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Chair

Mrs. Joy Smith

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● (1530)

[*English*]

The Chair (Mrs. Joy Smith (Kildonan—St. Paul, CPC)): Order, please.

Good afternoon, ladies and gentlemen, and welcome to the health committee. It's so good to see you.

We have with us some very well-informed guests. We thank you for coming.

Pursuant to Standing Order 108(2), study of health human resources, which is a very important study we've been doing here, we have witnesses from the Canadian Alliance of Community Health Centre Associations. Jack McCarthy is the chairperson. From the College of Family Physicians of Canada we have Dr. John Maxted, associate executive director of health and public policy. Welcome, Dr. Maxted. From the Local Health Integration Network we have Mr. Gary Switzer, chief executive officer, Erie St. Clair.

We will start with Mr. McCarthy, please.

Mr. Jack McCarthy (Chairperson, Canadian Alliance of Community Health Centre Associations): Thank you, Madam Chair.

My name, as mentioned, is Jack McCarthy. I'm both the chair of the Canadian Alliance of Community Health Centre Associations and an executive director of the Somerset West Community Health Centre here in Ottawa. I've just come from meetings on flu assessment centres, so it's within that kind of busy frame that I appear before the committee.

In my opening remarks, I will be drawing a lot on my experience at the community health centre where I am the executive director. I'm here today to present what, in our experience, is a solution to optimally deploy health human resources across the country, and that's the use of salaried health professionals working in inter-professional teams.

I will advance that CHCs are a solution to the problem of not enough family physicians and an opportunity to shift focus to the recognition of the contribution of other health professionals, such as nurse practitioners, in the delivery of comprehensive primary health care. The solution we seek is not about adding more health human resources necessarily, but currently redeploying and using our existing health human resources in a different way.

I will tell you a bit about what community health centres are. They're non-profit organizations governed by boards of directors or advisory boards and use salaried physicians side by side with other salaried health professionals. They focus on access, removing the structural barriers, whether it be cultural, economic, or social, and provide a range of primary health care, social, recreational, non-institutional services with an emphasis on prevention, health promotion, health education and community development. We work in partnership with organizations in other sectors, such as education, justice, recreation, and economic development, to promote the health of the whole community.

The CHC model has eight specific attributes. It's comprehensive, accessible, client-centred, and community-centred, integrated with other health system partners, community governed, inclusive of the social determinants of health, and grounded in a community development approach. My comments this afternoon are going to focus on one of those attributes, and that's inter-professional teams.

Inter-professional teams allow community health centres to provide the right care by the right provider at the right time. Our team at Somerset West CHC in downtown Ottawa includes doctors, nurse practitioners, dieticians, social workers, kinesiologists, acupuncturists, chiropodists, social service workers, nurses, health promoters, and of course, administrative support staff. This inter-professional team is a dynamic process in which two or more health care professionals with complementary skills or backgrounds, sharing a common vision in health goals, work together to plan, assess, evaluate, and deliver client-centred care.

The key to a successful inter-professional team is communication, collaboration, and consultation. These three conditions result in shared leadership and a positive sense of community, balanced with individual autonomy and, of course, a focus on client care. Unlike a multidisciplinary team, inter-professional teams do not function as independent practitioners but rather weave together tools, methods and procedures to deliver care and overcome common problems and concerns. At Somerset West we are participating in a pilot project that includes physician assistants as a part of our primary health care team. In the future, we would love to add a pharmacist as a part of our comprehensive primary health care team.

Unlike a visit to the traditional family physician, our model does not presume that your care needs to be directed or prescribed solely by the physician. Somerset West, located in downtown Ottawa, as I mentioned, operates a non-appointment based walk-in clinic, staffed by nurse practitioners. We see, on average, 31 clients per day, most of whom suffer from at least one chronic illness, such as a major mental illness, heart disease, chronic obstructive pulmonary disease, COPD, or diabetes. This is I think a key point. In this totally nurse practitioner-staffed clinic, a medical doctor is consulted on only 0.5% of all visits. In other words, for every 200 patient visits, only one involves a physician consultation. With a $52,000 differential in starting salaries between a medical physician—$125,000—and a nurse practitioner—$73,000—I think there's an obvious significant cost advantage in using nurse practitioners.

● (1535)

All members of the team have the ability to refer or consult with other members of the team as determined by the needs of the patient. Sixty-four per cent of all our clients see three more different types of providers. Unlike the vast majority of family physicians in Canada, all our doctors are salaried, enabling the inter-professional planning of care based on client need rather than based on a fee schedule. Many of our clients have one or more chronic medical conditions. Having physicians on salary permits our doctors the necessary time to thoroughly assess and treat, and even prevent, further disability.

Unlike other health care organizations, Somerset West enjoys both a high level of staff satisfaction and very limited turnover in our medical, nursing, and other professional staff. I think this can largely be attributed to the organization, culture, and client-centred care created through the adoption of an inter-professional model of care. The versatility of this model of primary care is designed to respond to the unique needs of specific communities and clients. It is also nimble enough to be able to respond in times of crisis, such as the latest H1N1 pandemic where our community health centre and the other health centres of Ottawa stepped up to be flu assessment centres. We coordinated very well with Ottawa Public Health in providing this service.

I have other comments in my document related to international medical graduates, and we'll deal with that in the question and answer period.

In concluding my opening remarks, I want to say it has been my pleasure and experience that health care professionals, whether nurses or doctors, are motivated to provide the best possible care to their patients, and happy workers provide better care. I think the current crop of medical graduates is largely women, and that's a good thing. I think this new breed of family physician places an equal value on non-work aspects of their lives, such as raising a family. That's why most of our physicians are women. Most work part-time. Most have young children.

Without systemic change in how we structure medical practice in this country, these changing expectations of providers will result in reduced access to primary care for Canadians. In the CHC model where doctors are on salary and part of a collaborative team, we see few, if any, examples of doctors suffering from the pressures of time and long hours that result in burnout and sometimes, as a result, poor-quality care. They can focus on providing services to their patients.

I'll leave it at that, and I'd be pleased to answer any questions.

● (1540)

The Chair: Thank you very much.

We'll go on to the College of Family Physicians of Canada.

Dr. Maxted, please.

Dr. John Maxted (Associate Executive Director, Health and Public Policy, College of Family Physicians of Canada): Thank you very much, Madam Chair. I'm pleased to address the standing committee today on health human resources, an issue of ongoing concern to family physicians and the College of Family Physicians of Canada.

With over 22,000 members across the country, the CFPC is the professional organization responsible for establishing standards for the training, certification, and life-long learning of family physicians in this country. As the voice of family medicine, we also advocate for specialty family physicians and, very importantly, their patients.

About half of all doctors in Canada are family doctors, which is one of the strengths of our country's health care system, yet we still have roughly four million people in Canada without a family doctor. For many years we have sought ways to increase the number of Canadians with a family doctor, but the CFPC cannot do this alone. Key stakeholders include government and medical schools.

We believe two issues are central to family physician planning: the balance of supply and demand, and changes in patterns of practice. These two are intertwined.

The number of medical students choosing family medicine as a career is a vital issue affecting supply. We need to have 45% of all graduates enter first-year family medicine residency programs if we are to have enough family physicians to meet present and future workforce requirements.

While we strive to train more family doctors and more young family doctors, we also face the realities of an aging workforce, where 13% of the family physician workforce is older than 65 and looking at retirement. Many young family doctors are also seeking better work balance. Changes in work and scope of practice are having an effect on the number of family physicians we need. Over 50% are women who require time away from active practice during their child-bearing years. Governments must be cognizant of shifting patterns in family practice if they are to plan for sufficient family physicians in the future.

A priority for the CFPC is the training, recruitment, and retention of family physicians who provide a broad range of medical services for their patients. However, one-third of today's family physician workforce has a special interest in practice. While this affects the total number providing comprehensive care, these physicians are meeting health care needs within their communities. Family physicians with special interests or focused practices collaborate with their associates, and they are changing the way comprehensive care is delivered. The CFPC recognizes this, and it is supporting these physicians.

With an aging population, we see an increase in patients with chronic diseases and, in turn, complex co-morbidities. These factors are placing more pressure on the demand for family physician services at the same time as demographic factors affect supply. While Canada has begun to address its past mistakes in physician resource policies, it could take another decade to reach the goal that developed nations have already attained in some areas, and that is every person with a family doctor.

Just as population migration from rural to urban communities leaves many towns and villages with scarce human resources, the shortage of family physicians can often be felt more acutely in rural locations. There is thus a disproportionate shortage of family physicians in remote communities and a dire need for medical services for high-risk populations in first nations, Inuit, and Métis communities. These challenges continue to call for a strategic approach.

I'd like to speak briefly about international medical graduates. IMGs are highly valued contributors to our family physician workforce, but we should not rely solely on IMGs to address our physician shortages. We must consider the ethical implications of luring family doctors from countries that need their services.

Further, for those Canadians who are educated at accredited foreign medical schools, we need to ensure there are enough training spaces available to welcome them home to practise in Canada. For its part, the CFPC is pleased to report that we now have reciprocal agreements to certify and welcome board-certified American physicians and Australian-certified family medicine graduates. And we're working on other countries as well.

It's essential that those responsible for physician resource planning address all of these issues. Our college would welcome an opportunity to meet with the FPT Advisory Committee on Health Delivery and Human Resources to discuss the changing horizons in family medicine.

Finally, we would be remiss not to highlight the growing importance of inter-professional collaboration in primary care teams as an increasing preference for many family physicians. Overwhelmingly, young family doctors now prefer to work in collaborative health care environments. We are thankful for the support our governments have given to this development.

Taking all our concerns into consideration, the CFPC believes all these challenges call for a pan-Canadian coordinated approach to health human resource planning. Physician resource planning, as with all other health human resource planning, is a national issue that affects all of us.

