wealth of information from multiple sources that resulted in the risk of mixed messages, and others not enough, resulting in family physicians working in uncertainty.

Responsibility for communication must be defined and coordinated to decide who, for example, advises family doctors about the most suitable infection control procedures and escalating levels of precaution and isolation in clinical settings. The CFPC wants to play an important role in communicating with family physicians, but it does not want to deliver inconsistent, untimely messages.

A number of questions were asked by Canada's family physicians about access to resources during the H1N1 outbreak; for example, what masks to use and how to triage patients in practice settings. The practical answers to these questions may vary by location, but they must also recognize vulnerable populations most at risk. We may still question why Canada's first nations communities were hit hard in Canada, but waiting for research on this should not delay our commitment to respond urgently to the health care needs of the first nations peoples and other people at vulnerability with a well-defined and clear plan of action.

To summarize, the CFPC recommends the following actions.

Pandemic information must be provided in a timely and consistent manner to all family physicians and front-line health care providers. This is critical for managing patients who could potentially have the H1N1 flu and who present first to their family doctor in a practice or primary care setting during a pandemic.

Timely public health resources must be readily available, including, for example, appropriate swabs, masks, and antivirals. If local public health authorities haven't delivered these effectively during the H1N1 pandemic, what will happen when twice as many Canadians are asking for an H1N1 vaccine this fall, in comparison to our usual volumes during flu season? And that is in the midst of a potentially larger crisis created by a rejuvenated H1N1 virus.

Family physicians want to be involved in deciding how to respond to a pandemic. They want to maintain regular contact with their local public health authorities and medical officers of health. The CFPC wants to assist in the development and distribution of the most appropriate information for family physicians and other front-line providers, including clinical practice guidelines related to pandemic preparedness and response.

● (1555)

In closing, the CFPC and family doctors in Canada are confident that by working with local provincial or territorial and federal levels of government we can collaboratively improve our public health response to a pandemic outbreak. Canadians expect this of us.

Thank you very much, Madam Chair.

The Chair: Thank you so much, Doctor.

Ms. Kasperski.

Ms. Jan Kasperski (Chief Executive Officer, Ontario College of Family Physicians): Thank you.

I represent 9,000 family physicians in the province of Ontario. We were at ground zero during SARS. In 2003, following the outbreak of SARS in Toronto, the Ontario College of Family Physicians was asked to present to the Campbell commission in Ontario and to the National Advisory Committee on SARS and Public Health. Our discussion document, entitled “The Mushroom Syndrome: SARS and Family Medicine”, and a second document, written with our community partners, called “SARS and Community Care: Impact and Opportunities”, outlined the struggles we faced in Toronto during the SARS outbreak and the heroism of family doctors, our specialist colleagues, nurses, and other health professionals as we worked tirelessly in a confusing fog related to a lack of surge capacity, a lack of supplies, and a lack of proper communication systems to provide the guidance and advice that we desperately needed during this tragic episode. The recommendations in those two papers focus on the needs of family doctors and our community-based professionals in relation to pandemic planning. But just as importantly, they focus attention on the need to repair our health care system and to better align public health units with family practices and other community-based services.

When news of H1N1 hit the front pages of the national newspapers, controlled panic overtook the health care community in Toronto, especially among those who were providing care in family practices. We relived our experiences with SARS. You see, during SARS, the public was in a panic and so were we. With every sniffle, the public feared that they had SARS. They were worried about going to emergency departments or to SARS clinics. Instead, they headed in droves to their family doctors' offices.

Family doctors not only work in their offices; they work in emergency departments, they deliver babies, they look after people in hospitals and in long-term care facilities, and they look after palliative care patients and home-bound patients in people's homes. When SARS hit, they continued to perform all these tasks. They also manned the SARS clinics and took over the emergency departments and the ICUs when other physicians were deadly ill with SARS. But no one thought about their needs and those of their families. They worried of exposing their loved ones to that deadly disease, and their families worried about them. Most frightening of all, many of our patients in those days were our own colleagues, the ones we worked with day in and day out. We thought health care professionals were invincible and we found out that they weren't.

For the most part, SARS was confined to hospitals in Toronto, but the only physician who died from SARS acquired it in his family practice. Not until that family practice was brought to its knees did the system start to appreciate the role that family doctors were playing during SARS. It took our college and the family doctors themselves to make people take notice of them. Believe me, it was a tiring and stressful process to get noticed.

Post-SARS, a great deal of health planning has occurred. We are very much more prepared than we were then. Family doctors have actually had a place at the planning table in Ontario. We were first invited to the table with dentists, pharmacists, funeral directors, and the like, people who may have a role to play in the outbreak, but not the central role that family doctors play. Unfortunately, health care planners may still believe that the outbreaks are hospital-centric and they forget about the central role that family doctors play in our health care system, particularly through influenza.

During the initial few weeks following the H1N1 outbreak in Mexico and across Canada, communications were swift and concise. But since we don't have one list of all the physicians in the province that can be used to send information, news briefs from the Public Health Agency of Canada, the Ministry of Health, and our agency on health promotion and prevention were sent through a variety of organizations, so the same message was received multiple times. Fortunately the messages were usually concise and usually consistent, but there has to be a better way of getting the right information at the right time to physicians. The information needs to come from someone in a trusted position. Where physicians are concerned, the information needs to come from a physician with the authority to say, “This is what you will do, and you will do it now.”

