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Wednesday, September 30, 2009

Chair

Mrs. Joy Smith

Standing Committee on Health

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● (1535)

[*English*]

The Clerk of the Committee (Ms. Christine Holke David): Honourable members of the committee, I see a quorum. We can now proceed to the election of the chair of this committee.

[*Translation*]

I must inform the members that the clerk of the committee can receive only motions for the election of the chair, and no other types of motions. He cannot entertain points of order nor participate in debate.

[*English*]

I am ready to receive motions to that effect.

Pursuant to Standing Order 106(2), the chair must be a member of the government party.

Mr. Carrie.

Mr. Colin Carrie (Oshawa, CPC): I would like to nominate Joy Smith.

The Clerk: It has been moved by Mr. Carrie that Mrs. Joy Smith be elected chair of this committee.

Are there any further motions?

Is it the pleasure of the committee to adopt the motion?

I declare the motion carried and Mrs. Joy Smith duly elected chair of the committee.

[*Translation*]

Before I invite Ms. Smith to take the chair, if it pleases the committee, we will move on to the election of the vice-chairs.

[*English*]

I am now prepared to receive motions for first vice-chair.

Pursuant to Standing Order 106(2), the first vice-chair must be a member of the official opposition.

Ms. Kirsty Duncan (Etobicoke North, Lib.): I'd like to nominate Ms. Murray.

The Clerk: It has been moved by Ms. Duncan that Ms. Murray be elected first vice-chair of the committee.

Are there any further motions?

Is it the pleasure of the committee to adopt the motion?

I declare the motion carried and Ms. Murray duly elected first vice-chair of the committee.

[*Translation*]

I am now prepared to hear nominations for the position of second vice-chair. Pursuant to Standing Order 106(2), the second vice-chair must be a member of an opposition party other than the official opposition.

Mr. Luc Malo (Verchères—Les Patriotes, BQ): I nominate Judy Wasylycia-Leis.

The Clerk: It has been moved by Mr. Malo that Judy Wasylycia-Leis be elected second vice-chair of the committee.

Are there any other nominations?

Is it the pleasure of the committee to adopt the motion?

(Motion agreed to.)

The Clerk: I declare the motion carried and Ms. Wasylycia-Leis duly elected second vice-chair of the committee.

[*English*]

I will now invite Mrs. Joy Smith to take the chair.

● (1540)

The Chair (Mrs. Joy Smith (Kildonan—St. Paul, CPC)): Good afternoon, committee members. I want to thank you so much for getting the selection out of the way.

I want to welcome Ms. Hall Findlay. It's very nice to have you here today.

I want to congratulate Ms. Murray and Ms. Wasylycia-Leis for being vice-chairs of this auspicious committee. This is very nice.

The order of the day previously planned for today has changed, and I have to explain that. The deputy minister, Morris Rosenberg, and Dr. Paul Gully are not available today to brief the committee on the body bag inquiry. In light of this, we've tried to reschedule the weekly briefing at 3:30 p.m. today, but the Public Health Agency officials are not available before 4:30; therefore our meeting will only start at that time.

I'm sorry about this. I've just been given this notice.

I want to make one comment. The minister met with the chiefs last week, and I was in that meeting with Chief Ron Evans and Chief Harper, and committed to discussing the findings of the report prior to making it public. So the minister agreed with that. Consequently, the deputy minister requested his appearance be delayed for one week, until October 7, in order to honour the minister's commitment and to respect the concerns of the chiefs. That's a result of her visit to Winnepeg with the chiefs last week.

Do we have agreement to suspend until we are called again at 4:30, or do we have some discussion on this?

Ms. Davidson.

Mrs. Patricia Davidson (Sarnia—Lambton, CPC): Thank you, Madam Chair.

Perhaps I could ask one question for clarification. Did you say that the chiefs asked that the report be delivered to them before it was made public?

The Chair: I wasn't in that actual discussion, but when they came from the meeting it was agreed on both sides. The minister said she would like to have her investigation finished before we went any further with any discussion on it. The chiefs agreed this was the best way to do it. Chief Ron Evans, Chief Harper, and all the people around the table did agree to that.

Mrs. Patricia Davidson: Thank you.

The Chair: Can we suspend the meeting until 4:30, at which time our guests will come?

Some hon. members: Agreed.

The Chair: Thank you. The meeting is suspended until 4:30 p.m.

● _____ (Pause) _____ ●

The Chair: Welcome back, colleagues. We will continue now. Thank you very much for your patience.

We have before us the witnesses from the Department of Health, Dr. Paul Gully, senior medical advisor, and from the Public Health Agency of Canada, Dr. David Butler-Jones, who is the chief public health officer, and Elaine Chatigny, director general of communications. Welcome.

Dr. Butler-Jones, I'd like to again relay my congratulations to you on your reappointment. I can't guarantee you will get your life back for a good long time, but we're glad you're with us today. It's an honour to have you.

Could we start with the Department of Health? We will have a ten-minute presentation as usual, Dr. Gully, then seven-minute rounds of questions and answers. Thank you.