To conclude, the CFPC respectfully encourages the government's support for a pan-Canadian health human resources plan that assesses the health needs of the population in each and every community and ensures that we have enough doctors, nurses, and all other professionals to meet our population's health needs. This plan must address the right number and appropriate mix of health care providers, including the training, recruitment, and retention of family doctors, as well as other medical graduates.

● (1545)

An adequate supply of physicians, including family physicians, continues to be a top priority for Canadians. It should remain a top priority for governments and health planners. To maintain the number of family doctors required to meet the health needs of people in Canada, we require a commitment from our health system and medical schools to have 45% of graduates enter family medicine.

We must also ensure that IMGs, international medical graduates, have appropriate opportunities to be assessed and to be offered further training, when necessary, so that they can enter the physician workforce alongside Canadian medical graduates.

Family physician teachers and other resources required for family medicine academic and distributive learning sites are currently strained and need to be augmented if we are to assess and train more family physicians.

Comprehensive care must be supported through our health care system to encourage family physicians to provide patients with the broad range of front-line medical services they need from cradle to grave. As advocated in our recently released discussion paper, “Patient-Centred Primary Care in Canada: Bring it on Home”, governments should support new or enhanced primary care models through which patients have access to a family doctor and an inter-professional team of providers.

We must maximize the use of electronic information in pulling teams together. This nation is trailing most developed countries in this area, and it should be addressed with urgency.

In closing, the CFPC and family doctors in Canada are confident that by working together with government, we can improve access to high-quality health care for all Canadians. To achieve this, we need a health human resource plan that ensures that every Canadian has a personal family doctor.

The Chair: You need to slow down just a little bit so the translator can keep up to you. We got so interested in your topic that we didn't notice. Thanks.

Dr. John Maxted: Well, I'm actually finished, Madam Chair.

Thank you very much.

The Chair: Thank you. We'll just wait for the translator to finish now.

We'll now go to Gary Switzer of the Local Health Integration Network, please.

Mr. Gary Switzer (Chief Executive Officer, Erie St.Clair, Local Health Integration Network): Thank you, Madam Chair.

First, let me speak to you today on behalf of the 14 LHINs in Ontario. I represent Lambton County, Chatham-Kent, and Essex County. We refer to it as the gateway to Ontario because of the two major bridges we have as access points.

I'm relatively new to health care. In previous careers I've had the enjoyment of travelling quite a bit around the world. When I travelled, everybody would notice my red Maple Leaf, and they'd come up to me and talk to me about Canada Dry, our ginger ale. But then they'd come up to me and say, “You have good health care.”

If you could look at Canada as a brand, one of our brand attributes is universal health care. It helps to define us as a nation and as a culture. We have plenty to be proud of as Canadians, and I'm especially proud of the health care we deliver across Canada. However, our current health care system was built on fundamentals of the 1950s and 1960s. Since then, our population has aged, chronic diseases are on an increase, and our current cost structure is no longer sustainable.

What I would like to address with you today is what I would call “health care 2020”. Health care 2020 is a call to action to create a vision of transformation for health care in Canada. It is recognition that our current system is antiquated and incapable of meeting 21st century needs. A vision is needed to protect the Canadian brand promise so our children and grandchildren will continue to benefit from our publicly funded system. To do so, I will submit the following three suggestions to the committee: we need to address our human resource issues, both shortages and scopes of practice; we need to transition from episodic care to a comprehensive model of care; and finally, we need to invest in an e-health infrastructure to fully and uniformly transition to the 21st century.

l'II frame this issue with a brief glimpse at our current population health. Our landscape is changing. The prevalence of chronic disease is on a significant increase. This is driving the overutilization of our health care system. This is only compounded by the lack of primary care right across Canada, and especially in Ontario. In Erie St. Clair, we have a shortage of 124 physicians, and that's for a population of 650,000. That leaves approximately 150,000 residents without a family physician. The future doesn't look any better. Over 78% of our physicians are over the age of 50. The bottom line is that our people's health is declining and our system is overburdened.

We need a national health human resource plan that will seek to make the best use of available resources. If we continue as is, we will not have the professionals we need to meet our community needs. We need to redesign the system to work smarter, not harder. To do so, a national plan needs to look at how to maximize the scope of practice of all allied health professionals, such as our nurse practitioners and pharmacists. We also need to look at the barriers we impose across the provinces. A national plan needs to look at a system of redesign to promote the recruitment and retention of our health professionals.

In Erie St. Clair, over 90% of our emergency department visits are for non-life-threatening issues. Most relate to the provision of primary care. However, emergency departments were not designed for that. Collaborative or team-based care is the future of the health care system. It relies on a team of professionals that can look at the individual as a whole and is ideally suited to the provision of chronic disease management. It makes the best use of all allied health care professionals.

As a consumer entering a collaborative family practice, be it a CHC or a family health team, you will not see the sign on the wall saying “One issue only per visit”. They say it takes a village to raise a child. Think of a community health centre or a family health team as a village of care supporting a community. It's all under one roof. The alternative to this system will be an individual going to their family doctor, only to have to go back for another referral, only to have to visit another specialist.

For rural communities, this one-stop shopping experience is a great opportunity to introduce a new level of equality and accessibility in health care, avoiding costly and prohibitive trips to town for these services. In Erie St. Clair we've been working very hard with the local government to expand our community health centres and our family health teams. We've also extended this concept to developing teams for the provision of home care and end-of-life services.

New family practice collaborative models such as family health and community health centres are attractive to new graduates and have been widely successful. We must continue with this success. Collaborative care will depend on access to information technology to unlock its true potential. Health care has been lagging on this front, and so we have not yet seen the benefits of a uniform and functional e-health infrastructure.

We need to align our systems to ensure interoperability. I'm not talking about a system that's Canada-wide or province-wide; I'm talking about a system within our community. Eight-five per cent of the care our residents receive is in our community. We know our referral patterns, which will take us to 98% of our community.That's where we need interoperability.

● (1550)

Secondly, every Canadian needs an electronic patient record. Until this happens, our system will remain in the dark ages. Physicians should not have to work without access to somebody's medical history. They shouldn't have to order redundant tests and they shouldn't have to worry about reactions to prescriptions.

To change this is like working on a moving train. However, in the 21st century nothing less will suffice. Information technology is at the core of everything we do, and it should be at the core of our health care system.

To summarize, what I've discussed today is the challenges we have in preparing for our resources for 2020 and the need to have a national plan to address these challenges, and secondly, the need to change to a comprehensive model of care. And finally, we must learn to leverage our technology.

The federal government can provide assistance, just as it has shown with the wait-time strategies. Make it a national priority to maximize every health care professional skill for practice. Invest with the provinces to assist in the transformation to collaborative care. Help us build villages of care in all communities, both urban and rural, and provide the incentives that would allow the provinces to make courageous decisions to align our backrooms and our clinical platforms.

In all the places I've visited, health care is a common denominator. Our health care system does indeed help define us, and as a nation we must ensure that our system will live up to the health care brand we are so famous for. Let's continue our promise to Canadians and make the necessary steps to safeguard our universal health care.

Thank you.

● (1555)

The Chair: Thank you very much.

We'll now go into our seven-minute round with questions and answers. We'll begin with Ms. Murray.

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

Thanks for being here to help us understand the state of the issue and some possibilities.

In calling for federal leadership, I know that 10 years ago there was a primary care transition fund that was set up for this kind of innovation, so it's not new that we know we need to go in that direction.

In 2004, the health accord led to a FPT human health resource committee that was referred to earlier but I don't believe is active at all. So we seem to have had a golden age of leadership on this kind of innovation. Would it be fair to say that the interest from the federal government has kind of ebbed in terms of taking a leadership role?

Dr. John Maxted: I certainly would support that. You pick up on the whole issue around primary care and the fact that there was $800 million given toward a number of primary health care transition fund projects, and there was some really good activity that occurred during that time. I'm afraid that when that time ended, after three to five years, a lot of that went into the library somewhere and into the archives—although there was some good development, and I don't want to ignore that.

I think where the development was probably most prominent was in the development of inter-professional teams, which all three of us have been talking about this afternoon. Nevertheless, the loss of focus on primary care at the federal level probably was a big disappointment to a lot of us.

Mr. Jack McCarthy: If I might add, I had the good fortune to work at Health Canada at the time when it was rolling out the primary health care transition fund, and I would certainly agree with John. I think there were some incremental changes at making primary care—not primary health care, but primary care—more efficient and effective. I think it was not successful in terms of major reform, because the move to teams, a team-based approach, which is in document after document after document for the last thirty years, has not happened. I think one of the huge barriers to that happening is the remuneration system that's in place. You can't incent one category of health professional—physicians in this case—for doing certain things on a fee-for-service basis and then have other staff on salary. Such a huge challenge, I think, needs a common remuneration system or your teams will not get off the ground.

In my judgment, where the problem stalled out was that a lot of provincial medical agreements were not so much for reforming the system but were more dealing with issues of compensation for physicians.

Ms. Joyce Murray: Thank you.

I was pleased to hear you list acupuncturists in the team.

There are a lot of Canadians who choose as their primary care physician, for example, a naturopathic physician. What's your comment on how a team would be formulated? Would it include... well, clearly acupuncturists, but who decides and how would you see some of the complementary medical practitioners being part of this?

Mr. Jack McCarthy: The beauty of the community health centre model is that it's responsive to the local community. For example, in the CHC where I'm the director, there is a large Asian community, so it was a no-brainer for us to have an acupuncturist as a part of our comprehensive team. To understand the needs of a particular community is to know what kinds of interventions fit best with that particular community. That's one of the advantages of this model.

Who decides? I think it should be a group of residents on a board, working with staff, assessing community needs and resource requirements. Is there a high concentration of people with type 2 diabetes? Do we need to help people deal with COPD? It's an iterative process, a community engagement process. I wear my bias with pride. That's why the CHC model has this kind of community engagement focus.

● (1600)

Mr. Gary Switzer: One of the exciting changes in Ontario is that we have the LHIN, which stands for Local Health Integration Network. And we work with our CHCs all the time. I'd like to highlight Grand Bend, which is the centre of excellence. We have a senior population. They identify their needs through their board, they come to us through their admin staff, and we invest in them. We have the ability to allocate funding according to their needs, and we can turn this around very quickly. It's based on local needs and local decision-making.