● (1600)

The system we did use provides some degree of two-way communication. The OCFP regularly communicates with our members, and they're used to e-mailing us back with questions, concerns, and solutions. We received a lot of e-mails during those early days of H1N1, and we passed them on to the ministry. The ministry also set up a hotline to provide information to the public and to health care professionals. Those who answered the phone were confident and very well meaning, but it soon became clear that they were not able to address the clinical questions that family physicians were asking. We assisted the Ministry of Health by recruiting retired family physicians and some of our members who were on maternity leave to be a valuable source of providing that telephone contact. This strategy gave the Ministry of Heath an opportunity to hear from the field, and news briefs were then used to address most of the questions that were coming up the pipe. Hospital departments of family medicine also play a really key role in supporting and informing their members.

We still have a lot of work to do, as we approach the fall, in improving that two-way communication system. We need to address public education and messaging, and soon. While we certainly don't want to alarm the public unduly, it seems as if the public and professionals alike have been lulled into thinking that H1N1 is a non-event. People need to better understand the potential for a severe reaction to the virus, and they need to—

The Chair: I hate to interrupt you, Ms. Kasperski, you're two minutes over. I'm wondering if you have much more. I want to give everyone a chance.

Ms. Jan Kasperski: I'll simply emphasize the fact that we need supplies, we need information, and we need to have the human resources to keep our offices open.

The Chair: Thank you very much. There will be time for questions and answers too.

We'll now go to the Federation of Canadian Municipalities and start with Mr. Vrbanovic.

You have 10 minutes. I understand you're sharing your time with Mr. Normand. Is that correct?

Mr. Berry Vrbanovic (Councillor, City of Kitchener; and Second Vice-President, Federation of Canadian Municipalities): I'll be speaking for all three of us.

The Chair: Okay, go right ahead, then. Thank you.

Mr. Berry Vrbanovic: *Merci beaucoup, madame la présidente* and members of the committee. It is a privilege to be here today to speak about a pressing challenge facing our country, the H1N1 pandemic.

My name is Berry Vrbanovic, and I'm a vice-president with the Federation of Canadian Municipalities and a councillor in the city of Kitchener, Ontario. I'm joined today by Alain Normand, who is with the City of Brampton's emergency measures and corporate security department; and Joshua Bates, a policy adviser with the Federation of Canadian Municipalities.

The Federation of Canadian Municipalities, or FCM, has been the national voice of municipal government in this country since 1901. With more than 1,800 members, FCM represents the interests of municipalities on policy and program matters that fall within federal jurisdiction. Members include Canada's largest cities, small urban and rural communities, and 18 provincial and territorial municipal associations. Collectively we represent almost 90% of the Canadian population.

The H1N1 influenza virus is a global pandemic that respects neither borders nor jurisdictional boundaries. Already, this deadly strain of influenza has killed more than 60 people in Canada, and health experts warn that a second wave of the virus could result in many more deaths during the coming flu season.

The central question facing all orders of government in this country is, are we as prepared as possible to effectively manage the H1N1 outbreak and protect Canadians?

It is FCM's position that any national pandemic plan is incomplete unless it includes provisions to keep key municipal services operating under the most difficult circumstances. We are therefore asking that the federal government design and implement a national plan, with municipal input, to keep critical front-line workers safe and on the job. This requires planning now to ensure that critical front-line municipal workers, such as police, firefighters, road crews, public transit operators, water and waste water workers, and municipal public health professionals, remain on the job during the worst of a pandemic. Without these workers on the job, the nation's entire pandemic response will be jeopardized, no matter how robust the rest of the plan.

Today there are 270,000 men and women working in these critical service areas for Canada's more than 3,600 municipal governments. Currently there is no national strategy, guidelines, or resources in place to ensure that these workers have timely access to the H1N1 vaccine, sufficient antiviral medications, or personal protective equipment; nor is there funding, resources, and expertise to respond to a pandemic crisis in the event it's needed. Only the federal government can provide the national leadership and coordination to address this gap.

A global pandemic such as H1N1 requires international and national coordination and the engagement of all orders of government. Canada must not limit itself to a patchwork of regional pandemic responses. Cities and communities from St. John's to Whitehorse must be assured that their citizens and the essential services they rely on will be protected by an effective national strategy that meets national guidelines.

Since the spring, FCM has engaged federal health officials, including Minister Aglukkaq, on these issues and concerns. We recognize that the federal government has taken important steps to protect Canadians against a pandemic. A national plan to protect the health sector has strengthened federal-provincial-territorial coordination in this area and provided a framework that can be extended to the municipal sector. Actions to increase a national antiviral stockpile and to secure a vaccine supply are also positive and welcome. However, the H1N1 outbreak has exposed a long-standing gap in the federal government's overall pandemic preparedness strategy, a gap that has been present under successive governments: a national plan to help cities and communities protect their critical front-line staff and to ensure they have the resources and expertise needed to carry out pandemic response roles assigned to them by federal, provincial, and territorial governments. As a country, we must safeguard the health of the men and women who will be on the front lines during a pandemic and responsible for keeping our cities and communities running while protecting the public.