● (1630)

Dr. Paul Gully (Senior Medical Advisor, Department of Health): Thank you, Madam Chair.

Good afternoon. Thank you for the opportunity to provide you with an update on pandemic influenza planning and response on first nations reserves.

Nationally, the number of cases of influenza-like illness in first nations communities, as for the rest of Canada, remains low since the peak of the first wave in mid-June to early July.

First nations continue to receive health care and anti-viral drugs based on provincial guidelines. Our forward strategy for first nations preparedness and response includes assisting communities to finalize and test their pandemic plans, to roll out H1N1 vaccines in collaboration with the provinces, and provision and restocking of medical equipment and supplies, including anti-viral medications. And I can confirm that these medications have in fact been pre-positioned in the first nations communities under our responsibility.

Next, contingency planning for key health services. We're focusing on ensuring that first nations individuals who are severely ill get the treatment they need rapidly, with ongoing communications with first nations communities and leadership to ensure that first nations have the best public health advice to implement their plans.

In terms of pandemic preparedness in particular, we continue to focus on that. According to the interaction between the regional offices and the first nations communities, they report to us that 94% of those communities do in fact have plans.

We know we need to focus on the communities that feel they need more support and information, and we are doing that in communication with the communities. Testing of the plans plays an important role. At the present time, approximately 80% of communities have tested their plans, and that figure actually is increasing.

So we continue to support community testing and provide informational support when it's needed.

I think the example of the community of Ahousat, in British Columbia, shows how well a community in fact can respond. They activated their plan in September, and the community has been dealing with the situation there in collaboration with Health Canada staff and with the Vancouver Island Health Authority. There have been no severe cases of H1N1 in the community, and anti-virals were pre-positioned in that region and were utilized.

In relationship to immunization, we continue to ensure that the immunization will cover first nations communities and the vaccine will be administered by qualified health professionals in nursing stations or via special immunization clinics.

All regional offices have mass immunization plans in place, including transportation, storage, and the necessary supplies. To support surge capacity for immunization, Health Canada has identified additional staff in national headquarters that can be deployed as necessary.

We will work with first nations communities in remote and isolated situations to receive the vaccine as soon as possible. We continue to communicate all this to first nations communities, and as you all know, Health Canada, with INAC, Indian and Northern Affairs Canada, signed a communications protocol with the Assembly of First Nations. That protocol outlines the roles and responsibilities that each one takes in terms of pandemic planning in clear communications.

I look forward to answering your questions and further briefing this committee as you so wish.

Thank you, Madam Chair.

● (1635)

The Chair: Thank you, Dr. Gully.

Dr. Butler-Jones.

[*Translation*]

Dr. David Butler-Jones (Chief Public Health Officer, Public Health Agency of Canada): Thank you again for the opportunity to discuss this matter with you.

[*English*]

I'm going to be very brief. I'm just going to touch on a few things, because I know you really want to get to questions.

The first is on the situation where we're at. We normally would see, with influenza season, a bit of an uptick in September after the kids come back to school. Then it would settle down. Then we would start seeing more cases again as you move later into the fall and through Christmas. It would really pick up after Christmas and would peak in January and February.

We are seeing clusters and outbreaks scattered across the country in different areas. At this point, obviously, we are continuing to track the numbers week by week to see what's happening. Whether next week there will be more or fewer—to speak to the point of whether we are in the next wave—only time will tell in which direction the cases will go, although as I was remarking at the media event today, for those of us, and many of you, who spend a lot of time on planes, I must say that I've started hearing a lot of coughing on planes, which I hadn't heard a week or two ago. Whether that is H1N1 or whether that is para-influenza or whether it is some other rhinovirus or other thing is hard to say. But obviously, we're paying close attention.

What has provoked a lot of media interest are the as yet unpublished case control studies that looked at people who had received vaccine against seasonal flu in doctors' offices and had then presented and been tested for H1N1, which suggested that somewhere in the range of perhaps twice as many of those who presented and were positive for the new pandemic H1N1 had had a seasonal flu vaccine. That could be for any number of reasons, one of which is that it does increase the risk. Or it could be that those who are more likely to get the vaccine are also more likely to go to a doctor's office and want to be tested for H1N1.

Given that no other country has seen this, and they've looked, and that they have the same, or similar, vaccines as us and have not seen that association.... It is, though, something we've seen now in several provinces when we look at it in the general population. There isn't really a good biological rationale for why that would be. We've never seen it before with influenza vaccines, and we're not seeing it anywhere else.

Again, it's speculative to say at this point, because a lot more work needs to be done to actually understand it, but there are a number of things that make Canadians different. We are a country that immunizes and has a greater awareness of influenza than just about any other country. We immunize more people than anybody else does. We have more campaigns, I think, focused on the importance of influenza vaccine, and so on, and we're fairly conscious of that. Now, would that actually drive people to do that in more ways to create that association? We don't know. It's an association. It's not a cause until we have a better picture of it. But you have to pay attention. You can't ignore that kind of information.