Ms. Joyce Murray: In the long term, do you see this model reducing health care costs for Canada? Do you see this as being an additional cost for better service and better access to a physician, or do you see it as a cost reduction over time?

Dr. John Maxted: We have to be careful about how we approach the topic of cost reduction in primary care. The research, both in this country and throughout the world, has shown that if you strengthen your primary care system—and I would quote some of the research from Barbara Starfield—you can save your health care system money and improve the quality of care. We want to deliver the message that we need a strong primary care system if we are to improve the whole health system in Canada.

Mr. Jack McCarthy: If we don't invest in our primary care system, we're going to bankrupt the system, because acute care is just too expensive. It's very expensive. We need to focus on keeping people healthy before they get to emergency. We need programs that engage people in managing their diabetes and chronic diseases through exercise, good dietary practices, and so forth. If we don't invest there, as countless federal reports have said we should, then we're going to bankrupt the health system. If this happens, the health care portion of overall spending will rise.

The Chair: Thank you, Mr. McCarthy. I'm sorry, you're going over the time.

Monsieur Dufour.

[*Translation*]

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

I wish to thank the witnesses for being here today.

My first question is for Mr. McCarthy. In the case of the community health centres which, in Quebec, include the CLSCs and the CHSLDs, might the situation be different, depending on where the community health centre is situated?

[*English*]

Mr. Jack McCarthy: Within the CLSCs? I'm sorry, but I caught only the tail end of your question.

[*Translation*]

Mr. Nicolas Dufour: In Canada, are you seeing different situations depending on where the community health centre is situated, and this would include the CLSCs and the CHSLDs in Quebec?

[*English*]

Mr. Jack McCarthy: The CLSCs in Quebec have been the leader across this country in the provision of comprehensive community-based services. The beauty of the CLSCs, which is comparable to the CHCs in other provinces, is that they're responsive to local communities. What you have in downtown Montreal may be very different from what you'd find in rural Quebec. That's the beauty of the model. Quebec has the advantage of covering the whole geography of the province with CLSCs. As the chair of our national association, I'd like to say that other provinces need to follow Quebec's lead in having CHCs that cover the whole geography.

I'm not sure I'm responding to your question.

[*Translation*]

Mr. Nicolas Dufour: You have indeed responded to my question. We can see that the situation is really different, between the rest of Canada and Quebec, with regard to the community health centres. That is what I understand from your statements.

[*English*]

Mr. Jack McCarthy: I would also say that I think from discussion with my colleagues in Quebec, now that the CLSCs are in a broader group called the CSSSs, Centres de santé et de services sociaux, there has been a real focus on helping the individual access seamless care. While I would submit that is important, it is not sufficient. You have to make sure that you can still have the grassroots community input into deciding the kind of care.

It's not all about helping an individual get faster medical care. It's about making sure that we keep and build healthy communities. I think the history of the CLSCs has to be strengthened in terms of its community-based approach and not simply helping individuals navigate a seamless health system.

● (1605)

[*Translation*]

Mr. Nicolas Dufour: Mr. Maxted, you were telling us earlier that what is really required faced with this situation is a national pan-Canadian strategy. Given that the area of health falls under the exclusive jurisdiction of the provinces, do you really believe that a pan-Canadian plan would change something?

[*English*]

Dr. John Maxted: Yes, I do. When I put that out there, I'm putting that out there not just on behalf of my particular College of Family Physicians of Canada, but on behalf of the other two organizations that we often work together with, the Royal College of Physicians and Surgeons of Canada, as well as the Canadian Medical Association, all of whom believe that this country needs some kind of pan-Canadian infrastructure for the coordination and management of health human resources in this country.

The problem is that it is happening haphazardly across the country. It's happening in different jurisdictions. Some are doing better than others. We could sit here for the next two weeks talking about the patchwork of good locations and bad locations to practise or to work in. There are places where people have access to health care, primary care services, and places where they don't. Some of that is the result of poor planning, but it's difficult for those jurisdictions to plan solely on their own.

As we've gone around the country, we've realized that we really don't know at the end of the day who has access and who doesn't have access unless we start to create some kind of registry, unless we start to actually try to distribute a little bit more equitably than what's being distributed right now.

[*Translation*]

Mr. Nicolas Dufour: I must tell you, Mr. Maxted, that it is not really being left to chance, it is much more being left to the provinces. Furthermore, if we take the two pan-Canadian groups that you named, we are certainly not talking about the Collège des médecins du Québec, for example, nor any other Quebec physicians' association.

Mr. Switzer, in the case of the Local Health Integration Network, it is mentioned on your Website that "[...] people living locally were better able to define their health care needs and priorities". It is also stated that communities are the best able to determine their needs.

In that context, how might the federal government be useful other than in providing the necessary funding for your operations?

[*English*]

Mr. Gary Switzer: Thank you.

The federal government, from our view, could help—as they've assisted the provinces in the past with wait time strategies—to provide the focus on a provincial basis, a national basis on wait times, for critical issues that we face right across Canada. There are challenges with funding through Infoway, for example, and to provide the motivation and the investment to help us stitch our networks together is very important. It's not going to take away the benefit of having a local community define their needs, just as we were talking about with the community health centre understanding the local population and the population's help in designing a system to satisfy them.

[*Translation*]

Mr. Nicolas Dufour: Madam Chair, I will be asking no further questions, given that, of course, we know that this is an area that falls under the exclusive jurisdiction of Quebec, such that there is no point in this debate.

I am in complete agreement with several of the positions that you have advanced. It is clear that there must be a sharing of information on the good and the bad moves. The only problem is that it is not within the Parliament of Canada that this must be done, but probably between the provincial legislatures, which have exclusive jurisdiction over health care issues. I therefore have no further questions.

[*English*]

The Chair: Thank you, Monsieur Dufour, for your very eloquent questions.

Now we'll go to Ms. Hughes.

Mrs. Carol Hughes (Algoma—Manitoulin—Kapuskasing, NDP): Thank you.

There are quite a few questions we could ask and will be asking.

You said your doctors are salaried?

Mr. Jack McCarthy: That's correct.

Mrs. Carol Hughes: I know that the community health centre in Sault Ste. Marie has salaried doctors as well. I'm just wondering if you've had difficulty attracting doctors because it's on salary.

Mr. Jack McCarthy: I'd answer that in two ways. At the particular CHC I have been at, we have not had difficulty attracting physicians, and certainly we have retained our physicians. That's been my direct experience. I think keeping the salary competitive with the other models of primary care delivery has been a challenge for CHCs in recruiting and retention. There's always that need to keep salaries competitive with other models of remuneration. Maybe that answers the question.

So yes, there has been some difficulty in recruiting physicians to community health centres with salaried models, particularly in rural and northern areas in the province of Ontario, which I'm most familiar with.

● (1610)

Dr. John Maxted: If I may, fee for service took a bit of a slam earlier this afternoon. I think what you need to recognize is that fewer than 50% of family doctors across the country are making more than 90% from fee for service, and 70% to 80% of doctors would prefer a blended funded formula whereby they would make their compensation, remuneration, from a variety of sources. Fee for service is losing a lot of popularity, and as I said, fewer than 50% are getting greater than 90% from it at this point in time.

So it's not a popular way of being funded, and it certainly is becoming less and less popular.

Mr. Gary Switzer: I'd add that in our CHCs we've had great success in recruiting. A lot of our doctors are over the age of 50 and 60. They're winding down in their careers and their volumes, and they're working 20 hours a week at our CHCs. They bring their experience, their networks, their relationships, the relationships with the hospitals, to that CHC, and they're usually within the community they work in. So we've had great success with that.

Mrs. Carol Hughes: Nearly 25% of Canadians in the rural areas are without a family doctor, compared to 8% in the urban areas. Have you noticed whether there has been an increase in stress leave among the health care professionals?

Second, I come from an area that has a high rate in terms of an aging population, and we're seeing that across Canada as a whole. In Elliot Lake, for example, their main focus is to attract seniors to the area, but when the seniors get there, they're being told, oh, they'll get a doctor eventually. I know that from province to province your ability to obtain a doctor varies, depending on which province you live in and where you're moving to. I had a call from a lady in Elliot Lake last week. She's been there for two years, and she is still not able to get a doctor. In order for her to obtain another family physician, she needs to get off the Ontario plan with her doctor, the authorization that she signed with that doctor. And she's not guaranteed that she's going to get a family physician.

So she has to remove herself from the list of the Toronto physician in order to try to obtain one.

These are problematic areas. I don't know if the LHIN is dealing with that, but Mr. Maxted, you'd probably be able to answer with regard to the stress on the family physicians. I'm just wondering how we are dealing with the aging workforce, because we also have doctors who are retiring. What do we need to do? How short are we going to be in the next 10 years?

Dr. John Maxted: You're going to be a little surprised by my answer, but my answer is that the doctors in the rural communities are happier than the doctors in the urban locations.

Mrs. Carol Hughes: They're happier?

Dr. John Maxted: Yes. In the studies that we've done—and I quote the National Physician Survey from 2007 as an example of that database—they say they're more professionally satisfied. There are different reasons for that, which we won't go into right now, but I honestly believe that the approach, in order to improve the resources, is not just a question of trying to get more family doctors—and I've certainly referred and spoken to that in my notes—I believe it's also looking at the changes in patterns of practice and taking a more inter-professional approach to care.

We have to emphasize once again the primary care models developing across the country. There are numerous examples. Quebec was mentioned earlier, and we've talked about Ontario, but there are the PCNs, the primary care networks, in Alberta; there are the physician integrated networks in Manitoba. There are other models throughout the country, jurisdictional though they be, that have some very unique and common characteristics that I think are actually the way of the future, and they're going to be one of the solutions to the challenges you're posing.