A serious disruption in critical services such as policing, waste management, or public health would put Canada's pandemic response plan on life support and bring our cities and communities to a grinding halt. For example, without enough transit operators on the job, bus and light rail service would suffer and traffic gridlock would worsen. Doctors, nurses, and public health workers would struggle to get to hospitals, clinics, and temporary flu centres.

● (1605)

Establishing a strategy to protect and equip critical workers is a long-standing priority of municipalities. Well before the emergence of the H1N1 virus, many municipalities adopted comprehensive plans to minimize health and economic impacts of a pandemic.

More recently, municipalities have stepped up their preparations by training staff, preparing local flu treatment centres, implementing communication strategies to quickly share information with employees and citizens, and fast-tracking procurement of personal protective equipment to add to existing stockpiles. FCM's pandemic preparedness working group, established in April 2008, includes public health workers, emergency managers, and front-line emergency service providers from across the country.

We are fortunate to have Alain Normand, an emergency manager from the City of Brampton and a member of that working group, here with us today. The working group shares information about recent developments and best practices and relays information to the federal government about issues playing out on the ground, but local governments cannot go it alone. To keep cities and communities functioning during a pandemic, front-line municipal workers need access to a national vaccine, antiviral and personal protective equipment stockpiles, as well as resources and expertise.

I would point out that in 2008 a task force of the Public Health Agency of Canada recommended that the agency work with all orders of government to identify critical infrastructure workers and ensure they have access to rapid assessment and early treatment. More recently, federal officials have publicly stated that critical workers should receive priority access to an H1N1 vaccine.

Municipal leaders have been encouraged by recent public statements suggesting that the federal government understands the importance of protecting critical front-line staff, but we must implement a national standard or strategy to equip and protect these workers, and municipalities should be consulted by the federal government to help develop such a plan.

The challenge now is to put these words into action and to do so quickly. Cities and communities across this country are ready to help federal, provincial, and territorial governments identify and protect front-line municipal staff. With the flu season approaching, there's still time to fix this problem, but there is no time to waste.

Given the urgency of the current situation, we would ask that the Government of Canada implement the following four recommendations: one, design and implement a national plan with municipal input to keep critical front-line workers safe and on the job; two, implement the task group on antivirals for prophylaxis recommendation to engage all orders of government to ensure that critical infrastructure workers have access to rapid assessment and early treatment; three, ensure that critical infrastructure workers have prioritized access to the H1N1 vaccine; and four, ensure that municipalities have the expertise and resources required to fulfill pandemic response roles mandated by federal, provincial, and territorial governments.

Thank you, ladies and gentlemen. My colleagues and I will be pleased to answer any of your questions.

● (1610)

The Chair: Thank you very much for that presentation.

We will now go into a seven-minute round with questions and answers, and we'll begin with Ms. Neville.

A voice: Were you going to mention Dr. Kendall?

The Chair: I should mention that. Thank you.

Dr. Kendall is going to be presenting at 4:30 via video conference, so we have to keep that in mind. I'm trying to move this along quite quickly so we stick to timelines.

Ms. Neville.

Hon. Anita Neville (Winnipeg South Centre, Lib.): Thank you, Madam Chair.

Let me begin by thanking each of you for coming here today, particularly on somewhat short notice, I think. Thank you for your presentations.

You raised a number of important issues. If you will allow me, Madam Chair, one of you spoke about the patchwork of responses across the country, and I want to go on record right now, Madam Chair, of identifying what I believe was misinformation of the previous panel, particularly as it related to first nations communities and the preparedness in first nations communities.

I had the opportunity on Monday to meet with Treaty 3 first nations leadership on health issues, and quite clearly, a third of those communities do not have plans. As well, many of the other plans that are in place are not current and need revision. So I think that is a kind of misinformation or patchwork of responses. I'm well familiar with what's happening or not happening in the province of Manitoba, and again, it gives me concerns about the patchwork of responses that we're seeing in first nations communities and that we may well, indeed, be seeing across the country.

I want to thank you very much, because what both organizations have done in different manners is to identify the gaps, as you have seen them, in the plans. Each group spoke about the recommendations made following SARS, and I wonder if both groups would again elaborate on those gaps, as you see them, and what kind of input and consultation your respective organizations would like to see to address those gaps.

Ms. Jan Kasperski: In Ontario, at the family medicine level, it's really important for the committee to understand that H1N1 and seasonal flu are community infections. SARS affected the hospital environment; it was a very severe disorder, and people needed to be in hospital.

What we're dealing with is outbreaks that affect the communities and the people who live and work in the communities. I don't think there has been as much emphasis on supplying the equipment, the human resources, and the information that the front-line family doctors and public health nurses need in order to really get ready for both seasonal flu and H1N1 flu.

We need, in each and every season, to get as many people as possible vaccinated for the seasonal flu. That taxes both public health and family practices. We will now be dealing with a vaccine for two different strains almost simultaneously, by the time we get seasonal flu into people and start doing H1N1, at the same time as we're trying to deal with very sick patients in the community. We're very worried about our abilities to cope with the workload.

We haven't been given the supplies that we require, both from—

● (1615)

Hon. Anita Neville: Can I interrupt you for a minute? What I'm interested in as well is what input you had into federal planning in the preparation.