At the same time, we've undertaken some of our own studies, which are a little more easily controlled in terms of those confounding errors, such as looking at hospital and ICU cases. Unlike just choosing to go to a doctor for a viral illness, being admitted to an ICU or a hospital is not a self-selection. Someone else decides for you. There is a clear end point. You're severely ill and you need to be in hospital or in an ICU. In that group, there is no difference between those who are immunized and those who are not immunized. In other words, the rate of immunization is the same in the cases as it is in the controls, which would suggest that there's no increased risk of severe disease. So whether there is an increased risk of developing pandemic H1N1, having received, in the past, an annual flu vaccine, clearly, the evidence we're seeing would suggest that even if that were true, your risk of having severe disease really is no greater, which is pretty reassuring. It's pretty fundamental. But there's still a lot more work to do.

Seasonal flu continues to be a major challenge. We don't know when it will come. Usually it's not, again, until later in the season. We know that we will be seeing H1N1. We are seeing H1N1. The focus of all jurisdictions is to get a vaccine out as rapidly as possible and available for people who wish it, and to deal with the other issues related to a pandemic. There will be variations between the provinces and territories as to how they will roll out and deliver and think about their seasonal flu campaigns. As many don't actually start until mid-October to late October, which is around the time and close to the time when we're anticipating immunization against H1N1, again, as part of their planning, I think this is all fairly prudent.

● (1640)

From the international panel that we commissioned to look at that data, again not suprisingly I expect that what we will see is that yes, they're reasonable studies, but all case-controlled studies like this have confounding errors, self-selection being a major one of them.

I think I'll probably leave it at that for now and await questions.

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

We'll now go to Dr. Duncan for seven minutes of questions and answers.

Doctor.

Ms. Kirsty Duncan: Thank you, Madam Chair.

Thank you all for coming and thank you for your presentations.

Dr. Gully, it's encouraging to hear these percentages. You've said that 94% of communities have plans and 80% have tested. I really hope that's the case, because we were struggling with having heard from northern Manitoba of 30 communities that had a plan too, and none had been tested. Is that an anomaly? What is the oversight to ensure that there is indeed a plan and that it's a sufficient plan, that the supplies are in place, and that those communities are going to have the HR resources?

● (1645)

Dr. Paul Gully: Thank you for that question. In Manitoba, for example, the regional director wrote to the chiefs of all the communities and in that letter informed the chief of the information and of where the information was obtained for each community. The information was obtained most often not from the chief but in fact from another individual, a person working in the health field or specifically in pandemic preparedness. That's where the information was from.

We requested them to express concern about the plans and readiness, given that information. In fact, I think we got just one response, which was negative, in relation to this. We have made efforts to confirm the information we had from certain individuals in the communities about that level of preparedness, and then we continue to offer assistance.

The challenge is the assessment of what is meant by preparedness, realizing that having a plan is not an assurance of preparedness necessarily and therefore doing exercises, but also visiting those communities that are of concern in terms of their ability to respond, which is what has been taking place in Manitoba.

Ms. Kirsty Duncan: So have you been visiting the communities that...? Do we have a list of communities we're concerned about?

Dr. Paul Gully: Manitoba has that list; the regional office has a list of those communities where they think further assistance will be required. This is another reason for sending that letter, and visits have taken place to certain communities to further assist them.

Is it possible for every community to say they're absolutely prepared? I think the answer to that is no. Therefore, I can assure you that what we'll continue to do is work with those communities in every way—not only in terms of their plans, but in terms of supplies, antivirals, and so on—to assist them to get prepared as quickly as possible to respond.

Ms. Kirsty Duncan: I'm going to ask a number of questions, and perhaps then they could be answered.

What percentage of the hospitalizations, ICU cases, and deaths were among aboriginal peoples, and how do these compare with those for the Canadian population at large? I'm concerned about the time from symptoms to treatment for aboriginal communities and for people who require to stay in ICU.

I'll ask one more and then make a comment, if I may.

What was the average length of time on a ventilator and the average stay for an ICU patient, again for the aboriginal versus the Canadian population at large?

The other thing I wanted to briefly mention is that I was looking at our communications for this. If I compare what I see on the American sites, we tend to lag in terms of when things are updated. One of my concerns is for pregnant moms and breastfeeding moms. That information has not been updated since July 10, and I know the U.S. right now is struggling with new guidelines for.... There's no mention of even vaccine on that site.

I've probably asked way more questions than you can answer.

Dr. Paul Gully: We also will be responding in writing to those questions, Dr. Duncan.

In terms of hospitalization, the data available from the Public Health Agency of Canada—and there are various ways of getting information from the Public Health Agency of Canada, but also then directly from our regional offices—show that out of almost 1,500 hospitalized cases, about 17.5% were aboriginal, not only first nations. Of the 288 admitted to intensive care units, 15.3% were aboriginal. And out of the 76 deaths, nine or 11.8% were aboriginal.

The aboriginal population of Canada is about 4% and that of first nations around 2%. So it's undoubtedly the case that there is an overrepresentation of aboriginal peoples in those data, which one can try to analyse in a variety of ways. If the disease is present in a first nations community, for example, and if, for reasons that I think we well know in terms of challenges in those communities, it may spread more rapidly—this is what we saw in Manitoba—then, given that this is where the disease occurred and spread in the way it did, this overrepresentation may not be surprising.