Mrs. Carol Hughes: But on the family health teams, there are still big waiting lists there for people to see physicians.

Maybe we can get there in a little bit, in regard to the flu season and how you're dealing with that, but I understand there's also a big waiting list for these family health teams even though they have an integrated approach. It all started out so well, yet there are still some big problems. Maybe the family doctors in the rural areas are happy, but the patients aren't, because they're still waiting for a family doctor.

● (1615)

Mr. Gary Switzer: Perhaps I could help here.

We've launched 150 family health teams in Ontario, and 50 new teams have been approved. So we keep adding new family health teams. There was a slow adoption rate for family physicians to move to that model, but once they moved to that model, for the physicians I talked to, their stress level went down. Why did it go down? It's because they have access to a nutritionist, access to a nurse educator, access to NPs, and access to social workers, plus their income went up. So they're very satisfied. But there are still lineups quite a bit, and as a result of that, we're also introducing nurse practitioner only clinics.

Mrs. Carol Hughes: The issue here is still that there are patients out there who are not able to access even the hospital care, because if a patient is mandated to this one doctor in Toronto, for example, as this lady is, even to go to the hospital to get a service, she is being denied because her file is not down there, unless they call it an emergency thing. Going there for her allergy shots won't work.

The Chair: Ms. Hughes, I'm sorry, we're over time. Do you mind if we have him answer that?

Mr. Gary Switzer: Don't you want me to answer that?

We're in a race that never ends. There's a significant shortage of primary care right across Canada, and unfortunately we will have lineups. Without electronic health records to transfer files in real time or to have a portal so that physicians can dip in and read the file of a patient from another community, we're going to have these bumps along the way.

The Chair: Thank you.

Ms. Davidson.

Mrs. Patricia Davidson (Sarnia—Lambton, CPC): Thank you very much, Madam Chair. I'm going to be sharing my time with Mrs. McLeod.

Thanks very much to the three of you for appearing before us this afternoon. Certainly I think we've been hearing some interesting points of view and maybe something a little bit different from what we've heard at the committee thus far. So it's good to hear that.

Gary, I want to ask you about the LHINs. We all know that they're in Ontario. Are there comparable bodies in the other provinces and territories?

Mr. Gary Switzer: Yes. Ontario was actually the last jurisdiction to go this route. We have what we call a made-in-Ontario solution that is quite unique, where we maintain the local provider boards for local governance and direction in their community and the devolution of authority. We do not include public health. We do not include OHIP, for example. We do not include labs.

Mrs. Patricia Davidson: But you include all the other disciplines, do you?

Mr. Gary Switzer: It's long-term care, the community care access centre, the Meals on Wheels, the Alzheimer Society, and all the small community agencies.

Mrs. Patricia Davidson: What do you see as the biggest challenge with our health human resources? Do you think it's any one thing or do you think it's a whole combination of things? Is it the aging workforce? Perhaps some of us see it as a misuse or an abuse of the existing system. Is there any one thing that is an issue?

Mr. Gary Switzer: In my view, it's the absence of a national plan to address this on a national basis. We're spending close to 50% of our tax dollar in Ontario on the delivery of health care. I consider our health care professionals a national resource. It's 50% percent of our tax dollar. So we should invest in that with a strategy on how to attract them, how to retain them, how to make it easy for professionals to maximize their potential.

In my view, nurse practitioners are just the best new item that came to primary care. We need to do more of that. And let's do it across the country. As I said, this is part of our brand. We should be proud of this.

Mrs. Patricia Davidson: How many patients would a doctor typically see in a community health centre as compared to a private office setting? Is it comparable?

Mr. Gary Switzer: No. I can defer that to Jack, seeing that he runs a CHC.

Mr. Jack McCarthy: It varies. There's a high degree of variability. We just completed a study with the University of Ottawa looking at panel sizes of physicians and a benchmark—I don't know if I can be saying this yet, but I'll go ahead—in terms of looking at 1,200 patients per physician at a CHC.

Again, there is a high degree of variability. This is a benchmark that we're in discussions with in terms of all the different CHCs. It could be higher in a rural setting. This is more an urban figure. Based on this more recent assessment of panel sizes of physicians in CHCs, this is the figure that is being talked about as—

● (1620)

Mrs. Patricia Davidson: How does that compare to a private office setting?

Mr. Jack McCarthy: It would be less. John may know the panel sizes for doctors. I'm not exactly sure of the comparable models.

Dr. John Maxted: The average family doctor across the country has about 1,200 to 1,500 patients per practice.

Coming back to the models, there's a very nice model very close to your own city here in Ottawa where they set up a primary care team. They have six to eight family doctors, but they also have a number of other professionals. They have the electronic means of sharing information and managing the patients there, and right now, over the last year or so, they've been putting ads in their local papers to take on an extra 250 patients every six to eight weeks. This is the result of newer technology, more inter-professional care, and more effectiveness and efficiencies within the practice setting itself as a result of model development.

Mrs. Patricia Davidson: We've talked about the CHCs for health care as family physicians and so on, but what does this do for the acute care system? Does it free up emergencies?

Gary.

Mr. Gary Switzer: Of our business in our emergency departments, 90% is for non-urgent care. They are visits that could be deferred. It could be a prescription renewal. It could be having access to a nurse to have stitches removed.

By having our CHCs in the community and working closely with the hospitals, we can divert a number of non-urgent cases. Specifically in Essex, in our three CHCs there, we keep open appointments in the morning and the afternoon so that when patients present in the emergency room, if they are CTAS V, which is the least urgent, they are rerouted immediately. They are connected and go over to the CHC for a real-time appointment.

The other benefit of our CHCs is that they have a direct connection to orphaned patients who are discharged from hospitals, those patients who do not have a family physician. There's a strong tie to our CHCs, where they'll accept orphaned patients. They bring them in and assign them to a family physician and a nurse practitioner. That is a very strong element in reducing the impact on emergency departments, which allows for increased flow and better access to acute care.

Mrs. Patricia Davidson: Right. Thank you.

Mr. Jack McCarthy: Might I add a quick point to that? With the recent H1N1 outbreak in the city of Ottawa, when there was a huge surge at all the emergencies, the CHEO, Children's Hospital of Eastern Ontario, with usually 150 emergency visits a day, went to 350, resulting in having to cancel out-patient clinics, having to cancel surgeries and so forth. We activated flu assessment centres, which were the CHCs and a couple of other sites, and within five to six working days we saw those levels in emergency departments start to drop. This is to show there's good collaboration between primary care settings, like CHCs, and the hospital settings in terms of managing some emergency volumes.

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

You are certainly speaking of something near and dear to my heart. I believe that every Canadian should have access to a family physician who is supported by a comprehensive team or a nurse practitioner.

I have two comments. One is that I have real concern that what we have right now is a sort of scattering of models, and I think in some ways where we have effective teams—I'll use integrated health networks in British Columbia—you have people who are attached to a physician in those settings where you could, perhaps, see a respiratory therapist within a few days for a spirometry versus having to wait six months for the regular system. So until we fully flip into a model that works in each province, we have really created some real inequities. I guess that is a concern.

I don't know if anyone has any comments on that.

Dr. John Maxted: I have a comment I could make, and that is to point to some of the research that's coming out right now on the medical home. The college recently released a paper on the Canadian medical home and tried to define what its pillars are and what its foundation is, etc. The concept has really caught on in the United States, where, if I may, the primary care system tends to be in more disarray than it is here in Canada, and therefore, of course, it tends to be appealing.

But what is appealing about the medical home is to actually refer to those basic requirements that each primary care model should have. I really don't care what they want to call it in each of the jurisdictions. If we put some emphasis on what the basic elements are that each of those models need to have, then we will be creating models, regardless of what they are called, that will actually supply the needs of the population, as defined by the population they are serving.

● (1625)

The Chair: Thank you, Ms. McLeod. I really appreciate your questions.

I want to thank the witnesses very much for coming here today. All of your insightful comments are very useful to our committee.

I have a couple of questions to ask the committee quickly before we go into our next segment, so I will thank you, and we'll now go into our other part of the meeting for a couple of minutes. I'll give you a minute to depart.

Thank you.

Committee members, we're going into the H1N1 issue very shortly and we also have Dr. Bennett's motion. Because bells are ringing at 5:30, I want to ask the committee, when do you want to deal with this motion? What time should we adjourn to deal with that motion?

Hon. Carolyn Bennett (St. Paul's, Lib.): I understand that it's much easier for Dr. Butler-Jones to come here at 4:30. As long as we have an agreement in the committee that with votes or whatever we'll make sure there is adequate time for us to do our work as a committee....

I have sent to the clerk a number of names of witnesses who I think would be prepared to make some commentary or enlighten us in terms of how things are going on the ground.

[*Translation*]

In the province of Québec, in particular, there are Drs Massé, Lessard and Poirier.

[*English*]

There's also Dr. Isaac Sobol in Nunavut, who has his already done.

Also, there are some of the local medical officers of health.

In B.C., there's Dr. Perry Kendall, who gave excellent testimony in the summer. We'd like to see how things are going there.

Obviously there's Dr. Daly from Vancouver, who is worrying desperately about the effect on the upcoming Olympics. We don't know whether—

The Chair: Of course. Do you want to do that today or Monday? What should we do, then? We have a lot to discuss.

Hon. Carolyn Bennett: It would be a matter of the clerk and the researchers sorting out whether we use the full meeting next week for H1N1 or the week after that. I'm sure they're not all available on the same day, but I think we should hear from a number of these people, as well as the officials, between now and Christmas to see how things are going. I think it was the agreement of the committee that we would hear from people as we needed in order to do our job.

The Chair: Dr. Bennett, I'm assuming that you're withdrawing your motion, because you've agreed that if the briefings are held from 4:30 to 5:30, it's fine. So is the motion withdrawn, then? Okay. That's great.

Now, I want to make you aware that we have some new things. I would like the clerk to quickly speak to this. We have some of the other issues that you brought up and we do have a time squeeze between now and the break. I'll let the clerk explain that to you.