Ms. Jan Kasperski: I can speak to the Ontario scene. One family physician has been working with the Agency for Health Protection and Promotion, and another has been working with the ministry. The ministry consults with us from time to time, but I wouldn't say we've had an extremely strong voice during the planning. I think we're at a stage now where we really need to have that happen.

Hon. Anita Neville: My time is limited, because I have only seven minutes. I want to hear from the municipalities too.

What I'm really quite concerned about are the concrete measures that are available to your organizations. Mothers are sending their children off to school, whether it's day care, elementary, or post-secondary education. We need to know at every level that there are plans in place to address this and that the host organizations or those most close to the ground have the input into the communication.

Mr. Berry Vrbanovic: Thank you.

Ms. Neville, very simply, I think what we're looking for is the federal government to design and implement a national plan, with municipal input, that will keep critical front-line workers safe and on the job during a pandemic. Specifically with respect to your question about the dialogue that has occurred, we've had a long-standing dialogue with the federal government about the need for this. In light of the H1N1 outbreak, we raised the issue again in a letter from our president to the Minister of Health in early May. Since then, our staff has had dialogue with federal officials, including the public officer for health, and we've been encouraged by recent statements suggesting that they understand the importance of critical front-line workers having their needs addressed, but so far we are yet unaware of a national plan that will actually do that.

My colleague Mr. Normand might want to add something as well from a staff perspective.

Mr. Alain Normand (Manager, Emergency Measures and Corporate Security, City of Brampton, Federation of Canadian Municipalities): Yes, Madam Chair. We were involved during SARS ourselves and we had to respond. We had a number of situations that were totally under the radar because all the attention was on the health aspect and on hospitals. Meanwhile, for example, our bus operators threatened to walk off the job completely, en masse, because they felt that they had inadequate protection during SARS. We know they didn't really need any special equipment; however, there was not enough information flowing to the front-line workers to enable them to make those judgment calls. So we had to step in and scramble to get all sorts of information in order to help our front-line workers.

That's just one example. The focus was really all about hospitals, whereas the background, the infrastructure needed to make sure those hospitals actually continue to function, was totally ignored. We would like to see a lot more municipal involvement in the development of plans in order to make sure that when the H1N1 comes around again we have the capacity to respond in a better way than we did during SARS.

The Chair: Thank you so much.

We'll now go to Mr. Malo.

Hon. Carolyn Bennett: I think Mr. Maxted had something to say.

The Chair: Well, Mr. Malo, we're two minutes over. Perhaps you can continue with Dr. Maxted, if you choose. Mr. Malo, it is your choice. Please go ahead.

[*Translation*]

Mr. Luc Malo: Madam Chair, I would like to make a special request. Since there is one witness we have yet to hear from, would it be possible to take only half of my time and use the other half following the next witness' presentation?

● (1620)

[*English*]

The Chair: I'm sorry, I was consulting with the clerk on something. Go ahead, Mr. Malo.

[*Translation*]

Mr. Luc Malo: Madam Chair, since we have yet to year from one witness, would you allow me to use half of my time now and use the other half once I have heard the last witness' testimony, so that we can have a complete round?

[*English*]

The Chair: Well, I'm trying to stay within the timelines. We have another person who does want to ask the question, so would that be using your own time then, Mr. Malo?

[*Translation*]

Mr. Luc Malo: I will take three and a half minutes now and three and a half minutes later.

[*English*]

The Chair: Okay, sure. Absolutely. Thank you.

[*Translation*]

Mr. Luc Malo: My question is for our witnesses from the Federation of Canadian Municipalities. Since the cities come directly under the responsibility of the provinces, would you say the lack of communication you referred is a general problem, or are there some places where things are working better? Are you able to answer that question?

[*English*]

Mr. Berry Vrbanovic: What I would say in response to your question is that we need to remember that a situation like a pandemic does not recognize jurisdictional boundaries, whether they are municipal, provincial, territorial, or federal. The reality is that we need to have a comprehensive plan that relates to each and every Canadian from coast to coast to coast and helps ensure that the needs of all our communities are being addressed—and specifically, in the case of municipalities, the needs of our front-line workers—in order to ensure that we can respond to our citizens if and when the situation were to get worse.

[*Translation*]

Mr. Luc Malo: So, you are saying that in terms of developing the action plan, there is very little, if any, consultation with the municipalities. Is that correct?

[*English*]

Mr. Berry Vrbanovic: As I indicated in my response earlier, since our letter to the minister in early May from our president, we have had dialogue with federal officials about this issue. In recent weeks we've been encouraged by some of the announcements that have been made in terms of public statements around the need to address the protection of front-line workers and also some of the announcements with respect to the acquiring of both antivirals and vaccines. However, we still have not seen or heard of a national plan that specifically addresses the needs of those front-line workers in our municipalities that, we believe, are absolutely essential in terms of the implementation of a successful national pandemic strategy.

Ms. Judy Wasylycia-Leis: Thank you, Madam Chairperson.

In three or five minutes, let me first ask Mr. Normand. You are an expert in the whole area of emergency preparedness. Obviously, all of you together are not exactly enamoured of the federal government's approach and you are feeling there's a need for a national plan with funding and consultation and with teeth. Let me ask some specifics, though.