● (1650)

Ms. Kirsty Duncan: Dr. Gully, may I ask a question there, if you don't mind?

If this had started in Southeast Asia, one of the ways we were going to attempt to slow the virus was through government quarantine and antivirals. When it started in Mexico and by the time it was in Canada, that opportunity had passed, although in first nations communities, where there are great distances, I'm wondering why we didn't do more in terms of containment.

The Chair: We're running out of time.

Dr. Gully.

Dr. Paul Gully: I'll come back to your other specific questions, to which in fact I don't have an answer because the data do not exist for aboriginal people or I think in general for other Canadians, and further research would have to be done.

In terms of your other question, the theoretical possibility that one could actually contain and stop the pandemic is done on the basis of modelling, as we well know. The impression I have is that by the time that, especially in a small community, H1N1 became evident by disease, it was probably too late to do intensive social distancing and other methods of containment. Then one would want to use antivirals and other methods to respond. I think we've learned things, from experience in the spring, such that we may do things slightly differently in terms of antivirals next time.

The Chair: I know that Dr. Butler-Jones also wants to comment on this.

Dr. David Butler-Jones: I'll briefly finish off.

Clearly, in this pandemic, if you're seeing the first cases in the world, it's a different issue. Once it's established, which it was—well-established by then—early treatment is key for those who are most vulnerable, and remote communities are vulnerable. That's why antivirals are pre-positioned, so that early treatment can take place. And we've noticed a major difference in the impact, once this has been implemented.

On the issue of updates, there really hasn't been much change since July; things are updated as changes occur and develop. The guidelines around vaccine are being developed currently—that's for everybody. They need to be in place before we actually do immunize, but they don't need to be as of today.

The Chair: Thank you.

Monsieur Malo.

[*Translation*]

Mr. Luc Malo: Thank you, Madam Chair.

And thank you to our witnesses for being here this afternoon.

I am also glad to see Ms. Chatigny, Director General of Communications, because, as I am sure you would agree, we are hearing a lot about the H1N1 virus. There are even emails going around about a possible conspiracy. Certain people in the health sector are taking a critical look at vaccination.

What is your comprehensive communications strategy to get across your point of view, which, as we have seen, is based on science and research, research that you have done and continue to do?

Do you feel that you have the financial resources necessary to get the right message across?

Ms. Elaine Chatigny (Director General, Communications, Public Health Agency of Canada): Thank you, Madam Chair.

As for resources, that is not a concern at this time. We have to do what we have to do.

In terms of the amount of information going around, you are absolutely right: there is a lot. A lot is being said, and we cannot systematically respond to every bit of information, blog or comment out there. You were right when you said that we need a more comprehensive communications strategy to try to communicate with all Canadians across the board. But we also need to develop more targeted strategies for certain at-risk groups. That is what we are doing, and we are not doing it alone, as the federal government. As you know, we are working with the provinces and territories, which, for a long time now, have been committed to working with us on a national communications strategy through a number of committees.

As for vaccines specifically, we have clinical trial research, information on the risks and benefits, and contraindications. Health Canada will clearly identify and communicate that information. We are also developing several communication products, not only for the Web site, but also for a multimedia campaign that we will be launching very soon. In the coming weeks, we will launch the next phase of the marketing campaign, among other things; it is a document approximately 20 pages long describing the symptoms of the H1N1 virus and the steps to take in looking after yourself and loved ones. We will also talk a little bit about the vaccine and prepare the public for the third phase, which is relevant and detailed information on the vaccines. We are talking about a risk communications strategy here. In other words, not a public relations campaign. We are not trying to sell the public on anything; we must provide fair and appropriate information and address the risks and benefits. Ultimately, we are leaving it up to Canadians to make an informed decision about their own health, and the health of their children and loved ones.

Those who object to the vaccine are not necessarily basing their opinions on science. Obviously, we are going to try to present information that is science-based, but we will still give people the chance to make their own choice. We will be using a number of communication measures to achieve this goal. We will use all the tools available to us. As I said before, this campaign will have several phases.

● (1655)

Dr. Paul Gully: Can I add something with respect to aboriginals? Health Canada has an agreement with the AFN

[*English*]

the Assembly of First Nations,

[*Translation*]

on hosting a virtual summit specific to the H1N1 virus in aboriginal communities. The purpose of the summit is to give people an opportunity to ask questions about immunization and to answer those questions. I hope that the summit will take place at the same time as immunization and that it will specifically answer the questions that aboriginals have.

Mr. Luc Malo: Dr. Butler-Jones, “pandemic” is a loaded word. For ordinary citizens, it may bring to mind the Spanish influenza pandemic of 1918, causing them to automatically associate it with a virulent and fatal phenomenon, whereas the actual definition of a pandemic, according to the WHO, is a widespread phenomenon worldwide. It does not mention virulence.