The Clerk of the Committee (Ms. Christine Holke David): The minister is available on December 7 from 3:30 to 4:30 on supplementary estimates (B). Her officials will be staying for the full two hours. That means the December 7 meeting will no longer be the drafting of the two draft reports: HHR and sodium. We need to discuss this with the researchers to see when we are going to slate that in. It's important.

I also want to advise the committee that Bernard Michel Prigent is available to appear before the committee on Monday, November 30, from 4:30 to 5:30. During the first hour of November 30, we will have the Auditor General as agreed.

I will be distributing an updated calendar to the members throughout this next portion, but I would like the researcher to also address the issue of the draft reports.

● (1630)

Hon. Carolyn Bennett: First, could you explain about the estimates and December 7? Is it by the end of the day? If we wanted to make a change to the estimates, what would happen? Are they not deemed reported by December 7?

The Clerk: At this point in time, yes, but the last supply date hasn't been determined yet; that's my understanding. So it's still an iffy date, to tell you the truth. December 7, at this point, is the last date to report the supplementary estimates (B), but that might change. We are going to find that out, I was told today, sometime next week.

The Chair: Could I have the analyst talk about the reports quickly while we're doing this?

Ms. Karin Phillips (Committee Researcher): What I was going to suggest, since we can no longer consider the reports on December 7—and I still have to confirm this with my colleague—is that we discuss the sodium report on December 2 instead of having an HHR panel on labour mobility, and then we look at the HHR report on the 9th.

The Chair: This is the schedule we have to—

Ms. Karin Phillips: But I have to confirm this with my colleague, in terms of translation dates and making sure that everybody has the report on time to consider.

The Chair: Having said that, this is how the schedule can unfold. Because Dr. Bennett has withdrawn her motion, I'll set some time for business. You'll have some time to think about this and run it over in your minds. And I'll set maybe 15 or 20 minutes for business on Monday so we can continue to discuss anything without taking away from the reports right now.

Is that agreed, everybody?

Some hon. members: Agreed.

Hon. Carolyn Bennett: Wait a second. I would suggest that is the very important, ever-anticipated meeting on isotopes. I am not sure we want time taken away from that, but if the clerk and the researchers can come forward with a plan that we could quickly adopt, that's different from actually having a full debate. We've been waiting to hear about isotopes for a very long time.

The Chair: That would be better, because we have planned the isotopes.

We'll continue on, then, as we have pre-planned, unless Ms. Davidson has something.

Mrs. Patricia Davidson: I just had a question.

Are we putting forth witnesses, then, to come to the one-hour briefing? Is that what is happening? I heard Dr. Bennett talking about having all these people who she thought wanted to come. I'm sure the rest of us d too.

The Chair: We have a very full schedule. Dr. Bennett has withdrawn her motion, but we could still have that discussion.

Mrs. Patricia Davidson: We haven't decided that yet?

The Chair: No, we haven't decided that.

Is there anything else, Dr. Bennett?

Hon. Carolyn Bennett: I'm sure in all of our ridings there are people who have suggestions or ideas. If any member of the committee had been approached by somebody who would like to appear before the committee, I think it would be appropriate to let the clerk know. Maybe there would be one meeting where we could do H1N1 or have a long meeting or a round table on H1N1. Between now and Christmas, we could do a full Monday morning or we could do a proper round table before we break for the holidays.

The Chair: I'm just going to let the analyst speak to that, because she's been working with this issue. We're just running out of time. We don't have time for this.

Ms. Karin Phillips: Essentially, if we devote an entire meeting to H1N1, then we won't be able to consider the reports. That's the long and short of it. We don't have enough time. We'd have to cancel—

The Chair: We're as tightly scheduled as we possibly can be right now. As Ms. Phillips said, there's just no time.

Ms. McLeod.

Mrs. Cathy McLeod: Madam Chair, we do need 10 or 15 minutes in a future meeting, but I think we also discussed the importance of leaving the full hour. We have our witnesses here, so if we don't have the motion to deal with, could we maybe—

● (1635)

The Chair: That's just what I was about to say before I answered your hand.

I'd like to welcome our guests today.

Dr. Butler-Jones, you're well known to this committee, as is Dr. Gully and Elaine Chatigny.

Can we start with Dr. Butler-Jones?

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

[*Translation*]

I am very pleased to be providing you with a brief update on the situation regarding the influenza A (H1N1) virus.

[*English*]

We're now well into the second wave of this pandemic, seeing increases on all fronts. As of yesterday, a total of 198 deaths were reported. In the week ending November 7, the number of reported hospitalizations in one week is close to what we saw in the whole of the first wave. There was a large number of admissions to intensive care units, 136 in one week, compared with a total of 289 over the 18 weeks of the first wave.

These are sharp increases, but fortunately—or unfortunately—they're what we might expect at this point during the pandemic. It's important to recognize that if not for the efforts at all levels to ensure effective prevention and appropriate treatment, the number would be much higher.

Provinces and territories are also well into their vaccination campaigns and are reporting steady progress. For example, Nunavut announced today that they have now immunized about 60% of their population.

[*Translation*]

There have been several new and important elements from the viewpoint of the federal government since my last update to the Committee.

[*English*]

These include approval of unadjuvanted vaccine, freeing up 1.8 million doses; distribution of additional unadjuvanted vaccine ordered from CSL, our Australian supplier; and continuing distribution of adjuvanted vaccine to provinces and territories.

Since our last update, we have also seen that the vaccine is providing remarkably high immune response in those receiving it. The response is in the range of mid- to high 90%. Normally seasonal flu vaccines provide effective antibody levels in the range of 60% to 80%.

Further, since clinics opened, the Public Health Agency of Canada and Health Canada, with the collaboration of provinces and territories, the Canadian Paediatric Society, and a network of researchers, have been actively monitoring serious adverse events following immunization with the vaccine. This surveillance began once the campaign began.

The most frequent reported events are minor and include nausea, dizziness, headache, fever, and soreness at the injection site.

There were several reports of allergic reactions. These have onset mostly within minutes of the immunization and have been treated promptly by medical personnel.

Serious adverse events are reactions that could cause life-threatening illness, hospitalization, disability, or death, such as a severe allergic reaction. Amongst the first 6.6 million doses that were distributed, there have been only 36 serious adverse events reported. These included reports of febrile seizures, a seizure brought on by high fever, and anaphylaxis. Anaphylaxis is a severe allergic reaction.

[*Translation*]

We take seriously all of the serious adverse event reports, which all trigger an investigation.

[*English*]

It should be noted that these are rare. The rate of serious adverse events following immunization in any campaign is about one for every 100,000 doses distributed. It's important to remember that even though a medical event follows vaccination, it may not have been caused by the vaccine itself. It may have been caused by other factors, such as a pre-existing medical condition.

By the end of this week, 10.4 million doses will have been distributed across the country. As we stated at yesterday's news conference, this is enough to immunize close to one-third of Canada's population. To put it in perspective, this is close to the volume we deliver in a whole regular flu year, and we're only a few weeks in. Our supplier is continuing to ensure that there is much more vaccine coming every week.

Our goals have not changed—namely, to reduce the overall impact of a pandemic—and we remain on track to have enough vaccine available for every Canadian who wants it by the end of December. This puts us in one of the best positions in the world. However, we cannot be complacent. Pandemics are unpredictable. Like any flu season, changes to our approach are necessary as we receive new evidence about the virus and its behaviour. Thanks to our experiences in dealing with outbreaks and our years of comprehensive pandemic planning, we are better able to adapt to these new challenges as they arise.

● (1640)

[*Translation*]

And if Canadians continue to get vaccinated as they are doing now, as a country, we will avoid a lot of infections.

[*English*]

We have a great deal of work ahead of us still on all fronts. Paramount in our efforts is the push for vaccination.

I look forward to providing further updates as we move forward.

Thank you.

The Chair: Thank you.

Dr. Gully, you're up next.

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

As Dr. Butler-Jones has said, we're still seeing widespread influenza activity across Canada. And the experience among first nations, as we know it, is a reflection of that. This means that we will see some severe illness, hospitalizations, and deaths in first nations and among other aboriginal people. We will continue to monitor activity in the community nursing stations to watch for issues on which we have to provide extra advice.

On immunization, we're finding that the rollout of H1N1 vaccine on reserves has been well planned, well managed, and well received by the communities. During the first three weeks of immunization, approximately 93% of first nations communities held immunization clinics. In fact, probably all those communities that have a significant number of individuals have been covered. There are some very small communities and also some communities that are seasonal. It's important to note, though, that 100% of remote and isolated first nations communities have in fact launched immunization.

Over 162,000 doses of H1N1 vaccine have been administered on-reserve. To this point, approximately 40% of on-reserve first nations populations have been immunized. However, that does not take into account the fact that we do not have the most up-to-date information from two large provinces. Therefore, that is an underestimate. For those regions for which we have up-to-date information and are confident about it, the coverage rate ranges from 55% to 85%.

There have been some challenges, as one might expect. As per other communities across the country, there has been some slowing down of the vaccine rollout. But as Dr. Butler-Jones said, that will continue to be dealt with. Health Canada is helping the affected communities readjust their plans accordingly by rescheduling clinics, adjusting volunteer schedules, and in fact, in some cases, reallocating supplies of vaccine among communities.

Health Canada continues to monitor the vaccine rollout, and the regional offices are monitoring any communities where there are significant challenges with clinics. We expect that the immunization of first nations on reserve will be completed at the same time as, if not before, the rest of Canada.

I'd like to update you now on the virtual summit, which was held November 10. It was shown live over the Internet and was co-hosted by the Minister of Health and the national chief of the Assembly of First Nations. This was a live webcast provided to first nations and other partners across the country. It provided a comprehensive overview of first nations pandemic preparedness and response.

There was a panel that led the discussion that included Dr. Kim Barker, from the Assembly of First Nations; Dr. David Butler-Jones; Gina Wilson, who is the senior assistant deputy minister for INAC; and me. Initial feedback indicates that it was a success and certainly achieved the goal of delivering important information on H1N1 to first nations communities.