Right now we're at August 12 and they're predicting that an outbreak could happen in September. What direction have you now received from the federal government in terms of very specific things—for instance, for an ambulance driver? Are you instructed to wear a mask if you're carrying a patient who has H1N1? Or if you are a police officer and asked to enforce a quarantine, have the police been given specific directions from the federal government through this process for how to handle that?

Mr. Alain Normand: Thank you, Madam Chair.

Yes, we have received some communication. We received, actually last week, a communication from the federal government directed at the front-line responders—police, fire, paramedics. However, it was a very short communication. It was very succinct and had only very basic information. We would like to see more, and we're willing to come to the table and work with the federal government to come up with some more extensive guidelines.

The guidelines really talk about how to wash your hands, how to wear the mask. I have to say that in the city of Brampton we're fortunate. We're a larger community, and we've taken the time way back to actually fit-test the masks for every single one of our emergency workers. I can't say it would be the same for all smaller communities. They do not necessarily have the same level of resources as we have, and that's my concern. Even though I may come from Brampton, as a representative from the FCM, I am concerned about the capacity in other communities as well.

● (1625)

Ms. Judy Wasylycia-Leis: Did that kind of directive come down after your fairly substantive letter on July 27 to the minister?

Mr. Alain Normand: Actually, I think it came very close.

Ms. Judy Wasylycia-Leis: Obviously, your speaking out caused a reaction. Maybe today we'll get another reaction.

Mr. Alain Normand: We're hoping that we can engage in this form of dialogue. That's our reason for being here today.

Ms. Judy Wasylycia-Leis: Let me ask you this, Dr. Maxted. You made a comment in your remarks about the need to act now, the time for study is over, and if we know enough information now about first nations communities and Inuit people being affected more severely by H1N1 than others, why aren't we taking measures to deal with that?

Just to respond to Mr. Clarke's comments from earlier, I don't think that's being “un-Canadian”. I think that's recognizing that there might be a disproportionate impact on certain populations, and that if it was, for example, the case that more women were affected than men, we'd be asking the same questions.

So I'd like to know from you, what should we start doing immediately on that front? If we're lucky enough to get another meeting with the minister soon on this issue, what should we be asking her that wasn't addressed today?

Dr. John Maxted: I've noticed a lot of your questions today have to do with questions around planning: where's the plan for this, and where's the plan for that, and the other thing? I'd suggest to you that a plan is only as good as its implementation, and in fact we have plans out there, or at least there are plans out there. I could refer you to the 600- to 800-page pandemic national plan, which probably very few of us have actually read, although I, for one, have. And I could refer you to other plans that different municipalities, hospitals, and other health regions, and so on, have created, all of which have substance, have value to them. But the plan is only as good as the implementation.

It's in the implementation that we have begun to realize, through H1N1, that there are problems, and some of the problems that I have identified are the problems around communication. Somebody used the word “patchwork”. I think that in fact across this great country we've seen a patchwork. We've seen a patchwork of communicating with front-line providers, who, by the way, are some of the most important providers in this whole network. It's not the community medicine specialists necessarily, and not the intensive care experts, who in fact are looking after those who are dying. It's the vast majority of the population walking into the primary care centres who we should be paying attention to, because those are the people who are not walking in with labels on their foreheads that say they have H1N1, but need to be diagnosed and need to be treated and managed accordingly in order to deal with this situation before they get to intensive care units.

So I think it's the implementation that really needs to be focused on, the availability of resources. My comments ended simply with the fact that we're willing to work with both the public health agencies as well as local public health authorities. We haven't seen the same response back sometimes from some of those same places.

The Chair: Thank you so much, Dr. Maxted, for your insightful comments and for all of your comments here on committee.

We're now going to go to Dr. Perry Kendall, who is with the Pan-Canadian Public Health Network.

Good afternoon, Dr. Kendall. Welcome to our committee today. Can you hear me? There's no audio, I'm sorry. Do you hear anything?

Dr. Perry Kendall (Provincial/Territorial Co-Chair, Special Advisory Committee on H1N1, Pan-Canadian Public Health Network): Good afternoon. Can you hear me?

The Chair: Dr. Kendall, I think we can hear you now.

My name is Joy Smith. I'm the chair of this committee. We've had, as you know, witnesses here today who have discussed our topic of the H1N1 issue. What you will have is a 10-minute presentation, Doctor. Following that, we'll go into the question period.

So I would welcome you to begin your presentation.

Dr. Perry Kendall: Thank you, Madam Chair.

I really appreciate the committee fitting me in and arranging for me to speak to you today. I am the provincial health officer for British Columbia. Since 2005 I have been the provincial/territorial co-chair of the Pan-Canadian Public Health Network, which you will know was established by the ministers of health post SARS to knit Canada's public health systems together federally, provincially, and territorially.

The Public Health Network consists of senior federal-provincial-territorial public health officials who report to the Conference of Deputy Ministers of Health. It has six expert groups, who draw on expertise across the country, looking at emergency planning, public health laboratories, surveillance, communicable disease control, population health promotion, and chronic disease prevention. It has links to the Council of Chief Medical Officers of Health across the country, who in fact make up about half the membership of the council. It also has links to the national collaborating centres for public health.

One of our major pieces of work since our formation in 2005 has been preparing and updating the Canadian pandemic plan.