Do you think that the WHO should change its definition of a pandemic so as not to confuse the public?

Dr. David Butler-Jones: There is currently a big debate on the importance of clarifying the differences between large-scale pandemics and smaller scale pandemics, but all pandemics affect a large population. Even if the death rate is less than 1% among several billion people, that still represents a lot of deaths. It is very different from the annual flu.

To distinguish between this situation and a tsunami, a hurricane or similar disaster, in the future, everyone can have a system to identify the different levels. This virus may be very similar to the virus of the first pandemic in the 20th century because the world is now very different. We have antiviral drugs, vaccines and good treatment. A lot of progress has been made since the First World War. Things are very different, but the virus has characteristics similar to the influenza virus, the flu. In addition, healthy people are more affected. They have a higher death rate.

● (1700)

[*English*]

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

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

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

I want to start by asking about a concern raised with us by the Canadian Federation of Nurses Unions. I don't know if you've seen their documentation, but their concern is that the general guidelines being circulated for input and discussion by the federal government on health and safety are weaker than those of other provinces, and in particular they reference Ontario.

They would like to know if the government is prepared to look at those guidelines and change them to ensure that health care workers in Canada get the best personal protective equipment available, to ensure that a nurse in one province is protected as much as a nurse in another.

In particular, they reference two things out of the SARS report. One is the use of N95 respirators for health care workers. The other is the inclusion of references to occupational health and safety, as opposed to health and hygiene, as important in reflecting the provincial and legal realities.

Dr. David Butler-Jones: The guidelines are based on the science, not on opinion. It is also important to recognize that they are guidelines based on the science on a national basis. That does not take away from health and safety occupational health-based considerations, for which there is legislation in every jurisdiction; nor does it take away from the importance of an assessment of the situation the worker is in. It does not override or change that. It is based on the science that in most situations a surgical mask is perfectly adequate and appropriate, and in fact is better for dealing with droplet infections.

There are certain conditions where you're generating a large aerosol, where you're in close contact, etc., and where an N95 mask may be more useful. But the reality is that wearing an N95 mask on a constant basis is very difficult. In fact, we now have research suggesting that nurses who are using N95 masks have the same rate of infection as those who are using surgical masks. So it does not actually provide any additional protection in the general situation. You can think of many reasons for that around the appropriate use of surgical masks: they're uncomfortable, they take time, it's difficult to move quickly. As soon as you touch your eye or face you've negated any effect from that.

As far as the washing of hands, appropriate hygiene, and being careful when you're working around patients—not just about H1N1—that requires a local assessment and decision-making by the professionals involved. None of these guidelines take away from that, but they do provide the best science and advice for most situations we will encounter. We're confident about the appropriateness of them. Again, that does not take away from whatever occupational health standards or individual situation decisions that people need to make.

● (1705)

Ms. Judy Wasylycia-Leis: I appreciate that response. In one of the letters they wrote to us, they cited the Council of Canadian Academies, which states that N95 respirators protect against inhalation while surgical masks offer no significant protection against inhalation of alveolar, tracheal, or bronchial-sized particles.

Dr. David Butler-Jones: That's absolutely true, but we're not talking about a virus like measles. We're not talking about tuberculosis. We're not talking about viruses like smallpox that are airborne as opposed to droplet-borne. So that's absolutely true if I were dealing with a case of smallpox. I would want a heck of a lot of protection. But when you're dealing with a virus that is basically transferred when you cough, you handle it—you rub your nose, you touch your eyes, or you put your hands in your mouth. That and close contact are the ways it spreads, and a surgical mask will reduce that. The studies we are now seeing would suggest that a mask works as well as an N95 respirator for influenza.

Ms. Judy Wasylycia-Leis: Thank you.

I'd like to ask a question about the sequencing that was announced—the H1N1 vaccine sequencing—which we appreciated receiving. What I found noticeably absent under the health care workers section was the question of first responders and where firefighters, paramedics, police, RCMP, and anyone else who is involved on a first-response basis fits into this sequencing.

Dr. David Butler-Jones: To the extent that sequencing is related to the fact that we will have enough vaccine for the whole population within a matter of weeks, unlike other jurisdictions where it will be many months, or not at all for some...it's about timing as it relates to that.

The reason certain groups are there is because they are most vulnerable to get severe disease. You want to protect them first because they're the ones more likely to die. In general, firefighters and police are not more likely to die from this disease. You also want to ensure that those who are actually going to manage the pandemic and those who are going to care for those who are ill, if they do get ill, are immunized first so that they're available to actually work in the hospitals to care for people.

In general, first responders will be very quickly immunized, and certainly if they have underlying risk conditions, then they're obviously at the top as well. But that is the target for the first group versus the second group, which includes all first responders as well as others.

Ms. Judy Wasylycia-Leis: In the case of first nations communities, they're isolated and they may rely on a single RCMP officer. I assume that in isolated communities that person would be vaccinated as a priority. What happens if that person—I'm asking hypotheticals because that's what I think we're faced with—gets sick, leaving the community without a vital support person or an RCMP officer? Or what happens if that person feels that their health is at risk and they're in danger of contracting H1N1 and decide to leave their job? I think that is probably allowable under the Canada Labour Code.