There were over 1,000 unique log-ins during the roughly two-hour webcast, but it is difficult to estimate the total number of individuals it reached, as quite likely there were a number of individuals at each site. The recording of the webcast will be up on the AFN website until the end of December for anyone who wishes to consult it.

● (1645)

The virtual summit fulfills a key commitment under the joint communications protocol of the AFN, INAC, and Health Canada and was an excellent example of collaboration among the parties. In particular, the use of modern communication tools ensured that the summit was relevant to first nations youth. Members of the AFN National Youth Council were involved in the summit through pre-recorded video segments. They expressed their thoughts and concerns and posed youth-focused questions that were put to and responded to by the expert panel.

Thank you very much.

The Chair: Thank you.

We'll go into our first round.

Dr. Bennett.

Hon. Carolyn Bennett: Thanks very much.

The first question would be for Dr. Butler-Jones.

Obviously we all have concerns about the healthy people with no pre-existing conditions who have succumbed to this illness. Have you seen any pattern? Did they wait too late to seek attention? Did they not get their Tamiflu in time? What have we learned from that and what could we do?

There was a CBC piece this afternoon about an older gentleman who died in Gander who did have pre-existing conditions and had been sent away from the hospital. He'd been given a Tamiflu prescription but he didn't get it filled until 24 hours later.

What have you learned? What could we do differently in terms of changing this?

Dr. David Butler-Jones: A couple of things are relevant, and we have seen a change since the spring. The pattern of illness is one that is seen in pandemics, that middle group of previously healthy. For whatever reasons, their immune system is not able to cope, or they develop a complication like myocarditis or something like that, which leads to arrhythmia and death. It is unpredictable, but what we have seen, certainly in the ICU review, is that for those who present late, those who are initially getting well and get sicker, we recognize that this is an important sign that you may either have a secondary infection or something is happening that's different. If you have severe illness or shortness of breath—as you have seen through the summer, our messaging has been pretty clear about the importance—if you have these signs or a more severe disease, get medical treatment as soon as possible.

We have seen a change. For example, in the spring we saw a number of pregnant women in ICUs. We're just not seeing that anymore. Unfortunately, we've now had around 200 deaths. But when we look back, if we'd seen the patterns...if we hadn't got the antivirals out there in communities, if we hadn't got the work with the ICUs around sharing of best practices, we would be seeing a considerably greater number. So continuing that message even after people are immunized is going to be important.

Finally, the more people who get immunized, the risk of spreading it to someone, who we can't predict will have a severe outcome, is less. Clearly, if people are getting sicker at home, they need to be seen, and the antivirals have proven an effective treatment, and not just if you get them early. Even for those who are going sour, starting antivirals at any point rather than waiting improves your outcome.

Hon. Carolyn Bennett: A lot of us are pleased to see the new brochure that lists the symptoms people should be looking for and the severity indicators, although I still think the language is a little.... I'm not sure if everybody even knows what "indicators" means.

When we were visiting some of the local public health units last week, we saw the need to get these into other languages and then the retranslation back from that language, because particularly if it's just sent to ethnic media that don't have a public health background.... The retranslation is very important to make sure the message has been delivered correctly. I'm still asking whether it is possible to have these kinds of messages on the Public Health Agency of Canada website for local public health to download. It's not a lot, but would it not be possible to have this kind of message in 60 languages on your website so small public health units that only have a small pocket of a certain community could avail themselves of the federal resources?

● (1650)

Dr. David Butler-Jones: I will get Elaine to speak to that.

Ms. Elaine Chatigny (Director General, Communications, Public Health Agency of Canada): The issue of different languages is being looked into. I cannot say right now how many or which ones.

Dr. David Butler-Jones: Having been a local medical officer, I know that is something that we used to do. We would take these and we would adapt them to the population we have. One of the things we found was that national translations were not always useful. We got continuous complaints about things that were done one time nationally—even French—and so we had to constantly adapt them to the local dialects and languages in the communities.

I think having them out there, being able to adapt them, to the extent that we can facilitate that and share that information from those who have done it, obviously we're interested in doing that, so we're looking at that. But it seems to be a practical reality that we faced on the other end, and we ended up doing our own translations.

Hon. Carolyn Bennett: I guess we're still pushing for that to be an option for local public health, but if it was available nationally, particularly just "shortness of breath, rapid breathing or difficulty breathing"—that message seems to be the most important one, that those are not normal symptoms of the flu, and these people need to know that they have to seek medical attention right away.

Kirsty, do you have a question?

Ms. Kirsty Duncan (Etobicoke North, Lib.): First of all, thank you all for coming. We're grateful.

Dr. Butler-Jones, I want to personally thank you for your time you gave me last week.

I'm wondering if you can provide a breakdown, by province, not in terms of what's been distributed but whether we actually know how many people have been vaccinated, how many of our provinces have begun vaccinating children and teenagers, and when all provinces will be vaccinating the general population.

Dr. David Butler-Jones: It does vary a bit by jurisdiction. Essentially what the provinces have told us is that between seven and ten days following receipt of vaccine they're able to distribute it and immunize people. We have seen some reductions in people seeking vaccine, so as they've gotten through their higher-risk groups they've now opened it up. Ontario announced today, for example, and others as well.

It does vary by jurisdiction, and it is something that the provinces do share with us. But because it's very quickly moving, it is important that people do listen to their provincial or territorial medical officer. In the case of the territories, they're essentially done their immunization, so I could probably just say provincial.

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

We'll now go to Monsieur Malo.

[*Translation*]

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

Thank you to our witnesses.

I have four questions; I hope I will have enough time to put all of them to you. I will be very brief, in order for you to have the opportunity to answer them.

At the present time, we have 1.8 million doses of non-adjuvanted vaccine intended for pregnant women. Dr. Grondin was telling us last week that there was too much vaccine for this population group and therefore that other people would be able to receive the non-adjuvanted vaccine doses not needed for pregnant women.

Given the shortage that was announced approximately two weeks or more ago, the supplier having had to shift its production from the adjuvanted to the non-adjuvanted vaccine, and given also that we had ordered 200,000 doses of non-adjuvanted vaccine from Australia — which is probably sufficient to vaccinate pregnant women, of whom there are about 200,000 —, I am simply wondering why, when you saw that you had enough vaccine for pregnant women, you did not ask the supplier to concentrate production on the adjuvanted vaccine, with the option of producing non-adjuvanted doses later on if supply was lacking.

● (1655)

[*English*]

Dr. David Butler-Jones: Thank you.

[*Translation*]

The production in Canada of non-adjuvanted vaccine was done in October. Before that, we had approached CSL Australia because during the summer it had been impossible to obtain non-adjuvanted vaccine from the manufacturers. They were all engaged in commitments made to other countries, and the only option for Canada was to obtain the non-adjuvanted vaccine from GlaxoSmithKline. In our case, this is a major advantage that most countries do not have. CSL Australia was able to supply the vaccine because its vaccination season is over down there. We had the option of buying vaccine once the season there had passed.

The non-adjuvanted vaccine was produced in October by GSK, after which four to six weeks were required to test the formulas and the methods in order to ensure the quality of the vaccine. These decisions were made a long time ago.

Mr. Luc Malo: On November 7, we learned that the premiers of the provinces were asking the federal government for more timely information regarding the distribution of the vaccine.

Could you tell me how the agency responded to this important request from the provinces, that must ensure proper planning of deployment?

Dr. David Butler-Jones: It is not possible to ensure the total number of doses. There is the preparation, the quality assurance process, etc., but every time we have information, we relay it to the provinces. Every week, we have the list of the doses intended for each of the provinces and territories for the following week. The information is produced at the same time for the provinces and for us.

Mr. Luc Malo: You say that you are unable to better plan with regard to that aspect. Why is that?

Dr. David Butler-Jones: Everything is carried out in real time: the production of the vaccine, its distribution, the quality assurance. Everything begins at the same time. Even if there were a few months of preparation before the pandemic and if the vaccine was prepared last year, it is very important, now, that all of the doses be supplied to the provinces when they are ready. However, the number changes as soon as the preparation work is done.

Mr. Luc Malo: Mr. Butler-Jones, in some regions, there is a shortage of vaccine, whereas in others, the vaccine has expired and must be thrown out. Could you explain how such a situation was able to come about?

Dr. David Butler-Jones: The provinces determine which regions will need the vaccine. These predictions are perhaps based on population numbers. From time to time, the level of interest of the population in the vaccine may vary from region to region within the province. The distribution or the prediction of the people's interest in the vaccine might be the root of the problem. Then, the provinces redistribute the vaccine to others. This vaccination campaign is voluntary. We are able to predict most of the challenges, but not all of them.

Mr. Luc Malo: One person died after having received the vaccine. Obviously, an investigation is underway in order to determine the exact circumstances involved. However, we know that this individual was 80 years old. From what I understand, the vaccine was to be given on a priority basis to people under the age of 65.

Could an older person have been placed on the priority list?

● (1700)

Dr. David Butler-Jones: That depends on the region and on the province. At present, the risks for the entire population have gone down and access to vaccination is better. With regard to this death, it is very important to understand the difference between the risk of infection and the mortality risk. The risk of infection is a concern for young people, whereas the mortality risk is greater for the elderly, just like in the case of the seasonal flu. These people become less often infected, but if they suffer from a chronic ailment, the risk of sickness and of death becomes much higher.

Mr. Luc Malo: I understood, based on what you stated, that the incidence of anaphylactic shock and of death were exactly those set out in the models, or even lower. Is that the case?

Dr. David Butler-Jones: Generally speaking, yes, but we are at the stage where we are observing reactions and gathering statistics. More than 6 million doses are in the system and are being used to evaluate reactions. There might be others. The reactions that have however thus far been observed resemble the common reactions we see with the regular seasonal flu vaccines.

Mr. Luc Malo: Has the Tamiflu supply issue been resolved? Will there be doses for children, adults, etc.?