In mid-April there was the emergence of a novel H1N1 influenza virus in Mexico. The Public Health Network and the federal-provincial-territorial deputy ministers established what were virtually daily calls to coordinate the activities and responses to this H1N1 emergence.

Some time in April or May, the deputy ministers of health created a special advisory committee on H1N1, consisting of every chief medical officer of health across the country, every representative on the Public Health Network, and the Public Health Agency of Canada. I have co-chaired that since its inception, with Dr. David Butler-Jones. This committee met daily until early June, and since that time it has been meeting twice weekly and reporting weekly to the federal, provincial, and territorial deputy ministers of health.

The organization is to focus on H1N1, and part of our work was to develop an organization that could respond in a timely fashion to the cross-Canada needs from H1N1. So we have created what's called a pandemic coordinating committee, which is a smaller group of folk from the network, including our relevant expert groups and experts from across the country. It is like an executive committee that focuses on the response and forward planning over the summer for what we believe will be the re-emergence or resurgence of H1N1 in the fall, when children go back to school.

That coordinating committee has put together a number of structures that draw on provincial, territorial, and clinical and epidemiological expertise from across the country. So we have a task group that is working on surveillance, epidemiology, and laboratory preparedness. We have another task group that has been preparing guidelines on infection control and occupational health. We have a group that has been working on a communications platform and building on existing work the Public Health Network did.

Part of our pre-existing pandemic preparedness that has obviously helped this year had been building antiviral stockpiles, developing proposals for accessing vaccines and plants for delivering vaccines, and building a communications platform for influenza in general that can be easily adapted to H1N1. We have a pandemic vaccine working group, which has been working on criteria for purchasing and developing a pandemic vaccine. We also have a group of our infectious disease control people looking at other vaccines—for example, a pneumococcal vaccine—and at seasonal influenza vaccine criteria.

We have a group that has been working on public health measures, school closures, summer camp guidelines, mass or group meetings, etc.

We have a group that is working with the chief veterinarians of Canada to look at human-animal transmission, the zoonoses implications for avian or swine infections on humans, for example.

We have a group that has been looking at clinical care guidelines. They have developed clinical care guidelines for pregnant women and are also developing clinical care guidelines for emergency room physicians, etc.

● (1630)

We have a group as well that has been looking at the use of antivirals and prioritization of groups and the necessity for antivirals. We have a group that has been looking at the antiviral stockpile management and the refresh, and we have a group that has been applying a lens across all these products to ensure that remote, isolated, and first nations communities are taken into account.

The work that these task groups have been doing over the summer, much of which has been completed and much of which still remains to be done, has been giving us a sense of where H1N1 is going globally, in the southern and northern hemispheres, tracking the spread of the disease, tracking its severity, tracking its impact on individuals, on communities, on the health care system, and on the broader social service system, and then producing guidelines that are evidence based, that can be used in the jurisdictions across Canada or, if they're not used identically—because they're not meant to be cookie cutters—will give the evidence-based principals on which jurisdictions can formulate responses, can provide guidelines to nurses, physicians, hospitals, health care workers, ambulance attendants, and so on, schools, day camp operators, or in fact the general public, so that we will have an evidence-based response in place and ready as we move into the fall, when we expect to see the second wave of H1N1 enter the northern hemisphere.

I could go into more detail on the work plans that have been approved by this group and presented to and approved by the deputy ministers of health, who would be ultimately reporting to ministers of health; or I could stop there and give you more time for questions rather than go through a list of the outcomes that we're going to deliver by the end of the summer.

● (1635)

The Chair: Then perhaps I'll ask the will of the committee. Would you like to continue with the questions?

Monsieur Malo, as I promised—you have to remember this—I'll give you the two and a half minutes now.

Thank you.

[*Translation*]

Mr. Luc Malo: Thank you, Madam Chair.

Dr. Kendall, thank you for being with us this afternoon.

When the Minister left earlier, she made an announcement in the hallway that she did not make in front of the members of this Committee. She announced that she would be presenting a plan for the schools next week. We all know full well that schools are not managed by the federal government; rather, they fall within the purview of the competent authorities in the different provinces.

As the provincial-territorial co-chair of the Special Advisory Committee on H1N1, can you tell me whether the various provinces are intimately involved in developing this plan for the schools?

[*English*]

Dr. Perry Kendall: Thank you. That's a good question.

We know that schools act as a culture ground for the spread of influenza viruses. When these viruses enter a community, they first affect younger people, because younger people are naive and have little resistance. In Australian day cares and schools, because of the close contact, we see the level of replication of the virus multiply in those communities before they move to families, before they then move into the adult population, and before they move into the community at large.

One of our criteria has been, what should we do when we get outbreaks in schools? Should we be closing schools? There is evidence that, because viruses will spread in the schools, should we close the schools and should we keep all children at home, we slow down the spread of the virus and delay its entry into the general population. In fact, that's what's happening over the summer holidays. We had the virus in the broader community, the schools broke for holidays, and the levels of influenza activity have continued but at lower levels. When the kids come back, they're going to ramp up.