Dr. David Butler-Jones: We should have Labour Canada deal with the specifics of the labour code, but there were issues of people with fear. Your risk of working in a community is the same risk, by and large, as working in Ottawa, Toronto, Montreal, or wherever. This is a virus that is essentially anywhere. You cannot run away from it unless you climb to the highest mountain where there's no other person for the next hundred miles. That's the first thing.

The second thing is that all of these communities do have antivirals for early treatment, which is key. As you presumed correctly, when the community is immunized, it's not like some will be immunized and some won't. Everybody in that community will be offered the vaccine.

The Chair: Dr. Gully, I think you wanted to make a comment.

Dr. Paul Gully: I would just like to emphasize that it's not only the first nations communities that are isolated, but other individuals who are living close to those communities would be covered, not only by immunization programs but also with access to primary care that exists in those communities.

The Chair: Dr. Carrie.

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

First of all, I would like to congratulate officials on your information campaign. I mentioned to Dr. Butler-Jones that I've heard your radio commercials. But you often wonder if these things are working. I actually had my seven-year-old come home with the first cold of the school season and she was coughing into her arm. So I guess you are very popular with the seven-year-old crowd with a high volume of boogers or whatever.

Dr. Gully, you've been on the job now for a month. We've heard from different witnesses. Some have said that 90% of communities have their plans in place and 80% have been tested, but I've been on some panels with colleagues and some of the chiefs are saying that's not even close. Could you explain a little bit more about the discrepancy? We've heard about the importance of communications with the first nations communities—and these are significant discrepancies.

I listened to your answer to my colleague Dr. Duncan. Is it that the communications are going to the health stations, and the health stations are the ones that are stating that they have a plan and it has been tested, but perhaps information is not getting disseminated to the local communities? Are you able to help us with that discrepancy that we keep coming back to?

● (1710)

Dr. Paul Gully: I appreciate the opportunity to answer that question. When I was in Manitoba recently, I went through the list of communities with the regional office and asked them where they got the information about the existence and status of those plans. Sometimes it was one of the health care workers; sometimes it was the pandemic influenza coordinator. It was always somebody from the community who we got the information from about the status of those plans.

I'm not going to hypothesize about why the assessment from some individuals is different, because I think all we can do is rely on what we are actually getting. As you said, the letter we wrote went from the region to the chiefs of the communities, telling them where we got the information from so that they could come back if they were actually concerned about that.

As I said before, I think there's a sense that, because of the increased challenges in those communities, therefore it is actually more difficult for a community to be prepared, and I accept that, because then the challenges in the community in terms of spreading infection are greater. Those concerns are there, which is why we're concentrating on those communities, concentrating on getting responses to those communities, and in fact then working with the communities where there is most concern about the capacity to implement those plans that actually go out there.

Mr. Colin Carrie: What is Health Canada doing to ensure that the first nations receive timely information? Could you go over a little bit more of the detail? I know we recently signed a communications protocol agreement between Health Canada, the Assembly of First Nations, and INAC. Specifically, how will it help first nations communities address the H1N1 influenza?

Dr. Paul Gully: That works at a variety of different levels. It works at the level of the Assembly of First Nations and that recognition that prompt, regular communication between the AFN and the Government of Canada is important. In addition, though, it also sends a message to the government departments that they will continue to have a close relationship at the regional level and at the community level.

For example, I do know that in certain regions, as part of the tripartite process, there are actually regular—and I know in Manitoba they're weekly—meetings between the tripartite members at the present time so that information is transmitted and then questions can be asked.

In addition to that, there have been a number of calls with national aboriginal organizations to ensure they are updated and then to receive their concerns—for example, about immunization.

Finally, as I mentioned earlier, there is the virtual summit, which is being organized between Health Canada and the Assembly of First Nations. That hopefully will enable many communities and many individuals to pose questions in a virtual way over a period of time and get answers to their concerns. That's using more up-to-date technology. The protocol is important, because it does send a message to the Government of Canada, but also then to the first nations communities and organizations, that we do mean to carry this through.

We will continue to do that and continue to have meetings at various levels, as we did last week with the grand chief in Manitoba.

● (1715)

Mr. Colin Carrie: All right.

As parliamentarians, we all have our different constituents. Can we be confident in saying that 90% of first nations communities do have these plans, and they have been tested? We can bring that answer back to our constituents?

Dr. Paul Gully: Exactly. That's exactly what we're sharing.

In fact, it would be interesting to pose that question to all communities across the country of varying sizes about preparedness. We have that information and that's what we have given to you. We have confidence in that information.

Mr. Colin Carrie: I know we have that in my own community of Oshawa. We have the ads in the paper, and as I said, the radio is coming through quite clear.

I wonder if you could address this discrepancy. This is with regard to sufficient supplies in first nations communities. I've heard that there's some concern that maybe there aren't the supplies there.

How do we have that communication feedback so that we can confidently tell our constituents that, yes, we are looking after first nations; that they are indeed receiving the supplies that they require; that all the reports saying that they're not there are false reports? How do we know?