Dr. David Butler-Jones: Yes, there is a lot of Tamiflu for the population. In the southern part of the country, pharmacists have the ability to prepare doses for small children using adult doses. In the northern part of the country, there is not always a pharmacy, because of the remoteness of certain areas. This is why we must supply these regions with doses for children.

[*English*]

The Chair: Thank you.

I'll now go to Mrs. Hughes.

Mrs. Carol Hughes: I thank you for being here. I'm sure it's been quite hectic for you.

I want to ask about some of the things you've mentioned. Did you say that the territorial communities are done?

Dr. David Butler-Jones: Pretty much.

Mrs. Carol Hughes: Is that because they managed to get all the vaccine they needed? I'm trying to get some sense of this. It's not the same story throughout the country.

Dr. David Butler-Jones: Remote communities are a high priority because of access to treatment. The decision was made, in cooperation with the provinces and territories, that we would provide in the first tranche sufficient vaccine for all of the territories. Most of the people in the territories live in remote communities. Our people would be able to fly into a community, do a whole community, and then move on to the next. They were provided with a small number of total doses, and they have now largely completed their programs.

Mrs. Carol Hughes: You're saying there's still a small percentage that's not done.

Dr. David Butler-Jones: Yes, but they're pretty close to being finished in all three territories.

Mrs. Carol Hughes: Is that because of a lack of vaccine?

Dr. David Butler-Jones: No, they have sufficient vaccine. It's a matter of how they rolled it out. I think they've been to all the small centres, but in the larger centres they're still hoping to finish off.

For example, in Nunavut 60% of the population has been immunized. But there's still a percentage of the population, if they're willing to come forward, in Iqaluit or wherever, who we would want to immunize. In that sense, there could still be immunization going on, but the mass campaign, the initial campaign, is essentially completed.

Mrs. Carol Hughes: Are you also encouraging people who have already had the H1N1 to get the vaccine, or should they not bother?

Dr. David Butler-Jones: People who have confirmed H1, people who have a lab test saying they had the H1 virus, do not need the vaccine. But if you had a flu-like symptom in the spring, you can't be sure it was H1, because many other viruses were circulating at the time. In these cases it's a good idea to get the vaccine, because if you didn't have H1 last spring, you would not be protected.

● (1705)

Mrs. Carol Hughes: We saw some of the cases with the allergies. We don't know whether it's safe for everybody. I'm not trying to deter people from getting it; I'm just saying that there are exceptions.

Dr. David Butler-Jones: If you don't know if you are immune, the risk of the vaccine is tiny, less than if you were to get the flu.

Mrs. Carol Hughes: You said that there were probably underlying circumstances for the people who have had reactions. Do you know what some of those underlying circumstances are? How could people prepare for this?

Dr. David Butler-Jones: In respect of the vaccine, I might have been talking about the question of severe illness as opposed to reactions to the vaccine. As for allergic reactions, we see this with all medications and all vaccines. Fortunately, it tends to appear in less than one in 100,000 doses. Some people know they have an allergy to thimerosal or to one of the constituents of the vaccine. But since we're doing a mass immunization campaign, immunizing people who normally don't get a flu vaccine, there will be a percentage who may be allergic to what's in the vaccine.

The numbers are similar to what we see in seasonal flu, for which people are immunized regularly. But you won't know until it happens. That's why it's important to stay behind for 15 minutes. If you have symptoms, make sure you tell the nurse, because prompt treatment will deal with it. Clearly, if an elderly person has a severe allergic reaction, it's more difficult because of their physical condition, but generally they're all managed well.

Mrs. Carol Hughes: We're looking at headlines such as this one, which says, “Quebec drug manufacturer falling behind demand”. Based on the government's own numbers and its failure to ensure a regular supply, we now see that the vaccination program will be going well past Christmas. It will go until February, from what we can see.

What are you seeing as the difficulties that are holding the company up? We're not yet even close to the three million per week that were promised, and at one point we were down to 500,000. This week there have been two million.

Dr. David Butler-Jones: Part of it was the switch to the unadjuvanted vaccine. Every manufacturer around the world has had challenges in producing this vaccine as quickly as they anticipated. Canada actually has the most stable secure supply in the world at the moment. That is actually a huge advantage to Canada.

We've already immunized, as far as we can tell, as many as or more than any other population in the world as a percentage of population. We are anticipating that 75% of the population will be immunized, and we should be able to do that. Those have always been our planning assumptions. That should be done by Christmas or, at the very latest, by the end of the year.

If we find that more people wish to be immunized, that's a huge bonus, and we will continue to immunize people as long as they wish to be immunized, but we expect that anybody who wishes it will be able to be immunized by the end of the year. My hope is that it will be before Christmas.

Mrs. Carol Hughes: You're still saying before Christmas, but based on the numbers, it would appear that it's not going to happen until February.

Dr. David Butler-Jones: We will be seeing the numbers increase very quickly, very rapidly.

Mrs. Carol Hughes: You made a comment with regard to the reduction in the number of people seeking the vaccine. Are you attributing that at all to the chaos that's been out there?

I know that especially in the Sudbury area they've managed to buffer it, in a sense, by opening clinics that will just deal with flu symptoms. That has been great for the hospitals, but I was just trying to get some sense of it, because the health unit was still advertising this weekend that all the clinics were cancelled because they had a lack of vaccine again.

With regard to the reduction in people seeking the vaccine, is it your view that the number may increase because people are still having a hard time getting the vaccine?

Dr. David Butler-Jones: I think more and more people will be seeking vaccine. I think people have become quite respectful of the risk categories and are therefore waiting their turn. I've talked to many people. They come up to me and say, “I'm going to get the vaccine, but I'm going to wait until they say it's safe for me”, etc., so I think people will continue to be immunized. Short-term vaccine availability really relates to the great level of interest in people coming forward and being immunized. As more and more vaccine is available, more and more will be immunized.

I think the efficiency is very impressive. I think the lessons of the first week in terms of the challenges, not in terms of being able to move a lot larger number of people through these clinics sufficiently, have been learned. I had my own shot today, and I was very impressed. I lined up like everybody else, and I was very impressed with how quickly and efficiently they did this today in Ottawa.

● (1710)

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

Now we'll go to Dr. Carrie.

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

I want to thank the witnesses again for being in front of us. We've found the information you've been giving us weekly very helpful in our communications.

Dr. Butler-Jones, in terms of the number of vaccines delivered over a period of weeks, could you compare how the rollout is going this year versus the usual seasonal flu vaccine rollout? You mentioned the efficiency that we're seeing. Can you give us an idea of how it compares to the usual thing we see in Canada every year?

Dr. David Butler-Jones: Certainly.

While we all acknowledge some of the challenges and some of the issues with lineups in the first rush, I have been exceedingly impressed with the efforts by local public health and by provincial and territorial public health to not only learn the lessons from that but also to immunize a mass of people. In the space of three weeks and into the fourth week, we will have immunized essentially the number of people we normally immunize over a whole flu season. This is really unprecedented, and it has required efforts and professionalism at all levels, not just by public health professionals but by other people working in hospitals and the volunteers working with them.

We all would like things to go more smoothly, but in the midst of all of this, given the task they undertook, I must say I have been very impressed.

Mr. Colin Carrie: Well, I've been very impressed too, and I do commend you for your good work and the coordination with the provinces. I really would like to commend our workers on the ground. Some of them have stepped up to the plate, working the long hours to get the job done.

How is this comparing internationally, with different countries and their challenges with their rollouts? Do you have any information or data you could share with us?

Dr. David Butler-Jones: Well, some of it's obvious in the media. There's a lot of close observation of our American cousins, and the Mexicans and Europeans. At the moment I think we and the Swedes are probably fairly close. The Australians, fortunately, are well out of their season, so they'll be preparing for the next season to come. But certainly in terms of percentage of population immunized and going forward, not only have we already immunized as many, if not more, of the population than anywhere else, but as we go forward we actually are one of the very few countries that have the option that anybody in country could eventually be immunized.

Mr. Colin Carrie: What are you finding in the communications and feedback you're getting at the local level? You mentioned how efficient this has been. Are you seeing great cooperation, for example, in tracking the number of illnesses versus the seasonal flu? How well are we tracking the demographics? What's really important—and I know this is really important for you—is research and follow-up, what we're going to learn from this virus.

How would you compare Canada in terms of how we're getting that feedback from the front lines and the hospitals?

Dr. David Butler-Jones: I'll speak for Canada because of the work that we've done.

Each jurisdiction and every country organizes based on what seems to work best for them. But in terms of having the public health network, having the systems and relationships in place for sharing information, for developing plans jointly to actually be able to implement them, the chances that they will be implemented well and effectively are much greater when people actually are part of their development. So having all jurisdictions involved in this, I think, has proven its worth.

Then on the application of it, I think we've seen, as we're getting more and more experience with this virus.... You have to remember that seven or eight months ago nobody had even heard of this or anticipated that today it would be this bug and this pandemic. So there's a level of learning, and we see that translated into.... When you think, even in clinical medicine, of how quickly best practices are being adopted, how quickly people have picked up on what this is and what we need to do, adapting it; and as I've said, the work around preventing pregnant women from becoming seriously ill, with early treatment, with antivirals; the work at developing and getting systems in place for the whole range of things with this....

Anyway, it's going to be really interesting to look back at how we've applied that. But we are getting the information. Again, they're struggling to deal with what they're facing, and as soon as they can, they are sharing the best lessons and the information that we need. That's really key as we go forward, as we get a clearer and clearer picture of what this disease is and what it potentially could do.

● (1715)

Mr. Colin Carrie: Again, I know it's really important for you—the research on the virus, how it's behaving, the best practices. We've learned some things. You mentioned earlier the risk of infection versus the risk of mortality. You talked about seniors, that they may not get infected as often but when they do get the infection, there's a higher risk of mortality.

Is there something you could tell the Canadian public who are listening today about the latest that we've learned about this virus and what we should be looking for in our population?