Our initial response in British Columbia and south of the border in the United States, when we identified H1N1 in schools, was to close those schools down. Other provinces didn't. We've looked at the evidence as to whether school closures can be effective in mitigating or ramping down the spread of influenza. If this influenza were really severe, were really making many children very, very sick, had serious implications for the health structure or health of the broader population, it might be worth incurring the social costs of closing schools down—because that has impacts on the broader economy, impacts on parents who have to stay home. It only works if children actually stay home in relative isolation. If we close the schools down and the kids mingle in the malls, we've accomplished nothing but disrupting their educational process in civil society.

We've looked at the evidence, and the documents that the minister was talking about are in fact evidence-based guidelines for what public health officials and school officials can do or should do in response to outbreaks of H1N1 influenza in schools, which is essentially focused on prevention by keeping sick children home, focused on hygiene, focused on identifying kids who are ill and isolating them until they can be sent home, and basically keeping the schools going as long as there is a sufficiency of adult staff to keep the school safely open.

● (1640)

The Chair: Thank you, Dr. Kendall.

We'll now go to Dr. Colin Carrie for his questions.

Mr. Colin Carrie: Thank you very much, Madam Chair, and I want to thank Dr. Kendall for joining us today.

I realize, Dr. Kendall, your job is quite sensitive at times. You're doing quite the juggling act ,and I want to commend you for the good work you're doing in regard to all these federal-provincial-territorial jurisdictional issues. My colleague from the Bloc brought up a very important point with schools, to make sure that we have an evidence-based response to these different scenarios that we're going to be presented with.

Our colleagues from the municipalities brought up some good points too. I think everyone's aware that PHAC is responsible for the H1N1, but for critical infrastructure, what the municipalities are dealing with at the grassroots is public safety. So I see there such a huge coordination.

One of the points brought up was that it doesn't appear that we have a federal plan. That's exactly what we do have. We do have a federal plan and we're working through that plan, and you are a very key player for that.

I was wondering, number one, with the concerns of the municipalities here...they said that there really isn't a plan for those front-line workers. Could you elaborate on a plan that you have been working on?

We had some comments from the Canadian College of Physicians, but also Dr. Butler-Jones, about improving the communications. I think this is what this is all about. We have certain stakeholders who don't feel that we have a plan. Apparently we do have a plan, but it's not being communicated.

Would you be able to comment on what we can do, perhaps what the federal government can do, to work with the provinces? Municipalities are creations of the provinces, so how can we work with the provinces to better communicate and get those lines of communication out to the municipalities that have very valid concerns with the overall plan that we have with the government?

I know that's a long question, but please do the best you can.

Dr. Perry Kendall: Thank you. It's another good question.

Our Canadian pandemic plan has two primary goals. One is to reduce mortality and morbidity, particularly in the most vulnerable, and the other is to, if you like, maintain the infrastructures that go to creating a civic society and the critical infrastructure pieces. The two are linked in that if we keep people as healthy as possible and minimize the rates of infection and illness and absenteeism, we have a larger workforce in place to manage the health care system, or to maintain bridges, ferries, transportation, municipal infrastructure services, fire, police, ambulance, etc. So part of our focus is on keeping those front-line workers healthy by focusing on, in this case, early intervention through access to antiviral drugs, particularly for people who have become ill or are at particular risk for serious illness.

The other piece of the pandemic planning goes back a number of years and has to happen, as I think you pointed out, at the provincial or the territorial or the local level, where local regional health authorities or local public health agencies have to engage with their municipal counterparts. Certainly in B.C., and I believe across the rest of the country, the fundamental primary responsibility for disaster and emergency response lies with municipalities. They are the foundational piece of that.

We and, I think, most provinces have put up annexes of their pandemic plans, which do include guidelines for municipalities and in fact businesses in general, on how to prepare for predictable things like pandemics in terms of looking at mission critical structures and ensuring that you have plans in place for a reduced workforce through increased absenteeism, that your critical infrastructure pieces are duplicative so that at least you have somebody who knows where the critical switch is that manages the water treatment plant or electricity or power grid. That has to be done at the local level, and it really has to be done in intense cooperation with the local public health folk who can know the details.

I think that prior to the arrival of H1N1, across the country we lapsed a bit into pandemic planning fatigue. There was so much going on that it was hard to maintain the focus on that; it should have been kept up year after year after year. I think it has taken H1N1 to give us a wake-up call, particularly for some people, perhaps, to realize that they didn't keep their planning up to date, that they weren't up to date with their websites or that we didn't develop the linkages that we need to develop at that very local level.

● (1645)

Mr. Colin Carrie: Are you saying to the members of the committee that we actually now are making those linkages? I know the minister brought up the point that she was working on an MOU with the provinces. What I found very interesting is that our municipal colleagues brought up some interesting things about prioritization of the antivirals and the vaccine. You said that you are actually doing that right now, but it appears they're not aware of it.

We've worked very hard on this plan. It has been there since 2006, and we've put $1 billion into it. But what can the federal government do to improve things in working with the provinces so that these communications get out a little bit better, so that our front-line workers...? We recognize they are the responsibility of the municipalities, but we need to have this coordinated response. How can the federal government help to get the messages out? It appears you're doing what has been asked, but the message isn't quite getting out there.

So do you have some advice?

Dr. Perry Kendall: Yes, I do. Thank you again.