Dr. Paul Gully: I can confirm. I've seen the figures and I have the information in terms of the supplies that have been purchased by Health Canada and distributed by the regions to the communities. That includes the N95 mask, which may be useful at times. It includes the gown, the gloves, and so on. They were purchased for the use of health care workers to enable them to carry out their work, to protect them, but also to ensure that they remain well so that they can carry on doing their work.

I think the difference occurs when there's an assessment of what supplies are there. I know there's a concern about access to Tylenol, for example, or anti-fever drugs. The nursing stations certainly have that. They certainly have that available so that if a person is sick, they can go; it could be prescribed, if necessary.

We would rather in this situation that sick individuals did seek care from the nursing station, which is available in those communities, so that if those individuals are ill and are becoming severely ill, then the most quick and appropriate treatment in terms of certainly antivirals, but then also, if necessary, medial evacuation, can occur as soon as possible.

Mr. Colin Carrie: So then—

The Chair: Sorry, we have to go now to Ms. Murray.

Thank you.

Ms. Joyce Murray (Vancouver Quadra, Lib.): Thank you, Madam Chair.

I would like to ask a bit about resources. I'd like to go back to the comment that resources aren't an issue and we'll do what needs to be done—which was good to hear. So $400 million was set aside as a contingency fund in budget plan 2006. How much money is in that contingency fund? Who has the authorization to spend it? How is it being allocated?

That is my first set of questions. Then I have another concern, which I would like to get to next, that comes from the chief medical officer in British Columbia.

Dr. David Butler-Jones: Sure. I'll try to be quick.

Basically, there was the original $1 billion, of which $600 million was allocated over a number of years. Then there's the $80 million per year that would expire—as we've talked about previously at the committee—if it wasn't spent, wasn't needed. Then there's this year's, which has been allocated amongst the departments, focusing on the surge and the challenges we had in the spring.

We've been encouraged, as we need it, to come forward if additional resources are required. Again, that would require the approval of cabinet, Treasury Board, etc.

Ms. Joyce Murray: So it was down to the $80 million, but that's now been used with the spring surge.

Dr. Butler-Jones, you're the one who has the pen in allocating that?

● (1720)

Dr. David Butler-Jones: Well, it's our department, as well as Health Canada, as well as CFIA and others. In terms of that contingency, it was basically those three departments. But other costs related to this—to actually address, anticipate, and respond to—are more than that. That's an ongoing discussion.

But particularly the Public Health Agency's role, I'm responsible for that.

Ms. Joyce Murray: My understanding is that the federal government has signed a 40:60 cost-sharing agreement with the provinces on the vaccines—

Dr. David Butler-Jones: Correct.

Ms. Joyce Murray: —but that there have been requests for cost-sharing with municipalities and provinces on all the other costs. I don't know what they are, but I guess they would be things like supplies, plan preparation, training, extra human resources, and so on. But that's been turned down, or there hasn't been a response to that. I know it's a frustration in the province of British Columbia.

I'm trying to square that with the comment that there's no problem with adequacy of resources.

Dr. David Butler-Jones: There are federal, provincial, and municipal roles to deal with this. In a pandemic, as in any outbreak, we all have parts to play. At this point we don't know what the long-term costs and impacts will be. Our ministers have said previously that, at least from the health standpoint, those would be addressed as needed. We have a draft MOU with the provinces and territories that also makes reference to, once we get through this, looking at what's involved in terms of our capacity to actually address it. Immunization is normally a provincial responsibility. In order to ensure equity and access, the federal government will be paying 60¢ on the dollar, and we have done the same with anti-virals as well for the stockpiles.

Ms. Joyce Murray: I'm not sure I understood correctly. I'm hearing from the province that there's a request for funding help, cost-sharing with all of this important stuff around getting plans, supplies, training, getting all that readiness, and it's been turned down. So might there be municipal or provincial programs or communications that are not happening because they don't have the money?

Dr. David Butler-Jones: These preparations, plans, and responses are a normal part. Every influenza season, hospitals experience surge. Every influenza season, there are additional costs. We have an MOU. Part of that is a commitment from all parties to sit down and look at what that means should there be extraordinary costs on the health side.

Ms. Joyce Murray: So I can go back to B.C. and say, if after the fact it can be shown that there were extraordinary costs related to this pandemic, they'll be retroactively covered?

Dr. David Butler-Jones: No. We don't know at the end of the day whether the costs dealing with the pandemic.... It could be, if we do this right, not much more than an annual flu year. So what we've all committed to is to continue to work together, to collaborate, to make sure that what needs to get done is done, and if there are extraordinary costs, then we'll sit down together and see what we do with that. And they are a party to that same MOU.

Ms. Joyce Murray: So you're not concerned that things that should be done in terms of preparedness won't get done?

The Chair: I'm sorry, Ms. Murray we have to move on.

Dr. David Butler-Jones: Absolutely not. All jurisdictions have committed to do the work, and we'll worry about those other things later.

The Chair: Thank you.