Dr. David Butler-Jones: There are a couple of things.

One is that the basic character of the virus has not changed. The usual spectrum of illness, plus those, as Dr. Bennett was referring to earlier, who previously, as far as we could tell, were healthy who succumb or get seriously ill with this virus, has not changed. We are seeing larger numbers. As we move in through the second wave, we will see more. Even once we reach the peak, there's still the other half of it. Hopefully what we'll be able to do is truncate or reduce that because of the number of people who are immunized.

In terms of the risk of infection, again, as I said, the very young are at much greater risk of becoming ill with this disease, but their risk of mortality is less. As we're getting more experience, we're starting to see that in, for example, the 40- to 64-year age group, what we saw in the first wave is that for those who were perfectly healthy before, their risk of dying is somewhere between one in 20,000 to one in 100,000 cases, whereas if they have underlying conditions their risk of dying is more in the one per 400 to one in 2,000. Those are not necessarily severe underlying conditions. It could be somebody with well-controlled asthma.

It is something, though, that really does concern us in terms of being able to afford effective treatment and, ultimately, to immunize as many as possible in order to avoid that.

Mr. Colin Carrie: Thank you very much.

The Chair: We will now go to Ms. Duncan.

Ms. Kirsty Duncan: Thank you, Madam Chair.

Dr. Butler-Jones, you said that once the vaccines are distributed, in seven to ten days the provinces use them, but do we actually know the numbers? Is there a tracking system? Can we say that in Ontario versus Alberta there have been this many vaccines?

Dr. David Butler-Jones: They are collecting that information as they go. Again, the focus is on getting people immunized more than the counting. But every single immunization is documented, including the lot numbers, etc., in case there are any issues we're concerned about. We will eventually have those numbers for the country.

As I said, Nunavut announced today that they had covered 60% of their population. We will look to the provinces to identify that as they go, but they have been telling us that they are actually gearing up and, whatever vaccine is available, they will be able to deliver it.

Ms. Kirsty Duncan: I know you said that you're still hoping for 75% of the population to be able to be vaccinated by Christmas. Is that correct?

Dr. David Butler-Jones: The planning assumption has been for 75% of the population to be immunized. I am hoping for more, obviously. We are certainly quite confident that we will have sufficient vaccine to accomplish that before the end of the year.

The Chair: Would you like to add some comments, Dr. Gully?

Dr. Paul Gully: Might I add to that? As I've alluded to, we do have good information in terms of coverage on the first nations communities. What we've learned is that the effort that has to be put into getting the consent form, recording that, collecting that information, which may be by fax to a regional health authority and to the province, and then collecting all that, is actually a huge effort.

Certainly for the larger provinces, it means it will take time to get information on the coverage. I'm sure it will come, but it will take time. We realize that putting needles into people's arms is part of it, but there's a lot more around it as well.

● (1720)

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

One of the things I struggle with, and maybe you can help me, is that delivery has always been the big issue. When we started planning for H1N1, it was actually how do you get the vaccines to as many people in as short a time as possible. There was talk of triage centres, there was talk of doctors, and talk of a combination. I'm wondering what oversight existed to ensure that there would be effective delivery. That is one issue.

The other piece of this is that we are dealing with 1950s technology. I think we know that there could potentially be slowdowns. What was the contingency plan for those slowdowns and how do we change the system going forward?

Dr. David Butler-Jones: It doesn't matter whether it's a big outbreak or a small outbreak; we always review the lessons learned in terms of how things might be done differently another time. Each jurisdiction has its experience, its responsibilities, and its interest in doing this as quickly and as efficiently as possible. They've adapted very quickly to address that.

Ms. Kirsty Duncan: Was there federal oversight there—

Dr. David Butler-Jones: Basically, this is provincial jurisdiction. The federal oversight is to try to coordinate and ensure that people have access to the tools they need and the information they need, that we do have a safe, effective vaccine as quickly as possible, that we have joint stockpiles, that we have plans in place, and that we have all of these things. At the end of the day, we have senior public health professionals in every jurisdiction in this country. We have ministers, we have governments, we have others, and they are quite competent to actually deliver this.

Ms. Kirsty Duncan: Dr. Butler-Jones, I understand that. I was speaking to a group this week, and there was some frustration from the front lines. As everyone here tries to recognize, they're the people doing great work, but they felt that they've done their planning for several years and they planned on the federal government being responsible for the distribution. When there were slowdowns, it was difficult for them.

What is the oversight and what is the contingency plan to help?

Dr. David Butler-Jones: In terms of the slowdown, no manufacturer in the world has produced as much vaccine as quickly as they'd hoped to. Our American cousins, with five manufacturers, have less vaccine per capita than we do, so moving forward—

Ms. Kirsty Duncan: But that comes back to the technology.

Dr. David Butler-Jones: Well, one of the things is that we are using an adjuvant that gives us four doses for one and gives us excellent immunity, including for those who normally do not mount good immunity. This is the next generation of vaccines in terms of influenza.

So in terms of what we can do moving forward to see if there's anything that would be different, we'll obviously be revisiting all of this to see what we can do, as every jurisdiction will be, and as every local health authority will also be examining, and as they already have, because we've seen how they've changed their programs in response to what they saw in the first two weeks of the campaign.

The Chair: Thank you so much.

Now we'll go to Ms. McLeod.

Mrs. Cathy McLeod: Thank you, Madam Chair.

I was quite puzzled, actually, to hear my colleague talk about 1950s technology. To me, it's absolutely astounding that we have a new virus and that we've identified this virus and created an effective vaccine. We've tested that vaccine for safety and we've looked at mass production and distribution. All of this is in only seven short months. So although there perhaps have been challenges along the route, I think we have to be so thankful that our medical system has the capacity and that we have your agency overseeing it.

I think that if you look into the future.... In some of the conversations we had in our earlier sessions, we talked about how perhaps a comprehensive medical electronic health record would help and whether for the medical home there are future opportunities, but I want to congratulate you on the work to date.

I do have two questions. One is for Ms. Chatigny.

You're doing some significant communication activities. Do you have any process whereby you're doing a rolling evaluation in terms of the effectiveness of those activities?

● (1725)

Ms. Elaine Chatigny: Yes. In particular, under the communications policy of the Government of Canada, we have to do evaluations of all of our marketing activities, the major marketing activities, so we do have plans in place to go back into the field and to assess whether or not levels of knowledge and awareness were attained through some of the marketing activities we've undertaken. Of course there may be more to come, and therefore we will be doing this kind of evaluation in the months ahead as well.

Not all of the communication in the entire communications enterprise is formally evaluated. For example, how do you formally evaluate the 46 news conferences that the minister and Dr. Butler-Jones have held, and whether or not their messages were properly captured and disseminated, other than in media analyses or those kinds of evaluation that are not very formal from a methodological perspective?

So we have a mix of means of understanding how the message is being disseminated and how it's being captured. Ultimately, we also do some ongoing assessment of whether or not we're seeing behavioural change as a result of our communications. We do know that we're seeing a greater number of Canadians report a change in their behaviours around handwashing, coughing into their sleeve, and staying home when they're sick. We're seeing progress in that regard. That's in terms of the behaviours and whether or not they noticed our ads and our work.

For example, on the pamphlet you have received today, which was distributed to 10 million households, we know that almost 400,000 Canadians have called Service Canada, 61% as a result of having seen our pamphlet. So we can, through a whole host of means, assess whether or not our messages are being captured, read, understood, and acted upon.

Mrs. Cathy McLeod: Thank you.

On my next question, perhaps you talked about it a little bit earlier and I just didn't quite click into it. It's on the unadjuvanted vaccine, which of course we have more of than we have pregnant women. Is that being distributed and given out to the regular population? What is happening with that?

Dr. David Butler-Jones: Yes, it has been distributed already. What we've fortunately found with the unadjuvanted vaccine is that in those with healthy immune systems—adults with healthy immune systems—it gives a percentage elevation of antibodies in the low nineties, so we have two very effective vaccines in that population.

It's not suitable for seniors, and it's not suitable for kids in terms of not producing a good enough immunity, or for those who are immunocompromised, but for the rest.... So it's now part of the mix, and much of that has already been distributed, other than some reserve to ensure that they do have capacity, should they need it, for additional pregnant women.

Mrs. Cathy McLeod: We certainly are focused on the H1N1. We were also looking at what we call the typical flu. Is that happening right now? I don't know which particular strains you were looking at this year. Are we identifying a normal flu season that could happen?

Dr. David Butler-Jones: Not yet. In influenzas, essentially it is almost all the H1N1 pandemic strain.

This is actually early for regular flu season. Whether we'll see a return of influenza B or the H3N2, it's unlikely we'll see a return of the old seasonal H1. I think that's unlikely. We may not see much in H3N2. I am concerned about B, because usually we see that late in the season and that can be a problem. That is part of the seasonal flu vaccine as well.

We're watching very closely, but at the moment it's basically all H1 all the time, when it comes to influenza. There are other viruses out there, though, that cause colds and flu-like symptoms. They're not as miserable as influenza, but they're out there.

Mrs. Cathy McLeod: Australia went through this before us. Did they have to look at the two coinciding together? How did it play out in Australia this year?

● (1730)

Dr. David Butler-Jones: When we had to make all the decisions about seasonal flu vaccine, etc., most countries in the southern hemisphere were seeing both. But as the season went on, basically H1 crowded out most of the other influenza A, depending on the country. Some countries had both.

What we will see going forward is impossible to predict. Particularly as we protect people against H1, will another seasonal influenza return? Will we see B, as we normally see in the spring? Again, we'll hedge our bets. Fortunately, we have both vaccines.

The Chair: Thank you, Dr. Butler-Jones, Dr. Gully, and Ms. Chatigny. We really appreciate your time at committee. I know you're so busy. Your expertise is reassuring, and your leadership in this has been amazing.

Thank you so much for joining our committee.

Dr. David Butler-Jones: It's always a pleasure. Thank you.

The Chair: The meeting is adjourned.

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