I think we've been focused very much on the health care sector with our local planning. What the communication strategies need to do, with leadership from the Public Health Agency and the federal government, is to liaise with organizations such as the Federation of Canadian Municipalities to tell them what is going on, to engage with them to determine what they think their critical communication leads are, and then to have your provincial and territorial counterparts liaise with.... We have the Union of B.C. Municipalities, for example, which will be meeting in September, and I anticipate that H1N1 preparedness will be a key focus of what we'll do in British Columbia.

So I think we need a template of broad messaging and to get people to build into a social marketing or informational database or campaign and pick out what those key messages are and then drive them down into the provinces and territories, and then further down, in B.C. for example, into our regional health authorities—or in Ontario it would be through, I guess, their 38 public health units, which were often creatures of the municipality, or were co-funded by them.

The Chair: Thank you very much, Dr. Kendall.

Now, Dr. Bennett, please.

Hon. Carolyn Bennett: Hi, Dr. Kendall. It's Carolyn Bennett.

I wanted to congratulate you on the great work you're doing with the Public Health Network. I think your leadership has been hugely important. I guess I want to say I sleep better in my bed at night, knowing that you guys are there worrying about all of these things, In particular, I think that federal-provincial collaboration at your level has been way better than what we've seen before.

What we're hearing is concern that some of the other partners haven't necessarily felt included, in terms of the cities, but also some of the stakeholder groups, whether it's the chiefs or the family doctors, the people who are going to have to actually implement this plan. They aren't feeling confident that they know where all of this fits, given all of the various committees that have been working hard.

So I'd like to know what keeps you awake at night. What are you worried about, as we go forward into the fall, in terms of the potential gaps? What do you see needs to be done in terms of the people to man this plan and in terms of the human resources? But also, do you think the people at your level, in terms of the provinces, feel they have enough money to do this out of their regular budgets? Do you think it would be appropriate for us to be calling on the federal government to ask for more money for some of the resources that people are clearly saying they need, whether for masks or training sessions or rollouts of these things, because just handing down guidelines without a training module, without a tool kit or any of these things.... Certainly the people we've been talking to across the country don't yet feel confident they know what they will have to do this fall.

● (1650)

Dr. Perry Kendall: Thank you, Dr. Bennett.

I think the public health infrastructure across this country is thin. It doesn't have a lot of depth. If a few key people leave or are ill, then there are big gaps that are hard to fill. We have made this point on numerous occasions, I think, to federal, provincial, and territorial minsters of health.

I think there's bad news and good news. The bad news is that H1N1 has come along at a time of extraordinary economic constraint. The ability of provinces and territories to put any additional resources into their health care systems is strained. I can speak for British Columbia, where I know we are seeing constraints there. Nonetheless, some extraordinary purchases have been made and some funds have been made available both provincially and territorially and, I would think, federally.

What would have kept me awake at night was if this H1N1 had a much greater degree of severity that was closer to either the avian H5 that we were looking at, or the 1918 H1N1. Looking at what has happened in the southern hemisphere, where they haven't had the advantage of preplanning—Australia, New Zealand, and Chile have had very similar experiences—it has certainly stressed and strained their health care systems. It has not overwhelmed their health care systems; it has not created mass absenteeism in the health care or other workforces. So I feel that if we see the same patterns as they have seen in New Zealand and Australia, we'll actually come through this. We'll be able to cope with this. It won't be any worse, for example, than the 1996 A/Sydney, though it will certainly be worse than the last two or three years, which have been very, very mild.

I think that in a way it's a training virus. I think we could use more resources, certainly. I think if I were to put resources into one particular area, for sure it would be communications, because we do have vulnerable populations. We know there will be vulnerable populations in the fall: pregnant women in their third trimester or in the first four weeks post-partum, younger people under the age of 55 with chronic conditions of morbid obesity, smokers, first nations people, etc. I think we should be now very aggressively promoting these vulnerable groups to be visiting with their physicians to talk about what to do in the fall and how to get quick and easy access to antivirals for people who will really benefit from them, people who are most at risk of respiratory complications or pneumonitis, who are also the people most likely to end up in hospitals. So I'd like to see a really strong campaign directed to them.

I'd also like to see a strong campaign talking to physicians about how to proactively talk to and manage and maybe pre-emptively write prescriptions for antivirals for those people who will fall into those risk groups. Our great limiting factor, until we get the vaccine, is rapid access to antivirals, within 24 hours ideally, for people who most need them, who are most at risk. So I'd like to see a really strong, vigorous campaign talking about that, focusing on people, and focusing on their physicians, outlining the mutual responsibility they could have toward each other.

Then I'd like to also see a campaign that talks about what we could expect in the fall for schools and universities, etc., and be assured that we have plans in place to communicate those expectations. Then I think we'll be looking at delivering a vaccine at the end of November. My guess is that we will have had the second wave of vaccine after that, so we need to get through the fall in a way that manages to minimize morbidity, mortality, and pressures around the infrastructure pieces that we talked about.

The Chair: Thank you, Dr. Kendall. Your input into today's committee has been of paramount importance. We thank you for joining us today and we look forward to speaking with you further on this. Thank you.

I want to especially thank the witnesses who have come forward.

We will go in camera now. I would ask all people who are not committee members or designated staff members to be so kind as to excuse us. I'll suspend the meeting for one minute so you have time to leave the room. Thank you.

[*Proceedings continue in camera*]

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