Ms. McLeod, you're next.

Mrs. Cathy McLeod (Kamloops—Thompson—Cariboo, CPC): I have three quick questions.

My first question is for Ms. Chatigny. In terms of the strategy around communication, I'm just wondering if you've done any focus groups and polling in terms of trying to create a certain outcome. Are you actually seeing where you're at right now and seeing if you are managing to create that outcome with your communication strategy?

The Chair: Ms. Chatigny, maybe you could go into the other question as well, as you're answering.

Ms. Elaine Chatigny: We have been doing research going back to 2004, trying to establish a baseline around, first of all, people's attitudes and behaviours and levels of knowledge around infection-prevention issues and, at the time, avian influenza, pandemic influenza, and seasonal flu, for example. In the early days our strategy was to try to clarify the differences between bird flu and human flu. Subsequently, our research has continued to delve into other areas of pandemic response, particularly vaccines and attitudes and knowledge about vaccines. So yes, in our communication strategy the outcome is very much the ending for us, which is a behavioural outcome ultimately.

So, for example, in the spring we were testing very much people's levels of awareness and behaviour around handwashing and cough etiquette and the infection-prevention behaviours we wanted them to adopt. Throughout the spring we could actually track changes in people's behaviours. In the early days we saw a tracked change in behaviour around handwashing, and coughing in the sleeve was slow. It's really amazing, you could see a change in behaviour as you changed your messaging, and when you changed your tactics as well. Then mid-course, when we started pushing the message around sneezing in your sleeve more aggressively, we started seeing a shift as well in the numbers.

But what's also true is that the moment you stop aggressively pushing a message, people can revert to old behaviours. We saw that during SARS, a big change in behaviour around handwashing, then two or three years later we saw that the numbers were going down again, which speaks to the importance of collectively working with our partners, provinces and territories, all of our partners in public health, to continue to communicate certain messages.

In terms of messages and behaviours, what we know about people's attitudes towards vaccine is that they shift week to week in terms of uptake, intention to uptake, which is why—to Mr. Malo's questions earlier—a strategy will shift very soon to more sustained messaging on the risks and benefits of vaccination in the hopes, of course from a public health standpoint, of seeing a certain uptake in vaccine.

How we define success is something we could all debate, whether success is ensuring that Canadians have the information they need to make a well-informed decision or whether success is a certain rate of uptake. That's something we're in the process of finalizing as part of the strategy.

● (1725)

Mrs. Cathy McLeod: I'm going to try to squeeze in two quick other ones. There's been criticism of the Government of Canada that we don't have a specific approach to pandemic planning for first nations communities, and it sounds like it's creating confusion.

To Dr. Gully, you've been there for a couple of months. Simply put, do we have a plan for first nations, and are we following it?

Dr. Paul Gully: Yes, we do. There's annex B in the Canadian pandemic influenza plan, which specifically relates to first nations and roles and responsibilities. And what we are doing for first nations, particularly remote and isolated communities where we're responsible for care and treatment, is ensuring that what we would expect the province to do elsewhere in terms of access to care and treatment and tertiary care and so forth is available in those communities—recognizing, though, that there are certain specifics relating to difficulties of transportation, but also recognizing the increased risk of transmission in some communities as well, which is being recognized in the sequencing of vaccines relating to remote and isolated communities. Also, there's recognition of the need to continue to communicate, as I mentioned before, with first nations at all levels to ensure there's an understanding and recognition and that we get feedback about those plans.

The Chair: Thank you so much, Dr. Gully.

We'll now go to Monsieur Dufour.

[*Translation*]

Mr. Nicolas Dufour (Repentigny, BQ): Madam Chair, thank you for giving me a few minutes to ask my questions.

I am going to ask you three quick questions in a row, and then you can answer.

Why does the H1N1 vaccine contain an adjuvant, when the flu vaccine does not?

In Europe, they have already authorized the commercialization of vaccines manufactured by GSK, GlaxoSmithKline. Why are we still at the clinical testing phase in Canada?

Ordinarily, Health Canada does not recommend the use of adjuvants, but GSK is being allowed to use AS03, one of the least used adjuvants on the market.

● (1730)

Dr. David Butler-Jones: There are many reasons for using this adjuvant. First, for each content... perhaps four vaccines, with an adjuvant. Second, the adjuvant protects against virus mutations, which is an advantage. Third, there is evidence that certain groups, particularly seniors, have a better immune response with this type of adjuvant.

The Americans and Europeans have worked with us on developing regulations. We have reviewed the tests and research studies. All of the studies are good. Health Canada has reviewed the information and will make its decision very soon.

Mr. Nicolas Dufour: We could get approval very soon.

Dr. David Butler-Jones: Yes. No one has the vaccine yet, not the Americans, the Europeans or us. But we will have it. I think that the next two weeks will be critical in the decision-making process.

[*English*]

The Chair: Dr. Butler, I'm so appreciative of all your insightful comments, and Dr. Gully and Ms. Chatigny. I thank the committee.

Bells are ringing now, so I guess we have to go and vote.

The committee is adjourned.

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